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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	Irma Martinez to Sharon Gill re: Medicare event names (partial) (1 page)	06/24/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
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FOLDER TITLE:
Medicare [Folder 2]

2012-0463-S
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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).
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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]
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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]

Document No. _____

WHITE HOUSE STAFFING MEMORANDUM

CLOSE HOLD

Date: 6/27/99 ACTION / CONCURRENCE / COMMENT DUE BY: 6/28/99 noon

Subject: _____

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☑	☐	MOORE	☐	☐
PODESTA	☑	☐	NASH	☐	☐
ECHAVESTE	☑	☐	REED	☑	☐
RICCHETTI	☑	☐	RUFF	☐	☐
LEW	☑	☐	SOSNIK	☐	☐
BERGER	☐	☐	SPERLING	☐	☐
BLUMENTHAL	☐	☐	STEIN	☐	☐
CAHILL	☐	☐	STERN	☐	☐
FRAMPTON	☐	☐	STREETT	☐	☐
IBARRA	☐	☐	TRAMONTANO	☑	☐
JOHNSON, B.	☐	☐	UCELLI	☑	☐
JOHNSON, J.	☐	☐	VERVEER	☐	☐
KLAIN	☐	☐	WALDMAN	☐	☐
LANE	☐	☐	YELLEN	☐	☐
LEWIS	☐	☐	C. Jennings	☑	☐
LINDSEY	☐	☐	_____	☐	☐
LOCKHART	☐	☐	_____	☐	☐
MARSHALL	☐	☐	_____	☐	☐

REMARKS:

Comments to Michael Waldman

RESPONSE:

Draft 6/27/99 6:00 p.m.
Glastris

PRESIDENT WILIAM J. CLINTON
REMARKS ON STRENGTHENING MEDICARE
THE WHITE HOUSE
June 29, 1999

Since the early days of our Republic, each generation of Americans has been called on to fortify and renew our nation's institutions in ways that look to the future. I believe our generation has begun to meet that sacred duty, for at the dawn of the 21st Century, America is a nation in renewal. Our economy is the strongest in decades, perhaps in history. Our armed forces have proven themselves once again, in Kosovo, to be the most advanced, effective, and professional in the world, and I am committed to strengthening them even further. Our cities, once in decline, are again vibrant with economic and cultural life. Even our rutted and congested Interstate highways are being repaired and expanded all across America—to the exasperation, I'm afraid, of many summer travelers.

The renewal we see all around us is the consequence the hard work of millions of Americans. But it is also the result of the fiscal discipline we have pursued since 1993—discipline that has transformed vast budget deficits into growing budget surpluses. In my State of the Union address earlier this year, I proposed that we invest the bulk of the surplus over 15 years to strengthen and renew two other great American institutions, Social Security and Medicare--and to do so in a way that pays down the public debt and fuels greater economic growth for years to come.

Today, I am here to announce the specifics of my plan to strengthen and modernize Medicare for the 21st Century. My plan extends the life of the Medicare Trust Fund to the year 2027. It provides a long-overdue prescription drug benefit. And it takes tough, realistic, and necessary steps to contain the costs of Medicare while improving quality.

In the 34 years since it was created, Medicare has eased the suffering and extended the lives of hundreds of millions of older and disabled Americans. It has given young families the peace of mind of knowing that they will not have to mortgage their children's' futures to pay for their parents' and grandparents' health care. Medicare has become so much a part of America that it is almost impossible to imagine life without it.

Yet life without Medicare is exactly what we will get unless our nation acts soon to strengthen this vital program. With Americans living longer, the number of Medicare beneficiaries is growing faster than the number of workers paying into the system. By the year 2015, the Medicare Trust Fund will be insolvent, just as the baby boom generation begins to retire and enter the system.

I have often called this crisis in Medicare a high-class problem, because it is the result of something wonderful: the fact that our parents and grandparents are living longer. And they are living longer--and blessing our lives and our children's' lives with their presence---as a direct result of the better health care they receive through Medicare.

Medicare was founded on the principle that as medical science advances, so too must our commitment to the health care of our seniors. As President Johnson said when he signed the bill in 1965: "The benefits of this law are as varied and broad as the marvels of modern medicine itself."

Yet modern medicine has changed tremendously since 1965, and Medicare has not fully kept pace. The original Medicare law was written at a time when patients' lives were more often saved by scalpels than by pharmaceuticals. Many of the drugs we now routinely used to treat heart disease, cancer, and arthritis did not exist in 1965. Yet Medicare still does not cover prescription drugs. Many of the procedures we now have to detect diseases early, or prevent them from occurring in the first place, did not exist in 1965. Yet Medicare has not fully adapted itself to these new procedures. Many of the systems and organizations that the private sector uses to deliver services, contain costs, and improve quality—such as preferred provider organizations and pharmacy benefit managers—did not exist in 1965. Under current law, Medicare cannot make the best use of these private-sector innovations.

Over the last six and a half years, we have taken some important steps to improve Medicare. When I first became President, Medicare was scheduled to go broke this year. But we took tough but necessary action to contain costs, first in 1993, then in 1997. And we have fought hard against waste, fraud, and abuse in the Medicare system, saving tens of billions of dollars. These measures have helped us extend the trust fund to 2015.

But with the elderly population set to double in the next three decades, and with the pace of medical science quickening, we must do more to fully modernize Medicare for the 21st Century. The plan I am releasing today does that, first, by providing what every objective expert has said Medicare must have if it is to survive: more funds. As I promised in my State of the Union address, my plan would devote 15 percent of the federal budget surplus over 15 years to Medicare. There is no more important use for our hard-won surplus that guaranteeing quality health care for all our seniors.

Second, my plan will empower Medicare to adopt the best practices from the private sector to keep traditional Medicare prices in line while improving quality. For instance, currently Medicare cannot bid competitively for lab services to get the best quality at the best price. Under my plan, Medicare will have that ability.

Improve clinical care & reduce prices

DM use centers of excellence & disease mgmt

5 pts vs 2

Third, my plan will use the forces of competition to keep costs in line by empowering seniors with more and better choices. To make it easier for seniors to shop for coverage based on clear criteria of price and quality, all private plans that chose to participate in Medicare will be required to offer the same core benefits. This will eliminate the apples-and-oranges comparisons that flummox consumers and insulate providers from real competition.

Fourth, my plan will eliminate all deductibles and all copayments for all preventative care under Medicare. This means that seniors will never again have to hesitate, as many do today, to get screenings for cancer, diabetes, or osteoporosis. To help cover the costs of these and other crucial benefits, we will ask beneficiaries to pay a small part of the cost of other lab tests that are prone to overuse. And to insure the soundness of the Medicare Part B program, we will the Part B deductible to inflation.

Fifth, we will take action to make sure that Medicare costs do not shoot up after the year 2003, when cost containment measures put in place in 1997 are set to expire. And to make sure that health care quality does not suffer, my plan includes, among other things, a $7.5 billion quality assurance fund, to be used whenever there is serious evidence that any cost containment measures are eroding quality.

These five steps will go a long way towards strengthening and modernizing Medicare. But Medicare will never be truly modernized until it includes an affordable benefit for prescription drugs. My plan provides such a benefit for all Medicare recipients, paid for largely through cost savings from the five steps I have outlined. This benefit will cover half of all prescription drug costs up to $5000 when fully phased in, with no deductible, plus an additional price discount through volume purchasing, all for a premium starting at $25 per month--far below the price of private Medigap coverage. It will provide additional help to low-income seniors, and any money the federal government gets back in the suit we will be bringing against tobacco companies will go to finance coverage for drug costs above that $5000 cap.

Medicare is like any great American institution: it must periodically be modernized with new investments to meet new demands. Our Interstate highways would crumble if we fail to upgrade them to handle new traffic levels. Our armed forces would not be successful if we fail to invest in advanced weaponry to meet deadly new threats. Medicare is no different. If Congress can understand the need to rise above partisanship and invest in the modernization of our highways and our military, then surely there can be no good reason why Congress should fail to embrace our efforts to strengthen and modernize Medicare.

With our economy strong, our people confident, and our budget in surplus, we have an opportunity—and the responsibility—to fortify and renew Medicare for the 21st Century. It is the right thing to do for our parents and grandparents, for ourselves and our children--and for our nation. Like every generation of Americans before us, our generation has begun to fulfill our historic obligation strengthen our institutions and renew our nation. With God's help we finish that solemn task.

Chris Jennings' Schedule

SATURDAY, June 26, 1999

12:00 - Stem Cell Research
Podesta's ofc

Monday, June 28, 1999

9:15 – DPC Team Leader's mtg
(Bruce's ofc)

10:00 – Pharma mtg w/ Woolley - **Rm 211**

11:00 – AMA mtg w/ Woolley - **Rm 211**

12:00 – AAHP mtg w/Woolley - **Rm 211**

1:00 – HIAA mtg w/ Woolley - **Rm 211**

3:00 – Mtg w/ David Folkenflik
from Baltimore Sun
Medicare Issues ~~Rm~~ – **216**

7:00 - Conf. Call (Woolley & Seniors)

8:00 – Conf. Call (Woolley & Disability)

Karen
What
Center
is like

65716

THE WHITE HOUSE

WASHINGTON

TO:	Dan M.	395 4995
	Nancy Ann	690 6262
	Rich T.	690 7380
	Gary C.	401 7321
	Mark M.	622 2633
	Melissa S.	690 5673
	Jane H.	690 8425
	Mark M.	395 3910
	Bonnie W.	690 8168

FROM: Chris and Jeanne

Attached is a draft of the press paper and the q&a for tomorrow's event. It would be great to get comments back from folks by 2:30 pm.

Thanks a lot for the quick turnaround.

DRAFT: PRESIDENT CLINTON'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

June 29, 1999

Today, President Clinton unveiled his plan to modernize and strengthen the Medicare program and prepare it for the health, demographic, and financing challenges it faces in the 21st Century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit; and (3) make an unprecedented long-term financing commitment to the program which would extend the life of the Medicare Trust Fund until 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and contributed towards extending the life of the Medicare trust fund from 1999 through 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new and/or broader authority for competitive pricing, incentive payments for physicians for better medical outcomes, care management for high-cost beneficiaries, and other best-practice private sector purchasing mechanisms. Savings: $25 billion over 10 years.

- **Extends competition to Medicare managed care plans.** The proposal would, for the first time, inject true price competition between managed care plans in Medicare. Plans would be paid for covering a defined benefit, including a new subsidized drug benefit, and would compete over cost and quality. Such price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: $8 billion over 10 years.

- **Takes administrative and legislative action to smooth out Balanced Budget Act (BBA) of 1997 provider payment reductions.** The proposal includes a provider set-aside designed to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. The Administration would work with Congress and outside groups and experts to determine appropriate policy solutions. The plan also includes a number of administrative actions that are designed to moderate the impact of BBA 1997 on health care providers' ability to deliver quality services to beneficiaries. Cost: $7.5 billion over 10 years.

- **Constrains out-year program growth, but more moderately than BBA 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the Balanced Budget Act of 1997 expire in 2003, the proposal includes out-year policies that protect against a return to unsustainable growth rates. These policies are more modest than those included in the BBA of 1997. Savings: $XX billion over 10 years (including interactions).

DRAFT

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries can access affordable prescription drug and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and reforms the current Medigap market. Finally, it integrates the President's Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between 55 and 65. His plan:

- **Establishes a new Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic, voluntary outpatient prescription drug benefit would have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to $5,000 in spending ($2500 in plan payments) when fully phased-in by 2008. In addition to its coverage of the cost of prescriptions, the plan would give beneficiaries a private sector volume discount (estimated to be, on average, over 10 percent) for each prescription purchased – even after the $5,000 cap is reached. Beneficiaries opting for this coverage would pay about $24 (?) per month beginning in 2002 (when the benefit starts at a $2,000 cap) and $40 (?) per month when fully phased in. Beneficiaries with incomes below 135 percent of poverty ($11,000/$17,000 single/couples) would not pay premiums or cost sharing, and those with income between 135 and 150 percent of poverty would receive premium assistance as well. Because older and disabled Americans rely so heavily on medications, about 35 million beneficiaries would benefit from this coverage each year [check]. Cost: $12? billion over 10 years.

- **Uses potential Medicare recoveries from the Justice Department tobacco lawsuit for expanded coverage protection.** In this year's State of the Union address, the President announced that the Justice Department would take the tobacco companies to court to recover costs to the taxpayers of smoking-related illnesses. This plan would allocate a portion of the potential Medicare recoveries to finance coverage for beneficiaries with prescription drug costs above the $5,000 cap.

- **Eliminates all cost sharing for preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would eliminate all copayments and the deductible for every preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, prostate cancer screening, diabetes self management benefits, and mammographies. It would initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries. It would also invest $10 million for a new, nationwide health promotion education campaign targeted to all Americans over the age of 50. Cost: $3 billion over 10 years.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would rationalize the current cost sharing requirements for Medicare by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation. The modest lab copayment would help prevent overuse and reduce fraud. The Part B deductible index would guard against the program assuming a greater share of Part B costs because, over time, inflation would decrease the amount of the deductible in real terms. Savings: $9 billion over 10 years.

DRAFT

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's reforms to Medicare; (2) directing the Secretary to determine the feasibility and advisability of the traditional fee-for-service program offering Medigap-like coverage as a competitive alternative to private supplemental plans; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer any American between the ages of 62-65 the choice to buy into the Medicare program for approximately $300 a month if they agreed to pay a small risk adjustment premium once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The $1.4 billion cost is offset in the President's FY2000 budget.

STENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY. The Medicare reforms the President is proposing would modernize the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic Medicare services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along the inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, he would dedicate 15 percent of the surplus ($794 billion over 15 years) to strengthen Medicare. His plan:

- **Extends the life of the Trust Fund until 2027.** Dedicating part of the surplus to Medicare not only assures the financial health of the Trust Fund through at least 2027, but it will also eliminate the need for future excessive cuts and radical restructuring that would inevitable in the absence of these resources.

- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The vast majority of the $125 (?) billion Federal cost of the new Medicare prescription drug benefit (over 60 percent) would be offset through program efficiencies and savings. The remaining $50 billion would be financed by using less than one-seventh of the surplus allocated to Medicare. Policy experts advising the Congress (MedPAC, CBO, and GAO) have consistently underscored their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success in combating fraud, waste, and abuse. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

DRAFT

MEDICARE QUESTIONS AND ANSWERS

USING THE SURPLUS FOR TO PAY FOR THE DRUG BENEFIT

Q: Are you using the surplus to pay for any other piece of the reform plan in addition to the 15 percent set-aside for Part A solvency? In January, didn't the President pledge to pay for the prescription drug benefit through program savings as opposed to using the surplus?

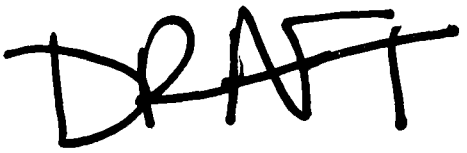
A: A small portion of the surplus – less than one-seventh of the amount being dedicated to the Medicare program – is being used to help fund the prescription drug benefit. There is a very good reason for this development. There is a sound policy rationale for this. Since the President's State of the Union address, the fiscal well being of the Trust Fund has improved immensely and projected spending has declined significantly. HCFA, CBO, GAO, and MedPAC have all testified that a great deal of these additional savings are the result of our successful anti-fraud and abuse efforts. We believe that many of these additional savings can and should be dedicated for a new drug benefit.

Q: The President pledged in January to extend the solvency of the Trust Fund by 12 years. Hasn't he reneged on that promise by using part of the surplus set aside of 15 percent to pay for a prescription drug benefit?

A: No. The President continues to dedicate 15 percent of the surplus to the program, and his Medicare reform proposal still extends the life of the Trust Fund by 12 years. The only difference is that the exhaustion date is 2027 – not 2020.

Q: How can you use surplus funds for a new benefit that will likely spiral out of control rather than assuring trust fund solvency? Won't a future Congress have to raise taxes to pay for this new benefit entitlement if the surplus does not fully materialize?

A: The President directed his staff to develop a meaningful prescription drug benefit that is affordable for both beneficiaries and the program. He insisted on policies that would ensure that the drug benefit was fully financed for both the short and the long term. As such, the projection for this benefit, which has been scored by the independent Medicare actuary, clearly illustrates that the combination of savings and the modest dedication of the surplus more than adequately finances this benefit for each and every one of the next 30 years.



INVESTING 15 PERCENT OF THE SURPLUS IN THE TRUST FUND

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

A: One of the most important achievements of this Administration is that it has reinstated the credibility of government economic forecasts. Each and every year that I have been in office, our economic forecasts have been conservative relative to the economy's actual performance. Having said this, even if the surplus is not fully realized, the program savings assumed in the proposal are projected to parallel the growth in the cost of the prescription drug benefit. This is one of the benefits of designing a fiscally responsible, while still meaningful, drug benefit.

Q: Your shift in emphasis from using the surplus to extend the solvency of Medicare to using it to pay for a new benefit illustrates that this is simply a political strategy to prevent the Republican Congress from using the surplus for tax cuts. What is the rationale for using tax overpayments (surplus) to create a new entitlement as opposed to returning to the people their own money to spend as each taxpayer sees fit?

A: The President's proposal reflects his belief that the first claim on surplus dollars must be used to help prepare Social Security and Medicare for the population explosion that is about to occur with the retirement of the baby boom population. Funding an irresponsible and dangerous tax cut that could harm the economy should not be our first priority. However, as his FY 2000 budget illustrates, he is supportive of carefully targeted tax cuts that, for example, provide enhanced incentives for savings, assistance with long term care, child care, and resources for school construction.

PROVIDER REIMBURSEMENT

Q: How can you ignore the growing concern about the impact of the BBA on providers? How can you propose additional provider savings without restoring some of the excessive savings of the BBA?

A: The President is certainly not ignoring the concerns that have been raised by providers in the wake of the implementation of the BBA. He has instructed HHS to implement administrative actions that would relieve unnecessary burdens that could undermine the ability of providers to deliver quality services. In addition, the President's proposal explicitly provides for a $7.5 billion set aside to help smooth out problems that can be clearly documented to have harmed beneficiaries. Moreover, his Medicare reform proposal includes no additional savings for any provider group until 2002, when the BBA proposals are set to expire. Although his reform proposal includes proposals to constrain out-year spending, they are much more moderate than those included in the BBA. They do not include any hospital outpatient department savings, no DSH savings, no nursing home reimbursement savings, and no new home health care provider savings.

DRAFT

Q: How could you possibly propose more provider pain when BBA is already wreaking havoc on so many different sectors of the health care industry?

A: While the President's proposal does recognize the potential for policy interventions that can help smooth out the effects of BBA 1997, he also believes we need to be vigilant in guarding against excessive out-year cost growth and the negative impact it can have on the economy, the program, and on beneficiaries. It would be irresponsible to do anything else.

Q: How do you know that $7.5 billion is the right amount for correcting the overreach of the BBA?

A: The $7.5 billion set aside was designed to be responsive to legitimate provider concerns without opening the door to unsubstantiated complaints. It is based on a serious analysis of a range of provider concerns, but there is no one specific package of provider modifications that is linked to this amount.

Q: If Congress moves forward with legislation to restore excessive provider savings, how should the funds be allocated? Which industries have the most pressing problems, and how much should we pay them?

A: While there have been a number of concerns raised, including those related to the arbitrarily imposed therapy cap, we believe it is premature to assign any specific policy or funding amount to any one provider group. We need additional evidence to make informed decisions, and we look forward to working with the Congress in a collaborative and constructive manner.

PLAN CONTENT

Q: Is your proposal really Medicare reform? Aren't you just tinkering around the edges and recycling old ideas?

A: The President's proposal represents a comprehensive initiative to strengthen and modernize the Medicare program and prepare it for the challenges it faces in the 21st century. It's inclusion of traditional fee for service reforms, true competition between managed care plans, and savings contributions from providers and beneficiaries alike, a new drug benefit, the elimination of all copayments and deductibles for all preventive services, and an explicit dedication of 15 percent of the surplus to extend the life of the trust fund can be defined as nothing short of comprehensive reform.

Q: In the past, the Senate and members of the Medicare Commission showed great courage in proposing reasonable measures that require some sacrifice on the part of beneficiaries (eligibility age change, income related premium, home health copayments) for the long term benefit of the program. Hasn't the President missed an historic opportunity by making people think they can have something for nothing?

A: The President directed his advisors to undertake a comprehensive review of the provider and beneficiary savings assumed in the recommendations of the Medicare Commission and from other bodies. Our review led to beneficiary and provider savings recommendations that we believe have a sound policy foundation. Those that were rejected were rejected because we thought they were either flawed, politically untenable, or both. For example, on the income related premium – although the President supports the concept – it became clear in our consultations that it was unsupportable on the Hill and would serve only to detract attention from long overdue and needed program reforms. In addition, the President felt strongly that raising the eligibility age at a time when the most rapidly growing number of the uninsured is between 55 and 65 is unwarranted and ill-advised.

Q: You criticized the Breaux-Thomas plan because it relied on cost shifting to beneficiaries and had only minimal savings from structural reforms. Is it true that the President's plan has almost no savings from structural reform other than what you have taken from the Commission's report?

A: No. The President's plan has significant savings that have been achieved through structural reforms such as traditional FFS modernization, a brand new competitive reimbursement model for managed care contracting, and some very real provider and beneficiary savings.

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

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

DRAFT

Q: Doesn't your plan impose an unfunded mandate on states? How do you justify making states spend more Medicaid funds through increased cost sharing while not providing any real relief on care management and cost control for dual eligibles?

A: The states will receive a windfall of savings associated with the implementation of a prescription drug benefit for Medicare beneficiaries because Medicare serves as the primary payor of health care costs for beneficiaries who are dually eligible for the Medicaid and Medicare programs. Recognizing this, the President's proposal requires states to help fund low-income protections for prescription drug premiums and copayments for low-income beneficaries. This provision may require some additional contribution from the states, but we believe the liability to be more than manageable.

Q: Why did you reject Senator Breaux and Congressman Thomas' premium support proposal and what type of structural reform will you have in your plan?

A: We need to inject more competition into the Medicare program, for both the traditional fee-for-service program as well as the managed care plans serve beneficiaries. As we have mentioned, we believe that the premium support proposal advocated by Senator Breaux and Congressman Thomas suffers from serious flaws, including consequence of higher premiums for the traditional program. The proposal the President is unveiling injects, for the first time, true price competition in managed care through a requirement that makes plans compete based on cost and quality. It also would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs.

PRESCRIPTION DRUG BENEFIT

Q: Why are you paying for a drug benefit when over 60 percent of beneficiaries already have some form of coverage?

A: We know that today, almost 15 million Medicare beneficiaries do not have prescription drug coverage at all, and we know that millions more will lose their coverage as private insurance becomes more expensive and less accessible. For example, over the last several years, there has been more than a 20 percent reduction in businesses offering retiree health benefits, including prescription drug coverage. In addition, Medigap benefits are both costly and extremely limited, and managed care prescription drug benefits are either being dropped or significantly constrained. At the same time, prescription drugs have never been more important to basic health care. For this reason, the President's drug proposal will be available and affordable, but optional for all Medicare beneficiaries.

DRAFT

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

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

Q: Haven't you done the American people a disservice by putting out a plan that implies we can have a huge and costly new benefit with almost no sacrifice to pay for it?

A: First, beneficiaries have already indirectly sacrificed for this drug benefit by paying higher premiums, which were the result of projections that did not adequately reflect Medicare's continued low inflation rate. We believe those savings, as well as savings associated with fighting fraud and abuse, should be reallocated to strengthen and modernize the program. And finally, the President's plan does require sacrifice. Both beneficiaries and providers will help offset the costs of the drug benefit through clinical lab copayments, part B indexing, and outyear provider savings.

Q: How is your drug benefit different from the catastrophic benefit proposed over a decade ago? Didn't catastrophic fail because beneficiaries did not want to pay for a benefit they already had? Why is this not the same?

A: This benefit is different in numerous respects. First, it has no deductible, whereas the catastrophic health care legislation had a very high deductible. Secondly the President's proposal supplements the beneficiary contributions with provider competition and surplus savings; conversely the catastrophic benefit was financed solely by Medicare beneficiaries. Lastly and most importantly, this benefit is completely optional; the catastrophic legislation linked the benefit to the Part B program.

Q: Will this new prescription drug benefit cover Viagra?

A: If a physician determines that a drug is medically necessary, the private sector contractor will be required to cover it. However, as is the case in the Medicaid program and with other private insurers, prior authorization can be required to ensure that the medication is being properly utilized. In general, all therapeutic classes of drugs will be covered under the Medicare Part D benefit. The only exceptions are those drug classes excluded under Title XIX, including drugs for weight loss or gain, promoting fertility, symptomatic relied of coughs or colds, prescription vitamins or minerals, and all other non-prescription

drugs (except that prescription smoking cessation drugs not covered under Medicaid will now be covered under Medicare Part D.

DRAFT

June 27, 1999

Gary
Bonnie
Jane
Rich
Melissa

Dan M
Mark McC
Mark M

TO: MEDICARE TEAM

FROM: Chris J. and Jeanne L.

RE: FINAL DOCUMENTS FOR CLEARANCE / CLOSE HOLD

Attached is the competition paper, that reflects some staff edits over the weekend. Comments due to Jeanne by 3pm if possible

To give a sense of the bigger picture, the following is the list of paper that we are going to try to clear, as well as their status:

- **Press paper**: Circulated at 10am / comments to Devorah by 2:30pm
- **Walk-through document:** Will be circulated around noon / comments by 5pm
- **Prescription drug paper**: Will be circulated around noon / comments by 5pm. We are also hoping to attach some tables with examples, which will be circulated separately.
- **Competition paper**: Attached / comments to Jeanne by 3pm.
- **Long, detailed policy paper**: Will be circulated by 2pm / comments by COB.
- **Top-line qs and as**: Circulated at 10am / comments to Devorah by 2:30pm

I think that we also have rural, beneficiary, and women's papers in draft form that we will use internally, but probably cannot get out by tomorrow.

Thanks for all your input so far – almost there!

DRAFT: PRESIDENT'S PLAN TO MAKING MEDICARE MORE COMPETITIVE

FLAWS IN THE CURRENT MANAGED CARE PAYMENT SYSTEM

- **Medicare pays a flat rate, set by a complex statutory formula, that has nothing to do with managed care plan prices.** Under current law, Medicare pays a flat rate to managed care plans. One rate is set for every county based on complicated statutory rules. These rates build in a relatively modest discount of 4 percent relative to the average traditional program costs to approximate the lower cost of delivering care in managed care. All managed care plans, regardless their actual costs, get paid the same rate by Medicare. As a result, the only way that Medicare can save from managed care is when a beneficiary switches from the traditional program to managed care. Medicare does not save when a beneficiary choose a more efficient plan, since it pays both plans the same amount.

- **Event after the Balanced Budget Act changes, experts still think that plans are overpaid.** Before 1997, all experts agreed that the discount built into managed care payment rates was not enough to account for managed care efficiencies, resulting in overpayments. Although the BBA took steps to correct for this, a June 1999 report from the General Accounting Office found that managed care plans still appear to be overpaid. For example, managed care plans in Los Angeles can provide the basic traditional Medicare benefits package for 79 percent of what they are currently paid.

- **Today, the only way that plans can compete for beneficiaries is by providing attractive extra benefits.** Managed care plans must use government overpayments to offer extra benefits – they are not allowed to offer beneficiaries the same benefits at a reduced premium. The 7 million beneficiaries in managed care usually join plans because of these benefits. Under today's system, where prescription drug coverage can be otherwise unaffordable or inaccessible for many beneficiaries, managed care may be the only way to get this coverage. However, this type of competition has several flaws:

    - **Unfair to subsidize benefits only in high-cost areas.** Over 11 million beneficiaries nationwide, including nearly 75 percent of rural Medicare beneficiaries, do not have access to any Medicare managed care plan. Another 5 million beneficiaries have access to only one plan which typically offers fewer benefits. Even though these 16 million beneficiaries pay the same Part B premium, they do not have access to extra benefits.

    - **Hard to compare benefits**: The additional benefits offered by managed care plans are difficult to compare. For example, it is not clear whether an uncapped drug benefit with a $50 premium is more valuable than a capped benefit, with no premium and extensive preventive services. Moreover, beneficiaries cannot select which extra benefits they need – the plan designs the entire package, and for beneficiaries, it is take it or leave it.

    - **Easy to manipulate to attract healthy/discourage sick beneficiaries from enrolling**. Managed care plans tend to offer benefits like extra prevention and health education classes, but not services like personal assistance needed by people with chronic or severe illnesses. Some plans have begun to put quarterly limits on their drug spending (e.g., $200 for January through April) to encourage sick people to disenroll.

PROPOSED MANAGED CARE COMPETITIVE PAYMENTS SYSTEM

- **Competitive managed care payment system.** This proposal would complement the modernization of the traditional program by injecting price competition into managed care payments It would begin in 2003, when Medicare's risk adjustment system is almost fully implemented. It would save about $9 billion for the Medicare program and $x billion for beneficiaries [check/actuaries] from 2003-09. Specifically, this plan includes:

    - **Managed care payments based on price competition, not fixed rates.** Managed care plans would be paid based on their competitively-bid prices, not a flat rate set by a complicated statutory formula. The lower the price, the less beneficiaries would have to pay to enroll in the plan. When beneficiaries choose these lower cost plans, both beneficiaries and the government save. As such, Medicare spending would be reduced through competition, not by artificially lowering managed care payment rates.

    - **Beneficiaries' premiums based on their managed care choice.** Beneficiaries could, for the first time, reduce their Part B premiums by choosing a low-cost managed care plan. They also could remain in traditional Medicare and pay the same premium that they would under current law. Thus, unlike other competitive proposals, it would encourage beneficiaries to choose more efficient plans using a "carrot" of allowing them to share in the savings rather than the "stick" of raising premiums for traditional Medicare which forces beneficiaries to opt for managed care.

- **Encourages competition on price and quality.** Price and quality competition would replace today's practice of managed care plans competing solely on how many and what type of extra benefits they can offer. Beneficiaries enrolling in lower cost plans would have a lower Part B premium. They could choose to keep these savings or use them to purchase extra benefits from their managed care plan.

  The ability of this competition to work effectively is strongly linked to the President's plan to add a prescription drug benefit to Medicare – this creates a level playing field between traditional Medicare and managed care plans, and frees beneficiaries from seeking out managed care plans only because they need prescription drug coverage.

- **How the managed care competitive payment system would work:**

    1. **Managed care plans would set their prices.** Managed care plans would set their prices based on the Medicare basic benefits, including the new prescription drug benefit and benefit improvements (plans would have a separate price for beneficiaries who do not choose the voluntary drug benefit). Plans could include in their prices the cost of reducing Medicare cost sharing, so long as the cost of that reduction does not exceed 10 percent of the value of the base package. Because the premium that beneficiaries pay is based on their price, plans would have an incentive to make this price as low as possible to attract enrollees.

2. **Prices would be compared to traditional Medicare to set beneficiary premium.** This is intended to promote fair competition between managed care and traditional fee-for-service. Three simple rules would be used to assess how much beneficiaries pay in premiums:

   ° Plans priced about the same as traditional Medicare: Beneficiaries choosing a plan whose price is slightly less than traditional Medicare's cost would pay the current law Part B premium. This is intended to continue the current policy of allowing the government to share in the savings from managed care (the 4 percent discount is the amount that is estimated to be built into the rates in 2003)

   ° High-priced plan: Beneficiaries choosing a plan whose price is above that of traditional Medicare would pay all of the additional price. This occurs today in some Medicare managed care plans that charge extra premiums.

   ° Low-priced plan: Beneficiaries choosing a plan whose price is below traditional Medicare's would pay a lower premium. Specifically, they could keep 75 percent of the difference between traditional Medicare's average costs and the plan's price. This would buy down the Medicare Part B premium, so that beneficiaries choosing plans whose prices are at or below 83 percent of traditional program costs would pay no Part B premium.

3. **Government payments are determined by plan price.** In general, the government would pay the difference between the plan price and the beneficiary premium. For average- or high-price plans, the government would pay managed care plans what it pays today: the discounted average costs of traditional Medicare. For low-price plans, the government would get a 25 percent share of the savings (beneficiaries get 75 percent). As such, both the government and beneficiary save when low-price plans are chosen.

- **Risk adjustment**. To ensure that competition is based on price, a strong risk adjustment system would need to be in place at the start of this proposal. Risk adjustment increases or decreases private plan payments based on the likelihood that a beneficiary will develop costly health problems. It lessens the incentive for private plans to search out healthy beneficiaries and avoid sick beneficiaries. The Balanced Budget Act required a comprehensive risk adjustment system, which will be phased in by 2004.

- **Geographic adjustment.** The proposal would adjust the government's share of managed care payments to account for geographic cost differences. Since there is one, nationwide premium for traditional Medicare, this adjustment is needed to ensure that premiums for managed care are comparable to traditional Medicare in all areas. The government would pay an amount reflecting the full geographic costs in high-cost areas, which is higher than current law. In low-cost areas, the plan payments would reflect a blend of local and national rates included in the BBA.

EXAMPLE: HOW MANAGED CARE COMPETITION SYSTEM WOULD WORK

The table below shows how this system would work in an average cost area. It assumes that the Part B premium is $50 per month (it is projected to be $48.50 per month in 2000).

- A beneficiary choosing a managed care plan that costs about the same as traditional Medicare ($500) would pay the same premium that he or she would pay to stay in traditional Medicare -- $50. Similarly, the government would pay the same managed care payment that it pays under the current system (96% of traditional program costs).

- A beneficiary choosing a managed care plan whose price is equal to traditional Medicare ($520) would pay $65 per month. The government would pay $455. This amount – what the government pays for private plans equal to traditional Medicare -- is the maximum that it would pay for any higher priced plans. This can be seen in the "high-price plan" example – the government would pay $455 while the beneficiary would pay the full $10 amount that the price is higher than traditional Medicare's average costs ($75 per month).

- A beneficiary choosing a medium-price managed care plan which is $10 less ($490) would keep 75 percent of that savings, or $7.50. As a result, his or her premium would be $42.50 rather than the $50 Part B premium. The government payments would also be reduced, by 25 percent. Its payment would be $447.50 rather than $450 (a savings of $2.50 per month).

- If the managed care plan's price were $84 or 20 percent lower ($416), then the beneficiary would have no premium payment.

Example: Competitive Managed Care Payments

Option	Plan Price (monthly)	Split of Plan Payments	
		Beneficiary	*Government*
Low-Price Plan	$433.33	$0.00	$433.33
		0%	100%
Medium-Price Plan	$490.00	$42.50	$447.50
		9%	91%
Plan with Premium Equal to Traditional	**$500.00**	**$50.00**	**$450.00**
		10%	**90%**
Plan with Price Equal to Traditional	$520.00	$65.00	$455.00
		13%	88%
High-Price Plan	$530.00	$75.00	$455.00
		14%	86%

NOTE The beneficiary premium rate is $0 for managed care plans whose price is at or below 83 percent of traditional Medicare; an amount equal to $0.75 for every dollar that the price is above 83 percent of traditional Medicare for plans with prices between 83 and 100 percent of traditional Medicare; and an amount equal to the premium at 100 percent of traditional Medicare plus 100 percent of all the additional amount that the price is above traditional Medicare.

ADVANTAGES OF THE PRESIDENT'S PROPOSAL FOR MANAGED CARE COMPETITIVE PAYMENTS

- **Saves through competition, not through explicit rate reductions**. This proposal produces Medicare savings by paying managed care plans based on their prices and encouraging competition on price and quality for Medicare's defined set of benefits. By aligning beneficiary incentives to choose low-price plans with Medicare payment rates, Medicare spending would be lowered as a result of beneficiaries' choices, not due to legislated rate reductions. In the long-run, this should make Medicare a more efficient program.

- **Maintains a strong, viable, competitive traditional Medicare program**. The President is committed to strengthening and improving the traditional program, which serves over 80 percent of all Medicare beneficiaries. By giving it private sector cost containment and quality improvement tools, this proposal would reduce traditional Medicare's costs and make it a sustainable, reliable option for beneficiaries in this competitive system, further strengthening competition in Medicare. Moreover, the premium for traditional Medicare would set as it is currently and in fact would be lower than current law due to the savings in the proposal. This keeps traditional Medicare as an affordable option in this more competitive system.

- **Assures that the government payments for managed care keep pace with inflation.** Unlike voucher options for restructuring Medicare (which typically fix the government contribution at a particular rate and then index its growth), this proposal would base the government payment on the traditional program costs. Thus, over time, the maximum government payment would grow at the same rate as the traditional program. This would protect beneficiaries from assuming an increasing share of the premium over time. However, if the traditional program growth rises excessively, beneficiaries would have an even greater incentive to enroll in managed care, since managed care plan costs would fall relative to traditional Medicare, lowering the premiums that beneficiaries would pay to enroll. This would put pressure on traditional Medicare to reduce its cost growth.

- **Promotes fair competition between managed care and traditional Medicare.** This proposal bases its price competition on a central concept: beneficiaries choosing a managed care plan whose price is about the same as the traditional program would pay the same Part B premium as those in the traditional program. Those choosing more expensive plans would pay more, and those choosing less expensive plans would pay less. This encourages fair competition between managed care and traditional Medicare, but does not penalize beneficiaries that believe that traditional Medicare best fits their needs. Additionally, the government payments would be geographically adjusted to assure that the beneficiary premiums are different only due to efficiency and quality, not higher local costs.

- **Begins in 2003, assuring an adequate transition**. One concern about any restructuring proposal is that it is too ambitious and causes too much disruption in a short period of time. This proposal would begin in 2003, when the implementation of Medicare risk adjustment is nearly complete. This would also allow time for beneficiary and managed care plan education as well as preparation and systems changes to assure efficient administration.

DRAFT

President Clinton's Plan To Modernize and Strengthen Medicare:
Communications Rollout Plan:
June 23, 1999

The purpose of this document is to spell out our Medicare rollout strategy and the key tasks that must be completed before, during and after the announcement of the President's Medicare proposal on Tuesday, June 29th.

Goals:

- Establish the President's proposal to reform and strengthen Medicare as a credible and substantive plan with lawmakers, reporters, opinion makers and elites.
- Communicate directly to the American people that the President's proposal benefits them through non-national media, including: daytime television, regional newspapers, radio, constituency groups/publications and the internet.
- Mobilize key constituency groups in support of meaningful reform to communicate their support for the proposal and affect its adoption.

Administration Briefers:

It has been suggested that each briefing be conducted by a team of three people, to be composed of one person from the Economic Team, one person from the Health Care Team and one Senior White House staff person. These teams can be drawn from the following people:

Senior White House Staff: Podesta; Ricchetti; Stein; Johnson
Economic Team: Rubin; Sperling; Lew; Mathews
Health Care Team: Shalala; Thurm; Jennings; DeParle

Administration Officials to Book for Interviews:

John Podesta, Bob Rubin, Gene Sperling, Donna Shalala, Ann Lewis

Friday, June 25th

Late Afternoon/Evening Hill Briefing – Daschle/Gephardt Health Staffers:

Jennings goes to Hill Friday to brief top health care staffer for Sen. Daschle and Minority Leader Gephardt. (No paper.)

Sunday Shows (?):

Based on early coverage, decide whether to book Administration officials on Sunday shows to do curtain raiser on Medicare.

Shalala on Face the Nation
Coordinate Rich, Jane, Gary
talk tonight

Mark 65645.

Monday, June 28th

POTUS – Mid-Session Review Event:

Announcement of Mid-Session Review and new surplus numbers.

Constituency Calls:

Sperling:

Max Richmond and Martha McSteen, Natl. Cmte. to Preserve Soc. Security and Medicare
Horace Deets, AARP

Sperling or Thurm: Jennings

Conference calls with seniors, disabled and women's groups.

Evening Hill Briefing – Key Committee Staff:

Jennings goes to Hill to brief key staffers on Ways & Means, Commerce, Finance & Health committees.

Tuesday, June 29th

Television:

Morning TV: Book Shalala, Sperling and other Administration officials on network morning shows, and early cable news segments

Daytime Cable News: Reach John King and others to shape early news stories. Book Rubin, Shalala, Podesta, Sperling, Lewis and others on key daytime cable news programs/segments. (depends on early coverage…)

Network Anchor Calls: Podesta (?) calls the three network anchors to shape Tues. evening news and Wed. morning news.

Financial News Shows: Book Secretary Rubin on Financial news programs.

Evening/PM TV: Book Administration officials on network news; the Newshour; and cable news programs (Larry King; other?).

Radio:

Morning Radio: Someone from WH does 2 minutes with NPR early am [redacted]

Actualities: Rubin for financial programs (?); Shalala

Roundtable Give radio networks chance to get better sound at separate briefing in Roosevelt Room between 10:30 and 11:00?

Internet:

Have full plan and paper on the White House web site to be available as the 2:30 event begins.

White House Briefings:

6:00am **Conference or Individual Calls to Major Health Care Reporters**

Jennings (and ~~Sperling?~~) do either a conference call or individual calls to major health care reporters. EMBARGOED UNTIL 10:00 A.M.

Reporters:Laurie McGinley, WSJ; Alissa Rubin, LAT; Laura Meckler, AP; Susan Page, USA Today; Amy Goldstein, Wash. Post; Robert Pear, NYT

7:00am-11:00am **Individual Calls To Key Validators**

Sperling/Lew/Jennings divide up a list of key economic/budget/health care experts to call. Pete, Melissa, Rob

Validators:

Karen Davis –	Robert Reischauer – gene/Jack
Diane Rowland –	Uwe Reinhardt
Ken Thorpe	Marilyn Moon –
Laura Tyson – gene	Judy Feder –
Stuart Altman –	Bruce Vladek Lew

[NOTE: Should Secretary Rubin call 3-5 financial/Wall Street type validators?]

9:00am-11:00am **Calls to Key 15-20 Senators and Members of Congress (Chief of Staff's Office)** Chris

Podesta and Stein, along with someone from both the economic and health care team make calls to key 15-20 Senators and Members of Congress – or calls are slit up among different sub-teams.

10:00 a.m. **Briefing in White House briefing room conducted by Jennings and Sperling to explain proposal to White House reporters.**

ON THE RECORD, NOT FOR BROADCAST

10:00am-10:20am **Communications Talkers Conference Call (Loretta's Office)**

Loretta hosts conference call with regular, weekly in-town Democratic friends with someone from below the first tier from the Health or Economic Team.

11:00am **One Large Briefing for Key Constituency Groups**

(Room 450)

Jennings/Thurm/Matthews brief key groups invited by OPL in Room 450 briefing.

12pm Map Room Mrs. Clinton & McLarne

12:30 p.m. **Roosevelt Room briefing for Pundits.**
Conducted by a team consisting of a Senior White House staff person, someone from the Economic Team and someone from the Health Care Team. Chris

2:30pm **Rose Garden POTUS Event**

TBD AFTER Event **Regular White House Briefing –**
Tier One Team Briefs White House Press Corps

Briefing by Podesta/Rubin/Shalala/Sperling

After Event **Editorial Board Calls**

Rubin calls Weinstein (NYT)
Sperling calls Milius (Washington Post)
Shalala calls LA Times and USA Today

After Event **Political/Intergovernmental Calls (?)**

Wednesday, June 30

- **Possible POTUS interview on way to Chicago.**
- **Prescription Drug Event in Chicago**
- **Daytime T.V.:** Book Shalala on daytime television to communicate to America how the President's Medicare proposal will help them (i.e. Rosie O'Donnell?).
- **Reach Magazine Writers and Columnists:** Calls to key magazine reporters and columnists by Podesta, Sperling and others.

  Magazines: Time, Newsweek, U.S. News, Business Week

  Columnists: Gerry Seib, Robert Samuelson, Bob Herbert, E.J. Dionne, Maureen Dowd

- **Radio**

HHS to book national and regional talk shows.

Shalala/DeParle to do syndicated shows: NPR's Diane Rehm, Dr. Dean Edell; The Joan Hamburg Show, and the Dr. Terry Mason Show. Regional radio to include: the Michael Jackson Show in LA; the Paul W. Smith Show in Detroit; WINZ-AM in Miami; WISN and WTMJ in Milwaukee and WTDY-AM in Madison.

- **Specialty Press**

  Conference calls/mailings with seniors, women's and minority press. (Beverly Barnes to coordinate).

  Target publications with high seniors readership, i.e. Modern Maturity.

- **Satellite Feeds:** Set up satellite interviews for Shalala into targeted markets for next two days.

- **Roundtable with Key Constituency Groups:**

- **Regional Editorial Boards:** Calls and mailings to the major regional editorial boards, including markets with high seniors population. (Beverly Barnes)

  HHS: conference calls into the following sta tes: New York, Florida, Connecticut, Michigan, Maine, Los Angeles, North Dakota, Iowa, Nevada, Indiana, New Jersey, Wisconsin, Ohio, Tennessee and Idaho.

- **Op-eds:** Coordinate Op-eds from validators in national papers, and seniors publications, through end of week and regional press during week of July 5.

- **Online-Interviews:** Set up 2-3 Internet interviews with Jennings/Sperling on CNN/MSNBC websites.

Thursday, July 1

- **Sperling at Sperling Breakfast** to explain plan and set up Sunday shows.

- **Continue Satellite Feeds:** Satellite interviews for Shalala into targeted markets.

Friday, July 2

- **USA Today Interview with Admin Rep TBD** perhaps on Rx drugs.
  This will be the 4th of July weekend edition, one of the most read editions

of the year.

Possible interview with Shalala and her mother for "real person" view of how the President's proposal helps Americans.

Sunday, July 3

- **Medicare Team back on Sunday shows.**

2:15 brief

2:30

2:45 event on steps side of garden

② Robin
① Shalala
③ POTUS

3:20-3:45

more people may come on
Mon if leg affairs wants
JJ11 standing

meet & greet w/ members

2:45 → 2:55 if we need to

DATE: 6-25-99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

PHONE: (202) 690-7627 **FAX: (202) 690-7380**

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
ROOM 416-G HUMPHREY BUILDING

TO Chris T.

OFFICE :

PHONE NO :

FAX NO : 456-5557

TOTAL PAGES (INCLUDING COVER): 3

FROM:

[X] RICHARD J. TARPLIN
[ ] HELEN MATHIS
[ ] KEVIN BURKE
[ ] ROSE CLEMENT LUSI
[ ] ALICE ARTIS
[ ] FRANKIE MELTON
[ ] HAZEL FARMER

REMARKS: Draft rollout per our discussion

Congressional Medicare Roll-out Strategy

Friday (June 25) - 7:00 pm:

- Conference call to brief Daschle and Gephardt staff.

[Sunday Night (June 27) - Monday AM (June 28):

- White House to brief select members and staff from Democratic Leadership, Budget Committees, Finance and Ways and Means Committees re: Mid-session review (see separate roll-out document). Briefings will include general reference to proportion of surplus dedicated to Medicare and financing of prescription drug benefit.]

Monday (June 28) - early evening:

- Conference call briefing for House and Senate leadership, Finance, Ways and Means, Commerce, and Budget Committee Democratic STAFF (WH/Leg., Jennings, HHS/Leg., Treasury Leg.)

Tuesday (June 29) - 8:00 AM - 11:00 AM:

- Administration principals make individual calls to brief members prior to announcement (See attached proposed assignments for Podesta, Sperling, Rubin, Shalala, Lew, Stein, Ricchetti, Jennings, DeParle).

- Administration staff make individual calls to brief key staff not included in Monday evening conference call (Murguia, Brain, J.Johnson, Tarplin, Thomas, Mendelson).

- Briefing during weekly Senate DPC lunch?

Wednesday (June 30) - Times TBA

- Bipartisan Finance Committee Staff Briefing
- Bipartisan Ways and Means Committee Staff Briefing
- Bipartisan Commerce Committee Staff Briefing
- Briefing during weekly House Democratic Caucus?
- Briefing for House Democratic Budget Task Force

Thursday (July 1) - Times TBA

- Briefing for Senate Legislative Assistants (hosted by Finance Committee)
- Briefing for House Legislative Assistants (hosted by Ways and Means and Commerce)

MEDICARE ROLL-OUT TELEPHONE LIST

Podesta	Sperling	Rubin/Summers	Shalala	Lew	Stein	Ricchetti	Jennings	DeParle
Daschle	Stenholm	Moynihan	Dingell	Rangel	Spratt	DeLauro	Stark	Cardin
Gephardt	Kerrey	Roth	McDermott	Waxman	Graham	Frost	Allen	Tanner
Hastert	Conrad	Archer	Bilirakis	Kennedy	Domenici	Breaux	Thomas	Kleczka
Lott	Chafee		Brown	Collins	Bryan	Robb	Rockefeller	Johnson (CT)
	Lieberman		Jeffords	Snowe	Lautenberg	Baucus	Wyden	Thurman
			Mikulski		Nickles			Mack
								Grassley

Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. email	Irma Martinez to Sharon Gill re: Medicare event names (partial) (1 page)	06/24/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20469

FOLDER TITLE:
Medicare [Folder 2]

2012-0463-S
rc787

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]

(b)

Irma L. Martinez
06/24/99 12:48:35 PM

Record Type: Record

To: Sharon K. Gill/WHO/EOP@EOP

cc:

Subject: Medicare event names -Reply

Treasury invitees -- I still owe you HHS:

Alan Cohen P6/(b)(6) [001]
622-0056

David Wilcox P6/(b)(6)
622-2200

Mark McClellan P6/(b)(6)
622-0563

Ruth Marti Thomas P6/(b)(6)
622-0725

Linda Robertson P6/(b)(6)
622-1900

19

188 OEOB

Karin Kullman 06/25/99 01:25:26 AM

Record Type: Record

To: Sharon K. Gill/WHO/EOP@EOP, Irma L. Martinez/WHO/EOP@EOP

cc: Devorah R. Adler/OPD/EOP@EOP
Subject: medicare staff for event

Here is the list of people that DPC feels are important to invite. Can we accommodate these people?
---------- Forwarded by Karin Kullman/OPD/EOP on 06/25/99 01:23 AM ----------

Jeanne Lambrew
06/24/99 06:00:49 PM

Record Type: Record

To: Karin Kullman/OPD/EOP

cc:
Subject: medicare staff for event

Hello,

Devorah told me that you would help make sure that the people who have helped work on the Medicare plan get invited to the event. HEre is my list, that I will also send to HHS so there is no double counting

HCFA:
- Rick Foster 410/786-6374 • Nancy Ann Deparle 6906726
- Sally Burner [same]
- Greg Savord [same]
- Sol Mussey [same]

- Bonnie Washington 690-5960
- Ira Burney 690-5960
- Barbara Cooper 690-7063
- Sharman Stephens 690-7063
- Carlos Zarabosa 690-7063

Other HHS people:
- Gary Claxton 690-6870
- Jack Hoadley 690-6870
- Jane Horvath 690-7450

Treasury:
- Mark McClellan 622-0563
- Phil Ellis: 622-2342

OMB:

- Mark Miller 5-7810
- Caroline Davis 5-7842
- Bob Donnelly 5-4930
- Yvette Shenouda 5-7843

Jonathan Blum 5-4930

Some of these people are politicals / assistant secretaries who may get invited in other ways, but I wanted to make sure that they are on the list

Thanks!

MIDSESSION REVIEW AND MEDICARE ROLLOUT

Midsession Review

Sunday Evening

- Gene, Jack and Larry to brief House and Senate Budget Committee Staff (Tom Kahn, Sue Nelson, Bruce King) and Leadership Staff on a conference call.
- Gene, Jack and Larry to brief Daschle and Gephardt.
- Gene, Jack and Larry to call Lautenberg, Obey, Spratt.

Monday

- 8:30 am – Gene, Jack and Larry to brief the House Budget Committee and Ways and Means on a conference call. (Should these be separate or together)
- 9:00 am – Gene, Jack and Larry to brief the Senate Budget Committee and selected Members of the Senate Finance Committee on a conference call. (Should these be separate or together)
- Jack and Larry to call Conrad and Domenici (separately).
- Gene and Larry to call Pomeroy.

Please note – Gene suggested that we have a story embargoed w/ the AP until the end of the briefings. (Based on this proposal, I guess 9:00am or 9:30am)

Based on the POTUS' schedule, at this time it appears as if the midsession announcement may be at 8:30am. Larry thinks that this is untenable and suspects that the time will change.

Medicare Rollout

Sunday

- Conference call w/ Andi King (Gephardt) and Jane Lowenson (Daschle).
- Joel to talk to Elmendorf

Monday

- Conference call to Democratic Health Staff

- Calls to be divided among:

Podesta, Ricchetti, Rubin, Shalala, Sperling, Lew, Stein, Jennings

Rangel
Dingell
Stark
Waxman
Cardin
Sherrod Brown
Tanner
Stenholm
Spratt
Allen
DeLauro
Frost
Pomeroy

Moynihan
Kerrey
Graham
Breaux
Kennedy
Rockefeller
Conrad

Tuesday

POTUS event scheduled from 2:15pm – 3:30pm.

Calls to R's after the announcement, including:

First Tier
Chafee
Domenici (Lew or Stein)

Roth (Rubin)
Hastert (Podesta)
Bilirakus
Thomas

Second Tier
Grassley
Jeffords
Snowe
Collins

Wednesday

Bipartisan Staff mtg on House and Senate sides