HEALTH CARE Q&A

PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP UNITE BEHIND A MEDICARE PRESCRIPTION DRUG PLAN

May 10, 2000

Today, President Clinton will join Senate Democratic Leader Daschle, House Democratic Leader Gephardt, and many other Democratic members of Congress to unveil their voluntary Medicare prescription drug benefit plans. These detailed proposals are consistent with the President's Medicare reform initiative and his principles for a prescription drug benefit option that is affordable and available to all beneficiaries. The President will praise the Democratic leaders and the members of their caucuses and will point out that a strong unified Democratic position will help lay the foundation for eventual bipartisan consensus, as was the case with the Norwood-Dingell Patients' Bill of Rights compromise. He will also highlight a new report today that underscores the importance of a Medicare prescription drug benefit for older women. The report, to be released today by the Older Women's League, states that women on Medicare spend 13 percent more out-of-pocket than men for prescription drugs, but have incomes that are on average 40 percent lower.

UNIFIED DEMOCRATIC SUPPORT FOR A NEW, PRESCRIPTION DRUG BENEFIT OPTION THAT IS AFFORDABLE AND AVAILABLE TO ALL BENEFICIARIES.
Today, Senate Democratic Leader Tom Daschle and House Democratic Leader Dick Gephardt, together with numerous Democratic members of the House and Senate, will announce the details of their plans to provide for a voluntary Medicare prescription drug benefit. The plans would be:

- **Voluntary and Accessible To All Beneficiaries.** Both plans ensure that all beneficiaries can access prescription drug coverage, whether they are in traditional Medicare, managed care, or a retiree health plan. Employers will receive financial incentives to provide retiree coverage and maintain existing coverage.

- **Designed To Give Beneficiaries Meaningful Protection.** Both plans will cover up to half of a beneficiary's drug costs up to $5,000 when phased in and provide protection against catastrophic drug costs. In addition, the plan will create financial incentives to ensure that beneficiaries in rural and hard to serve areas can access prescription medications.

- **Affordable To All Beneficiaries And The Program.** Under the plan, Medicare will contribute at least 50 percent of the prescription drug premium to make it affordable for all beneficiaries. The plans will also include special protections for low-income beneficiaries; those with incomes below 135 percent of the poverty level will receive full coverage of cost sharing and premiums, and those with incomes between 135 and 150 percent of poverty will receive premium assistance on a sliding scale.

- **Administered Using Private Sector Entities And Competitive Purchasing Techniques.** Private sector entities will negotiate prices with drug manufacturers and administer the benefit, a mechanism used by most private insurers. Drugs will be purchased at privately negotiated rates, giving beneficiaries the bargaining power they lack today. As a result, beneficiaries will not only receive prescription drug coverage for the first time, they will receive better prices for their drugs.

NEW STATISTICS UNDERSCORE THE IMPORTANCE OF A MEDICARE PRESCRIPTION DRUG BENEFIT FOR OLDER WOMEN. Today, the President will highlight a new report being released by the Older Women's League entitled "Prescription for Change" that underscores the importance of a Medicare prescription drug benefit for women. Key findings from the report include:

- **On Average, Women Spend More Out-Of-Pocket For Prescription Drugs Than Men.** Women on Medicare spend 13 percent more out-of-pocket than men for prescription drugs, but have incomes that average 40 percent lower.

- **More Than One in Three Women on Medicare Lack Prescription Drug Coverage Throughout the Year.** Fully half of women on Medicare without any drug coverage have incomes above 150 percent of poverty. In addition, women with coverage are less likely to have employer-sponsored coverage.

- **More Likely to Have Catastrophic Drug Costs.** Nearly three in five beneficiaries with out-of-pocket drug expenditures of more than $1,000 are women.

A UNIFIED DEMOCRATIC FRONT PROVIDES THE FOUNDATION FOR BIPARTISAN CONSENSUS. President Clinton today will point out that a strong, unified Democratic position enhances the likelihood of passing a Medicare drug benefit, just as it helped to assure the eventual House passage of a strong, enforceable, and bipartisan Patients Bill of Rights. He will hail the announcement of Democratic consensus on the details of a drug benefit and urge Congress to move forward on this vital issue.

FOOD SAFETY RADIO ADDRESS
Q&A
May 6, 2000

Q: What did the President announce today?

A: Today the President announced an aggressive new strategy to combat foodborne illness caused by ***Listeria monocytogenes.*** The President directed the Departments of Agriculture (USDA) and Health and Human Services (HHS) to report back to him within 120 days on aggressive steps they will take to significantly reduce the risk of illness and death from *Listeria monocytogenes* in ready-to-eat foods. In particular, the President directed USDA to complete proposed regulations that include any appropriate microbiological testing and other measures by industry to: 1) prevent cross-contamination in the processing environment; 2) ensure that the processing of ready-to-eat products meets appropriate standards; and 3) ensure that such products are safe throughout their shelf life. In addition, the President directed HHS to develop an action plan identifying additional steps necessary to reduce *Listeria monocytogenes* contamination. This plan should include consideration of the identification of control measures for at-risk foods and the publication of guidance to processors, retailers, and food service facilities. Finally, both USDA and HHS will consider whether enhanced labeling is necessary to provide additional safeguards for consumers. These actions, taken together, should allow the Administration to reach its Healthy People 2010 goal of reducing by half the number of illnesses caused by *Listeria* from 0.5 to 0.25 cases per 100,000 persons by 2005 –five years early.

Q: How dangerous is *Listeria monocytogenes*?

A: *Listeria monocytogenes* can cause a severe infection called listeriosis. Listeriosis is a significant public health concern, and is especially lethal, resulting in death in about 20 percent of the cases. The Centers for Disease Control and Prevention estimate that 2518 persons become ill and 504 persons die each year from listeriosis. Pregnant women with listeriosis can pass the infection on to their fetuses, potentially resulting in severe illness or death in the fetus or newborn infant. Others at high risk for severe disease or death are the elderly and those with weakened immune systems. Ready-to-eat food products, such as lunch meats, smoked fish, certain types of soft cheeses, and hot dogs, are among the foods most commonly associated with food-related illness from *Listeria.*

Q: How does this announcement fit with USDA's action plan on *Listeria* and the joint USDA/HHS *Listeria* risk assessment?

A: This announcement complements and builds upon USDA's accomplishments and strengthens the planned actions to reduce the threat posed by this deadly pathogen. The joint USDA-HHS *Listeria* risk assessment, which is scheduled to be completed this summer, will estimate the level of consumer exposure to *Listeria monocytogenes* and will determine particular foods of concern based on their contribution to overall deaths and serious illness caused by foodborne *Listeria.* The results of this risk assessment will

form a scientific basis for any proposed regulations and other actions that USDA and HHS will take to combat illnesses caused by *Listeria.*

Q: Did the President make this announcement because of the Bil Mar outbreak last year?

A: The Bil Mar outbreak focused the nation's attention on the need to take further steps to ensure the health of the American public by combating *Listeria monocytogenes* in all kinds of ready-to-eat products. That outbreak, other illnesses caused by *Listeria*, and the large number of recalls throughout the nation due to products adulterated with *Listeria*, contributed to the President's decision to take action.

Q: How many people were stricken by that outbreak and what caused it?

A: There were 101 illnesses and 21 deaths (15 adult and 6 miscarriages or stillbirths) in that outbreak. The illnesses were linked to hot dogs and luncheon meats processed by Bil Mar Foods, a Zeeland, Michigan, processing plant.

Q: What is listeriosis?

A: Listeriosis is a serious and potentially fatal infection caused by eating food contaminated with the bacterium *Listeria monocytogenes*. The disease affects primarily pregnant women, newborns, and adults with weakened immune systems. There have been few documented cases of healthy people contracting listeriosis. A person with listeriosis has fever, muscle aches, and sometimes gastrointestinal symptoms, such as nausea or diarrhea. If infection spreads to the nervous system, symptoms such as headache, stiff neck, confusion, loss of balance, or convulsions can occur. Infected pregnant women may experience only a mild, flu-like illness; however, infections during pregnancy can lead to premature delivery, infection of the newborn, or even stillbirth.

Q: Why hasn't USDA already required testing, shelf life studies, or labeling?

A: Following the listeriosis outbreak in 1998-99, USDA required manufacturers of ready-to-eat products to reassess their science-based preventive food safety plans to determine if *Listeria* is adequately addressed; issued guidance materials addressing environmental and product testing; continued its testing of approximately 3,500 product samples per year; initiated a consumer education campaign; and began plans for research on this difficult pathogen. Based on the industry's response to USDA's guidance on testing, the Administration determined that it should take the next steps and build upon those efforts already underway.

Q: What exactly will USDA propose in its regulations?

A: USDA will propose any appropriate microbiological testing, measures by industry to prevent cross contamination in processing plants, standards for the processing of ready-to-eat meat and poultry products, and documentation on the continued safety of meat and poultry products throughout their shelf life. USDA will hold a public meeting on May 15th and meet with the National Advisory Committee on Meat and Poultry

Inspection on May 16 and 17, where its response to the President's announcement and other future actions will be discussed.

Q: Can you give me information about the *Listeria* public meeting?

A: The meeting is scheduled for Monday, May 15, at 9 a.m. at the Holiday Inn, 415 New Jersey Ave., NW, Washington, D.C. The meeting will address USDA's plans to further protect the public from foodborne illnesses associated with *Listeria monocytogenes*.

Q: Is *Listeria monocytogenes* a problem only in meat and poultry products?

A: No. USDA and HHS are working on a risk assessment of products that cause listeriosis, including ready-to-eat seafood products and cheeses in addition to meat and poultry products.

Q: How can consumers reduce their risk of contracting listeriosis?

A: Consumers can reduce risks from all foodborne illnesses by cleaning hands and surfaces with hot, soapy water; separating ready-to-eat foods from raw foods to avoid cross-contamination; cooking to safe temperatures; and promptly chilling perishables. People at risk for listeriosis should reheat ready-to-eat foods to steaming; wash hands and surfaces after handling ready-to-eat products; avoid soft cheeses and unpasteurized milk (or cheeses made from unpasteurized milk); and observe all expiration dates.

Budget

Q: What did the President request in his FY2001 budget for food safety?

A: A total of $422 million is included in the President's budget for his food safety initiative -- a $68 million, or 19 percent, increase over FY 2000 enacted. The initiative includes an additional $40 million for the Department of Health and Human Services (HHS) to achieve annual inspections of high-risk domestic foods such as unpasteurized juice; expand the number of inspections of imported foods; enhance the national network of public health laboratories capable of subtyping foodborne pathogen DNA for rapid response to disease outbreaks (PulseNet); and expand research, risk assessment and education activities. The Department of Agriculture's (USDA) $28 million increase would extend risk assessment modeling and data collection to include the pre-harvest phase for all foods and support bioscience research to develop effective methods of handling and treating agricultural products to minimize microbial contamination. Funding is also proposed for HHS and USDA to begin implementation of the Egg Safety Action Plan adopted by the President's Council on Food Safety.

Q: What action did Congress take on President's food safety budget request?

A: Just this week, unfortunately, the Congress took a major step backward by refusing to fully fund the President's food safety initiative. In fact, Congress voted to block funding for our new efforts to protect millions of American families from the dangers of salmonella poisoning in eggs. The President's Egg Safety Action Plan aims to cut in half

by 2005 the number of Salmonella Enteritidis (SE) illnesses attributed to eggs, and will set a goal of eliminating such illnesses altogether by 2010. Nearly 3.3 million eggs in the U.S. are infected with the SE bacteria annually, and in 1997 alone, there were an estimated 300,000 cases of SE infections. The estimated costs of these illnesses are as high as $870 million each year.

Legislative Proposals

Q: What did the President say in his radio address about the FDA import legislation?

A: The President called on Congress to pass food safety legislation, introduced by Senators Milkulski, Kennedy and Durbin, and Rep. Eshoo, that gives the FDA greater authority over imported foods. This legislation will ensure that imports of fruits, vegetables, and other food products meet U.S. food safety requirements or provide the same level of protection as is required for U.S. products. The legislation also will authorize FDA to bar, under certain circumstances, imports of foods associated with outbreaks of foodborne illness.

Q: How is this different from current authority?

A: This legislation increases the FDA's authority to refuse imports for foods. Currently, the FDA can only refuse imports after inspection or testing at the border when the FDA determines that the food appears to be unsafe or otherwise violates U.S. law. This new legislation will ensure that food products entering this country were grown and processed in conditions that meet U.S. food safety requirements or otherwise achieve the level of protection required for U.S. produced food, and will create an incentive for exporting countries to make systemic changes in their food safety systems. This authority is necessary because experience has shown that inspection and testing of products at the border may not be sufficient in all cases to ensure the safety of food products. It may be necessary to identify and address the source of potential contamination to ensure that products offered for sale in the United States meet domestic food safety requirements or otherwise achieve the level of protection required. FDA currently has such authority with respect to domestic production.

Q: What did the President say in his radio address about the USDA mandatory recall/civil penalties legislation?

A: The President called on Congress to pass the Food Safety Enforcement Enhancement Act, sponsored by Senators Harkin, which gives USDA the ability to assess civil fines and to order mandatory recalls of unsafe meat and poultry products. Currently, the USDA can respond to food safety violations only by bringing criminal actions or withdrawing inspections; all recalls are done on a voluntary basis and no civil penalties are available. This new legislation will give USDA additional enforcement tools to prevent consumers from ingesting and becoming ill from dangerous meat and poultry.

PRESIDENT CLINTON ANNOUNCES AGGRESSIVE FOOD SAFETY STRATEGY TO COMBAT LISTERIA IN HOT DOGS AND OTHER READY-TO-EAT FOODS

May 6, 2000

In his radio address today, President Clinton will announce an aggressive new strategy to significantly reduce the risk of foodborne illnesses caused by *Listeria monocytogenes* in ready-to-eat foods such as hot dogs and lunch meats. According to the Centers for Disease Control and Prevention, 2,518 people each year become ill from *Listeria* – and 20 percent of cases result in death. Foodborne listeriosis has particularly high fatality rates for newborns, the elderly, and those with weakened immune systems. The President today will direct the Departments of Agriculture and Health and Human Services to take a range of actions, including new regulations, to cut the risk of illness and death from *Listeria.* He will also push Congress to fully fund his food safety initiative and criticize Congress for voting just this week to undermine that initiative.

TAKING ACTION TO REDUCE ILLNESSES FROM READY-TO-EAT FOODS. Today President Clinton will announce an aggressive new interagency effort to combat foodborne illness caused by ***Listeria.*** In particular, the President will direct USDA to complete proposed regulations that include any appropriate microbiological testing and other measures by industry to: 1) prevent cross-contamination in the processing environment; 2) ensure that the processing of ready-to-eat products meets appropriate standards; and 3) ensure that such products are safe throughout their shelf life. In addition, the President will direct HHS to develop an action plan identifying further steps to reduce *Listeria* contamination, including identification of control measures for at-risk foods and the publication of guidance to processors, retailers, and food service facilities. Finally, both USDA and HHS will consider the need for enhanced labeling to provide additional consumer safeguards. The Administration's goal is to cut in half, by the year 2010, the number of illnesses caused by *Listeria* (from 0.5 to 0.25 cases per 100,000). Today's actions should enable the Administration to reach this goal five years early.

CALLING ON CONGRESS TO SUPPORT HIS FOOD SAFETY INITIATIVES. Just this week, Congressional committees voted to block funding for the President's food safety initiative. The President today will urge Congress to provide the full $68 million increase he has requested for the initiative, which would, among other things, protect millions of Americans from the dangers of salmonella poisoning in eggs and enable FDA to expand the number of inspections of imported and certain domestic foods. The President also will call on Congress to pass two key pieces of food safety legislation. One bill, sponsored by Senators Mikulski, Kennedy, and Durbin and Rep. Eshoo, ensures that imports of fruits, vegetables, and other food products meet U.S. food safety requirements. The second bill, sponsored by Sen. Harkin, gives USDA authority to issue mandatory recalls and impose civil penalties for unsafe meat and poultry.

BUILDING ON A STRONG RECORD OF ENSURING FOOD SAFETY. The Clinton Administration has made food safety a high priority by seeking substantial funding for such initiatives as a nationwide early-warning system for foodborne illness, increased inspections, and the expansion of food-safety research, risk assessment and education. The Administration has put into place improved science-based standards for meat, poultry, and seafood products. The President has also created a Food Safety Council, which is now developing a comprehensive plan to ensure the safety of the nation's food supply into the 21st century.

CLINTON-GORE ADMINISTRATION: A RECORD OF IMPROVING FOOD SAFETY

To ensure that our food supply remains among the safest in the world, the Clinton-Gore Administration has made reducing foodborne illness a national priority. The Administration has put in place improved safety standards for meat, poultry, and seafood products, and developed enhanced standards for fruit and vegetable juices. Research, education, and surveillance efforts have also been greatly expanded. Significant milestones in the Administration's efforts:

December 1999	Announced Egg Safety Action Plan that will cut in half by 2005 the number of *Salmonella* Enteritidis (SE) illnesses attributed to eggs, and will set a goal of eliminating such illnesses altogether by 2010.
July 1999	Announced efforts to improve egg safety by requiring that shell eggs be stored at 45 degrees Farenheit or below during transport, in warehouses, and at retail stores - and by requiring safe handling statements on egg cartons.
July 1999	Directed the Department of HHS and the Treasury Department to explore additional actions to protect consumers from unsafe imported foods.
Jan. 1999	Implemented new science-based inspection system called Hazard Analysis-Critical Control Points (HACCP) in almost 3,000 small meat and poultry plants.
Oct. 1998	Published guidance for growers, packers, and shippers of fresh fruits and vegetables to provide information on good agricultural and management practices.
Aug. 1998	Created the President's Food Safety Council, charged with developing a strategic plan for federal food safety activities and ensuring that all relevant agencies work together to develop coordinated food safety budgets each year.
July 1998	Announced Joint Institute for Food Safety Research, which will develop a strategic plan for conducting and coordinating all federal food safety research activities, including with the private sector and academia.
	Announced new warning labels on packaged fresh fruit and vegetable juices that have not been processed to prevent, reduce, or eliminate illness-causing microbes.
May 1998	Formed national computer network of public health laboratories, called "PulseNet," to help rapidly identify and stop outbreaks of foodborne illness. The new system enables epidemiologists to respond up to five times faster than before in identifying serious and widespread food contamination problems by performing DNA "fingerprinting" on foodborne pathogens.
Feb. 1998	Announced proposed food safety budget, which requests approximately $101 million increase for food safety initiatives.

Jan. 1998 Implemented new, science-based HACCP system for 300 largest meat and poultry plants.

Dec. 1997 Approved irradiation of meat products to control disease-causing microorganisms. Implemented seafood HACCP regulations for all seafood processors.

Oct. 1997 Ordered additional actions to improve the safety of domestic and imported fruit and vegetables.

Established Partnership for Food Safety Education, an ambitious federal-private partnership to reduce foodborne illness by educating Americans about safe food handling practices. The Partnership has launched a multi-year, broad-based public education campaign to teach Americans about safe food-handling practices.

May 1997 Announced comprehensive new initiative to improve the safety of nation's food supply—"Food Safety from Farm to Table"--detailing a $43 million food safety program, including measures to improve surveillance, outbreak response, education, and research.

Jan. 1997 Unveiled National Food Safety Initiative, a five-point plan working with consumers, producers, industry, states, universities, and the public to strengthen and improve food safety.

Announced new early warning system, the Foodborne Outbreak Response Coordinating Group (FORC-G), a partnership of federal and state agencies, to develop a comprehensive, coordinated national foodborne illness outbreak response system to increase coordination and communication among federal, state, and local agencies; guide efficient use of resources and expertise during an outbreak; and prepare for new and emerging threats to the U.S. food supply.

Aug. 1996 President signed Safe Drinking Water Act of 1996, which requires drinking water systems to protect against dangerous contaminants such as *Cryptosporidium* and gives people the right to know about contaminants in their tap water.

President Clinton signed Food Quality Protection Act of 1996, which streamlines regulation of pesticides by FDA and EPA and puts important new public-health protections in place, especially for children.

July 1996 Announced new HACCP regulations that modernize the nation's meat and poultry inspection system for the first time in 90 years. New standards help prevent *E. coli* bacteria contamination in meat.

Jan. 1996	The Foodborne Diseases Active Surveillance Network (FoodNet), a collaborative effort among HHS and USDA, along with state health departments and local investigators around the country, begins collecting data to better track the incidence of foodborne illness and monitor the effectiveness of food safety programs in reducing foodborne illness.
Dec. 1995	Issued new rules to ensure seafood safety, using HACCP regulatory programs to require food industries to design and implement preventive measures and increase the industries' responsibility for and control of their safety assurance actions.
1994	Embarked on CDC strategic program to detect, prevent, and control emerging infectious disease threats, some of which are foodborne, making significant progress toward this goal in each successive year. Reorganized USDA to establish Office of the Under Secretary for Food Safety. This increases the visibility of food safety within USDA and separates food safety functions from marketing functions carried out by other parts of USDA. Reorganization also creates a new Office of Public Health and Science within FSIS to improve the scientific base needed to make sound regulatory decisions, based on public health.
1993	Vice-President Gore's National Performance Review issued a report recommending that government and industry move toward a system of preventive controls for food safety.

PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP HIGHLIGHT NEW STUDY DOCUMENTING PRESCRIPTION DRUG PRICE INCREASES THAT DOUBLE INFLATION RATES

Families USA Report Validates the Need for a Medicare Prescription Drug Benefit

April 26, 2000

President Clinton today, along with Senator Tom Daschle and House Democratic Leader Dick Gephardt, will join Families USA in releasing a new report on prescription drugs. The report shows that, on average, the price for the 50 drugs most commonly used by seniors increased at nearly twice the rate of inflation during 1999. The President will point out that this finding, combined with the recent HHS report showing that the price differential for older and disabled Americans with and without coverage has nearly doubled, underscores the need for a voluntary Medicare prescription drug benefit. While praising the House Republican leadership for endorsing the principle of the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. He will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option.

NEW ANALYSIS INDICATES THAT PRESCRIPTION DRUG PRICES WILL CONTINUE TO RISE. While senior citizens generally live on fixed incomes that are adjusted to keep up with the rate of inflation, a new report by Families USA entitled *Still Rising* demonstrates that prescription drug costs have risen at double that rate over the past six years – and are expected to continue to rise. Key findings of the Families USA report include:

- **In 1999, the prices of the prescription drugs most commonly used by seniors increased at almost double the rate of inflation.** The report found that prices of the 50 prescription drugs most frequently used by the elderly rose by nearly two times the rate of inflation during calendar year 1999. On average, the prices of these drugs reportedly increased by 3.9 percent from January 1999 to January 2000 (versus 2.2 percent for general inflation).

- **Moreover, these increases are part of a trend: Over the past six years, the prices of the prescription drugs most commonly used by seniors also increased by twice the rate of inflation.** The report finds that the price of the 50 prescription drugs most commonly used by older Americans increased by 30.5 percent since 1994 – twice the rate of inflation. More than half of the most commonly used drugs that were on the market for the entire six year period had price increases that were double the rate of inflation. In addition, the Families USA report concludes that more than 20 percent of these prescription drugs increased in price by three times the rate of inflation over that time period.

- **Seniors with common chronic illnesses are often forced to spend well over 10 percent of their income on prescription drugs.** The new Families USA study demonstrates that a widow with diabetes, hypertension, and high cholesterol, living on an annual income of $12,525 (150 percent of the poverty level) will spend 18.3 percent of her annual income on prescription medications. The same woman with an annual income of $16,700 (200 percent of the poverty level) will spend 13.7 percent of her income on these medications. This finding, which is consistent with the conclusions of studies conducted by HHS, clearly demonstrates that failure

to provide a voluntary, affordable, and accessible Medicare prescription drug benefit will impose a continuing and growing burden on middle-class older Americans and people with disabilities.

PRESIDENT CLINTON CHALLENGES THE REPUBLICAN LEADERSHIP TO MODIFY THEIR POLICY TO MATCH THEIR STATED GOALS. While praising the House Republican leadership for recognizing the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. Their current approach is underfunded, unlikely to be available to all beneficiaries, and would almost inevitably be unaffordable to millions of seniors and people with disabilities, even if it is available in some places. In addition, because of its lack of details, it raises more questions than it answers, including how much the premiums are, what the benefit would be, and how much it will cost. The President will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option. The House Republican proposal:

- **Reneges on funding commitments for a meaningful prescription drug benefit.** Earlier this year, the Republicans indicated they would commit $40 billion for a prescription drug benefit, but their budget resolution dedicated as little as $20 billion to improve the Medicare program to include a prescription drug benefit. Moreover, the lack of their willingness to release 10-year numbers on their prescription drug proposal raises serious concerns that their tax policy consumes virtually all revenue necessary to adequately fund a drug benefit into the future.

- **Does not assure availability of prescription drug coverage.** Because the Republican plan relies on private insurers to offer a drug-only benefit voluntarily, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. In testimony before the Congress, the insurance industry itself has expressed skepticism about the effectiveness of the Republican approach.

- **Not affordable for most seniors, even if it is available.** Furthermore, because it provides direct premium assistance only to beneficiaries with annual incomes of under $12,600, the Republican benefit will almost certainly fail to be an affordable option even if it's available. If enacted, the Republican proposal would mark the first time in the program's history that Medicare would not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program. Finally, because of the proposals reliance on the Medigap insurance market, which frequently does not negotiate lower prices on behalf of its enrollees, it casts doubt on whether beneficiaries would have access to market-leveraged discounts.

Medicare – CBO Home Health Care Report
Q&A
April 21, 2000

Q: Today's New York Times suggests that Medicare cuts in home health care spending are so excessive that the most vulnerable seniors and people with disabilities are being denied services. How does the Administration respond to this?

A: The Administration has consistently stated its commitment to payment rates that ensure access to quality health services for Medicare beneficiaries. For this reason, we supported and signed into law changes that mitigated the effects of the Balanced Budget Act on home health care providers last year. We are reviewing this new information and all other available reports to determine if additional changes are necessary to guarantee accessible, high quality health care for older Americans and people with disabilities.

School Based Services
Q&A
April 5, 2000

Q: What is your response to the charge that HCFA never provided guidance on the appropriate use of these dollars?

A: In 1997, HCFA provided state Medicaid agencies with guidance on appropriate claiming procedures for both medical services and program administration costs. In May of 1999, in response to reports that states were not following stated policy, HCFA issued guidance that restated and clarified the 1997 policy with respect to transportation and placed a temporary moratorium on certain types of claims. In February of this year, HCFA issued a draft guide for claming of administrative costs to clarify and consolidate current guidance on claiming for state Medicaid programs.

Q: When will your final guidance on administrative claiming be issued?

A: The comment period for the draft guide ended on Monday, after being extended for one month to provide education and health care advocates with sufficient time to submit their comments. HCFA is working with the Department of Education to review these comments, and will work to ensure the guide is completed as soon as possible. However, it's more important to get this issue done right than it is to get it done quickly.

Health Care – Medicare Fraud and Abuse
Q&A
April 5, 2000

Q: The Inspector General says Medicare is wasting hundreds of millions a year on inappropriate outpatient psychiatric services. What is your response?

A: In July, HCFA will implement new payment safeguards for psychiatric services as part of the outpatient prospective payment system. These edits will identify potentially improper claims before they are paid – reducing the opportunity for waste, fraud and abuse. Our contractors also are doing more provider education to ensure that health-care providers understand how to properly document and bill the care they deliver to beneficiaries.

Q: Doesn't this just prove that HCFA can't run the Medicare program?

A: Of course not. Since 1993, HCFA has taken strong action to fight waste, fraud and abuse of the Medicare program, which pays more than $200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered nearly $500 million as a result of health-care prosecutions. Medicare has also reduced its improper payment rate sharply from 14 percent four years ago to less than 8 percent last year, and HCFA is committed to achieving further reductions in the future.

Health Care – Organ Allocation
Q&A
April 5, 2000

Q: What's your response to yesterday's vote in the House on organ allocation?

A: We are disappointed, but view it as a short term detour to arriving at a sound policy. We believe either the HHS regulation or alternative legislation will eventually prevaiil. Most important, we believe that the politics need to be removed from this issue. This is about the use and allocation of lifesaving resources, and it is our judgement that we should follow the best guidance of scientists and ethicists included in last year's Institute of Medicine's report. We believe that the Administration's approach best reflects that guidance, and continue to strongly object to an approach that threatens the fairest and best way to distribute these organs. If the original House bill were to pass, the President's senior advisors would recommend a veto.

Having said that, as we are focused on allocation, we must give even greater weight to the importance of organ donation, and increase our attention on the ensuring an adequate supply of organs – the very issue that will reduce or eliminate the tension over the allocation of these extraordinary resources.

Q: Won't the new Federal organ allocation rules jeopardize small donation programs by re-routing organs to other communities with sicker patients?

A: The Institute of Medicine has evaluated this claim and found it to be untrue. We are troubled by efforts to derail the implementation of long-overdue regulations that will move towards a more fair allocation of these lifesaving resources. As we have stated repeatedly, the decisions about the distribution of organs should not be a political matter and should be based solely on the science and the best ethical and medical practices. The Institute of Medicine analysis of this issue affirmed the approach that was to be implemented by HHS on this matter, and we believe these regulations should be go final without delay.

PRESIDENT CLINTON URGES LEAD CONFEREES FROM BOTH PARTIES TO ACT NOW TO PASS A STRONG, ENFORCEABLE, PATIENTS' BILL OF RIGHTS

March 11, 2000

Today, President Clinton will meet with a bipartisan group of members of Congress who serve on the Patients' Bill of Rights Conference Committee. He will underscore his concern about the delay in passing a strong, enforceable Patients' Bill of Rights and ask the members for a status report. The President will reiterate his standing offer to provide any technical assistance necessary to advance the passage of this bill. He will point out that delaying the passage of this legislation has serious consequences, endangering the health of thousands of patients every day. The President will note that the bipartisan Norwood-Dingell Patients' Bill of Rights, which he has repeatedly indicated he would sign into law, passed over seven months ago. Yet, with very few working days left in this Congress, the Conference has not even discussed, much less agreed to, the crucial issues of how many Americans would receive new protections or how these new protections would be enforced. Finally, the President will express his concern that Patients' Bill of Rights not be further delayed or threatened by the inclusion of extraneous provisions that could further destabilize the insurance market and undermine the bill's prospects of passage.

CONFEREES HAVE YET TO MAKE PROGRESS ON ISSUES FUNDAMENTAL TO THE PASSAGE OF A STRONG, ENFORCEABLE BILL. Last October, the House passed the Norwood-Dingell Patients' Bill of Rights with overwhelming bipartisan support. This is strong legislation that the President would be proud to sign. Even after that landmark achievement, the Conferees have yet to address issues essential to the passage of a strong, enforceable Patients' Bill of Rights. A strong Patients' Bill of Rights would:

- **Providing protections for all Americans in all health plans,** not coverage of some patients in some plans as provided under the Senate Republican plan.

- **Include an enforcement mechanism that holds health plans accountable for actions that harm patients,** not weak enforcement provisions that provide the illusion of security without real protections.

In addition, despite protracted negotiations, agreements have not been reached on provisions that:

- **Guarantee access to needed health care specialists,** allowing patients with life-threatening, degenerative and disabling conditions to have access to standing referrals to specialists.

- **Ensure continuity of care protections,** protecting patients from abrupt transition in care if their providers are dropped.

- **Provide access to a fair, unbiased and timely internal and independent external appeals process,** ensuring the independence of external reviewers by taking the decision about whether a case is eligible for an external appeal away from the health plan.

DELAYING THE PASSAGE OF A STRONG BILL HAS DEVASTATING CONSEQUENCES FOR AMERICAN FAMILIES. Unnecessary delay in passing legislation to curb insurance company abuse results in harm to thousands of patients daily and millions of patients annually. Each day without a strong Patients Bill of Rights results in: 14,000 physicians seeing patients harmed because a plan failed to provide coverage for a prescription drug; 10,000 physicians seeing patients harmed because a plan refused a diagnostic test or procedure; and 7,000 physicians seeing patients harmed because their insurance plan refused a referral to a specialist, according to a new analysis of Kaiser Family Foundation data by the Democratic staff of the Senate Health Education Labor and Pensions Committee.

ACTION ON THIS ISSUE IS LONG OVERDUE. This legislation, endorsed by over 200 health care provider and consumer advocacy groups, is the only proposal currently being considered that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful. The President's record on this issue is longstanding and includes:

- **Appointing a Quality Commission to examine potential quality concerns in the changing health care industry.** In 1996, the President created a non-partisan, broad-based Commission on Quality and charged them with developing a patients' bill of rights as their first order of business.

- **Challenging Congress to Pass a Patients Bill of Rights.** In November of 1997, the President accepted the Commission's recommendation that all health plans should provide strong patient protections and called on the Congress to pass a strong, enforceable patients' bill of rights. He also called on the Congress to make passing the patients' bill of rights a top priority in his 1998, 1999, and 2000 State of the Union Addresses.

- **Extending Critical Patient Protections to All Federal Health Plans.** In February of 1998, the President directed the federal health plans, covering 85 million Americans, to implement the patients' bill of rights. Over the next year, critical steps were taken to meet this goal. For example: the Office of Personnel Management issued their annual call letter notifying their 285 health plans they needed to implement patient protections to participate in FEHBP; the Department of Labor issued a proposed regulation establishing a timely and fair internal appeals process with an expedited review process for urgent claims for the 120 million Americans in private employer based plans; the Administration issued an Interim Final regulation to implement patient protections for older Americans and people with disabilities covered by Medicare; and the President announced proposed rules to bring the Medicaid and S-CHIP programs into compliance.

Medical Privacy
Q&A
October 27, 1999

Q: Are these new regulations really necessary?

A: Under today's system, there are no comprehensive Federal protections to protect medical records privacy. We worked together with the Congress in 1996 to authorize the Administration to promulgate regulations in the absence of new statutory protections. Congress had three years to act and did not – so although the President would have preferred to have the Congress pass legislation, he is using his authority to move this issue ahead.

Q: Won't these new regulations be too costly to implement?

A: We do not believe that there will be an excessive cost burden associated with these regulations. Congress is working on legislation that would have a similar, if not greater cost burden because they are broadening the scope of the entities covered and limiting the reuse of information by entities not covered by the regulation. The cost of not moving ahead in this area is that patients are deprived of essential protections for their most private health information.

Q&A
PRIVACY REGULATION
October 25, 1999

Q: How do you respond to today's article in the *Wall Street Journal* on the privacy regulation currently being drafted by HHS?

A: We can't go into any detailed response to any article on any regulation prior to its being published. However, the Justice Department has already testified earlier this year before the Senate Health, Education, Labor, and Pensions Committee that they would slightly alter their current position to accommodate legitimate privacy concerns. The rule, which will be published in short order, is being designed to achieve an acceptable balance between individuals' need for privacy and law enforcement's legitimate need to access information in pursuit of a criminal. Clearly, the work of this Administration is to strike the appropriate balance between these two competing and appropriate priorities. Any further inquiry on this issue needs to be directed to the lead Administration agency on this issue – HHS.

Anna Richter
10/04/99 11:26:06 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: See the distribution list at the bottom of this message
Subject: PBOR Q&A

PBOR
Q&A
October 4, 1999

Q: Some Republicans in Congress have indicated that they would like to extend insurance coverage to the uninsured as well as address managed care reform. How can you possibly be opposed to this approach?

A: The problem is, this is just a cynical parliamentary gimmick to load up this legislation with extraneous provisions and to deny the straight up-or-down vote it deserves. This strategy will make it impossible for the bill to be passed and enacted into law. The only interest that serves is the special interests who oppose the Patients Bill of Rights. I would point out that many Republicans who have traditionally supported these access provisions are now explicitly opposing their attachment to the Patients Bill of Rights because they know it will kill any opportunity to pass these important patient protections this year.

[NOTE: Although we haven't seen the amendments, we fully expect them to include medical savings accounts, multi-employer welfare associations, health marts, and other initiatives that have the potential to harm the insurance market much more than help it by segregating healthy individuals from sicker populations. It may also have additional tax credits that further eat into the off-budget Social Security surplus. Few independent analysts would suggest that any of these policies would decrease the number of uninsured in this country.]

Q: Some Republicans are suggesting that they could support everything in the Norwood-Dingell legislation other than the right to sue provisions. Would you support such legislation?

A: The Patients Bill of Rights would not be meaningful if there were not provisions that ensure that health plans can be held accountable for actions that harm patients. In the absence of such provisions, there would be little to no incentive for plans to comply with the law. Obviously, at least 21 Republicans in the House agree with this position.

Having said this, we have always been open to alternative enforcement approaches. It is worth noting that the bipartisan legislation introduced by Congressmen Dingell and Norwood severely limits punitive awards to ensure that there are no unnecessary and frivolous lawsuits.

Q: Opponents of this legislation say that the Norwood-Dingell bill, particularly the right to sue provisions, would increase costs and decrease coverage. What is your response?

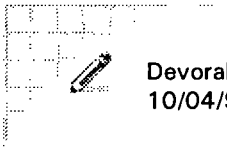
A: This is nothing but a red herring argument made by special interests who oppose a meaningful Patients Bill of Rights. As the Washington Post reported just this past week, those states (such as Texas) that have enacted provisions allowing patients to hold health plans accountable have experienced extremely few lawsuits. These provisions are clearly being used as more of a disincentive for plans to make the wrong decision in the first place rather than providing incentive for numerous frivolous lawsuits.

It is worth noting that, even before the Norwood-Dingell compromise dropped punitive damage awards from all but the most egregious cases, analysis based on figures produced by the Congressional Budget Office concluded that costs would not increase more than two dollars a month.

The Norwood-Dingell compromise limits even the possibility of access to punitive awards. In fact, such awards would only be available only to those individuals whose managed care organizations ignore the ruling of an independent external appeals board. This ensures that there would be no unjustified and expensive awards.

In addition, there are over 300 health and consumer groups who have been consistent and dedicated advocates of providing affordable health care to all Americans that have endorsed the Norwood-Dingell legislation. They would never support this legislation if it were to increase costs and decrease coverage.

Message Sent To: _____



Devorah R. Adler
10/04/99 10:52:36 AM

Record Type: Record

To: Cathy R. Mays/OPD/EOP@EOP, Anna Richter/OPD/EOP@EOP

cc: Jeanne Lambrew/OPD/EOP@EOP
Subject: two edits from cj that he wants bruce to review

The edits from CJ are in italic --

if Bruce approves, pls just let Anna know.

Thanks.

Devorah

CPS Survey on Uninsured Americans
Questions and Answers
October 2, 1999
(For Internal Use Only) DRAFT

Q: What is your general reaction to the 1998 Census Bureau numbers released?

A: We have just received the 1998 health insurance data from CPS and will be analyzing it closely in the coming days. However, we are disappointed that there was an increase of one million uninsured people from 1997 to 1998, even though the proportion of Americans who are uninsured did not change by a statistically significant amount. *This underscores why the President has been aggressively pushing to enroll the millions of Americans now eligible for coverage and urging the Congress to pass additional reforms that would succeed in insuring more people.* We will step up efforts to both create new options (e.g., Medicare buy-in, Medicaid buy-in for people with disabilities) and increase participation in existing options. The Administration's ongoing efforts include:

Ensuring rapid, aggressive implementation of the new Children's Health Insurance Program (CHIP) which targets uninsured children of working families. In addition to approving all state plans, the Administration has launched an aggressive public-private outreach campaign to educate families about this new program.

Last month, the Departments of Health and Human Services, Justice and Education and 10 national, nonprofit organizations, kicked off more than 45 community events to enroll children around the country in CHIP and Medicaid. These efforts have focused on outreach to minority communities, including the Hispanic community to which we

have distributed Spanish language television and radio PSAs and print articles and op-eds on how to enroll in CHIP and Medicaid.

Earlier this year, the President, along with the National Governors' Association, launched the Insure Kids Now campaign, including a national toll free number, 1-877-KIDS-NOW and the *insurekidsnow.gov* web site, which gives families specific information on how to enroll in CHIP and Medicaid.

Improving Medicaid. This Fall, HHS will send teams to work with state officials this fall to review programs and identify and remove possible barriers to enrollment in Medicaid and CHIP. Earlier this year, we also took action to assure and encourage legal immigrants to receive health insurance through Medicaid and CHIP. Since 1993, HHS has approved several Medicaid waivers to states for comprehensive health care reform projects to control costs and expand coverage and waivers for welfare reform projects. When fully implemented, these demonstration projects will extend health coverage to 2.2. million parents and children who otherwise would be uninsured.

Q: Isn't it true that the decline in Medicaid is due to welfare reform? What has caused the number of uninsured to increase?

A: First let me say, this Administration has demonstrated an unprecedented commitment to reducing the numbers of uninsured and would not take any action that would reduce access to health insurance for low-income people.

It is important to note that although Medicaid enrollment has declined, the number of uninsured people classified as poor has declined by 87,000.

Why Medicaid rolls are declining is a complex question with no easy answer. One explanation is that the improving economy has made it possible for many low-income people once enrolled in the Medicaid program to find jobs that offer health insurance benefits. The Census data show that the decline in Medicaid coverage occurred only among poor people, where there was also an offsetting increase in private coverage. Another answer is that individuals may not realize they are still eligible for the Medicaid program even if their income increases slightly.

It is also important to note that the Census Bureau explicitly warns that the changes in Medicaid coverage estimates from one year to the next should be viewed with caution, since Census Bureau data under-reports Medicaid coverage. In fact, preliminary 1998 Medicaid enrollment data from the Health Care Financing Administration show that there were 40 million Medicaid enrollees, while the 1998 Census Bureau numbers only report 28 million Medicaid enrollees. As such, it would not be appropriate to rely solely on the Census Bureau data to draw conclusions about the effect of welfare reform on Medicaid.

KEY FIGURES IN MARCH 1999 CPS

- **Number of uninsured Americans increased from 43.4 to 44.3 million in 1998.** The rate of uninsured Americans rose from 16.1 to 16.3 percent, not a statistically significant change. This is about half that of the increase between 1996 and 1997.

  - **Most of the increase is in the middle class.** The number of uninsured who are poor dropped by 87,000. This is even more dramatic for people below $25,000: there were over 1 million fewer uninsured in this income group. At the same time, the number of uninsured with income above $50,000 increased by 1.7 million.

UNINSURED BY INCOME

	1995	1996	1997	1998	1995-1998	1997-1998
< $25,000	18.713	18.47	18.361	17.229	**-1.484**	**-1.132**
Rate	*23.9%*	*24.3%*	*25.4%*	*25.2%*	***5.4%***	***-0.8%***
$25-49,999	13.697	13.585	14.527	14.807	**1.110**	**0.280**
Rate	*16.2%*	*16.6%*	*18.1%*	*18.8%*	***16.0%***	***3.9%***
$50-74,999	4.974	5.63	5.678	6.703	**1.729**	**1.025**
Rate	*9.3%*	*10.0%*	*10.1%*	*11.7%*	***25.8%***	***15.8%***
$75,000+	3.197	4.03	4.882	5.542	**2.345**	**0.660**
Rate	*6.7%*	*7.6%*	*8.1%*	*8.3%*	***23.9%***	***2.5%***

Note: Rate changes are percent change in rates (not the subtraction of rates).

  - **Number of uninsured children is stable.** There was a slight but statistically insignificant increase in the number of uninsured children, from 10.743 to 11.073 million, an increase of 330,000. As with adults, this change occurred among the non-poor and, similarly, Medicaid coverage was down for the poor but up for the non-poor. The number of uninsured adolescents (ages 12 to 17) declined while the number and rate of uninsured among younger children rose.

  - **Coverage trends vary by state**. Eight states saw the proportion of their populations who are uninsured fall: Arkansas, Florida, Iowa, Massachusetts, Missouri, Nebraska, Ohio and Tennessee. Most of these states have Medicaid waivers to expand coverage or aggressive CHIP and outreach programs. Additionally, four of these states (Florida, Missouri, Nebraska and Ohio) passed comprehensive patient protection bills in 1996 or 1997 – suggesting that concerns that such protections will increase the uninsured are unjustified.

Anna Richter
10/04/99 11:11:43 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: See the distribution list at the bottom of this message

Subject: Uninsured Data Q&A (attachement will follow)

Uninsured Data
Q&A
October 4, 1999

Q: The economy is doing well and the poverty rate has fallen, so why is the number of uninsured increasing?

A: The problem of the uninsured in the United States is a complicated issue. We have just received the 1998 Census data and will be analyzing the data closely in the coming days. But it appears that the increase in the proportion of uninsured between 1997-1998, which is not statistically significant, is not concentrated among the poor. Neither the number nor the rate of uninsured poor people increased significantly. In fact, the number of the uninsured who are classified as poor dropped by 87,000 (see attachment).

However, the rate of uninsured among the middle class did go up: the percent of people with income between $50,000 and $75,000 who lack insurance increased from 10.1 to 11.7 percent -- or over a million people. This appears to be happening because slightly fewer middle-class people are insured through their employers. Also, as people leave poverty, fewer are eligible for Medicaid, leaving them no affordable or accessible options.

Q: What is the Administration going to do to reduce the numbers of uninsured?

A: The President has been aggressively pushing to enroll the millions of Americans now eligible for coverage and urging the Congress to pass additional reforms that would succeed in insuring more people. We will step up efforts both to create new options (e.g., Medicare buy-in, Medicaid buy-in for people with disabilities) and to increase participation in existing options. The Administration's ongoing efforts include:

Ensuring rapid, aggressive implementation of the new Children's Health Insurance Program (CHIP) which targets uninsured children of working families. In addition to approving all state plans, the Administration has launched an aggressive public-private outreach campaign to educate families about this new program.

Last month, the Departments of Health and Human Services, Justice and Education and 10 national, nonprofit organizations, kicked off more than 45 community events to enroll children around the country in CHIP and Medicaid. These efforts have focused on outreach to minority communities, including the Hispanic community to which we have distributed Spanish language television and radio PSAs and print articles and op-eds on how to enroll in CHIP and Medicaid.

Earlier this year, the President, along with the National Governors' Association, launched the Insure Kids Now campaign, including a national toll free number, 1-877-KIDS-NOW and the *insurekidsnow.gov* web site, which gives families specific information on how to enroll in CHIP and Medicaid.

Improving Medicaid. This Fall, HHS will send teams to work with state officials this fall to review programs and identify and remove possible barriers to enrollment in Medicaid and CHIP. Earlier this year, we also took action to assure and encourage legal immigrants to receive health insurance through Medicaid and CHIP. Since 1993, HHS has approved several Medicaid waivers to states for comprehensive health care reform projects to control costs and expand coverage and waivers for welfare reform projects. When fully implemented, these demonstration projects will extend health coverage to 2.2. million parents and children who otherwise would be uninsured.

Q: Why hasn't CHIP reduced the number of uninsured children already?

A: We are encouraged that the CPS numbers show the number of uninsured children remained stable from 1997 to 1998. We expect that this number will begin to decline now that CHIP is fully implemented. CHIP was only passed by Congress and signed by President Clinton in August of 1997. To date, HHS has approved 56 plans -- all 50 states, 5 U.S. territories and the District of Columbia. So far, we estimate that 1.3 million children have been enrolled and states expect to enroll 2.6 million by October 2000. In 1998, the year that the Census data covers, 43 states had programs in operation, but only 4 states had been enrolling children throughout that year.

We will continue to work with state and local communities and forge more public-private partnerships in our efforts to enroll all eligible children in CHIP and Medicaid.

Q: Isn't it true that the decline in Medicaid is due to welfare reform?

A: No. This Administration has demonstrated an unprecedented commitment to reducing the numbers of uninsured and would not take any action that would reduce access to health insurance for low-income people.

It is important to note that although Medicaid enrollment has declined, the number of uninsured people classified as poor has actually declined by 87,000.

Why Medicaid rolls are declining is a complex question with no easy answer. One explanation is that the improving economy has made it possible for many low-income people once enrolled in the Medicaid program to find jobs that offer health insurance benefits. The Census data show that the decline in Medicaid coverage occurred only among poor people, where there was also an offsetting increase in private coverage. Another answer is that individuals may not realize they are still eligible for the Medicaid program even if their income increases slightly.

It is also important to note that the Census Bureau explicitly warns that the changes in Medicaid coverage estimates from one year to the next should be viewed with caution, since Census Bureau data under-reports Medicaid coverage. In fact, preliminary 1998 Medicaid enrollment data from the Health Care Financing Administration show that there were 40 million Medicaid enrollees, while the 1998 Census Bureau numbers only report 28 million Medicaid enrollees. As such, it would not be appropriate to rely on the Census Bureau data to draw conclusions about the effect of welfare reform on Medicaid.

Q: **Aren't the CPS numbers regarding Medicaid enrollees much lower than HHS' estimates?**

A: Yes. Preliminary 1998 Medicaid enrollment data from the Health Care Financing Administration show that there were about 40 million Medicaid enrollees, while the 1998 Census Bureau numbers only report 28 million Medicaid enrollees, including 14 million poor people. Similarly, administrative data show close to 20 million children covered by Medicaid, whereas the Census numbers report only 14 million.

Again, it is important to note that the Census Bureau explicitly warns that the changes in Medicaid coverage estimates from one year to the next year should be viewed with caution, since Census Bureau data under-reports Medicaid coverage.

Message Sent To: _____

Medicare
Q&A
September 27, 1999

Q: Recently, a new study was released stating that President's Medicare reform plan would give employers an excuse to drop their current insurance coverage for retirees. It also says that if the President's plan were implemented, 75 percent of retirees would lose their private coverage. What is your response?

A: First, consider the source. The organization releasing this report is almost completely underwritten by the pharmaceutical industry, which has chosen to unfairly and inaccurately characterize the President's proposal. Secondly, the report masquerading as an independent analysis is inaccurate. In fact, the Congressional Budget Office testified that the vast majority of Medicare beneficiaries in retiree health plans would retain their coverage. This is because the President's plan provides for a new, currently unavailable, over 10 billion dollar financial incentive for businesses to establish or retain private prescription drug coverage. Lastly, even without a prescription drug benefit, all the trends illustrate that employers are dropping retiree health coverage - in fact, in the last four years, there has been a 25 percent decline in the proportion of firms offering retiree health coverage and its accompanying prescription drug benefits. That, precisely, is why we believe that the President's plan, which offers another option to retirees, is necessary.

Once again, we call on the drug industry to stop utilizing their vast resources to mischaracterize the President's plan. We would hope that they will refocus their efforts towards helping the millions of disabled and older Americans who have no, extremely limited, and/or unaffordable prescription drug coverage.

Q: What about the survey that says that 82 percent of the people that currently have drug coverage would not like to switch to the President's plan?

A: That's not surprising. The President's proposal is explicitly designed to encourage those who have comprehensive retiree health coverage to be able to keep it. The independent CBO projects that 75 percent of those who currently have retiree health benefits will opt to keep their current benefits. That's consistent with the survey results being described by the drug industry, and reflects the expected and desired outcome of the President's policy. The President's plan simply represents another option for Medicare beneficiaries.

Q: What do you think about the industry's refusal to pull their current ads and actually expanding their campaign against the President's proposal?

A: We have spent a lot of time attempting to constructively engage with the pharmaceutical industry and have an honest dialogue about policy differences. Clearly, we are disappointed in their choice to expand their misleading and false ad campaign. Although we believe it is a strategic mistake by the industry, they have every right to spend millions of dollars on an ad campaign. Of course, we would prefer that these funds be

spent to help people without coverage or invested in the research and development that the industry professes to care so much about.

Q: The ads sponsored by the drug companies say that the President's plan will make it difficult for seniors to access the medications they need, reduce the options available to seniors, force private companies to drop their drug coverage, and implicitly suggest that the plan will lead to widespread price controls. What is your response?

A: First, the President's prescription drug proposal uses the best practices developed by the private sector to provide this new coverage option. Rather than limiting access to prescription drugs, it significantly expands access to these lifesaving medications. It assures that every therapeutic category of drugs is covered and that a physician can prescribe and pharmacists can dispense any medically necessary drug on behalf of his or her patient.

Second, the President's plan provides an affordable option for prescription drug coverage to all Medicare beneficiaries, but no beneficiary is required to take this option. The plan simply offers a new option for Medicare beneficiaries at a time where most Medicare beneficiaries are seeing their prescription drug coverage options become increasingly limited or nonexistent.

Third, the President's plan provides billions of dollars through the tax code for businesses to establish or retaining private prescription drug coverage.

And lastly, there is absolutely no provision in the President's proposal that provides for price controls. It advocates the use of private contracting with pharmacy benefit managers (PBMs) or other entities to purchase medications and uses the best practices developed by the private sector to provide the appropriate, high quality care provided by private health plans today.

Medicare
Q&A
September 21, 1999

Q: **Recently, a new study was released stating that the President's Medicare reform plan would give employers an excuse to drop their current insurance coverage for retirees. It also says that if the President's plan were implemented, 75 percent of retirees would lose their private coverage. What is your response?**

A: First, consider the source. The organization releasing this report is almost completely underwritten by the pharmaceutical industry, which has chosen to unfairly and inaccurately characterize the President's proposal. Secondly, the report masquerading as an independent analysis is inaccurate. In fact, the Congressional Budget Office testified that the vast majority of Medicare beneficiaries in retiree health plans would retain their coverage. This is because the President's plan provides for a new, currently unavailable multi-billion dollar tax incentive for businesses to establish or retain private prescription drug coverage. Lastly, even without a prescription drug benefit, all the trends illustrate that employers are dropping retiree health coverage – in fact, in the last four years, there has been a 25 percent decline in the proportion of firms offering retiree health coverage and its accompanying prescription drug benefits. That, precisely, is why we believe that the President's plan, which offers another option to retirees, is necessary.

Once again, we call on the drug industry to stop utilizing their vast resources to mischaracterize the President's plan. We would hope that they will refocus their efforts towards helping the millions of disabled and older Americans who have no, extremely limited, and/or unaffordable prescription drug coverage.

MEDICARE QUESTIONS AND ANSWERS

PRESCRIPTION DRUG BENEFIT

Q: Why are you providing coverage to the over two-thirds of beneficiaries who already have private insurance coverage for prescription drugs?

A: **This charge is false. Less than one-third of Medicare beneficiaries have private insurance coverage – either retiree health coverage or Medigap.** Over the last four years, the number of firms offering retiree health coverage has declined by 25 percent. Beneficiaries purchasing Medigap find it to be inadequate and excessively expensive. Beneficiaries choosing the publicly financed Medicare HMO option are finding that it less frequently provides for a drug benefit and, even when available, is increasingly limiting coverage for this essential need.

Prescription drug coverage is essential to a modern Medicare program. No one designing the Medicare program today would exclude prescription drug coverage. It is as central to health care as hospital care was in 1965. My proposal simply provides an option to access this critically necessary benefit.

Means tested benefit excludes the middle class. The instability of private and Medicare managed care coverage has resulted in a growing number of uninsured throughout the income, demographic and geographic spectrum. Fully 40 percent of beneficiaries without drug coverage are middle class (with incomes above $16,000 for singles, $22,000 for couples). Means testing the benefit, as some suggest, would result in an inequitable and unfair system that would leave in an elderly widow with income of $19,000 without access to desperately needed prescription drug coverage.

The Republican approach, using tax deductibility of private drug coverage, excludes millions of middle-class beneficiaries. Recently, the Republicans on the Ways and Means Committee unveiled a proposal to attempt cover prescription drugs by allowing beneficiaries to take a tax deduction for premiums for private drug coverage. This approach has several critical flaws. First, tax deductions matter more the more income you have – helping Ross Perot and other wealthy seniors more than the majority of middle-class seniors. Second, over 55 percent of seniors have no tax liability at all and thus would not benefit from this policy. And, third, making all private Medigap plans offer drug coverage does not necessarily make it more affordable. In fact, it could lead to less access to private coverage as insurers raise premiums or drop out of Medicare altogether.

Q: Why should the Medicare program subsidize a drug benefit for Ross Perot and Bill Gates?

A: This issue is nothing but a red herring utilized by those who do not want to provide a prescription drug benefit to the vast majority of Medicare beneficiaries who are middle class. It is the same argument that was used by those people opposing enactment of the Medicare program in the first place. Medicare was created as a program where everyone who pays in gets a benefit upon retirement. We have never means tested Medicare's benefits and there is a very good reason for that. It would be inconceivable to have a Medicare program that would disqualify an 85-year old widow who has had a stroke from hospital coverage because she has an income of $25,000. Similarly, it is incomprehensible that prescription drug coverage in Medicare depends on how much income you have.

Equally as important is the fact beneficiaries who are sick – regardless of income – cannot access insurance in many places at any price. It is this sort of discrimination against the sick and the elderly that served as the rationale for creating the Medicare program to begin with.

Q: Will this new prescription drug benefit cover Viagra?

A: In general, the private sector contractors who will manage the Medicare drug benefit will be required to cover prescriptions that are medically necessary, including Viagra. However, as is the case in the Medicaid program and with other private insurers, the private contractors can use prior authorization or other limitations for drugs for which there are documented abuses.

INVESTING 15 PERCENT OF THE SURPLUS IN THE TRUST FUND

Q: Aren't projections always wrong? Isn't your dependence on the yet-to-be fully realized surplus dangerous and irresponsible?

A: No. One of the hallmark achievements of this Administration is that it has reinstated the credibility of government economic forecasts. In each and every year of this Administration, our economic forecasts have been more conservative than the economy's actual performance. If the surplus turns out to be less than our forecasts projects, it will translate into a less significant extension of the trust fund. In contrast, if the surplus is fully spent on a tax cut, the consequence of misestimates means deficits and new taxes.

PROVIDER REIMBURSEMENT

Q: How can you propose additional provider savings without restoring some of the excessive savings of the BBA?

A: I am certainly not ignoring the concerns that have been raised by providers in the wake of the implementation of the BBA. I have instructed HHS to implement administrative actions that would relieve unnecessary burdens that could undermine the ability of providers to deliver quality services. In addition, his proposal explicitly provides for a $7.5 billion quality assurance fund to help smooth out problems that Congress and the Administration decide, based on objective evidence, have resulted in harm to beneficiaries. Although the reform proposal includes proposals to constrain out-year spending, they are much more moderate than those included in the BBA and those recommended by the Republican majority of the Medicare Commission. They do not include any hospital outpatient department savings, any disproportionate share payment reductions, any nursing home reimbursement savings, and any new home health care provider savings.

POLITICS OF MEDICARE AND THE 2000 ELECTIONS

Q: Isn't your proposal just another political ploy to help Al Gore and the Democrats take back the Congress and entice the seniors back to the Democratic tent?

A: Of course not. I am committed to strengthening and modernizing both Social Security and Medicare. I believe that the surplus provides a golden opportunity for members of both sides of the aisle to contribute to the development of important reforms essential to these important programs. It serves no one's interest – Democrats or Republicans – to ignore challenges facing the programs. It is my hope and expectation that the majority of the members will come to that conclusion as well and take advantage of this extraordinary opportunity.

Q: Does Mrs. Clinton support the President's Medicare proposal?

A: Mrs. Clinton supports my Medicare proposal. Because of her concern about the impact of the Balanced Budget Act on health care providers across the nation, and her longstanding concerns about teaching facilities in America, she also particularly supported provisions in my package of administrative and legislative changes that will smooth out the impact of the Balanced Budget Act on health care providers across the nation, including those in New York. For this reason, she strongly supported the inclusion of the $7.5 billion quality improvement fund, and has made clear that she believes that we need to be particularly responsive to the concerns of academic health centers – the "crown jewel" of America's health care system. I explicitly raised concerns in this area and believes we need to work with the Congress to develop an approach to respond to these

provider concerns.

PBOR
Q&A
September 15, 1999

Q: Do you support or oppose the Coburn-Shadegg bill?

A: We are reviewing this legislation now, so it would be premature for me to discuss it in detail. We welcome anyone who is trying to develop strong patient protections that are long overdue. We must make sure that there are meaningful enforcement mechanisms to ensure that the rights are real. As the President has stated previously, rights without remedies are not rights at all. We look forward to working with Congressmen Coburn and Shadegg, as well as all other members of Congress, in our commitment to passing a strong, enforceable Patients' Bill of Rights.

Q: Would you accept a different enforcement mechanism than that included in the Norwood-Dingell bill? If so, what would that be?

A: The President has always been open to alternative enforcement mechanisms, but we have consistently stated that the enforcement mechanism must be meaningful. Norwood-Dingell achieves that end, and we would be interested to see an acceptable, workable alternative in any serious piece of legislation in the House.

Q: Opponents of this legislation say that the Norwood-Dingell bill, particularly the right to sue provisions, would increase costs and decrease coverage. What is your response?

A: First, the Norwood-Dingell compromise limits even the possibility of access to punitive awards. In fact, it would only be available to those individuals whose managed care organizations ignore the ruling of an independent external appeals board. This ensures that there would be no unjustified and expensive awards.

Second, there are over 200 health and consumer groups who have been consistent and dedicated advocates of providing affordable health care to all Americans that have endorsed the Norwood-Dingell legislation. They would never support this legislation if it were to increase costs and decrease coverage.

Third, even before the Norwood-Dingell compromise dropped punitive damage awards from all but the most egregious cases, analysis based on figures produced by the Congressional Budget Office concluded that costs will not increase more than two dollars a month.

It's clear that this argument is a red herring argument made by special interests. Patients want to and deserve to know that their insurance policies are worth the paper they are written on. These protections will ensure that they are.

Q: Some suggest that the only difference between the Republican bills and the Norwood-Dingell bill is the right to sue and that you care more about trial lawyers than providing quality coverage to Americans. How do you respond?

A: The Patients' Bill of Rights would not be meaningful if there were not provisions that ensure that health plans can be held accountable for actions that harm patients. In the absence of such provisions, there would be little to no incentive for plans to comply with the law. Obviously, at least 21 Republicans in the House agree with this position.

Having said this, we have always been open to alternative enforcement approaches. It is worth noting that the bipartisan legislation introduced by Congressmen Dingell and Norwood severely limits punitive awards to ensure that there are no unjustified and expensive lawsuits.

Second of all, there are numerous shortcomings in the Senate Republican bill beyond its totally inadequate enforcement provision. To name a few, it does not include access to specialists, has a wholly inadequate continuity of care provision, leaves out over 100 million Americans, and covers less than 10 percent of the people in HMOs.

VP Health Care Plan
Q&A
September 8, 1999

Q: What is your reaction to the health care plan outlined by Al Gore yesterday?

A: The President thinks that the health care proposals put forth by Al Gore are bold and well thought out. They offer a pragmatic approach to significantly expand health care coverage for those who don't have it and improve it for those who do. It provides an important vision for health care in the 21st century.

We need to complete the unfinished agenda that the President and the Vice President have been working on – such as strengthening and modernizing the Medicare program, providing critical support for families with long-term care needs, ensuring strong medical privacy protections, and passing a strong enforceable patients bill of rights -- so that we can move on to the important next steps that the Vice President has proposed.

AIDS
Q&A
August 31,1999

Q: How do you respond to the widely reported finding that there has been a reduction in the decline of AIDS deaths?

A: Clearly, we are concerned about any report that provides disturbing information about AIDS trends. However, it is not overly surprising that the mortality rate is stabilizing, as many individuals who already know they are infected are receiving treatment. This explains why there has been a decline in the number of deaths from 50,000 in 1995 to under 20,000 in 1998 (the latest data available). And even with this most recent report, it is important to note that AIDS deaths nationwide fell 20 percent between 1997 and 1998.

Of course, we are concerned that there has been no significant reduction in the number of people newly infected with HIV between 1997 and 1998. More disturbing is the news that AIDS death rates in African Americans are nearly ten times higher than in whites. This news provides a notable opportunity to reiterate the importance of prevention. The President's FY 2000 budget includes $4.3 billion for AIDS prevention, treatment, and research, an increase of $2.2 billion over FY 1999 funding levels.

Q: CDC reports that although African Americans represent only 13 percent of the US population, they account for 49 percent of AIDS deaths. What are you doing to address this issue?

A: To address the severe and ongoing health crisis caused by HIV/AIDS in racial and ethnic minority communities, the President directed HHS to invest an unprecedented $156 million to improve our effectiveness in preventing and treating HIV/AIDS in African-American and Hispanic communities. In June of this year, HHS sent Federal Crisis Response Teams to major metropolitan areas across the country to meet with local officials, public health personnel, and community based organizations to help them develop targeted strategies to curb the rapid spread of HIV/AIDS among minorities. These new efforts complement ongoing Federal efforts and an investment of over $60 million to eliminate racial and ethnic disparities in health status nationwide.

MEDICARE REFORM
Questions and Answers
June 21, 1999

PRESCRIPTION DRUGS

Q: Now that you can get to 2020 solvency without using all of the 15 percent of the surplus, are you now going to use some of the surplus for prescription drugs?

A: The President has proposed to dedicate 15 percent of the surplus to strengthen the Medicare program. We believe a new prescription drug benefit should be included as part of, not independent from, a broader set of reforms for the Medicare program. We will announce the details of the financing when the President unveils his proposal sometime this month.

FOLLOW-UP

Q: Are you denying that some of the surplus will be used for prescription drugs in the President's proposal?

A: I am not going to go into any details about the financing of the Medicare reform proposals until the President makes his final decisions, which will be after he returns from his trip.

Q: Can you confirm that the prescription drug benefit will be between $10 and $25 , as recently reported in the *New York Times?*

A: I am not going to discuss details on this or any other aspect of the Medicare reform proposal other than to say that this story is wrong. It would be impossible to provide for a meaningful benefit for a $10 premium without a fiscally imprudent expenditure of Federal dollars. As has been indicated by White House staff previously, we are designing the Medicare prescription drug benefit to be significantly less costly than what is available in the Medigap market – about $90 per month.

Q: What will the design of the drug benefit be? How will it be financed and administered?

A: We are not releasing any information on the design of the drug benefit or any other aspect of our Medicare reform proposal. There are still final policy decisions that need to be made, and no one in the Administration will release this or any aspect of the reform proposal until the President makes his announcement, which will be at the end of this month.

Q: The Breaux-Thomas proposal did not provide a prescription drug benefit to all beneficiaries because over 60 percent of beneficiaries already have some form of coverage. Won't your proposal replace private sector dollars with a large government subsidy?

A: No. We know that today, over 15 million Medicare beneficiaries do not have prescription drug coverage at all, and we know that millions more will lose their coverage as private insurance becomes more expensive and less accessible. This comes at a time when prescription drugs have never been more important to basic health care. For this reason, the President's drug proposal will be available and affordable to all Medicare beneficiaries.

Q: How do you reconcile a brand new entitlement with the need to constrain the growth of the Medicare program?

A: It's widely acknowledged by that you cannot modernize the Medicare program without including a Medicare prescription drug benefit. Prescription drugs today are as important as hospital care was when Medicare was created. This can be done in a way so that both the government and beneficiaries share the cost. It also would take advantage of private sector management approaches that can constrain the cost of purchasing these needed medication without the use of price controls. This benefit will be fully financed in the President's overall Medicare reform plan.

PLAN CONTENT

Q: You've indicated that you want to modernize the program and make it more competitive. Does that mean that your proposal will include a premium support mechanism (or a similar provision) ?

A: We need to inject more competition into the Medicare program, for both the traditional fee-for-service program as well as the managed care plans serve beneficiaries. As we have mentioned, we believe that the premium support proposal advocated by Senator Breaux and Congressman Thomas suffers from serious flaws, including consequence of higher premiums for the traditional program. We support competition based on choice, not based on the financial coercion that results from these higher traditional program premiums. We do need to inject more market oriented approaches into the Medicare program, and we are reviewing the best options to achieve that goal while still protecting beneficiaries from excessive increases in out-of-pocket costs.

Q: Will your Medicare proposal include an income related premium?

A: No final decisions about this or any other aspect of the Medicare reform package has been made. Having said this, the President has historically indicated an openness to considering this structural reform (in 1992, during the campaign; in 1993, during the Health Security Act; and in 1997, in discussions with Congress on the BBA). But, like

any other provision of the Medicare reform package, we will view this in the context of the broader set of reforms before making any final decision.

Q: Doesn't the recent Trustees Report eliminate the pressure to reform Medicare?

A: Absolutely not. Medicare reform is both about solvency and about making Medicare more efficient, equitable, and adequate in terms of benefits. Our successful stewardship of Medicare does not diminish the future challenges facing the program. Under any scenario, enrollment in Medicare will climb from 39 million to 47 million in 2010, and to 80 million by 2035. We must modernize and strengthen the Medicare program by making it more competitive and instituting the best market-oriented practices of the private sector, and as we have previously indicated, the President's plan will do just that.

PROVIDER CUTS IN REIMBURSEMENT

Q: Providers have been stating that the cuts in provider reimbursement in the Balanced Budget Act went too far and undermine their ability to provide quality care. Are you going to address this issue in your Medicare reform package?

A: We have consistently said if there is evidence that the Balanced Budget Act Medicare provider payment reductions threaten quality, access, and the ability of providers to deliver needed services, we would be open to considering changes to smooth out this legislation. We are currently evaluating all available evidence on this matter. If we determine there are problems, we will seriously consider administrative and/or legislative options to address these problems.

JEFFORDS-KENNEDY
Questions and Answers
June 21, 1999

Q: **Last week, Senator Kennedy announced that the President had made a commitment to pay for the cost of the Jeffords-Kennedy Work Incentives Improvement Act by cutting entitlement programs. What is your response?**

A: The President's FY 2000 budget fully paid for the cost of the Work Incentives Improvement Act. It included a range of offsets, including Medicare fraud and abuse savings. In addition, we indicated our support for the financing mechanism passed out of the House Commerce Committee by a vote of 16 to 2. The President's hope and expectation is that between the two financing approaches, we can develop a set of offsets that can achieve broad based consensus on this issue.

MEDICAL RECORDS PRIVACY
Questions and Answers
June 21, 1999

Q: What is the Administration's position on the medical records privacy legislation currently being considered by the Senate Committee on Health, Education, Labor, and Pensions?

A: As the President made clear in his State of the Union Address, he wants Congress to pass a strong, comprehensive medical records privacy bill this year. In the absence of progress in this area, he has committed to using the authority granted to him under the Health Insurance Portability and Accountability Act to implement privacy protections administratively. We applaud Senator Jeffords for the bipartisan process the committee has established to work through the legislation. While several of our concerns have been addressed, we share the concerns of outside advocates about the legislation produced by the Senate Committee on Health, Education, Labor, and Pensions. The President's preference continues to be legislation that will expand our authority to protect medical records privacy. His hope and his expectation is that Senator Jeffords, Senator Kennedy, and other leaders in this area will improve on the legislation that has been produced to date.

THE PATIENTS' BILL OF RIGHTS
Questions and Answers
June 21, 1999

QUESTIONS AND ANSWERS ON THE PATIENTS BILL OF RIGHTS

Q: Isn't the only outstanding issue between you and the Republicans passing a PBOR your insistence on providing for a right to sue?

A: First of all, there are a number of Republicans who do support a strong, comprehensive, Patients Bill of Rights (For example, Congressman Norwood and Congressman Ganske.) Second of all, there are numerous shortcomings in the Senate Republican leadership bill beyond just the enforcement provision. To name a few, it does not include access to specialists, has a wholly inadequate continuity of care provision, and would only apply to the self insured, leaving out over 100 million Americans in the individual and group markets from needed protections. These are serious shortcomings that need to be addressed, but we are confident that they can and will be if there is an open debate over these provisions.

FOLLOW UP QUESTION

Q: Are you saying that the President would veto a Patients Bill of Right s that did not allow Americans to sue their health care plans?

A: We're not going to be talking about a veto at a time where we see momentum moving towards a strong, comprehensive, enforceable, PBOR. What we are saying is that we need an enforcement mechanism that ensures these rights are real – that they don't represent an empty promise. We are open to working with Republicans and Democrats to determine the best enforcement provision, but I am not going to negotiate in public on this matter.

Q: The House Republicans have introduced their own version of the Patients' Bill of Rights. Would you support this legislation?

A: First, let me say that we are glad that the House is engaging in this issue. We are convinced that there are a majority of members who support a comprehensive Patients' Bill of Rights, and we are hopeful that the Republican leadership will help expedite Committee and floor consideration of this important legislation this summer. However, the bill introduced yesterday is unacceptably flawed in that it has an inadequate independent appeals process that does not protect against arbitrary decisions made by HMOs, does not cover individuals in all health plans, and has weak enforcement mechanisms that are unable to assure that patients are protected. In addition, the protections themselves are wholly inadequate because they do not include, among other provisions, guarantees for access to specialists. We are convinced that there is a majority of members on both sides of the aisle who would support a strong Patients' Bill of Rights

that the President would be proud to sign, and we urge the Congress to move quickly to pass a bill that gives all Americans the protections they need.

Michele Ballantyne 06/21/99 06:58:33 PM

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Subject: Prep for AP Reporters Roundtable - Tues. 9:45am

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MEDICARE Q&A

Q: What will be in your Medicare reform proposal?

A: It will be consistent with the principles that I outlined for the program earlier this year and will improve Medicare's ability to provide affordable, quality health care to the over 39 million elderly and disabled beneficiaries it serves. It will modernize and strengthen the program by making it more competitive and instituting the best market-oriented practices of the private sector. And, to bring the program into the 21st century, it will provide for a meaningful prescription drug benefit. Lastly, it will of course include my proposal to dedicate 15 percent of the surplus to strengthen the financial status of the program, to prevent excessive increases in out-of-pocket costs for beneficiaries, and to avoid harmful provider payment reductions.

Q: When are you going to unveil your plan?

A: I am committed to getting this plan right, and will not commit to a specific timetable today. However, there is no question that I will send it to Capitol Hill early enough for the Congress to review it and to take action on Medicare reforms this year.

Q: Doesn't the recent Trustees Report eliminate the pressure to really reform the Medicare program?

A: Absolutely not. Medicare reform is both about solvency and about making Medicare more efficient, equitable, and adequate in terms of benefits. Our successful stewardship of Medicare does not in any way diminish the challenges facing the program. Under any scenario, enrollment in Medicare will climb from 39 million to 47 million in 2010, and to 80 million by 2035. We must modernize and strengthen the Medicare program by making it more competitive and instituting the best market oriented practices of the private sector, and as I have previously indicated, I plan on submitting a proposal to do just that.

Q: Now that you can get to 2020 solvency without using all of the 15 percent of the surplus, are you now going to use some of the surplus for prescription drugs?

A: Our primary goal is to dedicate the surplus to improving Medicare solvency. I believe that a new prescription drug benefit should be included as part of, not independent from, a broader set of reforms for the Medicare program. The exact details of the financing we'll be announcing

with our plan, and I don't want to say exactly what the financing structure will be until we put our plan out.

Q: You've indicated that you want to modernize the program and make it more competitive. Does that mean that your proposal will include a premium support mechanism (or any other specific provision)?

A: I believe that we need to inject more competition into the Medicare program, for both fee for service as well as the managed care plans that participate. As I have mentioned, I believe that the premium support proposal advocated by Senator Breaux and Congressman Thomas suffered serious flaws, including its impact on higher premiums for the traditional program. We do need to inject more market oriented approaches into the Medicare program, and we are reviewing the best options to achieve that goal while still protecting beneficiaries from excessive increases in out-of-pocket costs.

Q: What are the specific problems with the Breaux Thomas Plan?

A: The Breaux-Thomas proposal has advanced the debate and recommended a number of ideas that are worth serious consideration; however, the proposal falls short in a number of important areas.

The plan does not address Medicare's financing, thereby avoiding the economic reality confirmed by every independent Medicare expert --that the demographic explosion of the Medicare program will require new funds that cannot be generated through structural reforms.

The Breaux-Thomas plan also raises the age of eligibility for Medicare to 67. I strongly believe that raising the eligibility age to 67 without a viable policy that insures the number of the uninsured does not increase is unwarranted and ill-advised. There are already over 3 million, uninsured people just under age 65, and this is the most rapidly growing age group of the uninsured. Without Medicare or some accessible, affordable alternative, many of the 65 to 67 year olds who would have Medicare would become --or remain --uninsured.

Finally, the Breaux-Thomas plan includes a flawed " premium support" proposal, which would raise premiums for traditional Medicare by 10 to 30 percent for most beneficiaries. Although I am committed to adding competition to the Medicare program, I believe that this increase in beneficiary costs is unacceptable.

Q: You said your goal was to extend the life of the Trust Fund until 2020. Are you now suggesting that you are raising the bar and

making the Congress go further than 2020 to meet your desires on Medicare?

A: I always have and will continue to firmly believe that we should dedicate 15 percent of the surplus to Medicare. The fact that the Trustees are now projecting that the program is in better shape does not in any way alter the need for the dedication of new funds. The demographics and the costs are still overwhelming. As the Trustees themselves say, " substantially greater changes in income and/or outlays are needed, in large part as a result of the impending retirement of the baby boom generation." It is important to recall that even with the new changes in estimates, Medicare remains in worse financial shape than Social Security (2015 vs. 2034 as it relates to projected exhaustion dates). The new projections simply mean that we can use the surplus to extend the life of the Trust Fund longer than 2020 and, in the context of broader reform, help pass a long-overdue prescription drug benefit for some of our most vulnerable of the nation's citizens.

Q: FOLLOW-UP. So prescription drugs will be financed at least in part through the surplus?

A: We are not going to get to details of my plan before it has been completed. Again, I have made no decisions on this provision --or any other provision --at this time.

Q. Is it true that raising the age eligibility is off the table?

A. Raising the eligibility age will not be a part of my package. I believe that raising the eligibility age for Medicare without policies to prevent the uninsured from increasing is going in the wrong direction.

Q: How do you respond to the GAO and CBO's contention that your proposal to dedicate some of the surplus to Medicare does not represent real reform?

A: I believe that preparing the Medicare program for the next century will require both additional revenue and reforms to make the program more competitive. In the State of the Union, I set out a plan to provide the program with the necessary new funds and proposed working on a bipartisan basis to develop appropriate reforms. I believed that it was appropriate to await the recommendations of the Commission before proposing specific reforms. Now that the Commission has reported its recommendations, it is incumbent on me to submit my own proposal to modernize and strengthen the program, and as I have previously indicated, I plan on doing that in short order.

To: Bruce Call or page w/ P's.
Fr: Chris J This is a draft to help John P. prep for Cabinet meeting. (CJ)

TOP LINE MEDICARE Q&As FOR HOUSE DEMOCRATIC LEADERSHIP MEETING

Timing

Q: When is the President going to release his Medicare reform proposal?

A: We hope to unveil it in a matter of weeks; we certainly would not expect anything later than a June time frame. However, we don't want to lock ourselves into a specific release date because it is far more important to us that we get the policy work done right, have all the provisions scored by the Medicare actuary, and develop and implement an effective roll-out of the policy with you and Senator Daschle. We also want to have the benefit of your counsel as we start to present final options to the President. That is part of the reason we are here today.

Prescription Drug Benefit Design

Q: Will your drug benefit be available to all Medicare beneficiaries AND just how will it be designed?

A: We are considering designs that assure that all Medicare beneficiaries -- whether they are in HMOs or in the traditional program -- have access to affordable prescription drugs. This is not an inexpensive proposition. While we are reviewing all types of different options, we are leaning toward a benefit that has a small or no deductible in order to assure that virtually all beneficiaries see and feel the new benefit. Going in the opposite direction may ignore the painful lesson taught to us by the Medicare Catastrophic Coverage Act. In addition, we clearly want to keep the premium to a low as rate as possible. Having said this, there are many other policy design tradeoffs, including copayments and coverage caps. Obviously, we will not be able to afford a Cadillac benefit plan. We certainly want to have the benefit of your thoughts on this challenging issue.

Q: How much will the drug benefit cost and how will you pay for it?

A: The cost depends completely upon the plan's design. It could be anywhere between $10 to $30 billion a year (OR "it clearly would be billions of dollars a year" -- if we do not want to list specific figures). Beneficiary premiums, copayments, deductibles and benefit caps are the primary moving pieces. The more comprehensive the insurance coverage and the greater the subsidy for the premium, the more the cost.

As for financing, we are looking for Medicare program savings to help offset the cost of the drug benefit. Recognizing there are not a lot of provider savings still on the table, there may have to be other sources of offsets as well, including beneficiary contributions and possible outside revenue. We wanted to take this opportunity to discuss these ideas with you.

Q: What about the BBA extenders? Are you going to use them for offsets? Will you moderate the pain that so many of our providers are enduring?

A: We don't think it is wise to simply extend the BBA. While there will have to be some provider savings, particularly in the out-years, we believe we need to have a separate review of appropriate future constraints. We also well recognize that you all are being barraged by provider complaints about the Balanced Budget Act. There may well be a justification for addressing some of the concerns that have been raised and we are open to considering them. Having said this, we also believe we need to be careful not to reopen the entire BBA to a Medicare provider feeding frenzy. We believe any consideration of any change in direction from the BBA should be based on solid and documentable policy rationale. If we don't insist on such information, it will be much more difficult to draw needed lines of distinction between providers lobbying you and us for changes.

Q: What about the means testing of the Medicare program? Will that be in your plan?

A: First, we are not contemplating means testing of the benefit package. We have always opposed proposals that denied total access to the benefit based on income. Having said this, the President has repeatedly said (in 1992, 1993, and 1997) that he is open to reducing the premium subsidy for higher income beneficiaries IF it is included in the context of a broader set of constructive reforms. He has not made any determination about an income related premium, but I must say we would be surprised if he did not consider it as one viable offset to help pay for the cost of a drug benefit.

Q: Are you going to have some premium support proposal in the President's plan?

A: We aren't going to support or propose any alteration in Medicare plan payments that increases premiums -- whether implicitly or explicitly -- in the traditional program, such as was included in the Beaux-Thomas plan. While we are always looking to find ways to more efficiently purchase health care goods and services for the Medicare program, we will not go down any road that undermines the traditional fee-for-service program or raises its premiums.

Q: What about the surplus? Are you going to use it to help pay for the drug benefit or to help calm down our providers?

A: We have not made any determination about accessing the surplus beyond using it to extend the life of the Medicare program. We believe we should try to extract as much savings from other sources as possible first before seriously contemplating using the surplus. It is important to remember that one of the advantages we have over the Republicans is that the President's 15 percent proposal effectively extends the life of the Trust Fund to beyond 2025; if we allocate too much of the surplus to prescription drugs (or provider fixes), we may effectively make it too easy for Republicans to match our Trust Fund target date with a flawed plan that nonetheless may be attractive to some conservative Democrats.

Medicare Proposal
June 1, 1999

Q: When will the President release his Medicare plan?

A: The President hopes to unveil his proposal to strengthen and modernize the Medicare program sometime this month. He wants to make sure, however, that the plan is reviewed carefully, scored accurately, and has benefited from consultation with members of Congress, aging advocates, providers, and other interested parties.

Q: Did the President make any decisions today? What happened at the meeting?

A: The President made no decisions today. He was briefed on a range of issues and options, and asked for more information.

Health Care Q&A's
April 21, 1999

Q: **Yesterday, the American Cancer Society, the National Cancer Institute, and the Centers for Disease Control released a study indicating that cancer rates are in decline for most of the population. However, the incidence of all types of cancer (except breast cancer) is higher in blacks and Hispanics than in whites. What is your response?**

A: We are pleased to see that the study indicates that the declining popularity of smoking is an important factor in the overall decline in cancer rates. However, the study also demonstrates an alarming rise in the prevalence of teen smokers which, if accurate, will eventually eliminate our hard-won successes. This completely validates the President's commitment to reduce smoking among out nation's youth and do everything we can to prevent the 3,000 children who become regular smokers each day from picking up their first cigarette.

Since the beginning of the Administration, the President enacted into law an 48 percent increase in NIH funding ($5.3 billion dollars), and the good news in yesterday's report indicates that these investments are paying off, as the rates of new cases and deaths for all cancers is down again.

The President remains concerned about the evidence demonstrating a higher rate of cancer in minorities than the rest of the population, and has taken strong steps to address this issue, investing $145 million in this year's budget for health education, prevention, and treatment services for minority populations. He has also proposed additional critical steps to fight cancer, including expanding access to cancer clinical trials, continuing our commitment to research, and assuring access to quality treatments for all Americans.

Health Care Q&A
April 13, 1999

Q: Since you have become President, the number of uninsured has increased, and now health care costs are going up. You failed to pass large-scale health care reform, and some of your more recent proposals are facing tough sledding as well. How do you think your record on health care will be viewed after you leave office?

A: There are still shortcomings in out health care system, including the unacceptably high number of uninsured, and we must continue to work hard on this issue. But I am proud of what we have done to improve health care for millions of Americans. We have worked with Congress to pass legislation that improves access to insurance; makes insurance more affordable for different vulnerable populations, including children and immigrants; constrains costs within Medicare and extends the life of the trust fund from 1999 to 2015; increased emphasis on preventive care in Medicare by eliminating cost sharing for certain preventive benefits, including mammographies; significantly increased our commitment to biomedical research; and improved the quality protections in health insurance plans.

As important as these improvements have been, I believe that there is much more we can accomplish before my term is up. I will continue to fight for a strong, enforceable Patients Bill of Rights; work to modernize and strengthen the Medicare program, including by providing a Medicare prescription drug benefit; push for targeted reforms that provide health insurance to foster children, uninsured employees of small businesses, and older Americans who are unable to afford health insurance but who are not old enough to be eligible for Medicare; seek viable long term care options for the millions of Americans with long term care needs and the families that care for them; work to ensure the privacy of medical records for all Americans; and protect Americans from genetic discrimination.

Medicare Q&A's
April 13, 1999

Q: What will be in your Medicare reform proposal?

A: My proposal will be consistent with the principles that I outlined earlier this year. It will improve Medicare's ability to provide affordable, quality health care to the over 39 million elderly and disabled beneficiaries it serves. It will modernize and strengthen the program by making it more competitive and instituting the best market oriented practices of the private sector. And, to bring the program into the 21st century, it will provide for a meaningful prescription drug benefit. Lastly, it will of course include my proposal to dedicate 15 percent of the surplus to strengthen the financial status of the program, to prevent excessive increases in out-of-pocket costs for beneficiaries, and to avoid harmful provider payment reductions.

Q: When are you going to unveil your plan?

A: I am committed to getting this plan right, and will not commit to a specific timetable today. However, there is no question that I will send it to Capitol Hill early enough for the Congress to review it and to take action on Medicare reforms this year.

Q: Doesn't the recent Trustees Report eliminate the pressure to really reform the Medicare program?

A: Absolutely not. Medicare reform is both about solvency and about making Medicare more efficient, equitable, and adequate in terms of benefits. Our successful stewardship of Medicare does not in any way diminish the challenges facing the program. Under any scenario, enrollment in Medicare will climb from 39 million to 47 million in 2010, and to 80 million by 2035. We must modernize and strengthen the Medicare program by making it more competitive and instituting the best market oriented practices of the private sector, and as I have previously indicated, I plan submitting a proposal to do just that.

Medicare Q&A's
February 17, 1999

SURPLUS

Q: Doesn't your plan to reserve part of the surplus for Medicare represent a "pass" on real Medicare reform?

A: Absolutely not. Improving and strengthening Medicare requires adequate financing, as well as reforms to make the program more competitive and ensure a modernized benefits package. By infusing much-needed revenue, my proposal adds years to the life of the trust fund while making it easier for Democrats and Republicans to come together to develop reforms that strengthen the program.

Q: Could the surplus just be used for a new prescription drug benefit?

A: I believe that a new prescription drug benefit should be included as part of a broader set of policies to improve the Medicare program, and that it would be irresponsible to expand benefits without addressing the financial and structural challenges facing the program.

MEDICARE COMMISSION

Q: Do you support Senator Breaux's Medicare proposal?

A. First, let me remind you of my position on Medicare. I believe that we should dedicate 15 percent of the projected surpluses over the next 15 years to extending until 2020 the life of the Medicare Trust Fund. As I've indicated, however, my preference is to add these new resources at the same time as we make improvements in the program to make it more efficient and provide a modernized benefits package that includes a prescription drug benefit. I do not want to comment on Senator Breaux's draft proposal yet, because the Commission is still working on and changing it. I will evaluate any proposal to see that it:

- Dedicates the Surplus to Secure the Trust Fund until 2020;
- Modernizes the Program and Makes It More Competitive;
- Guarantees a Defined Set of Benefits without Excessive New Costs to Beneficiaries; and
- Uses Savings from Reforms to Help Fund a Prescription Drug Benefit.

I look forward to working with Senator Breaux and the rest of the Commission as they move forward with their important work.

Q. What do you think of the premium support proposal that the Commission is considering?

A: "Premium support" is a concept worth considering but, as with any initiative, the devil is in the details. Again, I will carefully review any proposal emerging from the Commission to see whether it meets four key principles -- that it:

- Dedicates the Surplus to Secure the Trust Fund until 2020;
- Modernizes the Program and Makes It More Competitive;
- Guarantees a Defined Set of Benefits without Excessive New Costs to Beneficiaries; and
- Uses Savings from Reforms to Help Fund a Prescription Drug Benefit.

Q: The Medicare Commission may propose to raise the Medicare eligibility age from 65 to 67 -- making it consistent with the phase-up for Social Security. What is the Administration's position on this proposal?

A: As I have said many times, I have serious concerns about raising the Medicare eligibility age. Indeed, I have emphasized the need to provide insurance coverage for Americans between the ages of 55 and 65, who are the most rapidly growing group of the uninsured. So I would view any proposal to raise the Medicare eligibility age with a good bit of skepticism.

Q. Is it possible for this Medicare Commission to finish its work on time, and if not, would you support an extension past its March 1 deadline?

A. It would be inappropriate for us to comment on the Commission's time frame before consulting with Senator Breaux and Mr. Thomas. At the moment, they have not asked for an extension.

Q: Senator Breaux is recommending an income-related premium. Do you support this idea?

A: I am open to the concept, but would consider such a proposal only in the context of a larger package of reforms.

PRESCRIPTION DRUGS

Q. Your appointees to the Medicare Commission have said they would support the proposal of the Commission only if it includes a prescription drug benefit. Is this a litmus test for you?

A. I believe that a broad proposal for Medicare reform should include a meaningful prescription drug benefit for all beneficiaries. I do not favor, however, providing this benefit without at the same time addressing the financial and structural challenges facing the program.

Q. Won't a prescription drug benefit, even in the context of broader reforms, result in higher Medicare spending? How can the program afford this benefit at a time when it faces a serious financing crisis?

A. As Senator Breaux has said, not having a prescription drug benefit in 2000 is like not having hospital coverage in 1965. Prescription drugs have become an essential part of medical treatments and cures, and they are expected to play an even greater role in health care in the next century. I believe that additional savings from making Medicare more efficient should be used to help finance this long-overdue benefit for Medicare beneficiaries. It would be penny-wise and pound-foolish not to add this benefit.

Patients Bill of Rights Q&A
February 17, 1999

Q: Is the "Patients' Bill of Rights" stalling out? Is it still a priority? What are your plans to push for and promote passage of this legislation?

A: Passing a strong, enforceable Patients' Bill of Rights remains one of my top legislative priorities. As I did in my State of the Union Address and in New Hampshire yesterday, I will continue to challenge the Congress to pass a strong Patients' Bill of Rights early this year. This is one way for Congress to show that it can respond to the American people's needs, and I am hopeful that Congress will take advantage of this opportunity.

Congressman Dingell recently reintroduced his Patients Bill of Rights legislation and it already has attracted over 180 co-sponsors. Mr. Dingell expects virtually all 211 members of the Democratic Caucus to sign on to this bill. And, just last week, Congressman Ganske introduced a similar bill, which included an alternative but still very viable enforcement provision, which immediately attracted 10 Republicans. These actions indicate that a strong, enforceable bill will emerge from the House, which will place pressure on the Senate to do its part to pass this crucial legislation.

Medicare Q&A's
January 22, 1999

Q: Isn't the *Washington Post* editorial right -- that the President's plan to reserve part of the surplus for Medicare is a "pass" on real Medicare reform?

A: Absolutely not. Medicare reform is both about solvency and about making Medicare more efficient, equitable, and adequate in terms of benefits. This move by the President will help to achieve solvency and thereby allow the Medicare Commission and Congress to focus as well on other objectives.

Q: Isn't the President's plan to use part of the surplus for Medicare just throwing more money at the problem without any long-overdue structural reforms?

A: The President wants this proposal to be considered in the context of broader reforms. But virtually all independent experts confirm that because of changing demographics and rising health costs, the Medicare system requires more financing. All the structural reforms in the world won't change this fact. What the President's proposal does is to enable Congress to focus more on structural issues by partly taking care of the financing problem.

Q: Could the surplus just be used for a new prescription drug benefit?

A: The President believes that a new prescription drug benefit should be included as part of, not independent from, a broader set of reforms for the Medicare program. He believes that it would be irresponsible to focus only on expanding benefits without addressing the financial and structural challenges facing the program.

Q: Will the President reject the Commission's plan if it does not include a prescription drug benefit for Medicare?

A: It would be difficult to imagine a major reform proposal on Medicare that ignores the most indefensible aspect of the Medicare program -- its lack of prescription drug coverage. It is clear that most members of the Commission agree with the President that there should be increased access to prescription drugs for Medicare beneficiaries. The outstanding questions concern how the benefit should be structured and financed. We hope that the Commission report addresses these issues.

Q: Do you support the Medicare proposal being released by Senator Breaux?

A: We just received Senator Breaux's statement last night, and it would be premature to

comment on it. The statement also appears to leave many questions unanswered, and we would need more specifics about the policies and their impact on Medicare beneficiaries and providers. We look forward to working with Senator Breaux and the rest of the Commission as it moves forward.

Q. What do you think of the premium support proposal that the Commission is considering?

A: "Premium support" is a concept worth considering but, as with any initiative, the devil is in the details. We will carefully review the proposal and see whether it meets goals like improving efficiency, ensuring an adequate benefits package, modernizing Medicare, and protecting low-income beneficiaries.

Q: The Medicare Commission may propose to raise the Medicare eligibility age from 65 to 67 -- making it consistent with phase-up for Social Security. What is the Administration's position on this proposal?

A: As we have said many times, we have serious concerns about raising the Medicare eligibility age, particularly in the absence of a mechanism to ensure that this change does not increase the number of uninsured Americans. Recent data confirms that Americans between the ages of 55 and 65 are the most rapidly growing group of uninsured Americans and are some of the hardest to insure. Americans ages 65 to 67 could face similar problems. The Commission's draft plan states that it will develop a plan to ensure protections for the affected population. We anxiously await the details of this plan.

Q: What is your position on [graduate medical education reform, Medigap reforms, etc.] that are being considered by the Commission?

A: The President and the Congress created the Bipartisan Medicare Commission in recognition of the complexity of addressing Medicare's problems. The President believes it would be premature to comment on any specifics prior to the conclusion of the Commission's work.

Q. Is it possible for this Medicare Commission to finish its work on time, and if not, would you support an extension past its March 1 deadline?

A. It would be inappropriate for us to comment on the Commission's timeframe before consulting with Senator Breaux and Mr. Thomas on this matter. At the moment, they have not asked for an extension.

Disability Initiative Q & A's
January 12, 1999

Q. How is this initiative funded?

A. This initiative is fully funded through offsets in the President's proposed FY 2000 budget. All of these provisions will be described in the budget documents released in early February.

Follow-up: Isn't it irresponsible to announce specific spending proposals without announcing how these proposals will be financed?

Not at all. The President will ensure that this -- and all other new initiatives -- will be fully paid for as part of his overall balanced budget proposal. Like most budgets, the President's FY2000 budget will not contain a specific dollar-for-dollar link between new proposals and offsets. The bottom line, however, will reflect the President's long-standing commitment to a balanced budget. Moreover, not one dime will be taken away from the surplus for this initiative.

Q. Shouldn't this tax credit be refundable? Doesn't this mean that low-income people are not helped by this initiative?

A. No. The vast majority of low-income people with disabilities are already covered by Medicare and Medicaid. This initiative enables states to cover people who would be rendered ineligible by virtue of returning to work and gaining a higher income. Thus, most of the funding in this initiative is targeted toward those low-income people in the process of returning to work.

The tax credit helps offsets the higher costs of work (e.g., personal assistants, special transportation) for people with disabilities who pay taxes, irrespective of their income or state of residence. It also, unlike Medicaid and Medicare, allows the worker to use the funds for whatever expenses they incur.

Q. Why are we only doing tax initiatives? Are you rejecting traditional Medicare and Medicaid program expansions? Aren't you catering to Republicans?

A: Each policy in the President's budget was designed to be the most cost-effective approach to solving a particular problem. This tax credit for workers with disabilities is no exception. Workers with disabilities have very different costs -- for rural residents, it may be transportation; for people with limited use of their hands, it may be assistive devices. A tax credit offers the flexibility to assist with a wide-ranging and changing set of needs in a way that Medicaid expansions cannot.

Similarly, the informal, unmeasurable costs of family caregiving are best addressed through a tax credit, as proposed in our long-term care initiative. If Medicaid or Medicare expanded to cover respite care, for example, it would undermine rather than strengthen informal family caregiving and cost billions more.

In no way does the President's support for these tax credits undermine his commitment to Medicare and Medicaid. This President has an unparalleled record of protecting, strengthening and expanding these programs. For example, the President's aggressive actions to reduce Medicare fraud contributed to record-low spending growth in 1998 -- the same year that he added new preventive benefits, health plan choices, and low-income protections to Medicare.

Q. How many people will benefit from this proposal?

A. Between 200,000 and 300,000 people would likely benefit from the tax credit. Millions more could benefit from the new options, services and programs in the Work Incentive Improvement Act and the assistive technology initiative.

Q. What are this initiative's prospects of passing?

A. Removing barriers to work for people with disabilities goes beyond partisan politics. We can all agree that something must be done so that people with disabilities can fully participate in today's strong economy. Senators Jeffords, Kennedy, Roth and Moynihan have already committed to working hard for the Work Incentive Improvement Act. We hope that early passage of this bill can show the American public that this Congress and President can work together to address real problems that are affecting people's lives today.

Q+A

Q. Is your agenda dead on Capitol Hill?

A. No. We have a chance to make real gains in the next few weeks on education, environment, patients bill of rights and Social Security -- but only if Congress chooses progress instead of partisanship. Some in Congress want to cut education; I won't let that happen. Some in Congress want to squander the surplus instead of putting Social Security first; I won't let that happen, either. And I'm going to continue to do everything in my power to make progress for the American people, not wait for Congress to act. Tomorrow, we will announce that we are guaranteeing the protections in the patients bill of rights to the almost 40 million Americans in the Medicaid program, which means that over 75 million Americans will be receiving patient protections as the result of executive actions I have taken. (VA, DOD, Medicare, FEHB)

Q. Is PBOR dead?

A. No. Today, Senate Dems are trying to offer this as an amendment. I am confident that once Congress brings this to a vote, we will prevail and pass a strong, forceful, and bipartisan bill into law. I will continue to do everything in my power (eg, Medicaid reg) to push Congress and to make progress.

Q. HC costs
A. Watch it closely. Not return to inflation, just increased utilization. When I took office, hc inflation was rampant. Now Medicare and Medicaid growing 25% slower than the private sector.

Amer Reads
Head Start
Summer Jobs

Q&As on Patients' Bill of Rights

Q: What is the Administration's response to the patients' bill of rights proposal unveiled by the House Republicans?

A: President Clinton has been calling on this Congress to pass a patients' bill of rights for eight months, so that crucial medical decisions will be made by doctors, not accountants. We welcome the fact that the House Republicans have finally entered this debate by announcing their intention to introduce legislation on this issue. Their long-overdue announcement explicitly affirms the President's longstanding position that Federal legislation is needed.

However, the fact that Republicans have yet to introduce a bill with less than 37 days left raises serious questions as to whether they are truly committed to passing a patients' bill of rights or selling a bill of political goods to the American public.

Moreover, from what we have seen on the Republican proposal, it seems as if they are trying to address their political problems rather than patient concerns. For example, it does not guarantee patients access to the specialists they need, such as heart specialists or oncologists. It does not include limits on financial incentives for doctors to limit patient care, and it does not ensure continuity of care -- so that vulnerable patients will not have their care changed abruptly if their provider is dropped from a health plan. It does not include strong remedies for people who are seriously injured or who die because a health care plan wrongly denied them care.

In addition, the Republican proposal includes poison pill provisions, such as multi employer welfare arrangements (MEWAs), arbitrary caps on medical malpractice awards that supersede state laws, and medical savings accounts. These provisions are apparently designed to stall the progress on a patients' bill of rights.

Without important protections and with added poison pills, the Republicans' patients' bill of rights is nothing more than a bill of goods. However, the President remains committed to working together to pass a strong, bipartisan bill before this Congress adjourns.

Background: Important patient protections that are not included in the Republicans' patients' bill of rights and poison pill provisions, include:

-- **Access to specialists.** Again and again we have heard about cancer patients who are denied access to an oncologist. Assuring access to needed specialists is absolutely essential protection.

-- **Financial incentives for doctors.** Patients should not be put at risk through unknown destructive financial incentives to limit patient care.

-- **Continuity of care protections.** This assures some of the most vulnerable patients -- such as pregnant women or the chronically ill -- that their care will not change abruptly if their provider is unexpectedly dropped from a health plan.

-- **A workable enforcement mechanism that ensures recourse for patients who have been maimed or who have died as a result of health plan actions.** The Administration strongly believes that there must be a meaningful remedy to ensure patients can hold health plans accountable for their actions. A right without a remedy is simply not a right.

-- **Poison pill provisions,** including malpractice caps, multiple employer welfare associations, and medical savings accounts that appear to be designed to stall this important legislation.

Q: Isn't it true that the Democrats are holding up the patients' bill of right so they can use it as an election year issue?

A: Absolutely not. The President has been calling for Congress to pass a patients' bill of rights since last November when the Quality Commission first made these recommendations. Nearly eight months later the Republicans finally have an outline for a proposal. However, there are only 36 days left in this Congress and we have yet to see any legislation from the Republicans.

Moreover, the Republican proposal appears designed to address political problems not patient protections: it does not guarantee patients access to needed specialists; it does not ensure continuity of care -- so that vulnerable patients will not have their care changed abruptly if their provider is dropped from a health plan; and it does not include a strong enforcement mechanism that ensures recourse for patients who have been maimed or who have died as a result of health plan actions.

The Republican proposal also includes poison pills designed to stall this legislation We want to pass a patients' bill of rights, but we want to ensure that it provides Americans the protections they need and deserve.

Q: What is the Administration's position on enforcement? Do you support the state-enforced remedies in the Democratic bill?

A: The Administration wants to ensure that any bill of rights includes an enforcement mechanism that ensures recourse for patients who have been maimed or who have died as a result of health plan actions. We are willing to look at different types of enforcement mechanisms. State-court enforced remedies is one approach, but there may be other acceptable approaches as well to ensure these patient protections are real.

Q: If the Congress passed the Dingell-Kennedy-Ganske remedies/enforcement provision, would the President sign the bill into law?

A: Should the Congress pass the approach proposed by Dr. Ganske and Dr. Norwood, the President would sign it into law. However, we are open to considering any enforcement provision as long as it is strong and ensures that the patients' protections are real for Americans.

Q: Do you support the House enforcement provision?

A: First, we have yet to see the details on these proposals. However, from what we have heard from press reports, it appears to have little enforcement protections. It has low civil monetary penalties and is weakly enforced. It appears to only have few protections even for those patients who have been maimed or who have died as a result of health plan actions.

Q: What are the other types of enforcement mechanisms that would be acceptable?

A: As various Administration officials have consistently testified, enforcement through the Federal courts would also be an acceptable option combined with Federal agencies enforcement. However, as with all health policies, the devil is in the details. We would have to carefully review any enforcement mechanisms to assure they have patients' the recourse they need.

Q: How can the Administration draw a line in the sand on this issue when the President's own Quality Commission explicitly rejected any enforcement provisions?

A: It is totally inaccurate to say that they rejected an enforcement provision. They chose not to address this issue, due to time constraints and because they did not have universal consensus on how to proceed. The President has said that a right without a remedy is not a right. He is open to various approaches to ensure that these protections are real for Americans.

Q: Some say that the patients' bill of rights is going to significantly raise health care costs and increase the number of uninsured?

A: These claims are scare tactics used by opponents of this legislation. There is absolutely no evidence that these basic reasonable protections will significantly increase health care costs or the number of uninsured.

In fact, there have been a number of independent analyses that these patient protections would not significantly raise the cost of health insurance. The Kaiser Foundation estimated that patient protections would increase health insurance premiums less than one percent (less than $3 per family per month), and a Coopers & Lybrand study released this week even found that allowing patients to sue their health plans would only increase premiums between three and 13 cents a month.

Today, many Americans lack the protections necessary to ensure high quality health care. They may not be able to see the specialists they need, or to get emergency care wherever and whenever a medical emergency arises. They may not be able to talk freely with doctors and nurses about all the medical options available -- not only the cheapest. The improvement in the quality of health care that will result from these protections is more than worth the very modest premium increases.

Medicare Q&A
December 2, 1998

Q: **What is your response to today's report from the HHS Inspector General that Medicare contractors aren't adequately pursuing fraud?**

A: We are concerned about any reports which suggest that we can do better in our anti-fraud efforts. No Administration has been more committed than this one to weeding out fraud and abuse in the Medicare program. Since 1993, we have assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. As a result, convictions have gone up a full 240 percent and we have saved some $20 billion in health care claims. The Kassebaum-Kennedy legislation the President signed into law created -- for the first time ever -- a stable funding source to fight fraud and abuse. And last year's historic Balanced Budget Act gave us an array of new weapons to use in our fight to keep scam artists and fly-by-night health care out of Medicare and Medicaid.

There is, however, much more work to do, and we are extremely concerned about this new report showing that private Medicare contractors aren't adequately pursuing fraud. HHS investigators are already visiting contractor fraud units to determine how to improve their operations. In the light of this report, which we take very seriously, we are reviewing options for stepping up these efforts and/or taking other steps to improve the detection and punishment of fraud by Medicare contractors.

Q: Senator Breaux and Senator Frist accurately point out that the Medicare Trust Fund is projected to become insolvent far sooner than Social Security's Trust Fund. Both have stated that Medicare's more acute problem deserves serious attention and, in fact, have said that addressing Medicare should be the Administration's and Congress' first priority. (Senator Breaux is no longer saying Medicare first, but is definitely wants the program to get equal billing). How do you respond? Don't they have a point?

A: Assuring a strong, modern Medicare program has always been and always will be a top priority for this President. Last year, the President enacted into law arguably the most significant changes to Medicare since the program's enactment in 1965. A provision in that legislation, one that he strongly supported, was the establishment of the Medicare Commission. The Commission, which has 17 Members -- including four Administration appointees -- and is chaired by Senator Beaux, is charged with developing recommendations to begin dealing with the long-term health care delivery, financing, and demographic challenges facing the Medicare program. Because of the President's strong commitment to the program, we are closely following the work of the Commission and are hopeful that we will be able to embrace its final report, now scheduled to be released in March of next year.

Unlike Medicare, however, we have all benefited from the completion of the work of the Social Security Advisory Commission. This Commission produced a comprehensive analysis of the challenges facing Social Security and produced a series of options that are now being seriously reviewed by all parties interested in this critically important program. As a result, we now have a historic opportunity to ensure the solvency of Social Security well into the next century. We need to respond to this opportunity. Doing so now will make it easier for us to focus on the future of Medicare.

Q: Are you saying that the President and the Administration will do nothing about Medicare until the Commission files its report?

A: Of course not. The President has and will continue to take administrative actions and propose legislative initiatives that strengthen the Medicare program. For example, his record on advocating for anti-fraud and program integrity initiatives is clear. As such, we are currently reviewing options for this upcoming budget. However, we are doing so in a way that complements rather than undermines the Commission's work.