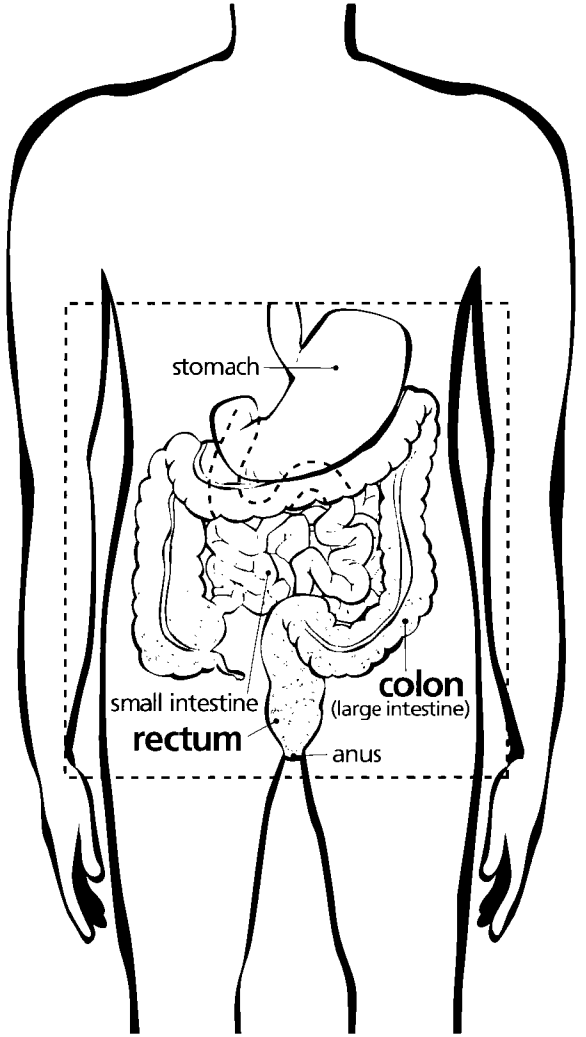
Diagram of the Colon and Rectum



Source: Centers for Disease Control and Prevention

For more information about colorectal cancer, contact:
NCI's Cancer Information Service

1-800-4-CANCER

or contact:
Division of Cancer Prevention and Control
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
4770 Buford Highway, Mailstop K48
Atlanta, Georgia 30341

1-888-842-6355

or visit

www.cdc.gov/cancer/screenforlife

www.medicare.gov

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Colorectal Cancer

Let's Break the Silence

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National Colorectal Cancer Action Campaign

www.cdc.gov/cancer/screenforlife

Colorectal Cancer Screening and Early Detection

Colorectal cancer causes more deaths than you might think.

Colorectal cancer, or cancer of the colon or rectum, is the second-leading cause of cancer-related deaths in the United States, claiming over 56,600 lives this year. An estimated 129,400 men and women will be diagnosed with colorectal cancer in 1999.

Many colorectal cancer deaths can be prevented.

Screening tests can find polyps, which are tiny growths that can become cancerous. Removing polyps early can prevent cancer. Screening tests also can find colorectal cancer early, when there may not be any symptoms and when treatment can be most effective.

Colorectal cancer can develop with no symptoms at first.

While early colorectal cancer often may have no symptoms, sometimes symptoms do occur. Symptoms to watch for include blood in or on the stool, a change in bowel habits, stools that are narrower than usual, general stomach discomfort, frequent gas pains, or weight loss. If you have any of these symptoms, discuss them with your doctor. Only he or she can determine the cause of the symptoms.

Who is at risk?

Colorectal cancer is most common in people aged 50 and over and the risk increases with age. Both men and women are at risk for colorectal cancer. Although all races are at risk for the disease, African Americans are more likely than whites to be diagnosed with colorectal cancer at a more advanced stage and more likely to die of it once diagnosed. A family history of colorectal cancer or colorectal polyps increases the risk of developing colorectal cancer.

There are steps you can take.

If you are age 50 or older and have never been screened, start now. Screening is the best way to find polyps before they become cancerous, or to find an early cancer, when treatment can be most effective.

Talk with your doctor or health care professional.

Talk with your doctor about the screening options that are right for you. There are several screening tests from which you and your doctor can choose.

Find out about insurance coverage of colorectal cancer screening.

Check with your health insurance provider to determine your colorectal cancer screening benefits. If you are 50 or older and are covered by Medicare, you may be eligible to receive colorectal cancer screening benefits.

Terms

Colon
The long, coiled, tube-like organ (also known as the large bowel or large intestine) that removes water from digested food. The remaining solid waste moves through the colon to the rectum and leaves the body through the anus.

Colonoscopy
An examination in which a doctor looks at the internal walls of the entire colon through a flexible, lighted instrument called a colonoscope. If polyps are found they can be removed at the same time.

Colorectal
Related to the colon and/or rectum.

Double Contrast Barium Enema
A test which includes x-rays of the lower intestines taken after a patient is given an enema containing white dye, or barium, followed by an injection of air. The barium outlines the intestine on the x-rays.

Fecal Occult Blood Test (FOBT)
A test which checks for blood in the stool.

Gastroenterologist
A doctor who specializes in diagnosing and treating disorders of the digestive system.

Polyp
A growth of tissue. These growths can occur in the colon or rectum and may later become cancerous.

Rectum
The last eight to ten inches of the large intestine

Sigmoidoscopy
An examination in which a doctor looks inside the rectum and lower half of the colon through a lighted tube.

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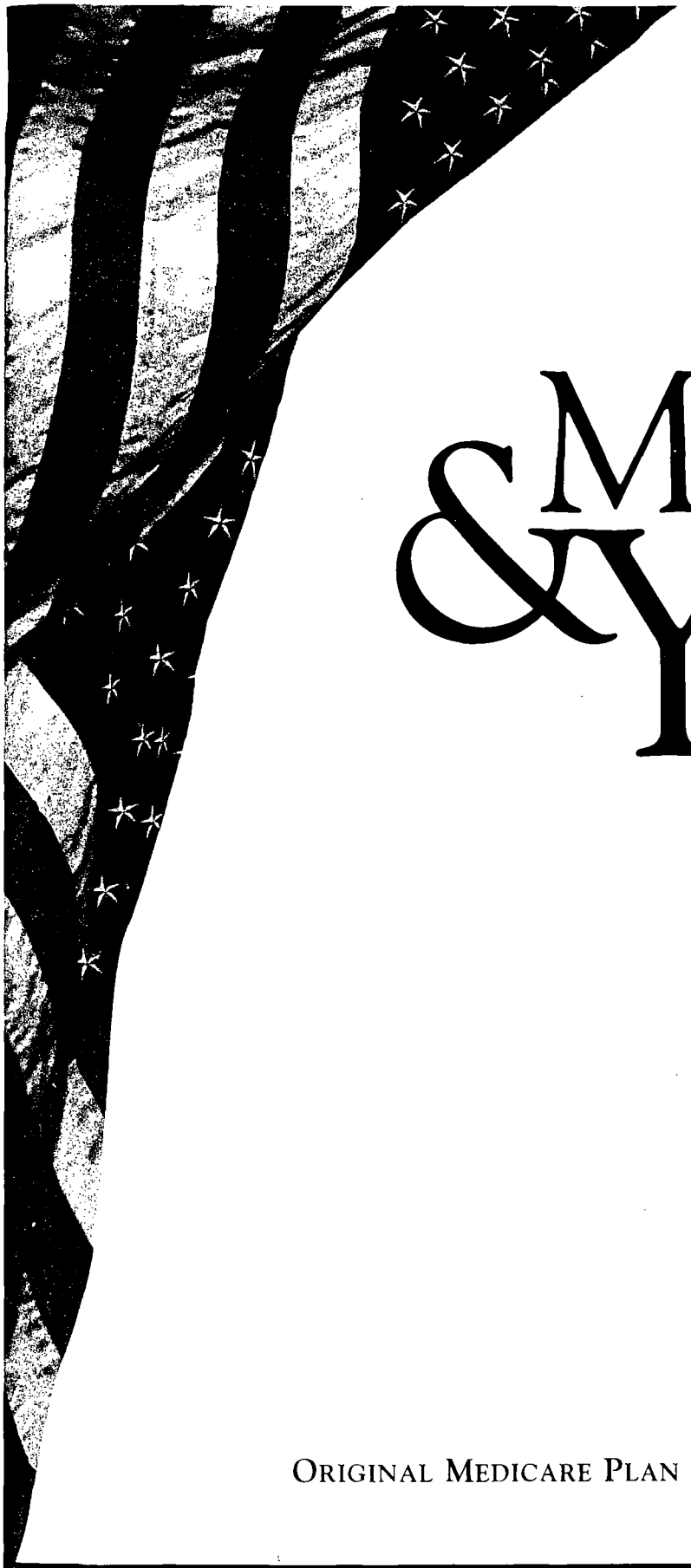

Medicare & You

ORIGINAL MEDICARE PLAN & OTHER MEDICARE HEALTH PLAN CHOICES

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

HEALTH CARE FINANCING ADMINISTRATION

BOB GRAHAM
FLORIDA

United States Senate

WASHINGTON, DC 20510-0903

April 26, 1999

Mr. Chris Jennings
Deputy Assistant to the President for Health Policy
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Chris:

Thank you for taking the time to meet with me last week to discuss reforming the Medicare program. In follow-up to our meeting, I wanted to be sure that we were clear regarding those items we agreed to that we would research and investigate separately and then provide each other with updates. I would like to receive an update, either in writing or through another meeting, on the issues listed below by May 12. Here are the items that I have identified as action items from our meeting:

White House Action Items

- Conduct an historical analysis of the Blue Cross/Blue Shield (BCBS) program since the inception of the Medicare program in 1965. The underlying assumption being that Medicare was originally based on the BCBS model and we should look to see how BCBS has evolved their model of health care delivery, benefit structure, and financing over the past 35 years.

- Investigate the possibility of working with the Social Security Administration (and possibly the Internal Revenue Service and the Office of the Surgeon General) to provide health promotion and prevention information in annual statement of accounts sent to prospective Social Security recipients.

- Investigate the feasibility of linking Federal litigation against the tobacco industry to fund an expanded prescription drug benefit.

- Keep congressional offices updated on Administration progress in developing a Medicare reform proposal and provide us with details prior to its introduction.

Senator Graham's Action Items

- I am providing you with a copy of my draft prevention proposal which includes a limited prescription drug benefit (see attachment).

If you have any questions regarding this information, please do not hesitate to contact Bryant Hall of my staff at (202) 224-1535.

With kind regards,

Sincerely,

United States Senator

Attachment

DRAFT (4/27/99) – FOR INTERNAL USE ONLY – DRAFT (4/27/99)

THREE TIER MEDICARE PREVENTION STRATEGY

1. New Applied Research Initiative

Despite significant advancements in general research for health promotion and disease prevention, there has been a failure in translating that research into practical applications (this failure was most recently documented in the Dartmouth Atlas of Health Care of 1999 in which current Medicare prevention benefits such as mammograms and colorectal cancer screening tests were utilized by only one-quarter to one-third of all beneficiaries). Due to a lack of definitive applied research in the field of prevention and the elderly, $25 million (this figure may be modified based on additional input from the Partnership for Prevention) should be provided to conduct new applied research. While the Balanced Budget Act of 1997 included a provision for the Institute of Medicine (IOM) to conduct a study on a limited subset of prevention issues for Medicare, the results of that study will not be available until late 1999 and the results will be limited to only three discrete areas (skin cancer, dental care, immunosuppressant cancer drug limits). In addition, the Health Care Financing Administration (HCFA) has contracted with the RAND Corporation for two studies on prevention and the elderly. One study focuses on the effectiveness and utilization of existing Medicare preventive benefits and the second study focuses on behavioral risk factor interventions (e.g. smoking cessation, fall prevention).

It is critical that any new applied research efforts reflect both the medical and social aspects of care for the elderly, including both the cost-effectiveness and quality of life impacts stemming from any initiative. To achieve this goal, any new applied research effort should be developed, monitored and evaluated by an inter-agency work group, chaired by the Secretary of Health and Human Services, and consisting of the heads of HCFA, the Centers for Disease Control and Prevention, the Agency for Health Care Policy Research, the Administration on Aging (AoA), and the National Institute on Aging.

Among the topics that should be considered for new applied research are the effectiveness of using different types of providers (e.g., non-physicians) and alternative settings (e.g., community-based settings such as senior centers) for the implementation of a successful prevention strategy. A related area of research would be to explore how to reimburse for these blended (medical-social) services. A second area of applied research would be to identify the most effective means of educating and incentivizing beneficiaries and providers about the importance of prevention for the elderly and increasing utilization of both new and existing services. Other topic areas can be supplemented by the Secretary in consultation with the Congress. Further, we encourage HCFA to expand its efforts to study and test the most promising behavioral modification of risk factors associated with prevention. Finally, we recommend that the National Library of Medicine develop and maintain a national clearinghouse of innovative and successful health promotion interventions targeting the elderly in a variety of settings from both published and unpublished sources.

The Secretary shall provide a report to Congress by no later than December 31, 2002 that addresses the following:

- the results of the overall applied research efforts,
- whether (as a result of the applied research efforts) or not certain prevention-related benefits or outreach/education efforts should be added or undertaken by the program (including discussions on quality of life and cost-effectiveness for each proposal),
- the utility of, potential for, and issues surrounding Medicare-sponsored health risk appraisals and targeted follow-up,
- how best to increase utilization of existing and recommended prevention services (including an education and public awareness component, discussion of financial incentives - for providers and beneficiaries - to improve utilization), and
- whether Medicare beneficiaries would benefit by increasing HCFA's administrative discretion to be able to respond more flexibly to preventive health issues without the need for statutory changes.

2. Limited Prevention Benefits

Although, as noted above, the area of applied research on prevention for the elderly is underdeveloped, there are some areas where there is sufficient evidence to warrant the addition of a few prevention benefits to the Medicare program. In fact, some of the approaches that should be included do not necessarily warrant the addition of new benefits, since they are targeted at population-based awareness and education efforts. The benefits related to direct patient-provider interaction that we recommend (which are largely contained and consistent with the recommendations of the U.S. Preventive Services Task Force's "Guide to Clinical Preventive Services") are: counseling for smoking cessation, hypertension screening, counseling for hormone replacement therapy (e.g., prevention of osteoporosis and heart disease), and screening for early detection of glaucoma. In addition to the benefits involving direct provider-patient interactions, we recommend a population-based effort focused on increasing awareness and education in the area of falls prevention among the elderly. While limited, we believe adding these benefits will have a significant, positive impact on the quality of life and the health of Medicare beneficiaries.

3. Limited Prevention-Related Outpatient Prescription Drug Benefit

To complement the benefits described above, and in light of the fact that the treatment of many preventable illnesses now involve the use of outpatient prescription drugs, it only makes sense to develop a limited prevention-related outpatient prescription drug benefit available to beneficiaries in both fee-for-service and managed care. To this end, we recommend the development of a limited prevention-related outpatient drug formulary for Medicare beneficiaries, including: outpatient drugs used as part of an approved smoking cessation program, outpatient drugs used in the treatment of hypertension, outpatient drugs used as part of an approved hormone replacement therapy program, and outpatient drugs used in the treatment of glaucoma.

Financial assistance would be provided to targeted low-income Medicare beneficiaries in the form of elimination of co-payments and deductibles. The drug benefit would be administered through a competitive bidding model which would utilize pharmacy benefit management organizations or entities similarly qualified to negotiate and administer an outpatient prescription drug benefit. Finally, the IOM would be instructed to undertake a study of the feasibility and issues involved in developing a comprehensive Medicare outpatient prescription drug benefit and report to Congress by no later than June 30, 2001. As part of the IOM's report, they would be instructed to develop a prioritized list of drug categories that could be added to the benefit based on the availability of funding.

We estimate that this limited prevention-related outpatient drug formulary would cost $2-3 billion per year (this is a temporary place holder estimate). It would be paid for through a combination of a $50 deductible, 20 percent co-insurance, a $10 Part B premium increase, and co-payments of $5 (these will need to be adjusted based on a more accurate estimate of the total cost). In the event the Federal government recovers funds stemming from its efforts to sue the tobacco industry for the recovery of Federal dollars related to the treatment of tobacco related illness, those funds would be used to enhance the drug benefit by paying for new categories of outpatient prescription drugs.

Measuring the Underuse of Preventive Care

Screening for Breast Cancer. The United States Task Force on Preventive Disease guidelines recommend mammograms at least once every two years for Medicare women age 65-69. In 1995-96, only 28.3% of women in this age group received at least one mammogram; compliance with the guideline for women between 65 and 69 varied from a low of 12% to a high of 50% (Figure 4.2). No hospital referral regions came close to the "best practice" benchmark provided by Kaiser-Permanente South, a California health maintenance organization, in which 82% of Medicare seniors received breast cancer screening (Figure 7.1). If 82% is the benchmark of achievable quality, there is extensive underuse of mammography in the rest of the United States: in 1995-96, 2.25 million, or 65% of eligible Medicare enrollees, did not have the mammograms they would have received had the quality of their care equaled that provided by the Kaiser Permanente Health Plan.

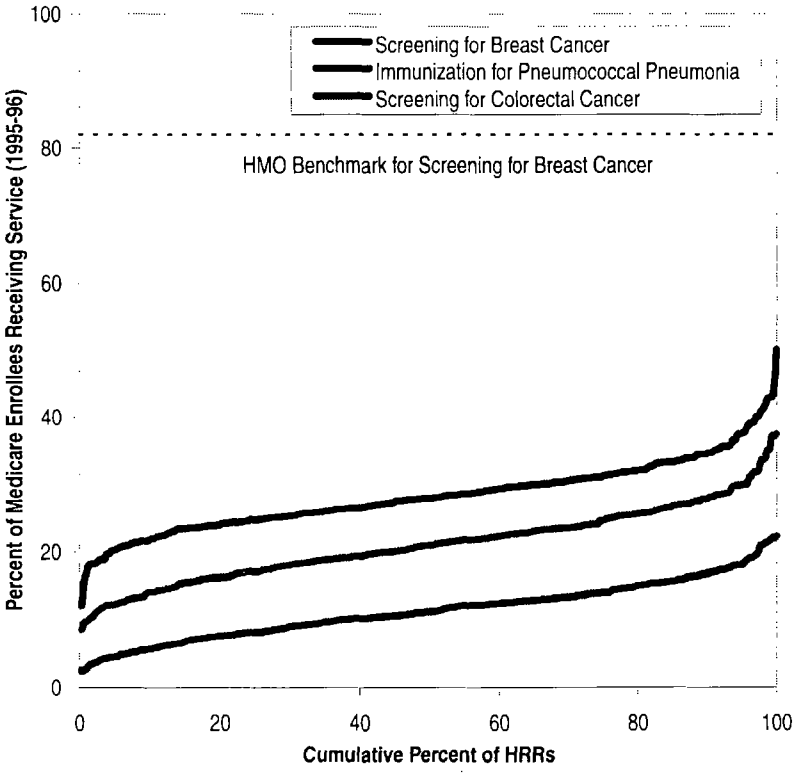

Figure 7.1. The Use of Selected Preventive Services by Medicare Enrollees by Hospital Referral Regions (1995-96)

The vertical axis shows the percent of Medicare enrollees receiving one or more of the selected preventive services in 1995-96. The horizontal axis is the cumulative percent of hospital referral regions, ranked from lowest (left) to highest in percent compliance with guideline. The figure also indicates the "best practice" benchmark for screening for breast cancer. All hospital referral regions fell well below the benchmark.

Immunization against Pneumococcal Pneumonia. To meet the minimal expectation for protection, the United States Task Force guidelines call for vaccination at least once every ten years, meaning that over the two year period 1995-96 at least 20%, or 5.8 million Medicare enrollees in fee-for-service Medicare, should have been vaccinated. Using this standard implies massive underservice: in 1995-96, only 21% of the 5.8 million Americans enrolled in fee-for-service Medicare received one or more vaccinations. Compliance with the guideline for vaccination varied from 9% of those who were eligible to 38% (Figure 4.1). We found no audited reports from health maintenance organizations to use as a "best practice" benchmark.

Screening for Colorectal Cancer. The United States Task Force calls for annual colorectal cancer screening by either fecal occult blood test or colonoscopy, or both. During 1995-96, years when Medicare did not pay for screening for colorectal cancer, only 12% of the 29.4 million Americans enrolled in fee-for-service Medicare had one or more colonoscopy or occult blood test. The percent of enrollees receiving screening ranged from 2% to 22% (Figure 4.3). We found no audited reports from health maintenance organizations to use as a "best practice" benchmark.

Measuring the Underuse of Care for Diabetic Patients

Eye Examinations. The Diabetes Quality Improvement Project recommends annual retinal eye examinations for diabetics. In 1995-96, 45.3% of the 3.1 million Medicare enrollees who were diagnosed diabetics received one or more eye examinations. According to this recommendation, 1.7 million Medicare patients with diabetes were underserved: compliance with the guideline ranged from 25% to 66%. No hospital referral region came close to the "best practice" benchmark provided by Kaiser-Permanente North, a California health maintenance organization (Figure 7.2), in which 69% of Medicare diabetics received at least one eye examination. Using 69% as the benchmark of achievable quality, there is evidence of extensive underservice among other Medicare populations. Although a few hospital referral regions came close (notably Fort Lauderdale, Florida), most were well below the quality benchmark. in 1995-96, 731,000 Medicare diabetics did not receive the services they would have received had the quality of their care equaled that provided by the Kaiser Permanente Health Plan.

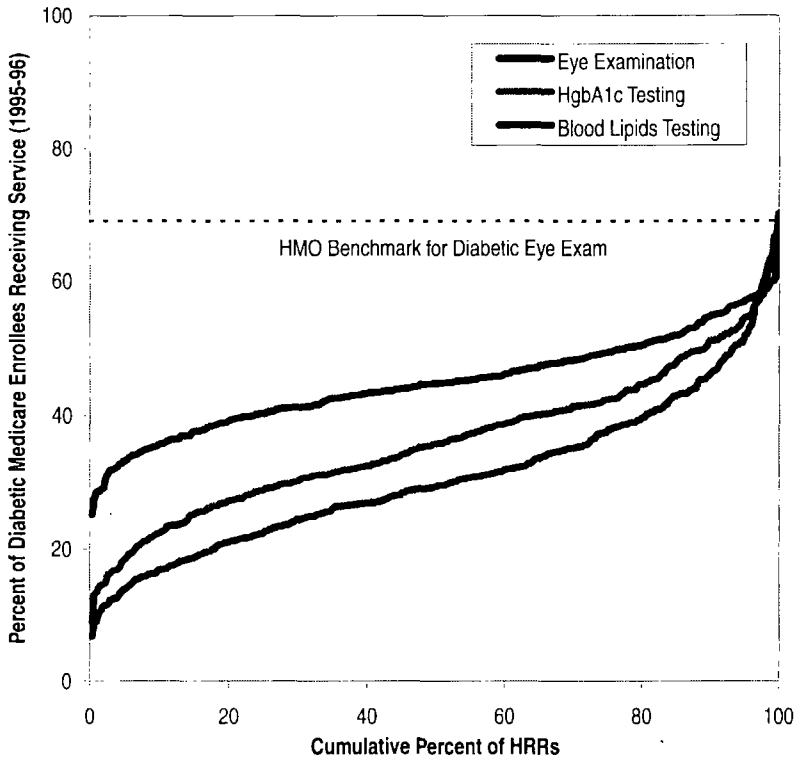

Figure 7.2. The Use of Selected Services by Medicare Diabetics by Hospital Referral Regions (1995-96)

The vertical axis shows the percent of Medicare enrollees receiving one or more of the selected services in 1995-96. The horizontal axis is the cumulative percent of hospital referral regions, ranked from lowest (left) to highest in percent compliance with guideline. The guideline calls for 100% of diabetic patients to have the service at least once annually. The "best practice" benchmark for diabetic eye examination is indicated. Compliance was well below the guidelines and the Kaiser-Permanente "achievable best practice" benchmark for eye examinations in all hospital referral regions.

Monitoring Glucose Control. The Diabetes Quality Improvement Project recommends routine monitoring of HgbAlc protein, a marker for glucose. Compliance with the guideline, however, fell far short of the recommendation. Two million diabetics went without the test during 1995-96; only 35.6% of diabetic patients had one or more tests. The proportion receiving the service ranged from 9% to 70%. We found no audited reports from health maintenance organizations to use as a "best practice" benchmark.

Blood Lipid Examinations. The Diabetes Quality Improvement Project recommends annual blood lipid examinations for diabetics. Compliance with this guideline was poor. Over the two year period 1995-96, only 33% of diabetic patients had one or more blood lipid examinations. In fee-for-service Medicare, 2.1 million diabetics went without the test. We found no audited reports from health maintenance organizations to use as a "best practice" benchmark.

The Underuse of Care for Medicare Enrollees Who Have Had Heart Attacks

Each year about one and a half million people in the United States have heart attacks. The toll in lives is heavy; about one-third of these patients die in the acute phase. The annual economic burden is more than $60 billion.

Because acute myocardial infarction is both common and serious, it has been the topic of intense scientific and clinical interest. One effort to incorporate evidence-based practice guidelines into the care of heart attack patients, begun in 1992, is the Health Care Financing Administration's Health Care Quality Improvement Initiative Cooperative Cardiovascular Project.

The Cooperative Cardiovascular Project developed quality indicators which were based heavily on clinical practice guidelines developed by the American College of Cardiology and the American Heart Association. Information about more than 200,000 patients admitted to hospitals for treatment of heart attacks was obtained from clinical records. Patients were classified as "eligible" or "ideal" for the specific therapies described by the quality indicators.

A study published in the Journal of the American Medical Association in February of 1999 found wide variations among hospital referral regions in the proportion of heart attack patients judged "ideal" for various treatments who actually received the recommended therapies (see the Endnote). The study documented substantial underuse of four potentially life saving treatments:

Beta-blockers at discharge. The American Heart Association and the American College of Cardiology recommend the use of beta blockers for all eligible patients *at the time of discharge from the hospital following acute myocardial infarction.* According to the Health Care Financing Administration's Cooperative Cardiovascular Project, compliance with this guideline varied substantially among hospital referral regions. Overall, only 49.5% of Medicare enrollees judged "ideal" candidates for beta-blockers actually got the medication. The proportion receiving the service ranged from 5.0% to 93.2%. In 25.7% of regions, less than 40% of "ideal" candi-

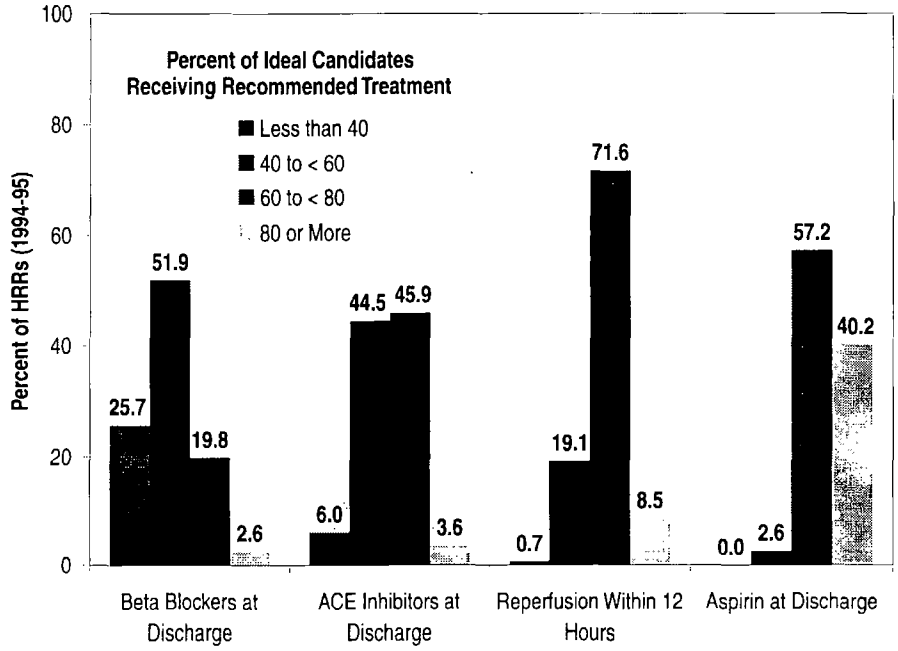

Figure 7.3. Percent of Medicare Residents with Heart Attacks Receiving Recommended Treatments by Hospital Referral Regions (1994-95)
The vertical axis shows the percent of regions, and the horizontal axis is the recommended treatment. For example, the light blue bar represents regions in which 80% or more of "ideal" patients actually received the treatment. Only 2.6% of regions achieved a level of at least 80% compliance with the guideline for beta-blockers at discharge. In 25.7% of hospital referral regions less than 40% of "ideal" patients were adequately treated (red bar). Only three regions had compliance with the guideline greater than the Kaiser-Permanente South "best practice" benchmark. (The guideline recommends that 100% of eligible heart attack patients receive beta-blockers.) In most hospital referral regions there was substantial underuse for each of these effective treatments.

dates received prescriptions for beta blockers; only a few regions exceeded the best practice benchmark of Kaiser-Permanente South, where 89% of "ideal" candidates received beta-blockers at discharge (Figure 7.3).

Angiotensin converting enzyme (ACE) inhibitors at discharge. The standards of care call for the use of ACE inhibitors at the time of discharge from the hospital for all eligible patients. Compliance with the this guideline varied substantially; overall, only 59.3% of Medicare enrollees who were judged as ideal candidates for ACE inhibitors following heart attacks actually got the medication. The proportion receiving the service ranged from 6.7% to 100%. In 6.0% of regions, less than 40% of ideal candidates received a prescription for ACE inhibitors. In 3.6%, 80% or

more received the recommended care. We found no audited reports from health maintenance organizations to use as a "best practice" benchmark (Figure 7.3).

Reperfusion with thrombolytic agents or percutaneous transluminal coronary angioplasty. The Cooperative Cardiovascular Project found that compliance with the guideline recommending reperfusion varied substantially. The proportion of "ideal" candidates who received the recommended reperfusion following heart attacks ranged from 33% to 93%. Overall, 62% of ideal candidates received the recommended treatment. In 0.7% of regions, less than 40% of ideal candidates were reperfused according to the guideline; in 8.5%, 80% or more received the recommended care. We found no audited reports from health maintenance organizations to use as a "best practice" benchmark (Figure 7.3).

Aspirin prescribed at discharge. Aspirin has been shown in randomized clinical trials to reduce mortality in patients who have had heart attacks. Compared to the other three guidelines, fee for service Medicare performed best when it came to prescribing aspirin at the time of discharge. Only about 22.2% of "ideal" candidates failed to get the recommended treatment. Compliance with the guideline ranged from 96% to 52%; no hospital referral regions had less than 40% compliance with the guideline, and 40.2% had better than 80% compliance. We found no audited reports from health maintenance organizations to use as a "best practice" benchmark (Figure 7.3).

More Medicare Spending Does Not Cure Underservice

The Dartmouth Atlas series has focused on the wide geographic variations in both underservice and variations in overall Medicare resources and utilization. But do areas that have larger per capita expenditures also provide better quality care? This is obviously a complicated and multidimensional question, and we cannot entirely resolve it. However, we can ask whether there is a relationship between areas with higher per capita Medicare expenditures and the rates at which enrollees receive appropriate and recommended screening tests. Figure 7.4 shows per capita Medicare spending by hospital referral regions, adjusted for age, sex, race, regional price levels, and illness burden (on the horizontal axis). The vertical axis is an index of underservice: the average proportion, by hospital referral region, of Medicare enrollees who (1) received immunizations for pneumococcal pneumonia; (2) had at least one mammogram (women age 65-69); (3) were screened for colorectal cancer; and (4)the proportion of diabetics receiving annual eye examinations; (5) the proportion of diabetics receiving glucose (Hgba1c) screening; and (6) the proportion of diabetics receiving LDL blood lipids testing. A score of 100 would mean that each eligible person had received the appropriate screen or tests; a score of zero would mean that no eligible person received the recommended preventive care. A higher index is indicative of better compliance with the guidelines for preventive and screening services.

Figure 7.4 demonstrates that there was no correlation between overall Medicare spending in hospital referral regions and the index of the quality of preventive services (R^2 = .01). It appears that, even in areas that spent up to $3,000 per capita more than other regions, the quality of preventive care was no better (and very slightly worse) than in regions with lower per capita lower spending.

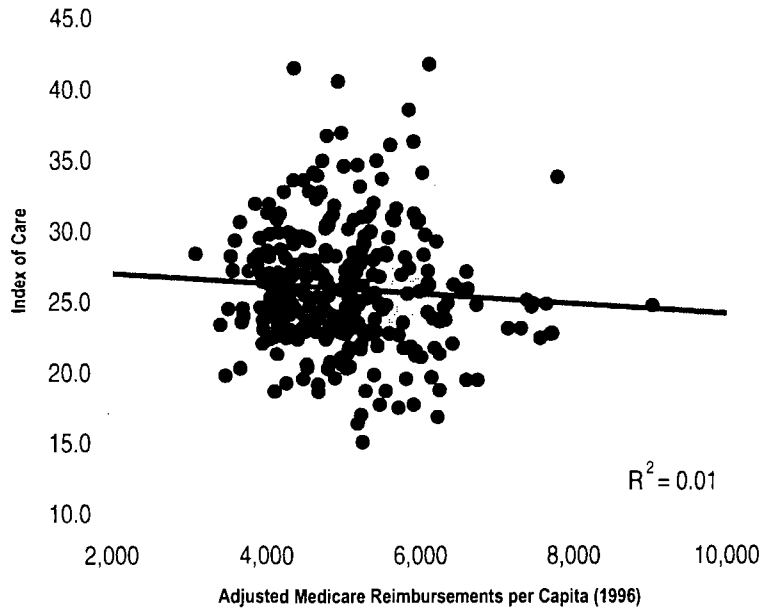

Figure 7.4. The Association Between Age, Sex, Race, Price and Illness Adjusted Medicare Spending (1996) and the Quality of Preventive Care (1995-96)

The vertical axis gives the values for the quality of care index (see text); the horizontal axis gives the fully adjusted Medicare per capita spending. There was little association between spending level and the quality of preventive care ($R^2 = .01$).

Underuse and Overuse of Surgery and The Quality of Clinical Science

Which surgical rate is "right?" Do patients in high rate areas suffer from overtreatment, while those in low rate areas receive less than adequate care? According to the Roundtable report, underuse represents the failure to provide effective treatments, and overuse means that patients are subjected to treatments for which the associated harms exceed the expected benefits. How do we know when treatments are effective, and when harms exceed benefits? Answering this question depends fundamentally on outcomes research — clinical trials and cohort studies which study the outcomes of care according to the treatment used. In many situations, however, judgments about overuse or underuse are impossible because medical science is so poor that we cannot make accurate prognoses for the use of given treatments. The research required to arrive at conclusions about harms and benefits has never been done.

The ten-fold variation in the incidence of surgery for prostate cancer is one example of how poor medical science inhibits the valid interpretation of outcomes. Rates of prostate cancer vary much less than rates of treatment, from which it can be inferred that in regions with low rates of surgery for prostate cancer, the condition is being treated in other ways (or not diagnosed at all). From the perspective of the outcome that matters most — life expectancy — the value of care has not been determined.

It cannot be said, on the basis of science, that active treatment of prostate cancer helps; nor can it be said that it does not. Under a strict interpretation of the Roundtable criteria, such as one the Food and Drug Administration uses in determining the value of drugs, any use of an unproven intervention in everyday practice is "overuse." Indeed, if prostate cancer surgery were a drug, rather than a procedure, its use would be forbidden by law until proof of efficacy had been established. Under the rules of everyday medical practice, however, most non-drug innovations escape rigorous evaluation. For such innovations, it is impossible to say, on the basis of evidence concerning outcomes, whether the observed rates constitute either underuse or overuse. Failure to evaluate the outcomes of care is, moreover, an incredible waste of the opportunity to learn what works and what patients want.

Medicare Beneficiaries: A Population at Risk Findings from the Kaiser/Commonwealth Fund 1997 Survey of Medicare Beneficiaries

Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland
December 1998

Executive Summary

Central to the debate on Medicare's future are the health care

needs of the millions of elderly and disabled Americans who depend on the program for basic health insurance coverage. As the National Bipartisan Commission on the Future of Medicare considers Medicare's role into the next century, a key challenge will be how to maintain or improve access to health care in the event of illness. Today, Medicare insures 34 million elderly Americans as well as 5 million permanently disabled beneficiaries under age 65. This population is generally at high risk for acute and chronic illness and has diverse health care needs and experiences.

To profile beneficiaries' experiences getting health care, examine their exposure to financial burden, and analyze how their experiences vary by income level, health status, and insurance coverage, The Commonwealth Fund and The Henry J. Kaiser Family Foundation jointly supported the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries. The survey, which included telephone interviews with 3,300 non-institutionalized Medicare enrollees, was conducted by Louis Harris and Associates, Inc., from November 1996 through June 1997. Beneficiaries reported on their health care access and costs, their supplemental insurance coverage, and their decision of whether to join a Medicare health maintenance organization (HMO).[1]

The survey's findings underscore the diversity of the Medicare population and point to the challenge of improving protections for the relatively large share of beneficiaries with low incomes and/or health problems.

Summary of Findings

Portrait of the Medicare Population

Overall, the survey's findings portray a population at high risk owing to problematic health and low or modest incomes. Contrary to popular media images of the wealthy and healthy retiree, two of three Medicare beneficiaries live on relatively low incomes or have health problems. One of three beneficiaries lives on an income below 200 percent of the poverty level (about $15,000 annually for an individual) and reports health problems. Half (49%) said they spend all (22%) or most (27%) of their monthly income on basic living necessities.

Beneficiaries with low incomes are more likely than beneficiaries with higher incomes to have health problems. They are more likely to be in fair or poor health, have one or

more impairments regarding activities of daily living (ADL), and experience certain health problems such as diabetes. Women are significantly more likely than men to have low incomes. Black and Hispanic beneficiaries have higher poverty rates than non-Hispanic whites.

Disabled Medicare beneficiaries under age 65—those receiving Social Security payments because of a permanent disability—are another vulnerable group. Compared with Medicare's elderly, these individuals were more likely to report fair or poor health status, functional impairments, and mental health problems. Compounding their health problems is poverty: more than two-fifths (43%) of Medicare's disabled under age 65 live at or below the poverty level. Two of five (41%) receive assistance from Medicaid, and less than a quarter (22%) have Medigap coverage or an employer-sponsored policy to supplement their traditional Medicare coverage.

Satisfaction with Medicare

Medicare beneficiaries generally gave the program high ratings, with more than half (57%) reporting they are "very satisfied," another quarter (27%) reporting they are "satisfied," and only a fraction (7%) reporting they are "dissatisfied." This high level of satisfaction holds true when analyzed by income level, health status, and type of insurance (traditional Medicare or Medicare HMO). Disabled beneficiaries under age 65 were a notable exception: they were significantly less likely than the elderly to report being "very satisfied" with Medicare.

Access Difficulties

In general, a relatively low proportion of Medicare's elderly and disabled reported health care access problems. Less than 3 percent of Medicare beneficiaries said they did not get needed care, a finding that underscores the value of Medicare's universal health insurance protection. One of seven beneficiaries (15%), though, did report difficulties obtaining needed care.

However, reports of health care access problems differ when broken down by beneficiary income, age, and health status. Beneficiaries with health problems or low incomes are at higher risk for experiencing difficulties gaining access to care: more than one of five beneficiaries (23%) who perceive their health to be fair or poor had difficulties getting needed care, and comparable rates were reported for those with long-term care needs and those living in poverty. The under-65 disabled are at relatively greater risk of having an access problem, with

a third (33%) reporting difficulties getting needed care and a quarter (25%) reporting problems obtaining home health services, mental health care, or specialist care.

Access problems also vary by type of insurance coverage. Those with Medigap or retiree health supplements to Medicare were less likely than all others to report difficulty getting needed care.

Financial Burdens

In general, the survey found that high cost-sharing requirements and gaps in Medicare's benefits package can expose Medicare beneficiaries to burdensome medical bills. One of 10 (9%) Medicare beneficiaries reported that paying medical bills in the past year had been "very difficult," while the same percentage reported spending all their savings on medical bills. Taken together, one of seven (14%) said either that paying their medical bills was "very difficult" or that paying these bills used up all their savings.

A higher share of the poor, the under-65 disabled, those in poor health, and those with ADL impairments reported problems paying their medical bills. One of four beneficiaries who are poor (27%) or in fair or poor health (24%) said that paying bills is very difficult or that doing so has exhausted all their savings. Among disabled beneficiaries, this rate increases to nearly one of three (30%).

Access and Financial Problems

One of four beneficiaries surveyed (24%) experienced access or cost problems, as determined by whether they had difficulty getting needed health care or problems paying medical bills. Among beneficiaries with health problems or low incomes, the proportion was even greater. Nearly half (47%) of all beneficiaries surveyed who are under age 65 and disabled reported access or cost problems—more than twice the rate reported by beneficiaries age 65 and older. Meanwhile, Medicare's poor were three times as likely to report access or cost problems as were beneficiaries with incomes more than twice the poverty level (41% vs. 13%). Four of 10 beneficiaries with fair or poor health status (39%) or ADL impairments (40%) reported access or cost problems.

Prescription Drug Use and Expenditures

Lack of prescription drugs under traditional Medicare exposes beneficiaries to greater financial liabilities. The vast majority (77%) of beneficiaries reported using prescription drugs on a regular basis, a reflection of the high incidence of chronic disease within the Medicare population. While some have

private supplemental insurance to fill gaps in coverage, only half (51%) of those with private supplemental insurance said their Medigap or retiree health plans cover prescription drugs.

One of 10 (11%) beneficiaries reported spending more than $100 out-of-pocket per month to pay for medications, above the amount paid in premiums. A somewhat higher percentage of the under-65 disabled population (18%) and the near-poor with incomes from 101 to 200 percent of poverty (14%) pay more than $100 per month for their prescriptions.

Role of Supplemental Insurance

To help fill in the gaps in Medicare's benefit package, most beneficiaries have some type of supplemental coverage. Medicare's poor are most likely to have Medicaid to supplement Medicare, although less than half (43%) of those surveyed with incomes below the poverty level were enrolled in both Medicare and Medicaid. Lower-income beneficiaries are least likely to have retiree health benefits from a former employer, with only 10 percent of Medicare's poor covered by employer-sponsored benefits, compared with 40 percent of those with incomes above 200 percent of poverty.

Reflecting their relatively low income levels, women are more likely than men to rely on Medicaid. Beneficiaries with private supplemental coverage were less likely to report access or cost problems than beneficiaries with Medicare alone. Beneficiaries covered by both Medicare and Medicaid had the highest rates of reported access or cost problems, most likely owing to their lower incomes and greater health problems.

Medicare and Managed Care

Medicare beneficiaries can also turn to HMOs for supplemental coverage, as had one of eight (12%) beneficiaries at the time of the survey. Reports from HMO enrollees indicate that, on average, they are about as likely as beneficiaries with other forms of private supplemental coverage to rate the care they receive as excellent. At the time the survey was conducted, HMO enrollees were more likely to rate their insurance benefits and cost-sharing positively because of the generosity of benefits provided and/or level of premiums charged.

However, reports on access experiences are slightly more mixed. HMO enrollees were about twice as likely to report access difficulties as those in traditional Medicare with private supplemental coverage (19% vs. 10%, respectively). Yet use of preventive care services is similar or, in the case of

mammograms, more extensive among those enrolled in HMOs. For both Medicare HMO enrollees and Medicare beneficiaries with private supplements, the proportion of those reporting problems paying medical bills was low when compared with that for beneficiaries with traditional Medicare only.

Cost protection appears to be one of the major factors driving HMO choice. HMO enrollees reported that lower premiums and better benefits are the leading reasons they join their HMOs—rather than a plan's reputation for quality or physician networks. Marketing activities, however, play a key role in informing the decision whether to join an HMO. More than a third (36%) of HMO enrollees said they first learned about their HMO from plan marketing sessions and advertisements. Two of five (42%) HMO enrollees said that they decided with the help of family or friends or that someone else made the choice for them.

In general, beneficiaries appear to be content to remain with the coverage they already have. The majority of Medicare HMO enrollees (88%) reported they plan to stay in their current plan; only 2 percent said they intend to switch plans, while 1 percent intend to return to the traditional Medicare program. The majority of fee-for-service beneficiaries (88%) have never considered joining a Medicare HMO. Only 4 percent of those in traditional Medicare said they intend to join a Medicare HMO in the future.

Implications

In general, the survey's portrait of Medicare beneficiaries' health and health care experiences underscores the physical and financial vulnerabilities of the Medicare population and the importance of sustaining and improving the program's protections in the future. Evidence suggests that special attention must be paid to the unique challenges faced by certain segments of the population—especially under-65 disabled beneficiaries and low-income beneficiaries. Reports of difficulties getting access to needed health care and paying medical bills among low-income beneficiaries signal a need to improve protections for Medicare's poor. Their struggles call for a reexamination of Medicare's basic benefits structure to improve coverage of basic services and financial protections for vulnerable beneficiaries in the event of major illness.

Findings From The Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries

Medicare Beneficiaries: Health Status and Income

As the nation's health insurer for nearly all the elderly as well as growing numbers of permanently disabled adults under age 65, Medicare by definition covers beneficiaries who are at high risk for acute, chronic, and disabling health conditions. Although the media often portray a relatively affluent and healthy older generation, in reality only one of three Medicare beneficiaries fits this image.

Two of three beneficiaries are at risk because of either low incomes or health problems. Two of five beneficiaries (42%) have health problems—that is, they rate their health status as either fair or poor—or receive Medicare because of a disability.[2] One-quarter of beneficiaries (26%) live on an income that is 200 percent of poverty or below, although they reported their health to be excellent or good. Only one of three (32%) beneficiaries is in relatively good health with an income well beyond poverty range. (Chart 1)

The majority of Medicare beneficiaries live on low or modest incomes. When asked about their ability to pay for basic needs such as food and electric bills, nearly one of five (19%) said they had "a lot" or "some" trouble. When probed further, half of beneficiaries said they spend all or most of their monthly income just to meet basic needs: 22 percent spend all and 27 percent spend most of their income to pay for the basics. Nearly two-thirds (63%) reported an annual income of $25,000 or less. (Table 1)

The lower their income, the more likely Medicare beneficiaries are to have health problems. Beneficiaries with incomes below poverty were twice as likely as those with incomes above 200 percent of poverty to rate their health as fair or poor (54% vs. 25%), and about twice as likely to suffer from diabetes or mental health problems. (Chart 2 and Table 1)

Functional impairments with regard to an activity of daily living (ADL)—as measured by the inability to perform regular activities such as eating or walking—further impair health and quality of life among Medicare's poorest beneficiaries.[3] Medicare's poor were two-and-a-half times as likely as those with incomes from 101 to 200 percent of poverty and four times as likely as those with incomes above 200 percent of poverty to report limitations in at least one ADL. (Chart 3)

Medicare's under-65 disabled population is particularly

vulnerable because of low income and health problems. Three-quarters (77%) of the disabled under age 65 reported incomes below 200 percent of poverty, and nearly half spent all or most of their incomes on basic needs. Three of five rated their health status as fair or poor, nearly twice the rate for those age 65 to 84. Medicare's under-65 beneficiaries are at notably high risk for mental health problems: 29 percent said they have a mental health problem, more than three times the percentage of beneficiaries age 85 and older who reported such a problem. (Table 2)

Among beneficiaries age 65 and older, Medicare's "oldest old"—those age 85 and older—have relatively low incomes and greater long-term care needs. Nearly two of five (39%) of those age 85 or older live on incomes at or below the poverty line, a rate 50 percent higher than the rate for those age 65 to 84 (22%). One of four beneficiaries (24%) reported at least one ADL limitation, nearly three times the rate for those age 65 to 84.

Women are disproportionately represented among Medicare's oldest old and Medicare's poor. Seventy percent of those age 85 and older are women. Two-thirds (68%) of poor Medicare beneficiaries are women.

Limited education exposes Medicare's most vulnerable beneficiaries to health and economic insecurity. On average, nearly two-thirds (62%) of survey respondents have at most a high school education, and one of four did not complete high school. Those with higher-than-average health risks and lower incomes tend to have less education: more than half (58%) of poor beneficiaries, 43 percent of those above age 85, and one-third (34%) of the disabled under age 65 have not completed high school.

One-third of all Medicare beneficiaries live alone. The poor, near-poor, and old are also more likely than the average beneficiary to be living alone, without the ready support of a spouse or family members: 36 percent of the poor, 40 percent of those with incomes from 101 to 200 percent of poverty, and 47 percent of those age 85 and older live alone. By comparison, 32 percent of all Medicare beneficiaries live alone. Women are twice as likely as men to live alone.

Health Insurance Coverage

Medicare covers hospital care, physician services, laboratory and X-ray services, home health care, and some skilled

nursing facility care. The program requires deductibles for hospital services ($760 per spell of illness) and physician services ($100 deductible) as well as cost-sharing for longer hospital stays and $20 coinsurance for physician services. The benefits package leaves beneficiaries exposed to catastrophic costs in the event of a serious or lengthy illness and to the full costs of benefits not covered, such as prescription drugs.

To help fill gaps in coverage, most Medicare beneficiaries rely on some form of supplemental insurance coverage. At the time of the survey, 12 percent of all beneficiaries had elected to join a Medicare HMO. The majority chose to remain in the more traditional, fee-for-service Medicare program with its open choice of physicians and medical providers nationwide. Most of those in fee-for-service Medicare have some form of supplemental coverage, whether private insurance (individually purchased Medigap or employer-sponsored retiree health coverage) or Medicaid. Including those beneficiaries enrolled in HMOs as well as those with private or public insurance supplements to Medicare, more than four of five (82%) had some form of supplemental coverage.[4]

Despite having a greater need for private supplemental coverage owing to their health problems and budget constraints, beneficiaries with low or modest incomes are less likely to have additional insurance. The interaction of income, health status, and cost of supplemental insurance leaves a significant proportion of Medicare's most vulnerable beneficiaries exposed to potential access barriers and financial burden. One-quarter (26%) of Medicare's under-65 disabled population and more than one of five of Medicare's poor (22%) have no supplemental coverage, despite their greater-than-average risk for health problems. (Charts 4 and 5)

The higher their incomes, the more likely Medicare beneficiaries are to have a retiree supplemental policy. Beneficiaries with incomes more than twice the poverty level are four times more likely than the poor and 50 percent more likely than the near-poor to have retiree coverage through a former employer. Purchasers are largely concentrated among those with incomes above poverty. Approximately one of four (24%) beneficiaries purchases his or her own Medicare policy. The under-65 disabled population reports lower levels of Medigap coverage, with only 8 percent owning a Medigap policy.

Medicare's poor and under-65 disabled beneficiaries rely

heavily on Medicaid to supplement gaps in their Medicare coverage. The poor are nearly three times as likely as the "average" beneficiary to rely on Medicaid to supplement Medicare (43% vs. 15%). Similarly, Medicare's under-65 disabled are more likely than the average beneficiary to be covered by Medicaid (41%). (Charts 4 and 5)

As the supplemental program for Medicare's poorest and sickest, Medicaid covers a particularly vulnerable group of beneficiaries. More than half of these dual enrollees rated their health as fair or poor (58%) and 34 percent reported difficulty with at least one ADL. Medicare beneficiaries with Medicaid are also more likely than the general Medicare population to have less than a high school education (59% vs. 28%) and to be living alone (43% vs. 32%). Two-thirds (66%) of all beneficiaries covered by Medicaid are women. (Table 3)

Medicare beneficiaries with traditional Medicare only, and no supplemental coverage, tend to have low or modest incomes. Two-thirds (67%) have incomes below 200 percent of poverty. Four of five live on annual incomes of $25,000 or less, while more than half (57%) live on $15,000 or less.

Having supplemental coverage varies significantly by race or ethnicity.[5] Black and Hispanic beneficiaries are three to four times as likely to be enrolled in both Medicare and Medicaid, and far less likely to be covered by a retiree supplemental plan, than are non-Hispanic white beneficiaries. (Chart 6) Race and ethnicity coverage patterns tend to reflect incomes: more than half of the black (57%) and Hispanic (56%) beneficiaries surveyed have poverty-level incomes, compared with about one of five white beneficiaries (22%). In contrast, nearly half (48%) of white Medicare beneficiaries reported incomes above 200 percent of poverty, compared with only one of five Hispanic (22%) and one of eight black (13%) beneficiaries.

Satisfaction, Access, and Financial Burden: Variations By Income

Satisfaction with Medicare, Health Services, and Physicians

Medicare beneficiaries as a group rate the program highly. A majority (57%) said they are "very satisfied" with Medicare as a program, while another quarter (27%) reported that they are "satisfied." Only a fraction (7%) reported they are "somewhat or very dissatisfied."

High program ratings hold across poverty groups yet vary by eligibility status and age. The under-65 disabled are least likely to be "very" satisfied (46%) and most likely to be "somewhat" or "very" dissatisfied (11%). These lower ratings are likely a reflection of the health problems faced by disabled enrollees and their limited access to supplemental insurance. In contrast, Medicare enrollees age 85 and older are the most likely to be very satisfied with Medicare. (Charts 7 and 8)

Beneficiaries, in general, also rated highly the health care they receive and the physicians who treat them. More than half (54%) said the health services they have received have been "excellent," and nearly three of five (59%) said their physician care has been excellent. A minority of beneficiaries gave negative ratings to health care services or physicians: 5 percent rated their physician and 6 percent rated the services they have received as fair or poor.

Beneficiaries with low incomes or health problems are less likely to rate their care or physician as "excellent." Less than half of beneficiaries with incomes at or below poverty rated health care services as excellent (47%), compared with nearly three-fifths of those with incomes above 200 percent of poverty (58%). (Chart 9) Similarly, the poor are less likely to rate physician care as excellent: half (51%) gave physicians excellent ratings, while 64 percent of beneficiaries with incomes more than twice the poverty level did so. (Chart 10) Lower ratings may well reflect perceived gaps in the Medicare benefit package.

Ratings of medical care also tend to be lower among those with health problems. Compared with beneficiaries who rated their health as excellent or good, beneficiaries who reported fair or poor health status were less likely to give their care (49% vs. 57%) or physicians (56% vs. 61%) an excellent rating.

Access Experiences

With Medicare as a foundation covering basic health care services, a relatively small share of beneficiaries (3%) reported a time they did not get needed care. Indeed, other surveys confirm that Medicare beneficiaries are significantly less likely to report not getting needed care than the U.S. population overall largely because of Medicare's universal coverage.[6]

Yet the survey finds that obtaining needed care can be a struggle, especially for those living on low incomes or those with health problems. Using a composite variable to measure

difficulties getting needed care, 15 percent of all beneficiaries reported some type of access difficulty.[7]

Reports of difficulties gaining access to health care vary significantly by poverty, age, and health status. Medicare beneficiaries with poverty-level incomes are more than twice as likely to have encountered difficulties getting health care as beneficiaries with incomes above 200 percent of poverty (23% vs. 10%). Low-income beneficiaries similarly reported problems getting specific services such as home health, mental health, or specialist services.[8] (Chart 11 and Table 5)

Beneficiaries with health problems or a disability were generally more likely to report access problems than healthier beneficiaries. More than one of five beneficiaries in fair or poor health (23%) or with at least one ADL impairment (21%) have difficulties getting care. Beneficiaries who are under 65 and disabled are particularly at risk: one-third (33%) have experienced difficulties getting care, more than twice the rate for beneficiaries age 65 to 84, and three times the rate for those age 85 and older. One of four under-65 disabled beneficiaries reported problems getting needed home health, mental health, or specialty care, more than twice the rate reported by beneficiaries age 65 to 84. (Chart 12 and Table 4)

Controlling for both income and health, those with low incomes and health problems are the most likely to encounter access difficulties. Beneficiaries with health problems who live on incomes at or below 200 percent of poverty are 50 percent more likely to have difficulty getting care (26% vs. 16%) or problems getting specific services (23% vs. 16%) than are beneficiaries with health problems who have incomes above 200 percent of poverty.[9] The incidence of access problems is markedly lower for those in excellent or good health in both income groups. Yet even among the relatively healthy segment of the Medicare population, lower-income beneficiaries were more likely to report access problems. (Table 5)

Use of preventive care services reflects access to basic, routine health care. To encourage preventive care, Medicare has expanded coverage of some preventive care services. At the time of the survey, Medicare covered flu shots in full and covered mammograms subject to a frequency schedule and a 20 percent copayment. The program did not cover prostate exams.

The survey found that substantial proportions of women and men in Medicare do not receive regular preventive care.

About two-thirds of those surveyed (64%) had received a flu shot, 51 percent of women had had a mammogram, and 59 percent of men had undergone a prostate exam in the past year.

Use of preventive care services varies widely by income and age. Just over half (55%) of poor beneficiaries surveyed had received a flu shot, compared with 70 percent of those with incomes above 200 percent of poverty. Poor and near-poor women were about 20 percent less likely to have had mammograms and poor men were nearly 50 percent less likely to have undergone prostate exams than were women and men with incomes more than twice poverty. Preventive care use is disproportionately low among the under-65 disabled. (Charts 13 and 14)

The strong link between lower income and lower use of preventive services remains even after controlling for health status. Beneficiaries with incomes at or below 200 percent of poverty are significantly less likely to receive flu shots, mammograms, or prostate exams whether or not they have health problems or are in excellent or good health. (Table 5)

Difficulties Paying Medical Bills

The survey found that gaps in benefits coverage can expose Medicare beneficiaries to the financial burden of medical bills. Nearly one of 10 (9%) beneficiaries reported that paying medical bills in the past year has been "very difficult." The same percentage reported spending all their savings on medical bills. Together, one of seven Medicare beneficiaries reported problems paying bills; that is, they reported that paying medical bills in the past year had been very difficult and/or that they had spent all of their savings as a result of these bills.

Problems paying medical bills are twice as likely among Medicare beneficiaries who are poor, who are under age 65 and disabled, and who rated their health as fair or poor. One of four beneficiaries who are poor (27%) or are in fair or poor health (24%), and nearly one of three disabled beneficiaries (30%), said that paying their medical bills is "very difficult" or that, as a result of bills, they have exhausted all their savings. (Charts 15 and 16 and Table 5)

The extent to which medical bills have drained savings for retirement will affect current and future economic security as well as access to health care. Although only 9 percent of all Medicare beneficiaries said they have depleted their savings paying off medical bills, one of five beneficiaries who is poor

(21%), is under age 65 and disabled (22%), has one or more ADL limitation (24%), or is in fair or poor health (17%) has exhausted all savings.

By controlling for both income and health, a strong association between income, health, and financial burden emerges. Beneficiaries with health problems and relatively low incomes are nearly three times as likely to have problems paying medical bills than are beneficiaries with health problems and incomes above 200 percent of poverty (30% vs. 11%). Low incomes also expose beneficiaries who rate their health as excellent or good to financial burdens: 11 percent of those with incomes at or below 200 percent of poverty who said they are in excellent or good health have problems paying bills. By comparison, only 2 percent of beneficiaries with incomes above 200 percent of poverty with similar health status have such problems. (Table 7)

Taken together, a quarter of all Medicare beneficiaries said they are having difficulties getting health care or problems paying medical bills. The risk for access or cost problems is particularly acute for low-income beneficiaries and those with health problems. Nearly half of the disabled under age 65 reported either an access or cost problem or both (47%), as did two of five of the poor (41%) and of those rating their health as fair or poor (39%). (Chart 17)

Prescription Drugs: Use and Cost Exposure

Although Medicare does not cover outpatient prescription drugs, the vast majority of beneficiaries surveyed said they regularly use them. Nearly 8 of 10 beneficiaries (77%) reported that they take prescription medications on a regular basis. Reflecting the relatively high incidence of chronic disease among Medicare beneficiaries, prescription drug use rates are high across income, age, and health insurance groups. (Chart 18)

Reports of out-of-pocket costs indicate that Medicare's lack of prescription drug coverage is exposing beneficiaries to ongoing costs that can be quite high. Eleven percent of beneficiaries said they spend more than $100 per month for their prescription drugs.

Those with health problems are at risk for high monthly payments for prescription drugs. Nearly one of five of those in fair or poor health (18%), with one or more ADL limitations (18%), or under age 65 and disabled (18%) said

they are paying more than $100 per month for prescription drugs. (Charts 19 and 20)

Beneficiaries with modest incomes are also at relatively high risk. Fourteen percent of those with incomes from 101 to 200 percent of poverty, compared with only 10 percent of those with incomes above 200 percent of poverty, are spending more than $100 per month for prescriptions. The near-poor group is also at higher risk than Medicare's poor. This exposure to high drug costs likely results from incomes that are too high to be eligible for Medicaid coverage yet too low to pay for more comprehensive supplements to Medicare, as well as from less access to retiree coverage.

The survey found that exposure to out-of-pocket drug costs is also attributable to limited prescription coverage under private Medicare supplemental insurance plans. Although the majority of beneficiaries have coverage that supplements Medicare, only half (51%) of those with private supplements to Medicare have some coverage for drugs.[10] (Chart 21)

HMO plans are an exception. Medicare HMO enrollees reported that their plans typically include prescription drug coverage: 80 percent of Medicare HMO enrollees said their plans include prescription drug benefits.

Most, but not all, Medicare beneficiaries covered by Medicaid have full coverage that includes some prescription drugs. Nevertheless, nearly one of 10 (9%) said they are spending more than $100 per month for prescription drugs.[11] (Table 6)

Satisfaction, Access, and Financial Burden: Variations By Type Of Insurance Coverage

Comparisons of satisfaction ratings, health care access, and medical bill problems by insurance coverage group indicate that experiences vary by type of insurance and type of supplemental coverage as well as by beneficiary income and health. When surveyed, 12 percent of Medicare beneficiaries had elected to join a Medicare HMO, while 15 percent were covered by Medicare and Medicaid, 28 percent by retiree supplements, and 24 percent by purchased Medigap policies; 18 percent reported no additional coverage.

The survey found generally high satisfaction ratings across insurance groups. Reflecting generally lower ratings by those with health problems and low incomes, beneficiaries dually enrolled in Medicaid and Medicare

were the least likely to give high ratings to the care they have received. HMO enrollees, as well as those beneficiaries with retiree coverage or Medigap policies, vary little in their likelihood of rating their care overall as excellent or of rating highly the Medicare program itself. (Chart 22 and Table 6)

Satisfaction with physician care is relatively low among Medicare beneficiaries covered by Medicaid and those in the traditional Medicare program who do not have supplemental coverage. For example, about 55 percent of beneficiaries with Medicaid or Medicare rate their doctor as excellent, compared with 65 percent of those with Medigap. Analysis reveals, however, that the lower ratings given by those on Medicaid tend to reflect health problems and low incomes. In logistic regressions adjusting for health status and income, Medicare/Medicaid beneficiaries were as likely or somewhat more likely to rate care as excellent as were those with Medicare-only coverage.[12]

The likelihood of having difficulty getting needed health care varies across the different insurance groups. In general, Medicare beneficiaries with either retiree or private Medigap supplemental coverage were less likely to report difficulties getting care or problems obtaining specific services than were HMO enrollees, beneficiaries jointly enrolled in Medicaid, or beneficiaries enrolled in Medicare only. Beneficiaries who are jointly enrolled in Medicaid, as well as those who are in Medicare only, were nearly three times as likely to report problems getting care as were those with private supplemental coverage. Medicare-only beneficiaries and HMO enrollees were about twice as likely to report difficulties (20% and 19%, respectively) as beneficiaries with private supplements to Medicare (10%). (Chart 23)

Beneficiaries either enrolled in HMOs or having private supplements are the most likely to have received basic primary care, as determined by flu shots, prostate exams, and mammograms received. Medicare beneficiaries in HMOs reported the highest rates of mammograms, with more than two-thirds (68%) of women having had an exam in the past year.

Compared with little more than half of those with retiree health benefits (55%) or Medigap (51%), Medicare beneficiaries with no supplemental insurance coverage and those with Medicaid have notably lower rates of receiving preventive care. Despite Medicaid's supplemental role and enhanced coverage of out-of-pocket costs, access to routine

and primary care services remains a problem for low-income Medicare beneficiaries. (Charts 24, 25, and 26)

Financial burdens due to medical bills vary across insurance groups. Medicare beneficiaries with retiree supplemental coverage and those enrolled in HMOs appear to be the best protected against prescription drug costs. Only 4 percent of HMO enrollees and 7 percent of beneficiaries with retiree coverage said they are spending more than $100 per month on drugs—half the rate of the Medicare average. In contrast, 19 percent of beneficiaries with Medigap policies said they are spending more than $100 per month on drugs, likely because of gaps in benefits coverage. While beneficiaries with Medicaid reported less exposure to burdensome drug costs than those with Medigap or Medicare-only coverage, prescription drug costs remain problematic for them given their low incomes: 9 percent of those with Medicaid reported they are paying more than $100 per month. (Chart 27)

Despite HMOs' reputation for low cost-sharing requirements and comprehensive benefits, 9 percent of Medicare HMO enrollees said they find paying medical bills "very difficult," and 8 percent reported they have spent all their savings as a result of bills. In all, 13 percent of Medicare HMO enrollees reported having financial burdens from medical bills. (Chart 28)

HMO enrollees and Medigap-covered beneficiaries were about equally likely to report financial burdens (13% and 11%, respectively). Rates for both groups, however, are well below the rates for beneficiaries with Medicaid or Medicare-only coverage. (Chart 27 and Table 6)

Beneficiaries with retiree supplemental coverage appear to be the best protected against medical bill problems. Only 3 percent said that paying bills is "very difficult," and 3 percent said that they have exhausted all their savings; 5 percent reported at least one of the two problems. In part, these responses reflect higher-than-average incomes: 45 percent of Medicare beneficiaries with retiree coverage have incomes greater than $25,000, and 63 percent have incomes more than twice poverty—significantly greater proportions than those for all other Medicare insurance groups.

Regarding access difficulties and cost problems, one of four HMO enrollees reported one or both types of problems, a rate significantly lower than that for Medicare beneficiaries with Medicaid but higher than that for beneficiaries with Medicare

supplemented with either retiree or Medigap coverage. Overall, beneficiaries with retiree supplements were the least likely to report these problems.

In general, beneficiaries dually eligible for Medicare and Medicaid fare the worst. Reflecting both their low incomes and their health problems, these individuals were the most likely to report access and/or cost difficulties, with 45 percent saying they have one or both types of problems. Medicare-only beneficiaries are also at high risk: 30 percent said they have difficulties getting care, paying bills, or both.

HMOs: Making The Decision To Enroll

Medicare offers beneficiaries the option of receiving benefits through an HMO, rather than through the basic Medicare program. In general, HMOs offer beneficiaries expanded coverage in return for agreeing to use their networks of medical care providers. To understand current enrollees' decisions to enroll and determine which sources of information they use to make these decisions, the survey asked current enrollees a series of questions about the decision-making process.

HMO advertising appears to have reached most Medicare beneficiaries. Roughly two-thirds (62%) said they had seen an advertisement for a Medicare HMO or received literature. Beneficiaries with incomes above 200 percent of poverty and those age 65 to 84 were the most likely to report having seen or received HMO advertisements. (Chart 29)

Medicare HMO enrollees reported that plan advertisements and marketing materials were their leading source of information about HMOs, followed by family and friends and employers. One-third (35%) said they first learned about their HMO from advertisements, while another 25 percent said they heard about their HMO from a family member or friend. Employers are also becoming a source of information: 14 percent reported learning about their HMO through their employer. (Chart 30)

Lower premiums and enhanced benefits coverage are the leading reasons HMO enrollees gave for making the decision to join an HMO. Almost one-third (32%) said premiums and another 18 percent said improved benefits were the main reason they joined their HMO. Beneficiaries were far less likely to cite an HMO's reputation for quality of care as the main reason for joining: only 2 percent mentioned quality,

while 6 percent mentioned the plan's reputation. (Chart 31)

Making the decision to join an HMO is often difficult and requires the help of others. Slightly more than half (56%) of beneficiaries said they made the decision on their own. However, a third made the decision jointly with a family member or friend, and one of 10 delegated the decision entirely (11%.) Medicare beneficiaries with low or modest incomes were more likely to report delegating the decision or seeking out help.

In general, beneficiaries appear to be content to remain with the coverage they already have. The majority of Medicare HMO enrollees (88%) plan to stay in their current plan; only 2 percent reported they intend to switch plans and one percent intend to return to the traditional program. The majority of fee-for-service beneficiaries (88%) have never considered joining a Medicare HMO. Only 4 percent of those in traditional Medicare said they intend to join a Medicare HMO in the future.

Implications

The survey findings confirm the wide popularity of the Medicare program among beneficiaries. Medicare has served the nation's elderly and disabled well for more than 30 years. Yet the findings indicate the importance of reexamining the program to ensure that it will be able to provide health and economic security for the elderly and disabled into the 21st century. Probing beneath the averages, the survey found that a substantial proportion of Medicare beneficiaries, especially the poor, the under-65 disabled, and those in poor health, are struggling under the financial burden of medical bills or are finding it difficult to get care when needed. In the quest to ensure Medicare's future, the voices of these Medicare beneficiaries speak of a vulnerable and diverse population and highlight issues of concern for any consideration of restructuring Medicare.

With two of three beneficiaries living on low or modest incomes, having fair or poor health, or being disabled, Medicare insures a population that is at high risk for needing health care and, absent adequate health coverage, faces financial burdens. Policy officials face the dual challenge of designing strategies to protect or assist those at high risk and assuring the program's long-term fiscal soundness.

Today, one of four beneficiaries reports difficulties with

access to care or paying medical bills—despite high rates of supplemental coverage. Medicare's high cost-sharing requirements and limited coverage for prescription drugs impose notable financial burdens on beneficiaries living on low or modest incomes.

Past efforts to protect low-income beneficiaries have relied on Medicaid to supplement Medicare. The survey finding that only 43 percent of beneficiaries with incomes at or below poverty are covered by Medicaid indicates the need to increase outreach efforts to those likely to be eligible for Medicaid's additional protection. A possible policy option for the future could be to federalize supplements for low-income elderly and disabled people, with Medicare directly administering the program.

For beneficiaries with higher incomes, as access to affordable supplemental insurance erodes, the pressure on their ability to pay for care is likely to intensify in the future. Retiree health coverage currently helps fill in gaps in program benefits for one of four beneficiaries. This coverage, however, is expected to dwindle in the coming years owing to recent trends in declining employer-paid retiree benefits.[13] In addition, rising Medigap premiums may limit access to supplements for another quarter of all beneficiaries who purchase policies individually. These trends, taken together, suggest that a growing proportion of beneficiaries will be forced to rely on their own incomes to supplement Medicare—incomes that, in turn, may be limited by future constraints on private pension coverage.

Reexamination of Medicare's basic benefits package could directly address some of the gaps in coverage and exposure to financial insecurity. Prescription drugs are of particular concern: traditional Medicare does not cover outpatient prescription drugs and, according to this survey, only half of beneficiaries with a private supplement have coverage for their medications. Prescription drugs are now an integral component of medical care, and eight of 10 Medicare beneficiaries regularly use prescription medication. Those with high monthly costs put themselves at financial risk or must forego needed medication. The risk increases with poor health: one of five beneficiaries with health problems or disabilities is paying more than $100 per month for drug expenses.

Recent Medicare changes designed to expand plan choices, if successful, are likely to heighten the complexity of beneficiaries' coverage decisions while creating the risk of

introducing new access problems or financial burdens. The heterogeneous nature of the Medicare population, combined with higher-than-average health care risks, poses major challenges for choosing wisely among plans. In addition to advancing age and disabilities, almost a third of Medicare beneficiaries have less than a high school education. As Medicare choices grow more complex, making good decisions will become even more difficult for an aging and disabled population. Lower education or reading levels will only compound the difficulty of this challenge. The task of understanding network limitations as well as the nuances of benefits packages emphasizes the urgency of developing program standards to ensure high-quality plans and an administrative structure capable of supporting informed choice among a vulnerable, high-risk population.

The survey confirms the widespread support Medicare now enjoys among beneficiaries. Other surveys find similarly strong support for Medicare among the general population.[14] By listening to and learning from the experiences of Medicare beneficiaries, the survey makes clear the need to improve protections for those who are vulnerable because of poor health, disabilities, or low incomes. Addressing beneficiary concerns for their health and economic security is central to the debate on how to ensure a more secure future for the Medicare program.

Survey and Study Methodology

The survey consisted of 25-minute telephone interviews with a random sample of 3,305 Medicare beneficiaries. Louis Harris and Associates, Inc., conducted the interviews from November 1996 through mid-June 1997.

The sample was drawn from a 5 percent random sample of all persons who were Medicare beneficiaries as of March 1996 according to Health Care Financing Administration (HCFA) records. The survey sample includes an over-sample of beneficiaries enrolled in Medicare risk-contract HMOs to permit comparisons of HMO enrollees with beneficiaries covered under the traditional Medicare program. The final unweighted sample consists of 1,579 HMO enrollees and 1,726 individuals enrolled in traditional Medicare.

To adjust for over-sampling and to produce nationally representative estimates for the Medicare population living in the community (not institutionalized), the final sample was weighted for the known demographic distribution of the

Medicare population based on the March 1996 Medicare enrollment file (denominator file). Data were weighted for eligibility status; age, race, and ethnicity; Medicaid buy-in status; and the proportion enrolled in HMO risk contracts. All findings are based on the weighted sample.

Interviews were conducted in English or Spanish, depending on the preference of the respondent. Where the listed person could not participate in the interview owing to health or disability, interviews were conducted with a proxy, whenever possible, who was knowledgeable about the beneficiary. In total, 12 percent of the interviews were conducted with proxies.

The resulting sample has an overall margin of error of plus or minus two percentage points at the 95 percent confidence level. For subgroups of 500 or less, the margin of error increases to plus or minus five percentage points at the 95 percent confidence level.

Definitions of Key Variables
The analysis used information from initial Medicare records on Medicare eligibility (disability and age), HMO enrollment, and Medicaid status, as well as information provided by beneficiaries to categorize different groups of Medicare beneficiaries. We drew on a variety of questions relating to access to health care and financial burdens to create summary variables indicating access and cost difficulties. Definitions of key variables are as follows:

Poverty: Respondents were asked to estimate annual family income within several income categories, with lower cutoffs based on 1996 average federal poverty levels for single-, two-person, and larger family sizes. We imputed one of three poverty classes for the 11 percent of the sample who did not provide income information based on other social and economic characteristics.

Difficulty getting care: The survey asked four questions regarding the ease or difficulty of getting care when needed. These included: whether getting care was "extremely," "very," "somewhat," "not too" or "not at all" difficult; whether there was a time the respondent had delayed getting care in the past year; and whether there was a time the beneficiary had not received either needed medical care or specialty care in the past year. A composite variable indicating difficulty included any respondent who said getting care was extremely, very, or

somewhat difficult, or who had delayed care or not received medical care or specialty care.

Bill-paying problems: The survey asked respondents whether, in terms of their family budget, paying medical bills was "very difficult," "difficult but manageable," or "not difficult." Anyone who had difficulty was then asked about the consequences of these difficulties, including whether medical bills meant that they had spent all of their savings. In the analysis, anyone who said paying medical bills was "very difficult" and/or said that they had spent all of their savings as result of medical bills was classified as having a problem paying medical bills.

Insurance groups: The initial listing of Medicare beneficiaries indicated whether or not the beneficiary was currently enrolled in a risk-contract HMO. The HCFA listing also indicated those Medicare beneficiaries who were also covered by Medicaid through state buy-in status. The questionnaire verified coverage status, asked about other forms of supplemental coverage, and determined whether any beneficiaries had switched into or out of HMOs. Anyone answering "no" to all types of supplemental coverage and HMO coverage was classified as having Medicare only. The combination of initial HCFA records on Medicaid buy-in status and HMO enrollment plus responses to the questionnaire was used to group the survey sample into insurance categories.

Age groups: The HCFA file also indicated whether the beneficiary was eligible based on age or whether the beneficiary was eligible as someone who was under age 65 and disabled or who had end-stage renal disease. Interviewing took place a year or more after the March 1996 date of HCFA beneficiary listing. In the analysis, any beneficiary eligible on the basis of disability was categorized as under-65 disabled. All other beneficiaries were grouped according to their age at the time of the interview.

Appendix B: Charts

Appendix C: Tables

Footnotes

[1]To enable comparisons by type of insurance coverage, the study over-sampled Medicare HMO enrollees. Appendix A provides further description of the

survey and sample design.

[2] In Chart 1, which divides survey respondents by health status and income level, all beneficiaries under age 65 who are on Medicare owing to a disability or end-stage renal disease are grouped with those beneficiaries who rated their health as fair or poor, regardless of their self-assessed health status.

[3]The survey asked about six ADLs: dressing, bathing, getting in and out of bed or chairs, using the toilet, eating without help, and walking short distances. For each, the respondent indicated whether he or she could do the activity alone, without the help of another person.

[4]Based on comparisons with the federal Medicare Current Beneficiary Survey, the survey sample may understate the extent of supplemental coverage. Recent data indicate that only 11 percent of beneficiaries have neither an HMO nor private or public supplements that would cover benefits beyond basic Medicare. Franklin Eppig and George Chulis, "Trends in Medicare Supplementary Insurance 1992-1996," Health Care Financing Review 19(Fall 1997):201-206.

[5]The survey was conducted in English and Spanish, depending on the preferences of the respondent. As a result, the sample underrepresents minorities who speak other languages.

[6]Cathy Schoen et al., Working Families at Risk: Coverage, Access, Costs, and Worries-The Kaiser/ Commonwealth 1997 National Survey of Health Insurance, April 1998; and Catherine Hoffman et al., Gaps in Health Coverage Among Working-Age Americans and Consequences, draft of a Kaiser/Commonwealth Fund paper, February 1998.

[7]Four questions were used to assess difficulty in getting care: whether there was a time the beneficiary had not received needed care in the past year, had not received needed specialty care in the past year, or had delayed getting care in past year, or whether getting care when needed was "extremely," "very," or "somewhat" difficult. Respondents answering "yes" to any one of the four questions were classified as having difficulty getting care.

[8]The survey also asked respondents to rate their ability to get specific services when needed as "excellent," "good," "fair," or "poor." Respondents giving a fair or poor rating to their ability to get home health, mental health, or specialist care were classified as having a problem getting specific services.

[9]Having health problems is defined as having rated health as fair or poor, or as being enrolled in Medicare as someone who is under age 65 and disabled.

[10]Lack of supplemental insurance coverage for prescription drugs likely reflects the cost of such coverage. Private supplements that include drugs are typically expensive and offer limited coverage. Lauren A. McCormack, Peter D. Fox, Thomas Rice, and Marcia L. Graham, "Medigap Reform Legislation of 1990: Have the Objectives Been Met?," Health Care Financing Review 18 (Fall 1996):157-174.

[11]Medicaid beneficiaries without prescription coverage could qualify for Medicare cost-sharing assistance, but not full benefits, under the Qualified Medicare Beneficiary (QMB) program or the Specified Low-Income Medicare Beneficiary (SLMB) program.

[12]In logistic regressions controlling for education, health, income, and other demographic characteristics, we found that Medicare/Medicaid enrollees were somewhat more likely to rate health services as excellent than were beneficiaries with Medicare-only coverage.

[13]Hewitt Associates, Retiree Health Trends and Implications for Possible Medicare Reforms, The Henry J. Kaiser Family Foundation, September 1997. See also Pamela Loprest and Cori Uccello, Uninsured Older Adults: Implications for Changing Medicare Eligibility, The Commonwealth Fund, March 1998.

[14]Henry J. Kaiser Family Foundation/Harvard University School of Public Health, National Survey on Medicare, October 20, 1998.

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Appendix C: Tables Part 1 | Appendix C: Tables Part 2
Medicare Beneficiaries: A Population at Risk

September 5, 2000

Governor George W. Bush

"Modernizing Medicare and Offering An Immediate Helping Hand"

"Since 1965, more than 80 million American seniors have found a measure of security – a measure of confidence and dignity – in Medicare. Medicare is an enduring commitment of our country, but it must be modernized for our times. We will work to modernize Medicare. But we will not wait to help seniors without prescription drugs." -- Governor George W. Bush

EXECUTIVE SUMMARY

Governor Bush believes the nation has a moral obligation to ensure that retirement is a time of health and security for America's seniors. Medicare has provided this security to millions of Americans since 1965. However, while medicine has advanced, Medicare has not: its outdated, "one-size-fits-all" benefit package does not cover prescription drugs, preventive care or many modern medical technologies. As a result, Medicare now covers only 53% of the average senior's annual medical expenses.

The financial health of Medicare is also in jeopardy. As the 77 million Baby Boomers start retiring at the end of the decade, Medicare will generate cash flow deficits beginning in 2010, and, unless it is reformed, become insolvent by 2025.

Over the last 8 years, the Administration has squandered the opportunity to fashion bipartisan Medicare reform and provide coverage for prescription drugs. This failure of leadership has left up to 12 million seniors completely without prescription drug coverage.

Having blocked fundamental reform, **Vice President Gore now proposes to tack a prescription drug benefit onto the existing Medicare system.** As Democratic Senator John Breaux has said, this merely "put[s] new gas in an old car." **In contrast, Governor Bush will lead a bipartisan effort to modernize Medicare itself, providing seniors with prescription drug coverage and a choice of modern plans. At the same time, he will provide an immediate prescription drug benefit – until such coverage is provided through reform.**

To modernize Medicare, Governor Bush will offer a $110 billion MediCARxES proposal for comprehensive reform, which will:

- Guarantee that every senior shall remain entitled to current Medicare benefits.
- Give Medicare recipients a choice of modern health plans, including coverage for prescription drugs.
- Cover the full cost of Medicare premiums for seniors with incomes at or below 135% of poverty, and subsidize the cost of prescription drug coverage for seniors with incomes between 135% and 175% of poverty.
- Cover catastrophic Medicare costs in excess of $6,000 annually for all seniors.
- Pay 25% of premium costs for prescription drug coverage for all seniors above 175% of poverty.

To ensure that low-income seniors do not have to wait for overall reform to have their prescription drugs covered, Governor Bush will establish the "Immediate Helping Hand" program, which will provide $48 billion of direct support to states for four years to:

- Cover all costs of prescription drugs for seniors with incomes at or below 135% of poverty, and a part of the cost for seniors with incomes between 135% and 175% of poverty.
- Cover any prescription drug costs in excess of $6,000 annually for all seniors.

Medicare Today

"When Medicare was passed in 1965, President Lyndon Johnson said: 'No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime.' Thirty-five years later, it is time for our nation to come together and renew that commitment." -- Governor George W. Bush

Medicare today provides health insurance for over 39 million people aged 65 years and over and certain individuals with disabilities. Enacted in 1965, Medicare was based on a fee-for-service model broken into two parts: hospital services and physician services. Thus, the Medicare program has two basic components:

- Part A (Hospital Insurance): Provides individuals who paid the Medicare payroll tax with premium-free care in hospitals, skilled nursing facilities, hospices and some home care. Part A is financed primarily by payroll taxes, shared equally by employers and employees.

- Part B (Physician Insurance): Provides coverage to individuals for physician services, outpatient hospital care, and certain other medical services not covered by Part A. Part B is financed 75 percent by general revenues and 25 percent by beneficiaries who currently pay a premium of $45.50 per month.

Since 1965, this system has successfully served the health care needs of more than 80 million seniors. However, it has failed to keep pace with 21st century medicine, and requires fundamental reform to address three challenges that are undermining its continued viability: demographic changes that threaten it with insolvency, a burdensome bureaucracy that is prone to abuse and slow to serve, and an outdated benefit package that fails to cover many preventive treatments, modern medical technologies, and prescription drugs.

Approaching Insolvency

"Medicare has long-term budget problems – rooted in rising costs and an aging population – that threaten to make it insolvent by 2025." -
- Governor George W. Bush

The government measures Medicare's solvency solely by the fiscal health of the Part A (Hospital Insurance) Trust Fund. This is not only misleading, since Part A represents only 60 percent of total spending on Medicare, but it also creates opportunities for increasing the appearance of solvency by merely shifting costs from Part A to Part B. This happened in 1997, when the Balanced Budget Act shifted the most expensive part of home health care from Part A to Part B.

The reality is that both Part A and Part B are facing financial pressures that cost shifting may help disguise but cannot solve. Since Part A is primarily funded by payroll taxes, its financial solvency is being undermined by the same demographic changes that are undermining Social Security.

In about 10 years, the first of the 77 million Baby Boomers will become eligible for Medicare. As the ranks of Medicare beneficiaries swell, the ratio of workers to beneficiaries will decline. Thus, the payroll taxes of fewer and fewer younger workers will be available to support the benefits of more and more retirees. As a result, using the intermediate assumptions of the Medicare Trustees, payments out of the Part A Trust Fund will exceed income into the Trust Fund by 2010, and the Trust Fund's assets will be exhausted by 2025.

In addition, Medicare Part B, which is financed primarily from general revenues, continues to grow about 5 percent faster than the economy as a whole. If nothing is changed, that number will increase substantially, leaving fewer federal dollars to support other government programs.

The only way to keep the Medicare system financially sound is to increase payroll taxes – or reform the system. Comprehensive reform – reform that modernizes the current one-size-fits-all benefit package with a variety of modern health plans – will not only give seniors more choice and more control over their own health care, but will also generate significant savings through competition.

Bureaucratic Complexity, Fraud and Abuse

> *"When you need a driver's license, bureaucracy can be frustrating. When you need medical care, bureaucracy can be a hazard to your health."* --
> Governor George W. Bush

The need for Medicare reform arises not only from the program's precarious finances but also from the complexity of the Medicare bureaucracy itself. The Health Care Financing Administration (HCFA), which administers Medicare, has published:

- Over 132,000 pages of regulations – three times longer than the U.S. Tax Code; and
- Over 10,000 different prices for medical care in 3,000 counties.

Medicare providers maintain that the program's burdensome regulations force them to take time away from patient care to comply with excessive and complex paperwork. Worse, an increasing number of physicians are threatening to no longer treat Medicare patients.

Excessive administrative complexity also makes Medicare prone to fraud and abuse. In 1999, the Inspector General determined that Medicare made $13.5 billion in improper payments. But, due to the complexity of the system, it is often difficult to tell where honest mistakes end and fraud begins. As Dr. Robert Waller, Chairman Emeritus of the Mayo Foundation has testified, "The public has been led to believe that the Medicare program is riddled with fraud, when, in reality, complexity is the true root of the problem."

Outdated Benefit Package

> *"Current Medicare benefits were modeled on a good private insurance plan – from 1965. Back then, the primary concern was hospital costs. Today, many seniors are now treated at home, or a doctor's office, with drugs and new medical technologies. Back then, in 1965, the focus was acute care. Today, there is a greater emphasis on preventive care. Medicare is an enduring commitment of our country, but it must be modernized for our times."* -- Governor George W. Bush

When Medicare was created in 1965, the benefit package was based on the most popular Blue Cross/Blue Shield insurance policy offered to many working Americans. However, while medicine has changed profoundly in the last 35 years, Medicare's benefit package has remained frozen in time.

Preventive Care

Today, the focus on health care is increasingly on areas not covered by Medicare: preventive medicine and outpatient care. For example, Medicare does not cover a variety of preventive and other treatments now routinely covered by private insurance:

- Annual physicals;
- Hearing tests and hearing aids;
- Eye care, eye glasses and vision tests;
- Dental care; and
- Long-term care.

Medicare also does a poor job treating chronic diseases. Instead of treating these health conditions early, the Medicare system provides incentives for beneficiaries to wait until their conditions become acute. This ends up costing seniors, and the Medicare system, more money.

Access to New Medical Technology

Medicare is also slow to provide seniors with access to new medical technology. Indeed, Medicare's procedures for adding new technologies to the benefits package have not been fundamentally overhauled since the program was established in 1965. The result is that many seniors are denied state-of-the-art care routinely covered by private insurers.

Most recently, a report by the Lewin Group found that it takes 15 months to five years, and sometimes longer, to add new technologies to Medicare. The report concluded, "the process for coverage, coding, and payment for many medical technologies is complicated and time-consuming, impeding patient access and discouraging innovation of breakthrough technologies. Potentially, thousands of patients could potentially go without an important new technology in the period of time required to obtain Medicare coverage." For example:

- Medicare still does not cover the use of Positron Emission Topography (PET), a unique diagnostic imaging technique approved by the FDA, for many of the indications that have been reimbursed by private insurance companies for almost a decade, such as brain tumors and epilepsy.

- Medicare does not cover the use of ultrasound technology to stimulate the healing of broken bones, despite the fact that it was approved by the FDA in 1994, has a 91 percent healing rate, and is currently being reimbursed by over 800 private insurers and health plans.

It even took an act of Congress in 1997 to get Medicare to cover a test for prostate cancer – even though it had been on the market for nearly a decade.

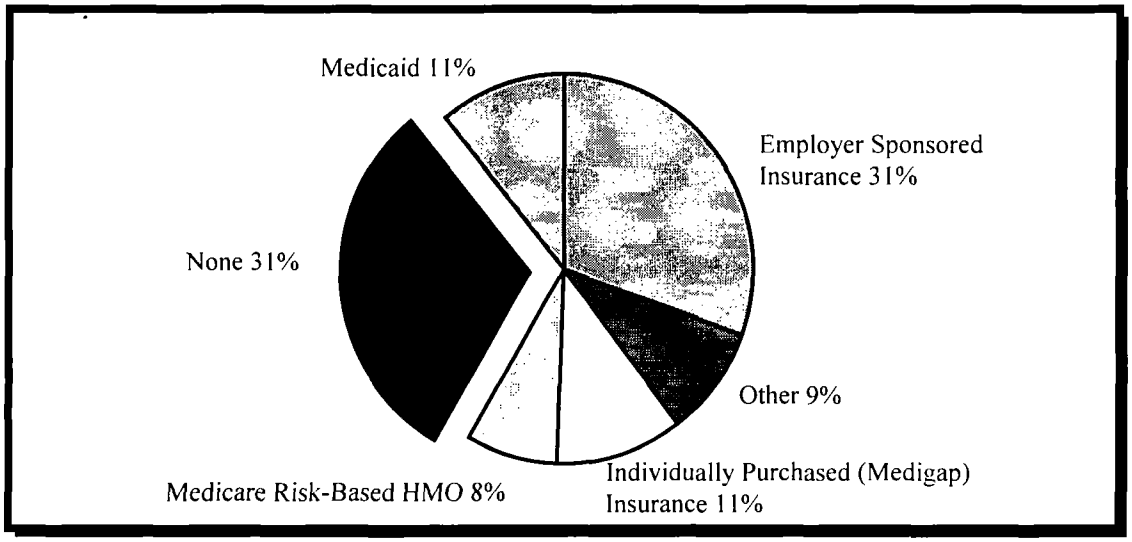
Lack of Prescription Drug Coverage

One of the most glaring omissions in the Medicare benefit structure today is the lack of prescription drug coverage. Today's medical science relies increasingly on prescription drugs to treat disease and reduce health care costs. For example, ulcer surgery that could cost upwards of $28,000 is declining because of the new "H2 antagonist drugs" which

cost $900 per year. Similarly, a year's worth of blood thinning anticoagulants, which help prevent the recurrence of strokes, are relatively inexpensive at $1,000 per year when compared with the $100,000 in total lifetime costs of taking care of a person who has suffered a stroke.

As medical science continues to advance, prescription drugs are becoming a more integrated part of how our nation delivers health care. In fact, in the last decade alone, 370 new medicines have been developed to fight cancer, heart disease, diabetes, Parkinson's, Alzheimer's, depression and arthritis.

Sources of Prescription Drug Coverage for Medicare Beneficiaries



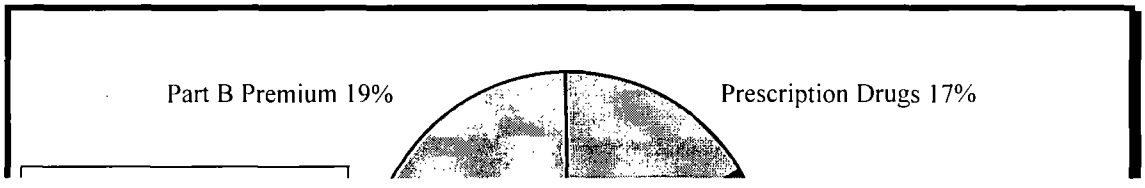
SOURCE: Congressional Budget Office

However, unlike 98 percent of private health plans today, Medicare does not offer a prescription drug benefit or a cap on out-of-pocket expenses. As a result, about one-third of Medicare beneficiaries pay for prescription drugs out-of-pocket or go without them. Worse, according to the American Association of Retired People (AARP), this financial burden falls heaviest on those least able to afford it.

Financial Impact of Inadequate Coverage

As a result of Medicare's failure to keep pace with modern medicine, seniors are increasingly paying out-of-pocket for various preventive treatments, access to medical technology, and prescription drugs. In fact, according to an analysis completed for the National Bipartisan Commission on the Future of Medicare, **Medicare's benefit package now covers only 53 percent of the cost of health care for the average senior**. According to the AARP, this meant that in 1999 Medicare beneficiaries spent an estimated $2,430 – or 19 percent of income – out-of-pocket for health care goods and services.

MEDICARE RECIPIENTS SPEND $2,430/YR. OUT-OF-POCKET ON HEALTH CARE



Source: AARP

The remaining costs are either not covered or are covered by insurance provided by "Medigap" or by employers for their retirees. But even most Medigap or retiree plans do not provide protection against financial exposure from the cost of outpatient prescription drugs, yearly physical exams, some preventive tests, routine hearing, eye or dental care, and long term care.

Congress created the Medicare+Choice program as part of the 1997 Balanced Budget Act to help expand the types of health plans available to seniors, as well as encourage coverage of areas of healthcare not covered by traditional Medicare. The expectations for this program, however, have not matched its reality. Because of burdensome regulations and uncertainty over reimbursements, even health plans that have had long histories of involvement with the Medicare program have been withdrawing from selected markets or from Medicare entirely and only a limited number of new plans have opted to join Medicare.

Lack of Leadership by the Administration

"This administration has been a roadblock to reform. In 1997, a commission of Republicans and Democrats was appointed to propose ways to modernize Medicare. It outlined a bipartisan direction for fixing the program. But, at the last minute, the Clinton-Gore Administration turned against the commission and undermined its work. Instead of solving an important problem, they chose to score political points."
-- Governor George W. Bush

During their 1992 campaign, Al Gore and Bill Clinton promised to save Medicare. In their first term, they promised to provide coverage for prescription drugs. However, instead of using this time of prosperity to save and strengthen Medicare, the Administration has stymied efforts at bipartisan reform and has actually proposed cuts in Medicare itself.

The National Bipartisan Commission on the Future of Medicare was created by statute in the Balanced Budget Act of 1997 and was required to make recommendations by March 1, 1999. The Commission, comprised of experts from the public and private sectors, was charged with examining the Medicare program and making recommendations to strengthen it before the "Baby Boom" population became Medicare eligible.

After initially supporting the Bipartisan Commission during its yearlong deliberations, the Administration publicly disavowed the Commission, sealing its fate. Each of the Administration's hand-picked appointees

voted against the final recommendations of the Commission, leaving the bipartisan plan one vote short of the 11 votes needed to ratify a plan.

While the Commission's final plan – which included coverage of prescription drugs – was not perfect, the Commission's proposal provided a clear opportunity to forge a bipartisan consensus to save and modernize the Medicare system. When the Administration rejected that opportunity, the Chairman of the Bipartisan Commission, Democratic Senator John Breaux, observed, "[t]here are entrenched people within the White House who don't want change." Democratic Senator and Commission member Bob Kerrey lamented, "[w]hat the President is doing with Social Security and Medicare is politically satisfying, but it is financially inadequate."

In addition to blocking bipartisan reform, the Administration has cut the Medicare budget. Vice President Gore actually cast the tie-breaking vote in the Senate for the FY 1993 Budget Conference Report that included $55.8 billion in Medicare cuts. The Administration's latest budget proposes cutting Medicare by $70 billion over ten years.

Together, the Administration's actions and lack of leadership have precluded Medicare modernization and access to prescription drug coverage for many seniors.

States and Prescription Drug Coverage for Seniors

Twenty-three states, representing approximately 60% of the U.S. population, have enacted state pharmaceutical assistance programs, accepting responsibility for insuring seniors where the federal government has neglected it. These state programs are vitally important and are helping to provide some access to prescription drugs to millions of seniors.

In Pennsylvania, for example, the Pharmaceutical Assistance Contract for the Elderly, (PACE), provides coverage for most prescription drugs to single seniors with incomes at or below $14,000 and married seniors with combined incomes at or below $17,200. Seniors participating in PACE can obtain prescription drugs, without meeting any deductible, and with a copayment of $6.

Low-income seniors who do not qualify for PACE may be covered under PACENET, which provides coverage for drug expenses over $500 to any single senior with an income at or below $16,000 and any married senior with an income at or below $19,200. Seniors at slightly higher levels of income may be covered under the PACENET program.

In Johnstown, Pennsylvania, for example, an 80-year old widow living on an income of $10,858 has a drug regimen that costs $2,500 annually. Without PACE, she would have had to sell her home to afford her medications. A 65-year-old woman living at her own home in Philadelphia takes six prescription medicines daily, costing nearly $300 per month. Living on an annual income of $13,000, this woman said that without PACE, she would have to choose between food and her medications.

In Minnesota, seniors with incomes at or below 120% of poverty without assets exceeding a certain level are eligible for prescription drug coverage from the state. Seniors who participate in the program are subject to a deductible. This program is providing coverage to many low-income seniors who otherwise could not afford to obtain prescription drugs to meet their health care needs.

With additional resources, states with prescription drug programs could cover more low-income seniors, increase their benefit packages, or provide other services that address the

health care needs of seniors. States without programs could offer coverage for prescription drugs to seniors who otherwise could not afford them.

Providing Leadership for Bipartisan Medicare Modernization

"I want to seize this moment to modernize Medicare. To increase, not just funding, but choices, and quality, and security. To provide a prescription drug benefit. And to place Medicare on firm financial ground." -- Governor George W. Bush

Governor Bush believes that seniors should not have to choose between paying for prescription drugs or paying for food. The best way to ensure that seniors have adequate prescription drug coverage – as well as access to preventive care and new medical technologies – is through fundamental Medicare reform.

Governor Bush will work to enact bipartisan Medicare modernization legislation. On May 15, 2000, he outlined six principles for such reform:

- Medicare's current guarantee of access to seniors must be preserved;
- Every Medicare recipient must have a choice of health plans, including the option of purchasing a plan that covers prescription drugs;
- Medicare must cover expenses for low-income seniors;
- Reform must provide streamlined access to the latest medical technologies;
- Medicare payroll taxes must not be increased; and
- Reform must establish an accurate measure of the solvency of Medicare.

Consistent with these principles, Governor Bush will offer a proposal for comprehensive Medicare modernization, called the MediCARxES plan. MediCARxES (Medicare Choice and Access to Prescription Drugs for Every Senior) builds on the Governor's six principles, and is modeled on the proven 40-year track record of the Federal Employees Health Benefit Program (FEHBP).

Today, FEHBP successfully provides health benefits to nine million federal employees - including Members of Congress - and retirees. The FEHBP provides federal employees with a wide range of choices in health plans. Each year, federal employees receive a book that includes a list of all qualified health plans and compares benefits available under each. Federal employees can then choose the benefits package that best suits their particular health care needs. This program for federal employees reports one of the highest levels of satisfaction of any health care system in the country.

Governor Bush believes America's seniors should have a similar choice of plans, providing coverage and care consistent with modern medicine. Thus, Governor Bush's MediCARxES plan for comprehensive Medicare reform will:

Provide $110 billion for Medicare Modernization: Comprehensive reform is expected to generate significant savings from the competition among health care plans. However, to ensure a smooth transition and adequate resources, particularly for new prescription drug coverage, Governor Bush will propose adding $110 billion to federal Medicare spending.

Guarantee Every Senior Remains Entitled to the Current Set of Medicare Benefits: All Medicare beneficiaries will be guaranteed the same benefits they are entitled to today. Seniors can stay in the current Medicare system without any changes.

Give Medicare Recipients a Choice of Plans Offering Expanded Benefits, Including Prescription Drug Coverage: Each health insurer, including the HCFA-sponsored plans that wish to participate in MediCAR$_X$ES, will have to offer an "expanded" benefit package, including outpatient prescription drug coverage and stop-loss protection. Plans may also include coverage for preventive care, such as annual physicals, hearing tests, eye care, and dental care, which are now not covered by Medicare. This will give seniors the opportunity to select a plan that best fits their health care needs. Seniors will also be able to change their health care plan if they are dissatisfied with their coverage – and will not be penalized in any way for making this yearly decision.

- Cover the Full Cost of Medicare Premiums for Seniors with Incomes At or Below 135% of Poverty: Individuals with incomes at or below $11,300, and couples with incomes at or below $15,200, will pay nothing for their prescription drug coverage. This will benefit more than 6 million seniors nationwide.

- Cover Some of the Cost of Prescription Drug Coverage for Seniors with Incomes Between 135% and 175% of Poverty: For seniors with incomes at or below $14,600 for individuals, and $19,700 for couples, a partial subsidy of prescription drug costs will be provided. More than 5 million seniors will benefit from this subsidy.

- Pay 25% of Premium Costs for Prescription Drug Coverage for All Seniors: All seniors with incomes above 175 percent of poverty will receive a subsidy for the premium on their prescription drug coverage.

- Cover Catastrophic Medicare Costs in Excess of $6,000 Annually for All Seniors: In addition to providing coverage to low-income seniors, Governor Bush will provide "stop-loss" protection to all seniors who have catastrophic medical expenses in excess of $6,000 a year.

Guarantee Access to a Prescription Drug Benefit Even for Beneficiaries Living in Areas Where There is No Competition Among Plans: All seniors will be offered at least the HCFA-sponsored standard and expanded benefit plans. This is to ensure that Medicare beneficiaries living in rural or medically underserved areas will not be left without the ability to access a health program with a prescription drug benefit.

Establish a Unified Trust Fund as the Measure of Medicare Solvency: Instead of measuring Medicare's solvency solely by the fiscal health of the Part A (Hospital Insurance) Trust Fund, costs for Part B (Physician Insurance) should be included as well. This more honest presentation of Medicare's solvency will preclude shifting costs from Part A to Part B merely to increase the appearance of Medicare's solvency. This "unified" measure of the financial health of the program should encompass all payroll taxes, general revenues, and premiums so that current and future beneficiaries are adequately protected and that appropriate action by Congress can be triggered.

Providing "An Immediate Helping Hand" on Prescription Drugs

"We will work to modernize Medicare. But we will not wait to help seniors without prescription drugs. We will give them direct aid now, by expanding state assistance programs. So today I am announcing an initiative called "An Immediate Helping Hand." For four years – during the transition to better Medicare coverage – we will provide $12 billion a year in direct aid to state governments. This will be enough to extend prescription drug coverage to low-income seniors in all 50 states."

-- Governor George W. Bush

Governor Bush believes that seniors have waited long enough for prescription drug coverage. Most importantly, after the Clinton-Gore Administration has squandered the last eight years, seniors should not have to wait for overall Medicare reform to have their prescription drugs covered.

Therefore, in order to provide immediate prescription drug coverage to low-income seniors and to protect all seniors against catastrophic drug expenses, as President, Governor Bush will:

Provide Immediately $48 Billion of Direct Support to States for Four Years: As an immediate and transitional step to comprehensive Medicare reform, Governor Bush will provide $48 billion over four years to the states to:

- Cover the full costs of a prescription drug program for seniors with incomes at or below 135% of poverty ($11,300 for individuals, and $15,200 for a couple); and
- Cover some of the cost of prescription drugs for seniors with incomes up to 175% of poverty (about $14,600 for an individual, and $19,700 for a couple).

This coverage can be provided much more quickly through the existing state programs than through any modification to Medicare, which will take more time. Working through the states will help approximately 9 million seniors now.

If a state already has a prescription drug program, the state could use the federal funds to increase its benefit package, increase eligibility standards or expend the funds in other ways to address the state's health care needs.

States may benchmark their plans based on several options: the drug benefit provided by the Blue Cross Blue Shield Standard Option plan for federal employees; the largest state employees health plan; or the state's Medicaid plan. States may also design their own benefit for approval by the U.S. Department of Health and Human Services.

Cover Any Prescription Drug Costs in Excess of $6,000 Annually for all Seniors: In addition to providing coverage to low-income seniors, Governor Bush will provide resources to the states to provide "stop-loss" protection to all seniors who have catastrophic prescription drug expenses.

Putting Bipartisan Medicare Modernization on a Fast Track

Governor Bush recognizes the tremendous progress made by the National Bipartisan Commission on the Future of Medicare. He believes that comprehensive Medicare reform will take strong leadership from the President and bipartisan support from the Congress and the American public.

In order to promote that bipartisan support and ensure rapid consideration of real Medicare modernization legislation, as President, Governor Bush will:

Create a White House Task Force on Bipartisan Medicare Modernization: Following on the extensive work already done by the National Bipartisan Commission, a bipartisan Task Force will be directed to prepare a formal legislative proposal for comprehensive Medicare modernization and to present their proposed bill to the President and Congress by September 1, 2001. Governor Bush's MediCARxES plan will be placed before the Task Force for evaluation, as would other proposed improvements.

Provide Expedited Consideration of Modernization Legislation: In his proposal establishing the Immediate Helping Hand program (which will be sent to Congress immediately at the start of its session), Governor Bush will include a provision ensuring expedited Congressional consideration for the Task Force's comprehensive Medicare modernization bill. Specifically, similar to "fast track" procedures already in existence, the bill would be guaranteed to receive final votes in Congress before the end of 2001. Amendments would be permitted; but filibuster and other delays of this critical legislation to modernize Medicare would not be permitted.