PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

FOR THE 21st CENTURY

National Economic Council / Domestic Policy Council

The White House

Clinton Denounces G.O.P. on Medicare

President Spends Day Raising Health Issues and Campaign Money

By ROBERT PEAR

CLEVELAND, March 13 — President Clinton today denounced proposals by Republican members of Congress to help elderly people buy prescription drugs, and he defended his own proposal, saying the government must subsidize drug coverage for all Medicare beneficiaries, not just for those who have modest incomes or use large amounts of medicine.

Rather than noting their similar goals, Mr. Clinton emphasized the differences between his approach and that of Republicans in Congress.

Some Republicans want to give federal grants to the states to help low-income elderly people buy drugs. But Mr. Clinton said that approach would "help only the poorest seniors" and would leave people just above the poverty line to fend for themselves.

That approach is unacceptable, he said. More than half of the Medicare beneficiaries who lack prescription drug coverage have incomes more than 50 percent above the official poverty level, he said.

A couple is classified as poor if its annual income, including Social Security benefits, is less than $11,250.

Likewise, Mr. Clinton rejected a proposal by some Republicans who want to give tax breaks to elderly people so they can buy private insurance covering prescription drugs.

"This proposal would benefit the wealthiest seniors, without providing any help to low- and middle-income seniors," he said.

Mr. Clinton came under attack on the issue as Representative Bill Archer, the Texas Republican who is chairman of the Ways and Means Committee, said today that the president had impeded Congressional efforts to expand Medicare to cover prescription drugs.

"One year ago this week President Clinton blocked a bipartisan plan to strengthen Medicare and help seniors get the drugs they need," Mr. Archer said, referring to the work of a bipartisan commission on the future of Medicare.

Mr. Archer said Republicans were determined to help those who most needed assistance, "without bankrupting Medicare or threatening coverage for millions of people who have prescription drug insurance."

A contention that Republican plans do not go far enough.

Congress is considering many proposals to provide Medicare coverage of drugs, and the issue promises to figure prominently in the presidential election and in many congressional races.

Medicare generally does not cover prescription drugs outside the hospital. But many elderly people have such coverage because they receive health benefits from former employers or because they buy private insurance to fill gaps in Medicare, and some of those Medigap policies pay for drugs.

In a report issued today, the White House emphasized the importance of drug coverage for the elderly, saying, "Middle-income beneficiaries without prescription drug coverage purchase 20 percent fewer drugs, but pay about 75 percent more out-of-pocket than those with drug coverage."

Mr. Clinton said Medigap insurance was no panacea. "Medigap drug coverage starts out expensive and then goes through the roof as seniors get older," he said. In Ohio, he said, a 65-year-old person pays an average of $146 a month for a Medigap policy covering prescription drugs, while an 80-year-old must pay $230 a month.

In addition, the White House report said, the tax and Medigap proposals would not achieve significant discounts because they would not exploit the purchasing power of the federal government. Under Mr. Clinton's proposal, the government would hire private companies to buy drugs for the elderly and to negotiate discounts from drug manufacturers and pharmacies.

Mr. Clinton insists that government-subsidized drug coverage should be offered to all 39 million Medicare beneficiaries. But many Republicans and some Democrats in Congress say the government should direct its assistance to people who have low incomes or high drug expenses.

The president's comments on prescription drugs, made before an audience of elderly people at the Cleveland Public Library, were squeezed into a day devoted mainly to political fund-raisers.

On his trip today, Mr. Clinton raised more than $1.1 million. He started the day here by speaking to 70 people at a luncheon that raised $350,000 for the Democratic Congressional Campaign Committee. Mr. Clinton then flew to Chicago, where he raised $87,500 at a reception and $700,000 at a dinner for 28 couples. At the dinner, arranged by the Democratic National Committee, each couple contributed $25,000 for the privilege of spending time with the president.

Clinton administration officials said the government would pay much of the cost for the president's trip today because it included an official event, the meeting with Medicare beneficiaries to discuss prescription drugs.

Mr. Clinton unveiled his drug proposal as part of a comprehensive plan to revamp Medicare on June 29 last year. He has not sent Congress any legislation to translate his ideas on drug coverage into reality, despite requests from lawmakers of both parties. White House officials said Mr. Clinton still intended to send draft legislation to Congress, but they could not say when.

Under Mr. Clinton's proposal, the government would pay half of the drug costs incurred by any Medicare beneficiary who wanted to sign up for coverage. The maximum federal payment would start at $1,000 a year per beneficiary in 2003 and would rise to $2,500 in 2009. Beneficiaries would pay monthly premiums, starting at $26 in 2003 and rising to $51 in 2009. The White House says the president's drug proposal would cost $160 billion over 10 years.

Mr. Clinton said he was willing to share credit with Republicans.

"Look," he said, "they can name this prescription drug program after Herbert Hoover, Calvin Coolidge and Warren Harding. It's fine with me. Put some Republican's name on it. I don't care. Just do it, because it's the right thing to do for the seniors of this country."

The New York Times

TUESDAY, MARCH 14, 2000

"We have not just the opportunity, but a solemn responsibility, to fortify and renew Medicare for the 21st century."

-President Bill Clinton
June 29, 1999

The President's Plan

* Modernizes Medicare's Benefits, including a Prescription Drug Benefit and Preventive Care
* Makes Medicare More Competitive and Efficient
* Strengthens Medicare's Financing for the 21st Century

Modernizes Medicare's Benefits.

Offers a New Voluntary Prescription Drug Benefit.

*Three Out of Four Older Americans Lack Decent, Dependable Private-Sector Prescription Drug Coverage. At least 13 million Medicare beneficiaries have no prescription drug coverage. Millions more have unreliable Medigap or limited Medicare HMO drug coverage. Only one in four Medicare beneficiaries has retiree drug coverage, which is the only meaningful form of private coverage.

*New Drug Benefit Option Makes Prescriptions Available and Affordable for All Beneficiaries. The Clinton-Gore Administration is taking a long-overdue step to ensure that all Medicare beneficiaries can have access to affordable prescription drugs.

*Provides Meaningful Coverage. Medicare would cover half of the beneficiary's drug costs, from the first prescription filled each year up to $5,000 in spending (fully phased-in by 2008).

*Affordable Premiums and No Deductibles. The drug benefit would have no deductible and will cost about $24 per month beginning in 2002 and $44 per month when fully phased-in. This is one-half to one-third of the typical cost of private Medigap premiums.

*Majority of Drug Benefit Costs Offset by Savings. This benefit would cost $118 billion over 10 years – less than 10 percent of total Medicare spending. Over 60 percent of the costs are offset by the proposal's savings. The rest comes from the federal budget surplus – representing less than one-twentieth of the available surplus.

Ensures Access to Essential Preventive Services.

*Preventive Services Are Important to the Well-Being of Seniors and Americans with Disabilities. Older Americans are the fastest growing age group in the U.S. and carry the greatest risk of developing chronic disease and disability. About 88 percent of those over the age of 65 have at least one chronic health condition, many of which are preventable, if detected early.

*Makes Preventive Services Much More Affordable. The President's Plan eliminates existing copayments and deductibles for every preventive service covered by Medicare, including:

- ✓ annual mammograms for all beneficiaries,
- ✓ cervical cancer screening and pelvic exams,
- ✓ tests to help detect osteoporosis (bone mass measurements),
- ✓ colorectal cancer screening,
- ✓ prostate cancer screening,
- ✓ flu and pneumonia vaccinations, and
- ✓ diabetes self-management.

*Ensures Access to Latest Preventive Services. The Plan does not stop at removing financial barriers. It invests in a nationwide education campaign to address the lack of knowledge about the importance and availability of preventive services. Finally, it launches studies of the cost-effectiveness and scientific merits of additional preventive services.

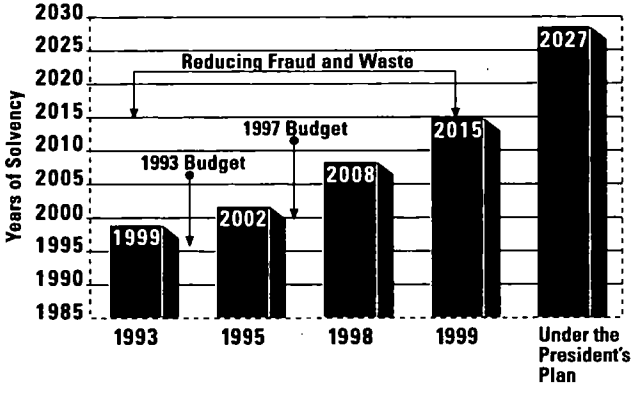
Makes Medicare More Competitive, Efficient and Accessible.

- **Makes Managed Care Payments More Competitive.** For the first time, managed care plans would compete on price and quality, giving beneficiaries lower premiums in return.
- **Modernizes Traditional Medicare.** The Plan gives traditional Medicare successful private-sector management tools to improve quality and reduce costs.
- **Ensures Quality Care.** Recognizing that some policies in the Balanced Budget Act of 1997 may limit doctors', hospitals' and other providers' ability to deliver needed services, the President's Plan sets aside a $7.5 billion quality assurance fund. This fund, plus administrative actions, will protect Medicare beneficiaries against any erosion of health care quality.
- **Improves Access to Medigap.** The Plan includes policies that make Medigap more accessible to beneficiaries with disabilities and those losing access to managed care plans.
- **Offers Medicare Buy-In to Many People Ages 55-65.** The Plan also provides a new insurance option for vulnerable people ages 55 to 65. They could buy into Medicare by paying the full premium (most up-front, the rest after they turn age 65). The Plan would also help people ages 55 to 65 whose employers drop their retiree health coverage. It allows them to buy into their former employer's plan until they turn age 65.

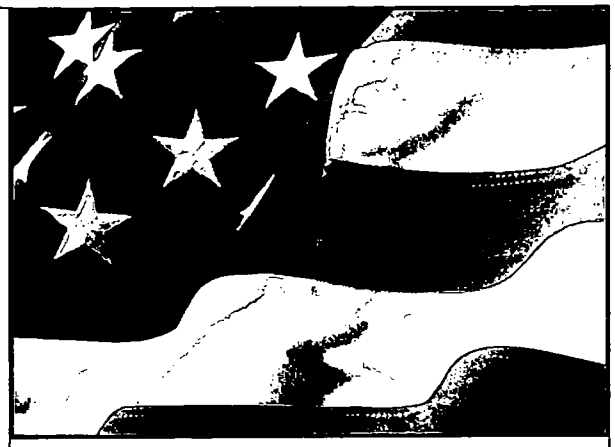
Strengthens Medicare's Financing for the 21st Century.

- **Extends the Life of the Medicare Trust Fund for a Quarter of a Century, to 2027.** The President's Plan would dedicate 15 percent of the budget surplus to strengthen Medicare. This amount, when combined with Part A savings, would extend the life of the Medicare Trust Fund for a quarter century, to 2027.
- **Securing Medicare Will Avoid the Need to Excessively Cut Doctors', Hospitals' and Other Providers' Payments.** Without the budget surplus dedication, Medicare spending growth per beneficiary would have to be held to under 3 percent per person each and every year to keep Medicare solvent until 2027. This rate is about 60 percent below projected private health insurance spending per person (7.3 percent).

Securing Medicare for More Than a Quarter Century



Extending the Solvency of Medicare to 2027



The President's Plan to Strengthen and Modernize Medicare for the 21st Century

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

TAB 1.

OVERVIEW: BUDGET PRIORITIES

BUDGET PRIORITIES:

Protect And Build On Our Prosperity? Or Threaten The Health Of Our Economy?

- We have the best economy in the world today. But remember, just six and a half years ago, the budget deficit was $290 billion and rising. Wages were stagnant, economic inequality was growing, social conditions were worsening.

  In the 12 years before President Clinton took office, unemployment averaged more than 7 percent. It's almost difficult to remember what it was like. No one really thought we could turn it around, let alone bring unemployment to a 29-year low, or turn decades of deficits, during which time the debt of our country was quadrupled in only 12 years, into a surplus of $99 billion. The keys to our prosperity have been fiscal responsibility and key investments in the American people.

- President Clinton has a responsible budget plan that *builds* on our prosperity, by putting *first things first*. The President's plan uses the surplus to strengthen Social Security and Medicare, including modernizing Medicare with a long-overdue prescription drug benefit. It provides targeted tax cutsfor childcare, long-term care and the President's USA Accounts proposal which helps middle-income Americans save for retirement. It provides for military readiness and strengthens our investment in domestic priorities like education, lawenforcement and the environment.

  And, the President's plan continues down the path of fiscal responsibility – and would eliminate the national debt by 2015.

- Republicans would spend nearly the entire surplus on a risky tax cut scheme that would *threaten* the continued health of our economy. Their plan does nothing to strengthen Social Security. Nothing to strengthen and modernize Medicare. Nothing about providing prescription drug coverage for Medicare beneficiaries.

  Fifty economists, including six Nobel laureates, signed a statement on July 21st which said: *"[C]ommitting to a large tax cut would create significant risks to the budget and the economy."* And on July 22nd, Federal Reserve Chairman Alan Greenspan said: *"I would prefer to hold off on significant further tax cuts."*

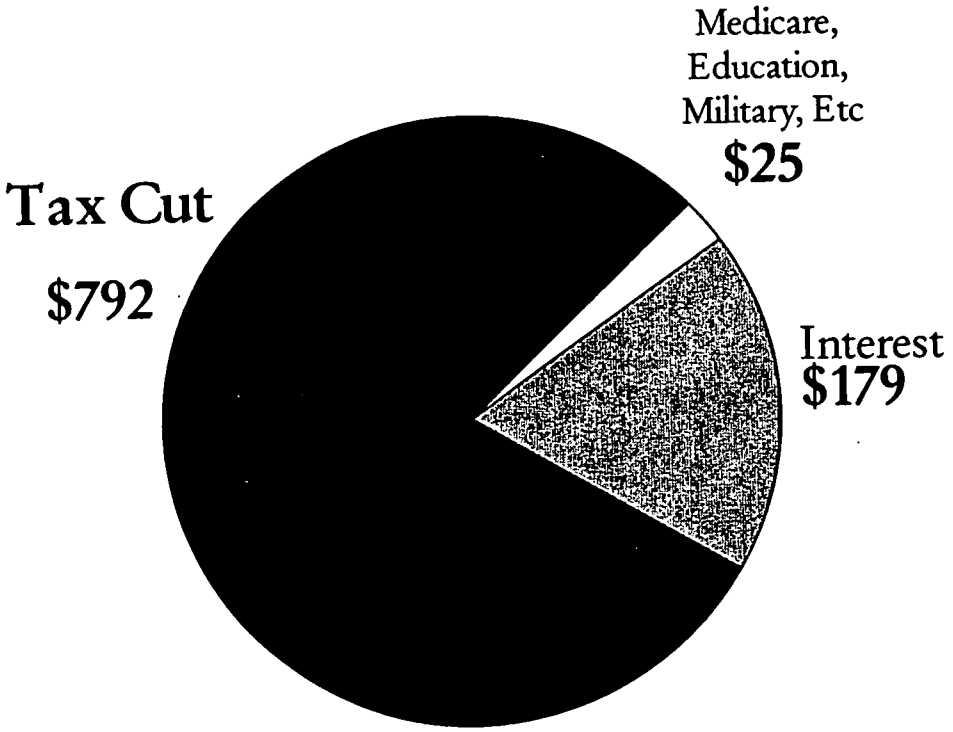
- Republican plans would lead to deep, across the boardcuts in domestic priorities. In order to pay for their risky tax cut and fund our military at the same level as the President, Republicans would have to cut *more than $700 billion* from domestic spending. In 2009, that would mean roughly a 50% cut in domestic programs across the board.

TAB 2.

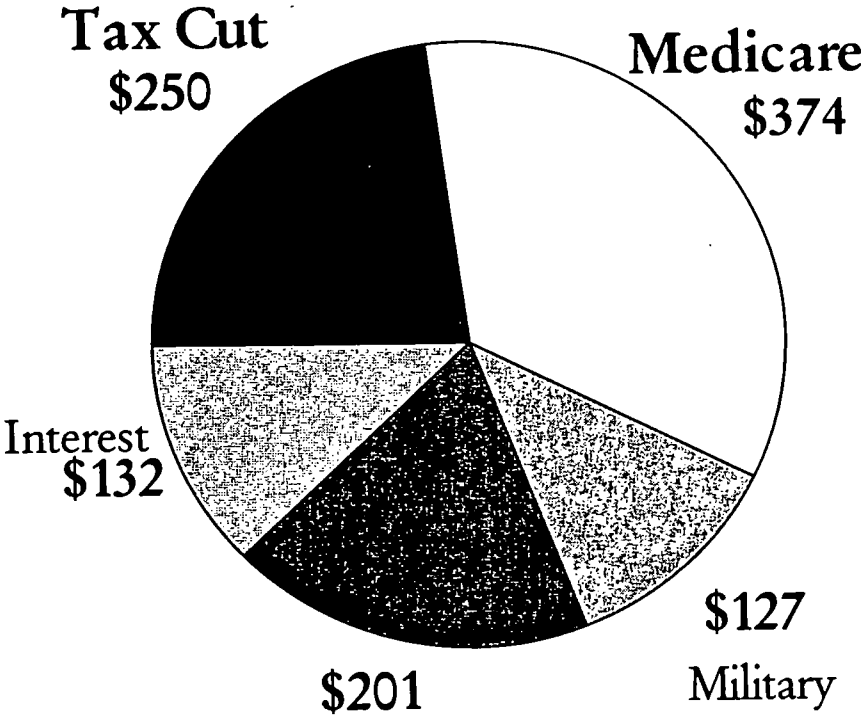
COMPARISON OF PRESIDENT'S AND REPUBLICANS' PRIORITIES

Plans For The On-Budget Surplus
(Dollars in Billions)

Republican Plan



President's Plan



FY 2000-2009; Republicans Use CBO, President Uses OMB Estimates

Impact of Republican Tax Plan

- **Fails** to extend Social Security Solvency
- **Fails** to dedicate surplus to Medicare to extend solvency for even one day
- **Fails** to fund adequately military readiness, education, environment, health, & other priorities

- **More than $700 billion cut** in domestic spending -- 50% in 2009. This means:
- Cutting services to 425,000 of 835,000 children in Head Start
- Reducing spending on bio-medical research by $9.8 billion
- Lowering NASA's budget to its 1984 level

Programmatic Impacts in FY 2009 of Republican Tax Cut
Assuming Defense is Equal to the President's Request

Education and Training

- A cut of this magnitude would force **Head Start** to cut services to **425,000** of the 835,000 children who would otherwise be served in FY 2009.

- About **306,000** summer **jobs and training opportunities** for low-income youth could be eliminated from the 577,700 that would otherwise be provided in FY 2009.

- **Title I, Education for the Disadvantaged** could be slashed, cutting more than **7.4** million children (from the total 14.6 million assumed in the baseline) in high poverty communities from key educational services necessary to improve their future prospects.

- The **Reading Excellence** program, which would otherwise help 1.2 million children learn to read by the 3rd grade, could serve **622,000** fewer students.

Environment and Health

- In FY 1999, the **VA Medical Care** budget projects providing treatment for 3,468,000 veteran patients, a figure that would drop by **1,622,00** should a cut of this magnitude take place.

- Funding for the **Health Resources and Services Administration** would be cut by **$2.5** billion from the current services baseline, resulting in the loss of health services for roughly **15** million women, children, uninsured people, and people living with AIDS from the total 30 million recipients assumed in the baseline.

- Funding for the **National Institutes of Health** would be cut by **$9.8** billion from the current services baseline, resulting in approximately **15,000** fewer biomedical research grants being funded from the total 31,000 assumed in the baseline. At this level, NIH might not be able to fund any new research grants, and support for research grants begun in previous years would have to be reduced.

- **Stopping Toxic Waste Cleanup** -- EPA's Superfund program would be cut by nearly **$1 billion,** eliminating funding for all new Federally-led cleanups due to begin in 2009. Major reductions would also be needed in emergency response actions, ongoing Superfund cleanups, negotiation and oversight of private party-led cleanups, cost recoveries, EPA's brownfields program, and support for other federal agencies and states. Over a thousand employees could lose their jobs, and Superfund contractors would be out of work.

Crime, Housing, and Other Priorities

- Cuts to the **Immigration and Naturalization Service** could result in a reduction of approximately **6,993** Border Patrol agents (from the total 8,947 assumed in the baseline). Cuts to the **FBI** could result in a reduction of approximately **7,187 FBI agents** (from the total 10,687 assumed in the baseline).

- Cuts of this magnitude to **HUD**'s housing rental subsidy could result in the termination of rent subsidies to approximately **1.5** million HUD subsidized low-income tenants in FY 2009.

- Cuts of this magnitude would reduce **NASA**'s funding to the lowest level since **FY 1984**. With this level of funding, NASA could support either a human spaceflight program or a science program relying on robotic missions, but not both.

- The **National Park Service** operating budget would be cut by **almost a billion dollars** below the FY 2009 baseline. Park rangers and other staff would have to be reduced through hiring freezes and RIFs. Seasonal workers could not be hired, resulting in widespread cutbacks in visitor services, seasonal programs, and hours of operations, as well as closures at many of the 378 park units serving almost 300 million visitors annually.

Source: Office of Management and Budget

TAB 3.

PRESIDENT'S MEDICARE PLAN

STRENGTHENING MEDICARE FOR THE 21st CENTURY

President Clinton has proposed to strengthen Medicare by making it more competitive and efficient; modernizing its benefits; and improving its financing. This plan would both offer a long-overdue prescription drug benefit to Medicare beneficiaries and use a portion of the surplus to secure the life of the Medicare Trust Fund for at least the next 25 years. It would also add structural reforms that constrain cost growth by making Medicare fee-for-service and managed care compete more effectively. Lastly, the plan would smooth out and moderate Balanced Budget Act provider payment changes that are excessive. *The New York Times* editorial board described the proposal as "well-considered" and said it would "constitute the most substantial change to Medicare since its creation in 1965."

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. In recent years, the President and Congress have worked together to extend the life of the Medicare trust fund from 1999 to 2015. Building on this success, this plan

- Gives Medicare new private purchasing and quality improvement tools to improve care and constrain costs;
- Injects true price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices and saving money over time for both beneficiaries and the program;
- Reduces average annual Medicare spending growth, ensuring that program growth does not significantly increase after most of the Medicare provisions of the Balanced Budget Act expire in 2003; and
- Takes administrative and legislative action, including a $7.5 billion quality assurance fund, to smooth out provisions in the Balanced Budget Act which may be affecting Medicare beneficiaries' access to quality care.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefits package does not include all the services needed to treat health problems facing the elderly and people with disabilities. To address this, the President's plan

- Establishes a new prescription drug benefit that is affordable and available to all Medicare beneficiaries. All beneficiaries would have the option to purchase this benefit that provides for privately-negotiated price discoun and covers 50 percent of the costs from the first prescription for spending up to $5,000 when fully implemented Premiums for this coverage would begin at $24 in 2002 and phase in to $44 per month in 2008;
- Eliminates copayments and deductibles for all preventive services covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, and mammographies;
- Rationalizes cost-sharing requirements to help pay for the prescription drug and preventive benefits by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation;
- Reforms Medigap policies by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and
- Includes the President's Medicare Buy-In proposal which provides an affordable coverage option for vulnerabl Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. Medicare enrollment will double from almost 40 million today to 80 million by 2035, creating a need to strengthen Medicare financing. To address this, the plan dedicates part of the budget surplus to secure the life of the Medicare trust fund for the next quarter centur

- It is impossible to reduce provider payments enough to extend the life of the Medicare trust fund for any significant length of time. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person.
- Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster, helping to eliminate public debt by 2015. This would make America debt-free for the first time in the 160 year

June 30, 1999

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*
ARTHUR OCHS SULZBERGER, *Publisher 1963-1992*

Improving Medicare

President Clinton's Medicare reform plan, if approved by Congress, would constitute the most substantial change to Medicare since its creation in 1965. Although no reform can instantly improve quality and increase cost-efficiency in the enormous program, Mr. Clinton has delivered a well-considered proposal that can shore up Medicare without heedlessly expanding costs or creating chaos for 39 million beneficiaries.

The plan takes a prudent, incremental approach in adding benefits and changing Medicare's structure. The proposal is premised on putting $794 billion into Medicare over the next 15 years from the projected $5.5 trillion Federal surplus. But any plan that does not greatly cut benefits or reduce eligibility through income tests or other means would need to put more money into Medicare in the next two decades as baby boomers reach retirement and technology makes it possible for more people to live longer. The Clinton plan would extend the solvency of the Medicare trust fund to 2027.

The Administration would spend $118 billion over 10 years to provide limited prescription drug coverage. That step is long overdue. A third of Medicare recipients have no drug coverage, even though drugs have become crucial to managing chronic illnesses and can help keep patients out of the hospital. The proposed voluntary program, beginning in 2002, would charge Medicare enrollees $24 a month. The Government would pay half the cost of prescription drugs for those who enroll, with a maximum Government payment of $1,000 a year. The monthly premium would gradually increase to $44 in 2008, with the maximum benefit cap rising to $2,500. Low-income people would receive help paying the monthly premiums and co-payments.

The drug plan, which would increase Medicare costs by about 5 percent in 2009, would not create an open-ended benefit. But it would enable Medicare to get volume discounts from drug companies, as large purchasers typically do, and to pass those discounts on to the elderly. The plan may also help staunch the decline in employer-paid retiree health benefits by covering some of the drug costs.

The Administration's package would also make it more attractive for beneficiaries to join managed care plans, a shift that is essential to future cost containment. Health plans bidding for Medicare patients would have to offer the same benefits as fee-for-service Medicare. If a plan could provide the same coverage for less money, enrollees would benefit directly from those savings, most likely through discounts off the current $45.50 monthly Medicare premium. That incentive could help pull more people into lower-cost plans. The proposal would increase competition and efficiency in the fee-for-service sector by enabling qualified, cost-efficient doctors to attract Medicare patients by offering patients lower cost-sharing than traditional Medicare, where patients usually pay 20 percent of the costs and the Government pays 80 percent.

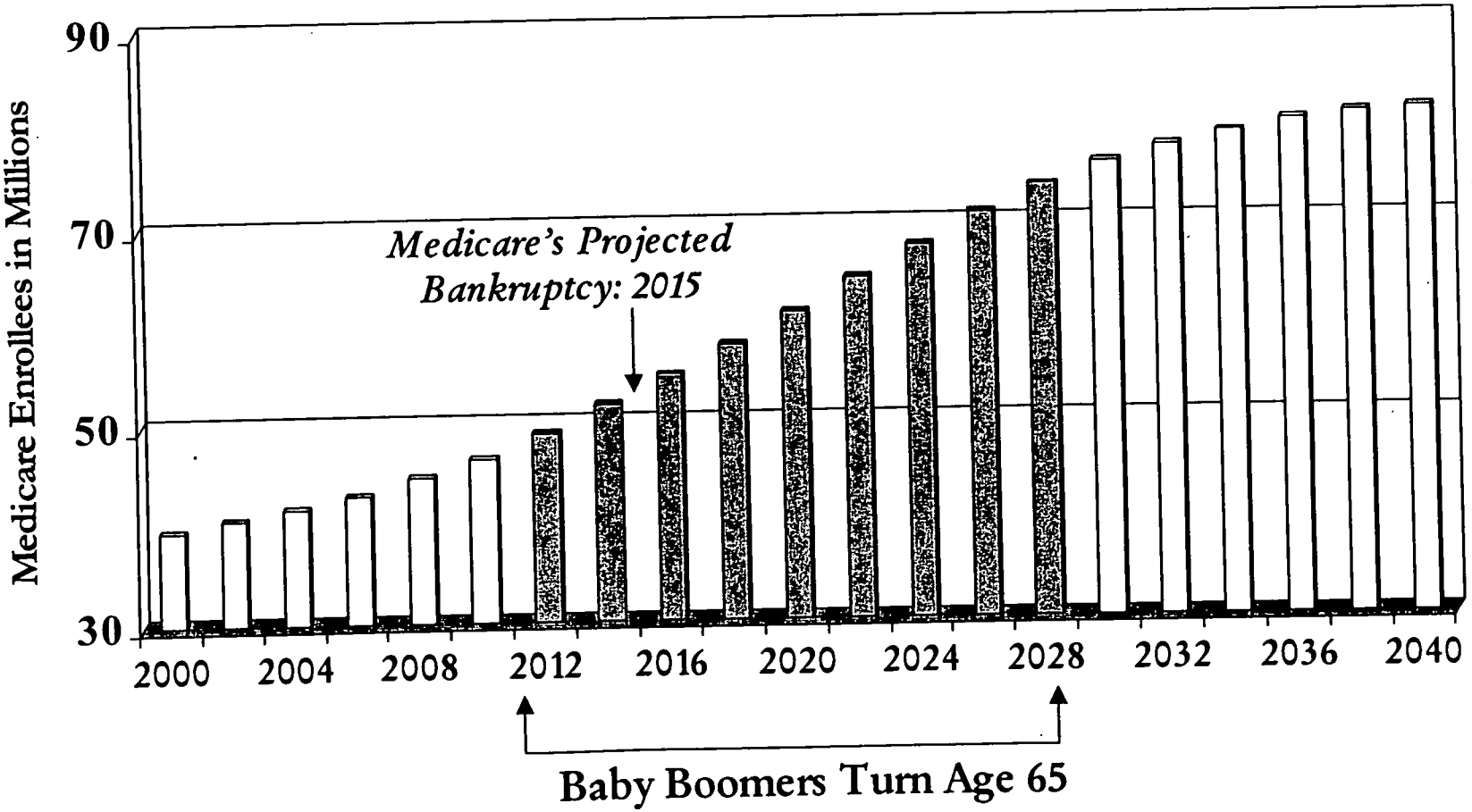
Reforming Medicare requires modernizing the benefits and improving cost controls. The Clinton proposal, made feasible by the surplus, offers some sensible ways to achieve those goals while keeping Medicare a broad-based social insurance program.

PRESIDENT'S PLAN TO MODERNIZE & STRENGTHEN MEDICARE

Plan To Modernize and Strengthen Medicare

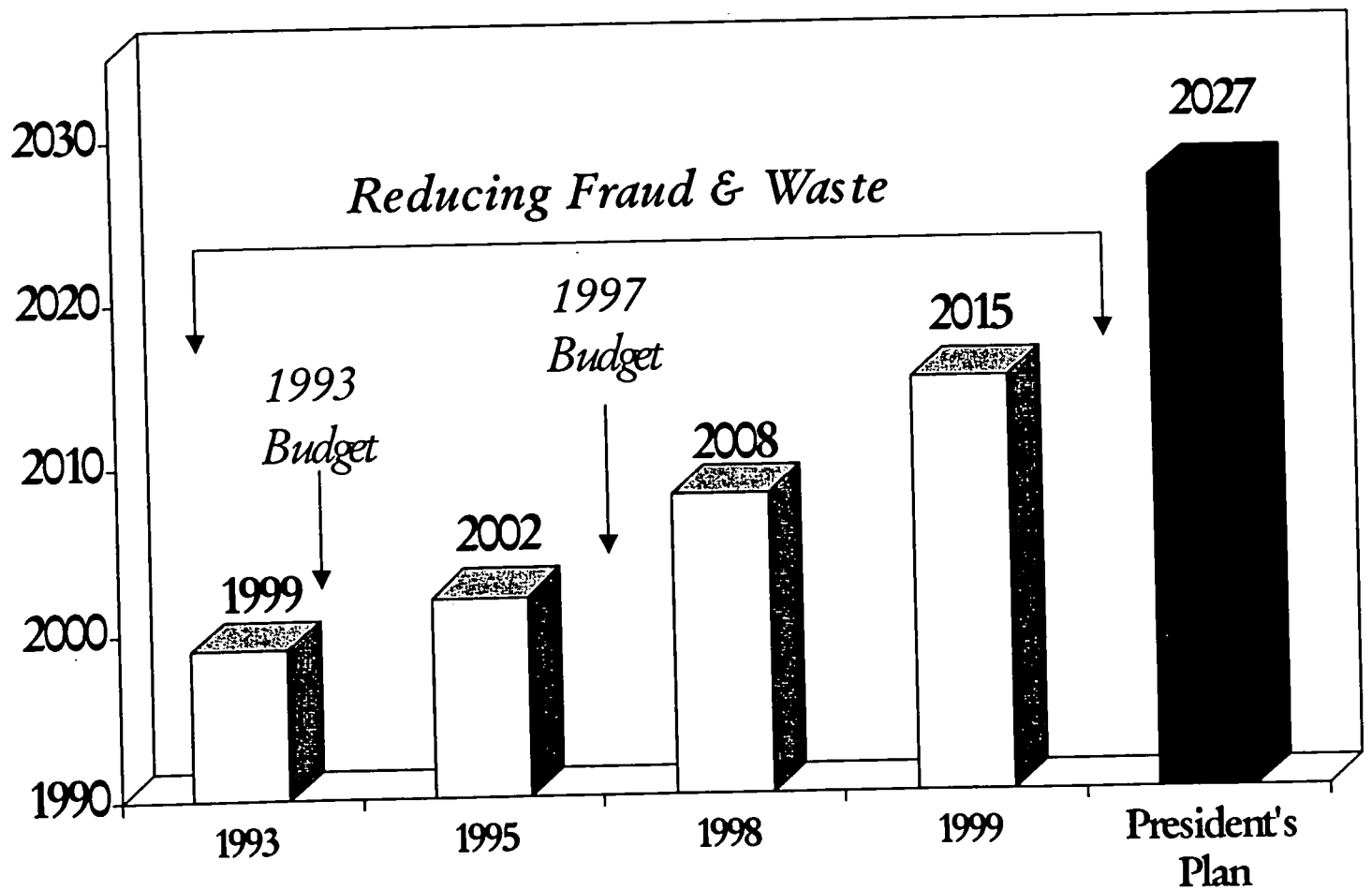
- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Financing for the 21st Century By Dedicating Part of the Surplus to Medicare

Medicare Enrollment Will Double As The Baby Boom Generation Retires



Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



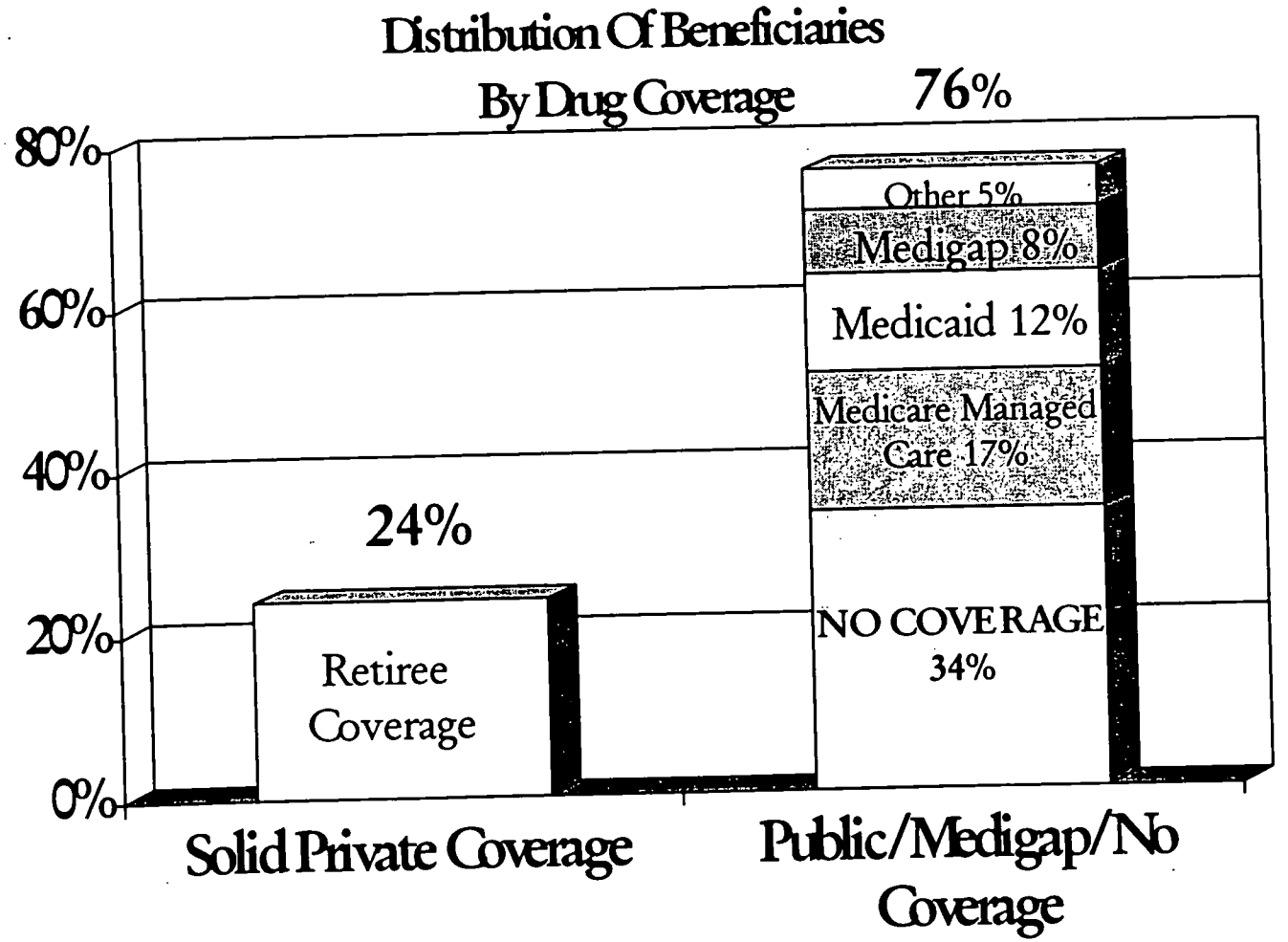
President's Proposal For Medicare Prescription Drug Coverage

- **Meaningful coverage:** Beginning in 2002, beneficiaries have the option to enroll in Part D:
  - No deductible -- coverage with first prescription
  - 50 percent copay with access to discounted prices
  - Benefit limited after $5,000 in costs (phased-in in 2008)

- **Affordable premiums:** $24/month, rising to $44/month when fully phased in. Includes low-income protections

- **Private management**, and incentives for retaining retiree health coverage

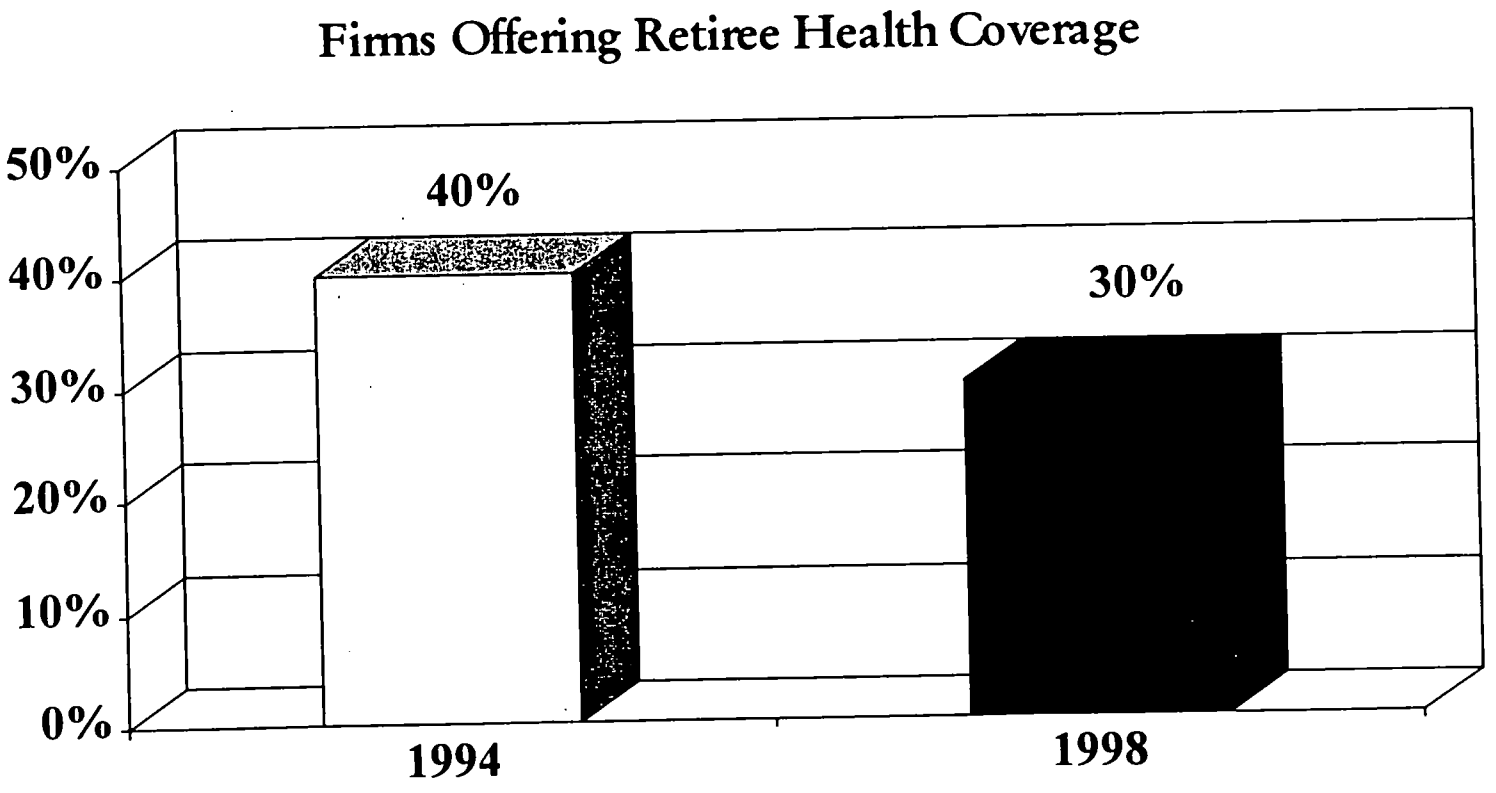
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

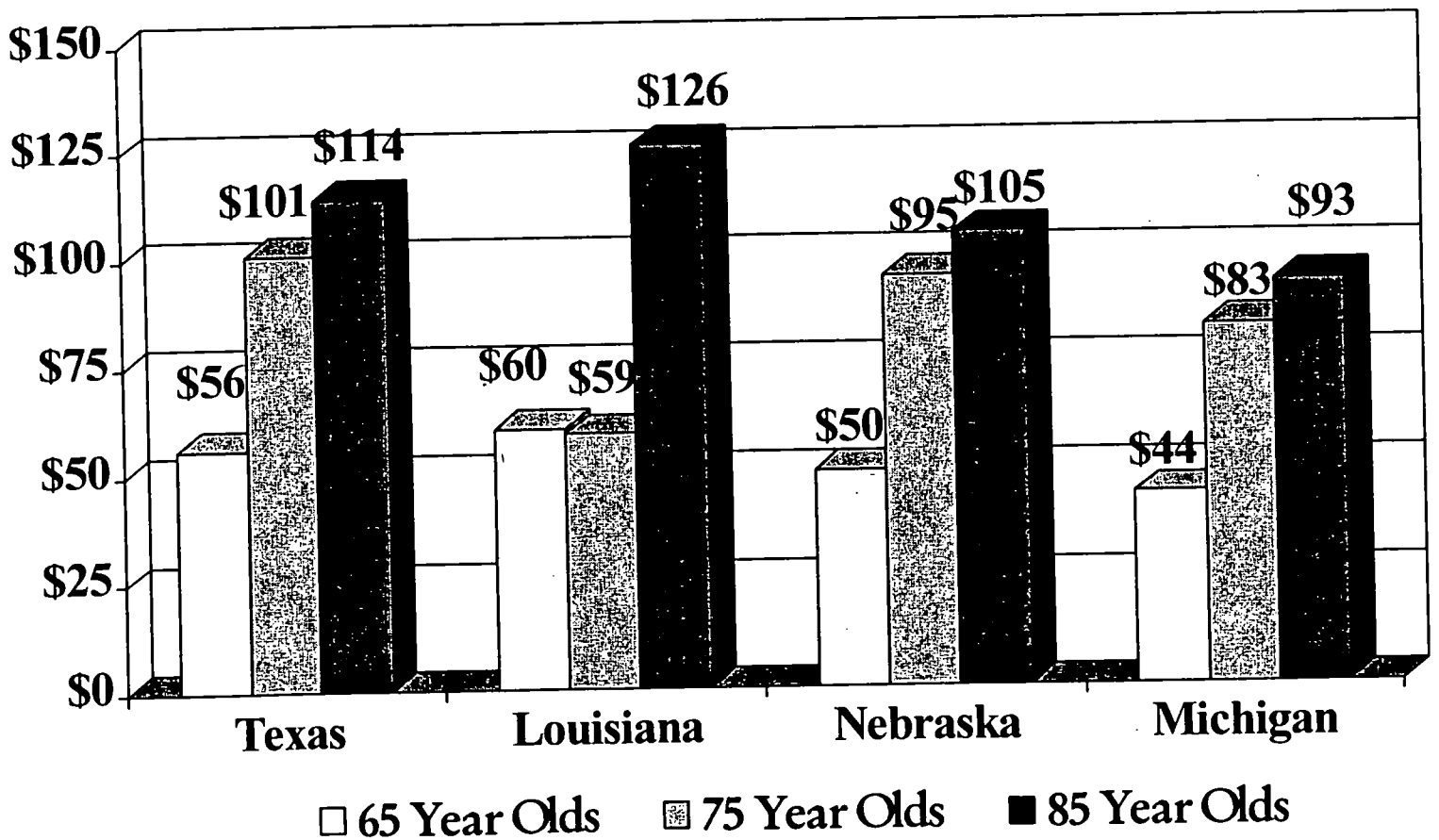
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

Premiums for Medigap, Which Only Covers 8% of Beneficiaries, Are High And Increase With Age

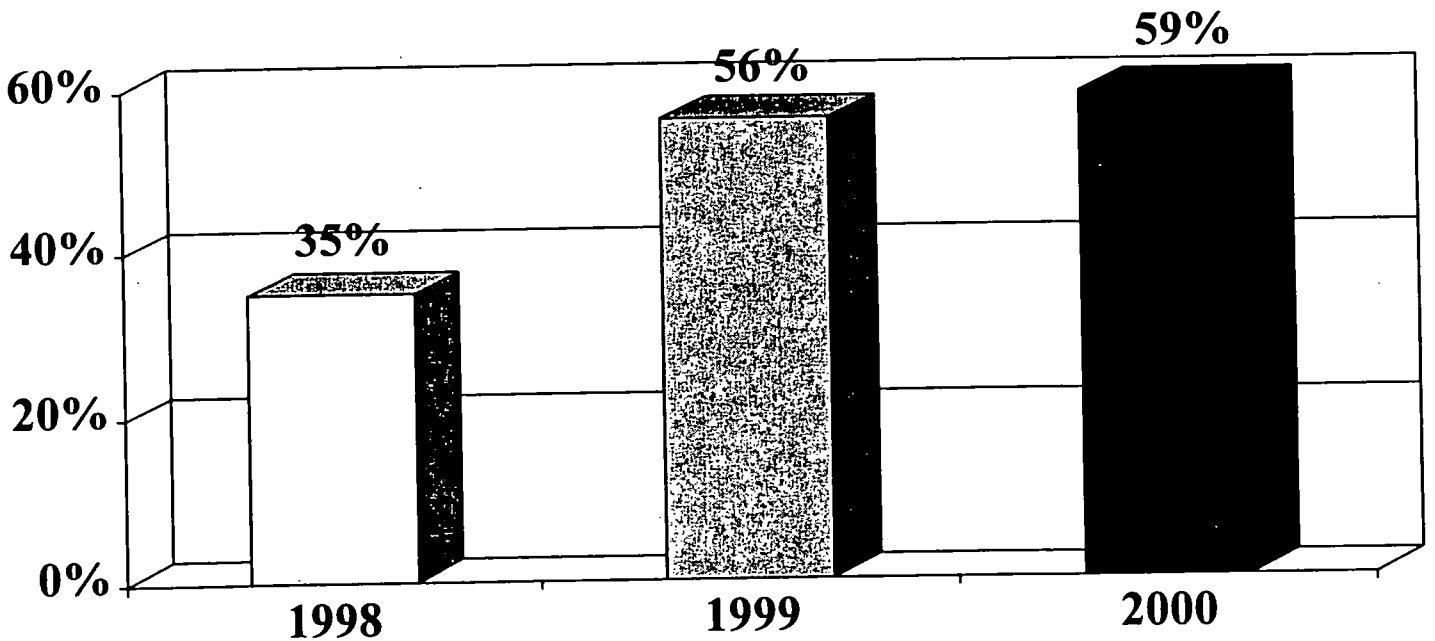


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

Value of Medicare Managed Care Drug Benefits Is Declining

Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000

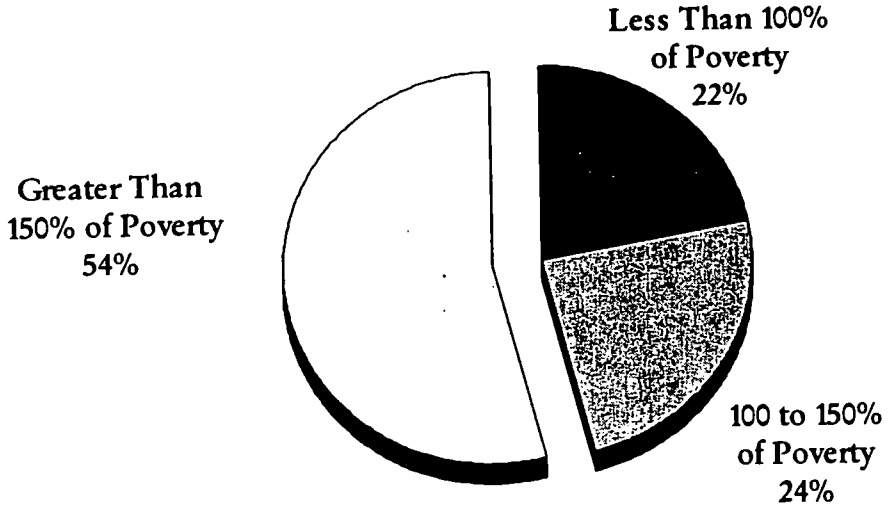
Proportion of All Plans With Limits of Less Than $1,000



Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

Income of Beneficiaries Without Drug Coverage
(As A Percent Of Poverty)



Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

Disproportionately Affects:

- **Rural beneficiaries,** since nearly half have no coverage
- **Older women,** for whom total prescription drug spending averages $1,200 -- 20% more than men's

SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, 150% of poverty for a single person is about $12,750, for a couple is about $17,000

Making Medicare Managed Care More Competitive

Current System	Competitive Defined Benefit
• No price competition	• Plans paid based on price and quality
• Plans compete by offering hard-to-compare benefits	• Plans compete by lowering premium & cost sharing for clearly defined benefits
• Over 1 in 4 beneficiaries do not have access to managed care -- or the extra benefits they offer	• Explicitly pays for drugs in managed care as well as traditional Medicare

Smoothing Out Balanced Budget Act Policies In The Short Run

- **Immediate Administrative Actions**, that moderate the impact on hospitals, academic health centers and home health agencies

- **Targeting Disproportionate Share Hospital Payments Directly to Hospitals**

- **$7.5 Billion Quality Assurance Fund**

TAB 4.

PRESCRIPTION DRUG BENEFIT

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

National Economic Council
Domestic Policy Council

July 22, 1999

DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

Table of Contents

OVERVIEW
DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

This report describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. This report shows that the accessing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance – it is an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

- **Prescription drug coverage is good medicine.**
    - Part of modern medicine. Prescription drugs serve as complements to medical procedures, such as anti-coagulants, used with heart valve replacement surgery; substitutes for surgery, such as lipid lowering drugs that reduce the need for bypass surgery; and new treatments where there previously were none, such as medications used to manage Parkinson's disease. In addition, as our understanding of genetics grows, the possibility for breakthrough pharmaceutical and biotechnology will increase exponentially.
    - Medicare beneficiaries are particularly reliant on prescription drugs. Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.
    - The lack of drug coverage has led to inappropriate use of medications which can result in increased costs and unnecessary institutionalization. Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. The consequence of inappropriate and underutilization of prescription drugs has also been found to double the likelihood that low-income beneficiaries entering nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.
- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drug coverage.**
    - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage.

- Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans' Affairs and other public programs.

- **Private trends: Decline in coverage and affordability.**

  - The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

  - Medigap premiums for drugs are high and increase with age. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the President. Moreover, unlike the President's proposal, premiums substantially increase with age as virtually every Medigap plan "age rates" the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach. This cost burden will particularly affect women, who make up 73 percent of people over age 85.

- **Public drug coverage trends: managed care benefits reduced.**

  - The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. This is part of a troubling trend of plans to severely limit benefits through low caps. In fact, the proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.

  - Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent. This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries. Inadequate outreach and welfare stigma contributes to these low participation levels and raise serious questions about the feasibility and advisability of using the Medicaid program to provide needed coverage for a population at higher income levels.

- Millions of beneficiaries have no drug coverage.

  - At least 13 million Medicare beneficiaries have absolutely no prescription drug coverage. The number of the uninsured is not concentrated among the low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels.

  - More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV and Parkinson's). Some of the major advances in public health – the near eradication of polio and measles and the decline in infectious diseases – are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

- **Greatest need for prescription drugs.** The elderly and people with disabilities are particularly reliant on prescription drugs. Not only do they experience greater health problems, but these problems tend to include conditions that respond to drug therapy. As a result, about 85 percent of beneficiaries fill at least one prescription a year. Some examples of common conditions include:

  - Osteoporosis: Over 1 in 5 older women have osteoporosis and about 15 percent have suffered a fracture as a result.[1] It is a leading risk factor for hip fractures, which affects 225,000 people over the age of 50. Estrogen replacement can reduce the risk of osteoporosis as well as that of cardiovascular disease. One commonly used drug costs $20 per month, $240 per year.

  - Hypertension: About 60 percent of people over age 65 have hypertension.[2] African Americans are more likely to have hypertension. For a person over age 55, hypertension increases the risk of a heart attack or other heart problem over 10 years by 10 percent.[3] Hypertension roughly doubles the risk of cardiovascular disease and is the leading factor for stroke. According to one study, treatment results in a one-third reduction in the probability of stroke and a one-quarter reduction in the probability of a heart attack.[4] ACE inhibitors which typically cost $40 per month, $480 per year are commonly prescribed to control hypertension, and are frequently used in combination with diuretics and /or beta-blockers.

  - Myocardial Infarction (Heart Attack): Heart disease is the leading cause of death for persons 65 and over. About 1.5 million Americans each year have heart attacks, which are fatal in about 30 percent of patients. Since people who survive heart attacks are much more likely to have subsequent attacks, disease management including drugs can significantly improve health and longevity. For example, a study of the use of a lipid lowering drug by people who had an acuate myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.[5] A common lipid reduction drug costs about $85 per month, $1,020 per year. A beta-blocker costs about $30 per month, $360 per year, and can reduce long-term mortality by 25 percent.[6]

  - Adult-Onset Diabetes: About 1 in 10 elderly have Type I or II diabetes.[7] Diabetes can lead to blindness, kidney disease and nerve damage. Glucose (blood sugar)

control can prevent or delay these conditions. Commonly used medications include cost around $60 per month, $720 per year.

- Depression: An estimated 1 in 10 to 1 in 20 community-based elderly experience depression.[8] Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.[9] New therapies can cost from $130 to $290 per month or $1,560 to $3,480 per year.

- **Many beneficiaries need drugs but do not use them as prescribed because they do not have well managed, affordable drug insurance.** Most research has found that drug coverage influences use of needed drugs:

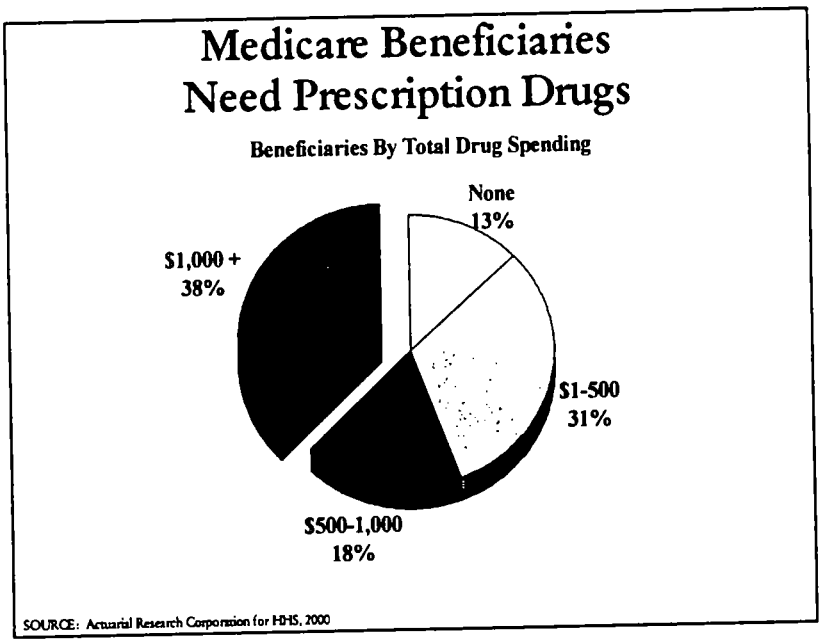
  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.[10] Many elderly must choose between prescriptions and other basic household needs.[11]

  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.[12]

  - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs. One study which classified the geriatric admissions to a community hospital found that drug-related hospitalization accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.[13]

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

- **Because of their greater need, the elderly and people with disabilities have greater health care costs.** The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug spending.



- **Over one-third (38%) of Medicare beneficiaries will spend more than $1,000 on prescription drugs.** Less than 5 percent will spend more than $5,000.

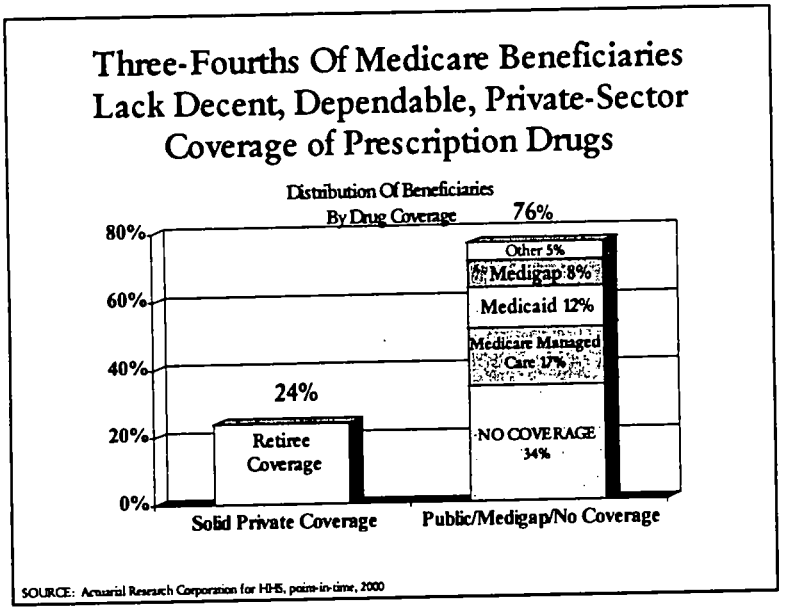
- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than $500.

- **Spending is higher for women.** Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.

- **Out-of-pocket spending is also high.** In 2000, Medicare beneficiaries are estimated to spend about $525 on prescription drugs out-of-pocket. This spending is linked to insurance coverage – it is much higher for those with no coverage ($800) and people with Medigap ($650) than those with retiree coverage ($400).

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

- **Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs.** As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.



- **Only one-fourth of Medicare beneficiaries have retiree drug coverage.** Employers provide health insurance for most Americans under the age of 65, but pay for supplemental coverage for only a fraction of their elderly retirees. When available, this coverage tends to have reasonable cost sharing and affordable premiums.

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs.** These beneficiaries include those with:

  - Medigap. About 8 percent of beneficiaries purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries.

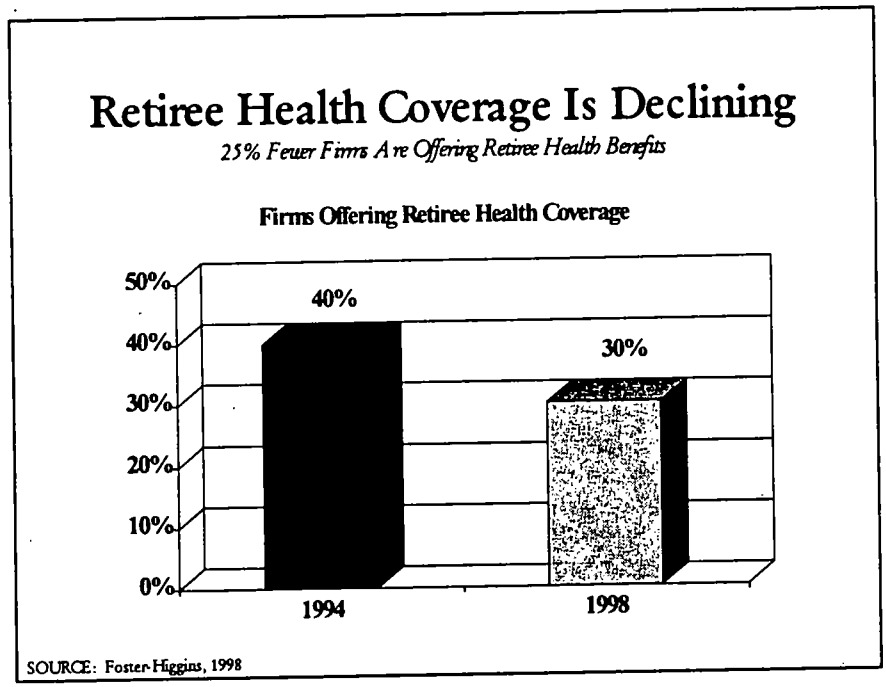
  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

  - Medicaid and other public programs. Medicaid covers about 12 percent of beneficiaries and programs like the Veterans' Administration cover another 5 percent of beneficiaries. Eligibility for these programs is very restrictive.

  - No coverage at all. 34 percent of Medicare beneficiaries has no drug coverage.

RETIREE HEALTH COVERAGE

- About one in four Medicare beneficiaries has prescription drug coverage through their retiree health plan. These employer-based plans offer decent, affordable coverage.



- **Firms offering retiree health coverage have declined by 25 percent in the last four years.**[14] Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage.

  - The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

- **Most serious effect will occur when the baby boom generation retires.** Although there are employers who are dropping health coverage for current retirees, most are restricting coverage for future retirees. This means that the access problems that are emerging now could be more severe in the future.

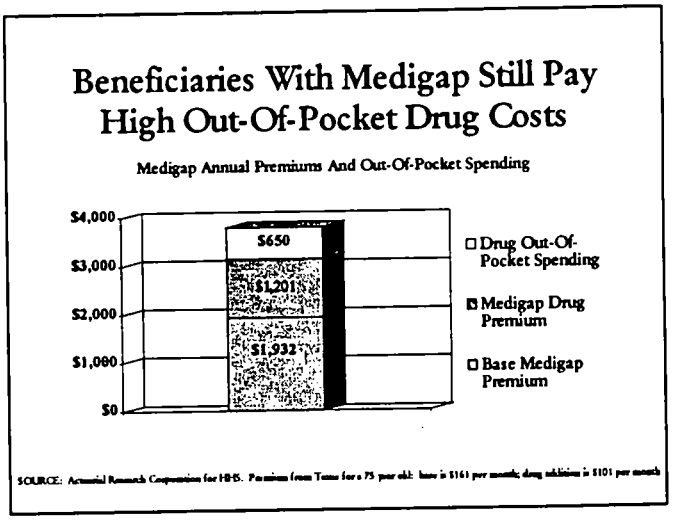
- **Firms are increasingly moving their retirees to Medicare managed care.** To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in 1996.[15]

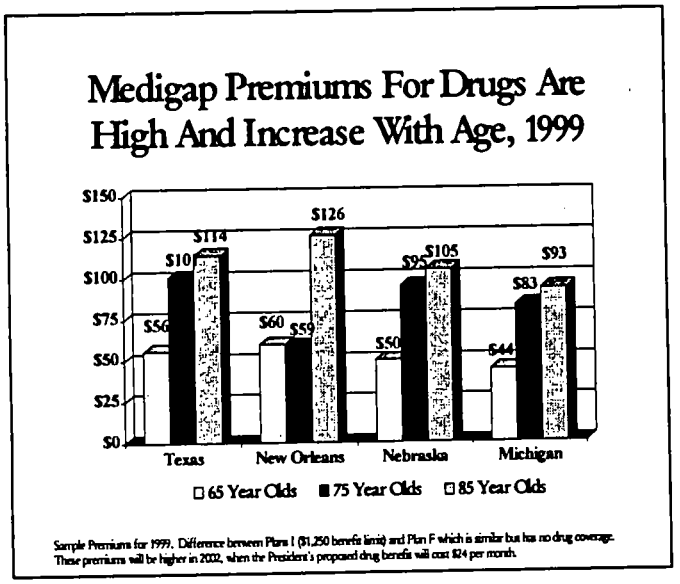
MEDIGAP PRESCRIPTION DRUG COVERAGE

- **Because of its high cost relative to its benefit, less than one in ten Medicare beneficiaries purchases a Medigap plan with prescription drugs.** Three of the ten standardized Medicare supplemental plans, (plans H, I, and J) include prescription drug coverage. All three plan types have a $250 deductible for the drug benefit and require 50 percent coinsurance. The H and I plans have a cap on drug benefits of $1,250 while the J plan caps the benefit at $3,000. The typical premium for a plan with the lower cap costs about $90 per month or $1,080 per year.

- **Medigap is expensive, inefficient, and often uses higher prices to discriminate against the oldest beneficiaries.**

  - Expensive. Medigap policies that cover prescription drugs are expensive relative to comparable policies that do not cover drugs. Additionally, premiums vary tremendously from place to place, and from beneficiary to beneficiary. Finally, a beneficiary cannot only pay for prescription drugs – they must also buy the other benefits in the package.





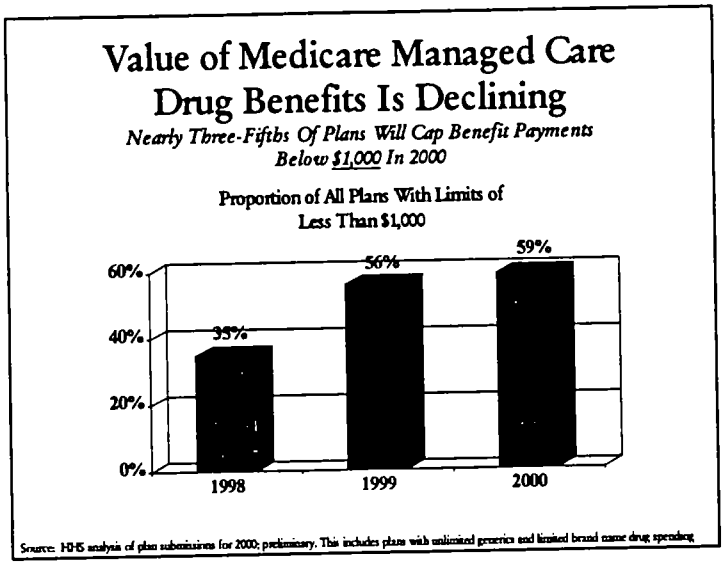
Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

Costs increase with age as well as health inflation. This "attained age" pricing practice causes excessive premiums for those who need it most – the very old. It also disproportionately affects women since they comprise nearly three-fourths of people over age 85.

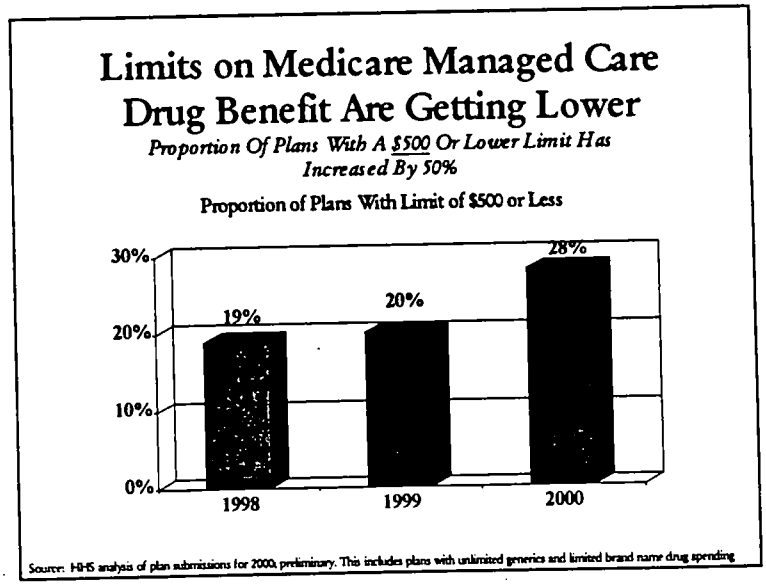
MEDICARE MANAGED CARE

- **The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent.** Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.

- **Drug coverage under Medicare+Choice is unstable.** Managed care plans are not required to offer a drug benefit, but can do so with any excess Medicare payments or by charging a premium. This results in wide variation across areas, since payments vary by area, and over time.



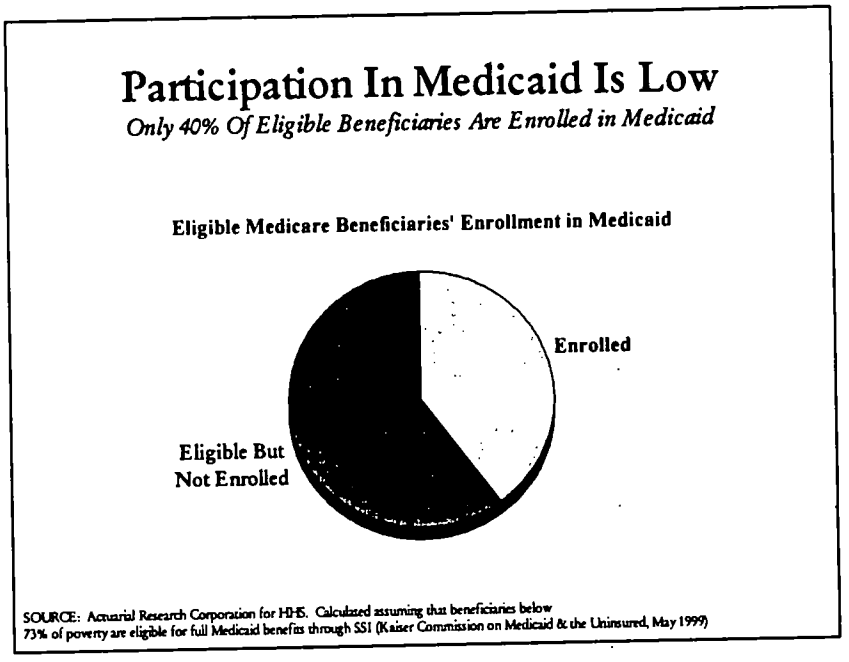
- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000. This is part of a troubling trend of plans to severely limit benefits through low caps.



- **Plans dropping out of Medicare limit access to drugs.** Nearly 80,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.

MEDICAID

- **About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit.** Most of these "dual eligibles" qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- $6,200 for a single, $8,300 for a couple in 2000). States have other options for covering the elderly and disabled, including "medically needy" or "spend-down" programs that extend eligibility to sick and/or institutionalized people.

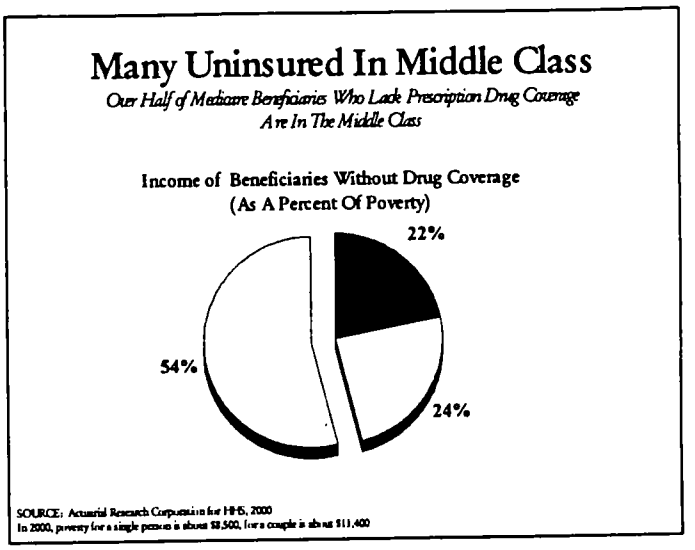


- **Participation by Medicaid eligible populations remains low.** Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.
  - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.
  - This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries.

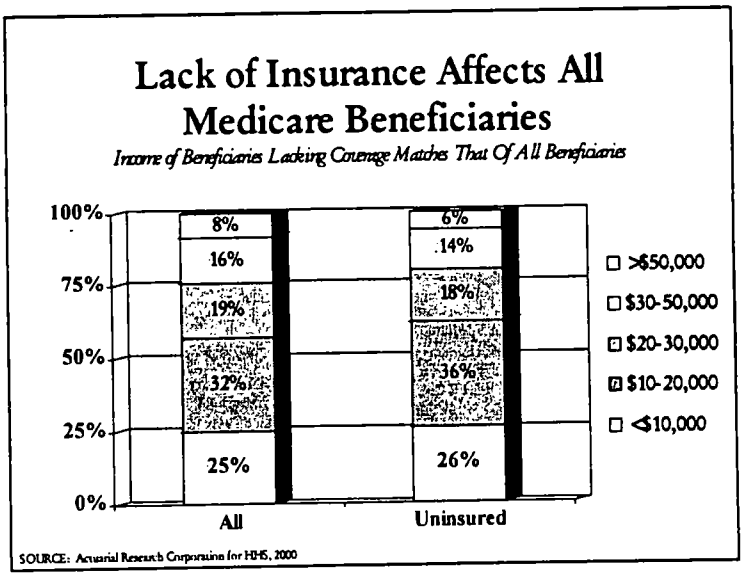
BENEFICIARIES LACKING DRUG COVERAGE

- **At least 13 million or 34 percent of Medicare beneficiaries have no insurance coverage for prescription drugs.** These beneficiaries pay retail prices for prescription drugs, which can often be significantly more expensive than what large firms or public programs pay for the same drugs.

- **More than half of Medicare beneficiaries without drug coverage are middle class.** Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This indicates that targeting a drug benefit only to the low-income cannot address even half of the problem.



- **The income distribution of beneficiaries lacking drug coverage closely parallels that of all beneficiaries.** This lack of difference suggests that everyone is at risk of losing their health insurance.



PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost the Federal government about $118 billion from 2000 to 2009. It would be fully offset, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare.

- **Meaningful coverage.** Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:

  - No deductible – coverage begins with the first prescription filled and

  - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

  The benefit would be limited to $5,000 in costs ($2,500 in Medicare payments) in 2008. It would phase it a $2,000 for 2002-2003; $3,000 for 2004-2005; $4,000 for 2006-2007; and $5,000 in 2008 (indexed to inflation in subsequent years).

- **Affordable premiums.** Beneficiaries who opt for Part D would a pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008 when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and, after an initial open enrollment for all beneficiaries in 2001, would occur when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would generally be deducted from Social Security checks.

  - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty ($17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty ($15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.

- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

APPENDIX: METHODOLOGY & ENDNOTES

Methodology. The Actuarial Research Corporation under contract with the Department of Health and Human Services conducted most of the analysis. The basis for the estimates is the Medicare Current Beneficiary Survey (MCBS) for 1995. These data were aged to CY 2000, converted to a point-in-time estimate, and adjusted for the increase in managed care enrollment. This enrollment increase was estimated by moving beneficiaries from retiree health coverage, Medigap and the uninsured to managed care in proportion to their enrollment in those plans.

Endnotes.

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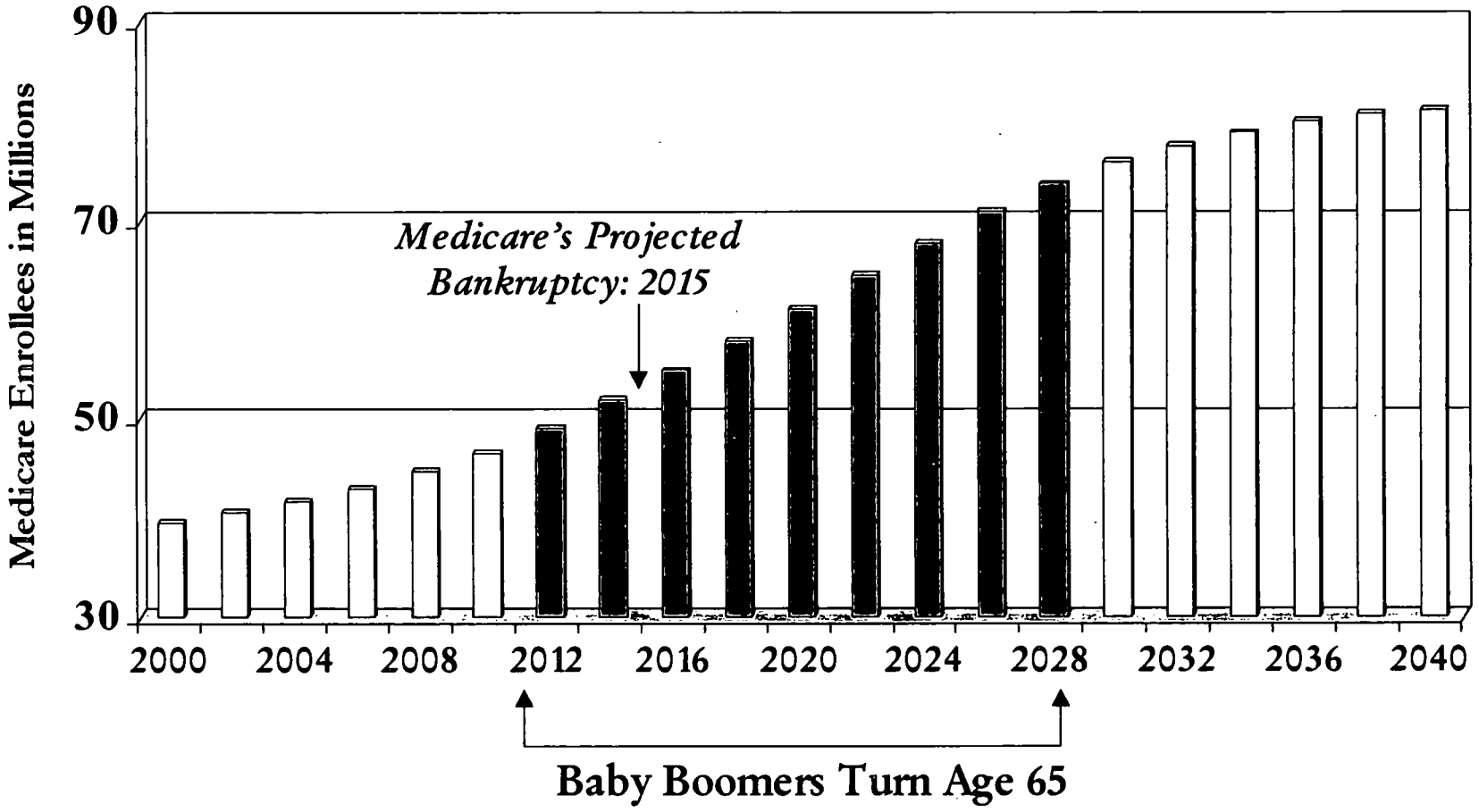
TAB 5.

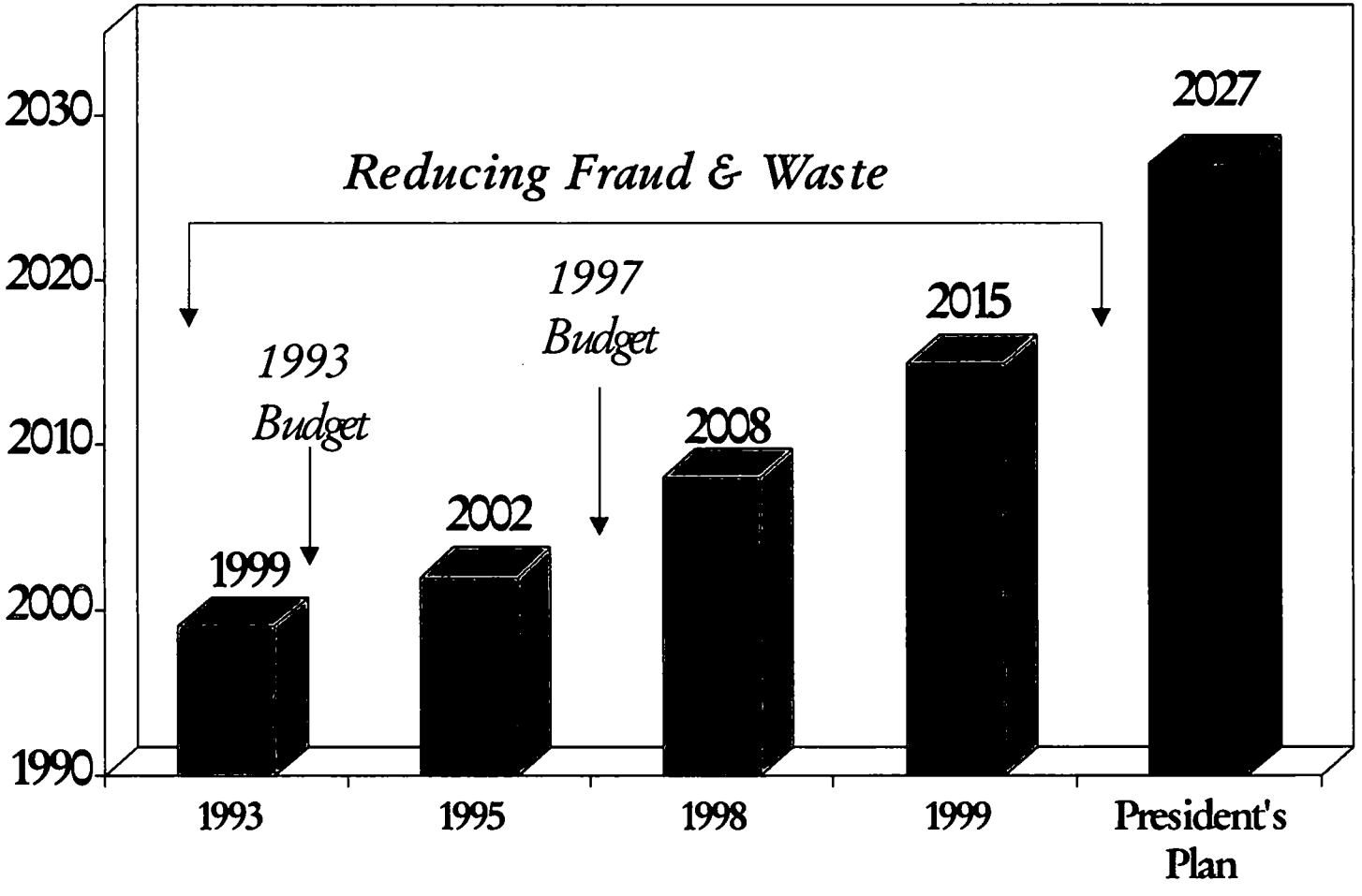
CHARTS

Medicare Enrollment Will Double As The Baby Boom Generation Retires

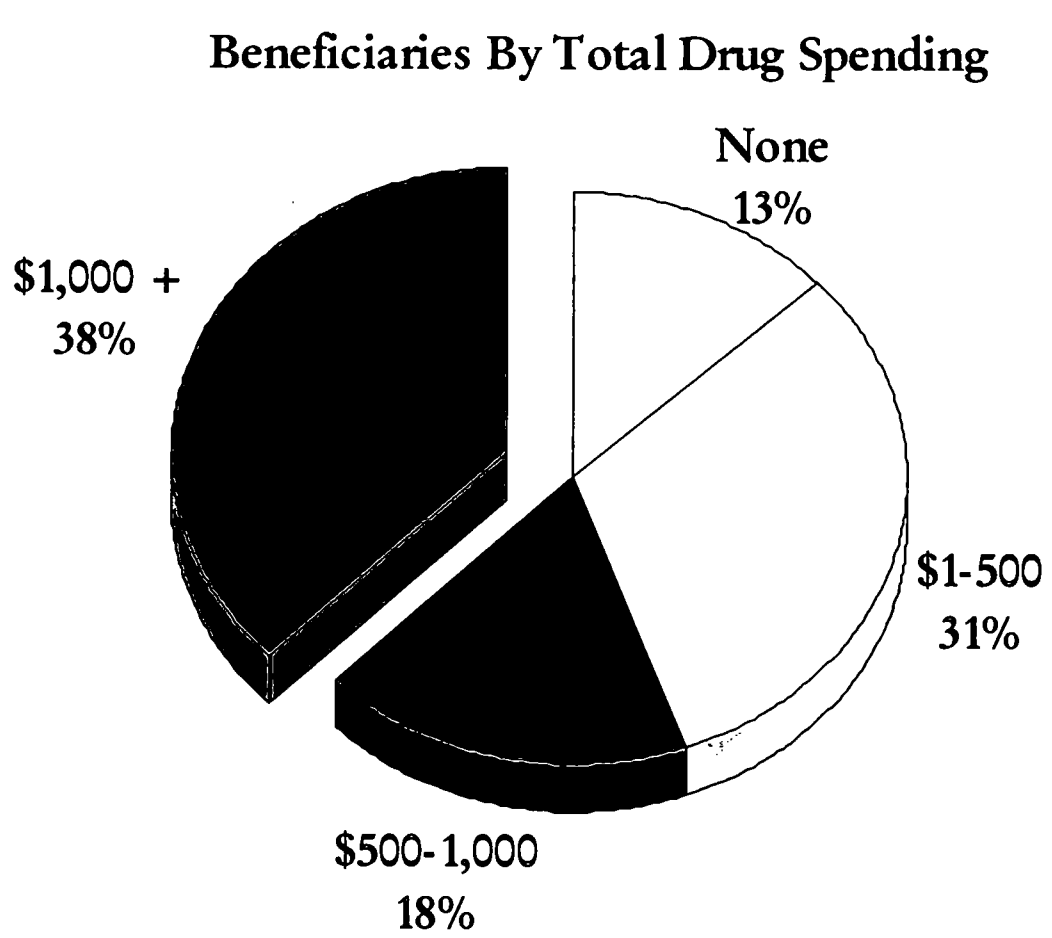


Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027

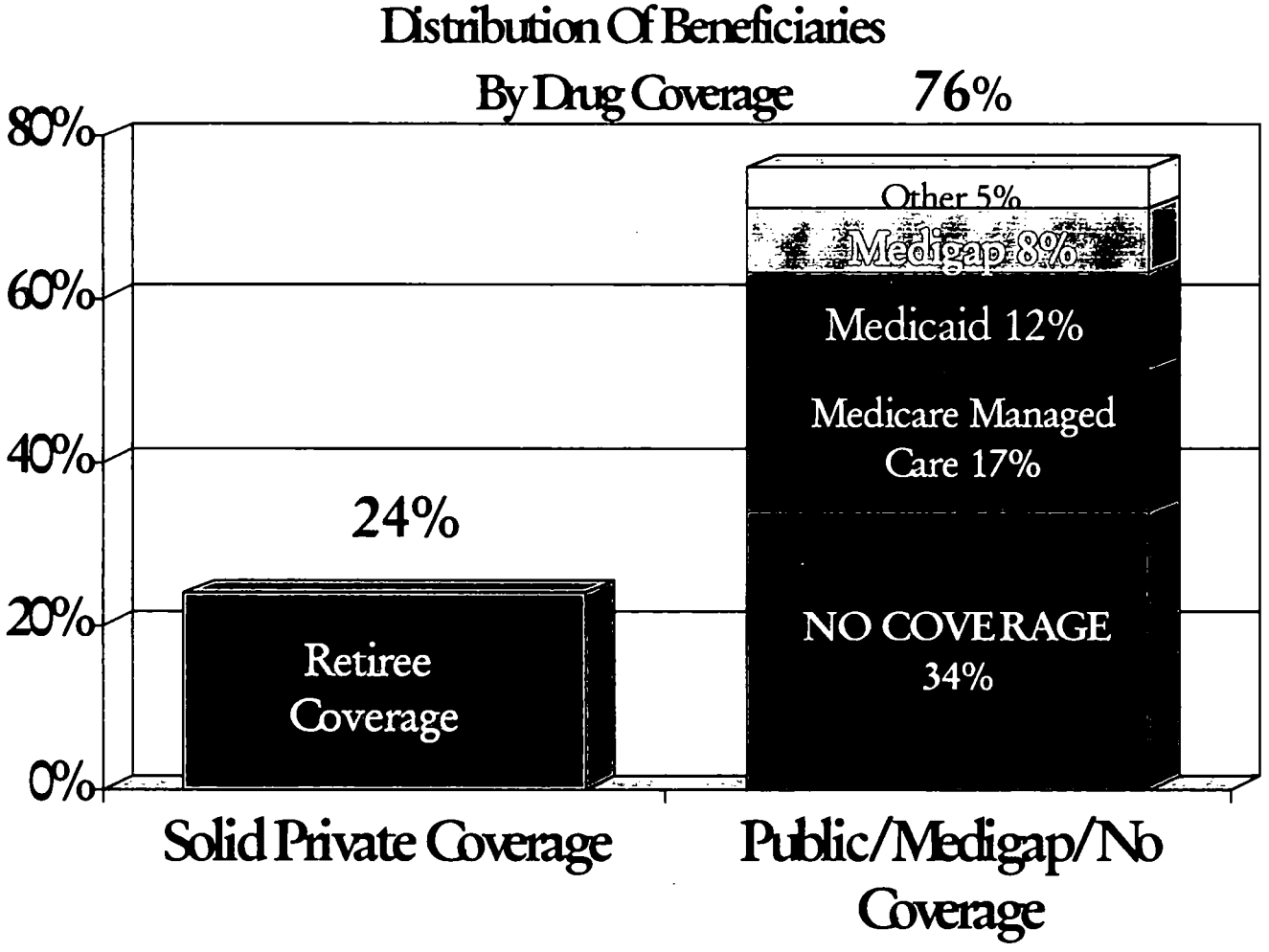


Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

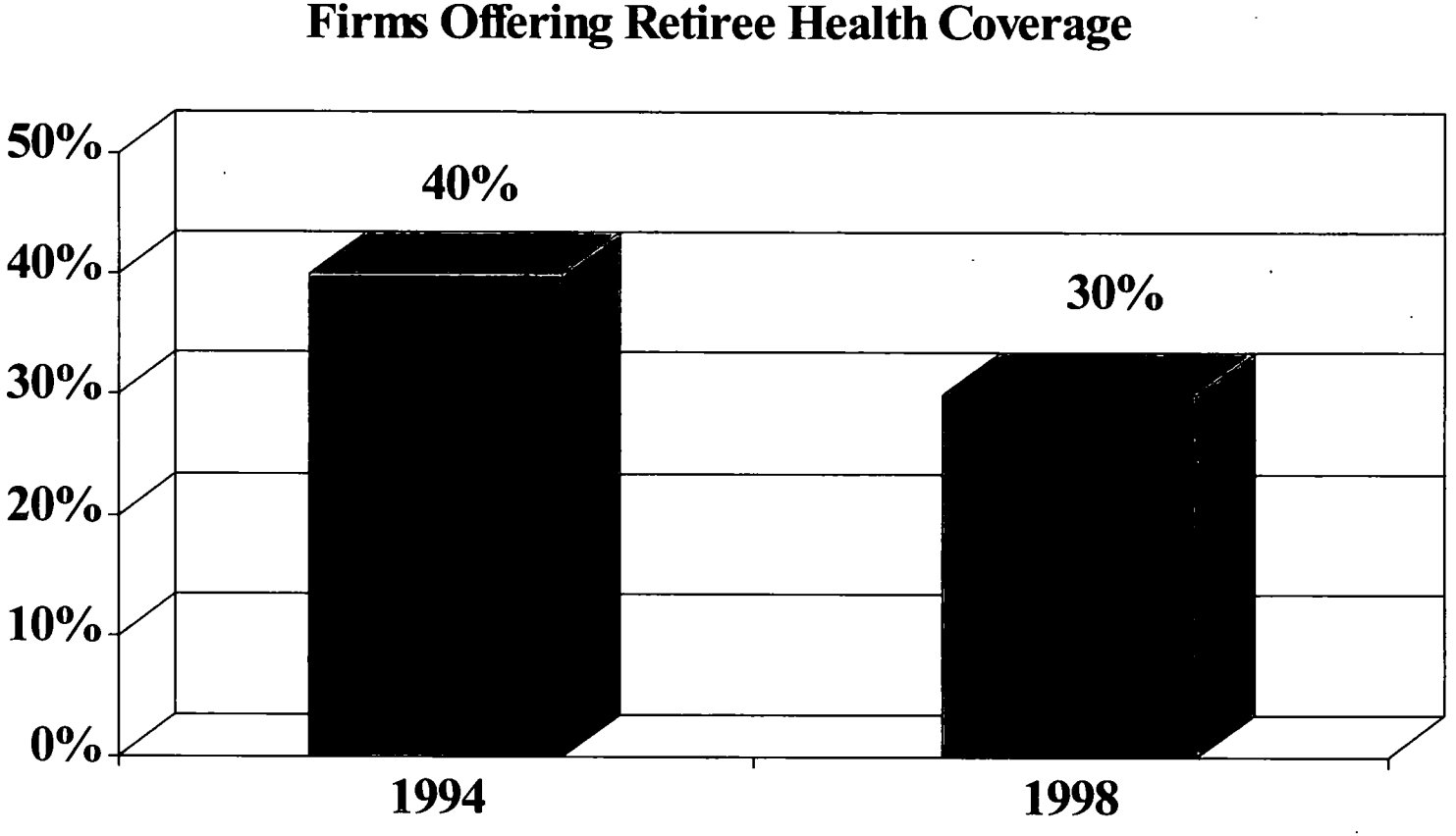
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

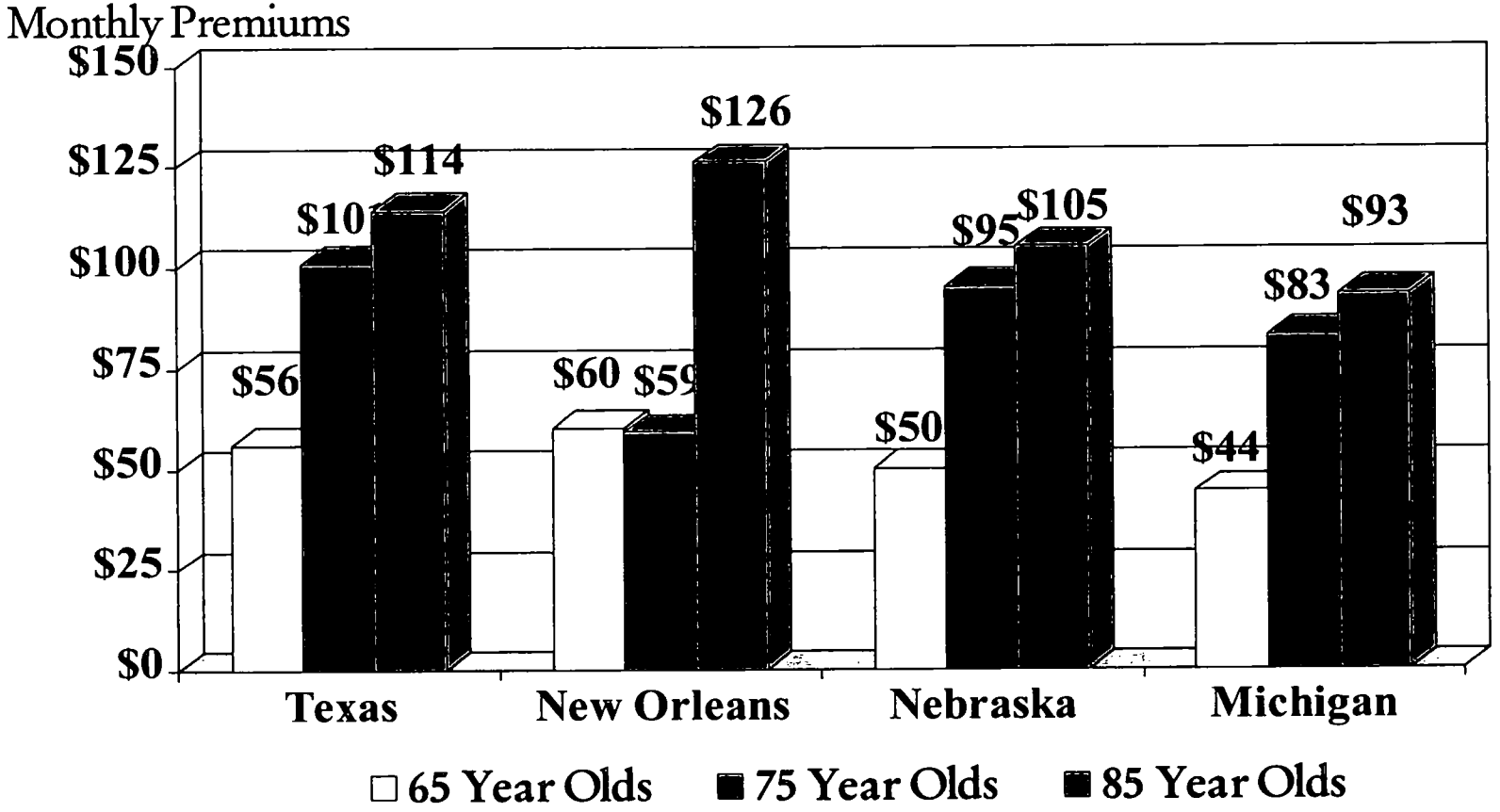
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

Medigap Premiums For Drugs Are High And Increase With Age, 1999

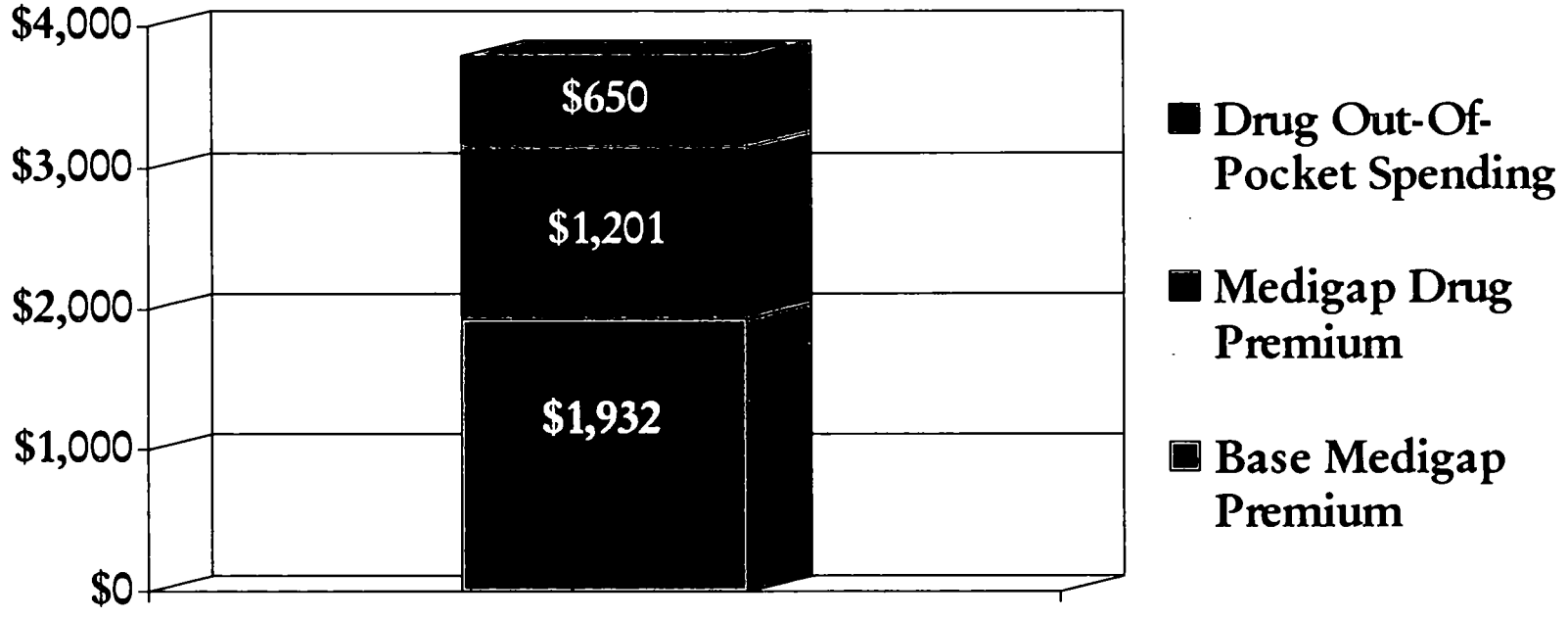


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

On Top Of The Premium For The Base Medigap, Beneficiaries Pay An Extra Premium For Drugs Plus Out-Of-Pocket Spending for Drugs

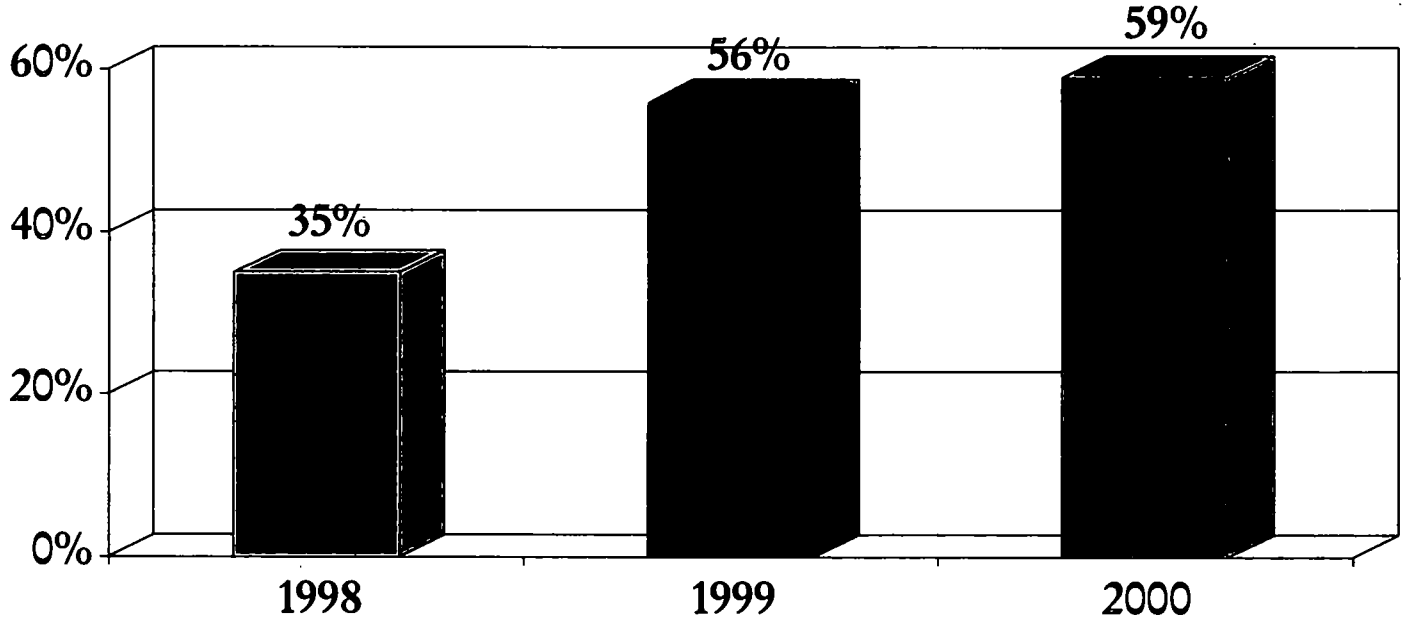
Medigap Annual Premiums And Out-Of-Pocket Spending



SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is $161 per month; drug addition is $101 per month

Value of Medicare Managed Care Drug Benefits Is Declining

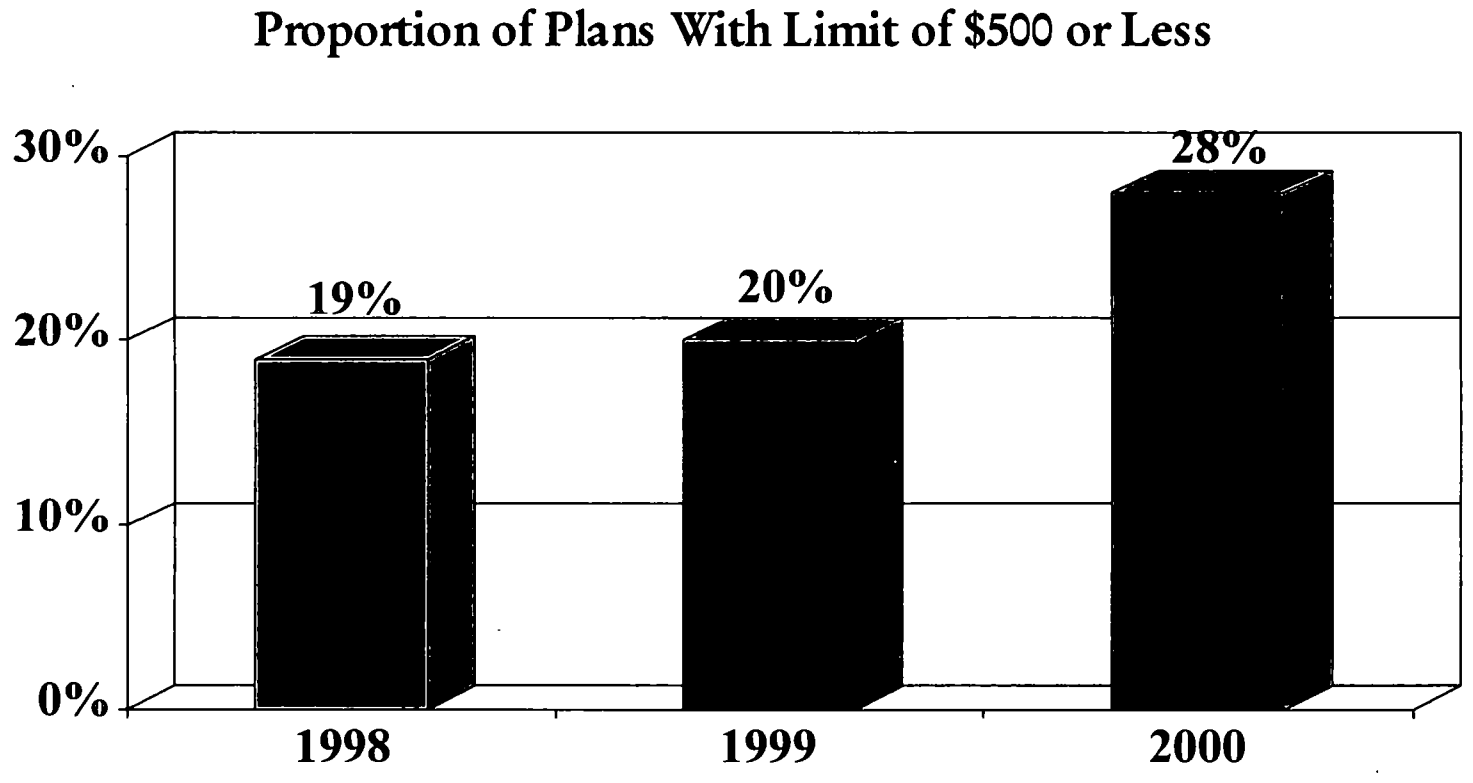
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

Proportion Of Plans With A $500 Or Lower Limit Has Increased By 50%

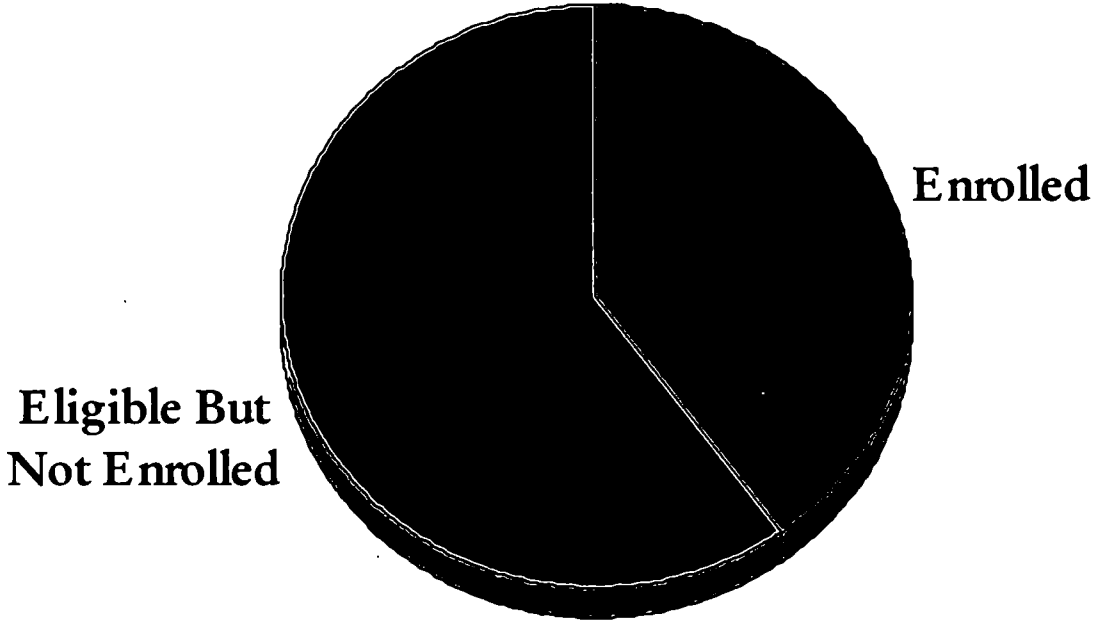


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



SOURCE: Actuarial Research Corporation for HHS. Calculated assuming that beneficiaries below 73% of poverty are eligible for full Medicaid benefits through SSI (Kaiser Commission on Medicaid & the Uninsured, May 1999)

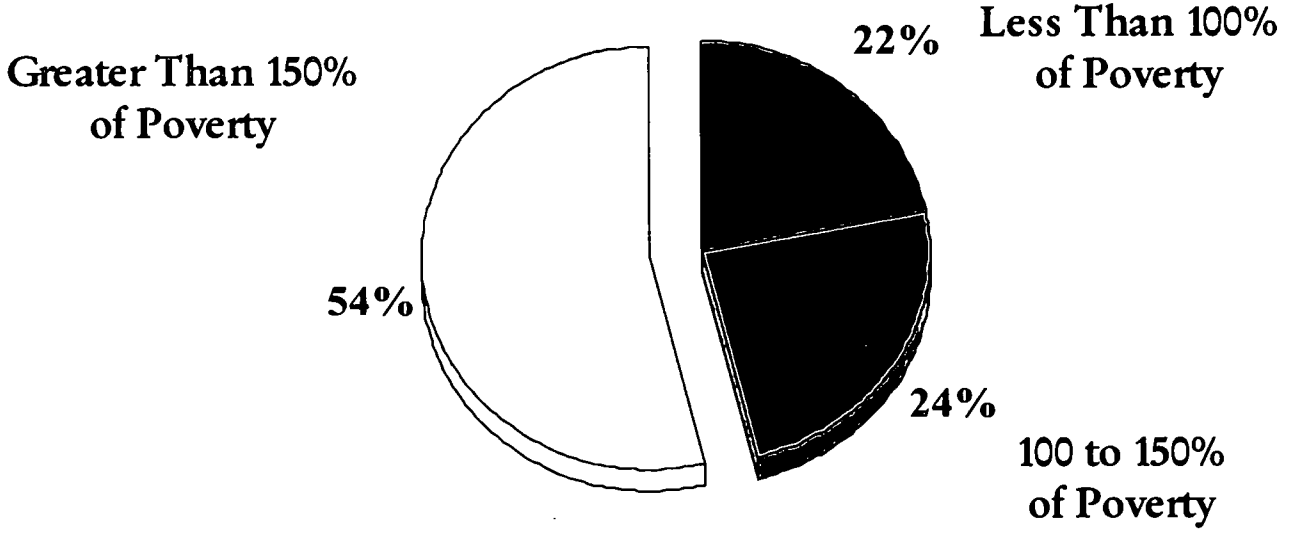
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

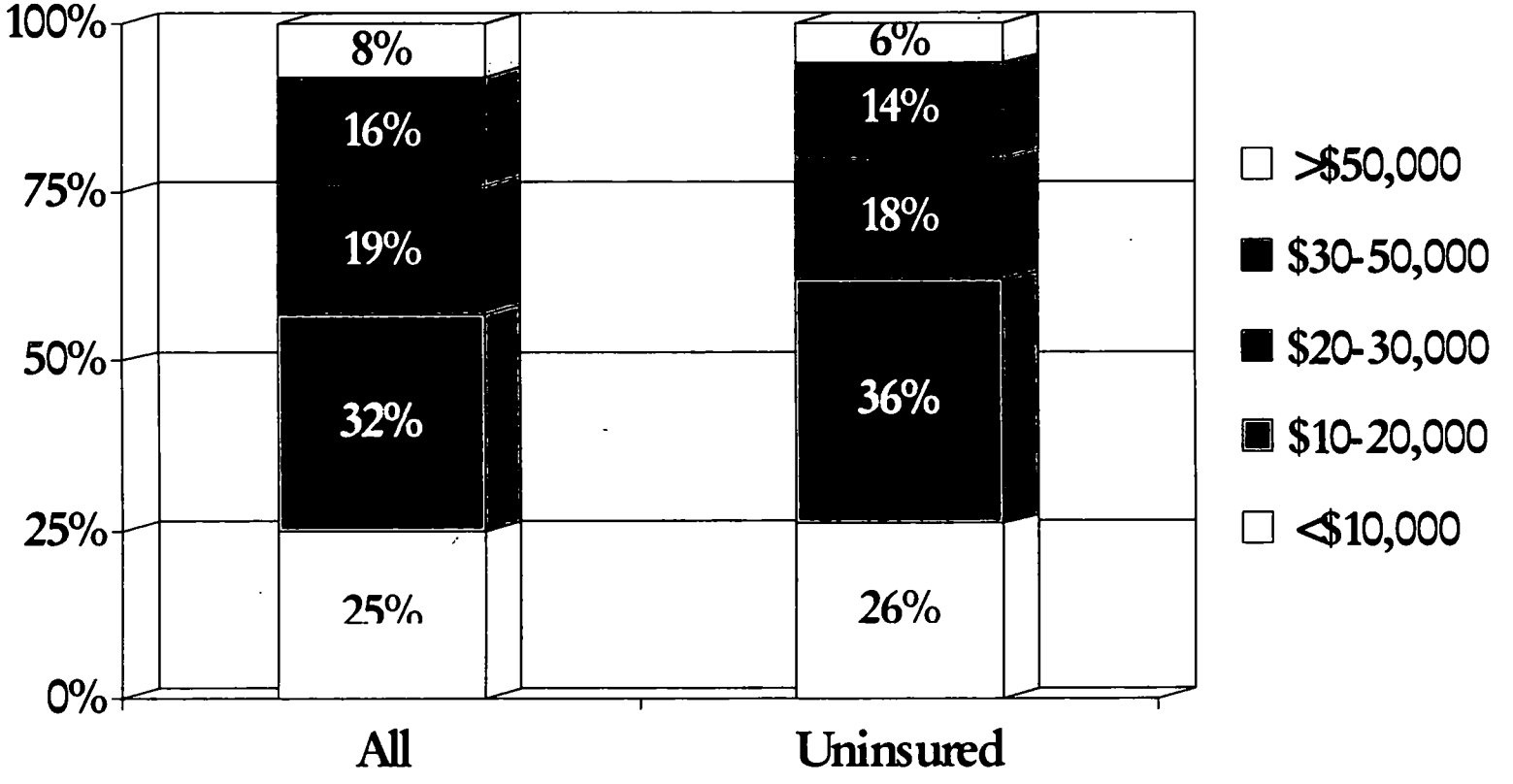
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, poverty for a single person is about $8,500, for a couple is about $11,400

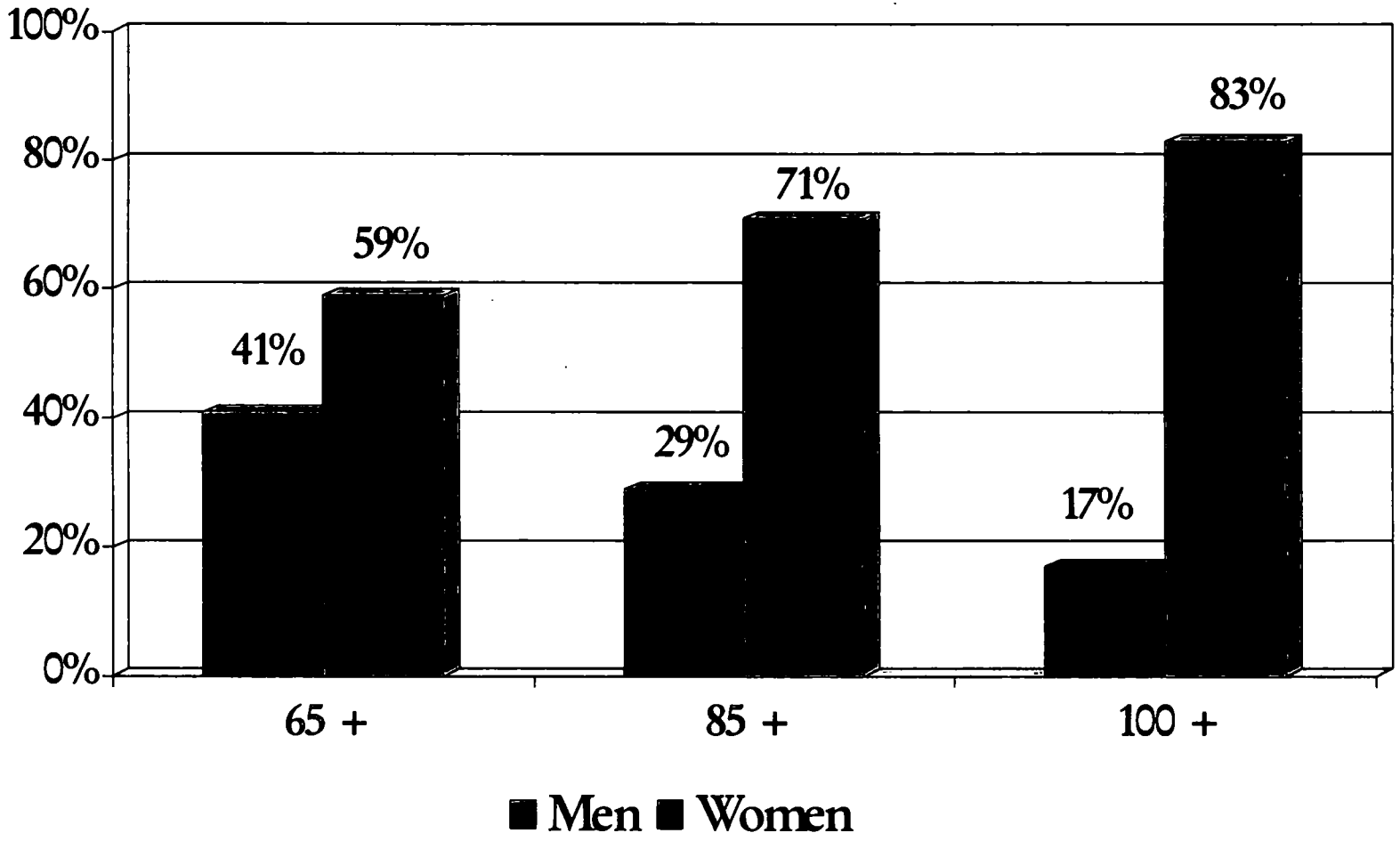
Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



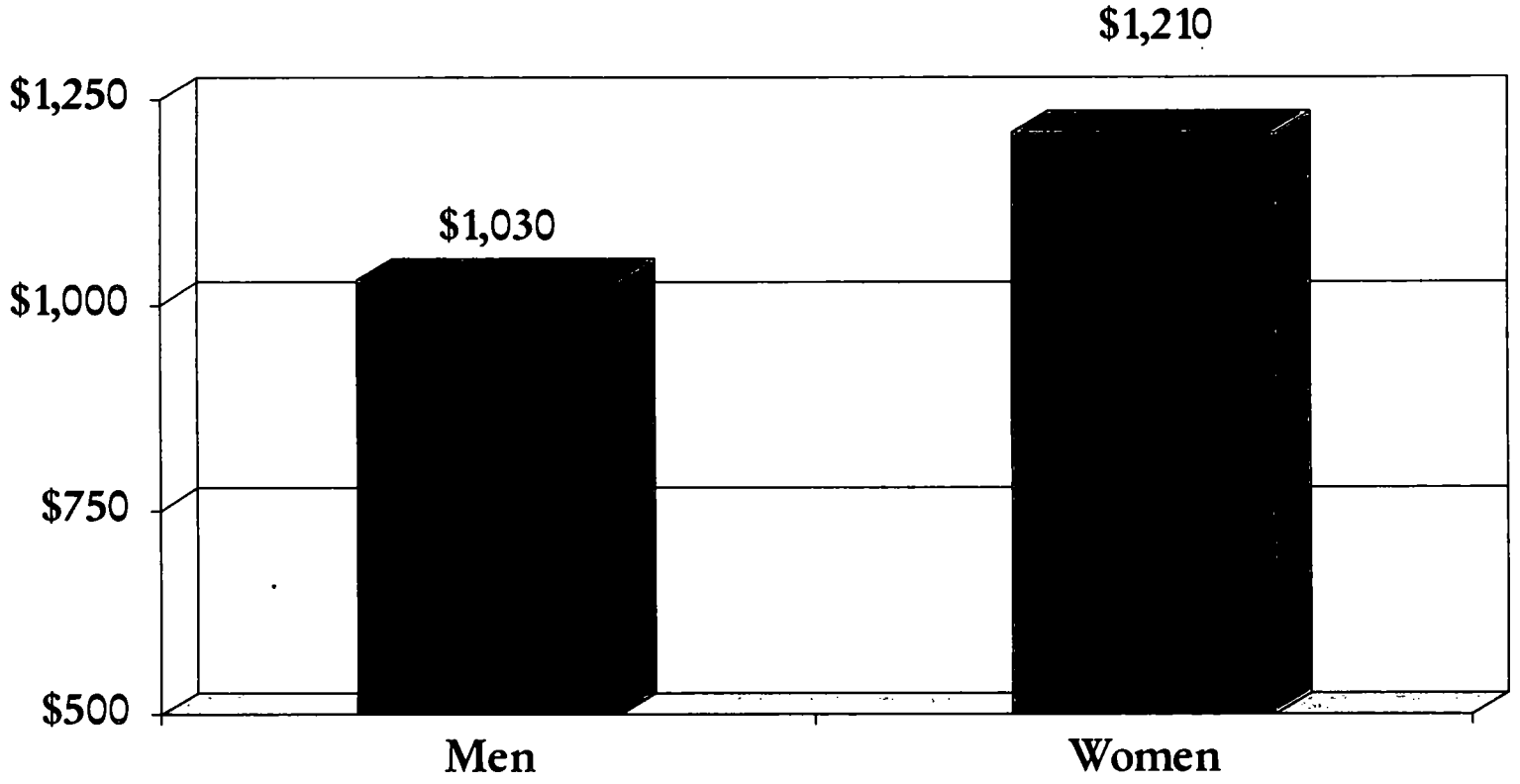
SOURCE: Actuarial Research Corporation for HHS, 2000

Most Medicare Beneficiaries Are Women



Source: U.S. Census Bureau projections for 2000. As cited in OWL Report

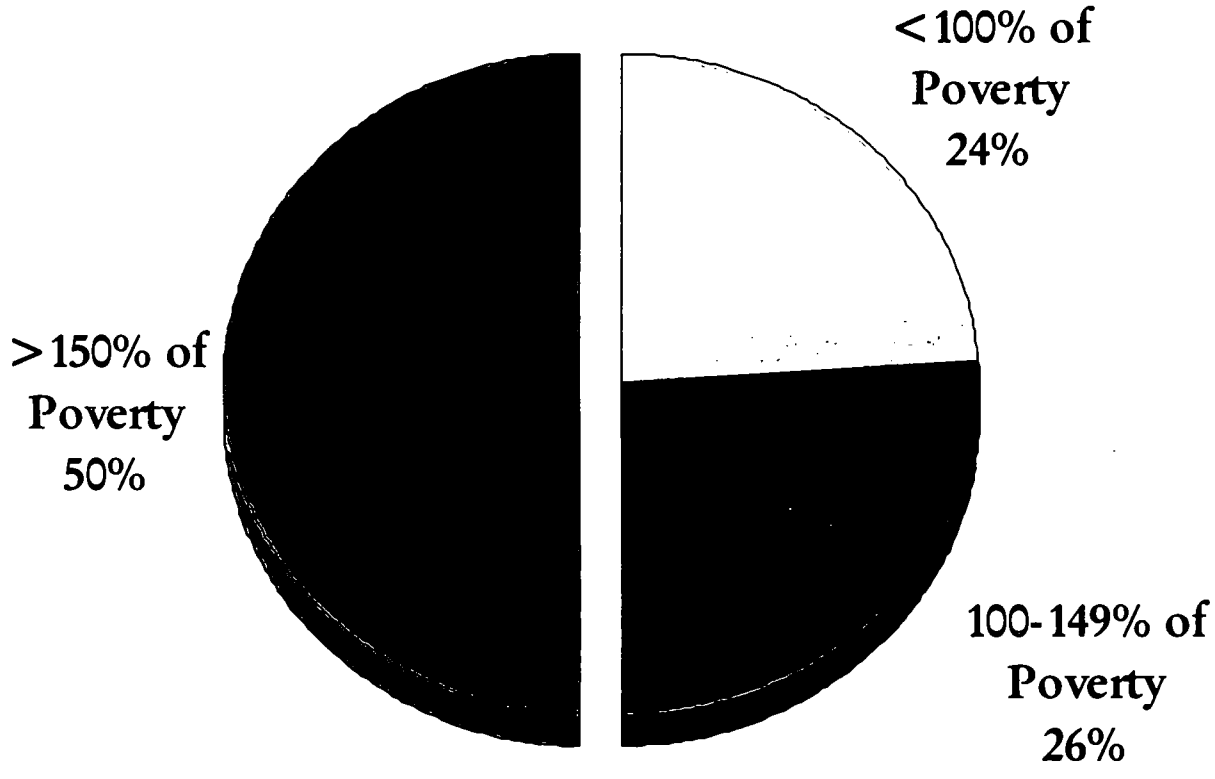
Total Prescription Drug Spending For Women On Medicare Is $1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

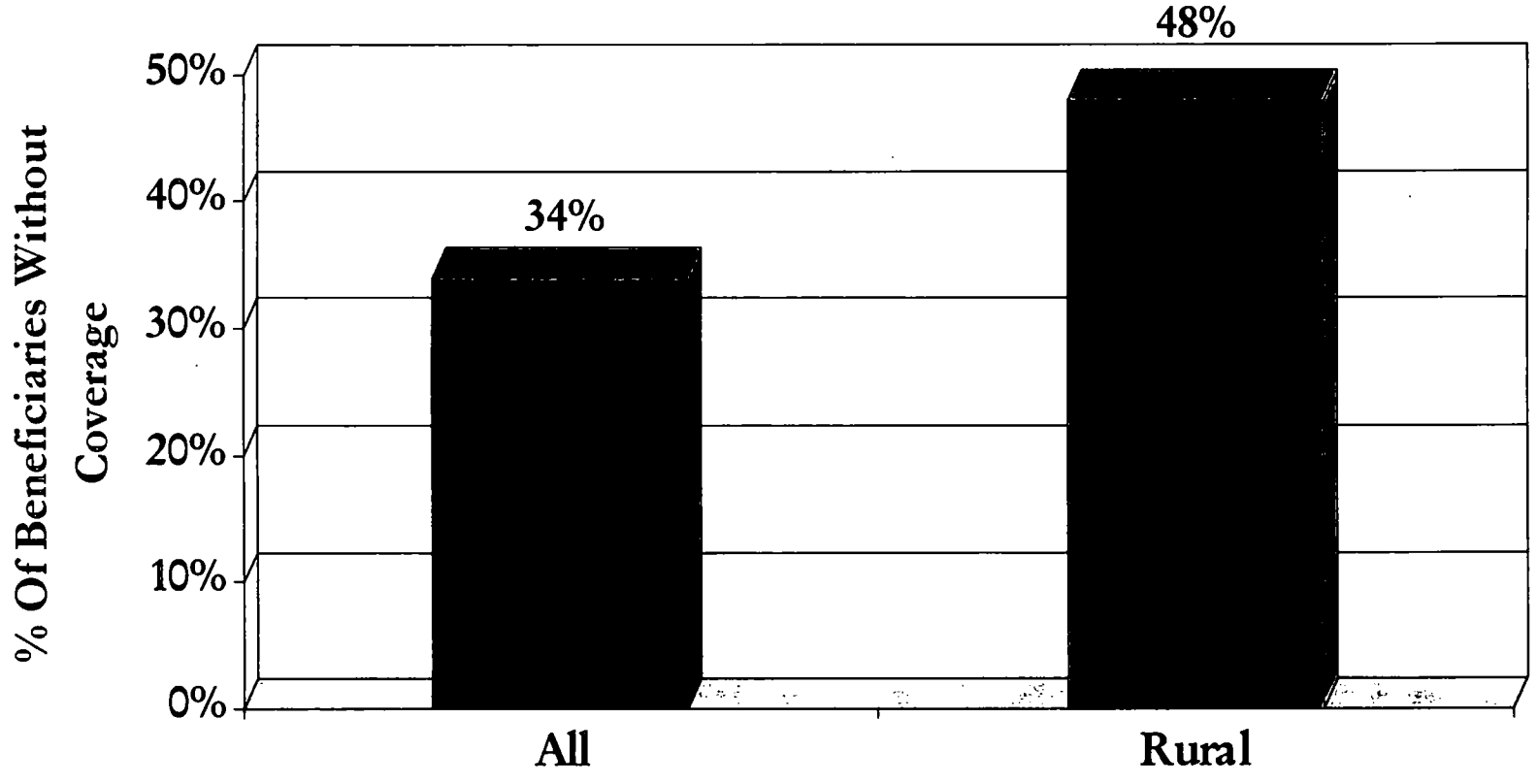
Source: Actuarial Research Corporation. As cited in OWL Report

Half Of Women on Medicare Without Drug Coverage Are Middle Income



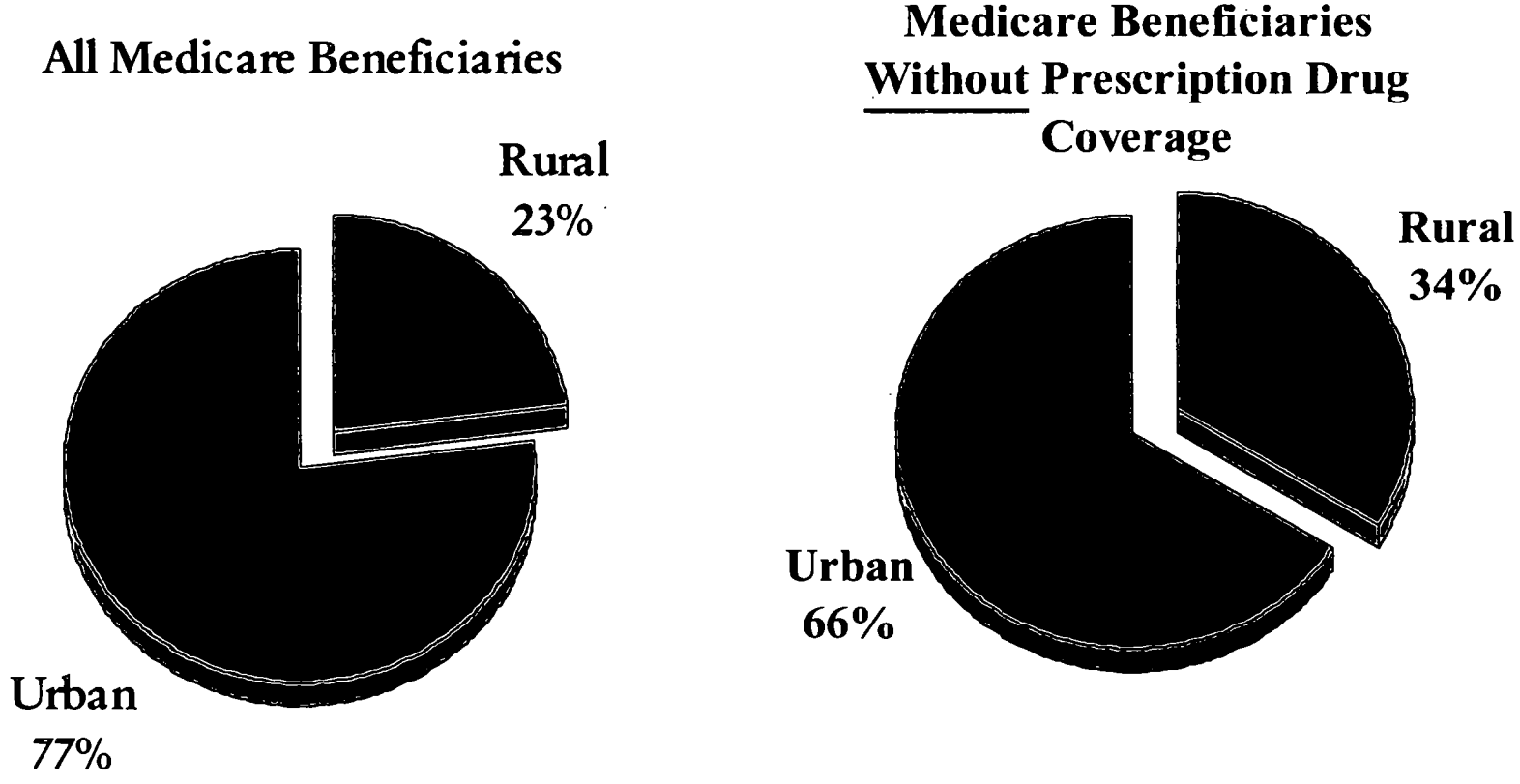
Source: Actuarial Research Corporation. As cited in OWL Report
150% of poverty is about $12,750 for a single, $17,000 for a couple in 2000

More Rural Medicare Beneficiaries Lack Prescription Drug Coverage



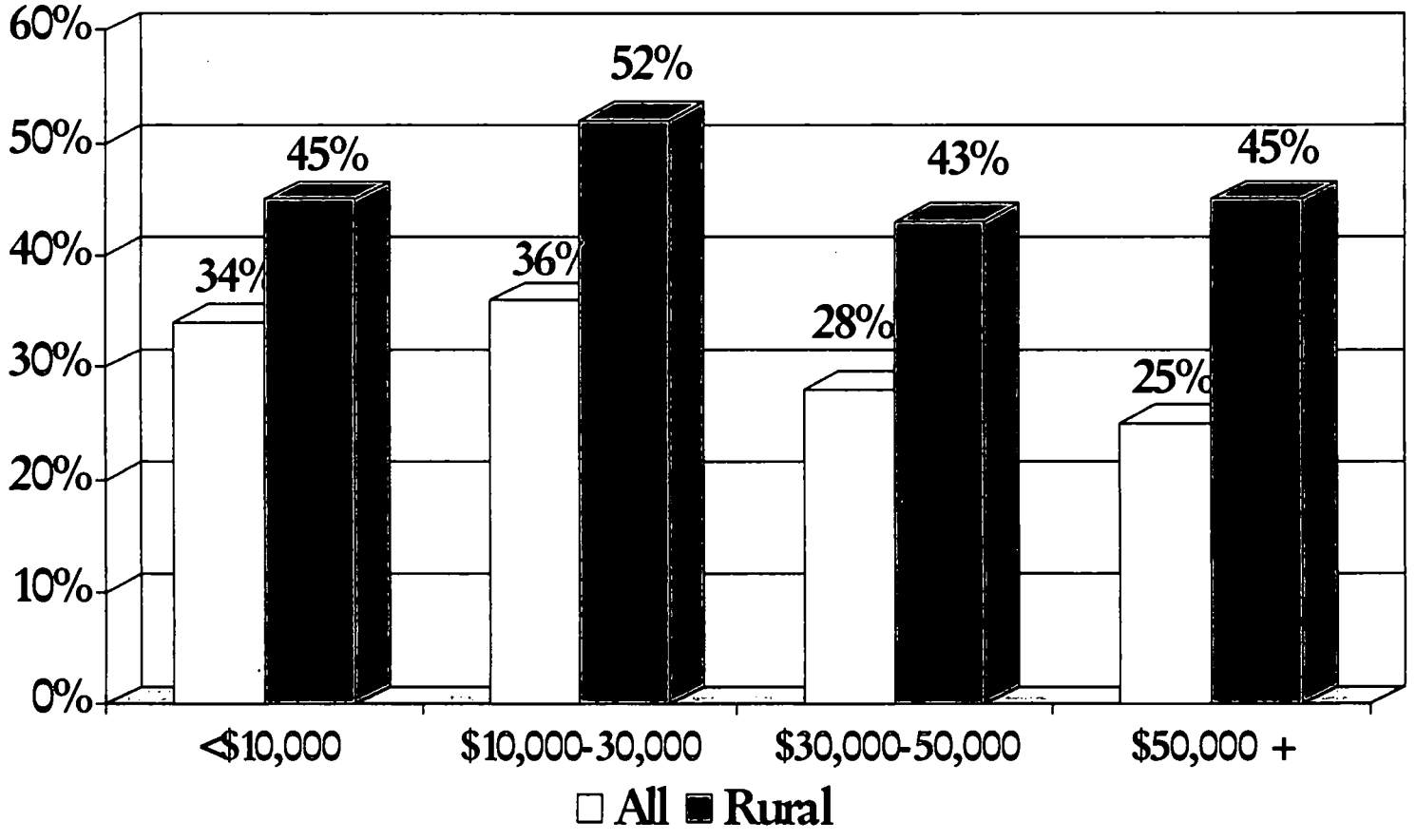
SOURCE: Actuarial Research Corporation for HHS, 2000

One In Three Beneficiaries Without Prescription Drug Coverage Lives In Rural America



SOURCE: Actuarial Research Corporation for HHS, 2000

Rural Beneficiaries Are Less Likely To Have Prescription Drug Coverage Across All Income Groups



SOURCE: Actuarial Research Corporation for HHS, 2000

TAB 6.

BREAUX-THOMAS
MEDICARE REFORM PLAN

ISSUES WITH BREAUX-THOMAS MEDICARE REFORM PLAN

In recent weeks, the Republican Leadership has claimed it does have a Medicare plan -- the Breaux-Thomas Medicare reform plan. Under the leadership of Senator Breaux, the Bipartisan Commission on the Future of Medicare made significant contributions towards the Medicare reform debate. However, the final plan did not receive the necessary votes to formally report its recommendations and has several major flaws that need to be addressed, including:

- **No dedication of surplus to strengthen Medicare**: All experts agree that the doubling of Medicare beneficiaries in the next 30 years cannot be accommodated through spending reductions alone. Such cuts would be too deep to be absorbed by providers without sacrificing quality of care for beneficiaries. Waiting to address Medicare's financing makes the problem much harder to solve and shifts more of the burden to our nation's children.

- **"Premium support" proposal increases premiums for traditional Medicare, effectively financially coercing beneficiaries into managed care**: The Breaux-Thomas "premium support" proposal caps the government contribution to private plans and traditional Medicare based on the national average. Since traditional Medicare will be above an average that includes managed care plans, its premium will rise nationwide – 10 to 30 percent according to the independent Medicare actuary. This would have the effect of coercing beneficiaries into managed care. Despite this, a significant amount of the savings achieved by this proposal come from raising premiums for the beneficiaries who remain in traditional Medicare.

- **Inadequate prescription drug benefit:** The Breaux-Thomas proposal limits drug coverage to beneficiaries with incomes below 135 percent of poverty (about $11,500 a year for a single, $15,400 for a couple). This helps only a fraction of beneficiaries without drug coverage; over half of beneficiaries without any drug coverage would not qualify. For example, a widow with $19,000 in income would not qualify for assistance for coverage. Nor would millions more beneficiaries who have expensive and/or extremely poor coverage.

- **Raises the age eligibility to 67 for Medicare, increasing the number of uninsured**: The most rapidly growing group of the uninsured is aged 55 to 65. Raising the Medicare eligibility age without a policy alternative would exacerbate the problem of the uninsured.

- **Includes an unlimited home health and nursing home copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits – without any limits. The more than 1 million beneficiaries who need more than 60 visits per year – who tend to be older, sicker and widows – could pay more than $300. In addition, beneficiaries would pay about $60 per day for the first 20 days of nursing home care which, for those without supplemental coverage, could be a real burden.

- **Calls for continuation of Balanced Budget Act cuts for hospital, nursing home, and other providers:** Breaux-Thomas proposes to extend virtually every cut included in BBA.

- **Provides no immediate relief from BBA cuts:** Unlike the President's plan, Breaux-Thomas provides for no immediate moderation of the payment reductions in the BBA.

TAB 7.

TOP-TIER QUESTIONS AND ANSWERS ABOUT MEDICARE REFORM

TOP-TIER MEDICARE QUESTIONS AND ANSWERS

PRESCRIPTION DRUG BENEFIT

Q1: How do you respond to critics that charge that a new Medicare drug benefit available to all beneficiaries is not necessary because "two-thirds" of the population already have coverage?

A: **Those who use the argument that "two-thirds" of beneficiaries do not need a Medicare drug option are out of touch and out of date.** The two-thirds number -- inaccurately used by opponents of prescription drug coverage -- does not reflect current facts or trends in coverage of the elderly and disabled of this nation. All one has to do is go to any senior center around the nation to get a sense of the magnitude of this problem.

About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage. Less than one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage. About one-third of Medicare beneficiaries – at least 13 million beneficiaries – have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is expensive and inadequate. About 17 percent have it through Medicare managed care, but plans are severely limiting coverage. The remaining beneficiaries are covered through Medicaid and other public programs.

The limited private coverage that exists is declining and becoming more unaffordable. The number of firms offering retiree health coverage has declined by a staggering 25 percent in just the last four years. Premiums for Medigap prescription drug coverage are extremely expensive and increase with age. The most frequently purchased Medigap policy is typically priced at two to three times the President's option, has a $250 deductible, and limits plan payments to $1,250. Medigap premiums usually increase dramatically with age, just when beneficiaries need the coverage the most and are least likely to have the income to afford it. This is a particular problem for women who make up over 70 percent of those over age 85.

Public coverage is decreasing in value and becoming more unreliable. Nearly three-fifths of all Medicare managed care plans are reporting that they will cap their drug benefits below $1,000 in 2000. In fact, the proportion of plans with $500 or lower benefit caps will increase by 50 percent between 1998 and 2000. Medicaid coverage is meaningful, but is available only for those with the lowest incomes (generally less than about $6,200 for a single elderly person). And, because of "welfare" stigma and other reasons, this program only enrolls 40 percent of the low-income elderly who are eligible.

The President's proposed drug benefit offers all beneficiaries another option. Beneficiaries can choose to take it, choose to keep their current coverage, or choose to remain uncovered. The same critics opposing this proposal are usually the advocates of more health care choices. This benefit is simply a new option.

Q2: How do you respond to opponents' arguments that the proposal represents another step toward socialized medicine and a government takeover?

A: The proposed drug benefit is purely voluntary. Beneficiaries can choose to take it, to keep their current coverage, or to remain uncovered. No one can credibly argue this is a government take-over; it is simply another choice for beneficiaries. Since 75 percent of beneficiaries lack reliable, affordable, decent private sector coverage, this option is clearly needed.

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. The President's proposal simply provides an option to access this critically necessary benefit.

Those who oppose the President's proposal are making the exact same arguments that opponents of Medicare's creation did over 34 years ago. It is striking how similar the arguments against the new prescription drug option are to the arguments that many Republicans used against the passage of Medicare in the first place. Clearly, Medicare has not led to "socialized medicine."

Q3: Why not just target the benefit to the low-income beneficiaries who really need it?

A: Over 50 percent of beneficiaries without prescription drug coverage are middle class. Those who argue we should design a benefit for just the lower income ignore the fact that such an approach would leave out millions of beneficiaries in desperate need of help. Fully 54 percent of all beneficiaries without coverage have incomes over 150 percent of poverty -- over $17,000 a year for couples. And this number does not include the millions of middle-class seniors and Americans with disabilities who have excessively expensive, inadequate and declining drug coverage.

The President's proposal provides special assistance to low-income beneficiaries. Beneficiaries with income below 150 percent of poverty would not pay premiums, and those with income below 135 percent of poverty would not pay coinsurance for prescription drugs.

Ironically, some of the same Republicans who suggest that any drug benefit should be targeted to the poor just supported the House Ways and Means Committee tax deduction provision that provides the greatest assistance to wealthier beneficiaries. Despite their rhetoric of concern about the poor, the House Republicans just passed a bill that allows seniors to take a tax deduction for Medigap premiums. This helps higher income beneficiaries like Ross Perot, but would leave out millions of beneficiaries since over 55 percent of seniors have no tax liability and would be ineligible for this tax break. Indeed, while Republicans feel that the middle class should be denied help on drug coverage, its House plan would give 4 times more in tax relief to the top 1 percent (families making over $340,000) than to the entire bottom 60 percent of taxpayers.

Q4: Why should the Medicare program subsidize a drug benefit for people like Ross Perot?

A: **This argument is nothing but a red herring used by those who are opposed to a prescription drug option for the millions of middle-class seniors who need it.** People making this argument are seeking to cut off prescription drug assistance at only $12,750 for a single, $17,000 for a couple – leaving the millions in the middle class with no coverage or weak coverage out in the cold. This is the real issue: a debate between those who want to provide an option to all beneficiaries so that middle-class seniors have access to affordable prescription drug coverage and those who believe that seniors making over $17,000 are like Ross Perot and don't need any help.

Moreover, many beneficiaries who are sick -- regardless of income -- cannot access affordable insurance. Premiums in the private Medigap market increase with age and, except when beneficiaries initially turn age 65, are usually medically underwritten. As such, seriously ill patients without coverage today cannot get coverage at virtually any price. In the absence of a new Medicare prescription drug benefit option, we are sentencing too many seniors who have worked hard and played by the rules to a Medigap market that will not provide the coverage that they need.

Q5: How will beneficiaries who already have very good retiree health coverage be affected by this new proposal?

A: **Since the new Medicare drug benefit is optional, the less than one-fourth of Medicare beneficiaries who are fortunate enough to have good retiree health coverage can -- and likely will -- keep their current coverage.** The prescription drug benefit is simply another choice, but it is an important alternative to even those beneficiaries with retiree coverage. This is because, over the last 4 years, the numbers of firms offering retiree health coverage has declined by 25 percent. Under the President's plan, if a beneficiary chooses to stay in his or her current plan and the firm subsequently drops the coverage, he or she will have the ability to opt for the Medicare option.

Most importantly, the plan provides new financial incentives to firms to keep and increase their commitment to private retiree health coverage. The plan provides firms that are offering prescription drug benefits, which are at least as good as the Medicare option, an estimated $11 billion over 10 years in assistance if they continue or start to offer private health coverage. This policy is designed to slow down the trend of firms dropping their retiree health coverage and to provide incentives for employers not now offering to do so.

Q6: 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 determined to be medically necessary, including Viagra. However, as is the case in the Medicaid program and with other private insurers, the private contractors who manage the Medicare benefit could require doctors to get prior authorization before prescribing drugs for which there are documented abuses.

Q7: How do you reconcile a brand new entitlement with the need to constrain the growth of the Medicare program?

A: The prescription drug benefit is not a stand-alone initiative; it is part of a broader reform package that modernizes Medicare, makes it more competitive and efficient, and dedicates part of the surplus to Medicare to keep it solvent until 2027. It is simply not credible to suggest that the Medicare program can be modernized without adding the option for prescription drug coverage. Prescription drugs today are as important as hospital care was when Medicare was created. Having said this, the drug benefit is designed in a way that is affordable to both the program and the beneficiaries it serves.

Q8: Does the prescription drug benefit impose an unfunded mandate on states?

A: The prescription drug benefit both relieves states from their current coverage of very low-income elderly and asks states to share in paying for the premiums and cost sharing for poor elderly, as they do for Medicare Part B premiums and cost sharing. All states currently provide prescription drug coverage to Medicare beneficiaries who also qualify for Medicaid (known as "dual eligibles"). Some states cover prescription drugs for all poor elderly. Since Medicare will take over primary responsibility for drug coverage, the states will receive a windfall that will be used to pay for the prescription drug benefits' premiums and copayments for all poor beneficiaries. The Federal government would pay 100 percent of the cost of drug premiums and copayments for those beneficiaries with income between 100 and 150 percent of poverty.

Q9: Will a prescription drug benefit eventually lead to some form of price control?

A: No. The prescription drug benefit will be administered by contracting with private sector benefit managers just like virtually all private health insurers and employers do. There are no price controls. Pharmacy benefit managers (PBMs) and other entities have developed and successfully employed innovative management tools to offer affordable, high quality, prescription drug coverage. Recognizing that drug therapy holds great promise, the plan does not include price controls that would discourage research and development.

IMPORTANCE OF DEDICATING PART OF THE SURPLUS TO MEDICARE

Q10: Why don't you use structural changes rather than dedicating surplus to extend the life of Medicare?

A: Both structural reforms and new financing are needed to significantly extend the life of Medicare. We need to make Medicare a more competitive and efficient program – but all experts agree that it is impossible to rely only on provider payment reductions to extend the life of the Medicare trust fund for any significant length of time, given the doubling of Medicare enrollment that will occur as the baby boom generation retires. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person. Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. Providers are already concerned that the BBA cuts were excessive, making it highly unlikely that significant additional savings could be achieved.

Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster – it contributes to eliminating public debt entirely by 2015. This would make America debt-free for the first time in the last 160 years.

UNCERTAINTY OF PROJECTED SURPLUS, SAVINGS, AND DRUG COSTS

Q11: What happens if the surplus doesn't materialize?

A: The uncertainty of projections is exactly why the most responsible approach to allocating the surplus is dedicating most of it to meet our existing obligations in Social Security and Medicare. If the surplus turns out to be less than our forecast 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.

Q12: How do you respond to the Congressional Budget Office (CBO) testimony that concluded that the Administration underestimated the cost of the prescription drug benefit and overstated the plan's savings?

A: The Administration's economic team and the HCFA Actuary did a thorough and careful analysis in developing a cost estimate for the President's plan. The Medicare Actuary is the same independent and respected career expert who has been cited repeatedly by Republicans in the past for his estimates on the Medicare Trust Fund. The Clinton Administration's health and economic forecasts have been consistently more conservative than actual experience.

PROVIDER REIMBURSEMENT

Q13: How can you propose additional provider savings without restoring some of the excessive savings of the BBA?

A: We are certainly not ignoring the concerns that have been raised by providers in the wake of the implementation of the BBA. At the President's direction, HHS will implement administrative actions that would relieve unnecessary burdens that could undermine the ability of providers to deliver quality services. In addition, the 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 Republicans on the Medicare Commission. They do not include any hospital outpatient department savings, disproportionate share hospital payment reductions, nursing home savings, and new home health care provider savings.

Q14: How do you know that $7.5 billion is the right amount for correcting the overreach of the BBA? How should this fund be allocated?

A: The $7.5 billion set aside was designed to be responsive to legitimate provider concerns without opening the door to unsubstantiated complaints. It is based on a serious analysis of a range of provider concerns, but there is no one specific package of provider modifications that is linked to this amount. While there have been a number of concerns raised, we believe it is premature to assign any specific policy or funding amount to any one provider group. We need additional evidence to make informed decisions, and we look forward to working with the Administration in a collaborative and constructive manner.

STRUCTURAL REFORM

Q15: What do you say to those who say that this is about politics not substance?

A: The President's plan represents a serious proposal to strengthening and modernizing both Social Security and Medicare. 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 program.

Q16: Does this proposal qualify as real, structural reform of Medicare?

A: The proposal represents a bold initiative to strengthen and modernize the Medicare program and prepare it for the challenges of the 21st century. Its inclusion of traditional fee for service reforms, true competition between managed care plans, and savings from providers and beneficiaries alike, a new drug benefit, the elimination of all copayments and deductibles for all preventive services, and an explicit dedication of 15 percent of the surplus to extend the life of the trust fund can be defined as nothing short of comprehensive reform. This has been validated by experts such as Robert Reischauer, former director of the Congressional Budget Office, who says that the President's proposal will "restructure Medicare at its root." (New York Times, July 1, 1999).

Q17: Does your plan suggest that Medicare can be fixed without beneficiaries have to bear any burden?

A: The Medicare reform plan asks all affected parties to contribute to the solution. Both beneficiaries and providers will help offset the costs of the drug benefit through a new clinical lab copayments, indexing the Part B deductible to inflation, and outyear provider savings. The additional costs are financed through savings in the surplus that have been largely achieved through our aggressive efforts to curb waste, fraud and abuse in the program.

Q18: What is the problem with Senator Breaux and Congressman Thomas' proposal?

A: Although the plan outlined by Senator Breaux and Congressman Thomas in March has made an important contribution to the Medicare debate, it has serious flaws that must be addressed, including:

- No dedication of the surplus to strengthen Medicare, passing on the inevitable financing crisis to our children;
- Higher premiums for traditional Medicare in its so-called premium support program, which has the effect of implicitly, financially coercing beneficiaries into managed care;
- A totally inadequate, means-tested prescription drug benefit. More than half of beneficiaries without drug coverage today would not be eligible;
- Raising the age eligibility which would increase the uninsured;
- An unlimited home health and nursing home copay;
- Continuation of the Balanced Budget Act cuts without relief in the early years.

Outpatient Co-pays

March 31, 2000

Medicare To Cap Outpatient Copays

A.P. INDEXES: TOP STORIES | NEWS | SPORTS | BUSINESS | TECHNOLOGY | ENTERTAINMENT

Filed at 1:50 p.m. EST

By The Associated Press

WASHINGTON (AP) -- Medicare announced new rules Friday that will limit older Americans' out-of-pocket costs for hospital outpatient services starting July 1.

The change will cap Medicare copayments for services received in hospital-owned outpatient care centers -- such as one-day surgery, radiology and rehabilitation therapy -- at a maximum equivalent to the program's inpatient hospital deductible. That's $776 this year.

Unlike most other services for which a retiree pays a standard 20 percent out-of-pocket share of the bill, with Medicare picking up 80 percent, copayments for outpatient services vary widely but average about 50 percent.

Under current law, that disparity is scheduled to diminish gradually, as the government slowly picks up more outpatient costs. But getting outpatient copays to the standard 20 percent is projected to take decades.

In the meantime, Congress and the Clinton administration agreed last fall to institute a new dollar-amount limit.

The cap will apply separately to each outpatient service. For example, each visit during a course of radiation therapy would be treated separately, and a patient could conceivably receive multiple services, each subject to a separate cap, during a single trip to an outpatient center.

For this reason, the new caps will have limited impact, mainly

reducing beneficiaries' bills for particularly expensive outpatient services such as one-day surgery.

Also, many retirees buy supplemental private insurance that covers Medicare copays.

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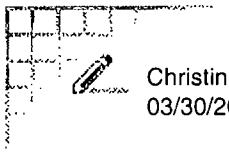
Medicare Trustees



Christine L. Anderson
03/30/2000 02:43:39 PM

Record Type: Record

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

cc:

Subject: Fact Sheet: Medicare Trustees' Report Shows Unprecedented Progress Under the Clinton-Gore Administration but Major Challenges Remain

MEDICARE TRUSTEES' REPORT SHOWS UNPRECEDENTED PROGRESS UNDER THE CLINTC ADMINISTRATION BUT MAJOR CHALLENGES REMAIN

March 30, 2000

Today, the Medicare Trustees projected that the life of the Medicare Trust Fund has been extended until 2023 -- 8 years longer than had been projected last year. This is a historic change from 1993 when the President came into office and received the Trustees report projecting that Medicare would become insolvent in 1999. In welcoming this news, the President highlighted the Administration's stewardship of Medicare which has resulted in the longest Medicare Trust Fund solvency in a quarter century and premiums that are nearly 20 percent lower today than projected in 1993. He pointed out, however, that Medicare still faces daunting demographic and health challenges. It is projected to become insolvent in the middle of the retirement of the baby boom generation. And, unlike virtually every private health plan, Medicare still does not cover outpatient prescription drugs. The President also emphasized his comprehensive plan to make Medicare more competitive and efficient; modernize its benefits including adding a voluntary prescription drug benefit; and dedicating part of the on-budget surplus to meeting the future financial shortfall. Based on preliminary analysis, these policies are projected to extend the life of Medicare beyond 2030. The President's Medicare plan is part of his fiscally disciplined framework to strengthen Social Security, invest in key priorities, and pay off the debt held by the public by 2013.

MEDICARE IS MUCH STRONGER BUT FACES UNPRECEDENTED DEMOGRAPHIC CHALLENGES

- **Best Solvency Status in a Quarter Century.** When the President came into office, the Medicare program was projected by the Trustees to go bankrupt by 1999. The Medicare Trustees project that the life of the Medicare Trust Fund has been extended by 8 years, to 2023, and that its actuarial deficit -- a measure of long-run solvency -- has been reduced to 1.21 percent of taxable payroll, an 76 percent decline from 1993. Today's announcement means Medicare is now in the soundest shape it has been since 1975.

- **Medicare Premiums for a Couple Are $200 Lower This Year Than They Were Estimated to Be in the 1993 Trustees' Projections.** The President's leadership has not only resulted in an improved Trust

Fund, but lower monthly premiums for seniors. In 1993, the projected Part B premium for 2000 was $54.50. Today, it is actually $45.50 per month. This is $9 less per month -- a 17 percent decrease from the Trustees' 1993 projections. For an elderly couple, this is an annual savings of over $200.

- **Improved Financial Status of Medicare Reflects the President's Economic and Medicare Program Management Policies.** The President's leadership in strengthening the economy and constraining inflation, as well as Medicare's success in modernizing payments and combating fraud and waste, has resulted in a strong and fiscally stable program. The improvements in the Trustees' Report confirm the soundness of the Administration's economic and management policies.

- **Major Health and Demographic Challenges Remain.** While significant, the Administration's recent success in extending the life of the Medicare Trust Fund does not meet the full challenges facing Medicare. The Trustees' Report projects that enrollment in Medicare will double from 39 million in 1999 to 81 million by 2035. Equally important, Medicare's benefits have not kept pace with modern medicine. Medicare does not cover prescription drugs and, as a result, 3 in 5 Medicare beneficiaries lack dependable prescription drug coverage. Most of these beneficiaries who need prescription drug coverage are in the middle class, with income between 150 and 400 percent of poverty ($12,525 to $33,400 for a single elderly person).

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE. The President's FY2001 budget dedicates $432 billion over 10 years -- over half of the on-budget surplus -- to strengthen and modernize Medicare to prepare it for the health, demographic, and financing challenges of the 21st Century, extending its solvency to at least 2030. This plan would:

- **Make Medicare more efficient and competitive.** The President's plan adds price competition and successful private-sector management tools to Medicare. These policies manage cost growth and allow flexibility to adopt innovative private practices to improve quality and efficiency.

- **Modernize benefits, including adding a prescription drug benefit.** The President's plan creates a voluntary prescription drug benefit that is accessible and affordable for *all* beneficiaries, and is managed competitively and efficiently. It provides high-quality, needed medications. It also creates a reserve fund that permits the Administration to work with Congress to design protections for catastrophic drug costs. If no consensus emerges, the reserve would be used for debt reduction.

- **Dedicate non-Social Security surplus to Medicare**. Without new financing, excessive and unsupportable provider payment cuts or beneficiary cost sharing increases would be needed. The President proposes to dedicate $299 billion over 10 years from the non-Social Security surplus to the Medicare Trust Fund, improving its financing and reducing debt.

Mark C. Sheppard 03/31/2000

Record Type: Record

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

cc:

Subject: RESEND: 2000 03/30 POTUS remarks

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release March 30, 2000

PRESS BRIEFING BY
NATIONAL ECONOMIC COUNCIL DIRECTOR GENE SPERLING
AND
DEPUTY ASSISTANT TO THE PRESIDENT FOR HEALTH CARE CHRIS JENNINGS

The James S. Brady Press Briefing Room

4:00 P.M. EST

MR. DORTON: Ladies and gentlemen, we now have Gene Sperling, Director of the National Economic Council and Chris Jennings, Deputy Assistant to the President for Health Policy to give an on-camera, on-the-record briefing on the Social Security and Medicare Trustees Report.

MR. SPERLING: Today, we had good news in the Trustees Report for Medicare and Social Security. It was good news across the board. Social Security insolvency date was extended from 2034 to 2037. The actuarial imbalance went down from 2.07 of payroll to 1.89. This was -- the things that had a positive impact on that were mostly a slight increase in wage growth and various technical changes.

With the current plan that the President of the United States has for saving the Social Security surplus for debt reduction and using those benefits, the interest benefits for Social Security, this would now allow the solvency to be extended to 2054. So, again, the down payment that the President of the United States has spoken of in terms of what we could do to Social Security solvency if we use the surplus to pay down the debt and use the interest savings to extend Social Security solvency, we could now make Social Security sound financially until 2054, 54 years from now.

In terms of Medicare, Medicare had its largest one-year increase in solvency in the history of the program. Medicare, which was projected by last year's report to be insolvent by 2015, is now projected to be solvent until 2023. Again, that is the largest one-year increase in the history of the program.

To give a sense of how far we have come, when the President came into office in 1993, Medicare was projected to be insolvent in the year 1999, last year. And there was projected to be an additional 5.11 percent payroll increase would have been needed at that time to keep Medicare solvent indefinitely.

Now, the projection is 2023, so there has been a 24-year increase in solvency. This is due in large part to not only the strengthening of the economy, but the 1993 deficit reduction plans, savings and reforms and Medicare, the 1997 Bipartisan Balanced Budget Agreement, as well as significant improvements in management affecting particularly fraud and abuse in the program.

Another way of detailing the benefits of this is that Medicare premiums are 25 percent of the program cost. The the premium was projected for this year to be $54.50. Instead, it is $45.50. So the savings and increased efficiency in the program mean that Medicare beneficiaries are today paying 17 percent less, or $9 less per month than they were projected to pay in 1993. So we've been able to improve solvency by 24 years, and have Medicare beneficiaries paying 17 percent less in premiums.

The caution we should all have is that these numbers have clearly moved around. They are long-term projections. And while the increase in Medicare solvency to 2023 is an improvement, one should note that anybody 42 years and under at this time is paying payroll taxes of 1.45 percent, and their employer is paying 1.45 percent, so a total of 2.9 percent in payroll taxes into a program that is projected to be insolvent by the time of their retirement.

So the fact that we still have a system, a program where every American under 42 years old who is working is paying payroll taxes into a program that's projected to be insolvent should show that we should not have any comfort that our work is done. That is why it's extremely important to maintain the first things first perspective of reserving a sizable amount of the on-budget surplus to deal with Medicare solvency. We believe if we do that, we can make Medicare solvent to at least 2030, while still being able to afford an optional prescription drug package for all Medicare beneficiaries.

In the President's budget, we have reserved $35 billion for a catastrophic element to our prescription drug benefit. With these improved numbers, this gives us much greater

confidence that that $35-billion reserve can and should be used to strengthen the catastrophic benefits of our prescription drug plan.

With that, let me have Chris Jennings, our top health care policy expert, and myself are happy to answer any questions.

Q Yesterday, Clinton outlined his top priorities. He did mention prescription drugs. He said nothing about Social Security. Why not?

MR. SPERLING: Well, we have stressed Social Security at each and every step of the way, and it's very clear that the President has offered at each and every step that we could at least do a down payment on Social Security. He has stressed this in each and every communication he has had on the Social Security earnings test.

He has said repeatedly that it was good that we were taking this incremental step, but that the next major step we should take, the next major down payment, was to take what seems to be a bipartisan commitment to pay down the debt and use the interest savings after 2010 to strengthen Social Security to 2050 while also seeking to deal with issues related to the high rate of poverty among single elderly women.

So we have made this message and this offer continually. Obviously, our ultimate goal would be 75-year solvency, but understanding that this has been controversial, understanding this is an election year, the President has put forward a reasonable bipartisan down payment that there's no reason that everyone shouldn't agree to.

If the Republicans are out telling people that they're going to take the Social Security surplus and save it for Social Security, they should have a way of insuring that Social Security is made more solvent. Right now, their plan doesn't extend the solvency of Social Security a single day.

The President pays down the debt with the Social Security surplus, but then generates and dedicates those interest savings to Social Security. Again, that's a fiscally responsible, pro-debt-reduction policy that we should be able to do as a down payment. I think in the President's remarks in the last couple days, what he has tried to do is take a couple of the areas where there seemed to be a little more bipartisan willingness so far and stressed that if those bills come to his desk, he could sign it.

But this President is as serious and enthusiastic about doing Social Security reform as he's ever been.

Q The President's put great emphasis on the

prescription drug benefit in Medicare, and there seems to be some action on the Hill with different plans circulating. To obtain this benefit, is the administration willing to compromise on some of the more contentious issues -- Medicare boards to administer the benefit, for example, or targeting the benefit to certain demographic segments as a down payment prior to making it a comprehensive benefit, for example?

MR. SPERLING: Well, certainly, we are willing to work with members of Congress of both parties and including their ideas into a prescription drug benefit. But we've had some very basic principles. And one of them is that prescription drugs should be available to all Medicare recipients.

There is considerable evidence that Chris can go through that shows that Medicare beneficiaries, well over the 200 percent of poverty line, often face grueling choices at times of their retirement when prescription drug costs go up. So to suggest that while the positive step of covering prescription drugs for those at lower incomes or why covering prescription drugs for those lower incomes is certainly a positive element, it would be extremely misguided to pretend that you would come anywhere near solving the problem by doing that, or that you would even be solving the most extreme forms of hardship.

Two hundred percent of poverty comes in around $16,000 a year. It only takes one or two years of a retirement where somebody has drug costs of $2,000, $3,000, $4,000, for somebody of that income to be in a situation where they are finding themselves making basic tradeoffs between food, shelter and prescription drugs. That makes no sense at all. What kind of dignified retirement is it if you say as long as you're healthy, our Medicare program works well for you, but if you should ever, as many of you will have, have significant prescription drug costs, all of that dignity in your retirement is thrown out the window and you're forced to be cutting back on food or shelter costs for prescription drugs.

It's an insurance policy, and an insurance policy isn't just about helping the people on average. It's about being there to provide people coverage in their worst year when they're in their worst health. That's what any common-sense prescription drug plan would do.

Let me just ask Chris to --

MR. JENNINGS: Very quickly, it's important to note that remember that 50 percent of the Medicare beneficiaries without drug coverage today, 50 percent, have incomes over 150 percent of poverty, and 40 percent have incomes over 200 percent of poverty, $16,000, $700 a year. So if you look at those numbers, it's very difficult to see targeting to only that segment of the population.

It's interesting to note that -- you were mentioning the proposals on Capitol Hill -- it seems that they're moving away from a block grant proposal to the states. There are a number of reasons for that and I could get into that, but it seems that they're now talking about a so-called "Medicare benefit," but that they're not making it affordable for those people over 200 percent of poverty -- in fact, even not affordable for some people, or accessible for lower than that.

I think our fundamental point here would be, we're very open to working with members of both aisles, as Gene mentioned, to have a structurally sound benefit. But it has to be affordable and accessible to all beneficiaries on a voluntary basis, and there are a number of proposals that can do that that aren't the President's approach.

But as currently constructed, some of the most recent policies that have been propounded by the Republicans in the House in particular, even those who are relying solely on a private plan drug-only option would not structurally work, and more importantly, the plans that they think would administer it, the private Medigap industry, are opposing them. So, we want to have a workable Medicare drug benefit that's affordable, optional, and accessible to all beneficiaries. There are different ways to get there; I'm sure we can get there.

Q So, Chris, what plans could do that that aren't the President's that can achieve your principals that aren't the President's approach?

MR. JENNINGS: Well, as we've said, Senator Graham and Senator Conran's proposal, certainly consistent with the broader principles the President's laid out, we haven't rejected any or endorsed any specific proposals other than the President's; but there are approaches that can work, that are consistent with the broader principles. And as you know, Senator Graham and Senator Conran have not finalized their proposal, so I can't comment or endorse or anything, but they do have a Medicare drug benefit that would be specifically designed to be available and affordable to all beneficiaries.

Q Chris, you said pretty much, or Gene, it's self-evident that these reports -- essentially, you're being defeated by your own good news, that this is going to make it tougher to get comprehensive reform, specifically on Medicare, and would you be more willing, then, since that may be true, to separate out the prescription drug proposal and just do that, instead of in the context of broader reform, as we've been insisting?

MR. SPERLING: You know, it's curious, because when we put forward our Social Security plans in '98, '99, the focus --

many people said to us, why are you focusing so much on Social Security, shouldn't you be focusing equally on Medicare so that -- because that becomes insolvent earlier. And you still have a situation where we all agree, uniformly, that Social Security is in need of a serious solvency solution. And yet, Social Security becomes insolvent in 2037. So Medicare now will become insolvent in 2023.

As I said, I don't think most people 42 years and under have great security. The fact that they're paying payroll taxes into a program that will be insolvent when they retire -- even somebody who is 50 years old or can look forward to the fact that eight, nine years into their retirement, Medicare would again become insolvent.

So I think that our feeling is that this does not in any way take away the basic common sense of saving a large portion of our surpluses to first close our existing long-term deficits before we go on to other initiatives. To the degree that you don't do that, you are simply kicking the problem down the road and asking the next generation or people to perhaps have to deal with this at a time when the economy is not so strong to gain the resources at this time.

So that being said, our, by far, preferred solution -- and I think the soundest approach is to strengthen and modernize Medicare by the type of efficiency reforms we have, by the type of choice proposal we have, which is an innovative choice proposal that allows for there to be more competition on the choice side, allowing even for people to be able to pay less fees on the managed care side, while also having reforms in the fee-for-service side.

To do that at the same time you're doing prescription drugs is to both strengthen the program, modernize it, make it more efficient, while plugging a major hole in our Medicare coverage, which is the lack of a voluntary prescription drug program. So, I think that most people who are serious about Medicare reform, who have been serious about us dealing with our long-term entitlement problem would feel that is is just as important now as it was yesterday that we deal with this comprehensively, both the reforms and efficiency and a voluntary prescription drug plan.

Q Does the prescription drug program have to be passed as part of broader Medicare reform or not?

MR. SPERLING: That is our very strong aspiration and policy, and that is what we are fighting for. I am not going to go into every proposed hypothetical down the road. All I can tell you is what our plan is and what we are trying to do.

MR. JENNINGS: Can I just say one -- the one other

thing is: remember that the first place this is going to happen, almost inevitably, is the Senate Finance Committee. It is very difficult for me to see the Finance Committee passing out a drug-only benefit in the Medicare program. Virtually every member of that committee has indicated that if they are going to be doing a drug benefit, as I think most of them want to do, it should be in the extent of our reform. So any likely vehicle that we are aware of right now is likely to include broader Medicare reforms and we think that they should.

Q I guess that this would be directed more toward Chris as well. When the White House unsuccessfully advanced its comprehensive health care package, it more or less left it --

MR. SPERLING: That wasn't all Chris's fault.

MR. JENNINGS: I wasn't -- in 1993. Okay, go ahead.

Q You're more or less acknowledged that in an incremental approach, it was the most realistic -- now, focusing first on children. Why is that such an unacceptable approach when it comes to prescription drugs? If you can't get them to agree on comprehensive voluntary universal, why can't you focus initially on the poorest?

MR. JENNINGS: Because remember, when we were talking about children, we were talking about an entire benefit package. Right now, we are talking about simply modernizing a benefit package. It is absolutely irrational to have a health care plan that does not cover prescription drugs, and then to say for some it covers some, and for others it doesn't.

There is no one in this room who has private health care who says, "Well, if you get a higher income, you don't get a particular benefit in your health care package, and if you have a lower income, you do." Everyone suggests on Capitol Hill that we should make the Medicare program more like the private sector. If we do, if we want to have it more like FEHBP, if we want to have it more like private health plans, we will have a Medicare prescription drug benefit as part of that package. It is good health care. It is good policy. And it should be done.

And lastly, if you do segment populations away from that benefit, you will be explicitly saying that populations in need -- a $20,000 widow, for example, who has an income of over 200 percent of poverty is somehow less deserving of a needed prescription drug benefit, and we just don't believe that is the case, and actually, we don't believe the public at large does as well.

MR. SPERLING: I would just add that I think if you go ask Democrats and Republicans alike, they will all say, "I think we would agree, with unanimous consent, that anybody creating a

Medicare program today, would absolutely include prescription drugs." They would not even think about not including prescription drugs, that prescription drugs have preventive benefits and cost savings as well as the relief that it provides people.

And so I really think, at this period, the burden should be on those who don't want to have uniform prescription drugs. They have to explain why the other initiatives they are putting forward, the tax cuts going to more well-off Americans, why that should come first over prescription drugs. I have absolutely no problem arguing that it is more important for us to be able to have prescription drug benefit available to that $20,000 a year widow or somebody or somebody making $22,000 or $23,000 who may have someone with Alzheimer's or a serious disease. That is a much higher priority both health care-wise, fiscally and morally than putting in significant, excessive tax cuts that would flow mostly to people who are the most fortunate in our society.

Q Slightly different topic -- on the subject of China, it appears the administration is beginning to work with Democrats on the Hill on separate, parallel legislation that could build support for the PNTR vote. What does the Administration think needs to be in that legislation, and could you accept legislation that would have sanctions against China, or restrictions against the multilateral lending, Ex-In bank lending, that kind of thing?

MR. SPERLING: We clearly believe -- strongly believe that the accession agreement we have with China is a one-way clean win for the United States, and that any vote on China's accession to the WTO cannot be one that makes discriminatory conditions on China, or has any type of linkages that would be clearly violative of the WTO and the GATT. And in fact, if we were to do that, we would likely -- almost certainly lose the benefits of our WTO agreement, because the GATT does not allow -- or the GATT insists on immediate and unconditional national treatment for all countries in. So we will not in any way step over that line.

On the other hand, we certainly are talking to both Democrats and Republicans about whether -- about what their concerns are, and whether any of their concerns can be met in ways that would be acceptable to the broad majority of supporters of China MFN, or China permanent NTR, on both the Democratic and Republican sides. There have certainly been some issues raised about how to keep a focus on human rights, and how to ensure that we have the proper spotlight on those issues that so many of us find offensive.

And to the degree that we have those discussions, and the degree that there are things that could be worked out that

would be acceptable to both Democratic and Republican supporters of passing China permanent NTR -- if they were parallel, if they did not require things that were linkage or sanctions or conditions, there's every reason for us to keep those discussions going, and to see, where possible, we can work out people's concerns.

We're not going to do things that would be acceptable to a few people, but would cause many others to feel they couldn't vote for the bill -- and most importantly, nothing that would be inconsistent with our obligations.

So we will obviously continue conversations with both Democrats and Republicans, and perhaps on some areas like human rights there's ways of having reviews that are not offensive or objectionable to any of the current supporters of permanent NTR for China.

Q Gene, can I just be clear on that? When you're talking about not doing things that are discriminatory or -- linkage and so forth, does that apply to what Gephardt was talking about, about cutting off international lending potentially, strictures like that? Or the provisions on import surges that are in the Levin proposal? Are you essentially taking those things off the table?

MR. SPERLING: First of all, I do not know of a formal proposal by Congressman Gephardt, so I'm not going to try to reply --

Q Well, he mentioned -- whether it's a formal proposal or not, I mean, that's what he was talking about.

MR. SPERLING: I know, but you know, one of the reasons I think I'm still here after eight years is, I don't respond to what the leader of the Democratic House says based on a news story that I never saw or read or verified.

I think that -- I think that it's safe to say that we do not feel that there should be things that would be in any way conditional. So for example, if somebody -- a proposal that would make China's accession conditional on some other factor, that would be a discriminatory condition on them that does not apply to anyone else, would not be acceptable.

But I think one has to look at each measure and ask whether it is something that does not offend the basically clean accession of China into the WTO, and ask whether it is something that could help broaden support without taking away any of the support of the existing members on both sides of the aisle who currently support permanent NTR.

Q Gene, what about the deadline? Do you believe

that if there's nothing done by June, it's dead? Or is that flexible?

MR. SPERLING: What I would say is that we have heard reports that the House Republican leadership is thinking or planning on having a day for a vote before Memorial Day, and we would consider that very good and very encouraging news.

This is a fight we have always thought would be a tough fight, but it is still one we expect to prevail on. And so to the degree that a vote would be set prior to Memorial Day, we would consider that positive and encouraging news.

Q But there's a group of -- apparently 19 House Democrats today have signed a letter to the President saying -- they've previously voted for NTR and now they're saying that they will vote against it because of human rights issues. Does that concern you, that it's getting, the number seems to be getting higher of the Democrats that won't vote for it?

MR. SPERLING: No. We think that -- we still feel that as tough a battle as this will be, that we will prevail. And we still are optimistic about that.

There are others who have not supported fast-track or NAFTA in the past who, because of the very strong agriculture agreement here, et cetera, are planning on voting for this for the first time. So there will be some crossovers both ways. But I think that we're still confident that at the end of the day it will be a tough fight, and perhaps down to the wire, but as we see things we still think this is a vote that we will prevail on.

And I will say that the administration, as evidenced by the Secretary of State's powerful speech on human rights, absolutely agrees that the human rights, the labor rights, the religious rights situation in China is very disturbing. It is one that we strongly disapprove of.

But that is not the question. The question is, will voting yes on permanent NTR help or hurt in terms of making things better in China -- in terms of opening the society; in terms of economic freedom; in terms of political reform. I do not understand the argument that suggests that if we close our doors to them, if we undermine the reformers within China who have sought to open their doors more, that we will somehow strengthen the situation of human rights within China.

That is not what, obviously, Martin Lee (phonetic), the democracy leader in Hong Kong, thinks. It is not what I think the overwhelming majority of people concerned with these issues believe. These are honorable differences, but we think the more it's discussed, the more people will see that voting yes on permanent NTR is a step towards improving things in China,

whatever -- however negative some of the situations may be.

MR. DORTON: Last question, guys.

Q Can you tell me, quantify for me, getting away from the politics for a moment, how much of the improvement in Medicare and Social Security's outlook is due to higher than expected payroll taxes, and how much is due to other factors?

MR. SPERLING: Within this report? Within this report, you have basically offsetting -- you have offsetting movement. You have -- the positive movement is that productivity is estimated to be at 1.5 instead of 1.3. And you have real wage growth being estimated at 1.0 instead of 0.9.

On the other hand, people are expected to live longer -- which I think most of us think is overall good news -- so that puts a little bit more strain on the system. And then every year that you don't solve the problem, you essentially include -- these are done on 75-year estimates. So you're essentially bringing in another bad year, every year you bring in -- 2075, now.

So you really have -- you have conflicting factors. Overall, when you added in some of the technical issues, there was an improvement, 0.18, in the Social Security solvency.

Chris, I don't know if you have any -- on Medicare --

MR. JENNINGS: I think we should -- I'll give you a breakout separately. I mean, I think it really is, goes both ways.

Q Gene, before you go, can I ask you a -- about the supplemental? I haven't followed it, but last I checked it was at something like $13 billion. You've talked a lot about fiscal discipline here. Is this thing getting out of hand?

MR. SPERLING: You know what, I'm going to take a pass on that, because I don't know what Jack Lew has said publicly today. And so I'll let him respond on the supplemental for today.

END 4:35 P.M. EST

Message Sent To:

Prescription Drugs

QUESTIONS AND ANSWERS ON PRESCRIPTION DRUGS
April 20, 2000

Q1: The White House is strongly criticizing the Republican prescription drug benefit. What are your concerns about this proposal, and does this mean that any possibility of a compromise on prescription drugs this year is dead?

A: **First, it is encouraging that the Republican leadership has finally begun to work on proposals to provide prescription drug coverage to Medicare beneficiaries.** Last year, the Republicans were unwilling to even discuss this issue, and this year, they are saying that they want to help make prescription drugs more affordable to all Medicare beneficiaries.

The policy doesn't live up to the rhetoric. While this is an encouraging development, the major problem is that their policies don't match their rhetoric. Their approach is underfunded, unlikely to be available to all beneficiaries, and would inevitably be unaffordable to millions of seniors and people with disabilities, even if it is available in some places.

- ***Reneges on funding commitment for a meaningful prescription drug benefit.*** Just recently, we learned that the Republicans proposed a budget resolution that dedicated as little as $20 billion to improving the Medicare program to include a prescription drug benefit. Moreover, because they are refusing to release 10-year numbers on their proposal, we fear they are attempting to conceal the fact that their exploding tax policy will eat up virtually all revenue necessary to adequately fund a drug benefit into the future.

- ***Does not assure availability of prescription drug coverage.*** And because the Republican plan relies on private insurers to voluntarily offer a drug-only benefit, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. The insurance industry itself has expressed skepticism on the Republican approach. Chip Kahn, president of the Health Insurance Association of America, said recently, "I don't know of an insurance company that would offer a drug-only policy like that, or even consider it...The idea of marketing a plan with just drugs has all kinds of problems."

- ***Not affordable for most seniors, even if it is available.*** Furthermore, because they only provide direct premium assistance to beneficiaries with annual incomes of under $12,600, the Republican benefit will almost inevitably fail to be an affordable option even if it's available. This would be the first time in the program's history that we did not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program.

Older Americans are not interested in placebos – they are interested in a real drug benefit. It is simply untenable for us not to act on this issue when we know the whole future of medicine will become increasingly dependant on the use of life-saving medications.

Policy must change to be meaningful to beneficiaries and acceptable to the President. It is our hope that just as the Republicans' interest in this issue has evolved from nothing to good principles but flawed policy, that it can further evolve into good policy as well as good principles. We stand ready to work with Republicans and Democrats – in the context of broader reform – to further strengthen and modernize Medicare.

Q2: Would the President veto a prescription drug plan that was limited to low income beneficiaries?

A: It is in no one's interest to entertain hypothetical questions. It is important to note, however, that the President believes that middle-income beneficiaries such as a widow who has a $25,000 pension, should have access to an affordable prescription drug option. Over half of Medicare beneficiaries without drug coverage have incomes above 150 percent of the poverty level and millions more have inadequate, expensive, and undependable coverage. It is hard to imagine why anyone in Congress would advocate a low-income only approach.

Q3: Would the President support an income-related premium for a drug benefit, like in the Graham-Conrad (Robb-Bryan) bill, for the program as a whole?

A: He has not ruled out any such approach. In fact, in previous years the President has supported this concept. This approach is completely different from a means tested benefit that would allow only low-income beneficiaries to access any voluntary benefit at all. However, we need to determine whether it would create an adverse selection problem, in which only the less healthy populations might opt for this benefit if it became too expensive. It also needs to be workable, administratable, and designed to attract bipartisan support. Last year, it became clear that many Republicans and Democrats had major concerns with such approaches. We all know that a necessary precondition for any successful health reform initiative is achieving bipartisan support. If it becomes clear that members in both parties are willing to entertain an income related approach, we certainly will work with them to see if a consensus position can be developed.

Q4: What is your position on the Graham-Conrad proposal for a Medicare prescription drugs benefit?

A: We are encouraged that it appears to meet the principles that we and the Senate Democratic leadership recently laid out, including being voluntary, affordable, accessible, meaningful, competitively managed, and consistent with overall structural reform. We look forward to seeing the final bill and will assess our position on it then.

Q5: Doesn't the revised Trustees' Report released today reduce the pressure for reform?

A: The Trustees' Report does not change the fact that the Medicare population will double from 40 to 80 million beneficiaries over the next 35 years. The longer we wait to reform the program, the harder it will become to address the challenges it faces. In particular, the baby boomers recognize the importance of starting now to make the program more efficient, prepare it to meet the challenges of the 21st century, and ensure they will not be a burden on their children. They also understand that avoiding this problem will not make it go away.

Q6: Why do you believe today's announcement from the Medicare actuary enhances the likelihood that the Congress will pass a prescription drug benefit this year?

A: Because of our successful efforts to make the program more efficient and reduce fraud and abuse, the program has become stronger and better prepared for a new, voluntary, prescription drug benefit. Moreover, the economy has never been stronger. As a consequence, we have the resources to help finance this drug benefit within the context of broader reforms that modernize and strengthen the program. To fail to take advantage of this opportunity is to suggest that excessive, unnecessary, and economically damaging tax cuts are more important than providing prescription drug coverage for our nation's seniors.

Q7: If Democrats and Republicans are so far apart, is compromise even possible?

A: The Republican party has moved a long way in just the last year. Last year, they wouldn't even mention the drug issue; then they suggested a low-income block grant approach; and now, although it is still severely flawed, they are suggesting some type of benefit for all Medicare beneficiaries. We hope and believe this evolution will continue, especially as we continue to inform the public and the Congress about the extent of this overwhelming health care challenge and realistic and workable policy options emerge from the Congress.

Q8: Why do you believe it is possible to pass a prescription drug benefit with so few days left before the elections?

A: The President has repeatedly stated that election years are times that we can get more accomplished than normal. In the last Presidential election year – 1996 – we passed and enacted the Kennedy-Kassenbaum, welfare reform initiatives, and an increase in the minimum wage. Elections have a way of bringing politicians closer to the people they represent, and because the public strongly supports the addition of a long overdue voluntary prescription drug benefit to Medicare, the President believes that it is very possible to see a bipartisan consensus emerge on this issue in the context of broader reforms for the program.

Q9: Aren't both the Democrats and the Republicans dedicating significant resources to a drug benefit? Is there really a difference between the two proposals?

A: Unfortunately, there is a large difference between the President's proposal and the House Republican outline. Although it's difficult to say for certain, since the Republican announcement raises more questions than it answers, it is clear that their approach could not assure access to an affordable, voluntary, prescription drug benefit for all Medicare beneficiaries. As the President has stated repeatedly, we need to have an adequately financed voluntary prescription drug benefit that all Medicare beneficiaries in need of coverage can access. The design of this policy, no matter how many dollars are dedicated to it, will make a difference in its accessibility and affordability to both beneficiaries and the program as a whole.

Having said this, it is also clear that the Republican leadership has not even agreed to dedicate the same level of resources that the President has.

Q10: The Medicare Payment Assessment Commission just recommended that hospital payment rates be increased. Does the Administration agree with this recommendation and reject its own budget proposal to cut Medicare provider payments?

A: We are always looking for any information that helps us best evaluate and ensure adequate payment to providers. As the President has made clear in the past, he wants to make certain that access to high-quality services is assured in the Medicare program. We are reviewing the MedPAC recommendation closely to determine whether any modification to our previous positions on provider payment is warranted. We have not finalized that review as of this time.

Q11: Won't the introduction of any Medicare prescription drug benefit give employers who are struggling to afford prescription drug coverage today an excuse to drop it?

A: A well-designed Medicare prescription drug option should not result in further erosion of retiree coverage – and could, in fact, increase coverage. Employers who offer prescription drug coverage to retirees today do so because they think it is an important part of their employee compensation package. While rising costs have resulted in a number of employers dropping this coverage, the President's proposal, which allows them to offer the same coverage for less, should stop – if not reverse – this trend. The proposal would make a special premium assistance payment for (1) employers that offer meaningful prescription drug coverage or (2) for beneficiaries whose employers buy them into the Medicare benefit. This is a voluntary incentive for employers and, in a recent survey, four out of five who now offer coverage said that they would take it. The Congressional Budget Office reports that 75 percent of retirees with coverage would elect to keep that coverage.

Q12: Merck-Medco recently announced that they will provide uninsured Americans over the age of 18 with price discounts on prescription drugs. Doesn't this indicate that the pharmaceutical companies are moving in the right direction without Federal intervention?

A: We welcome this recognition of and response to the fact that uninsured Americans are paying the highest prices in the world for prescription drugs. We are still reviewing the specific details of the policy and commend Merck-Medco for its initiative, but, as the company acknowledges, having access to a discount in no way replaces the need for prescription drug coverage for Medicare beneficiaries.

MEDICARE PRESCRIPTION DRUGS
April 10, 2000

What is your response to the pharmaceutical industry's assertion that there is a growing momentum behind a privately-run drug benefit for Medicare beneficiaries (an explicit rejection of the President's proposal)?

We see little or no momentum building for this type of policy. The only strong support for it seems to be coming from the pharmaceutical industry. It has been rejected by every independent organization representing seniors and people with disabilities, as well as the very insurers that the drug industry is suggesting could administer such a benefit. With this in mind, it's difficult to understand where the drug industry can point to real momentum for the policy they advocate.

What is the Administration's position on a privately-run drug benefit such as the one advocated by the pharmaceutical industry?

The policy the pharmaceutical industry and some within the Republican party are advocating is structurally flawed and would leave millions of uninsured and underinsured Medicare beneficiaries without access to an affordable drug benefit. It has been rejected by every independent organization representing seniors and people with disabilities, as well as the very insurers that the drug industry is suggesting could administer such a benefit. Because the policy would not provide any premium assistance for those beneficiaries with incomes over $16,700 (200 percent of the poverty level), it would, for the first time in the history of the Medicare program, means-test a benefit. Moreover, since the insurance industry has indicated it will not provide this coverage, it would not even be accessible for millions of beneficiaries, to say nothing of affordable. Under this policy, beneficiaries would do no better – and possibly do worse – than the status quo.

BACKGROUND: The yet to be released Republican policy rejects the President's proposal, replacing it with a private insurance policy for prescription drugs that would be offered to all beneficiaries but only subsidized up to 200 percent of poverty – $16,700 for an individual. It would include some sort of Federally run risk pool for extremely expensive Medicare beneficiaries in an attempt to address the serious risk selection problems a drug-only benefit would create. This approach is fundamentally unsound and has been rejected by the insurance industry – including HIAA.

The fact that Medicare beneficiaries without drug coverage pay more for their medications than Medicare beneficiaries with coverage is hardly surprising news. Did we actually learn anything new from this report?

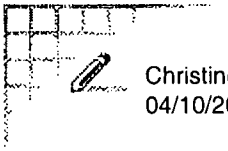
There are a number of new findings on cost and coverage, not the least of which is that the cost of prescription drugs is increasing at double the rate of inflation. Other new findings include: (1) not even counting manufacturers' rebates, prescription drug prices for those without coverage are typically 15 percent higher than prices paid on behalf of people with coverage; (2) this price gap almost doubled between 1996 and 1999; (3) Medicare seniors and people with disabilities without drug coverage are five times more likely to report being unable to purchase prescriptions as those with coverage; and (4) in addition to the millions of completely uninsured, nearly half of seniors with Medigap did not have that coverage for the entire year. But clearly, the most notable information is the detailed explanation of the discounting and rebate practices negotiations with the pharmaceutical industry. However, as the report makes clear, not enough is known about costs and pricing practices by the pharmaceutical industry. The Administration's conference exploring these issues, to be held this summer, will help further the policy debate.

Why do you believe it is possible to pass a prescription drug benefit with so few days left before the elections?

We have found that election years are frequently the time that much of our work gets done, because Members of Congress need to be much more responsive to the desires of their constituents. This, together with meeting the unmet needs of seniors through Medicare reform, makes us believe there is a real chance for action this year. We believe that the members will not want to return to their districts without addressing this issue.

If Democrats and Republicans are so far apart, is compromise even possible?

The Republican party has moved a long way in just the last year. Last year, they wouldn't even mention the drug issue; then they suggested a block grant approach; and now, although it is still severely flawed, they are suggesting some type of benefit for Medicare beneficiaries. We hope and believe this evolution will continue, and as we continue to inform the public and the Congress about the best policy approaches to dealing with this overwhelming health care challenge so that realistic and workable policies can emerge from the Congress.



Christine L. Anderson
04/10/2000 10:23:31 AM

Record Type: Record

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

cc:

Subject: Fact Sheet: President Clinton Releases New Prescription Drug Coverage and Pricing Study

PRESIDENT CLINTON RELEASES NEW PRESCRIPTION DRUG COVERAGE AND PRICING STUDY

April 10, 2000

Today, the President will release a new study by the Department of Health and Human Services (HHS) that shows, among numerous other findings, that seniors without drug coverage not only lack insurance against high costs, but do not have access to the discounts and rebates that insured people receive. He will underscore how this comprehensive report clearly validates the need for a voluntary, affordable prescription drug benefit that is available to all beneficiaries. Key findings include: (1) not even counting manufacturers' rebates, prescription drug prices for those without coverage are typically 15 percent higher than prices paid on behalf of people with coverage; (2) this price gap almost doubled between 1996 and 1999; (3) Medicare seniors and people with disabilities without drug coverage are five times more likely to report being unable to purchase prescriptions as those with coverage; and (4) in addition to the millions of completely uninsured, nearly half of seniors with Medigap did not have that coverage for the entire year. The study contains other findings confirming that Medicare beneficiaries without drug coverage fill fewer prescriptions and have higher out-of-pocket spending across all groups, even among the most ill. However, because of the limited information about price discounts, the President will announce that HHS will hold a conference on prescription drug pricing practices this summer.

KEY FINDINGS FROM "PRESCRIPTION DRUG COVERAGE, SPENDING, UTILIZATION, AND PRICES" REPORT. The HHS study, available in its entirety at http://aspe.hhs.gov/health/reports/drugstudy, demonstrates that:

- **Seniors without drug coverage not only lack insurance against high costs, but do not have access to the discounts and rebates that insured people receive.** In contrast, Medicare beneficiaries with drug coverage not only pay out-of-pocket a fraction of the prescription drug price, but that price is significantly lower than what is charged to beneficiaries without coverage.

- **Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug.** At the pharmacy level, people without coverage pay higher prices for drugs than the

amount paid on behalf of those with coverage through third-party payers, when controlling for the dose and strength of the drug.

° **The gap between drug prices for people with and without insurance discounts nearly doubled, from 8 to 15 percent, between 1996 and 1999.**

° **These differences do not take into account manufacturers' rebates, which could widen this gap by an additional 2 to 35 percent according to industry sources.** Pharmaceutical benefit managers, which pay for most prescription drugs in the U.S., typically get rebates and other forms of compensation from pharmaceutical manufacturers after the drug is purchased, to reward high volume or increased market share. However, due to data limitations, these additional reductions in price are not reflected in this study, so its results understate the gap between prices for cash and third-party payers.

• **Prescription drug spending and utilization is growing rapidly – more than twice the growth in other health spending.** Between 1993 and 1998, spending nationwide for prescription drugs increased at an annual rate of 12 percent compared to about 5 percent for all other types of health spending. Prescription drugs now account for about one-sixth of all out-of-pocket health spending by the elderly. This reflects the growing importance of prescription drugs in modern medicine.

• **The percent of Medicare beneficiaries without drug coverage who report not being able to afford a needed drug is about 5 times higher than those with coverage.** About one in ten beneficiaries without supplemental coverage reported that they needed prescription medicine in the last 12 months but did not get it because they could not afford it, compared to 2 percent of those with non-Medicaid coverage.

• **Uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.** Overall, these beneficiaries have annual out-of-pocket costs that are twice as high even though they use fewer medications. These utilization and spending differences hold up across income, age, health status and other categories. There is no significant decrease in the gap in drug spending as income rises, suggesting that drug coverage makes a difference across all incomes.

° **Chronically ill, uninsured Medicare beneficiaries spent over $500 more out-of-pocket than those with coverage.** This is despite the fact that these ill beneficiaries purchase fewer prescriptions than those with coverage.

• **Nearly half of Medicare beneficiaries do not have coverage for prescription drugs for the entire year.** While 31 percent of beneficiaries had no coverage for the entire year, 47 percent were uninsured for at least one month during the year, making them vulnerable to catastrophic drug costs. This is similar to the proportion of seniors who had no health insurance before Medicare was created in 1965.

• **One out of four Medicare beneficiaries with higher income (greater than 400**

percent of poverty or about $45,000 for a couple) has no coverage for prescription drugs throughout the year. This contradicts the belief that lack of coverage is a problem only for those with low-incomes. Similarly, the uninsured are not just healthy people who do not need coverage -- almost 30 percent of Medicare beneficiaries in poor health do not have drug coverage.

- **Rural and older beneficiaries are particularly vulnerable.** Rural Medicare beneficiaries are over 50 percent more likely to lack prescription drug coverage for the entire year than urban beneficiaries (43 to 27 percent). People age 85 and older are one-third more likely to lack coverage than those ages 65 to 69 (37 to 28 percent).

- **Medigap private insurance and Medicare managed care are particularly unstable.** Almost 48 percent of beneficiaries with drug coverage through Medigap policies and 29 percent who were enrolled in Medicare HMOs had drug coverage for only part of the year. Beneficiaries with part-year coverage have spending and utilization that more closely resembles that of the uncovered people -- using fewer medications and having higher out-of-pocket spending.

President WILL ANNOUNCE THAT ADMINISTRATION WILL hold a conference on drug costs and pricing practices. As the HHS study makes clear, not enough is known about costs and prevalent pricing practices by the pharmaceutical industry. To further the policy debate, HHS in collaboration with the private sector will convene a conference this summer including representatives of beneficiaries, purchasers, pharmacists, pharmaceutical manufacturers and researchers to clarify actual pricing and discounting practices and their impact on Medicare beneficiaries. Topics covered may include:

- **Pricing practices:** What are and what determines the pattern of cash discounts and rebates offered by manufacturers to different customers; to what extent are drug formularies influenced by price and other incentives; how has the growth of third-party pharmacy benefit managers affected the pricing structure of the industry; what explains geographical variations in prescription drug prices.

- **Models**: What are the best purchasing, delivery and quality improvement practices for prescription drugs; what is the best way to ensure continued innovation within the pharmaceutical industry under a Medicare prescription drug benefit.

STUDY RESULTS CALL FOR ENACTMENT OF PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

The study's findings underscore the need for a voluntary Medicare prescription drug benefit that is accessible and affordable to all beneficiaries. The President's plan would give these elderly and disabled beneficiaries the option to purchase a prescription drug benefit that covers half of all drug costs up to $5,000 when fully phased in and includes a stop-loss provision to protect seniors against catastrophic drug costs. Its premiums would be affordable to both beneficiaries and the program; it would be competitively administered; and it would assure access to needed medications. The President's prescription drug benefit is part of a larger plan to strengthen and

modernize Medicare. This plan also includes reforms to make Medicare more competitive and efficient and dedicates $432 billion to Medicare to help pay for the prescription drug benefit and to improve the program's financing, helping to extend the life of its trust fund to at least 2030.

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Message Sent To:

EXECUTIVE SUMMARY

Prescription drugs play an ever-increasing role in modern medicine. New medications are improving health outcomes and quality of life, replacing surgery and other invasive treatments, and quickening recovery for patients who receive these treatments. As important as prescription drugs are, not everyone has access to them. The newest drugs are often the most expensive, and millions of Americans - especially elderly and disabled Medicare beneficiaries - have inadequate or no insurance coverage for drugs. Nearly a third of all Medicare beneficiaries have no financial protection for the costs of drugs, if they can obtain them at all. Many additional beneficiaries find themselves moving in and out of the protection provided by insurance over the course of a year.

Medicare has generally excluded coverage of outpatient prescription drugs, as was common in private health plans when the program was enacted in 1965. Since then drug coverage has become a standard feature of private insurance, and it has become clear that the omission of outpatient drug coverage represents a crucial gap in protection for the most vulnerable Medicare beneficiaries. As part of a broader plan to modernize Medicare, President Clinton has proposed a new, voluntary Medicare drug benefit that would offer all beneficiaries access to affordable, high-quality prescription drug coverage while maintaining the fiscal integrity of the program. In Congress, there has also been growing bipartisan interest in finding ways of extending drug coverage.

As policymakers consider options to ensure that every American can have access to innovative drug treatments, there is an urgent need for comprehensive and reliable information on drug coverage, drug spending, and drug prices. On October 25, 1999, the President directed the Secretary of Health and Human Services to study prescription drug costs and trends for Medicare beneficiaries. He asked that the study investigate:

- price differences for the most commonly used drugs for people with and without coverage;
- drug spending by people of various ages, as a percentage of income and of total health spending; and
- trends in drug expenditures by people of different ages, as a percentage of income and of total health spending.

This report is the Department's response to that request. It represents the work of individuals and agencies throughout the Department, including the Agency for Healthcare Research and Quality (AHRQ), the Food and Drug Administration (FDA), the Health Care Financing Administration (HCFA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Chapter 1: Prescription Drug Coverage

While today, over 85 percent of Medicare beneficiaries use at least one prescription drug annually, beneficiaries must obtain drug coverage through a supplemental policy, by enrollment in a Medicare+Choice plan which includes coverage for prescription drugs, or through Medicaid. The result has been a patchwork of coverage that is not dependable, affordable, or accessible to all beneficiaries. Chapter 1 uses survey data to examine the sources of drug coverage for both the Medicare and non-Medicare population, describes the economic and demographic characteristics of those who have drug coverage and those who do not, and analyzes current trends in drug coverage.

Analysis of data on the duration of coverage for the Medicare population is also presented. Differences in coverage rates by alternative measures of health status are explored. Lastly, trends in drug coverage for the Medicare and non-Medicare population are analyzed.

Key findings include:

- Only 53 percent of Medicare beneficiaries had drug coverage for the entire year of 1996, although 69 percent had coverage for at least one month during the year.

- Most sources of drug coverage are potentially unstable. Almost 48 percent of beneficiaries with drug coverage through Medigap and 29 percent who were covered through Medicare HMOs had drug coverage for only part of the year. Additionally, while employer-sponsored retiree coverage, the most prevalent single source of drug benefits, covered 32 percent of Medicare beneficiaries in 1996, 14 percent of those beneficiaries had only part year coverage from their former employers.

- Drug benefits are becoming less generous. There is considerable evidence that cost sharing for prescription drugs is increasing and that overall caps on coverage are both becoming more common and are being set at lower levels. For example, Medicare+Choice plans generally have reduced drug benefits and increased enrollee out-of-pocket costs in 2000. Eighty-six percent of plans have annual dollar limits on drugs, including 70 percent of plans with annual caps of $1000 or less, and 32 percent with caps of $500 or less per enrollee - levels that are up from 35 percent and 19 percent in 1998.

- Drug coverage is likely to decline as fewer employers offer health benefits to future retirees. For example, one employer survey recorded a drop from 40 percent in 1993 to 28 percent in 1999 in the number of large firms offering health benefits to Medicare eligible retirees. Additionally, employers have tightened eligibility rules and increased cost-shifting to retirees. Of those employers that still offer medical coverage, the survey found that 40 percent are requiring Medicare-eligible retirees to pay the full cost of their benefits, compared to 28 percent in 1995.

- Beneficiaries with incomes between 100 percent and 150 percent of poverty (that is, individuals age 65 or older with incomes between $7,527 and $11,287 in 1996) have the lowest rate of coverage. Although coverage varies by income, nearly one-fourth of beneficiaries with incomes over 400 percent of poverty lack coverage.

- Beneficiaries are less likely to have coverage if they are very old or live outside of a metropolitan area. About 37 percent of beneficiaries age 85 and above lacked coverage at any time during 1996 compared to 28 percent of beneficiaries age 65 through 69. About 43 percent of beneficiaries living in rural areas lacked drug coverage, compared to 27 percent of beneficiaries living in urban areas.

- Coverage rates vary little by self-reported health status, but are considerably higher for those with five or more chronic conditions. But by all measures, at least one-fourth of those in any category of health status lack coverage.

- Nearly one in four in the non-Medicare population never had any coverage for drugs in 1996. About 80 percent of those with full-year coverage got that coverage through employers.

Chapter 2: Effects of Prescription Drug Coverage on Spending and Utilization

Insurance coverage for prescription drugs makes a major difference in the amount of drugs people obtain, in how much they spend on drugs out of pocket, and in how much is spent in total on their behalf. People with coverage not only fill more prescriptions than those without coverage; they are likely to have access to a broader array of therapies, including more costly therapies. People without drug coverage face greater financial burdens and may sometimes be unable to follow the courses of treatment ordered by their physicians. There are even some indications that physicians themselves may recommend different therapies to people with and without coverage. Coverage increases prescription drug utilization, and reduces financial burdens for all population groups. However, access to drug coverage is most important for the elderly, simply because they require more medications, including a higher prevalence of long-term maintenance drugs for chronic conditions.

Chapter 2 presents detailed comparisons of utilization and spending (including out-of-pocket spending) for Medicare beneficiaries and the total population with and without drug coverage. It also examines some of the possible reasons for those differences and considers the consequences of being without coverage. Finally, it summarizes trends in utilization and spending and some of the factors that influence these changes.

Key findings include:

- Medicare beneficiaries with coverage fill nearly one-third more prescriptions than those without coverage.
- Although total drug spending for beneficiaries with coverage is nearly two-thirds higher, those without coverage pay nearly twice as much out of pocket ($463 versus $253).
- On average, beneficiaries with coverage pay out of pocket for about one-third of their total spending on drugs. However, the share of spending paid out of pocket varies by source of coverage, from 58 percent for those with Medigap coverage to 20 percent for those with Medicaid.
- Differences in utilization and spending between Medicare beneficiaries with and without drug coverage generally hold up across different income levels, ages, health status, and other categories.
- Drug insurance makes an especially large difference in dollar terms for those in the poorest health. Among beneficiaries with five or more chronic conditions, those with coverage had much higher total spending ($1,402 versus $944) and much lower out-of-pocket spending ($412 versus $944) than beneficiaries without coverage.
- Self-selection does not explain the difference in spending between Medicare beneficiaries with and without drug coverage. Even among beneficiaries with the same poor health status, more prescriptions are filled by people with coverage.
- Among people who are not Medicare beneficiaries, similar differences in utilization and spending exist between prescription drug users with and without coverage. Those with coverage for drugs fill two-thirds more prescriptions but spend a third less out of pocket than

those without coverage.

- About a third of Medicare beneficiaries accounted for three-fourths of beneficiaries' total drug spending in 1996. Only 13 percent had no spending at all. Spending on prescription drugs in the non-Medicare population is even less evenly distributed.

- Prescription drugs take up about one-sixth of all health spending by the elderly. Out-of-pocket spending for prescription drugs is a larger proportion of health spending for the elderly than for younger people. Prescription drug spending also accounts for a larger share of spending by people with low incomes than it does for people with higher incomes.

- The burden of prescription drug costs creates access problems for some beneficiaries. Among Medicare beneficiaries, 10 percent of those with only Medicare coverage report not being able to afford a needed drug, compared to 2 percent of those with a non-Medicaid supplement.
-

- Drug spending has grown more quickly than other health spending throughout the 1990's. Price increases, higher utilization, and the use of newer, more expensive drugs all play a part in increasing drug spending.

Chapter 3: Prescription Drug Prices

In today's market for prescription drugs, most insurers obtain significant discounts on behalf of their insured beneficiaries. Individuals without coverage thus face not only the burden of paying for the entire cost of the drugs they need out of pocket, but they may also face higher prices for a given drug than do insurers and other large purchasers. Sorting out the differences in prices paid by those with and without coverage is not simple. The process by which prescription drug prices are determined is highly complex, involving numerous interactions and arrangements among manufacturers, wholesalers, retailers, insurers, pharmacy benefit managers (PBMs), and consumers.

In order to explain the complexity of this market, Chapter 3 begins with a description of the distribution channels for prescription drugs and how prices are established for different purchasers. It then offers an empirical analysis of whether prices paid for drugs at the retail level differ between cash customers and those with insurance coverage, using data from two sources: the Medical Expenditure Panel Survey (MEPS) and a widely used private sector data source on drug prices, IMS Health. A key limitation on the analysis of drug prices in this study, however, is our inability to incorporate the effect of rebates provided by manufacturers to insurers and PBMs. Given the greater market leverage of third party payers relative to individual consumers, it might be expected that cash customers will pay more than insurers for the same drugs at the retail pharmacy. Results from both sources, despite the absence of rebate data, support this hypothesis.

Key findings include:

- At the retail pharmacy level:

  Individuals without drug coverage pay a higher price at the retail pharmacy than the total price paid on behalf of those with drug coverage (based on analysis of MEPS data that do not include rebates but look across all drug purchases holding drug type, form, strength, and quantity constant). The differences generally held up when examining the Medicare and non-Medicare

populations.

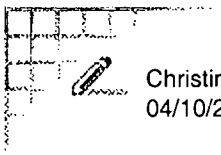
Cash customers (including those without coverage and those with indemnity coverage) pay more for a given drug than those with third party payments at the point of sale (based on IMS Health data for over 90 percent of the most commonly prescribed drugs). In 1999, excluding the effect of rebates, the typical cash customer paid nearly 15 percent more than the customer with third party coverage. For a quarter of the most common drugs, the price difference between cash and third parties was even higher - over 20 percent. For the most commonly prescribed drugs, the price difference between cash customers and those with third party coverage grew substantially larger between 1996 and 1999.

The pattern of differences in the price paid by cash customers and those with third party payments is different for generic and brand name drugs (based on both MEPS and IMS Health data). Percentage differences in the price paid are often smaller for brand name drugs, but absolute differences may be larger because average prices for brand name drugs are considerably higher.

- Data on manufacturer rebates, if available, would reduce the total amount paid by the insurer or PBM on behalf of insured customers, increasing the difference in the total net price. Data on rebate arrangements, however, are confidential and unavailable to this study. In some instances, the amount of the rebate may be significantly more than the price differences observed at the retail pharmacy level. In other cases, the rebates may add only modestly to the observed differences.

- Various sources produce estimates of rebates ranging from 2 percent to 35 percent of drug sales prices. These rebates are not reflected in retail prices, but are instead paid directly to insurers and other organizations that manage drug benefits after they have already reimbursed the pharmacy.

This study presents a detailed examination of multiple factors relating to coverage, utilization, and spending for prescription drugs, particularly by the Medicare population. It also raises a variety of issues that are ripe for further investigation. Suggestive relationships between demographic factors, insurance status, and prescription drug use were revealed. However, we were unable to examine the more complex interrelationships among these factors. Future multivariate analyses will allow us to come to a more nuanced understanding of these relationships. Future research should explore what can be learned from using more sophisticated definitions of drug coverage status and severity of illness than were available for this study. In addition, if more data were available on elements of manufacturer pricing, such as rebates, further research could probe more fully the differences in prices paid by different customers. Finally, ongoing analyses will allow us to continue to use the most recent data - rapid change in the pharmaceutical market requires that analyses be refreshed and updated on a continuing basis. Some possible avenues for future research are explored at the conclusion of this report.



Christine L. Anderson
04/10/2000 01:08:56 PM

Record Type: Record

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

cc:

Subject: Statement by the President: HHS Report on Prescription Drug Coverage, Spending, and Pricing Practices

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release **April 10, 2000**

STATEMENT BY THE PRESIDENT

Today's release of the Department of Health and Human Services' report on prescription drug coverage, spending, and pricing practices provides further evidence of the need for a voluntary, affordable Medicare prescription drug benefit that is available to all beneficiaries. This report makes clear that uninsured seniors not only lack prescription drug coverage, but also are denied the significant discounts and rebates that those with coverage receive. This price gap is wide and growing. It's time to level the playing field for both coverage and prices for all of America's seniors.

Although the HHS report provides the most comprehensive analysis to date on prescription drugs, there is still much that needs to be learned and conveyed to the general public and to policy makers on this important issue. For this reason, I am also announcing that the Administration will hold a national conference this summer on drug pricing and discounting practices and their impact on Medicare beneficiaries and pharmaceutical innovation. I believe this conference will help us determine how the best purchasing and quality improvement practices from the private sector can be incorporated into a Medicare prescription benefit.

I am encouraged that there is growing support from both parties to address the prescription drug cost and coverage problems that burden our nation's seniors and people with disabilities. As today's report makes clear, the challenge of prescription drug coverage for the uninsured and underinsured Medicare populations is one that afflicts millions of beneficiaries of every age and income level. However, we must make certain that any legislative proposal is more than a benefit in name only. As I have said repeatedly, the only way this issue can be adequately remedied is through a Medicare drug benefit that is voluntary, affordable, accessible, and administered competitively, using the most successful private practices to negotiate

discounts on behalf of seniors. It should enacted in the context of broader reform that modernizes and strengthens the program. I believe that the release of today's report shows how vital it is to reach this goal.

30-30-30

Message Sent To:

Uninsured seniors charged more for prescription drugs

Report: Many without coverage skip medicine

By Susan Page
USA TODAY

WASHINGTON — Older Americans who lack insurance for prescription drugs not only have to pay for the drugs, but they are also charged 15% more than what insurance companies pay.

As a result of the higher costs, people without insurance coverage are five times more likely than those with insurance to report that they didn't take a drug that they needed in the past year.

Those findings are contained in a study the White House will release today. The study examines the costs and usage of prescription drugs for seniors and disabled people in the Medicare program.

The report is sure to become fodder in the political debate over whether and how to provide drug coverage through Medicare, the federal government's health plan for the elderly.

When President Clinton ordered the study in October, he accused the pharmaceutical industry of telling "flat-out falsehoods" about his prescription proposal, particularly through a series of TV ads featuring an older woman named "Flo."

The report, written by the Health and Human Services Department, was supposed to be competed in 90 days, but it took nearly twice that long. It portrays seniors as increasingly reliant on prescription drugs but facing costs that are rising more than twice as fast as other health-care costs.

The lack of drug coverage isn't limited to the poor; more than half of those who lack coverage have incomes that put them more than 150% above the poverty line.

The availability of coverage affects medical treatment, the study finds.

"Insurance coverage for prescription drugs makes a major difference in the amount of drugs people obtain, in how much they spend on drugs out of pocket, and in how much is spent in total on their behalf," says the report, a copy of which was obtained by USA TODAY.

"People without drug coverage face greater financial burdens and may sometimes be unable to follow the courses of treatment ordered by their physicians. There are even some indications that physicians themselves may recommend different therapies to people with and without coverage."

Among the findings:

- The gap in the price of drugs charged to those with and without insurance coverage has nearly doubled in three years, to 15% last year from 8% in 1996.
- Medicare beneficiaries who lack prescription coverage buy one-third fewer drugs but pay nearly twice as much out-of-pocket as those with coverage.
- About one in 10 of those who lack coverage say they weren't able to afford a needed drug in the past 12 months, compared with about one in 50 among those who had coverage.
- Rural residents were 50% more likely to lack coverage than those in urban areas. Clinton will announce today that the administration will hold a conference this summer on drug costs and pricing practices. Beneficiaries, purchasers, pharmacists, pharmaceutical manufacturers and researchers are invited to attend.

Alan Holmer, president of PhRMA, a trade association for the pharmaceutical industry, issued a brief statement Sunday that criticized Clinton's approach. Industry officials say that a direct drug benefit through Medicare, as Clinton has proposed, ultimately could lead to price controls. Some Republicans have proposed subsidizing drug coverage for low-income people through private insurers.

"Expanded drug coverage is the answer, but the president's plan is the wrong solution," Holmer said. "Seniors need to be able to choose the private insurance plan that's best for them, not a big government, one-size-fits-all scheme. Momentum is growing in the Congress for a private-sector approach, and we hope the president joins in that initiative."

Schools' many standards don't cover safety plans

By Tamara Henry
USA TODAY

SAN FRANCISCO — As school officials fortify their buildings against violence, the lack of uniform safety standards to guide educators on matters such as installing metal detectors and hiring police patrols may hinder their efforts, school safety and security officials say.

But William Sidoran, chief of school police in Florida's Brevard County, got lukewarm response over the weekend when he proposed laying the groundwork for safety standards to a group of school security officials from across the country who met here to discuss violence prevention. Sidoran says the need for standards is underscored by the increasing fear of school violence with the approach of April 20, the first anniversary of the Columbine High School shootings.

"Post-Columbine, everybody understands that they need something, but they don't truly understand what they need and how much of it," he says.

Sidoran says the standards can simply require schools to have written policies to help determine deployment of such things as surveillance equipment or quantify the need for police officers.

"We don't have a ruler or yardstick for what administrators, what school districts or what police departments should do to provide a reasonable due-diligence standard of safe schools," he says.

The Houston Independent School District is one example of that, says Bruce Marquis, chief of school police in the Texas district. He strongly supports the creation of standards. "While national standards are a problem, we don't even have it across the state," he says.

As Houston schools install surveillance equipment, Marquis says, there are no standards to ensure that each school uses either the same or compatible equipment. Aside from the inability to coordinate the technology systemwide, if there is equipment failure, a school cannot go to the school district warehouse and get replacements, he says.

While there are standards for school utilities, occupancy, curriculum and even dress, they are notably absent from the national focus on school safety, both men say.

"There's a standard in every school district for fire alarms; there is no standard for intrusion or burglary alarms," Sidoran says.

And there's no agency or organization that keeps track of which states have standards and what they may be. Sidoran says law enforcement and hospital security standards would be an excellent model.

But the standards proposal would be difficult to implement, says Bill Modzeleski, director of the U.S. Department of Education's Safe and Drug Free Schools section. The USA has 15,000 school districts, and no set of standards would work in them all, he says.

HHS Cites 15% Higher Costs For Medicare Patients' Drugs

By Juliet Eilperin
Washington Post Staff Writer

A1

The Clinton administration is releasing a study today documenting that Medicare recipients pay an average of 15 percent more for prescription drugs than patients whose insurers have negotiated discounts, in an effort to pressure Congress to enact a universal drug benefit for senior citizens this year.

President Clinton, who ordered the Department of Health and Human Services last fall to conduct the survey, is scheduled to announce today that the White House will hold a conference on drug pricing this summer that will include representatives from the pharmaceutical industry.

The move comes as lawmakers debate whether to provide prescription drug coverage for the elderly before Congress adjourns this fall. Seniors are a key swing vote in the November elections, and Democrats are seeking to make drug benefits a pivotal question, with Senate candidates from Michigan to Montana transporting seniors across the border to Canada so they can fill their prescriptions for less money.

Even Republican Sen. Slade Gorton, who is seeking reelection from Washington state this year, is proposing that drug companies be prohibited from charging more for drugs in the United States than they do in Mexico and Canada. As many as 50 House Democrats are planning to hold prescription drug-related events in their districts during this month's spring recess.

White House officials said the study, which also shows that the gap between drug prices for people with and without insurance doubled between 1996 and 1999, demonstrates why Congress should adopt the president's plan to provide prescription coverage for all Medicare recipients. Clinton's plan would cover half of all drug costs up to $5,000 a year per person once it was fully implemented in 2009 and includes $35 billion for seniors with catastrophic drug costs during the last five years of the plan.

"The report underscores the need for a voluntary prescription drug care benefit for all Medicare beneficiaries, not only because it would provide needed insurance coverage but because it would utilize private sector negotiating practices to achieve discounts and rebates that would accrue to the benefit of seniors," said a White House official who asked not to be identified. "The president believes it just provides more attention to the need for prompt action by the Congress to pass legislation in this area."

House Republicans are planning to unveil their own prescription drug proposal this week, though their plan differs markedly from the president's. GOP lawmakers are focusing on providing private drug coverage to low-income seniors, and they have put aside $40 billion in the budget over the next five years to pay for a benefit and broader reforms in the Medicare program.

Rep. Bill Thomas (R-Calif.), who chairs the House Ways and Means health subcommittee and is helping to draft the GOP's plan, noted that in 2003 Clinton's plan applies to just $2,000 in drug costs, forcing seniors to shoulder the rest of their expenses.

"The point is all of this data clearly indicates that what seniors need is a private drug insurance plan that protects seniors from high out-of-pocket costs," Thomas said in an interview yesterday. "The president's plan doesn't do that, and we will present one that does."

Insurance industry representatives such as Health Insurance Association of America President Chip Kahn have objected to a stand-alone prescription drug benefit, saying they will be blamed once health insurance costs rise dramatically as a result. But Thomas said insurers were "just being typical naysayers" and added the GOP plan includes a proposal for "Medicare modernization" that would make it more affordable than the president's over the next decade. According to Congressional Budget Office estimates, Clinton's plan would cost $149 billion over 10 years.

The HHS study takes direct aim at Republican assertions that the elderly poor are most in need of drug coverage, stating that one in four Medicare beneficiaries with annual income four times above the poverty level, or roughly $45,000 for a couple, lack drug coverage each year.

The report emphasizes that because seniors and people with disabilities cannot take advantage of the discounts and rebates that other insured Americans enjoy, they often fail to purchase the drugs they need. About 10 percent of Medicare recipients without drug coverage reported in the last 12 months they did not fill a prescription because they could not afford it, compared to 2 percent who had coverage.

Prescription drug spending is increasing at an annual rate of 12 percent, twice as fast as other health spending, according to the report.

But Pharmaceutical Research and Manufacturers of America President Alan F. Holmer said rising drug costs do not justify administering a new drug benefit through the Medicare program.

"Expanded drug coverage is the answer, but the president's plan is the wrong solution," Holmer said in a statement yesterday. "Seniors need to be able to choose the private insurance plan that's best for them, not a big government, one-size-fits-all scheme. Momentum is growing in the Congress for a private sector approach, and we hope the president joins in that initiative."

The Washington Post
Monday, April 10, 2000

PUBLIC LIVES

Independent No Longer Alone in Fight Over Drug Costs

By ROBIN TONER

WASHINGTON

THE pharmaceutical industry has a lot of problems in Washington these days, its prices and profits proving an irresistible target for politicians with hard-pressed elderly constituents and an election on the horizon.

But there are few more persistent irritants than Representative Bernard Sanders, the democra[illegible] socialist from Vermont who[illegible]e of two independents in the House. Mr. Sanders, a gruff-spoken 58-year-old native of Flatbush, Brooklyn, with a thatch of white hair and a rumpled 60's-academic style, has twice taken elderly constituents on well-publicized trips to Canada to buy prescription drugs, highlighting the lower prices across the border.

Susana Raab for The New York Times

Bernard Sanders says pharmaceutical companies are on the defensive.

He has pushed legislation that he said would allow American pharmacists and distributors to "reimport" prescription drugs approved by the Food and Drug Administration from Canada and Mexico and sell them at lower costs.

When a lobbying alliance backed by the pharmaceutical industry set up a Web site to highlight the problems in the Canadian health care system (www.busfromcanada.org), Mr. Sanders quickly countered with a Web site about the inequities of American drug pricing and the legislative proposals to deal with them (bernie.house.gov/bustocanada).

In an interview on Thursday night, Mr. Sanders had the quiet glow of a man who believed that political lightning was finally striking his cause.

"You're dealing here not just with an economic issue or even a health care issue, you're dealing with a very profound moral issue," he said. "Time is long overdue for the Congress to stand up to these people and protect the American people."

Jac[illegible]ttrell, a spokeswoman for the Pharmaceu[illegible]d Research and Manufacturers of America, responded, "What's moral is to make sure medicines are available through insurance coverage, but also to make sure that Congressman Sanders and his allies don't stifle our ability to invent medicines that help and heal."

Mr. Sanders has focused on this issue since the 1980's when he was the mayor of Burlington, Vt., and created a task force on health care. Medicare, the health program for the elderly, generally does not cover outpatient prescription drugs, and a third of its elderly beneficiaries have no drug coverage at all. "You can't walk down a main street in Vermont without someone coming up and saying, 'Bernie, you've got to do something about the high cost of prescription drugs,' " he said.

THESE days, of course, nearly everyone says he wants to do something to help the elderly with drug costs, but Mr. Sanders stands out. He believes not only in new prescription drug coverage for the elderly, and not only in finding a way to end what he considers price discrimination against American consumers, but in a publicly financed national health insurance program, a Canadian-style system administered by the states, for everyone.

He does not seem to worry much about the drug industry's arguments that its prices in the United States are necessary to cover the cost of research. He said he met with some industry lobbyists last year and remembers that they were wearing "fancy shoes." He spoke not with irony but — to use his word — with "contempt."

In an age of careful centrism, there is an archaic quality to Mr. Sanders' political speech, not to mention a razor's edge.

"I know what it's like to live in a family without any money," he said, "the economic suffering that is totally unnecessary" among the uninsured, the working poor and many of the elderly. His father, who immigrated from Poland at the age of 17, was a paint salesman. "He worked very hard. He never made a lot of money," Mr. Sanders said in a quick staccato, his eyes focused on the floor. "Lack of money was a constant stress on my parents' relationship and in our household."

Mr. Sanders' only sibling, a brother, became a social worker. Mr. Sanders himself, after a year at Brooklyn College, went to the University of Chicago on a combination of loans, grants and part-time jobs. He was a lackluster student, he wrote in his autobiography, but "learned a lot more from my out-of-class activities" in groups like the Congress of Racial Equality and the Young People's Socialist League.

He moved to Vermont in the late 1960's, working at a mixture of state government, carpentry and writing jobs, and ultimately ended up in politics. Initially, he had little success, but he was elected mayor of Burlington from 1981 to 1989, and in 1990 won Vermont's only House seat, the first independent elected to Congress in 40 years. Mr. Sanders has four children, and his wife, Jane O'Meara Sanders, has been a key adviser in his political career.

While he tends to align with the Democrats, he said he never considered becoming one. Why?

"Both major political parties are heavily influenced by big money," he said. He noted that in nine years in Congress, he has spent one weekend in Washington. He talked scornfully of the journalists and the politicians who spend their time talking to one another, with "no sense of what's going on in the real world."

Mr. Sanders clearly feels he has the drug industry on the defensive. "What I try to do here is not to be an ideologue, but to talk issues," he said. "And when you talk issues, people respond positively." Still, he acknowledges, "I sometimes scratch my head that somebody like me ever made it to the U.S. Congress."

The New York Times

MONDAY, APRIL 10, 2000

The New York Times MONDAY, APRIL 10, 2000

White House Challenges Drug Companies for Charging Higher Prices to the Uninsured

By ROBERT PEAR

WASHINGTON, April 9 — The White House attacked the pricing policies of the drug industry today, saying drug companies charged higher prices to uninsured customers than to people with insurance, and President Clinton announced plans to hold a conference this summer to investigate how pharmaceutical companies set their prices.

The actions came as Mr. Clinton tried to fire up public support for Medicare coverage of prescription drugs, one of his top goals in his last year in office.

A new study, to be unveiled by Mr. Clinton on Monday, found that elderly people without insurance for drug costs typically pay 15 percent more than people with insurance for the same medicines. Moreover, it said, this gap has more than doubled in the last four years.

"Individuals without drug coverage pay a higher price at the retail pharmacy than the total price paid on behalf of those with drug coverage," said the report, which Mr. Clinton requested last October. "Seniors without drug coverage not only lack insurance against high costs, but do not have access to the discounts and rebates that insured people receive."

Medicare, the federal health insurance program for 39 million people who are elderly or disabled, generally does not cover prescription drugs for people outside the hospital. Many beneficiaries have some type of supplemental insurance to help pay drug costs, but the White House said such coverage was shrinking and was unreliable.

Seeking support for Medicare coverage of prescription drugs.

In its new study, the White House said that Medicare beneficiaries without drug insurance spent twice as much of their own money on prescriptions, but bought one-third fewer drugs than people with coverage. Health maintenance organizations and other large health insurance plans can obtain discounts for their members that are not generally available to individuals paying cash for prescription drugs, the report said.

Spokesmen for the drug industry said they agreed with the government's finding that insurance could help consumers get discounts on prescription drugs. And that, they said, was why they wanted the government to subsidize private insurance to cover such costs for Medicare beneficiaries.

"Expanded drug coverage is the answer," said Alan F. Holmer, president of the Pharmaceutical Research and Manufacturers of America, the trade group. "But the president's plan is the wrong solution. Seniors need to be able to choose the private insurance plan that's best for them, not a big government one-size-fits-all scheme."

Federal officials said drug prices were determined by a complex process that involved discounts, rebates and other financial arrangements among drug manufacturers, wholesalers, pharmacists and insurers.

The drug industry regards the details of those arrangements as proprietary information. But the White House said the conference on "prescription drug pricing practices" would investigate such rebates and discounts.

Chris Jennings, the White House health policy coordinator, said the administration and Congress needed information about drug discounts and rebates to help them design prescription drug benefits for Medicare.

"There is a basic need for policy makers to understand how this works," Mr. Jennings said in an interview.

"Medicare should use the best techniques of the private sector and should extract similar discounts from the pharmaceutical industry."

The Clinton administration's efforts to obtain such data are sure to cause apprehension among drug companies, which already fear that the White House wants to regulate drug prices, despite its protests to the contrary.

The White House said, "Our analysis tends to understate the ultimate price differences for insured and uninsured customers," because the government could not get data on rebates. Drug makers pay such rebates to benefit management companies that enhance their "market share" by including their products on a list of recommended drugs.

In the last month, the House and the Senate have endorsed budget blueprints that would provide up to $40 billion over five years for Medicare drug benefits. But President Clinton has not begun serious negotiations with Congress on how to design such a benefit.

These are some of the obvious questions: How much should the beneficiary pay in premiums, deductibles and co-payments? How much of each prescription should the government pay? Should Medicare provide special protection to people needing very expensive drugs? Should the government subsidize drug benefits even for high-income people?

The new report, "Prescription Drug Coverage, Spending, Utilization and Prices," makes these points:

¶Spending for prescription drugs is growing more than twice as fast as other health spending. From 1993 to 1998, drug spending increased an average of 12 percent a year, compared with an increase of about 5 percent a year for all other types of health spending.

¶Ten percent of Medicare beneficiaries without drug coverage reported that they needed a prescription medicine in the last year but did not get it because they could not afford it. Only 2 percent of beneficiaries with drug coverage reported having had such an experience.

¶About one-third of Medicare beneficiaries have no insurance to help them buy prescription drugs. Forty-seven percent of beneficiaries are uninsured for at least one month of the year; 53 percent have drug coverage for the entire year.

¶Nearly one-fourth of Medicare beneficiaries with incomes exceeding four times the poverty level — more than $45,000 a year for a couple — have no insurance coverage for prescription drugs. "This contradicts the belief that lack of coverage is a problem only for those with low incomes."

In addition, the White House said, the oldest Medicare beneficiaries are most likely to lack drug coverage. About 37 percent of beneficiaries 85 and older lack coverage, compared with 28 percent of beneficiaries age 65 to 69.

REPUBLICANS' PRESCRIPTION DRUG PROPOSAL: DESIGNED FOR THOSE WHO SELL DRUGS, NOT THOSE WHO NEED THEM

April 12, 2000

The House Republican Leadership recently released a broad outline of a proposal on prescription drugs for Medicare beneficiaries. It appears that the Republicans' proposal was developed more for those who sell drugs than those who need them. It provides no details of the premium for the policy, what the basic benefit would cover, or how much it would cost the Medicare program. The details that are in the Republican leadership's outline, which is consistent with proposals supported by the pharmaceutical industry, raise serious concerns, including (1) covering prescription drugs through drug-only private insurance plans rather than Medicare, even though insurers have raised doubts about their willingness to offer such policies; (2) limiting premium assistance for its basic benefit to beneficiaries with income up to 150 percent of poverty ($12,600 for a single and $17,000 for couples), leaving out millions of uninsured and underinsured seniors; and (3) encouraging private plans to participate by having the government bear most of the risk of covering sick beneficiaries.

RENEGES ON FUNDING COMMITMENT FOR MEANINGFUL PRESCRIPTION DRUG BENEFIT

- **The Republicans' budget chairmen have acknowledged that their budget resolution uses only half -- $20 billion – of its Medicare reserve for prescription drugs.** This is insufficient to finance a meaningful, affordable, accessible drug benefit for all beneficiaries. The Republicans have also refused to spell out their 10-year funding commitment for prescription drugs, raising the prospect that it is significantly underfunded, primarily due to their tax cut whose costs will explode after 2005.

DOES NOT ASSURE AVAILABILITY OF PRESCRIPTION DRUG COVERAGE

- **Private plans not required, and likely will not offer, coverage in all areas.** Relying solely on private insurers rather than providing plan choices through Medicare is likely to be an empty promise. Today, Medigap covers prescription drugs for only about 10 percent of Medicare beneficiaries. Although the proposal aims to encourage more private plans to participate by protecting them against high costs, it would not ensure that even a single private plan will offer coverage in all areas of the country. Moreover, major representatives of the insurance industries have stated that they have no desire to participate in this program. Thus, even those seniors qualifying for means-tested, direct premium assistance are not assured access to a private plan to provide them affordable coverage.

NOT AFFORDABLE FOR MOST SENIORS, EVEN IF IT IS AVAILABLE

- **Premiums much higher than the President's voluntary plan.** Its drug only, private insurance policy design assures that the premium will be significantly higher than the President's plan and will expose seniors and people with disabilities to significant out-of-pocket costs before the benefit begins. Moreover, direct premium assistance is limited to those with incomes below $13,000 to $17,000. This leaves out half of Medicare beneficiaries lacking drug coverage today, including a widow with income of $15,000 and a woman with Alzheimer's disease whose husband has income of $25,000.

NO SPECIFIED BENEFIT

- **Lack of a specific benefit asks the Congress and the public to buy a "pig in a poke".** Republicans would ask that Congress vote for a plan without a design, instead allowing a private plans and independent "entity" to make the critical decision about what type of prescription drug coverage seniors would get. Despite this flexibility, its design almost inevitably would result in plans with a high deductible, high premium, or both which would result in millions of beneficiaries continuing to have high out-of-pocket costs.

REPUBLICAN PRESCRIPTION DRUG PLAN: RHETORIC DOES NOT MATCH REALITY

Rhetoric: *"Expands seniors' right to choose the coverage that best suits their needs through a voluntary and universally-offered benefit."*

Reality: Unless the plan includes a mandate on private insurance to participate, there is no guarantee that prescription drug coverage will be "universally offered." Seniors in rural or high-risk communities may have a hard time finding a prescription drug plan, even if they qualify for the means-tested assistance.

Rhetoric: *"Lowers drug prices and expands access to prescription drugs for all beneficiaries...."*

Reality: This proposal will not lower prices for all beneficiaries since all beneficiaries will not be able to afford it – assuming that they even have an option at all. The Republicans have means tested their premium assistance to those with income below is $12,600 for a single and $17,000 for couples. Thus, a widow with income of $20,000 will face a premium that could easily more than twice the current Part B premium of $45.50.

Rhetoric: *"The plan provides coverage and security against escalating out-of-pocket drug costs for every Medicare beneficiary by setting a monetary ceiling beyond which Medicare would pay 100% of beneficiaries' costs. By contrast, the President's plan leaves beneficiaries vulnerable to pay full and unlimited drug costs above $2,000."*

Reality: The outline of the Republican plan does not include a specific policy for stop-loss protection. While the President also has not yet specified his stop-loss limit, he has explicitly dedicated $35 billion in surplus to assure that Medicare beneficiaries have meaningful protection against excessive out-of-pocket spending on medications.

Rhetoric: *"Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again."*

Reality: Private Medigap insurers today rarely negotiate for discounts, instead paying for half of the retail price for prescription drugs. The only way that the Republicans can assure that beneficiaries will "never" again pay retail prices is to mandate that private insurers negotiate for price discounts, which seems unlikely.

Rhetoric: *"The proposal invests $40 billion of the non-Social Security surplus to strengthen Medicare and offer prescription drug coverage to every beneficiary. The five-year investment sets aside $5.2 billion more than the President's plan."*

Reality: The Republican chairmen of the budget committees stated that only $20 billion of the $40 billion would be dedicated to prescription drugs – much less than what the Republican plan claims. Moreover, the Republican budget does not commit to any funding after 5 years, probably because the surplus will be used for a large and irresponsible tax cut – not a meaningful Medicare prescription drug benefit.

Rhetoric: *"Preserves and protects Medicare to keep program solvent for future generations."*

Reality: The Republican outline released today does not include a single specific policy that affects solvency or protects the program. In contrast, the President's plan, according to the Medicare actuary and Congressional Budget Office, not only adds a meaningful prescription drug benefit but slows Medicare growth, dedicates $299 billion of the non-Social Security surplus and extends the life of the Medicare trust fund to at least 2030.

MEDICARE PRESCIPTION DRUGS
POTUS GUIDANCE

The White House is strongly criticizing the Republican prescription drug benefit. What are your concerns about this proposal, and does this mean that any possibility of a compromise on prescription drugs this year is dead?

First of all, I do believe it is encouraging that the Republican leadership has finally talked about working on proposals to provide prescription drug coverage to Medicare beneficiaries. Last year, the Republicans were unwilling to even discuss this issue, and this year, they are saying that they want to address it.

While this is an encouraging development, the major problem is that their policies don't match their rhetoric. Their approach is underfunded, unlikely to be available to all beneficiaries, and likely to be unaffordable to millions of seniors and people with disabilities, even if it is available in some places.

Just this week, we learned that the Republican budget committee chairmen are dedicating as little as half of the $40 billion they previously committed to improving the Medicare program to a prescription drug benefit. Moreover, they are refusing to release 10 year numbers on their proposal because they know their exploding tax policy will eat up virtually all revenue necessary to adequately fund a drug benefit after 5 years.

And because they're relying on the private insurers to voluntarily offer a drug-only benefit (that the industry itself has said they cannot support), this policy cannot be guaranteed to be available to all seniors in need of a drug benefit.

Furthermore, because they only provide direct subsidies to seniors with annual incomes of under $12,600, their benefit will not be an affordable option even if it's available. This would be the first time in the program's history that we did not provide premium assistance to the benefits we provide to all beneficiaries, and I believe it would completely undermine the social insurance concept of the program.

Older Americans are not interested in placebos – they are interested in a real drug benefit. It is simply untenable for us not to act on this issue when we know the whole future of health care treatment will become more and more dependant on the use of life-saving medications.

It is my hope that just as the Republicans' interest in this issue has evolved from nothing to good principles but bad policy, that it can further evolve into good policy and good principles.

REPUBLICANS' PRESCRIPTION DRUG PROPOSAL: CONSUMER ADVOCATES KNOW IT IS DESIGNED FOR THOSE WHO SELL DRUGS, NOT THOSE WHO NEED THEM
April 12, 2000

- *Steve Protulis, Executive Director of the National Council of Senior Citizens:*

  "This is just another callous effort by Republican members of Congress to pit moderate income seniors against poor seniors. This plan deserves a grade of 'F' because it fails to cover all Medicare recipients...This plan is so bad that even the insurance companies will balk because they know they'll get blamed when they fail to keep the premiums affordable."

- *Howard Bedlin, NCOA Vice President for Advocacy and Public Policy:*

  "The National Council on the Aging is deeply disappointed that the much-anticipated Medicare prescription drug proposal from the House Republican leadership appears to provide little or no support for more than 60 percent of Medicare beneficiaries...Medicare was never intended to be a welfare program for the poor. A fundamental principle of Medicare is that affordable benefits should be available to all seniors, regardless of income."

- *Brian Lindberg, Leadership Council of Aging Organizations Health and Long Term Care Committee Chair:*

  "The Republican proposal appears to fail Medicare beneficiaries in two specific ways: access and affordability...By means-testing the benefit and subsidies, this proposal moves Medicare away from its universal approach and towards a welfare approach."

- *Martha McSteen, President of the National Committee to Preserve Social Security and Medicare:*

  "The National Committee is committed to a program that will serve all Medicare eligible older adults and individuals with disabilities with an affordable, voluntary benefit. This proposal fails to meet this standard."

- *Consortium for Citizens with Disabilities Health Task Force:*

  "[The] Republican plan for prescription drugs is an incremental approach to eliminating the entitlement to Medicare one benefit at a time...A separate private insurance plan didn't work for Medicare beneficiaries 35 years ago, and it won't work for prescription drugs for Medicare beneficiaries now."

- *American Association of People with Disabilities:*

  "We are concerned...that the Republican proposal does not build on the existing social insurance coverage model of Medicare but instead seeks to create incentives for private insurers to provide such coverage. The people who need prescription drug benefits the most – people with chronic conditions that require expensive medications – do not typically do well in a private insurance market."

- *John Sweeney, President of the AFL-CIO*

  "Unfortunately, the proposal offered today by House Republican leaders offers seniors little hope of getting access to essential but increasingly expensive drugs prescribed by their physicians. The proposal does not reform Medicare at all and fails to modernize the program to meet the needs of today's seniors."

G.O.P. Drug Coverage Plan Is to Include Private Insurers

By ROBERT PEAR

WASHINGTON, April 11 — House Republicans said today that their proposal for Medicare coverage of prescription drugs, to be announced this week, would use private insurance subsidized by the government to help pay drug costs for millions of people who are elderly or disabled.

The announcement will be a milestone on the road to such coverage, a firm proposal by leaders of the majority party in the House that says how they would spend up to $40 billion over the next five years.

A Republican working on the proposal said today: "Our plan is very similar to the president's, but better. We'll offer a voluntary drug benefit, available to all Medicare beneficiaries and run by the private sector, as the president wants."

President Clinton specifies details of the basic drug benefit, including the co-payments charged to beneficiaries; House Republicans will invite private insurers to offer a variety of competing drug plans.

"You could pick the policy that best suited you, depending on your needs and your income," said a Republican working on the proposal. "There would be more choice, more variety in the design of benefits."

House Republicans will announce their proposal a few days before the spring recess, when Democrats plan to hit the issue hard in political events around the country. "Our guys couldn't go home empty-handed," one representative said.

Comparing their proposal with Mr. Clinton's, House Republicans said their plan would provide more definite protection to people with high drug expenses; less insurance for routine, ordinary drug expenses, and less of a subsidy to affluent Medicare beneficiaries.

Under the president's plan, the government would directly subsidize premiums for everyone who signed up for drug benefits. Under the House Republican plan, the main subsidy would be indirect: the government would pay most of the costs for a small number of beneficiaries with the highest drug expenses, so insurers could charge lower premiums to everyone else.

Republicans in the House said they, like Mr. Clinton, would also provide financial assistance to low-income beneficiaries. The details have not been decided, they said, but they want to pay the premiums and perhaps other costs for people with incomes up to 35 percent or 50 percent above the poverty level. Under federal guidelines, a couple is classified as poor if they have less than $11,250 of income this year.

A milestone on the road to prescription drug coverage.

Chris Jennings, the health policy coordinator at the White House, said he did not know all the details of the House Republican proposal. "But from what we gather," he said, "it appears to be a structurally unworkable policy that does not ensure access to affordable prescription drugs for all beneficiaries."

House Republicans said they had consulted with the presidential campaign of Gov. George W. Bush. But the proposal was devised mainly by senior Republicans on the two House committees that share authority over Medicare. Speaker J. Dennis Hastert supervised the process; Representative Bill Thomas of California had the biggest role in shaping the proposal.

Both the House and the Senate have approved budget blueprints that would provide up to $40 billion over five years for Medicare drug benefits, roughly the same amount envisioned in the first five years of the Clinton plan.

In a document describing their proposal, House Republicans said it would provide "a voluntary private drug coverage option for all seniors." This approach is favored by the drug industry but opposed by the Health Insurance Association of America, which says its members are not interested in selling drug insurance because they could not keep the premiums affordable.

House Republicans said they would try to overcome the insurance industry's objections by having the government pick up most of the cost for a small number of beneficiaries with high drug expenses. This would permit insurers to charge lower premiums — and is therefore a kind of indirect subsidy — to all beneficiaries who buy drug coverage.

Drug expenses are highly concentrated; 5 percent of Medicare beneficiaries have drug costs exceeding $5,000 a year, but they account for 29 percent of all spending on drugs by people in Medicare's conventional fee-for-service program.

House Republicans will not be too specific this week. But they said that under their proposal, the government might pay 80 percent of the costs for the 5 percent of beneficiaries with the highest drug expenses. Insurers would be responsible for the remainder of those costs, so they would have a financial incentive to control the use of prescription drugs, Mr. Thomas said.

While clearly not embracing the House Republican plan, Charles N. Kahn III, president of the Health Insurance Association of America, said: "This proposal is different from others we have seen in the past. We need to study it before we decide what position to take on it."

Lisa J. Raines, senior vice president of Genzyme, the biotechnology company, said: "The House Republican proposal for a high-risk insurance pool, with significant federal subsidies, is an important intellectual contribution to the debate. This could bring down premiums 25 percent below what they would otherwise be. It would help drug-benefit plans manage their financial exposure, thereby making the Medicare market more attractive to them."

House Republicans said they would create a new entity, separate from the agency that now runs Medicare, to administer the drug program. Republicans said the new entity, known as the Medicare board, could eventually supervise the health maintenance organizations that now provide care to 6.6 million of the 39 million Medicare beneficiaries.

A summary of the Republican proposal, prepared by the House Commerce Committee, describes it this way: "All Medicare beneficiaries would have the option of purchasing drug coverage through the board. The board would contract with insurers operating on both a local and national basis and would provide information to beneficiaries about their options."

House Republicans said they assumed that insurers would work with companies that have years of experience in managing drug benefits. Such "pharmacy benefit managers" typically negotiate with drug manufacturers to obtain large discounts for their customers.

The New York Times
WEDNESDAY, APRIL 12, 2000

Bush Adviser Apologizes for Lobbying Effort

By JOEL BRINKLEY

WASHINGTON, April 11 — Ralph Reed, a senior consultant to Gov. George W. Bush's presidential campaign, apologized today for lobbying the governor on behalf of the Microsoft Corporation and promised not to lobby him again on behalf of Microsoft or anyone else.

"It is an error that we regret," said a statement issued by Mr. Reed's office at Century Strategies, the lobbying and political consulting firm he heads.

The Bush campaign, obviously irritated to learn that one of its senior consultants was also lobbying the campaign behind the scenes, said Mr. Reed "made the right decision," adding, "We're pleased that he will cease his effort to lobby the governor on this issue."

A campaign official said the governor had not known that Mr. Reed's organization was lobbying him.

An article today in The New York Times said Century Strategies was carrying out a quiet lobbying campaign on behalf of Microsoft to persuade prominent Bush supporters to write Governor Bush on behalf of Microsoft in an effort to undermine the government's antitrust suit against the company.

Last week, a federal judge ruled that Microsoft was in violation of federal and state antitrust laws. Within a couple of months, the judge will issue his penalty, or remedy, in the case. It could range from forcing Microsoft to modify its business practices to breaking up the company.

Microsoft explained that the lobbying effort was intended to counter "a comprehensive lobbying campaign by our competitors," who have been urging lawmakers and political candidates to support the government's antitrust suit and call for a tough remedy. A lobbyist familiar with the Century Strategies effort said one aim had been to persuade Mr. Bush to speak out on Microsoft's behalf in opposition to the government's lawsuit.

The Microsoft-Century Strategies lobbying effort had just begun. Late last month, John Podner, senior projects manager for Century Strategies, sent e-mails to local lobbying firms across the country, asking them to send him résumés of the Bush supporters who were to write the letters. Mr. Podner said he wanted to make sure they were sufficiently prominent and influential.

The lobbying campaign was to continue through the end of this month. So far, however, the Bush campaign has received just one letter from a Bush supporter on behalf of Microsoft, a Bush spokesman said.

Mr. Reed has worked for Microsoft since 1998, the statement said, but only recently began lobbying Governor Bush on behalf of the company. The statement said the Century Strategies campaign to lobby Mr. Bush was part of "a broader program to encourage citizens to express their views to presidential candidates of both parties, including Al Gore and Bill Bradley."

Both the Bush campaign and Century Strategies said Mr. Reed had never personally lobbied Mr. Bush and asked him to take a position on the Microsoft case.

Still, the company's statement said, "In an abundance of caution and to avoid any further misconception, this company has adopted a policy that we will no longer encourage citizens to make their views known to Governor Bush on behalf of Microsoft or any other clients in the future."

This evening, Microsoft spokesman Mark Murray, responding to the Century Strategies statement, said: "We think this is a fine resolution to the issue involving Century Strategies and the Bush campaign. We will continue to work with Century Strategies and other firms, both Democratic and Republican, to respond to attacks by competitors and to insure that our viewpoint is heard."

The New York Times

WEDNESDAY, APRIL 12, 2000

April 11, 2000

Drug Prices and Medicare

Forum

- Join a Discussion on Editorials

The Department of Health and Human Services issued a report yesterday that highlighted alarming disparities in prescription drug costs for Medicare beneficiaries. The Medicare recipients who lack drug coverage are charged significantly more -- and are thus forced to do without medicine more often -- than Medicare recipients who have obtained drug coverage one way or another.

Currently, about a third of Medicare beneficiaries have no drug coverage at all. The rest have drug coverage through plans provided by former employers, Medigap plans that they buy themselves, Medicaid, or through Medicare health maintenance organizations that provide drug benefits.

The new study found that Medicare recipients without drug coverage were typically charged 15 percent more for the same drug at the pharmacy than were individuals whose drug costs had been negotiated by insurers or by pharmacy benefit managers, companies that administer and negotiate drug prices for health plans. That is because those large entities are able to obtain price discounts for drugs from pharmacy chains. The report does not even take into account direct rebates from manufacturers that insurers and benefit managers can get for increasing a manufacturer's market share in a particular drug field. Such rebates can further reduce the price of prescription drugs between 2 and 35 percent.

The price disparities make a persuasive case for providing a drug benefit for all Medicare beneficiaries. A key part of President Clinton's Medicare drug benefit plan would allow those currently without drug coverage to get lower drug prices by using pharmacy benefit managers to negotiate with retailers and manufacturers. Several competing proposals in Congress also include contracting with private benefit managers to get group price discounts, though the plans differ in details.

The market is working unfairly against the elderly who have no drug coverage. Medicare reform must give them the means to use their collective purchasing power in getting better prices on prescription drugs.

Patient's Bill of Rights

In Session

Congress

Negotiators Say Patients' Bill Has Vital Signs

By Helen Dewar
Washington Post Staff Writer

Congress' target date for passage of legislation to protect patients in managed-care plans will come and go at the end of this week, with negotiators still far from agreement on the most glaring differences between House and Senate versions.

But key players say they are making important progress and remain cautiously optimistic about prospects for a deal before election-year politics makes it impossible.

After several weeks of talks, negotiators have agreed on many specific patient protections and say they are close on the critical issue of an appeals process that patients can use if they feel they have been improperly denied treatment.

Assistant Senate Majority Leader Don Nickles (R-Okla.), chairman of the conference, said Thursday he believes "we're pretty darn close" to an agreement on appeals. Sen. Edward M. Kennedy (D-Mass.) said he thinks agreement on appeals can be reached this week.

But the negotiators have not even begun to discuss the two mega-issues: whether to allow lawsuits against HMOs, permitted by the House but not the Senate, and whether to cover all 191 million privately insured patients, as the House would do, or just the 56 million in certain federally regulated plans, as in the Senate version.

Nickles, a leading foe of allowing lawsuits, said in what appeared to be a sign of flexibility on the issue that he believes a strong appeals process will help eliminate the risk of rampant litigation and lessen any impact on health care costs.

WANTED: The check is probably not in the mail, but Senate Foreign Relations Committee Chairman Jesse Helms (R-N.C.) figures he's made his point.

When he discovered that the State Department was plastering buildings in Europe with "wanted" posters offering up to $5 million for information leading to the apprehension of three accused Serbian war criminals, Helms dashed off a note to Secretary of State Madeleine K. Albright.

"I have the information you are looking for," Helms wrote her last week. And the reward money, he added, could be sent to one of his favorite charities in North Carolina, the Rev. Franklin Graham's Samaritan's Purse.

Finding the three men should not be all that difficult, Helms suggested. Yugoslav President Slobodan Milosevic, one of the accused, recently laid a wreath at a grave site and can otherwise be found at the "Presidential Palace, 15 Uzicka Street . . . Belgrade," Helms said. Gen. Ratko Mladic, who led Bosnian Serb military forces, recently "took a leisurely afternoon stroll" down a Belgrade street and attended a soccer match at a Belgrade stadium. Radovan Karadzic, the former Bosnian Serb president, "remains in the Pale area of Bosnia—living in the midst of thousands of NATO peacekeepers—where he has been seen regularly in public in recent months."

A State Department official, who noted that a key Bosnia Serb leader was arrested by NATO troops last week, wondered if Helms would support funding for the "hundreds of thousands of ground troops" who would be required to round up the rest of the suspects.

Helms is still awaiting an official response—and the check.

HONORING THE REAGANS: Former president Ronald Reagan and Nancy Reagan will be given Congress's highest honor—a Congressional Gold Medal—under legislation making its way through Congress. The House overwhelmingly approved the proposal last Monday and the Senate is expected to follow suit shortly.

In speeches, House members hailed Reagan for his role in ending the Cold War and restoring optimism to this country. They also praised the former first lady's efforts to help prevent drug and alcohol abuse among young people and to focus attention on Alzheimer's disease, which afflicts her husband.

The award, which dates to the earliest days of the Republic, was last awarded to Rosa Parks in 1999 in recognition of her contribution to the civil rights movement.

THE WEEK AHEAD: The Senate will consider a Republican bill to provide tax relief for married couples and another measure that would roll back at least part of the federal gasoline tax. The House will vote on several tax bills, along with one to reward states that impose tough sentences for gun-related crimes. Both chambers will start their spring break at the end of the week: one week for the Senate, two for the House.

Final 04/28/00 3pm
Josh Gottheimer

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON PATIENTS BILL OF RIGHTS AND PRESCRIPTION DRUGS
THE WHITE HOUSE
April 28, 2000

Good morning. Next week, when the full Congress returns from its Easter recess, they will have less than 75 working days left to make this a year of real progress for the American people. There is no more important critical piece of unfinished business than our need to ensure that every American -- young and old -- has adequate, affordable health care. Today, I want to again urge the Congress to step up to this challenge by making the passage of a strong patients bill of rights and the provision of a voluntary Medicare prescription drug benefit top priorities when they get back to Washington. This critical health care legislation is long overdue.

The more than 190 million Americans who use managed care or other insurance plans have waited too long for a strong, enforceable patients' bill of rights. They deserve the right to see a specialist; the right to emergency room care whenever and wherever they need it; and the right to hold health care plans accountable for harmful decisions.

Last year, in an overwhelmingly bipartisan vote, the House passed a strong patients' bill of rights that provides the right protections all Americans need and deserve. And it's a bill that I would sign. But more than six months later, the bill is still languishing in Congress. Despite their pledge to complete a real bill, the Republican majority has not only delayed action, it's actually considering legislation that would leave tens of millions of Americans without federal protections. A right that cannot be enforced isn't a right at all – it's just a request. We need a strong bill that protects all Americans, in all plans -- not one that provides more cover for the special interests, than real coverage for patients.

Congress also has an obligation to strengthen Medicare and modernize it with a voluntary affordable prescription drug benefit. No one creating a Medicare program today would even think of excluding coverage for prescription drugs. Yet more than three in five older Americans still lack affordable and dependable prescription drug coverage. Our seniors deserve better.

Just this week we saw further evidence of the unacceptable burden the growing cost of prescription drugs is placing on seniors Americans. According to a report by the non-profit group, Families USA, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years running. That's a burden that falls hardest on seniors who lack drug coverage -- because they simply don't receive the price discounts that most insurers negotiate.

Seniors and people with disabilities living on fixed incomes simply cannot continue to cope with these kinds of price increases. That is why we must take action to help them -- not next year or the year after that, but this year. My budget includes a comprehensive plan to

modernize Medicare, and provide for a long overdue prescription drug benefit for all beneficiaries.

I'm pleased that there is growing bipartisan support for tackling this challenge. Earlier this month, Republican leaders in the House put forth the skeletal outline of a plan that offers, as a stated goal, access to affordable coverage for older Americans. Unfortunately, their plan falls short of meeting that goal. Instead, it would subsidize insurance companies to offer prescription-drug-only policies for middle-income seniors -- policies the insurance industry itself has already said it will not offer. And because the plan would provide direct support only to low-income seniors and disabled Americans, it would do nothing for those with modest, middle-class incomes between $15,000 and $50,000. Nearly half of all Medicare beneficiaries who lack prescription drug coverage fall into that category.

Conventional wisdom says that nothing substantive can get done in an election year. But if you're a member of a managed care plan or an older American who depends on life-saving drugs to keep you out of the hospital, you don't care about partisan politics. You just care about getting well and staying well.

So I say to Congress, when you get back to Washington next week, let's get back to work on a strong and enforceable patients bill of rights. Let's get back to work on a voluntary Medicare prescription drug benefit. The healthcare of Americans is too important to be sidetracked by partisan politics. The need is urgent, and the time to act is now.

Thanks for listening.