

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
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001. fax	Rep. McGovern to Chris Jennings re: phone number (partial) (1 page)	11/02/1998	P6/b(6)
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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20463

FOLDER TITLE:

Massachusetts and Drugs [Folder 2]

2012-0463-S

rc783

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES
WASHINGTON, DC 20510-6300

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PATTY MURRAY, WASHINGTON
JACK REED, RHODE ISLAND

DATE:

10/19/98

TO:

Chris Jennings

FAX NUMBER:

456-5537

FROM:

David Nixon

(202) 224-7675 phone

(202) 224-3533 fax

NUMBER OF PAGES:

4

(including cover)

MESSAGE:

If you have trouble receiving this fax, please call (202) 224-7675

REVISED**LANGUAGE TO CLARIFY STATE PREEMPTION FOR APPROPRIATIONS BILL**

The BBA created a section (sec. 1856 (b) (3)) that excluded Medicare+Choice plans from state laws or regulations that require coverage of benefits, certain providers, etc. This was done primarily as a preemptive strike to prevent plans from being subject to future state laws; however, it also effectively repeals a state law in Massachusetts that ensures the availability of drug coverage for Medicare beneficiaries in managed care plans. No other state had such a law for prescription drug coverage.

The amendment/language

The following language is a targeted fix that would grandfather state laws on prescription drugs that were in effect prior to enactment of BBA, but allow continued preemption of all state laws passed after BBA's enactment:

Nothing in paragraph (3) of section 1856 (b) of the SSA shall be construed as to supersede any state law or regulation in effect on the date of enactment of the Balanced Budget Act of 1997 that requires coverage of prescription drugs.

To ensure compliance, the language also requires the affected plans to resubmit information required under 1854(a) within 15 days after enactment. Without the resubmission requirement, MA HMOs will be caught between state and federal laws. It does not affect Medicare coverage policy or spending.

Budgetary effect

Per Tom Bradley at CBO, this language has no budgetary effect.

Background

Massachusetts has had in effect for four years a state law that requires all Medicare plans to provide beneficiaries with an optional prescription drug benefit. Approximately 75 percent of the 211,000 beneficiaries who are enrolled in Medicare HMOs in the state currently purchase this benefit. The plans charge beneficiaries an extra premium for the benefit. The inclusion or exclusion of the benefit has no bearing on federal outlays or the payments made by HCFA to the plans, but it is very important for senior citizens in Massachusetts.

There is precedent for treating one state differently than another in title XVIII under the Medigap provisions. When Medigap standardization passed, three states (MA, WI, and MN) were given waivers from the standardization. In Massachusetts, the state law requires both Medigap and M+C plans to offer the same drug benefit. The market has been working well in the state, but the upcoming effective repeal of this law is causing chaos among the plans and the beneficiaries. The requirement on Medigap plans will remain, but M+C plans will be free to cancel or significantly reduce benefits. If the Massachusetts law is not grandfathered before this Congress adjourns, up to 150,000 seniors will lose most or all of their prescription drug benefits, effective January 1, 1999.

Contact: Cybele Bjorklund, 224-7675

October 12, 1998 12:30 p.m.

O:\GOE\GOE98.284

S.L.C.

AMENDMENT NO. _____

Calendar No. _____

Purpose: To clarify the non-preemption of certain State laws
in connection with Medicare+Choice plans.

IN THE SENATE OF THE UNITED STATES—105th Cong., 2d Sess.

(no.) _____

(title) _____

Referred to the Committee on _____
and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. KENNEDY

Viz:

1 At the appropriate place, insert the following:

2 SEC. ____ CONSTRUCTION CLARIFYING NON-PREEMPTION

3 OF CERTAIN STATE LAWS IN CONNECTION

4 WITH MEDICARE+CHOICE PLANS.

5 (a) IN GENERAL.—Nothing in paragraph (3) of sec-

6 tion 1856(b) of the Social Security Act (42 U.S.C. 1395w-

7 26(b)) shall be construed as to supersede any State law

8 or regulation in effect on the date of enactment of the

9 Balanced Budget Act of 1997 that requires the coverage

10 of prescription drugs.

O:\GOE\GOE98.284

S.L.C.

2

1 (b) INFORMATION SUBMITTED TO SECRETARY.—Any
2 entity that has submitted information to the Secretary of
3 Health and Human Services under section 1854(a) of the
4 Social Security Act (42 U.S.C. 1395w-24(a)) in order to
5 offer a Medicare+Choice plan in 1999, shall resubmit
6 such information to the Secretary by not later than 15
7 days after the date of enactment of this Act if such plan
8 will be affected by the provision in subsection (a).

O:\GOE\GOE98.284

S.L.C.

2

1 (b) INFORMATION SUBMITTED TO SECRETARY.—Any
2 entity that has submitted information to the Secretary of
3 Health and Human Services under section 1854(a) of the
4 Social Security Act (42 U.S.C. 1395w-24(a)) in order to
5 offer a Medicare+Choice plan in 1999, shall resubmit
6 such information to the Secretary by not later than 15
7 days after the date of enactment of this Act if such plan
8 will be affected by the provision in subsection (a).

Withdrawal/Redaction Marker

Clinton Library

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TO CHRIS
JENNINGS.

f: 456-5557

FROM: (Jim's PHONE:

P6(b)(6)

[061]

REP. MCGOVERN

RE: SATURDAY'S PHONE
CALL

HCFA & MA/HMOs.

Kennedy

Mike & Jane talking
to Nixon & Michael
Myers

① even if we gave them
more time, they couldn't
get an agreement, so
why should we wait.

② doesn't foreclose
anything we are trying
to tell them.

③ bennies in plans
that aren't real.
rules in MA about
medigap plans.

④ Fallon charges \$75
w/copays.

MA & HMDS.

Kennedy made a
pitch for Thursday -

Mike told them that
HGFA will go ahead.

didn't want to brief all
ahead of time.

Mike Myers ... do what
HGFA needs to do -
wants to discuss w/ someone
there before mtg begins.

talk tomorrow morning
talked to McCann's
office - mainly
concerned about FALLON.



HEALTH CARE FINANCING ADMINISTRATION

**ADDRESSEE:***Devorah***FROM:***Peter*

OFFICE OF THE ADMINISTRATOR
200 INDEPENDENCE AVE., S.W.
ROOM 314G
WASHINGTON, DC 20201

PHONE: _____

PHONE: 202-690-6726
FAX : 202-690-6262 .

TOTAL PAGES:**ADDRESSEE'S FAX MACHINE NUMBER:****DATE:****REMARKS:**

Business

D

Comics D16
Deaths D17
Business opportunities D20

THE BOSTON GLOBE • TUESDAY, NOVEMBER 10, 1998

Medex Gold enrollment halt sought

Blue Cross fears stampede of seniors over drug benefit

By Alex Pham
GLOBE STAFF

Blue Cross and Blue Shield of Massachusetts said it wants the Legislature to shut off enrollment for one year to its Medex Gold supplemental insurance for seniors who are currently on Medicare.

Advocates for the elderly said the plan to close Medex Gold was "unacceptable" because it would cut off the only option Massachusetts seniors will have for unlimited drug coverage.

Medex Gold will be the only insurance plan in Massachusetts that covers unlimited prescription drugs for seniors starting Jan. 1, when Medicare health maintenance organizations begin to limit how much they will pay for drugs.

■ US health agency, state's HMOs to meet on senior coverage limits. D6.

The controversy came to a head last month when a federal judge ruled that HMOs were exempt from a state mandate to offer unlimited prescription benefits, the only one of its kind in the nation.

At 54,000 Massachusetts seniors now pay \$208 a month for Medex Gold, a supplemental insurance that pays medical bills not covered by Medicare, including drugs. Blue Cross is required by state law to sell a plan with unlimited drug benefits.

The Blue Cross proposal, which would require approval from state lawmakers, would prevent seniors who are currently eligible for Medicare from buying Medex Gold in 1999. It would not apply to seniors who become newly eligible for Medicare in 1999.

The request was part of a larger proposal announced last week by Blue Cross to set up a foundation to fund unlimited drug coverage for 7,500 seniors who currently receive drug benefits as members of Blue Care 65, its HMO for seniors. Blue Cross said it would set up the foundation regardless of whether the Legislature agreed to restrict enrollment

BLUE CROSS, Page D6

LEVEL 1 - 18 OF 24 STORIES

Copyright 1990 The Time Inc. Magazine Company
Fortune

April 23, 1990, Monday

SECTION: THE FORTUNE 500; Who Did Best And Worst; Pg. 391

LENGTH: 432 words

HEADLINE: INDUSTRY MEDIAN

BODY:

✓ RETURN
ON SALES

	1989	1988
PHARMACEUTICALS	13.0%	13.5%
MINING, CRUDE-OIL PRODUCTION	9.6	3.3
BEVERAGES	8.1	8.0
FOREST PRODUCTS	7.1	8.7
PUBLISHING, PRINTING	6.5	7.1
METAL PRODUCTS	6.2	4.6
CHEMICALS	6.1	6.9
COMPUTERS (INCL. OFFICE EQUIP.)	5.9	6.2
TOBACCO	5.4	7.8
METALS	4.8	6.2
FURNITURE	4.5	5.6
APPAREL	4.4	4.3
SOAPS, COSMETICS	4.4	5.3
SCIENTIFIC AND PHOTO, EQUIP.	4.2	5.0
ELECTRONICS	4.2	5.1
RUBBER AND PLASTICS PROD.	4.1	4.4
INDUSTRIAL AND FARM EQUIP.	3.6	4.3
AEROSPACE	3.3	3.6
PETROLEUM REFINING	3.3	4.7
TRANSPORTATION EQUIPMENT	3.0	3.1
MOTOR VEHICLES AND PARTS	2.7	3.5
FOOD	2.6	2.8
BUILDING MATERIALS	2.2	4.5
TEXTILES	1.9	3.5
THE 500 MEDIAN	4.7	5.5

✓ RETURN
ON ASSETS

	1989	1988
PHARMACEUTICALS	14.0%	13.1%
FURNITURE	7.9	8.8
SOAPS, COSMETICS	7.8	8.9
PUBLISHING, PRINTING	7.7	7.3
FOREST PRODUCTS	7.3	8.4
BEVERAGES	6.8	6.8
METAL PRODUCTS	6.7	5.8

1990



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1990 Time Inc., Fortune, April 23, 1990

APPAREL	6.7	6.1
CHEMICALS	6.5	7.5
RUBBER AND PLASTICS PROD.	6.3	6.4
METALS	6.1	8.2
TOBACCO	5.3	6.0
SCIENTIFIC AND PHOTO. EQUIP.	5.2	4.9
FOOD	5.2	6.7
ELECTRONICS	5.2	6.1
COMPUTERS (INCL. OFFICE EQUIP.)	5.0	5.6
PETROLEUM REFINING	4.1	5.3
MINING, CRUDE-OIL PRODUCTION	3.7	1.3
AEROSPACE	3.7	4.9
TRANSPORTATION EQUIPMENT	3.5	5.4
INDUSTRIAL AND FARM EQUIP.	3.3	5.4
TEXTILES	3.0	4.7
BUILDING MATERIALS	2.7	4.9
MOTOR VEHICLES AND PARTS	2.5	3.9
THE 500 MEDIAN	5.9	6.8

✓ RETURN ON
STOCKHOLDERS' EQUITY

	1989	1988
PHARMACEUTICALS	25.5%	23.6%
BEVERAGES	23.2	22.8
TOBACCO	20.1	22.5
SOAPS, COSMETICS	18.4	18.5
METAL PRODUCTS	18.0	12.7
APPAREL	17.5	17.5
FOREST PRODUCTS	16.8	19.8
METALS	16.1	18.4
PUBLISHING, PRINTING	15.6	17.7
FOOD	14.7	15.7
ELECTRONICS	14.1	16.8
FURNITURE	13.9	15.9
CHEMICALS	13.2	16.8
SCIENTIFIC AND PHOTO. EQUIP.	13.0	12.1
COMPUTERS (INCL. OFF. EQUIP.)	12.7	14.7
AEROSPACE	12.0	11.4
RUBBER AND PLASTICS PROD.	11.4	15.8
TRANSPORTATION EQUIPMENT	10.9	13.4
MINING, CRUDE-OIL PRODUCTION	10.6	2.4
PETROLEUM REFINING	10.3	15.3
INDUSTRIAL AND FARM EQUIP.	9.3	12.7
TEXTILES	7.7	10.8
MOTOR VEHICLES AND PARTS	6.9	14.5
BUILDING MATERIALS	4.0	-3.3
THE 500 MEDIAN	15.0	16.2

LANGUAGE: ENGLISH



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LEVEL 1 - 9 OF 11 STORIES

Copyright 1991 The Time Inc, Magazine Company
Fortune

April 22, 1991

SECTION: WHO DID BEST AND WORST; Pg. 330

LENGTH: 1679 words

BODY:

INDUSTRY MEDIAN
RETURN
ON SALES

1991

	1990	1989
✓ PHARMACEUTICALS	13.6%	13.0%
MINING, CRUDE-OIL PRODUCTION	8.7	9.6
BEVERAGES	7.8	8.1
SOAPS, COSMETICS	6.3	4.2
COMPUTERS (INCL. OFFICE EQUIP.)	5.7	5.9
PUBLISHING, PRINTING	5.5	6.4
CHEMICALS	5.5	6.6
SCIENTIFIC AND PHOTO. EQUIP.	4.9	5.1
FOREST PRODUCTS	4.4	7.1
METALS	4.4	4.6
PETROLEUM REFINING	4.0	3.4
METAL PRODUCTS	3.9	6.2
RUBBER AND PLASTICS PRODUCTS	3.6	4.8
AEROSPACE	3.5	3.2
APPAREL	3.3	4.4
ELECTRONICS	3.2	4.2
INDUSTRIAL AND FARM EQUIP.	3.1	3.8
FOOD	3.1	3.6
TRANSPORTATION EQUIPMENT	2.9	3.0
FURNITURE	2.7	4.6
BUILDING MATERIALS	2.4	3.9
MOTOR VEHICLES AND PARTS	1.9	3.0
TOBACCO	1.6	5.4
TEXTILES	0.0	1.9
THE 500 MEDIAN	4.1	4.7

RETURN
ON ASSETS

	1990	1989
✓ PHARMACEUTICALS	13.1%	14.0%
SOAPS, COSMETICS	8.7	7.6
BEVERAGES	7.0	6.8
COMPUTERS (INCL. OFFICE EQUIP.)	6.4	5.9
FOOD	6.2	7.0
CHEMICALS	5.8	6.7
SCIENTIFIC AND PHOTO. EQUIP.	5.7	6.6
RUBBER AND PLASTICS PRODUCTS	5.2	8.0



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1991 Time Inc., Fortune, April 22, 1991

PETROLEUM REFINING	5.0	4.1
METAL PRODUCTS	4.8	6.7
PUBLISHING, PRINTING	4.8	7.7
AEROSPACE	4.6	2.9
MINING, CRUDE-OIL PRODUCTION	4.5	4.2
ELECTRONICS	4.4	5.2
METALS	4.4	6.1
FURNITURE	4.4	7.9
FOREST PRODUCTS	4.3	7.3
APPAREL	4.2	6.7
INDUSTRIAL AND FARM EQUIP.	3.9	3.9
TOBACCO	3.9	5.3
TRANSPORTATION EQUIPMENT	3.7	3.5
MOTOR VEHICLES AND PARTS	2.2	2.5
BUILDING MATERIALS	2.1	4.5
TEXTILES	0.1	3.0
THE 500 MEDIAN	4.8	5.9

RETURN ON

✓ STOCKHOLDERS' EQUITY

	1990	1989
PHARMACEUTICALS	26.4%	25.5%
SOAPS, COSMETICS	18.8	18.9
FOOD	16.5	20.7
BEVERAGES	15.5	23.2
MINING, CRUDE-OIL PRODUCTION	15.1	12.7
TOBACCO	14.8	20.1
PETROLEUM REFINING	13.8	10.4
CHEMICALS	13.8	15.9
ELECTRONICS	13.4	14.5
AEROSPACE	13.4	10.2
APPAREL	12.9	19.5
METAL PRODUCTS	12.9	18.4
COMPUTERS (INCL. OFFICE EQUIP.)	12.0	12.8
SCIENTIFIC AND PHOTO. EQUIP.	11.8	13.0
FURNITURE	11.4	14.0
INDUSTRIAL AND FARM EQUIP.	10.9	12.1
BUILDING MATERIALS	10.8	13.6
METALS	10.7	17.8
PUBLISHING, PRINTING	10.4	15.9
FOREST PRODUCTS	10.1	16.9
RUBBER AND PLASTICS PRODUCTS	9.8	12.9
TRANSPORTATION EQUIPMENT	8.6	10.9
MOTOR VEHICLES AND PARTS	7.2	9.8
TEXTILES	2.9	10.1
THE 500 MEDIAN	13.0	15.0

INDUSTRY MEDIANS

CHANGES IN

SALES

INCREASES

PETROLEUM REFINING	20.0%
MINING, CRUDE-OIL PRODUCTION	13.5
BEVERAGES	13.4



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LEVEL 1 - 34 OF 42 STORIES

Copyright 1992 Time Inc.
Fortune

April 20, 1992, Domestic Edition

SECTION: THE FORTUNE 500/SPECIAL REPORT; Pg. 287

LENGTH: 1955 words

HEADLINE: THE 500 INDUSTRY OVERVIEWS

BODY:

✓ **MEDIANS**CHANGES IN
SALES

RANK	INCREASES
	%
1 .TOBACCO	16.3
2 .PHARMACEUTICALS	10.9
3 .BEVERAGES	7.9
4 .SOAPS, COSMETICS	7.8
5 .COMPUTERS, OFFICE EQUIPMENT	7.2
6 .APPAREL	7.0
7 .SCIENTIFIC AND PHOTOGRAPHIC EQUIP.	5.4
8 .FOOD	5.0
9 .METAL PRODUCTS	3.8
10 .RUBBER AND PLASTICS PRODUCTS	2.9
11 .ELECTRONICS, ELECTRICAL EQUIPMENT	1.9
12 .CHEMICALS	1.3
13 .TRANSPORTATION EQUIPMENT	1.2
	DECREASES %
14 .PUBLISHING, PRINTING	0.0
15 .AEROSPACE	1.0
16 .FURNITURE	1.2
17 .TEXTILES	1.3
18 .MINING, CRUDE-OIL PRODUCTION	1.7
19 .INDUSTRIAL AND FARM EQUIPMENT	3.0
20 .FOREST PRODUCTS	3.6
21 .BUILDING MATERIALS	4.6
22 .MOTOR VEHICLES AND PARTS	5.7
23 .METALS	7.4
24 .PETROLEUM REFINING	7.6

✓ CHANGES IN
PROFITS

RANK	INCREASES
	%
1 .TOBACCO	27.2
2 .SCIENTIFIC AND PHOTOGRAPHIC EQUIP.	16.3
3 .PHARMACEUTICALS	16.0
4 .RUBBER AND PLASTICS PRODUCTS	13.3


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1992

Fortune, April 20, 1992

5 .FOOD	13.2
6 .BEVERAGES	5.9
7 .APPAREL	1.1
8 .COMPUTERS, OFFICE EQUIPMENT	1.1
9 .AEROSPACE	0.7
	DECREASES %
10 .METAL PRODUCTS	1.0
11 .ELECTRONICS, ELECTRICAL EQUIPMENT	9.3
12 .PUBLISHING, PRINTING	10.3
13 .TRANSPORTATION EQUIPMENT	11.7
14 .SOAPS, COSMETICS	12.9
15 .CHEMICALS	17.8
16 .FURNITURE	20.6
17 .INDUSTRIAL AND FARM EQUIPMENT	28.9
18 .FOREST PRODUCTS	39.6
19 .TEXTILES	49.5
20 .METALS	51.8
21 .PETROLEUM REFINING	52.1
22 .BUILDING MATERIALS	53.8
23 .MOTOR VEHICLES AND PARTS	58.7
24 .MINING, CRUDE-OIL PRODUCTION	61.9

✓ TOTAL RETURN
TO INVESTORS, * 1991
RANK

	%
1 .TOBACCO	137.3
2 .RUBBER AND PLASTICS PRODUCTS	90.3
3 .PHARMACEUTICALS	61.5
4 .TRANSPORTATION EQUIPMENT	54.3
5 .APPAREL	52.6
6 .SCIENTIFIC AND PHOTOGRAPHIC EQUIP.	50.2
7 .TEXTILES	45.2
8 .FURNITURE	41.5
9 .METAL PRODUCTS	40.8
10 .BUILDING MATERIALS	39.8
11 .ELECTRONICS, ELECTRICAL EQUIPMENT	37.6
12 .FOREST PRODUCTS	37.5
13 .AEROSPACE	35.5
14 .BEVERAGES	32.3
15 .CHEMICALS	31.9
16 .FOOD	26.7
17 .PUBLISHING, PRINTING	19.4
18 .SOAPS, COSMETICS	19.4
19 .METALS	18.2
20 .MOTOR VEHICLES AND PARTS	16.7
21 .INDUSTRIAL AND FARM EQUIPMENT	15.0
22 .COMPUTERS, OFFICE EQUIPMENT	12.3
23 .PETROLEUM REFINING	0.7
24 .MINING, CRUDE-OIL PRODUCTION	(5.5)
ALL INDUSTRIES	29.5

TOTAL RETURN TO INVESTORS *
1981-91 ANNUAL RATE
RANK

%



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1993

18	TOYS, SPORTING GOODS	2.65
19	COMPUTER, OFFICE EQUIPMENT	2.50
20	CHEMICALS	2.38
21	FOREST AND PAPER PRODUCTS	2.22
22	PUBLISHING, PRINTING	2.18
23	BUILDING MATERIALS, GLASS	2.16
24	PHARMACEUTICALS	1.96
25	MINING, CRUDE-OIL PRODUCTION	1.61
500	MEDIAN	2.92

SALES PER EMPLOYEE

RANK		%
1	PETROLEUM REFINING	607,296
2	MINING, CRUDE-OIL PRODUCTION	306,226
3	TOBACCO	274,652
4	SOAPS, COSMETICS	244,285
5	BEVERAGES	229,580
6	CHEMICALS	227,684
7	FOOD	226,828
8	METALS	185,385
9	FOREST AND PAPER PRODUCTS	181,104
10	PHARMACEUTICALS	178,860
11	TOYS, SPORTING GOODS	178,177
12	COMPUTER, OFFICE EQUIPMENT	177,397
13	BUILDING MATERIALS, GLASS	149,958
14	AEROSPACE	143,036
15	PUBLISHING, PRINTING	140,378
16	INDUSTRIAL AND FARM EQUIPMENT	138,793
17	MOTOR VEHICLES AND PARTS	138,659
18	METAL PRODUCTS	136,499
19	RUBBER AND PLASTICS PRODUCTS	135,660
20	SCI., PHOTO., AND CONTROL EQUIP.	132,810
21	ELECTRONICS, ELECTRICAL EQUIP.	123,998
22	TRANSPORTATION EQUIPMENT	122,354
23	FURNITURE	102,674
24	TEXTILES	98,804
25	APPAREL	63,725
500	MEDIAN	169,201

✓ MEDIAN

RETURN ON SALES

RANK		1992 %	1991 %
1	PHARMACEUTICALS	11.5	12.8
2	TOYS, SPORTING GOODS	6.5	--
3	SOAPS, COSMETICS	5.8	5.1
4	PUBLISHING, PRINTING	5.7	5.2
5	SCI., PHOTO., AND CONTROL EQUIP.	5.6	5.3
6	MINING, CRUDE-OIL PROD.	5.1	4.8



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7	METAL PRODUCTS	4.3	3.4
8	FURNITURE	4.0	2.1
9	FOOD	3.4	3.5
10	RUBBER AND PLASTICS PROD.	3.0	3.4
11	ELECTRONICS, ELECTRICAL EQUIP.	2.9	2.7
12	TOBACCO	2.6	2.1
13	APPAREL	2.5	3.4
14	CHEMICALS	2.3	3.9
15	TEXTILES	2.2	1.4
16	FOREST AND PAPER PRODUCTS	2.1	2.5
17	BEVERAGES	2.1	5.5
18	COMPUTER, OFFICE EQUIP.	1.0	4.9
19	INDUSTRIAL AND FARM EQUIP.	1.0	4.9
20	PETROLEUM REFINING	0.2	1.5
21	AEROSPACE	0.1	3.3
22	TRANSPORTATION EQUIPMENT	(0.3)	2.4
23	METALS	(1.2)	1.5
24	MOTOR VEHICLES AND PARTS	(1.3)	0.3
25	BUILDING MATERIALS, GLASS	(3.0)	(3.6)
500	MEDIAN	2.4	3.1

✓ RETURN OF ASSETS

RANK		1992 %	1991 %
1	PHARMACEUTICALS	11.7	12.1
2	TOYS, SPORTING GOODS	8.8	--
3	SOAPS, COSMETICS	8.1	6.8
4	FURNITURE	6.7	3.3
5	FOOD	6.6	7.1
6	SCI., PHOTO., AND CONTROL EQUIP.	5.9	6.3
7	TOBACCO	5.2	1.6
8	PUBLISHING, PRINTING	4.9	5.1
9	RUBBER AND PLASTICS PROD.	4.6	5.2
10	METAL PRODUCTS	4.5	4.3
11	APPAREL	4.2	6.1
12	ELECTRONICS, ELECTRICAL EQUIP.	3.2	3.1
13	TEXTILES	2.9	1.5
14	BEVERAGES	2.3	5.8
15	CHEMICALS	2.2	4.1
16	MINING, CRUDE-OIL PROD.	2.0	2.5
17	FOREST AND PAPER PRODUCTS	1.7	1.8
18	COMPUTER, OFFICE EQUIP.	1.5	4.9
19	PETROLEUM REFINING	0.3	2.8
20	INDUSTRIAL AND FARM EQUIP.	0.3	2.3
21	AEROSPACE	0.1	4.4
22	TRANSPORTATION EQUIPMENT	(0.1)	3.2
23	METALS	(1.2)	1.8
24	MOTOR VEHICLES AND PARTS	(1.9)	0.3
25	BUILDING MATERIALS, GLASS	(2.1)	(3.6)
500	MEDIAN	3.1	3.6



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RETURN ON COMMON EQUITY

✓ RANK		1992	1991
		%	%
1	PHARMACEUTICALS	26.7	26.1
2	TOBACCO	21.9	5.2
3	TOYS, SPORTING GOODS	17.0	--
4	FOOD	15.6	19.7
5	SCI., PHOTO., AND CONTROL EQUIP.	15.4	14.3
6	SOAPS, COSMETICS	14.4	14.7
7	METAL PRODUCTS	12.1	11.7
8	FURNITURE	12.0	10.2
9	APPAREL	11.6	13.6
10	PUBLISHING, PRINTING	11.3	10.7
11	RUBBER AND PLASTICS PROD.	10.6	11.6
12	CHEMICALS	10.5	12.6
13	TEXTILES	9.8	4.6
14	BEVERAGES	9.7	21.1
15	ELECTRONICS, ELECTRICAL EQUIP.	9.1	10.7
16	MINING, CRUDE-OIL PROD.	7.0	7.7
17	FOREST AND PAPER PRODUCTS	5.7	4.8
18	COMPUTER, OFFICE EQUIP.	4.6	10.2
19	AEROSPACE	3.6	12.4
20	TRANSPORTATION EQUIPMENT	3.6	8.9
21	PETROLEUM REFINING	2.0	8.5
22	INDUSTRIAL AND FARM EQUIP.	1.2	6.0
23	MOTOR VEHICLES AND PARTS	(11.1)	0.7
24	METALS	(13.2)	5.2
25	BUILDING MATERIALS, GLASS	(26.0)	(0.7)
500	MEDIAN	9.1	10.2

TOTALS

Note: This table may be divided and additional information on a particular entry may appear on more than one screen.

RANK		SALES	PROFITS	Rank
		\$ mil.	\$ mil.	
1	PETROLEUM REFINING	414,232	6,174	3
2	MOTOR VEHICLES AND PARTS	310,276	(31,078)	26
3	FOOD	215,199	9,910	2
4	ELECTRONICS, ELECTRICAL EQUIPMENT	194,259	6,172	4
5	CHEMICALS	173,694	(4,069)	23
6	COMPUTER, OFFICE EQUIPMENT	146,557	(6,051)	25
7	AEROSPACE	134,954	(890)	21
8	FOREST AND PAPER PRODUCTS	107,091	182	14
9	SCIENTIFIC, PHOTO., AND CONTROL EQUIP.	94,077	3,748	5
10	PHARMACEUTICALS	90,428	12,225	1
11	INDUSTRIAL AND FARM EQUIPMENT	82,304	(4,613)	24
12	BEVERAGES	62,765	3,157	6
13	SOAPS, COSMETICS	58,353	3,055	7
14	METALS	53,871	(3,316)	22
15	PUBLISHING, PRINTING	37,846	1,733	9



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500 MEDIAN

Despite all the
hardship, patent-
toting drugmakers still win
the triple crown for perfor-
mance. An impressive ROE
climbed even further.

RETURN ON REVENUES

INDUSTRY RANK		1994 %	1993 %
1	PHARMACEUTICALS	16.1	14.6
	COMMERCIAL BANKS	13.5	14.3
	COMPUTER AND DATA SVCS.	12.9	4.0
	DIVERSIFIED FINANCIALS	10.7	9.5
	ELECTRIC AND GAS UTILITIES	9.6	8.7
	FOOD SERVICES	8.2	4.0
	RAILROADS	7.7	6.3
	PUBLISHING, PRINTING	7.4	6.0
	TELECOMMUNICATIONS	6.6	0.5
	CHEMICALS	6.6	1.3
	BEVERAGES	6.2	4.1
	SOAPS, COSMETICS	5.9	3.0
	ELECTRONICS, ELECTRICAL EQP.	5.7	5.7
	PIPELINES	4.9	3.0
	SCI., PHOTO, CONTROL EQUIP.	4.8	0.7
	BUILDING MATERIALS, GLASS	4.7	1.3
	AEROSPACE	4.5	3.2
	ENTERTAINMENT	4.4	8.0
	METAL PRODUCTS	4.3	3.7
	HEALTH CARE	4.3	2.8
	COMPUTERS, OFFICE EQUIP.	4.3	2.4
	INDUSTRIAL AND FARM EQUIP.	4.2	2.8
	INSURANCE	4.2	4.2
	FOOD	3.8	3.0
	FOREST AND PAPER PRODUCTS	3.8	2.1
	MOTOR VEHICLES AND PARTS	3.7	1.6
	GENERAL MERCHANDISERS	3.2	3.3
	ENGINEERING, CONSTRUCTION	2.6	1.7
	PETROLEUM REFINING	2.6	2.8
	METALS	2.4	(1.6)
	SPECIALIST RETAILERS	2.2	2.3
	FOOD AND DRUG STORES	1.5	1.3
	BROKERAGE	0.8	8.8
	WHOLESALE	0.8	1.1
	AIRLINES	(1.5)	(0.5)
THE 500 MEDIAN		4.6	3.5

RETURN ON ASSETS

INDUSTRY RANK		1994 %	1993 %
1	PHARMACEUTICALS	12.7	12.7
	COMPUTER AND DATA SVCS.	11.5	5.4
	SOAPS, COSMETICS	9.1	3.5
	FOOD SERVICES	8.0	5.3
	BEVERAGES	7.1	4.6
	CHEMICALS	6.9	1.5
	PUBLISHING, PRINTING	6.8	6.1
	COMPUTERS, OFFICE EQUIP.	6.8	3.4
	FOOD	6.4	5.9
	ELECTRONICS, ELECTRICAL EQP.	5.9	5.4
	TELECOMMUNICATIONS	5.8	0.4
	HEALTH CARE	5.7	5.0
	SCI. PHOTO, CONTROL EQUIP.	5.4	1.0
	SPECIALIST RETAILERS	5.2	4.9
	GENERAL MERCHANDISERS	5.2	3.5
	MOTOR VEHICLES AND PARTS	5.2	1.3
	INDUSTRIAL AND FARM EQUIP.	5.2	3.0
	METAL PRODUCTS	5.2	5.3
	AEROSPACE	4.9	3.3
	RAILROADS	4.8	3.5
	BUILDING MATERIALS, GLASS	4.6	1.7
	ENTERTAINMENT	4.6	2.7
	FOOD AND DRUG STORES	4.0	2.8
	PETROLEUM REFINING	3.5	2.9
	ELECTRIC AND GAS UTILITIES	3.4	3.5
	ENGINEERING, CONSTRUCTION	3.2	2.8
	PIPELINES	3.0	2.2
	WHOLESALE	2.9	4.1
	FOREST AND PAPER PRODUCTS	2.6	1.2
	METALS	2.5	(1.8)
	COMMERCIAL BANKS	1.2	1.2
	DIVERSIFIED FINANCIALS	1.0	1.1
	INSURANCE	0.8	1.1
	BROKERAGE	0.1	0.6
	AIRLINES	(1.5)	(0.5)
THE 500 MEDIAN		3.7	2.7

RETURN ON EQUITY

INDUSTRY RANK		1994 %	1993 %
1	PHARMACEUTICALS	31.2	28.0
	SOAPS, COSMETICS	28.5	17.8
	FOOD SERVICES	25.6	25.1
	BEVERAGES	21.0	14.5
	BUILDING MATERIALS, GLASS	20.8	1.7
	COMPUTER AND DATA SVCS.	19.5	11.8
	FOOD	19.1	14.4
	MOTOR VEHICLES AND PARTS	18.5	11.3
	CHEMICALS	18.5	4.9
	DIVERSIFIED FINANCIALS	18.4	17.1
	RAILROADS	17.5	11.3
	INDUSTRIAL AND FARM EQUIP.	17.0	10.6
	HEALTH CARE	16.6	11.1
	ELECTRONICS, ELECTRICAL EQP.	16.5	15.0
	TELECOMMUNICATIONS	15.9	1.3
	COMPUTERS, OFFICE EQUIP.	15.7	6.9
	AEROSPACE	15.6	13.6
	COMMERCIAL BANKS	15.6	14.9
	SCI. PHOTO, CONTROL EQUIP.	15.2	1.3
	PUBLISHING, PRINTING	14.0	11.9
	SPECIALIST RETAILERS	13.6	13.7
	GENERAL MERCHANDISERS	13.5	12.9
	FOOD AND DRUG STORES	13.3	12.3
	WHOLESALE	12.2	13.8
	METAL PRODUCTS	12.1	11.1
	PETROLEUM REFINING	11.6	9.4
	INSURANCE	11.5	12.8
	ELECTRIC AND GAS UTILITIES	11.3	11.1
	PIPELINES	11.1	8.1
	ENTERTAINMENT	11.0	6.3
	METALS	9.6	(6.2)
	FOREST AND PAPER PRODUCTS	9.6	5.6
	ENGINEERING, CONSTRUCTION	9.2	10.6
	BROKERAGE	2.2	20.4
	AIRLINES	(10.6)	6.8
THE 500 MEDIAN		13.7	11.9

CONTINUED

MEDIANS

RETURN ON REVENUES

INDUSTRY RANK	1995 %
1 PHARMACEUTICALS	14.4
2 COMMERCIAL BANKS	13.3
3 DIVERSIFIED FINANCIALS	10.3
4 ELECTRIC AND GAS UTILITIES	10.3
5 COMPUTER AND DATA SERVICES	9.8
6 INSURANCE: P&C (STOCK)	8.9
7 PUBLISHING, PRINTING	8.6
8 CHEMICALS	8.2
9 INSURANCE: LIFE, HEALTH (STOCK)	6.8
10 RAILROADS	6.5
11 ELECTRONICS, ELECTRICAL EQUIP.	6.4
12 FOREST AND PAPER PRODUCTS	6.4
13 SCIENTIFIC, PHOTO, CONTROL EQUIP.	6.4
14 PIPELINES	5.7
15 METALS	5.4
16 COMPUTERS, OFFICE EQUIPMENT	5.1
17 BROKERAGE	5.1
18 BEVERAGES	4.9
19 INDUSTRIAL AND FARM EQUIPMENT	4.5
20 BUILDING MATERIALS, GLASS	4.4
21 FOOD	4.2
22 SOAPS, COSMETICS	4.2
23 MOTOR VEHICLES AND PARTS	4.1
24 HEALTH CARE	4.0
25 AEROSPACE	3.5
26 FOOD SERVICES	3.5
27 GENERAL MERCHANDISERS	2.9
28 AIRLINES	2.8
29 ENGINEERING, CONSTRUCTION	2.5
30 ENTERTAINMENT	2.4
31 METAL PRODUCTS	2.3
32 PETROLEUM REFINING	2.1
33 SPECIALIST RETAILERS	1.8
34 FOOD AND DRUG STORES	1.7
35 WHOLESALERS	0.8
36 TELECOMMUNICATIONS	0.2

THE 500 MEDIAN

4.8

RETURN ON ASSETS

INDUSTRY RANK	1995 %
1 PHARMACEUTICALS	13.2
2 COMPUTER AND DATA SERVICES	9.1
3 CHEMICALS	8.4
4 COMPUTERS, OFFICE EQUIPMENT	7.4
5 PUBLISHING, PRINTING	7.3
6 SOAPS, COSMETICS	7.0
7 FOOD	7.0
8 FOREST AND PAPER PRODUCTS	7.0
9 ELECTRONICS, ELECTRICAL EQUIP.	6.9
10 SCIENTIFIC, PHOTO, CONTROL EQUIP.	6.9
11 BEVERAGES	5.9
12 FOOD AND DRUG STORES	5.6
13 SPECIALIST RETAILERS	5.2
14 MOTOR VEHICLES AND PARTS	5.1
15 METALS	5.0
16 INDUSTRIAL AND FARM EQUIPMENT	5.0
17 FOOD SERVICES	5.0
18 GENERAL MERCHANDISERS	4.9
19 HEALTH CARE	4.8
20 ENGINEERING, CONSTRUCTION	4.5
21 AEROSPACE	4.2
22 PIPELINES	4.0
23 BUILDING MATERIALS, GLASS	3.9
24 RAILROADS	3.7
25 ELECTRIC AND GAS UTILITIES	3.6
26 METAL PRODUCTS	3.5
27 WHOLESALERS	3.4
28 AIRLINES	3.4
29 PETROLEUM REFINING	2.7
30 INSURANCE: P&C (STOCK)	2.2
31 ENTERTAINMENT	1.6
32 DIVERSIFIED FINANCIALS	1.2
33 COMMERCIAL BANKS	1.2
34 INSURANCE: LIFE, HEALTH (STOCK)	1.0
35 BROKERAGE	0.2
36 TELECOMMUNICATIONS	(0.2)

THE 500 MEDIAN

3.9

RETURN ON EQUITY

INDUSTRY RANK	1995 %
1 PHARMACEUTICALS	30.7
2 SOAPS, COSMETICS	25.0
3 COMPUTER AND DATA SERVICES	23.0
4 FOOD SERVICES	22.0
5 PUBLISHING, PRINTING	21.9
6 FOOD	21.4
7 MOTOR VEHICLES AND PARTS	20.2
8 CHEMICALS	19.8
9 INDUSTRIAL AND FARM EQUIPMENT	18.3
10 DIVERSIFIED FINANCIALS	18.2
11 BEVERAGES	17.9
12 FOREST AND PAPER PRODUCTS	17.6
13 AIRLINES	17.6
14 ELECTRONICS, ELECTRICAL EQUIP.	17.4
15 METALS	17.4
16 SCIENTIFIC, PHOTO, CONTROL EQUIP.	16.9
17 COMPUTERS, OFFICE EQUIPMENT	16.9
18 PIPELINES	16.4
19 AEROSPACE	15.7
20 COMMERCIAL BANKS	15.6
21 INSURANCE: P&C (STOCK)	13.2
22 SPECIALIST RETAILERS	13.1
23 FOOD AND DRUG STORES	13.0
24 BUILDING MATERIALS, GLASS	12.9
25 ELECTRIC AND GAS UTILITIES	11.9
26 RAILROADS	11.7
27 ENTERTAINMENT	11.3
28 WHOLESALERS	11.1
29 INSURANCE: LIFE, HEALTH (STOCK)	11.0
30 HEALTH CARE	10.8
31 BROKERAGE	9.8
32 ENGINEERING, CONSTRUCTION	9.6
33 GENERAL MERCHANDISERS	9.1
34 PETROLEUM REFINING	8.6
35 METAL PRODUCTS	8.0
36 TELECOMMUNICATIONS	0.8

THE 500 MEDIAN

14.0

FORTUNE 5 HUNDRED MEDIAN

4/1997

RETURN ON REVENUES

INDUSTRY RANK

1	PHARMACEUTICALS
2	COMMERCIAL BANKS
3	ELECTRONICS, SEMICONDUCTORS
4	DIVERSIFIED FINANCIALS
5	UTILITIES, GAS AND ELECTRIC
6	RAILROADS
7	SCIENTIFIC, PHOTO, CONTROL EQUIP.
8	TELECOMMUNICATIONS
9	METAL PRODUCTS
10	COMPUTER SOFTWARE
11	INSURANCE: P&C (STOCK)
12	BEVERAGES
13	SECURITIES
14	CHEMICALS
15	SOAPS, COSMETICS
16	COMPUTERS, OFFICE EQUIPMENT
17	PUBLISHING, PRINTING
18	INSURANCE: LIFE, HEALTH (STOCK)
19	INDUSTRIAL AND FARM EQUIPMENT
20	ELECTRONICS, ELECTRICAL EQUIP.
21	AEROSPACE
22	FOOD
23	PIPELINES
24	AIRLINES
25	PETROLEUM REFINING
26	METALS
27	SAVINGS INSTITUTIONS
28	FOREST AND PAPER PRODUCTS
29	ENTERTAINMENT
30	MOTOR VEHICLES AND PARTS
31	FOOD SERVICES
32	GENERAL MERCHANDISERS
33	ENGINEERING, CONSTRUCTION
34	BUILDING MATERIALS, GLASS
35	SPECIALIST RETAILERS
36	HEALTH CARE
37	FOOD AND DRUG STORES
38	WHOLESALE
	THE MEDIAN

RETURN ON ASSETS

INDUSTRY RANK

1	PHARMACEUTICALS
2	ELECTRONICS, SEMICONDUCTORS
3	COMPUTER SOFTWARE
4	SOAPS, COSMETICS
5	SCIENTIFIC, PHOTO, CONTROL EQUIP.
6	BEVERAGES
7	METAL PRODUCTS
8	TELECOMMUNICATIONS
9	CHEMICALS
10	FOOD
11	COMPUTERS, OFFICE EQUIPMENT
12	ENGINEERING, CONSTRUCTION
13	FOOD AND DRUG STORES
14	ELECTRONICS, ELECTRICAL EQUIP.
15	PUBLISHING, PRINTING
16	PETROLEUM REFINING
17	SPECIALIST RETAILERS
18	INDUSTRIAL AND FARM EQUIPMENT
19	AEROSPACE
20	HEALTH CARE
21	AIRLINES
22	RAILROADS
23	MOTOR VEHICLES AND PARTS
24	FOOD SERVICES
25	METALS
26	WHOLESALE
27	GENERAL MERCHANDISERS
28	UTILITIES, GAS AND ELECTRIC
29	PIPELINES
30	FOREST AND PAPER PRODUCTS
31	INSURANCE: P&C (STOCK)
32	BUILDING MATERIALS, GLASS
33	ENTERTAINMENT
34	DIVERSIFIED FINANCIALS
35	COMMERCIAL BANKS
36	INSURANCE: LIFE, HEALTH (STOCK)
37	SECURITIES
38	SAVINGS INSTITUTIONS
	THE 500 MEDIAN

RETURN ON EQUITY

INDUSTRY RANK

1	SOAPS, COSMETICS	33.0
2	PHARMACEUTICALS	28.1
3	BEVERAGES	25.8
4	SCIENTIFIC, PHOTO, CONTROL EQUIP.	22.8
5	BUILDING MATERIALS, GLASS	22.2
6	COMPUTER SOFTWARE	21.3
7	COMPUTERS, OFFICE EQUIPMENT	21.1
8	TELECOMMUNICATIONS	20.9
9	CHEMICALS	20.5
10	ELECTRONICS, SEMICONDUCTORS	18.5
11	DIVERSIFIED FINANCIALS	18.5
12	SECURITIES	18.3
13	AIRLINES	17.9
14	AEROSPACE	17.7
15	FOOD SERVICES	17.7
16	INDUSTRIAL AND FARM EQUIPMENT	17.0
17	PUBLISHING, PRINTING	16.8
18	FOOD	16.5
19	COMMERCIAL BANKS	16.5
20	ELECTRONICS, ELECTRICAL EQUIP.	16.5
21	PETROLEUM REFINING	16.2
22	MOTOR VEHICLES AND PARTS	16.1
23	METAL PRODUCTS	16.0
24	RAILROADS	14.9
25	FOOD AND DRUG STORES	14.3
26	PIPELINES	12.7
27	WHOLESALE	12.6
28	SPECIALIST RETAILERS	12.5
29	INSURANCE: P&C (STOCK)	12.2
30	ENGINEERING, CONSTRUCTION	12.2
31	UTILITIES, GAS AND ELECTRIC	11.5
32	METALS	11.5
33	INSURANCE: LIFE, HEALTH (STOCK)	10.5
34	GENERAL MERCHANDISERS	10.2
35	HEALTH CARE	9.0
36	FOREST AND PAPER PRODUCTS	6.8
37	SAVINGS INSTITUTIONS	5.4
38	ENTERTAINMENT	4.0
	THE 500 MEDIAN	14.1

CONTINUED

FORTUNE **5** HUNDRED MEDIAN

RETURN ON REVENUES

INDUSTRY RANK	1997 %
1 PHARMACEUTICALS	16.1
2 COMMERCIAL BANKS	13.6
3 DIVERSIFIED FINANCIALS	8.7
4 INSURANCE: P&C (STOCK)	8.1
5 RAILROADS	8.0
6 METAL PRODUCTS	9.0
7 PUBLISHING, PRINTING	8.2
8 SOAPS, COSMETICS	7.4
9 COMPUTERS, OFFICE EQUIPMENT	7.4
10 BEVERAGES	7.3
11 TELECOMMUNICATIONS	7.3
12 COMPUTER PERIPHERALS	6.8
13 UTILITIES, GAS AND ELECTRIC	6.4
14 SCIENTIFIC, PHOTO, CONTROL EQUIP.	6.3
15 SECURITIES	6.2
16 CHEMICALS	6.2
17 ENTERTAINMENT	5.8
18 AIRLINES	5.8
19 INSURANCE: LIFE, HEALTH (STOCK)	5.5
20 ELECTRONICS, ELECTRICAL EQUIP.	4.4
21 AEROSPACE	4.3
22 COMPUTER AND DATA SERVICES	4.7
23 INDUSTRIAL AND FARM EQUIPMENT	4.8
24 BUILDING MATERIALS, GLASS	4.4
25 METALS	4.2
26 PETROLEUM REFINING	3.9
27 MAIL, PACKAGE, FREIGHT DELIVERY	3.8
28 PIPELINES	3.3
29 FOOD	3.3
30 MOTOR VEHICLES AND PARTS	3.3
31 GENERAL MERCHANDISERS	3.0
32 ENGINEERING, CONSTRUCTION	2.8
33 SPECIALTY RETAILERS	2.4
34 HEALTH CARE	1.8
35 FOOD AND DRUG STORES	1.7
36 WHOLESALERS	1.1
37 FOREST AND PAPER PRODUCTS	0.5
THE 500 MEDIAN	4.9

RETURN ON ASSETS

INDUSTRY RANK	1997 %
1 PHARMACEUTICALS	14.9
2 COMPUTER PERIPHERALS	12.6
3 SOAPS, COSMETICS	11.5
4 BEVERAGES	10.1
5 PUBLISHING, PRINTING	7.8
6 METAL PRODUCTS	7.4
7 FOOD	6.5
8 AIRLINES	6.5
9 ELECTRONICS, ELECTRICAL EQUIP.	6.3
10 COMPUTERS, OFFICE EQUIPMENT	6.0
11 CHEMICALS	5.9
12 SCIENTIFIC, PHOTO, CONTROL EQUIP.	5.7
13 FOOD AND DRUG STORES	5.7
14 PETROLEUM REFINING	5.7
15 INDUSTRIAL AND FARM EQUIPMENT	5.6
16 MAIL, PACKAGE, FREIGHT DELIVERY	5.6
17 SPECIALTY RETAILERS	5.1
18 BUILDING MATERIALS, GLASS	5.1
19 AEROSPACE	4.8
20 TELECOMMUNICATIONS	4.8
21 GENERAL MERCHANDISERS	4.6
22 METALS	4.6
23 RAILROADS	4.1
24 ENGINEERING, CONSTRUCTION	4.0
25 COMPUTER AND DATA SERVICES	3.9
26 MOTOR VEHICLES AND PARTS	3.4
27 WHOLESALERS	3.1
28 ENTERTAINMENT	3.0
29 HEALTH CARE	2.8
30 UTILITIES, GAS AND ELECTRIC	2.8
31 INSURANCE: P&C (STOCK)	2.0
32 PIPELINES	2.0
33 DIVERSIFIED FINANCIALS	1.4
34 COMMERCIAL BANKS	1.2
35 INSURANCE: LIFE, HEALTH (STOCK)	0.8
36 SECURITIES	0.7
37 FOREST AND PAPER PRODUCTS	0.4
THE 500 MEDIAN	3.9

RETURN ON EQUITY

INDUSTRY RANK	1997 %
1 BUILDING MATERIALS, GLASS	35.3
2 SOAPS, COSMETICS	32.9
3 PHARMACEUTICALS	29.3
4 BEVERAGES	29.2
5 AIRLINES	28.1
6 COMPUTER PERIPHERALS	20.8
7 FOOD	20.5
8 PUBLISHING, PRINTING	20.5
9 CHEMICALS	19.8
10 COMPUTERS, OFFICE EQUIPMENT	19.5
11 SECURITIES	18.7
12 INDUSTRIAL AND FARM EQUIPMENT	17.4
13 MOTOR VEHICLES AND PARTS	17.1
14 COMMERCIAL BANKS	16.9
15 METAL PRODUCTS	16.9
16 AEROSPACE	16.9
17 PETROLEUM REFINING	16.7
18 SCIENTIFIC, PHOTO, CONTROL EQUIP.	15.8
19 ELECTRONICS, ELECTRICAL EQUIP.	15.8
20 METALS	15.7
21 MAIL, PACKAGE, FREIGHT DELIVERY	15.2
22 DIVERSIFIED FINANCIALS	14.9
23 RAILROADS	13.1
24 TELECOMMUNICATIONS	12.7
25 COMPUTER AND DATA SERVICES	12.6
26 FOOD AND DRUG STORES	12.2
27 INSURANCE: P&C (STOCK)	11.9
28 ENGINEERING, CONSTRUCTION	11.1
29 SPECIALTY RETAILERS	11.1
30 WHOLESALERS	10.6
31 UTILITIES, GAS AND ELECTRIC	10.4
32 GENERAL MERCHANDISERS	10.2
33 INSURANCE: LIFE, HEALTH (STOCK)	8.6
34 PIPELINES	7.6
35 HEALTH CARE	6.8
36 ENTERTAINMENT	6.4
37 FOREST AND PAPER PRODUCTS	2.2
THE 500 MEDIAN	13.9

CONTINUED

FORTUNE 5 HUNDRED MEDIAN

RETURN ON REVENUES

INDUSTRY RANK

1998 %

1	PHARMACEUTICALS	16.1
2	COMMERCIAL BANKS	11.1
3	TELECOMMUNICATIONS	9.1
4	PUBLISHING, PRINTING	8.0
5	DIVERSIFIED FINANCIALS	7.3
6	BEVERAGES	7.2
7	RAILROADS	7.0
8	INSURANCE: P&C (STOCK)	6.5
9	SOAPS, COSMETICS	6.5
10	INSURANCE: LIFE, HEALTH (STOCK)	6.2
11	SECURITIES	6.0
12	CHEMICALS	5.9
13	UTILITIES, GAS AND ELECTRIC	5.8
14	BUILDING MATERIALS, GLASS	5.8
15	METAL PRODUCTS	5.8
16	HOTELS, CASINOS, RESORTS	5.7
17	METALS	5.7
18	AIRLINES	5.7
19	COMPUTERS, OFFICE EQUIPMENT	5.6
20	AEROSPACE	5.6
21	COMPUTER AND DATA SERVICES	5.6
22	FOOD SERVICES	5.6
23	FOOD	5.6
24	MAIL, PACKAGE, FREIGHT DELIVERY	5.6
25	MOTOR VEHICLES AND PARTS	5.6
26	ELECTRONICS, ELECTRICAL EQUIP.	5.6
27	INDUSTRIAL AND FARM EQUIPMENT	5.6
28	GENERAL MERCHANDISERS	5.6
29	COMPUTER PERIPHERALS	5.6
30	PETROLEUM REFINING	5.6
31	SPECIALTY RETAILERS	5.6
32	FOOD AND DRUG STORES	5.6
33	ENGINEERING, CONSTRUCTION	5.6
34	FOREST AND PAPER PRODUCTS	5.6
35	PIPELINES	5.6
36	HEALTH CARE	5.6
37	WHOLESALE	5.6
38	ENTERTAINMENT	5.6
	THE 500 MEDIAN	5.6

RETURN ON ASSETS

INDUSTRY RANK

1998 %

1	PHARMACEUTICALS	16.1
2	SOAPS, COSMETICS	11.1
3	BEVERAGES	9.1
4	PUBLISHING, PRINTING	8.0
5	COMPUTERS, OFFICE EQUIPMENT	7.3
6	MAIL, PACKAGE, FREIGHT DELIVERY	7.2
7	COMPUTER PERIPHERALS	7.0
8	HOTELS, CASINOS, RESORTS	6.5
9	METAL PRODUCTS	6.5
10	FOOD	6.2
11	FOOD SERVICES	6.5
12	COMPUTER AND DATA SERVICES	6.4
13	FOOD AND DRUG STORES	6.2
14	CHEMICALS	6.0
15	AIRLINES	5.8
16	TELECOMMUNICATIONS	5.4
17	SPECIALTY RETAILERS	4.9
18	AEROSPACE	4.9
19	MOTOR VEHICLES AND PARTS	4.8
20	GENERAL MERCHANDISERS	4.5
21	BUILDING MATERIALS, GLASS	4.5
22	METALS	4.5
23	ENGINEERING, CONSTRUCTION	4.5
24	ELECTRONICS, ELECTRICAL EQUIP.	4.5
25	INDUSTRIAL AND FARM EQUIPMENT	4.5
26	WHOLESALE	4.5
27	RAILROADS	4.5
28	UTILITIES, GAS AND ELECTRIC	4.5
29	PETROLEUM REFINING	4.5
30	PIPELINES	4.5
31	DIVERSIFIED FINANCIALS	4.5
32	COMMERCIAL BANKS	4.5
33	INSURANCE: P&C (STOCK)	4.5
34	FOREST AND PAPER PRODUCTS	4.5
35	INSURANCE: LIFE, HEALTH (STOCK)	4.5
36	HEALTH CARE	4.5
37	SECURITIES	4.5
38	ENTERTAINMENT	4.5
	THE 500 MEDIAN	4.5

RETURN ON EQUITY

INDUSTRY RANK

1998 %

1	PHARMACEUTICALS	19.4
2	SOAPS, COSMETICS	15.9
3	BEVERAGES	10.2
4	BUILDING MATERIALS, GLASS	26.4
5	AIRLINES	24.6
6	HOTELS, CASINOS, RESORTS	22.5
7	TELECOMMUNICATIONS	22.3
8	PUBLISHING, PRINTING	22.0
9	FOOD	20.1
10	DIVERSIFIED FINANCIALS	19.8
11	COMPUTERS, OFFICE EQUIPMENT	18.8
12	INDUSTRIAL AND FARM EQUIPMENT	18.7
13	MOTOR VEHICLES AND PARTS	18.2
14	CHEMICALS	17.9
15	SECURITIES	16.8
16	ELECTRONICS, ELECTRICAL EQUIP.	16.5
17	AEROSPACE	16.4
18	COMMERCIAL BANKS	16.0
19	GENERAL MERCHANDISERS	15.5
20	ENGINEERING, CONSTRUCTION	15.4
21	MAIL, PACKAGE, FREIGHT DELIVERY	15.3
22	COMPUTER AND DATA SERVICES	15.3
23	METAL PRODUCTS	13.5
24	FOOD SERVICES	13.2
25	FOOD AND DRUG STORES	12.9
26	COMPUTER PERIPHERALS	12.4
27	WHOLESALE	12.3
28	SPECIALTY RETAILERS	11.3
29	INSURANCE: P&C (STOCK)	10.8
30	RAILROADS	10.8
31	METALS	10.4
32	UTILITIES, GAS AND ELECTRIC	10.2
33	INSURANCE: LIFE, HEALTH (STOCK)	9.2
34	HEALTH CARE	7.3
35	PIPELINES	7.3
36	PETROLEUM REFINING	6.0
37	FOREST AND PAPER PRODUCTS	3.2
38	ENTERTAINMENT	(0.6)
	THE 500 MEDIAN	13.4

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Shareholders' Equity**« [Return on Assets](#)
[Revenues Per \\$ of Assets](#) »

Industry Rank	Industry	1999 Profits as % of Equity
1	Pharmaceuticals	35.8
2	Soaps, Cosmetics	29.1
3	Beverages	27.7
4	Computer Peripherals	26.7
5	Publishing, Printing	25.2
6	Airlines	24.0
7	Scientific, Photo, Control Equip.	22.6
8	Securities	21.5
9	Computers, Office Equipment	21.3
10	Computer And Data Services	21.3
11	Food	21.1
12	Diversified Financials	21.0
13	Engineering, Construction	19.4
14	Commercial Banks	18.0
15	Aerospace	17.9
16	Motor vehicles and Parts	17.9
17	Chemicals	17.9
18	Food Services	17.4
19	Industrial and Farm Equipment	17.0
20	Building materials, Glass	16.8
21	Food and Drug Stores	15.4
22	General Merchandisers	15.3
23	Metal Products	15.3
24	Specialty Retailers	14.7
25	Telecommunications	14.5
26	Health Care	14.1
27	Petroleum Refining	12.5
28	Utilities: Gas & Electric	11.8

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29	Electronics, Electrical Equip.	11.8
30	Wholesalers	11.8
31	Insurance: P & C (stock)	10.6
32	Temporary Help	10.4
33	Mail, Package, Freight Delivery	8.8
34	Automotive Retailing, Services	8.7
35	Forest and Paper Products	8.6
36	Insurance: Life, Health (stock)	7.9
37	Railroads	7.1
38	Hotels, Casinos, Resorts	6.8
39	Metals	5.5
40	Entertainment	4.8
41	Pipelines	2.2

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SEARCH BY KEYWORD:

MOST PROFITABLE INDUSTRIES Return on Revenues

« [Growth in Profits \(5 Yrs.\)](#)
[Return on Assets](#) »

Industry Rank	Industry	1999 Profits as % of Revenues
1	Pharmaceuticals	18.6
2	Commercial Banks	15.8
3	Computer Peripherals	12.1
4	Telecommunications	11.7
5	Beverages	11.0
6	Scientific, Photo, Control Equip.	10.6
7	Publishing, Printing	10.5
8	Diversified Financials	10.1
9	Computer And Data Services	9.2
10	Securities	8.5
11	Computers, Office Equipment	7.3
12	Utilities: Gas & Electric	7.2
13	Soaps, Cosmetics	6.9
14	Insurance: P & C (stock)	6.4
15	Food Services	6.0
16	Railroads	5.9
17	Chemicals	5.7
18	Entertainment	5.6
19	Building materials, Glass	5.3
20	Aerospace	5.2
21	Airlines	5.1
22	Food	4.8
23	Insurance: Life, Health (stock)	4.8
24	Industrial and Farm Equipment	4.8
25	Forest and Paper Products	4.3
26	Engineering, Construction	4.1



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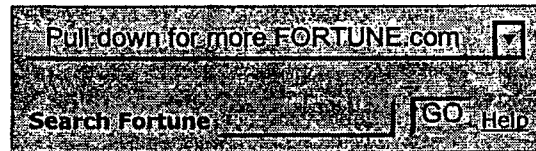
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29	Motor vehicles and Parts	3.5
30	Petroleum Refining	3.4
31	General Merchandisers	3.4
32	Mail, Package, Freight Delivery	3.1
33	Health Care	2.8
34	Specialty Retailers	2.6
35	Hotels, Casinos, Resorts	2.6
36	Food and Drug Stores	2.1
37	Metals	2.1
38	Temporary Help	1.8
39	Automotive Retailing, Services	1.2
40	Wholesalers	0.7
41	Pipelines	0.5

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MOST PROFITABLE INDUSTRIES

Return on Assets

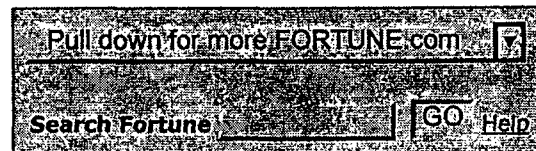
Return on Revenues

Return on Shareholders' Equity

Industry Rank	Industry	1999 Profits as % of Assets
1	Pharmaceuticals	16.5
2	Computer Peripherals	15.4
3	Soaps, Cosmetics	11.7
4	Beverages	11.2
5	Scientific, Photo, Control Equip.	10.4
6	Computers, Office Equipment	9.3
7	Publishing, Printing	8.9
8	Food Services	8.3
9	Food	7.9
10	Computer And Data Services	7.9
11	Specialty Retailers	6.7
12	Aerospace	6.3
13	Electronics, Electrical Equip.	5.9
14	Food and Drug Stores	5.9
15	Engineering, Construction	5.5
16	Chemicals	5.3
17	Airlines	4.8
18	Mail, Package, Freight Delivery	4.7
19	Metal Products	4.7
20	Motor vehicles and Parts	4.6
21	General Merchandisers	4.5
22	Telecommunications	4.4
23	Petroleum Refining	4.3
24	Temporary Help	4.2
25	Building materials, Glass	4.2
26	Forest and Paper Products	3.7
27	Industrial and Farm Equipment	3.5
28	Health Care	2.9
29	Wholesalers	2.8

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30	Hotels, Casinos, Resorts	2.7
31	Utilities: Gas & Electric	2.6
32	Automotive Retailing, Services	2.5
33	Entertainment	2.4
34	Railroads	2.0
35	Diversified Financials	1.7
36	Metals	1.7
37	Commercial Banks	1.4
38	Insurance: P & C (stock)	1.2
39	Securities	1.0
40	Pipelines	0.5
41	Insurance: Life, Health (stock)	0.4

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MEMORANDUM

TO: NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

FROM: HART RESEARCH ASSOCIATES

DATE: MAY 2000

SUBJECT: RESEARCH ON MEDICARE PRESCRIPTION DRUG COVERAGE

On behalf of the National Committee to Preserve Social Security and Medicare, Hart Research has recently completed a survey on the issue of prescription drug coverage for Medicare beneficiaries. A national sample of 825 registered voters were interviewed, including an oversample of 203 Medicare beneficiaries. This executive summary reviews the key findings of the opinion research.

Overview. The survey data points to three central conclusions about public attitudes on the issue of prescription drug coverage. First, the voting public ranks prescription drug coverage for Medicare beneficiaries as a top priority, and congressional candidates who support creating a Medicare drug benefit stand to gain substantial political support. For Medicare beneficiaries, prescription drug coverage is a central and overriding policy concern. Second, voters have an important message for Congress regarding what they consider to be the right approach for providing prescription drug coverage: do it through *Medicare*, not private insurance; provide a *universal* benefit, not a means-tested one; and get it done *soon*. Third, voters strongly embrace the Clinton Administration's prescription drug plan, and most Medicare beneficiaries indicate they are likely to subscribe if the plan is adopted.

Medicare prescription drug coverage has broad support, and is positioned to be a powerful voting issue in the 2000 electoral cycle.

By a substantial 64% to 27% margin, voters today favor adding a voluntary prescription drug benefit to Medicare coverage. This consensus is quite broad-based, with voters under 35 expressing just as much support (66% favor) as seniors (66%), and Republicans registering nearly as much support (65%) as Democrats (68%).

Driving this support is widespread recognition of the burden that escalating drug costs represent. Fully 80% of voters recognize that prescription drug costs for senior citizens are on the rise, including 55% who say these costs have risen "a great deal" (the corresponding figures for Medicare beneficiaries are 80% and 61%). In addition, beneficiaries identify the high cost of prescription drugs as their top health care concern today. The voting public also rejects the proposition that high drug costs are the price we pay for medical research and innovation, believing instead that "drug companies are charging far more for prescriptions than is necessary in order to increase their profits" (70% to 25%).

The survey data indicate that the prescription drug issue could play a powerful role in this year's elections. It ranks at the very top of voters' agenda for congressional action, by an overwhelming margin among Medicare beneficiaries (see table). In addition, congressional candidates who support establishing a prescription drug benefit stand to realize a substantial electoral gain. Registered voters say by a more than five-to-one margin that they are more likely (43%) rather than less likely (8%) to vote for a pro-benefit candidate.

VOTERS' TOP PRIORITIES FOR CONGRESS

	<u>All Voters</u>	<u>Medicare Beneficiaries</u>
Adding prescription drug benefits to Medicare	32	47
Cutting taxes	29	26
Passing tougher gun-control restrictions	25	25
Passing laws to protect consumers' privacy	21	15
Passing an HMO patients' bill of rights	20	16
Increasing the minimum wage	14	15

The public has three rules for providing prescription drug coverage: do it through Medicare, do it on a universal basis, and do it soon.

The survey results indicate that voters have some strong views about the right – and wrong – way to remedy the prescription drug coverage problem. Americans have a three part message for Congress as it considers different approaches.

A real solution is only possible through Medicare. Fully 72% of voters say that “Medicare needs to become involved” because current forms of coverage are eroding, while just 22% of voters oppose a Medicare-based program because “a big government program would undermine” the private and employer-provided coverage many people have today. A solution that rests on private or employer-based insurance, Americans say, is no solution at all.

Prescription drug coverage should be available on a universal basis, not a means-tested one. The voting public believes that a Medicare prescription drug benefit should be universally available, even when apprised of concerns that a universal plan could be “too costly.” The majority says that benefits “should be available to all seniors, regardless of income” (55%), rather than limited to seniors with incomes below \$16,000 who “cannot afford private insurance” (41%). The survey also clearly shows that the need for this benefit is not limited to low income beneficiaries. Among Medicare beneficiaries with incomes over \$20,000, fully 49% *strongly* favor a universal approach and 67% report they would definitely or probably enroll if the Clinton Administration plan were adopted. Finally, while the public wants all seniors to have access to a voluntary benefit, it also supports subsidies to reduce or eliminate premiums for the poorest seniors (61% identify this as a very important principle).

Congress should get to work and establish a prescription drug benefit soon. About one-third of voters believe that a prescription drug benefit should be enacted only as part of a more comprehensive reform of Medicare, so the system doesn’t “take on expensive new commitments until its long-term funding is secure” (35%). However, the large majority (61%) of voters disagree, agreeing instead that “because of the seriousness of the problem, a Medicare prescription medicine benefit should be enacted soon and should not have to wait for other Medicare reforms.” The public’s sense of urgency, and demand for action, could not be more clear.

Americans strongly support the Medicare prescription drug benefit plan put forward by the Clinton Administration, and most Medicare beneficiaries say they would probably enroll if the plan were offered.

Seven in ten voters (70%) say they favor the Clinton Administration's proposed Medicare prescription drug benefit, while only 16% oppose the plan. Support is equally strong among Medicare beneficiaries (68%) and non-beneficiaries (70%), with beneficiaries registering especially intense support (37% strongly favor). Support among Democrats is nearly universal (86% to 5%), but is also strong among independents (64% to 13%) and Republicans (54% to 31%).

The survey goes on to describe individual elements of the Administration's plan, and voter's response is quite favorable. Among the appealing provisions are:

- Low-income seniors would pay a reduced cost, or no premium, depending on income (80% appealing)
- Participation would be voluntary (75%)
- The new benefit would help pay some catastrophic drug costs for recipients with the highest drug expenses (69%)
- All beneficiaries would be able to purchase their prescriptions at lower prices negotiated by private-sector benefit managers (59%)

After voters learn more about the Administration plan, support grows to an overwhelming 82%. Increased support is especially dramatic among independents (up 14 points to 78%), and Republicans (up 16 points to 70%). Moreover, almost two in three Medicare beneficiaries (65%) report that they would definitely or probably enroll if this benefit were offered. Interest is especially strong among beneficiaries who are under age 70 (70%), currently lack drug coverage (75%), or face monthly drug costs over \$100 per month (78%). Interestingly, there is even substantial interest in subscribing among beneficiaries who currently have drug coverage (55%) and those with incomes over \$20,000 (66%). Demand for the type of benefit provided in the Administration plan is clearly both strong and broad.

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May 10, 2000

A.L. SINCLETON, CHIEF OF STAFF

JARVIS MAYS, MINORITY CHIEF COUNSEL

The Honorable William J. Clinton
President
The White House
Washington, D.C. 20500

Dear President Clinton:

Less than three years ago, the health care program for our nation's elderly and disabled was headed toward financial ruin by 2001. Yet in the face of severe opposition, we succeeded in saving Medicare for a generation - pushing back Medicare's imminent bankruptcy an additional 24 years to 2025.

But with that extra time comes the added responsibility of modernizing and strengthening Medicare for this and future generations this year. Our nation's elderly and disabled have waited long enough for Medicare to catch up with the miracles that modern medicine provides today through prescription drugs.

We are writing to you today asking your support to work with this Congress to help seniors without insurance coverage lower their drug bills. Our seniors deserve more than partisan politics on an issue as important to them as prescription drugs. We want to work with you in a bipartisan way to make a prescription drug benefit under Medicare a reality, not a political bumper sticker to be carried into the fall elections.

As you know, House Republicans have crafted a plan to lower drug prices for seniors and the disabled who currently have no drug coverage by helping them purchase insurance through Medicare. Our plan invests \$40 billion over the next five years to give Medicare's 40 million recipients real bargaining power to lower their prescription drug prices.

Further, our plan matches your plan in assisting low income beneficiaries, but it will also provide help for every person who elects to enroll. More importantly, our plan will not endanger existing drug coverage that seniors might already have through a

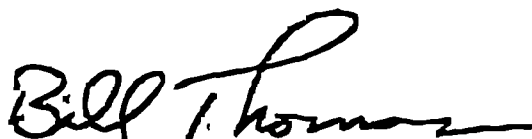
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former employer, which is a great concern we have with your plan. Finally, we are concerned that the government would have too heavy a hand in controlling the drug benefit, denying some seniors the right to choose the coverage that best fits their needs.

In short, we can accomplish a great deal for the American people this year, if and only if your Administration and Members of your party choose to work with us, like you did on the Social Security earnings penalty.

Americans want us to work together to protect Medicare and modernize the program with prescription drug coverage, and that's exactly what we intend to do. We can help seniors and the disabled with the costs of prescription drugs. If we put progress before politics and ideas before ambition, we can and will be successful in ensuring Medicare for generations to come. Our seniors and elderly expect and deserve no less.

Sincerely,



Bill Thomas
Chairman
Subcommittee on Health



Bill Archer
Chairman

66423

5/14/820

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NEX

UNITED STATES SENATOR JOHN BREAUX

TO: Chris Jennings

FROM: Sarah Walter

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WASHINGTON, D.C. 20510
(202) 224-4623 (OFFICE)
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United States Senate

WASHINGTON, DC 20510

"BREAUX-FRIST 2000" - REVISED TO BALANCE REAL MEDICARE REFORMS WITH SENIORS' NEED FOR PRESCRIPTION DRUG COVERAGE THIS YEAR

WASHINGTON (May 9) – In a renewed effort to win passage this year of Medicare reform legislation that includes prescription drug coverage, Sens. John BreauX (D-La.) and Bill Frist (R-Tenn.) proposed a more incremental alternative to their larger, bipartisan bill pending before the Senate Finance Committee.

The senators said congressional approval of "BreauX-Frist 2000" would put the country on the road to real Medicare reform, based on the comprehensive advancements included in their bipartisan "Medicare Preservation and Improvement Act" (S. 1895), introduced last November.

"We must use the growing public support for prescription drugs as our best opportunity to begin to upgrade Medicare for the 21st century," Sen. BreauX said. "We must act this year to put Medicare on solid financial footing so we can, in fact, guarantee that all seniors have access to affordable drugs."

"We're fortunate to have a window of opportunity in which to act this year," said Sen. Frist. "If we delay reform of this vital national program, we risk the future security of our seniors' health care. It's no longer a question of whether to add prescription drugs, it's how to add them while making the program stronger. Let's put Medicare back on solid footing to address the medical needs of our seniors and give them access to affordable prescription drugs."

Sens. BreauX and Frist stressed they have retooled some of the more attainable components of their original legislation, including a universal, affordable prescription drug benefit. They will urge the Senate Finance Committee to adopt this revised plan as the final Medicare proposal for full Senate consideration later this spring.

Incremental reform measures under "BreauX-Frist 2000" would immediately begin to improve coverage options and substantially subsidize prescription drug coverage for the nation's 39 million Medicare recipients. Seniors would also benefit from protections against catastrophic drug costs and improvements in the current, fee-for-service Medicare program.

BreauX-Frist 2000 also establishes an independent, executive-branch Medicare agency to oversee all competing health care plans and ensure plans offer at least the current Medicare core benefits along with the new prescription drug coverage.

The Medicare agency is modeled after the Social Security Administration with responsibilities similar to the Office of Personnel Management, which has a 40-year track record of providing competing health care coverage with prescription drugs for millions of federal employees and their families under the Federal Employees Health Benefits Program.

(Attached is a two-page summary, chart outlining major components, and a side-by-side comparison of the BreauX-Frist legislation vs. this new BreauX-Frist 2000 plan).

BREAUX-FRIST 2000

- Provides a universal, affordable prescription drug benefit
- Protects beneficiaries against catastrophic drug costs
- Improves the current, fee-for-service Medicare program
- Increases opportunities for participation in private plans
- Creates new Medicare agency to encourage choice and competition
- Establishes new measures to ensure Medicare's financial health

	S.1895 (Medicare Preservation and Improvement Act of 1999)	Breaux-Frist 2000
Administration	Independent Medicare Board	New executive branch Medicare agency with advisory board (similar to SSA)
Competition	Premiums linked to national weighted average	Premiums linked to fee-for-service
Drug Benefit	Drug benefit through high option plans with minimum actuarial value. Approved by Medicare Board.	Drug benefit through existing M+C plans and private entities with minimum actuarial value; reinsurance program to assist with high-cost cases; reserve fund for catastrophic benefit beginning in 2006; overseen by new Medicare agency.
Drug Subsidy	Full low-income subsidies up to 135%; sliding subsidy 135-150%; universal 25% subsidy over 150%.	Same
Solvency	Unified trust fund; general revenue funding limited to 40% of total program costs.	A and B Trust Funds remain separate; no trigger on general revenues; new measures to gauge Medicare solvency.

BREAU-FRIST 2000**Incremental Bipartisan Medicare Reform and Prescription Drug Proposal****SUMMARY**

Breaux-Frist 2000 is an incremental Medicare proposal that takes a meaningful first step towards long-term Medicare reform while adding a long-overdue outpatient prescription drug benefit to the program. The proposal strikes a balance between the need for improved benefits and an improved delivery system in Medicare, short of comprehensive reform.

1. MEDICARE AGENCY

Under current law, HCFA runs the fee-for-service and Medicare+Choice programs and controls the terms of competition between private plans and the HCFA-run fee-for-service plan.

Breaux-Frist 2000 would establish a new executive branch agency outside of the Health Care Financing Administration (HCFA) and the Department of Health and Human Services (HHS) to administer Medicare's competitive environment. The new Medicare agency would be modeled after the Social Security Administration with responsibilities similar to the Office of Personnel Management (OPM) under the Federal Employees Health Benefits Program. With the establishment of the new Medicare agency, the Secretary of HHS and the HCFA Administrator maintain full responsibility for fee-for-service Medicare and other non-Medicare functions, with the new Medicare agency overseeing competition between HCFA's fee-for-service plan and private plans.

The proposal also would create an advisory board within the new Medicare agency to advise and make recommendations on Medicare policy.

2. OUTPATIENT PRESCRIPTION DRUG BENEFIT

Breaux-Frist 2000 ensures affordable and accessible outpatient prescription drug coverage for all beneficiaries and provides meaningful protections against catastrophic drug costs. All Medicare beneficiaries will have access to an outpatient prescription drug benefit meeting a minimum actuarial value. Beneficiaries enrolled in Medicare+Choice will be offered the prescription drug benefit through the plan in which they are enrolled. Beneficiaries in fee-for-service Medicare may select a drug benefit offered by private sector entities.

All beneficiaries will receive a subsidy for the purchase of drug coverage. Low-income beneficiaries below 135% of the federal poverty level (FPL) will receive a full subsidy toward coverage; beneficiaries between 135%-150% of FPL will receive a subsidy based on a sliding scale. Breaux-Frist 2000 also provides a 25% universal subsidy toward coverage for all beneficiaries over 150% of FPL.

Breaux-Frist 2000 will also establish a reinsurance pool, which sets aside a specific dollar amount each year to help subsidize plans for their highest costs prescription drug cases. This in effect, provides an additional reduction in drug premiums for all beneficiaries. Additionally, the proposal includes a reserve fund beginning in 2006 to help pay for seniors' catastrophic drug costs.

All prescription drug benefits will be overseen by the new Medicare agency to prevent adverse selection and ensure that all seniors have access to an affordable prescription drug benefit.

3. COMPETITION AND STABILIZATION OF MEDICARE+CHOICE

Medicare+Choice plans will compete with fee-for-service Medicare based on price, quality, and benefits overseen by the new Medicare Agency. Premiums for the fee-for-service plan will remain the same as under current law. Premiums for private plans may vary (as in the original Breaux-Frist plan and in the President's proposal). Private plans would set their own premium bid, rather than being forced to accept payments dictated by HCFA, which would greatly stabilize private plan benefits.

All current Medicare benefits will be guaranteed, but existing administrative regulations will be simplified and greater flexibility provided for Medicare+Choice plans in managing cost-sharing and benefits.

4. FEE-FOR-SERVICE MODERNIZATIONS

HCFA will be given new flexibility to use private-sector tools to create greater efficiencies within the program and to become more skilled in private sector delivery mechanisms. HCFA may establish a preferred provider network for beneficiaries, designed to offer savings both to beneficiaries and the federal government. HCFA may also establish disease management programs to improve the health of beneficiaries in traditional Medicare. Civil service laws will also be relaxed to allow greater flexibility for management efficiencies within HCFA.

5. SOLVENCY MEASURES

The Part A and B Trust Funds will remain separate. A new mechanism will be established so that Medicare's financial health is measured by looking at total spending and revenues for the entire program. These measures would be used to sound an early warning and trigger debate as to policy decisions that are necessary to financially sustain Medicare. The Medicare agency will forward annual policy recommendations to Congress regarding the status of the trust funds.



FAX TRANSMITTAL SHEET

Date: _____

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To: _____

Chris Jennings

From: _____

Jeff Lemieux

Comments: _____

Some recent thoughts on
how case compromise - not
made public, but talked about
some — Jeff

If there are any problems with this transmission, please contact _____ at _____
or call (202) 546-0001. Thank you.

Fair?

Medicare Commission

President Clinton

Administration: Independent Medicare Board	Administration: Health Care Financing Administration (HCFA)
Competition System: FEHB-like Premium Schedule (allows zero premium plans) with reference price linked to National Weighted Average Premium for core (current Title 18) benefits.	Competition System: FEHB-like Premium Schedule (also allows zero premium plans) with reference price linked to Fee-For-Service (FFS) premium for current Title 18 benefits.
Drug Subsidies: Full subsidy under 135% of poverty.	Drug Subsidies: Full subsidy under 135%, sliding scale 135-150%, 50% premium subsidy for 150+%. Budget of \$35 billion in out-years for unspecified subsidies for catastrophic protection.
Drug Benefit: All plans (public and HCFA) have high option with drug benefit. Minimum standard for drug benefit defined by Medicare Board.	Drug Benefit: Stand alone drug program for those in FFS, with 50% premium, 50% coinsurance, benefit capped at \$1250, \$2500 when fully phased-in. Equivalent drug benefit required for private plans.
Drug Competition: Not clearly specified. Private plans offer drug benefits for FFS beneficiaries, under systems put in place by Medicare Board.	Drug Competition: One Pharmacy Benefit Manager (PBM) per region offers drug benefit for FFS beneficiaries.
Solvency: Combined Medicare Trust fund, general revenue funding limited to 40% of total program costs.	Solvency: General revenue infusion into Part A fund.
Cost: Savings probably \$-30 to \$-50 billion over ten years (for policies listed here). Additional savings from other policies not listed here. Some savings for beneficiaries.	Cost: \$185 over ten years. (Source: CBO.) Significant pressure to raise caps on drug benefit. Additional costs for states: \$4 billion. Large savings for beneficiaries. Long run savings unlikely because drug costs uncontrollable.
Advantages: Possibility of private national plans. Maintains fiscal discipline short and long run. Possibility of much improved benefits in all-in-one private plans.	Advantages: Uses Medicare Commission premium schedule except with guarantee that FFS premiums never higher than current law. Large savings for beneficiaries. HCFA-run drug benefit universally available.
Disadvantages: Too much federal savings for times of surplus. Not enough subsidy to ensure that drug benefits widely available. If private plans proliferate quickly (and federal savings higher than forecast), FFS plans could see premium hikes above current law.	Disadvantages: Very expensive in short run and potential for out-of-control drug benefit cost in long run if benefit caps lifted. Government on hook for future drug costs; that plus single PBM = likelihood of price controls. Inflexible drug benefit, inhibits innovation. HCFA conflict of interest maintained.
Comments: Center-right proposal, brought many Republicans in from deep right field (MSAland) on Medicare.	Comments: The far left is still skeptical of President's competition, even though it fully protects FFS. CBO may revise (upward) the cost of President's low-income subsidies (now \$20 billion).

Breaux-Frist**Incremental Proposal**

Administration: Independent Medicare Board.	Administration: Independent executive branch agency outside HHS with oversight by special Congressional Oversight and Advisory Boards. Medicare Agency runs Medicare +Choice until new competition system in place.
Competition System: FEHB-like Premium Schedule (allows zero premium plans) with reference price linked to National Weighted Avg. premium for core (current Title 18) benefits.	Competition System: FEHB-like Premium Schedule (allows zero premium plans) with reference price linked to Fee-For-Service (FFS) premium for core (current Title 18) benefits.
Drug Subsidies: Full subsidy (for least cost High Option plan) under 135%; sliding scale 135-150%; \$200 (25% of minimum average drug benefit value, indexed, taxable) over 150%.	Drug Subsidies: Full subsidy as in B-F under 135%; sliding scale 135-150%; \$200 (25% of minimum drug benefit value, indexed, taxable) over 150%. Additional \$30 billion program to reinsure health plans for highest cost (for drugs) cases.
Drug Benefit: All plans (public and private) have high option with drug benefit. Minimum average value \$800, benefit designs as OK'd by Board.	Drug Benefit: Same as Breaux-Frist. Additional \$30 billion reinsurance program gives strong incentive for plans to offer catastrophic coverage.
Drug Competition: Multiple Competing Plans working in Partnership with HCFA to form HCFA High Option plans (Board also approves arrangements).	Drug Competition: Same as Breaux-Frist. If no plans want to work with HCFA, fall back is multiple competing plans contracting directly with new Medicare Agency.
Solvency: Combined trust fund with 40% upper limit on general revenue financing.	Solvency. Stick with Part A and Part B for now. Instruct Trustees to report on percent of general revenues dedicated to Medicare, Medicare spending as a percent of GDP etc.
Cost: Approximately budget neutral. (\$-20 to \$+20 billion over ten years.) Considerable savings for beneficiaries. Long run savings likely.	Cost: Probably \$100-\$140 billion over ten years. Large savings for beneficiaries. Long run savings possible. (Weaker competitive savings than Breaux-Frist, but drug costs potentially controllable.)
Advantages: Budget neutral. Good likelihood of widely available public and private plans with comprehensive benefits.	Advantages: High subsidies make widely available drug coverage likely; strong incentives for excellent coverage (catastrophic protection).
Disadvantages: Some drafting errors in legislative language. Not enough done to give incentives for plans to have excellent (including catastrophic) drug benefits.	Disadvantages: Quite expensive in short run. Sticks with awkward Part A/Part B definition, which makes no analytic sense. No legislative language yet.
Comments: Limits on general revenue demagogued as entitlement cut. Competitive system that allowed potential (however remote) for HCFA-run FFS plans to lose so badly in the competition that they would have higher premiums than current law concerned many members (esp. rural).	Comments: Amounts to Breaux-Frist Lite. "Works Great, Less Savings."

Crude Estimate of Incremental Medicare Proposal

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	5 year	10 year
Cost of \$200 premium discount													
Enrollment		40,707,000	41,261,000	41,848,000	42,470,000	43,151,000	43,964,000	44,911,000	45,852,000	46,740,000			
Percent Eligible for \$200 (not already in low-income subsidy)				85%	85%	85%	85%	85%	85%	85%	85%		
Percent who take High Option or Drug Only (too high, but to be safe...)				90%	90%	90%	90%	90%	90%	90%	90%		
Subsidy (actually premium reduction)				\$200	\$220	\$242	\$266	\$293	\$322	\$354	\$390		
Crude fiscal year adjustment (assuming starts Jan 1)				0.75	1	1	1	1	1	1	1		
Percent NOT Taxed Back				93%	93%	93%	93%	93%	93%	93%	93%		
Total Cost (product of above items, in billions)				4	7	7	8	9	10	12	13	18	70
Cost of Back End Subsidy for Plans' Highest Cost Drug Cases				3	3	3	3	4	4	5	5	9	30
Low Income Subsidies (Like President's Plan)				0	1	2	3	3	3	3	4		
Boosted by 50% for revised estimate				0	2	3	4	4	5	5	5	5	28
Savings from Competition (Breaux-Frist linked to FFS like Pres)				-0	-1	-1	-2	-2	-2	-3	-3	-2	-14
Other Stuff (Medicare +Choice, FFS etc.)		2	2	2	2	2	0	0	0	0	0	10	10
Net Cost		2	2	9	12	15	14	15	17	19	21	40	125

Assumes Index for Drug subsidies set not to exceed 10% a year.

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INCREMENTAL MEDICARE MODERNIZATION PROPOSAL—incomplete?

SUMMARY

This incremental Medicare proposal builds on the best of the President's proposal and the proposal of Senators Breaux and Frist. Like the Breaux-Frist bill, the proposal would significantly expand opportunities for private Medicare options while improving the standard HCFA-run plan. Like the President's plan, the proposal absolutely protects beneficiaries in the HCFA-run plan from any possible premium increases. The proposal is designed to immediately begin improving coverage options, especially for prescription drugs. It avoids some provisions that could slow the proposal's legislative prospects, such as controversial proposals to create a combined trust fund (like Breaux-Frist) or make general revenue transfers to Medicare (like the President's plan).

The proposal would substantially subsidize prescription drug coverage, both through premium discounts and through government-provided reinsurance of the highest cost cases. Those subsidies are expensive. The subsidies are designed to be controllable, however, so that fiscal discipline is maintained in the long run, when discipline will be most important. The proposal would improve incentives for seniors to purchase health care wisely, and those incentives should make everyone more comfortable that Medicare will be a better value now and a fully sustainable program in the future.

The proposal is structured mostly on the Breaux-Frist plan, although it contains important elements of the President's plan and some new ideas for drug coverage. The following is a detailed outline of the proposal, with notes in italics that explain some important differences from earlier proposals.

Medicare Executive Agency and Advisory and Oversight Panels

The incremental proposal would move the overall administration of Medicare from the Health Care Financing Administration (HCFA) to a new executive agency outside of HCFA and the Department of Health and Human Services (HHS). The new agency would administer Medicare's competitive environment and would be responsible for coordinating and determining beneficiary eligibility and enrollment; negotiating contracts with entities offering Medicare plans; and disseminating information to beneficiaries with respect to benefits, cost-sharing, and quality indicators under Medicare plans.

Under current law, HCFA runs the fee-for-service and Medicare+Choice programs and controls the terms of competition between private plans and the HCFA-run fee-for-service plan. With the establishment of the new Medicare executive agency, HCFA will be responsible for administering its own standard and (possibly) high-option plans and the Agency will oversee competition between HCFA's plans and private plans.

The proposal also would create Congressionally-appointed advisory and oversight panels to report on the administration of Medicare and develop policy initiatives.

Note—The Medicare Commission and the Breaux-Frist proposal would have created an independent Medicare Board (outside of HCFA and HHS), with members selected by the President and approved

by the Senate, to run Medicare's competition. The President's plan would have left Medicare's competition system in the hands of HCFA. The incremental proposal is a slight modification of the Breaux-Frist approach. Instead of a seven-member Board, the proposal envisions a more typical executive agency, outside of HCFA and HHS, with additional advisory and oversight boards.

Benefit Package

All Medicare beneficiaries will at a minimum continue to be entitled to the same benefits they are entitled to today. For general coverage, beneficiaries could choose from a variety of plans, including private standard plans, private high-option plans, the HCFA-sponsored standard plan, or HCFA-sponsored high-option plans. No Medicare plan can be approved unless it covers at least the same Medicare benefits that beneficiaries have today. The Medicare Agency could not approve any benefit package designed to result in favorable selection of beneficiaries.

Standard and High-Option Plans

Under the proposal, all private entities offering Medicare plans must also offer a high-option plan. High-option plans include the standard core Medicare benefits plus outpatient prescription drug coverage and stop-loss protection for standard benefits. Outpatient prescription drug coverage must meet an minimum average value of \$800 in 2003 (adjusted annually for thereafter) as determined actuarially by the Medicare Agency. In any given year a beneficiary's out-of-pocket costs for current Medicare benefits cannot exceed \$2,000.

Beneficiaries would face substantial financial penalties for not enrolling in a high option plan at the earliest reasonable opportunity, or for switching from a high to a standard option plan. Exceptions to those penalties would include situations where employment based coverage was dropped, and similar situations.

HCFA-Sponsored Standard and High-Option Plans

HCFA will offer a nationwide standard plan to include all Title 18 benefits currently available under the Medicare fee-for-service program. HCFA will submit premium information for this plan to the Board as other plans do. Current payment and coverage rules and regulations applicable under the fee-for-service program will also apply to the HCFA-sponsored standard plan.

Beginning in 2003, HCFA would be authorized to offer one or more high-option plans, in addition to the standard plan, through partnerships with private entities. Insurers, pharmaceutical benefit managers, chain pharmacies, Medigap insurers, groups of independent pharmacies, or other qualified private entities may partner with HCFA to offer drug coverage as part of a HCFA-sponsored high-option plan. The HCFA-sponsored high-option plans must meet the same minimum actuarial value of drug benefits as other private high-option plans. HCFA may not exclude qualified private entities offering to partner with HCFA to form a high-option plan, as long all requirements established by the Medicare Board are met.

Only beneficiaries enrolled in the HCFA-sponsored standard plan would continue to be able to purchase Medicare supplemental insurance for coinsurance and deductibles for covered benefits. However, beneficiaries in high option plans would be allowed to purchase coverage for benefits not otherwise provided. For example, beneficiaries with employment-based coverage would be allowed to use that coverage to fill in any remaining gaps in their drug coverage.

Medicare Agency to Organize Drug-Only Coverage for Fee-For-Service Beneficiaries if HCFA Cannot or Will Not Organize HCFA-Sponsored High Option Plans.

In the event that private or HCFA-sponsored High Option plans would not be available to beneficiaries in a region, the Medicare Agency must establish drug-only coverage options for those beneficiaries. The Agency would arrange with private Pharmaceutical Benefit Managers (PBMs) or other private entities to offer drug-only coverage. That coverage would be subsidized in the same way as high option plans would otherwise be subsidized, and payments to PBMs or other private entities offering coverage would be adjusted for risk. The Agency would be required to arrange that all beneficiaries have the choice of more than one High Option or drug-only plan, so that competition would be ensured. If for a time there was no high option plans and only one drug-only plan in an area, the Agency would be allowed to use incentive or risk sharing arrangements with that plan, provided that federal costs did not exceed the drug subsidies (\$200 and reinsurance) otherwise budgeted for high option and drug only plans.

Competing drug-only options arranged by the Medicare Agency would have the same minimum average benefit value (\$800 in 2003 and indexed thereafter) as high option plans. The generous subsidies for high option or drug-only coverage--both premium discounts and subsidies for plans' highest cost cases (see below)--ensure that private drug options will be available to all Medicare beneficiaries.

Note--A concern with the Breaux-Frist Plan is that private entities may be unwilling to partner with HCFA to form HCFA-Sponsored high option plans, or that HCFA may be unable to organize such coverage in a expedient manner. A concern with the President's proposal, which would have HCFA contract with only one PBM in a region, is it would inevitably result in HCFA price controls and limitations on the flexibility of or innovations in benefit design. The incremental proposal bridges the gap by providing that plans will be available to all, but that competition and flexibility will result.

General Qualifications to Offer a Medicare Plan

In order to offer a Medicare plan, a plan must meet the requirements currently applicable to Medicare+Choice plans and organizations, including the offering of benefits and protections for Medicare beneficiaries. Plans must submit to the Medicare Agency a description of benefits, the bid for the package of benefits, and the proposed service areas. The Medicare Agency will review the information submitted and negotiate premium and benefit design with the plans.

General Payments to Medicare Plans and Computation of the Beneficiary Premium

- **Step 1:** The Agency publishes, with a reasonable amount of notification to plans, geographic and risk adjusters.
- **Step 2:** An entity submits a bid for a package of benefits to the Medicare Agency.
- **Step 3:** The Agency computes a premium for core benefits (for ease of computation in carving out the core benefits, for ease of computation, the Agency would allow de minimis additional benefits to be included in a plan's computation of its premium for core benefits).
- **Step 4:** The Medicare Agency calculates a premium schedule based on the premium for the HCFA-sponsored standard plan.

Note--The Medicare Commission proposal and the Breaux-Frist proposal linked the new premium schedule to the weighted average (core benefit) premium of all plans. The President's plan linked the premium schedule to the premium for the HCFA-run standard plan. The New Dem/Blue Dog incremental proposal links the premiums schedule to the HCFA-run standard plan, as the President proposed.

- **Step 5:** Beneficiary premiums are determined for both standard and high-option plans (as described below).
- **Step 6:** The amount of payment to a Medicare plan per enrollee is equal to the premium for the plan as approved by the Medicare Agency. That portion of the premium associated with core benefits is subject to geographic and risk adjustment.
- **Step 7:** In the case of high option plans, the Agency will subsidize plans' highest cost drug cases as outlined below.

Reinsurance for Plans' Highest Cost Drug Cases

The Medicare Agency would reimburse plans for 75% of plans' drug benefit costs for plan enrollees with drug benefit costs over a certain amount. That amount would be set each year, based on a predetermined budget for such reimbursement. The budget total for such reimbursements would be \$30 billion over ten years (2003-2010).

Note--This provision is similar to an idea that proposed by Rep. Bill Thomas (R-Ca.) in April. It would give plans a strong incentive to offer a maximum out-of-pocket (stop-loss) benefit as part of their drug benefits.

Computation of Beneficiary Premiums

- The beneficiary pays no premium if the premium for the plan selected is less than 85% of the premium for the HCFA-run standard plan for that year.
- For beneficiaries in the HCFA-run standard plan, or if the premium for a plan equals that of the HCFA-run standard plan, the beneficiary would pay an amount equivalent to 25 percent of Part B costs, as under current.
- If the premium for a plan is between the premium for the HCFA-run standard plan and 85% of that amount, the beneficiary premium would be based on a sliding scaled between zero and the beneficiary premium for the HCFA-run standard plan.
- If the premium for a plan is greater than the premium for the HCFA-run standard plan, the beneficiary premium is equal to an amount equivalent to 25 percent of Part B, plus the amount by which the plan premium exceeds that of the HCFA-run standard plan.

Premium collection for beneficiaries shall occur in the same manner as under current law, so that a beneficiary's share of the premium for Medicare benefits is deducted from their Social Security check. Medicare plans are not responsible for collection of premiums.

Premium Discount for Drug Benefits Under High-Option Plans or Drug-Only Plans

Low-Income Protection Package

Beneficiaries at or below 135% of poverty will pay zero premium for enrollment in the lowest cost high-option plan in their area. If no high-option plans are available, those beneficiaries would receive free coverage in the lowest-cost drug-only plan administered by the Medicare Agency. In either case, the cost would be split between the federal government and the states, based on a formula designed to protect states from new costs for current enrollees in state assistance programs, but also maintain the current state effort. Beneficiaries qualifying for this subsidy include dual eligibles, qualified low-income Medicare beneficiaries (QMBs), specified low-income Medicare beneficiaries (SLMBs), and certain qualifying individuals (QI-1s). The Medicare Agency will establish an arrangement with each state to determine eligibility for these beneficiaries.

A beneficiary whose income is above 135% of poverty but less than 150% of poverty will receive a discount for drug benefits in the same manner, phasing down from a 50% discount at 136% of poverty to a 25% discount at 150% of poverty.

In all cases, and as explained above, States must maintain their current level of assistance for premiums, cost-sharing, and deductibles, as required under current law, for beneficiaries at or below 135% of poverty.

If a qualified low-income beneficiary chooses a higher cost high-option plan or Agency-sponsored drug-only plan, the beneficiary will receive a discount based on the premium for the lowest cost high-option plan or drug-only plan.

Note—These provisions for low income subsidies blend features of the President's plan and the Breaux-Frist bill.

Beneficiaries above 150% of poverty

Beneficiaries above 150% of poverty choosing a high-option plan or an Agency-sponsored drug-only plan will receive a \$200 discount off the premium for that plan. That amount is 25% of the minimum value of drug benefits in high option or drug-only plans. (The \$200 discount would be indexed over time at the same rate as the minimum actuarial value of the high-option drug benefit or drug-only benefit). The value of the discount for drug premiums will be treated as taxable income for beneficiaries so that the discount is income-related.

Medicare Beneficiary Outreach and Education

The Medicare Agency may authorize the establishment of Medicare Consumer Coalitions (MCCs), where a non-profit organization, composed primarily of Medicare beneficiaries in a given area, is organized to provide for beneficiary outreach and education of Medicare benefit offerings. Specifically, MCCs will conduct programs to prepare and disseminate to Medicare beneficiaries comprehensive, accurate, timely and understandable information on qualified health plans or Medicare supplemental policies in which beneficiaries are eligible under the Competitive Premium System. All Medicare beneficiaries would be eligible to enroll in an MCC.

Trustees and Medicare Agency to Report on General Revenue Financing of Medicare and Other Measures

The Medicare Trustees would be required to report on the general revenue contribution to Medicare's total spending, and form projections of that share into the future. They would also be instructed to highlight other measures of total Medicare spending relative to the size of the economy and the federal budget. The Medicare Agency would also be required to report to Congress annually on the financial status of Medicare and the status of Medicare's competitive system and availability of benefits.

For accounting purposes, the federal savings from the new competitive system would be split between Parts A and B, as under current law. New federal spending for reinsurance of plans' highest cost drug coverage would also be split between Parts A and B, but would not affect the computation of the Part B premium. Premium discounts for drug coverage and those with low incomes would be accounted for as affecting offsetting receipts, not spending.

Recommendation for a Division of HCFA-Sponsored Plans

The proposal will recommend, but not require, that HCFA be divided into two divisions, the Division of HCFA-Sponsored Plans and the Division of Health Programs. The Division of HCFA-Sponsored Plans will only be responsible for administering HCFA's standard and high-option plans. The Division of Health Programs will continue to maintain all other non-plan and non-insurance functions, such as the Medicaid program, the State Children's Health Insurance Program, disproportionate share hospital payments and graduate medical education payments. The purpose of this provision is to allow HCFA to approach its requirement to offer the HCFA-run standard plan and any high option plans in a focused and businesslike manner.

HCFA Business Planning

Beginning on January 1 of each year, and no later than January 1, 2002, HCFA would be required to submit a business plan to Congress. This plan would include a comprehensive payment and management plan for all aspects of offering core benefits, information about partnership arrangements with private entities for prescription drug coverage in high-option plans, and recommendations for benefit coordination and improvements. The plan should include legislative specifications necessary to enact the business plan, if applicable. The business planning process should ensure that procedures for public comment are established. The CBO, GAO, and MedPAC would be required to submit reports to Congress evaluating the business plan's impact on cost, providers, and beneficiary access to care.

HCFA Administrative Flexibility

HCFA should be granted new flexibility to use private-sector tools to create greater efficiencies within the program and to become more skilled in private sector delivery mechanisms. First, HCFA would be allowed to establish Disease Management programs through private sector disease management organizations for particular health conditions, such as stroke, diabetes, and so on. Second, HCFA would be allowed to establish a Preferred Provider network (often referred to as a PPO), designed to offer savings both to beneficiaries and the federal government. Third, HCFA

would be granted greater flexibility in hiring and firing (relaxing current civil service rules) to allow management efficiencies within the agency.

Note--The Breaux-Frist plan contained a system of comprehensive HCFA reporting and a gradual relaxation of Congressional micromanagement of HCFA payments through process rules, such as fast track votes. The President's plan granted greater authority to HCFA without any reporting requirements. This proposal grants specific new administrative flexibilities in exchange for annual reporting to Congress.

Institute for Medicare Practice

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Box 1062
New York, NY 10029

To: Chris Jennings Affiliation: _____
Fax: (202) 456-5557 Phone: (202) 456-5560
From: Bruce C. Vladeck, Ph.D. Date: 5/8 # Pgs (including cover): C+11
Re: Dynamite Data!
☒ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

• Comments:

Take a look at this!
Then call me.
Cheers,
B.

MOUNT SINAI NYU
HEALTH

Drug Coverage and Out-of-Pocket Spending Among Medicare Beneficiaries: What is Changing in the Face of the Current Market Frenzy?

Dana Gelb Safran, ScD, Ira Wilson, MD, ScM, Margaret Davis, MHS,
Jana Montgomery, William H. Rogers, PhD, Hong Chang, PhD,
Barbara Cooper, Bruce C. Vladeck, PhD

Institute for Medicare Practice
Seminar Series
9 May 2000

AHRQ / NIA Grant #R01 HS09622

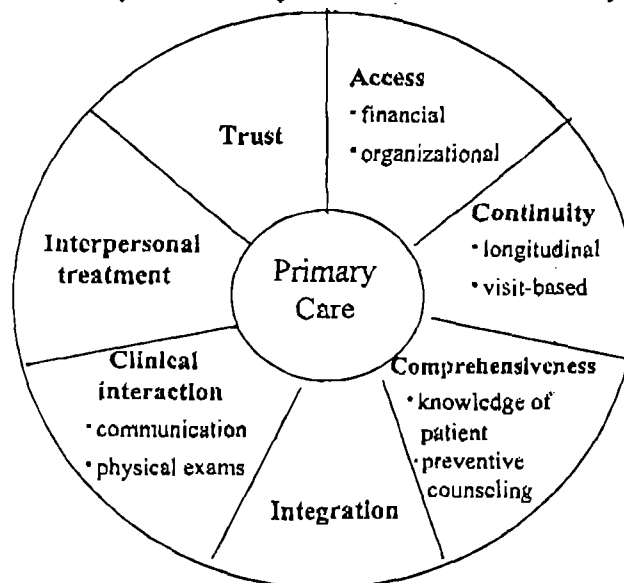
Choice & Quality in Senior Health Care: A National Study

- Longitudinal study of Medicare beneficiaries 65 years and older
- Comparison of primary care performance and outcomes in conventional (FFS) Medicare and Medicare HMOs
- Baseline data collection: Fall 1998
- First follow-up: Fall 1999
- Panel retention: 72 percent (n=6478)

Choice & Quality in Senior Health Care: A National Study (cont'd)

- A guiding principle of the study was to evaluate managed Medicare in its mature, not nascent, stages.
- We excluded:
 - States in which Medicare HMOs were just emerging
 - HMOs contracted after 1994 or with < 2500 members
 - Beneficiaries newly enrolled in their current HMO or in conventional Medicare (< 12 months)

Essential Attributes of Primary Care Measured by the Primary Care Assessment Survey (PCAS)



Medical Care. 1998; 36(5):728-739.

Sampling

States

- All states with substantial Medicare HMO enrollment in at least 2 plans since 1994 or earlier

AZ, CA, CO, FL, IL, MA, MN,
NM, NY, OR, PA, TX, WA

Plans

- All Medicare HMOs with ≥ 2500 enrollees since 1994 or earlier (n=121)

Sampling (cont'd)

Beneficiaries (n=16,000)

- Continuously enrolled in current Medicare HMO or in conventional Medicare (FFS) for at least 12 months
- Allocation model to define optimal sample sizes from each plan
- Random sample of allocated number from each plan
- FFS beneficiaries matched on age, sex, zip code (1:2)

Representation

- 80% of U.S. managed Medicare enrollees reside in the 13 states studied.
- The study's HMOs include 99.2% of all Medicare HMO enrollees in the 13 states studied.
- 28% of U.S. conventional Medicare enrollees reside in the 13 states studied.

Representation (cont'd)

- Probability sampling weights are applied to all analyses.
- The result is that the sample is representative of all Medicare beneficiaries:
 - In these 13 states.
 - In these mature HMOs or conventional Medicare.
 - Continuously enrolled in HMO or in CM for ≥ 1 year.

Questions Concerning Coverage and Prescription

35. Do you have insurance that covers any of the costs of prescription medicines?

☐ Yes
(1)

☐ No
(2)

43. How many different prescription medications are you supposed to use (include pills, liquid medicines, injections, and skin patches)?

☐
None
(1)

☐
1 or 2
(2)

☐
3-5
(3)

☐
6-9
(4)

☐
10 or more
(5)

Questions Concerning Coverage and Prescription

38. For your medications, how much money do you personally have to pay each month (not reimbursed by an insurance plan)?

☐
No
charge for
medications
(1)

☐
\$1-\$24
(2)

☐
\$25-\$49
(3)

☐
\$50-\$99
(4)

☐
\$100-\$199
(5)

☐
\$200
or more
(6)

- 39b. Do you ever skip medications or treatments because they are too expensive?

☐
Yes, often
(1)

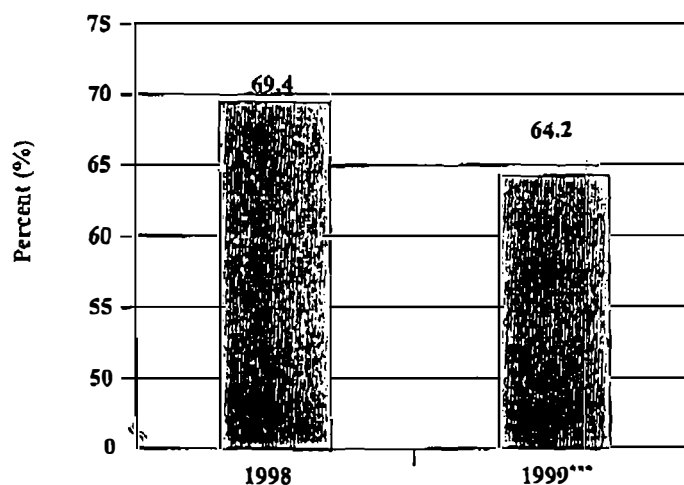
☐
Yes,
occasionally
(2)

☐
No, never
(3)

**Enrollee Characteristics:
Conventional vs. Managed Medicare, Weighted**

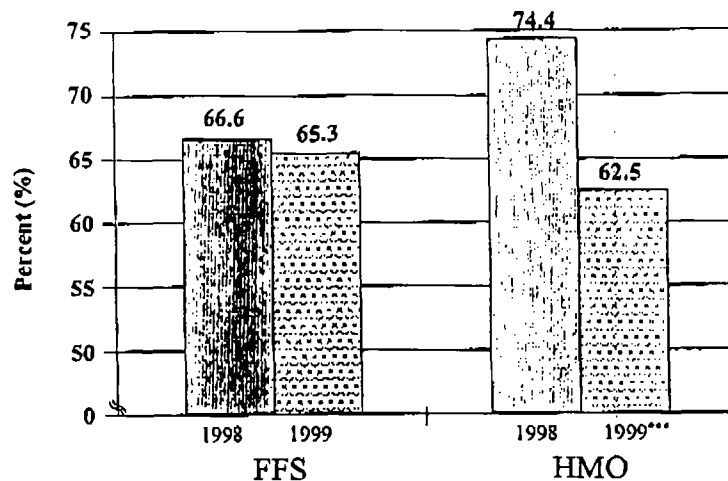
	FFS	HMO	
<u>SOCIODEMOGRAPHICS</u>			
Age (mean)	75.6	74.7***	
Female (%)	59.0	58.0	
White (%)	91.0	91.0	
Education (mean)	12.7	12.5**	
Income < \$20,000 (%)	38.0	46.0***	
<u>HEALTH</u>			
Physical health (summary)	40.9	42.1**	
Mental health (summary)	52.4	52.3	
Hypertension (%)	57.0	54.0*	
Diabetes (%)	16.0	14.0**	* p < .10
Asthma (%)	15.0	13.0*	** p < .05
Arthritis (%)	38.0	34.0**	*** p < .001

Medicare Beneficiaries with Drug Coverage, 1998 and 1999



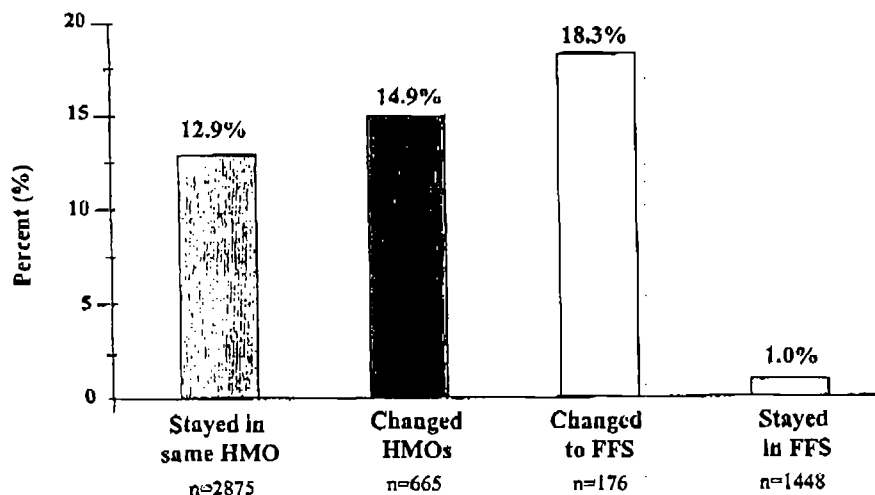
*** p < .001

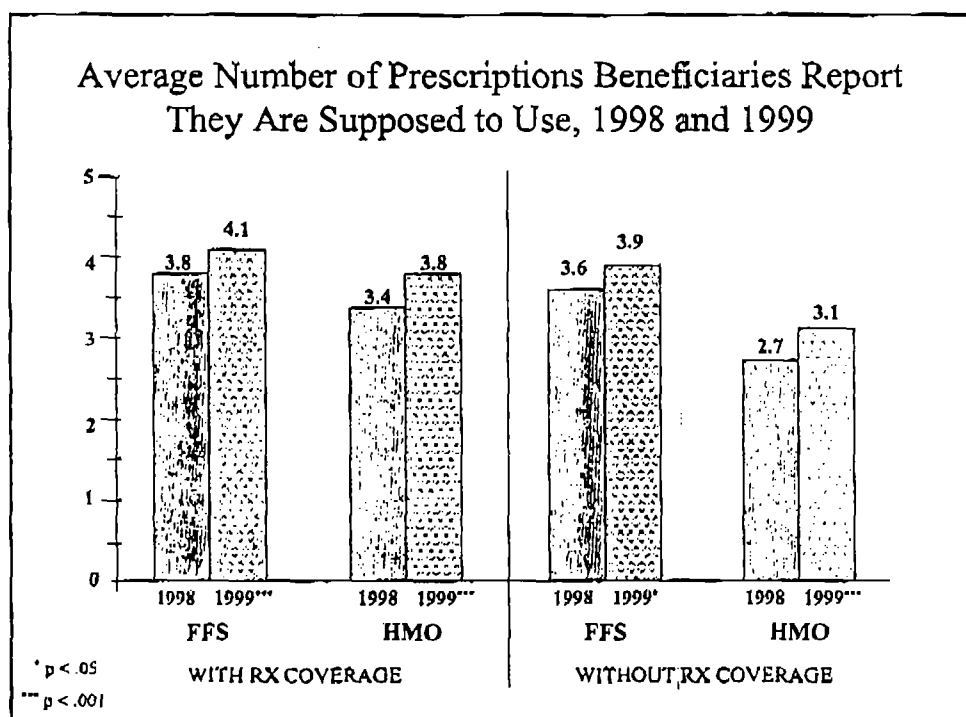
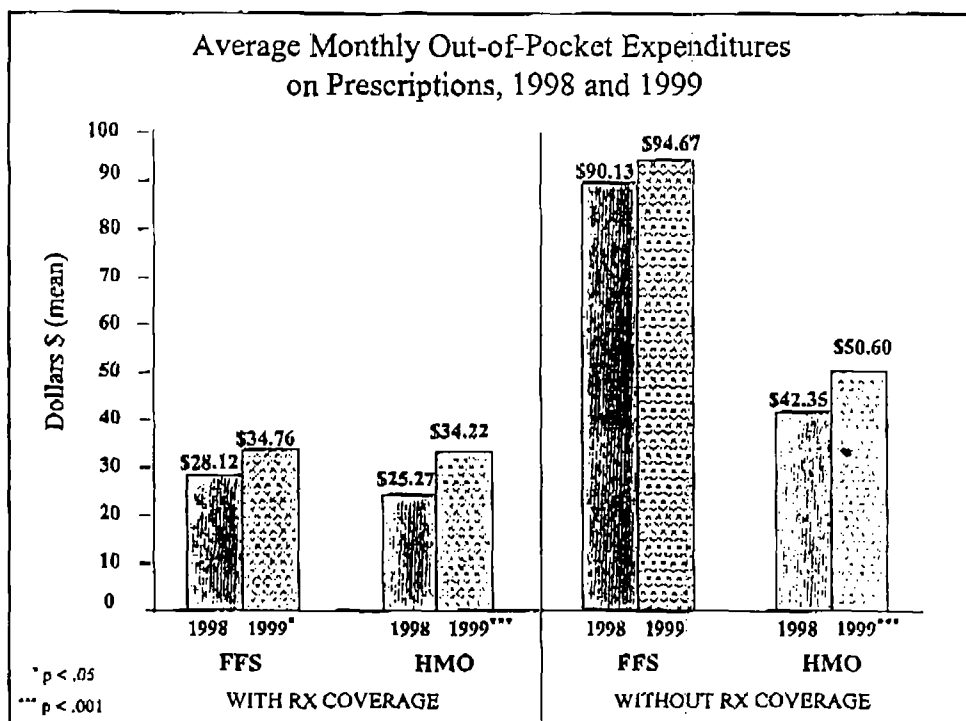
Medicare Beneficiaries with Drug Coverage, Conventional (FFS)
Medicare and Managed Medicare, 1998 and 1999

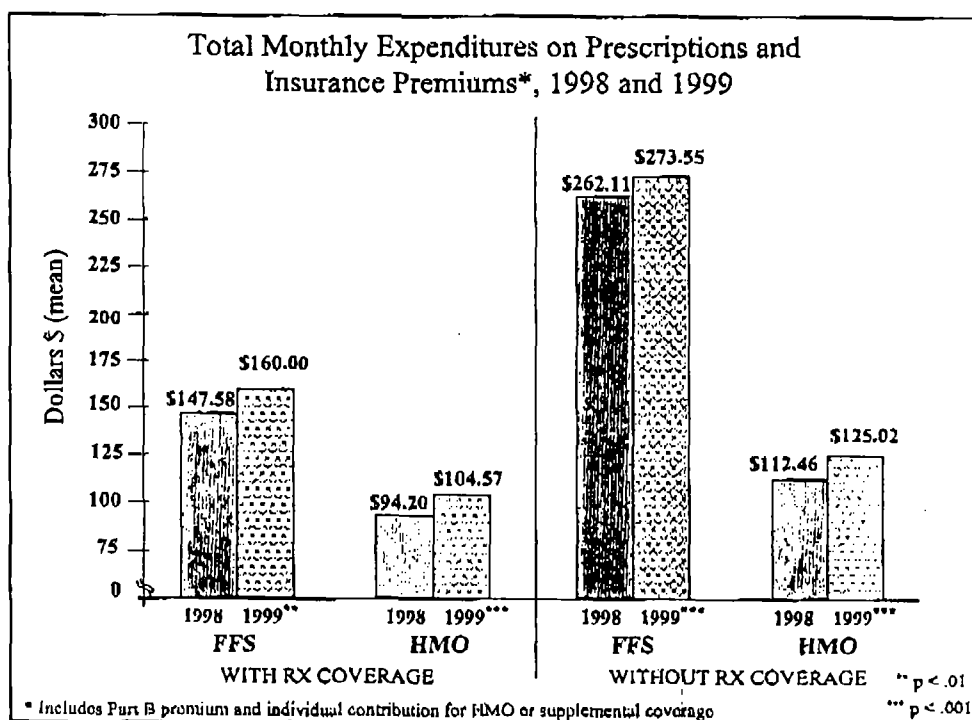
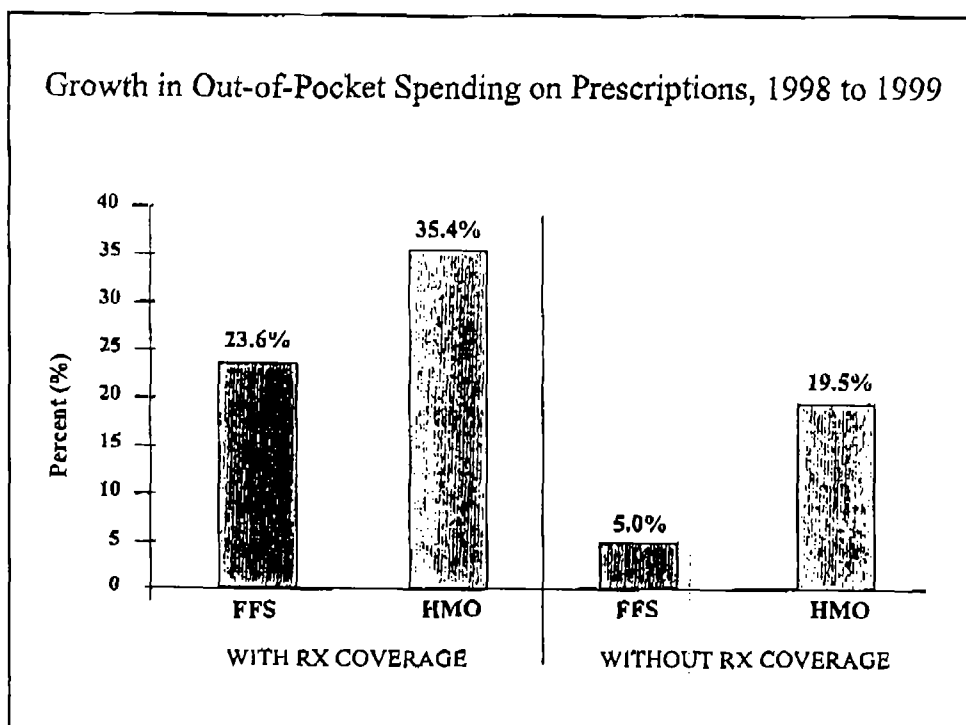


*** p < .001

Percent Decline in Beneficiaries with a Drug Benefit by
Enrollment Change Status, 1998-1999







The bar chart displays the percentage of patients with a primary diagnosis of mental illness who received a prescription for an antidepressant. The Y-axis represents the percentage, ranging from 0 to 25. The X-axis is divided into two main sections: 'WITH RX COVERAGE' and 'WITHOUT RX COVERAGE'. Each section contains two groups of bars: 'FFS' (Fee-For-Service) and 'HMO' (Health Maintenance Organization). For each group, two bars represent the years 1998 and 1999. The 1999 bars for the HMO group in the 'WITH RX COVERAGE' section are marked with three asterisks (***) indicating statistical significance.

Coverage Status	Provider Type	1998 (%)	1999 (%)
WITH RX COVERAGE	FFS	4.9	5.5
	HMO	5.5	8.9***
WITHOUT RX COVERAGE	FFS	14.1	17.8
	HMO	11.8	12.4

p < .001

- Between 1998 and 1999, the rate of drug coverage among Medicare beneficiaries declined substantially.
- The majority of the observed decline is accounted for by a sharp drop in rates of coverage among Medicare HMO members.
- Rates of drug coverage among beneficiaries in HMOs is now lower than among beneficiaries in conventional Medicare.

Conclusions (cont'd)

- For those with drug coverage, out-of-pocket spending on medications grew by 24% among those in FFS and 35% among those in HMOs -- with little change in the number of prescriptions reported.
- This suggests that in one year's time, the depth of drug coverage has eroded substantially, most particularly in the HMOs.

Conclusions (cont'd)

- The number of beneficiaries skipping medications because of cost is high and growing.
- The findings suggest that about 4 million U.S. seniors skip medications because they cannot afford them.



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Date: 9 May 2000

To: Karen Tramontano / Chris Jennings

Fax: 2/ 456-2030

From: Gerald M. Shea
Assistant to the President for Government Affairs

Number of pages (including cover sheet): 15

Re: FYI

May 10, 2000 (Embargoed for release at 10:30AM)

For information contact: Barbara Cebuhar, (540) 832-5665 or in DC (202) 393-0660.

NEWS RELEASE DRAFT3

PRESCRIPTION DRUG COSTS GREATER THAN PREVIOUSLY ESTIMATED: NEW CENTER REPORTS FIRST RESULTS OF NATIONAL STUDY

Washington, DC— RxHealthValue, an independent, non-profit information center formed by more than 30 organizations representing consumers, health plans, union workers, health care providers and employers today announced the findings of a study of 1.4 million continuously insured people, their use of prescription drugs and the resulting costs over the last three years. Annualized cost increases for the population surveyed were 28.8% (24.4% when adjusted for study group's aging) for each of the three years studied (1996-1999), a higher rate of increase than reported by any previous study.

RxHealthValue members asked the Schneider Institute for Health Policy at Brandeis University to undertake the study using the extensive data base of PCS Health Systems, a national pharmacy benefit management organization and a Center member. The study will be described tomorrow at the annual meeting of the Council on the Economic Impact of Health System Change at Princeton University. Stanley Wallack, Ph.D., Executive Director of the Schneider Institute and principal investigator for the study, says "This is the first research that documents the actual use of prescription drugs by an insured population over time and allows us to identify some never reported trends. These findings are significant in that we now know that price isn't the single factor driving escalating prescription drug expenditures. Americans are using more prescriptions, at younger ages and for more conditions and are substituting newer, more costly medications for more established products. This increase in cost per treatment day, coupled with the price and the substitution effect in a stable population of insured individuals has been the major contributor to the 28.8% annual increase during this period."

The Brandeis researchers determined that the increase in the number of people taking prescription drugs has been greatest among the 45-65 year-olds. The growth in prescriptions per person has been greatest for the 65 and older age group. New medications account for more than one third of the increase in total expenditures during this period. Additionally, focusing on three specific

drug classes - Proton Pump Inhibitors (GI agents); Cox-2 and NSAIDs (anti-arthritis) and Statins (cholesterol-lowering drugs), they found patients not only substituting new drugs for old ones, but also beginning drug therapy for conditions not previously treated with prescription medications.

With this increase in use and costs of prescription drugs, little objective comparative information is available. "Consumers, clinicians, payers and policy makers are at a distinct disadvantage," said John Golenski, Acting Executive Director of RxHealthValue. "Determining value has been almost impossible in the absence of an independent source of data and analysis." Golenski said RxHealthValue has been created to provide that kind of information. Since RxHealthValue's primary mission is the creation and dissemination of useful information for making value-based judgments, the Center's members made three initial recommendations today:

- Establishment of independent research institutes to determine the clinical and economic value of prescription drugs;
- Development of national standards for risk/benefit information disclosure in direct-to-consumer advertising of prescription medications; and,
- Improved post-marketing monitoring of adverse drug reactions, especially of "fast track" drugs, by the FDA.

In the next several months, RxHealthValue will be sponsoring additional research on prescription drug value and releasing additional recommendations to enhance and support value-based decisions. For more information about the research findings, contact Stanley Wallack, Ph.D. or Cindy Parks-Thomas, P.A., Ph.D. at 781-736-3900. ###

Biographies of RxHealthValue Speakers/Contacts

Christine K. Cassel, MD, MACP is Chairman of the Department of Geriatrics and Adult Development of Mount Sinai Medical Center and Professor of Geriatrics and Medicine. (212-241-4840; c_cassel@smtpink.mssm.edu) She joined Mount Sinai in 1995 after ten years as Chief of General Internal Medicine at the University of Chicago, where she was Professor of Medicine and Public Policy Studies, Chief of the Section of General Internal Medicine, Director of the Center on Aging, Health and Society, Director of the Center for Health Policy Research, and Director of the Robert Wood Johnson Clinical Scholars Program at the University of Chicago and George M. Eisenberg Professor in Geriatrics. Her work has brought together the biomedical, ethical and policy issues in general internal medicine and geriatrics. She completed her MD at the University of Massachusetts in 1976. Dr. Cassel took her training in Internal Medicine at Children's Hospital of San Francisco and at the University of California, San Francisco and did a Fellowship in bioethics at the University of California in 1979 and a Fellowship in Geriatrics at the University of Oregon and the Portland Oregon Veterans Administration Medical Center in 1981. Her leadership roles including past president of the American College of Physicians, Physicians for Social Responsibility and the Society for Health and Human Values. She was the first woman to Chair the American Board of Internal Medicine. She has been elected to membership in the Institute of Medicine of the National Academy of Sciences, and the Association of American Physicians. In 1997 she was

appointed to the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry and in 1999 to the Advisory Committee to the Director of NIH. She is currently Chair of the Board of the Greenwall Foundation and a Trustee of the Russell Sage Foundation. She has served as a consultant to the Veterans Administration, the Health Care Financing Administration, the National Institute on Aging, the Agency for Healthcare Quality and Research and the United States Congress.

Mark Cloutier, MPP, MPH., (mcloutier@rxhealthvalue.org, 510-757-5987) is the Acting Project Director for the RxHealthValue project and is the person that will be responsible for ongoing coordination of the research and education efforts the organization chooses to support in the years to come.

Elizabeth Dichter is Executive Vice President, Strategic Marketing of PCS Health Systems, Inc. (480-391-4450; www.pchs.com, Elizabeth.Dichter@pchs.com) one of the nation's largest physician benefit management companies providing drug and health management solutions for health plans and patients. PCS works to encourage proper drug use and helps to lower the cost of drugs for its clients. PCS manages and monitors 300 million individual prescriptions each year representing more than \$12 billion in drug expenditures. With a long history in public health and pharmacy benefits issues, she is responsible for creating PCS strategy and developing new market opportunities. Previously, Dichter was senior vice president of marketing and planning for Lutheran Health Systems, a major hospital chain, where she developed the first triple-option, point-of-service health plan for its employees. Earlier, she was vice president for managed health care plans for a BlueCross/BlueShield plan where she developed HMO and PPO products. Dichter established the first coalition of health care purchasers in Colorado, and served as advisor to Health Data Institute, Codman Research Group and other leading health research organizations. She earned a master's degree in public health in health care management from the University of Michigan and a bachelor of arts degree in economics and political science from the University of Colorado.

John Golenski, Ed.D., is the Acting Executive Director of the RxHealthValue Center and is the President and Founder of the Bioethics Consultation Group, Inc. of Berkeley, California. (510-486-0636; jgolenski@rxhealthvalue.org) The group advises national, regional, local and international clients in ethical reflection regarding three areas in health care – strategic planning and policy, clinical delivery systems and medical group management. He has provided assistance to a variety of complex resource decision-making projects including the Medicaid Prioritization Project in Oregon, the Governor's Blue Ribbon Panel on Cost Containment for Hawaii and has provided assistance to state health care reform projects in California, Arizona, Florida, New York, Kentucky and Rhode Island. He received his doctorate in Human Development from Harvard University and did post-doctoral studies in theology and ethics at the Jesuit School of Theology.

Sharon Levine, MD is the Associate Executive Director of the Permanente Medical Group in Oakland, CA since 1991 and a practicing pediatrician with the Permanente Medical Group since 1977. (510-987-3855, Sharon.Levine@nca.kaiperm.org) She has broad responsibilities for human resources, (recruitment, compensation, clinical and management training), diversity, public relations, health policy and community and government relations. Dr. Levine is board certified by the American Board of Pediatrics and is a member of the American College of Physician Executives, California Medical Association, American Medical Women's Association, and American Medical Association. She received her undergraduate degree from Radcliffe College and her MD from Tufts University School of Medicine. Statewide, The Permanente Medical Group employs 4,000 physicians and serves 3 million members enrolled in Kaiser Permanente, the state's largest HMO.

Jim Mortimer organized the Business Group in 1980 with a group of about twenty employers who came together from Illinois, Indiana, Iowa, Michigan, Minnesota, Ohio and Wisconsin (773-380-9090; Mortimer@mbgh.org, www.mbgh.org) to create a vehicle to help learn new ways to manage benefit plan costs. Now the Business Group has almost 110 member employers and spans an eleven state region. Its mission is to provide leadership and knowledge to continuously improve the quality and cost-effectiveness of health services. MBGH works with its members to research and develop new tools for health care purchasing and consumer information, and with local chapters to achieve health market reforms. Prior to the Business Group, Jim worked 14 years for Continental Bank in Chicago. He held the title of second vice president in the personnel division responsible for employee benefits, employee relations, medical services and employee counseling. He currently is on the U.S. Chamber of Commerce Health and Employee Benefits Committee; the National Business Coalition on Health Board of Directors; the American Health Quality Association Board of Directors, a Federal Agency for Health Care Policy and Research Advisory Committee; and the Electronic Data Interchange Task Force of the Illinois Hospital and Health Systems Association. He is a graduate of the University of Iowa with a degree in psychology and has pursued graduate courses in business and mathematics at Loyola University.

Scott Serota is acting President and CEO of the Blue Cross Blue Shield Association, a national federation of 48 independent locally-based Blue Cross and Blue Shield companies. (202-626-4780, scott.serota@bcbsa.com) This system provides health care financing and delivery for 74.5 million people – roughly one in four Americans. The organization provides a range of products including one of the largest managed health care providers, serving more than 50 million HMO, PPO and point-of-service plan members. He has served in a variety of capacities at the Association since 1996 including COO and Executive Vice President for System Development. He was charged with organizing support for clinical trials of investigative therapies and overseeing the Blue Technology Evaluation Center (TEC), the nation's leading source for evaluating the safety and efficacy of emerging medical treatments.

Gerald Shea is the Assistant to the President for Government Affairs of the AFL-CIO, a voluntary federation of 68 national and international labor unions, representing over 13 million working men and women across the country. (202-637-5237, gshea@aflcio.org) Prior to this appointment, Mr. Shea served as Executive Assistant to the AFL-CIO Secretary Treasurer and director of the Employee Benefits Department and held a number of positions with the Service Employees International Union. He is a member of the 1994-1996 Advisory Council on Social Security, Medicare Prospective Payment Advisory Commission and serves as a public representative of the Joint Commission on the Accreditation of Health Care Organizations. Making health care affordable and accessible to all and increasing health care quality are top priorities for the AFL-CIO. Unions represent more than one in four Americans with employer-based health insurance. Unions are also the largest group of organized health care purchasers and represent both providers and consumers of managed care.

John C. Rother is the Director of Legislation and Public Policy for AARP. (202-434-3704, jrother@aarp.org) He is responsible for the federal and state legislative advocacy activities of the Association, based on in-depth policy research and public information programs. He is an authority on Medicare, managed care, long-term care, Social Security, pensions and the boomer generation's retirement situation. Prior to coming to AARP, Mr. Rother was Special Counsel for Labor and Health to former Senator Jacob Javits (R-NY), and as Staff Director and Chief Counsel for the Special Committee on Aging, under its Chairman, former Senator John Heinz (R-PA). He currently serves on the National Committee for Quality Assurance, National Academy on Aging, Health Care

Quality Forum and Citizens for Long Term Care. He is a graduate of Oberlin College and the University of Pennsylvania Law School.

Cindy Parks Thomas, P.A., Ph.D., is a Senior Research Associate with the Schneider Institute for Health Policy (781-736-3921, cthomas@brandeis.edu) and developed the methodology and data associated with the Brandeis/PCS Survey and is conducting research for the Institute's Prescription Drug Analysis Group. Dr. Thomas is also currently directing a research project studying adoption of a new pharmaceutical therapy for use in alcoholism treatment, funded by the National Institute on Alcohol Abuse and Alcoholism. Dr. Thomas' experience and published work in health services include: case studies of technological innovation in health care, quality of care in free-standing primary care centers and in academic medical centers, access to support services among home health clients, and evaluation of health programs in developing countries. Prior to coming to the Schneider Institute, Dr. Thomas was Assistant Research Professor (now adjunct) at the Boston University School of Public Health Department of International Health. She also practiced as a Physician's Assistant in both a rural private practice and for Kaiser Permanente Health Plan. Dr. Thomas holds a Ph.D. in Health Policy from Brandeis University Heller Graduate School (May 2000) and a Master's Degree in Health Policy and Management from the Harvard School of Public Health.

Stanley Wallack, Ph.D., is the Executive Director and founder of the Schneider Institute for Health Policy and a member of the faculty of Brandeis University. (781-736-3900, wallack@brandeis.edu) The Institute has been a major policy research center for the Health Care Financing Administration, Administration on Aging and for the National Institute for Drug Abuse. From 1987 to 1998 he was Chairman of the Board and Chief Executive Officer of LifePlans, Inc., a Boston-based long-term care risk management company. He was Chairman of the Coalition for Long Term Care Reform from 1993-1997. After receiving his Ph.D. in Economics in 1969, Dr. Wallack taught at the University of Illinois in Champaign-Urbana, Illinois. He was a Brookings Institute Policy Fellow in 1969-1970. In the 1970's, he served as Deputy Assistant Director for Health, Income Assistance, and Veterans Affairs, at the Congressional Budget Office, and in the Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education and Welfare. Much of Dr. Wallack's extensive research and publications have focused on effective reimbursement systems and organizational arrangements for acute and chronic health care. He developed the concept of the Social Health Maintenance Organization, which integrates the financing and delivery of acute and long-term care services. He helped develop other innovative Medicare proposals including voluntary volume performance standards for physician groups and a capitated program for End Stage Renal Dialysis patients (ESRD). He has been a frequent contributor to a number of the nation's top health care policy and economic publications.

Dan Wolfson is the President and Chief Executive Officer of the Alliance of Community Health Plans; the nonprofit health plans serving communities throughout the United States. (732-220-1388, dwolfson@achp.org). He has guided this alliance of integrated, non-investor owned and provider-based health plans in its mission to focus on the highest standards of member plan performance and to facilitate improvement. During his tenure, Mr. Wolfson directed the development of the Health Plan Employer Data and Information Set (HEDIS 1.0), a nationally applied measurement to assess the performance of managed care companies. He also developed *Effective Clinical Practice*, the first clinically oriented journal targeted at managed care physicians and health care professionals. Prior to joining ACHP, Mr. Wolfson served as the director of planning and research for the Fallon Community Health Plan. He also served as project director for the first Medicare demonstration for contracting for Medicare on a risk basis. Mr. Wolfson earned a Masters of Health Care Services Administration at the University of Michigan School of Public Health and holds a BA in sociology from Boston University.

RxHEALTH VALUE RECOMMENDATIONS (5/2000)

Introduction

The success of pharmaceutical research has been a blessing for many Americans. New therapeutic agents relieve symptoms, ameliorate disabilities, improve the health and quality of life of all Americans and even cure disease. Ongoing research and innovation will continue to drive the proliferation of pharmacological success.

This blessing, however, comes at a high price. Drug costs have escalated dramatically taking an increasing percentage of health care resources. In the absence of independent data regarding the comparative value of new prescription drugs, purchasers, providers and consumers are asking whether they are obtaining good value for the resources expended. In addition, these rising costs are threatening the availability of prescription drug benefits for those consumers who have them and making it harder to expand benefits to those who currently lack them.

It is the conviction of the participating stakeholders in RxHealthValue that only a vigorous, open and information-rich dialogue can answer the question of value and secure access to health-improving prescription drugs for all Americans. They have convened this effort to advance their shared interest in increasing the amount and quality of independent information available to guide treatment, coverage, and policy decisions and to inform consumers who increasingly seeking information about health choices. RxHealthValue aims to inform Congress and state legislatures, educate the public and provide balance in the public policy debate with a focus on the value—clinical and economic—of pharmaceuticals. Rx Health Value has established three initial consensus recommendations:

1. Research

Objective: To provide objective information to consumers, providers, plans, purchasers, policy makers and the health industry to support better decision-making.

Recommendation:

The members of Rx Health Value recommend the creation of independent, non-profit, institutes, governed by boards with substantial consumer participation, to conduct and publish scientific research regarding the comparative value—clinical and economic—of prescription drugs.

Action Steps:

- *To encourage the creation of free-standing, scientifically-based entities to sponsor and conduct research regarding the comparative value of drugs within classes, value trade-offs with other forms of medical care, and the valuation of medications by clinicians and patients over time.*
- *Encourage pharmaceutical companies who advertise to provide access to comparative information linked directly to their advertising.*
- *Recommend reporting of success and failure rates, when data are available, of advertised drugs presented along with other drugs in the same class, comparable therapies, and placebo.*
 - *Seek funding from public foundations and government agencies as well as corporate sponsors with safeguards to prevent any threats to independence.*

2. Direct-to-Consumer Advertising

Objective: To create a framework for the disclosure of complete and balanced information to consumers and providers on drug efficacy, comparative efficacy costs, and comparable alternative treatments available to optimize patients and physician decision-making. RxHealthValue acknowledges that prescription drugs are different from other consumer products, carrying significant risk of harm.

Recommendation:

The FDA develop standards for full disclosure of risks and benefits information for all prescription drugs advertised directly to consumers in a collaborative process with consumer and patient advocates, providers and manufacturers.

Action steps:

Amend current regulations to:

- Require "fair balance" to be proactively enforced; namely, that full disclosure of risks and side effects are given equal print or airtime as description of benefits in the same communication.*
- Require success and failure rates, when data are available, of advertised drugs, presented along with other drugs in the same class, comparable therapies, and placebo.*

3. Safety

Objective: To reduce and, where possible, eliminate exposure of patients to harmful drugs due to lack of research on long-term effects, polypharmacy or improper prescribing or dispensing of prescription medications.

Recommendation:

Rx Health Value recommends that FDA require improved post-marketing surveillance of prescription drugs by manufacturers, especially of "fast-track" medications, to monitor adverse drug reactions (ADRs).

*Action steps:**Amend current regulations to:*

- *Require reporting of newly discovered adverse reactions to the FDA, as well as to manufacturers.*
- *Require that new side effects be added to drug labeling on an on-going basis;*
- *Require written notification to providers of newly discovered adverse reactions on an on-going basis;*
- *Depending on the level of identified adverse reactions, require restriction of distribution or withdrawal of drug from the market.*

Endorse allocation of additional FDA resources to:

- *Develop policies and procedures for more effective coordination between FDA post-marketing drug risk assessors and FDA's review division to better ensure that prompt and appropriate regulatory action is taken on those drugs identified in MARS (monitored adverse reactions);*
- *Develop and enforce standards for the design of drug packaging that will maximize safety. This includes language which is non-scientific/non-clinical at a reading level which is understandable for most consumers;*
- *Require pharmaceutical manufacturers to test proposed drug names to identify and remedy potential sound-alike and look-alike confusion with existing drug names;*
- *Work with physicians, pharmacists, and consumers to establish responses to problems identified through post-marketing surveillance.*

Support usage of technologies such as:

- *New hand-held prescribing devices and order entry systems to significantly improve the "front-end" information available to prescribers, patients, and pharmacists, including information about comparative efficacy, polypharmacy, and costs (where available).*

BACKGROUND

What: RxHealthValue Center – An independent non-profit information center dedicated to helping consumers, clinicians and policy makers secure balanced, objective information about the health and economic value of prescription drugs.

Purpose: The total cost of prescription drugs is quickly becoming a major part of the health care bill. Rx drugs are becoming a larger part of the total care provided. More drugs are being substituted for established, effective drugs sending patients to new products at higher costs. And we are using them at earlier ages to stave off effects of chronic disease. Important and costly decisions are being made without balanced information about their health and cost benefits. The continued affordability of Rx drugs and health benefits – depends on having good value-based tools to understand the risk/benefit/worth of a treatment or alternatives. There is a compelling need for this kind of comparative information – sifted and analyzed by the people delivering, using and paying for those therapies. The RxHealthValue Center – is committed to seeking good, balanced information that can be used to evaluate the benefit of prescription drugs and their impact on achieving access to affordable health.

What makes it unique: More than 30 groups of payors and users – representing consumers, unions, health plans, advocates, employers and clinicians – sitting down to the table to determine what information is necessary to make wise choices about prescription drug options. Consumers play a vital role in helping make these value-based decisions. This is the first time that users and purchasers of health care, most with diverse opinions about solving the health care financing picture, have come to the table to look at the value a product contributes to achieving overall health of the population. We are also proposing to do some new and exciting research to look at comparative information per drug class to determine benefit/risk models.

Why the urgency? Prescription drug therapies are increasingly important in treating disease and improving health status. Yet the benefits these treatments confer comes at a cost that has escalated rapidly in recent years, and is expected to continue to grow at rates far outpacing costs for other health care services.

- Spending on prescription drugs more than doubled between 1993 and 1998, from \$38 billion to \$91 billion, and are expected to double again between 1994 and 2004, from \$101 billion to \$212 billion.
- At the same time, overall health spending increased on 3.7% from 1993 to 1995, and is projected to increase in the 5-6% range from 1999-2004.

These trends translate into higher costs for consumers and employers. Analysts estimate that prescription drugs now account for 11 to 14 percent of total medical expenses for most health plans, up from 7 percent just a few years ago. Some of these new drugs are "breakthrough" products, which treat diseases and conditions for which no effective treatment currently exists. These breakthrough drugs are likely to be the treatment of choice by clinicians and their patients, and bring valuable benefits to individuals and their families. However, many of these new drugs are replacements for drugs already on the market and the replacements are generally much more expensive. These new substitutes often differentiate themselves existing older drugs by having less prevalent or severe side effects or easier dosing forms.

Today, there is no source of good data on the risks and benefits of these replacement therapies as compared to existing therapies. Nor is there good comparative data on the risks and benefits of multiple existing therapies that can treat the same condition. To make truly informed, *value-based* decisions consumers, physicians, and health plans need this information. RxHealth Value was formed to sponsor objective research and education about this critical issue.

Who: Organizational members include: AARP, Academy of Managed Care Pharmacy, AFL-CIO,

AFSCME, Alliance for Community Health Plans (nonprofit health plans), American Medical Group Association, Blue Cross/Blue Shield Association (48 Blues Plans), American Hospital Association, General Motors, GTE Corporation, Kaiser Permanente, Lahey Clinic, Managed Health Care Association, Midwest Business Group on Health, National Consumers League, National Council of Senior Citizens, National Institute of Health Care Management, PCS Health Systems, Inc., United Automobile Workers, US West, Washington Business Group on Health and several distinguished individual members including Stuart Alunan, Ph.D., Schneider Institute for Health Policy, Brandeis University; Christine K. Cassel, MD, Chair, Department of Geriatrics, Mt. Sinai Hospital and School of Medicine; Alain Enthoven, Ph.D., Graduate School of Business, Stanford University, Arnie Milstein, MD, William M. Mercer, Inc., Ira Ockene, MD, University of Massachusetts Medical Center.

Mission:

- To sponsor research to inform and educate consumers, providers, employers, government and third-party payers about the benefits and costs of prescription drugs as they contribute to overall health;
- To propose solutions in the market for prescription drugs that encourage competition, foster appropriate and safe utilization of drugs and encourage innovation that improves the health of the population;
- To encourage the creation of independent, nationally prominent, scientifically-based entities to conduct clinical research regarding the value of specific drugs or of specific therapeutic classes.

Our first research study indicates:

- More of us are using medications;
- For those of us using medications, we are each using more medications;
- We are using medications for more and for different conditions and at earlier ages than before;
- We are paying more for the medications that we are substituting for more established medications;
- We are paying a lot more for new medications that are unique that replaced other effective medications;
 - **Implications:** Before this trend escalates to a crisis – this group recommends more objective, comparative research to get to the root of the value that prescription drugs provide within the whole health care equation and to help clinicians and consumers make informed decisions.

Our recommendations: The Center offers the following recommendations to begin the process of providing this value-based information.

- Establishment of independent research institutes to determine clinical value of prescription drugs;
- Development of voluntary national standards for risks/benefits information disclosure in direct-to-consumer advertising of prescription medications, and;
- Improved post-marketing monitoring of adverse drug reactions, especially of "fast track" drugs, by the FDA.

Our next steps:

- Continue to expand on our current research to see what the net outcome of this increased use means and provide value insights into those increased costs;
- Look at the patent and financing picture of Rx drugs to see how the value equation is influenced by current extensions of patent franchises;
- Develop new, meaningful ways to talk about and make value comparisons, especially within drug classes using a comparative model; and
- Encourage a better way of talking about risk/benefit/worth questions in active partnership with consumers.

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SOURCES OF GROWTH IN PRESCRIPTION DRUG EXPENDITURES

Context

Prescription drugs play an increasingly important role in the treatment and prevention of disease, with advances in pharmaceutical therapy contributing to improved health and quality of life. Since the early 1990's, national expenditures on prescription drugs have increased between 10 and 15 percent annually, two to three times that of expenditures on other types of health care services. New medications are being approved at an increasing rate, and often cost more than the medications they replace. At the same time, first dollar insurance coverage for prescription drugs has increased in recent years, removing incentives for insured consumers to be price conscious. For people with no insurance for prescription drugs, especially the elderly, the cost of medications may be prohibitive.

The escalating cost of pharmaceuticals has raised concern about their affordability in both the public and private sectors. It has also prompted research to examine the underlying causes of this expenditure growth. Recent analyses have alternatively suggested that the primary driver of expenditure growth is increasing prices, or increasing use of medications, or the introduction of new and costly medications. While all factors are likely at play, there is little consensus as to what has had the greatest impact, and thus where to target public policy.

About the study

This study, by the Brandeis University Schneider Institute for Health Policy and PCS Health Systems, Inc., examines factors that contribute to the recent escalation of prescription drug spending nationally. In it, we look at 1996-1999 PCS prescription drug claims data to identify key questions regarding expenditure growth. PCS claims data provide information for people with first dollar coverage, ensuring a study in which prescription drug utilization behavior and costs can be followed with all utilization reported. Questions we address include: how much expenditure growth is due to increasing prices charged for drugs; how much is due to the introduction of new medications; how expenditure growth and utilization of pharmaceuticals differs by age group; and how expenditure and use patterns differ for different classes of medications.

Departing from most previous research on prescription drug expenditure growth,

this study follows a cohort of continuously insured people over time. This allows us to identify changing patterns of use and cost, keeping population constant. Thus, we can examine how prescription medication use has changed over an extended period of time as new medications are introduced, and how this differs by age.

Study population

- Insured population of 1.4 million people, continuously enrolled from October 1995 through September 1999
- Sample analyzed is representative of the age distribution of the U.S. population but ages differently over time than the overall population because the study sample excludes people who were born or died during the study period
- Study population is largely comprised of people covered by employer-based insurance, with generous prescription drug coverage

Results: Overall cost growth

- Prescription drug costs for this sample grew at an annual average rate of more than 28 percent per year
- This growth rate is higher than that found in most other published studies - partly as a result of limiting the sample to insured people who were enrolled continuously (no births, deaths, disenrollment)
- A continuously enrolled cohort ages faster than a 'natural' population (because no births, deaths)... and older people have higher drug costs
- If this sample had aged at a more 'natural' rate, we estimate their cost growth might have been about 25 percent per year

Components of expenditure growth

- Cost per day
- Days per prescription
- Prescriptions per user
- Number of users

Major drivers of expenditure growth

- Increasing cost per day
- Increasing utilization (number of prescriptions per user *and* number of users)
- New medications

Increasing cost per day

- Cost per day (the price of medication times the average daily dose) increased substantially - eight percent per year
- Most of the growth in cost per day was due to substitution among drugs (costlier for

cheaper ones)

- Little of the growth in cost per day was due to pure price inflation on existing drugs (the 1996 "basket" of drugs only cost 2.7 percent more in 1999 than in 1996)
- People are moving into using more expensive medications
- Medications in newer classes tend to be more expensive than those in older classes
- The price of new medications has remained fairly constant
- New breakthrough drugs have much higher costs, on average
- Medications thought to represent a significant gain over existing therapy in terms of efficacy or safety tend to be priced higher

Increasing utilization

- Utilization growth was a major expenditure driver during the study period
- The number of enrollees using any medications grew 3.5 percent per year
- New users are increasing fastest in the 45-64 year-old age group, with the proportion of persons using one or more prescriptions during the year increasing by seven percent
- Prescriptions per user grew 14 percent per year
- The number of prescriptions per person is rising fastest in the 65+ age group, from an average of 16 prescriptions in 1996 to an average of 23 by 1999
- Those who are using medications are using them from more therapeutic classes, representing more disease categories being treated per person
- The proportion of persons with medication expenditures greater than \$2,000 per year has grown three-fold, from 1.3 percent of the population to 5.3 percent

Role of new medications

- For the period 1996-99, about one third of increased expenditures is attributable to medications approved after 1996
- New medications had a different impact on different components of expenditures
- New medications accounted for half of the growth in cost per day
- New medications accounted for about 25 percent of the growth in utilization per enrollee
- For the same period (1996-99), 63 percent of the increase in spending is attributable to medications approved after 1992

Variations across types of medications

- Rates of expenditure growth and factors driving growth vary across therapeutic classes (disease categories), due to changing medication mix, availability of new medications to treat several diseases, and changing thresholds for treatment
- Gastrointestinal medications, 26 percent annual increase in total expenditures: large increases in number of users, changing drug class to new more expensive types of therapy, and more prescriptions per user

- Anti-arthritis medications, 33 percent annual increase in total expenditures: large increases in cost per day, movement to new medications (Cox-2 medications such as Celebrex), and increasing number of users
- Cardiovascular medications, 38 percent annual increase in total expenditures: large increases in number of users prescriptions per user, and increasing prevalence of use of cholesterol lowering medications

The Schneider Institute for Health Policy

The Schneider Institute for Health policy was founded at Brandeis University in 1978 by Professors Stuart Aluman and Stanley Wallack. During these last twenty years, the Schneider Institute has achieved national recognition as a leading health care policy and research institution. Staff from the Schneider Institute collaborate with other health services research organizations, as well as with service delivery systems that serve as laboratories for demonstrating and testing innovative financing and health care delivery strategies. Located in the Heller Graduate School for Advanced Studies in Social Welfare, the Schneider Institute examines the overall health care system from a variety of perspectives including questions of access to and quality of care, how health care is financed, delivered, and utilized, and the cost of such care. In many of its studies, the Schneider Institute focuses on the problems of our most vulnerable populations, including the elderly, individuals with chronic illness, those with substance abuse problems, and mental illness. A distinguishing characteristic of the Institute is its ability to undertake innovative research and move the findings into the real world of solution-oriented practice.

In early 1999, the Schneider Institute created a new Prescription Drug Analysis Group comprised of a multi-disciplinary team of health service researchers, including a pharmacist and pharmaco-economist to explore what is driving prescription drug expenditures, what are the underlying forces behind the recent trends and what value is derived from greater prescription use.

PCS Health Systems, Inc.

PCS Health Systems, Inc. is one of the nation's largest pharmacy benefit managers, providing drug and health management solutions for health plans and patients. As America's premier pharmaceutical care system, PCS works to encourage proper drug use and helps to lower the cost of drugs for its clients. PCS manages and monitors 300 million individual prescriptions each year representing \$12 billion in drug expenditures. PCS is a wholly owned subsidiary of Rite Aid Corporation [NYSE, PSE: RAD].