MEDICARE

Perhaps as at no time in its almost 40 years of existence, the Medicare program is at the center of a public debate. The enactment of a major new law in 2003, adding a prescription drug benefit and partly reshaping the way Medicare operates, has only intensified it.

KEYFACTS

- In 2003, Medicare covered 41 million people, including 35 million Americans age 65 and older and 6 million people under age 65 with disabilities or end-stage renal disease (ESRD). Spending totaled $280.8 billion, or 2.6 percent of gross domestic product.[a]
- The proportion of people over 65 is projected to nearly double to 70 million in the next 25 years. Today, seniors account for about one-third of all health care dollars spent in the U.S. — over $300 billion annually.[b]
- Medicare Part A (Hospital Insurance) covers inpatient hospital care, care in skilled nursing facilities, hospice care and some home health care. It is funded mainly through a payroll tax paid by employees and employers (1.45 percent each).[c]
- Medicare Part B (Supplementary Medical Insurance) covers physician and outpatient hospital care, lab tests, medical supplies, and most home health care. It is financed by a combination of beneficiary-paid premiums (25 percent of the total) and general federal revenues (75 percent).
- Medicare's trustees estimate that the Part A Trust Fund will be exhausted by the year 2019, unless changes are made to eligibility, benefits or financing.[d] The Part B Trust Fund cannot become insolvent because by law it can draw on the Treasury for whatever amounts are needed to pay Part B expenses.
- In 2000, elderly Medicare beneficiaries spent more than one-fifth of their incomes (22 percent) on out-of-pocket health care spending, a figure expected to grow to 30 percent by 2025.[e] Medicare pays only 53 percent of beneficiaries' total health care expenses.[f]
- About 7 million Medicare beneficiaries in 2002 had incomes low enough to qualify for help from Medicaid — the "dual eligibles."[g]
- The federal government will spend anywhere from $395 billion to $534 billion over the next 10 years to subsidize prescription drug coverage for Medicare beneficiaries.[h]

For key fact sources, see endnotes.

Medicare is among the most popular and most expensive programs run by the federal government, and has a significant impact on the U.S. health care system itself. With the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (known within the government as MMA), Medicare is expected to grow in prominence and expense in the years ahead.

About 41 million people — one in seven Americans — received Medicare assistance with their health care bills in 2003, at a cost of $280.8 billion.[1] Medicare accounts for nearly one-fifth (19 percent) of the nation's total health spending and comprises one-eighth (13 percent) of the federal budget.[2]

About 35 million Americans are eligible for Medicare because they are 65 years of age or older, and have paid payroll taxes for at least 40 quarters. Those 65 and older who have not paid the Medicare tax for a full 40 quarters can still enroll by paying an extra premium. Another six million beneficiaries are individuals with disabilities who have received Social Security cash disability payments for at least two years, or who have end-stage renal disease (ESRD), a condition requiring dialysis. (See Box, "Numbers of Beneficiaries By Age and Disability Status, 2003.")

Medicare is administered by the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, within the Department of Health and Human Services.

The Congressional Budget Office (CBO) projects that Medicare spending will grow by an average of 9 percent annually between 2004 and 2014.[3] It is the fastest growing of all federal benefits programs and will continue to grow rapidly, fueled not only by rising health care costs and benefit improvements, but also by the eligibility of baby

NUMBERS OF BENEFICIARIES BY AGE AND DISABILITY STATUS, 2003

65+:	**35.0 million**
Disabled:	**6.0 million***
Total:	**41.0 million**

*MedPAC estimates that approximately 300,000 of those who qualify for Medicare based on disability are patients with End-Stage Renal Disease (ESRD) [MedPAC (2004). "Report to the Congress: Medicare Payment Policy." March, p. 160].

Source: Medicare Board of Trustees (2004). "2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." Centers for Medicare and Medicaid Services, March, p. 3. (http://www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf)

boomers beginning in 2011. By the time the youngest baby boomer reaches 65 in 2030, the number of Medicare beneficiaries will have grown to about 79 million.[4] (See chart, "Medicare Beneficiaries.")

MEDICARE STRUCTURE AND BENEFITS

Medicare is divided into two major parts. Part A, the Hospital Insurance (HI) Program, covers inpatient hospital care and a number of other services. Part B, the Supplemental Medical Insurance (SMI) Program, covers physician services and outpatient hospital care, among other services. (See box, "Part A: Hospital Insurance, Part B: Medical Insurance.") Neither Part A nor Part B covers custodial long-term care services. (Medicaid does cover such services for those who are eligible, and is the largest single source of long-term care funding. See Chapter 7, Medicaid, for more information.)

PART A: HOSPITAL INSURANCE

Pays for hospital care

- Inpatient services
- Critical access hospitals
- Small rural hospitals that give limited outpatient and inpatient services
- Skilled nursing facilities
- Hospice care
- Some home health care

PART B: MEDICAL INSURANCE

Pays for services when deemed medically necessary

- Doctor's services
- Outpatient hospital care
- Physical and occupational therapy
- Most home health care

There is a Part C, under which Medicare pays managed care plans a flat fee to deliver Part A and Part B services, an arrangement that was altered substantially in the 2003 MMA law. More information on this aspect of Medicare appears in this chapter, under "Medicare Managed Care."

The 2003 MMA law also created Part D of Medicare, under which those covered by Medicare will receive limited prescription drug coverage. The details of this new benefit and its phase-in schedule are described in this chapter, under "New Medicare Drug Benefit."

MEDICARE FUNDING

Medicare Part A is funded mainly through a payroll tax. Employers and employees each pay 1.45 percent of the employees' income. Unlike the payroll tax for Social Security, this tax must be paid on entire earnings. There is no limit on the amount subject to this tax.[5]

When stories appear about the Medicare Trust Fund becoming insolvent or going bankrupt, the reference is almost always to the Part A Trust Fund. Part A spending is expected to grow much more rapidly than Trust Fund revenue, especially after the retirement of the baby boomers begins in 2011. The latest projection by Medicare's trustees is that the Part A Trust Fund will be exhausted by the year 2019 under current law.[6] Faced with nearer-term projections of Trust Fund exhaustion in the past, Congress has acted to adjust eligibility, benefits or financing to assure Medicare's continued viability.

Part B is financed by a combination of beneficiary-paid premiums ($66.60 per month in 2004) and general federal revenues. The Part B Trust Fund cannot become insolvent because by law it can draw on the Treasury for whatever amounts are needed to pay Part B expenses. General revenues cover some 75 percent of total Part B spending.

Some analysts and policy makers argue that Medicare's spending growth is unsustainable, while others disagree.

Over the long term, the Congressional Budget Office projects that by 2078, Medicare spending will account for more than 13.8 percent of the country's Gross Domestic Product (GDP), up from 2.6 percent of GDP in 2003.[7] Other analysts note that estimates extending that far into the future are very likely to be inaccurate, given how much of what will affect actual spending is unknown.

Despite the billions of dollars dedicated to Medicare from taxes, Medicare beneficiaries must still pay a substantial share of their health care expenses themselves. In 2000, for example, elderly beneficiaries spent on average more than one-fifth of their incomes (22 percent) on out-of-pocket health care spending.[8] In fact, Medicare pays for only about 53 percent of a beneficiary's total health care costs. These facts reflect Medicare's substantial cost-sharing, and the many health care services not covered by the program. In addition to long-term care services and outpatient prescription drugs (see "Medicare and Prescription Drugs," in this chapter), Medicare does not cover dental services, podiatry services, hearing aids, eyeglasses, and a number of other services.

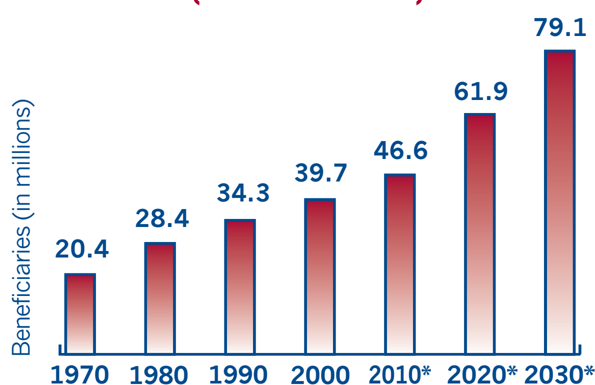
To fill these gaps in covered services, three-fourths of beneficiaries had some form of private coverage to supplement Medicare in 2001. These included coverage from a current or former employer, through a stand-alone supplemental policy (called Medigap) or as part of a Medicare HMO.[9]

LOW-INCOME ASSISTANCE

More than others, beneficiaries with modest incomes and no private supplemental insurance may face difficulty with formidably high health care bills. About 7 million Medicare beneficiaries in 2002 had incomes low enough to qualify for help from Medicaid, a means-tested program that offers health services to Americans of all ages who meet certain income and asset requirements.[10]

Almost three-fourths (71 percent) of those eligible for both Medicare and Medicaid, often referred to as dual eligibles, have annual incomes below $10,000. Most of these persons, about 6.4 million in 2002, were eligible for full Medicaid benefits. For them, Medicaid pays Medicare copayments, deductibles and monthly premiums. Medicaid also offers coverage for long-term care and other critical health benefits that Medicare does not offer.[11]

MEDICARE BENEFICIARIES
(SELECTED YEARS)



*** = Projected**

Source: Medicare Board of Trustees (2004). "2004 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds." Centers for Medicare and Medicaid Services, March. (http://www.cms.hhs.gov/publications/trusteesreport/2004/tr.pdf)

A smaller group of dual eligibles receives help from Medicaid for more limited benefits, e.g., payment of Medicare premiums and cost-sharing. The Qualified Medicare Beneficiary program (QMB, pronounced "Quimby") covers individuals with incomes up to the federal poverty level ($9,310 for an individual and $12,490 for a couple in 2004) and assets below $4,000 ($6,000 for a couple). For QMBs, Medicaid pays the Medicare premiums, deductibles and copayments.

The Specified Low-Income Medicare Beneficiary (SLMB, pronounced "Slimby") program is available for individuals with incomes between 100 and 120 percent of the federal poverty level (between $9,310 and $11,172 in 2004) and assets below $4,000 ($6,000 for a couple). This program pays only the Part B premium ($66.60 per month in 2004) for those enrolled, not Medicare deductibles or copayments. Approximately half of individuals eligible for GMB and SLMB are not enrolled in these programs, while enrollment rates are even lower for smaller programs offering similar assistance to those with somewhat higher incomes.

CATASTROPHIC COVERAGE ACT: THE MEDICARE PRESCRIPTION DRUG BENEFIT THAT CAME AND WENT

A benefit for beneficiaries with very high drug expenses was enacted as part of the Medicare Catastrophic Coverage Act of 1988. But pressure by certain senior advocacy groups and pharmaceutical companies opposed to the financing of the program, forced lawmakers to repeal the law in 1989, before the drug benefit ever went into effect. Since that time, the need for an outpatient drug benefit has grown steadily. Nonetheless, lawmakers failed to enact a drug benefit in part because they were wary of incurring the anger of politically active seniors if they should enact a benefit seniors didn't like.

MEDICARE AND PRESCRIPTION DRUGS

When the Medicare program was created in 1965, prescription drugs were not central for many medical treatments and Medicare did not cover outpatient prescription drugs. Private insurers did not normally cover them either.

Today, Medicare pays only for drugs administered to hospitalized patients and those drugs administered by a health professional because the patient cannot self-administer them. (See box, "Catastrophic Coverage Act: The Medicare Prescription Drug Benefit that Came and Went.")

Over the years, prescription drugs have come to play an increasingly important role in health care. New outpatient medications are greatly improving health outcomes and the overall quality of life. Many are replacing surgery and other invasive treatments.

As a result, outpatient drug use by Medicare beneficiaries has grown. Between 1997 and 2000 alone, the average number of prescriptions filled by people ages 65 and older rose from 20.7 to 25.5.[12]

Despite the lack of a Medicare drug benefit, a majority of beneficiaries have had some access to outpatient prescription drugs. Some have gotten limited drug benefits through retiree coverage from their former employer, or through supplemental private coverage (so-called Medigap plans), veterans health benefits, Medicaid, a Medicare managed care plan, or low-income pharmacy assistance plans that are offered in some states.

These sources helped about 62 percent of beneficiaries for at least part of 1999. The remaining 38 percent of beneficiaries had no financial assistance for the costs of drugs.[13] Among those beneficiaries who did have coverage, its scope varied widely.

As pharmaceutical costs rose, existing drug coverage eroded. Pressure increased on lawmakers to provide some type of federal assistance to help Medicare beneficiaries with their drug expenses. After several failed attempts, both houses of Congress approved legislation in 2003 to establish limited, voluntary outpatient prescription drug coverage for all Medicare beneficiaries. The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) was signed into law by President Bush on December 8, 2003.

NEW MEDICARE DRUG BENEFIT

Depending on whose cost estimate one uses, the federal government will spend anywhere from $395 billion to $534 billion over the next 10 years to subsidize prescription drug coverage for Medicare beneficiaries.[14]

The MMA legislation is comprehensive and complicated. Details of the new law are available, among other places, at the web site that follows: (http://waysandmeans.house.gov/legis.asp?formmode=read&id=723). Here are some of the key provisions:

- **Prescription drug benefit** — Beginning in 2006, beneficiaries will be able to enroll in either a private managed care plan with a drug benefit, or a private stand-alone prescription drug plan. Signing up is voluntary, but there are substantial penalties for late enrollment. Those who enroll late — more than 63 days after becoming eligible to do so — must pay a higher premium than those who enroll on time.[15]

  Those who join will pay a separate drug benefit premium that will be about $35 the first year. In addition, beneficiaries will still have to pay a substantial portion of their drug costs. (See box, "Cost-Sharing for New Medicare Drug Benefit.") After a $250 deductible is met, the program will pay 75 percent of the next $2,000 in expenses. Once a beneficiary's

COST-SHARING FOR NEW MEDICARE DRUG BENEFIT

If drug costs are	Beneficiaries pay	Up to	Total out of pocket
$0 – $250	100%	$250	$250
$251 – $2,250	25%	$500	$750
$2,251 – $5,100	100%	$2,850	$3,600
Over $5,100	5%	No limit	$3,600 + 5% of costs above $5,100

Note: Figures are in addition to estimated $35 per month ($420 per year) premium. Low-income subsidies are not reflected in the table. Amounts are indexed and will increase annually. Premiums do not count toward $3,600 threshold for out-of-pocket spending.

Source: Families USA (2003). "Understanding the New Medicare Prescription Drug Benefit." November 25. (http://www.familiesusa.org/site/DocServer/11-25_Q_A.doc?docID=2321).

drug costs reach $2,250 in a year, Medicare will pay none of the costs until they reach $5,100 for the year (the so-called doughnut hole). At this point, a beneficiary will have spent $3,600 out of pocket. Catastrophic coverage begins, and Medicare will pay 95 percent of all drug costs until the end of the calendar year. The drug deductibles, benefit limits and catastrophic thresholds are indexed to rise with the growth of spending in Part D. As a result, the size of the doughnut hole — during which the beneficiary is responsible for the entire amount — will grow from $2,850 in 2006 ($5,100-$2,250) to $5,066 in 2013.[16]

- **Low-income assistance** — Beginning in 2006, beneficiaries who are also entitled to receive full Medicaid services, the dual eligibles discussed earlier, will receive their drug coverage through Medicare rather than through Medicaid. Others with incomes up to 150 percent of the federal poverty level (FPL), and with assets under allowable limits, will be partially subsidized. (See box, "Federal Poverty Level for 1 & 2 Persons, 2004.)

  The rules governing these subsidies are complex. Briefly, institutionalized dual eligibles have no cost sharing and pay no premiums for their drug coverage. Dual eligibles who are not institutionalized and whose income does not exceed the FPL do not pay the deductible, but do have nominal copayments of $1 for generic and $3 for brand-name drugs. Dual eligibles with incomes above the FPL have higher drug copayments. Those with incomes up to 150 percent of FPL and assets of no more than $10,000 for an individual are eligible for subsidized premiums based on a sliding scale, and a lower annual deductible of $50. The federal government will reduce the Medicaid money it pays to states, to minimize any windfall to states from transferring to Medicare the responsibility for drug benefits for current Medicaid recipients. (For more information about the impact of MMA on states, see Chapter 6, Prescription Drugs.)

- **Private-sector drug coverage** — Retirees with private-sector drug coverage can remain in their plans. To encourage companies to retain health coverage for retired workers, subsidies will be paid to those employers offering drug coverage to retirees, if it is at least as generous as Medicare's coverage.

- **Role of private plans/insurers** — In most cases, the new drug benefit will not be available through Medicare itself. Beneficiaries can get the new drug coverage in either of two ways. They can enroll in a managed care (Medicare Advantage) plan that will include a drug benefit. If they choose to remain in fee-for-service Medicare, in order to get coverage they will have to enroll in a privately run prescription drug plan (PDP), which will provide that benefit separate from the rest of Medicare.

- **Drug discount card** — Beginning in June 2004, until the regular drug benefit begins in January 2006, Medicare is sanctioning the sale of discount cards by drug companies, pharmacy benefit managers, associations and others. Cards cost no more than $30 a year, and are estimated to carry discounts (from unspecified retail base prices) of anywhere from 10 - 25 percent. Beneficiaries with incomes below 135 percent FPL ($12,570 for an individual in 2004) will not have to pay the annual fee, if any,

FEDERAL POVERTY LEVEL FOR 1 & 2 PERSONS, 2004*

	1 Person	2 Persons
100%	$ 9,310	$12,490
135%	$12,570	$16,860
150%	$13,970	$18,740

* Annual household income. Amounts are higher in Alaska and Hawaii.

Source: U.S. Department of Health and Human Services (2004). "The 2004 HHS Poverty Guidelines." May 3. (http://aspe.hhs.gov/poverty/04poverty.shtml) Retrieved on March 19, 2004.

and can receive a credit worth $600, imbedded in the card, on their drug purchases for each of 2004 and 2005. CMS estimates that as many as 7 million beneficiaries are eligible for the $600 credit.

(For non-drug related provisions of the law, see box, "MMA Changes Not Part of Rx Benefit.")

MEDICARE MANAGED CARE

Managed care plans have participated in Medicare since the 1970s. Beneficiaries who sign up for these plans, primarily health maintenance organizations (HMOs), agree to stay within a network of providers in return for benefits that often exceed those available in traditional fee-for-service Medicare. These benefits can include coverage for Medicare deductibles and copayments, dental and vision care, and some outpatient prescription drugs. Some policymakers have promoted Medicare managed care as a way to control rising program costs through market competition.

But Medicare managed care hasn't been completely successful. Managed care companies cut back on benefits and withdrew from specific markets over the last few years, complaining about inadequate Medicare reimbursement, and also responding to opportunities in other lines of business. As a result, enrollment in these plans declined from its peak in 1998-99 (16 percent of beneficiaries) to just 11 percent in May 2003.[17]

The new Medicare law (MMA) made a number of important changes in the Medicare managed care program, now called the Medicare Advantage program. Payment rates to plans were immediately increased for 2004 by an average of 10.6 percent over 2003 rates.[18] Plans may use the increases to improve benefits or cost-sharing for beneficiaries, or to increase payments to providers. Beginning in 2010, plans in six demonstration areas will compete for business against traditional fee-for-service Medicare based on price. Proponents see these demonstrations as a way to bring fiscal discipline to Medicare. Critics argue that sicker beneficiaries will remain in the traditional Medicare program, which will therefore experience higher costs. These increased costs will, critics assert, will be passed on to traditional Medicare enrollees, thus penalizing sick, more vulnerable beneficiaries.

CURRENT POLICY DEBATES AND PROPOSALS

Given that Congress and the president finally ended years of vigorous debate with the enactment of new Medicare prescription drug and reform legislation, one might expect that Medicare would fade from the forefront of health care policy debates. But in the fall of 2004, Medicare is just as contentious as ever in both policy and political arenas.

Adequacy of new benefit

The amount projected as the 10-year cost of the new drug benefit — $395 to $534 billion — represents the largest benefit expansion in the near-40-year history of Medicare. Yet, it is just a fraction of the $1.8 trillion expected to be spent on drugs for Medicare beneficiaries during that time. Many senior advocates argue that the new program is not nearly generous enough. They want to improve the benefit before it becomes effective in 2006. Others describe it as a good beginning, which can form the foundation for further improvements.

Role of private insurers

Private insurers or drug plans will be the vehicle for almost all beneficiaries who choose to receive the new drug benefit. Beginning in 2010, a six-area demonstration will force traditional fee-for-service Medicare to compete on price with privately run Medicare plans.

Those opposed to these changes say these inroads by private firms and other groups will weaken the social insurance nature of Medicare. They are particularly

MMA CHANGES NOT PART OF RX BENEFIT

Several major provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) changed Medicare in ways not directly connected to the new prescription drug benefit. Here are some of the most important non-drug Medicare provisions:

Means-testing - Part B premiums. Beginning in 2007, Part B monthly premiums will increase to single beneficiaries with incomes over $80,000. After a five-year phase-in, single beneficiaries with incomes over $200,000 will pay monthly premiums more than three times as large as middle-income beneficiaries.

Part B deductible. This will increase from $100 to $110 in 2005, and will be indexed to Part B spending growth after that.

New benefits. Beneficiaries are eligible for a "welcome to Medicare" initial physical exam, and some new preventive benefits, such as screenings for diabetes and cardiovascular disease.

No fee cut for doctors. The 4.5 percent reduction in Medicare payments to physicians scheduled for January 2004, and an additional cut in 2005, were canceled. Instead, physicians get a 1.5 percent increase in both years.

Rural providers. Payments to rural hospitals, doctors, nurses and other providers are increased in a number of ways. (For more information, see "Better Benefits - More Choices," April 12, 2004 from the Department of Health and Human Services (www.cms.hhs.gov/medicarereform/issueoftheday/04122004iotd.pdf)

wary of the competition demonstrations, which they characterize as voucher plans designed to end Medicare's status as a social insurance program. Supporters of the changes say they are the only way the country can afford to retain Medicare at all. Otherwise, its cost will become an unsustainable burden on government and society.

Cost containment

The new law makes some changes to speed up the availability of cheaper generic drugs once patents for brand-name drugs have expired. But the law explicitly prohibits the federal government from using its negotiating power to gain price concessions from drug companies.

Critics of this provision say that it denies government the ability to use its market influence to negotiate the best deal for both beneficiaries and taxpayers. They note the low prices negotiated by the Department of Veterans Affairs for the drugs it provides eligible veterans. Supporters of this provision say it will prevent the government from, in effect, fixing prices. They note that, according to the Congressional Budget Office, getting rid of the prohibition on price negotiations would not save the federal government substantial money.

Reimportation

MMA has language on prescription drug reimportation, including a requirement for the Department of Health and Human Services to produce a study on the topic no later than March 2005. The provisions were added in part to respond to urgent calls by state and local governments for the federal government to liberalize current law, which sharply restricts the practice. At present, pharmaceuticals produced in the U.S. and sold abroad may be reimported only by U.S. drug manufacturers, which have a strong financial incentive not to reimport their own products at low prices.

The politics of amending current law on reimportation are complex, and Congress has made several attempts to deal with concerns about whether reimportation would compromise drug safety. None of the measures recently enacted, however, have squarely addressed the safety issues. Broadly defined, reimportation, or parallel trade, is the practice where products sold by a drug manufacturer to one or more countries outside the country of origin are imported by third parties, e.g., wholesalers, from a country where prices are low, to a country where prices are higher. More narrowly, reimportation could be defined to refer to pharmaceutical products that are made in the U.S. and exported to other countries, and then reimported back to the U.S. by entities from one country — e.g., Canada — or from multiple countries. For more on the reimportation issue, see Chapter 6, Prescription Drugs. (See "Candidates' Views," next page.)

STORY IDEAS

- With substantial increases in the fees being paid to Medicare managed care companies in 2004, what are companies in your state or area doing with the extra money? Providing improved benefits?

Lowering cost-sharing? Giving higher payments to doctors and hospitals? Is enrollment rising? Will these plans participate in Medicare in the future?

- How many beneficiaries are signing up for the new drug discount cards? Which cards are most popular in your area, and why? Are low-income beneficiaries signing up for the cards with $600 a year subsidies? Do they even know about them? Where can seniors and persons with disabilities go to get more information about the cards? Is the enrollment process simple and consumer-friendly?

- Does your state operate its own program to make prescription drugs more affordable for low-income seniors or others? If so, how is it, or will it be, affected by the new law?

- Do area employers that offer retiree health coverage plan to continue that coverage? Does the new subsidy available to them play a part in their decision one way or the other?

- What do state and local government officials believe is important for consumers to know about purchasing drugs reimported from abroad? Have any officials set up arrangements for government employees or others to obtain drugs from Canada? With what results? What do physicians in your area think of reimporting prescription drugs? What are the relative advantages and disadvantages of reimporting drugs from Canada only, as compared to the European Union and other industrialized nations? How does reimportation affect the prices and safety of consumer products other than pharmaceuticals?

- Which companies in your state or region are gearing up to offer beneficiaries prescription drug coverage in 2006? Are these companies also sponsoring Medicare prescription drug discount cards in 2004 and 2005? How do the companies plan to structure the benefits, i.e., will there be tiered pricing for drugs included in the formulary versus those outside of the formulary? What do various stakeholders — HMOs and plans, advocacy organizations, government officials, and researchers — see as the major challenges in implementing the Medicare drug benefit? Are any insurance companies in your areas planning to offer Medicare PPOs? Why or why not?

CANDIDATES' VIEWS

President Bush argues that the new Medicare law (MMA) is the most significant improvement in the Medicare program since 1965, and that few, if any, changes in the law are needed.[19] Senator Kerry has proposed amending MMA to permit Medicare to negotiate directly with drug manufacturers on pricing provisions[20] — a position that President Bush opposes, and which the statute as written prohibits. Senator Kerry would also require pharmaceutical benefits managers (PBMs) to disclose any fees or discounts paid by drug companies.[21]

Beyond the new Medicare law, Senator Kerry has proposed to help seniors and others cope with high drug costs by allowing reimportation of "safe, FDA-approved drugs" from Canada and other nations. President Bush has suggested that reimportation of prescription drugs from Canada and other countries poses significant safety concerns, but has also stated that, if those concerns can be addressed, allowing limited reimportation "makes sense."[22]

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