

Prescription Benefits Would Be Received Through Private Plans:

The goal is to modernize the Medicare program by restructuring Medicare to private Insurance Plans. Privatizing Medicare would cause many beneficiaries to lose their choice of doctors. Private plans are costing patients more and more. Out of pocket costs for those in Medicare + Choice nearly doubled from 1999 to 2002. In 1999 the average Medicare beneficiary in a private managed care plan paid \$976 out-of-pocket and in 2002 that amount was \$1,786, an increase of 83%.

Although the bills are said to be traditional fee-for-service Medicare, under both the House and Senate versions, beneficiaries would actually receive benefits through private plans. Two private insurance companies would be selected to provide prescription benefits in each region, which would have great latitude over establishing the amount of premiums, the benefit structure and where beneficiaries would go to receive prescription drugs. Prescription Drug benefits is not a guaranteed benefit.

Private plans are not available in every part of the country, and vary considerably from state to state. According to a report published by Families USA, 80.2% of rural Medicare beneficiaries (9.3 million) live in counties that currently have no private plan, and many others live in rural areas where only one private plan exists.

Under the House plan if no drug benefit only private plan enters the market there is no requirement for a government “fall-back” to provide the benefit. An individual is considered to have access to coverage as long as a private HMO or PPO is offering a drug benefit as part of their package.

Because the benefits in both the House and Senate proposals are based on private plans, there is considerable leeway given to the insurer in the premium, formularies they establish. Private plans only have to guarantee two years of coverage and after that are free to drop coverage, leaving beneficiaries scrambling to obtain coverage elsewhere.

The House plan requires traditional fee-for-service providers to competitively bid for Medicare patients in 2010. Premiums for sicker, older individuals who remain in fee-for-service will increase significantly. The plan sets up competition between these private plans and the traditional, government-run Medicare system, beginning in 2010. Premiums would depend on how much each plan and how much the government spends on care.

The Senate plan creates an experimental program in 2009 that sets payments to PPOs through competitive bidding.

While both the House and Senate plans include a proposed “average” premium of \$35, in actuality private insurers could set the premium at whatever price they determine, as long as the benefit meets an “actuarial value” of a standard coverage plan. Currently HMO premiums for existing drug benefits range from \$99 to \$16.

Main Drug Benefit:

Neither the House or Senate prescription drug plans are as generous as seniors might be expecting.

Beginning in 2006, drugs would be subsidized for all Medicare beneficiaries who sign up for a stand-alone drug plan or who join a private health plan that offers drug coverage.

Premium:

House and Senate: Estimated at \$35 per month, or \$420 per year. Both plans waive or subsidize the premium for lower-income seniors, though Senate bill is more generous.

Deductible:

Senate: Individual must spend \$275 out-of-pocket before benefits start.

House: Individual must spend \$250 out-of-pocket before benefits start.

Coverage:

Senate: Insurance pays 50 percent of drug costs from \$276 to \$4,500.

House: Insurance pays 80 percent of drug costs from \$251 to \$2,000.

Coverage gap (Donut hole):

Senate: No coverage for drug costs between \$4,501 and \$5,800.

House: No coverage for drug costs between \$2,001 and \$4,900.

Catastrophic coverage:

Senate: When out-of-pocket spending reaches \$5,801, then 90 percent of drugs are covered.

House: When out-of-pocket spending reaches \$4,901, then 100 percent of drugs are covered

Employers would likely reduce retiree prescription drug benefits and current retirees could lose employer-based coverage, which in some cases is considerably better than the current House and Senate plans. The Congressional budget office estimates that from 35-37% of beneficiaries currently receiving prescription drug coverage through employers could lose that coverage. The employers payment for prescription drugs would not count toward the out-of-pocket spending.

Lack Of Universal Coverage:

Currently all Medicare enrollees, regardless of income, are eligible for all the benefits the program offers. Both the House and Senate proposals would change that.

The Senate proposal excludes individuals who are “dually eligible” from receiving the new Medicare prescription drug benefit. State Medicaid programs, which differ considerably in coverage and benefit, would be responsible for providing drug coverage, an optional Medicaid benefit, to low income Medicare beneficiaries eligible for Medicaid.

Means testing. The House proposal includes a provision whereby the benefit for catastrophic coverage is based on an individual’s income, creating a dangerous precedent that puts at risk the universality of Medicare as a defined benefit for all eligible individuals.

Impact on higher-income beneficiaries:

House: Individuals with incomes greater than \$60,000 (and couples with income greater than \$120,000) would have to spend more on drugs before the catastrophic coverage begins. This out-of-pocket amount increases on a

sliding scale; people whose annual income is \$200,000 would have to spend \$12,000 a year before coverage occurs.

Lack Of Meaningful Cost Controls:

Both bills side step the critical issue of making prescription drugs more affordable to seniors and people with disabilities.

Neither the House nor the Senate plan includes any comprehensive provisions to hold down the prices of prescription drugs. The House Bill prohibits Medicare from negotiating prices.

Although both plans include provisions to try to make lower-price generic drugs more available, the Senate measure would allow the reimportation of medicines back from Canada subject to the Administration's approval.

Both the Senate and House Bill speeds generic drugs to the market by limiting ability of pharmaceutical companies to block cheaper equivalents.

The Senate and House would allow individuals, pharmacists and wholesalers to import U.S. made drugs from Canada, where they are sold for less because of the Canadian government's price controls. Both bills require the Department of Health and Human Services to certify that the imports would be safe and would save money, something HHS has declined to do. The House says it included additional guidance for HHS that could get the agency to change its mind.

Part B Deductible Would Increase:

Senate: Increases the annual deductible for Part B -- which covers doctors and out-of-hospital care -- from \$100 to \$125 in 2006, and allows for increases every year after that with inflation.

House: Increases Part B deductible in 2004 to about \$106 and allows it to rise each year as Medicare costs rise.

Interim Drug Card:

House: In 2004 and 2005, all seniors would be offered a drug card that will give some savings on prescriptions. All seniors who do not have drug coverage would have \$100 credited to their cards, people with incomes near poverty level would have \$500 credited and people with the lowest incomes would be credited with \$800. Seniors and others could make additional contributions to the cards. The program would operate for only two years.

Senate: In 2004 and 2005, all seniors would get discount cards, with \$600 credited to low-income seniors' cards.

Rural Health:

Senate: Would spend about \$25 billion to increase payments to hospitals and physicians in rural areas, and others. Many of these increases would take effect in 2005.

House: Would spend about \$28 billion to increase payments to those in rural areas, beginning in 2004.

New Benefits:

House: Medicare would cover an initial doctor's visit and blood lipid screening. There would be no deductible for colorectal cancer screening. Payments to doctors administering mammograms would increase.

Senate: No similar provision

How The U.S. Congressmen From Baltimore County Voted on the Bills

Senators

Paul S. Sarbanes – NO

Barbara A. Mikulski – YES

Representatives

1st District, Representative Wayne T. Gilchrest (R) - YES

2nd District, Representative C.A. (Dutch) Ruppberger (D) – NO

3rd District, Representative Benjamin L. Cardin (D) - NO

7th District, Representative Elijah Cummings (D) - NO

8th District, Representative Roscoe G. Bartlett (R) - YES

The differences in the House and Senate the bills will be resolved in conference.

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Some information provided by: Center for Aging Policy, and n4a.