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COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20471

FOLDER TITLE:

Medicare [Folder 5]

2012-0463-S

rc788

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.

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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]
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- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
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- 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]

EDWARD M. KENNEDY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510-2101

cc: KT
Larry Stein
Sperting
Reed

May 14, 1998

Chris T.

The Honorable John D. Podesta
Chief of Staff to the President
The White House
Washington, D.C. 20500

Dear John:

It was good to talk with you yesterday. This letter is to follow up on our conversation. I'll be dropping the President a note on this next week, as well.

As you develop a Medicare prescription drug proposal, I wanted to share my thinking on some key concepts:

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- The biggest potential source is the surplus that is already allocated to Medicare under the President's budget. I do not see any conflict in using a portion of these funds for financing a prescription drug benefit. Medicare cuts were the biggest single source of spending reductions creating the surplus. The solvency of Medicare has improved dramatically since the President made his proposal. The President said that the surplus was to be used to improve and strengthen Medicare. There is nothing more important to improve and strengthen Medicare than coverage of prescription drugs. If one-half of the portion of the surplus designated for Medicare is used to pay part of the drug benefit, it would raise \$172 billion over the next 10 years--and still make it possible to extend the solvency of the Trust

Page 2

Fund to 2020, the President's original target.

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 - Any program savings from the President's reform package should be dedicated to prescription drug coverage.
 - The elderly organizations were all very comfortable with the relatively high \$200 dollar deductible included in our bill. It largely financed the cost of the catastrophic benefit.
- (4) Strategically, the most important step is to launch a benefit that the elderly will rally around. If we get this program enacted, in the end it will be part of some overall agreement with the Republicans, and not necessarily tied to any specific financing source.

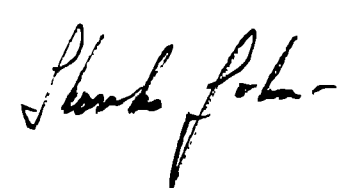
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I hope these thoughts are helpful. The President's leadership on this critical health issue has been inspiring, and there are reasonable prospects for success this year.

With thanks and appreciation,

As ever,

Edward M. Kennedy





DATE: _____

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

FROM:

TO : Chris Jennings

OFFICE : _____

PHONE NO : _____

FAX NO : 456 - 5557

TOTAL PAGES
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[] RICHARD J. TARPLIN

[] HELEN MATHIS

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[] HAZEL FARMER

REMARKS: _____

April 8, 1999

The Honorable Donna E. Shalala
Secretary
Health and Human Services
200 Independence Avenue, SW
615F
Washington, DC 20201



Copies to: Jan
Garyc

Fax to: Tenning
Dan M.

Dear Secretary Shalala:

The American Hospital Association (AHA) is dismayed at comments you made last week that the President's Medicare Reform Plan will incorporate a proposal to extend Medicare reductions included in the 1997 Balanced Budget Act (BBA) beyond the year 2002. On behalf of the nearly 5,000 hospitals, health systems, networks and other providers of care that we represent, we strongly oppose this concept.

There is simply no sound rationale for further hospital or other provider reductions on top of the \$115 billion included in the BBA. During the recent round of congressional budget negotiations, the House and Senate agreed, and rejected additional hospital reductions, recognizing that hospitals already face tremendous financial pressure and uncertainty as a result of the BBA.

This is based on the fact that currently about 26 percent of hospitals have negative Medicare PPS inpatient margins, which means that one in four hospitals loses money treating Medicare inpatients. (Source: HCFA PPS 13 Hospital Data Set, August 1998). And, this represents only a portion of a bigger and bleaker picture. Reportedly "high" PPS inpatient margins represent but a slice of the overall financial health of hospitals. They include only revenues from Medicare inpatients, and do not reflect the losses from outpatient care, the care provided in hospital-based skilled nursing facilities or home health agencies. Taken in total, the overall Medicare margin is a mere 2.3 percent.

Moreover, the full impact of the five-year BBA payment reductions of \$53 billion to hospitals and health systems alone have yet to be fully implemented. Indeed, even in the early years, the picture is not a pretty one. Total hospital Medicare margins with respect to items and services provided to Medicare beneficiaries are expected to decline from 4.3 percent in fiscal year 1997 to only 0.1 percent in fiscal year 1999. (Source: *A Comprehensive Review of Hospital Finances in the Aftermath of the Balanced Budget Act of 1997*, Ernst and Young LLP, March 1999).



Washington, DC Center for Government and Public Affairs
Chicago, Illinois Center for Health Care Leadership

Liberty Place, Suite 700
325 Seventh Street, N.W.
Washington, DC 20004-2802
(202) 638-1100

The Honorable Secretary Shalala

Page 2

April 8, 1999

Additional Medicare spending reductions over and above the \$115 billion already in place under the BBA would have a substantial negative impact on the ability of providers to meet the needs of the Medicare beneficiaries in their communities. Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC) and former administrator of the Health Care Financing Administration recently stated: "I would be reticent to recommend additional reductions now. I think you ought to look to see what you've done before you do more." In fact, we already are hearing from our members who have had to cut skilled nursing and home health services as a result of the BBA's reductions - even before the full impact of the BBA has been felt.

Recent downgrades in hospital bond ratings for some large and successful health care delivery organizations suggest that the private sector may be viewing the health care field with skepticism. National bond rating services are concerned about the future profitability of some organizations, noting the softening of the economic health of hospitals in managed care situations and a payment scene that is uncertain.

The AHA supports efforts to reform Medicare through true restructuring of the program, rather than simply resorting to the unjust approach of cutting more and more out of provider payments. In the long run, this approach cannot be sustained if hospitals and health systems are to continue to provide the quality of care and access to Medicare beneficiaries that they take such pride in doing on a daily basis in their communities. We urge the Administration to reject including in its Medicare reform plan any proposal that would add additional years of cuts on top of the BBA reductions.

Thank you for your attention, and I look forward to your response.

Sincerely,



Rick Pollack

Executive Vice President

UNITED STATES SENATE
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
WASHINGTON, DC 20510-6300

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DATE:

5/14/99

TO:

Chris Jennings

FAX NUMBER:

451e-5557

FROM:

David Nexon

(202) 224-7675 phone
(202) 224-3533 fax

NUMBER OF PAGES:

3

(including cover)

MESSAGE:

For your information

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United States Senate

WASHINGTON, DC 20510-2101

May 14, 1998

The Honorable John D. Podesta
Chief of Staff to the President
The White House
Washington, D.C. 20500

Dear John:

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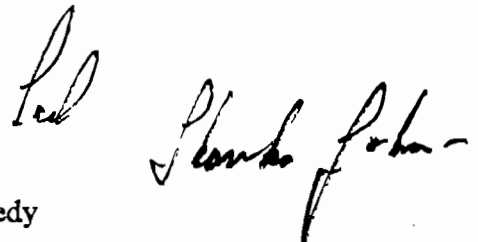
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With thanks and appreciation,

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UNITED STATES SENATE
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WASHINGTON, DC 20510-6300

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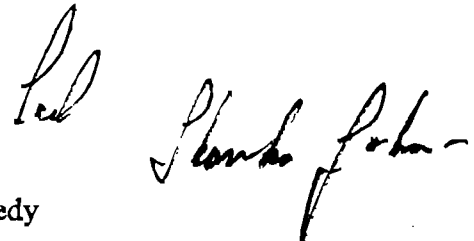
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WILLIAM M. THOMAS
71ST DISTRICT, CALIFORNIA

COMMITTEES
CHAIRMAN, HOUSE OVERSIGHT COMMITTEE
CHAIRMAN, WAYS AND MEANS SUBCOMMITTEE
ON HEALTH
MEMBER, WAYS AND MEANS SUBCOMMITTEE
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2208 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-0521
(202) 225-2915



ADMINISTRATIVE ASSISTANT
CATHERINE M. ABERNATHY

DISTRICT OFFICES
4100 TRUXTON AVE #220
BAKERSFIELD, CA 93309
(805) 327-3611

319 WEST MURRAY AVENUE
VISALIA, CA 93291
(209) 627-6549

Congress of the United States
House of Representatives
Washington, DC

Testimony of Bill Thomas to the Senate Finance Committee

May 26, 1999

Mr. Chairman, Senator Moynihan and Members of the Finance Committee, thank you for inviting me to testify about the Breaux-Thomas Medicare proposal. This proposal was supported by 10 of the 17 Members of the Medicare Commission. I note that this 60 percent margin would meet the high threshold to pass in this chamber. I was pleased that 4 of the 5 Senators on the Commission voted for the proposal and 3 of those 4 are on your Committee. Clearly, you have a bipartisan foundation upon which to move forward.

How Premium Support Works: Myths and Reality

Premium Support, the core-concept in the Breaux-Thomas proposal was not dreamed up at a think tank. Rather, it is based on the largest pool of insured individuals next to Medicare itself: 9 million federal employees and their families including Members of Congress. Premium Support will modernize Medicare by integrating innovations of the marketplace while preserving the entitlement and safety net.

Under premium support, qualified private plans and the government-run fee-for-service plan would submit bids based on the actual costs of providing health care to Medicare beneficiaries. The government contribution would be 88% of the weighted national average of these negotiated bids. This guaranteed government contribution is equal to the current government-beneficiary ratio, since the beneficiary Part B premium of 25% amounts to 12% of total Medicare costs.

Beneficiaries would then choose whatever health plan best suits their needs. If they chose an average plan, they would pay 12% of the premium. They could choose a more munificent plan if they wanted to add their own dollars, or choose a more efficient plan and reduce or even eliminate their premiums.

Medicare will now have the ability to harness the market power to control costs through competition. The Congressional Budget Office commented that the Breaux-Thomas plan "would foster greater competition among plans and greater choice for beneficiaries" and that "increased competition will reduce costs."

Recently, there has been much castigating of Premium Support and use of pejorative terms to describe the proposal. I would like to set the record straight:

Premium Support is not a defined contribution. A defined contribution is based on an arbitrary number and index that may or may not provide the sufficient funds to meet beneficiaries' needs. In contrast, Premium Support guarantees the current benefit package. Secondly, under Premium Support, when health care costs rise, the government contribution rises commensurably.

Premium support is not a voucher. A voucher implies handing seniors some money and asking them to go off in the cruel world to see if they can find someone to sell them insurance. In contrast, the Breaux-Thomas proposal establishes a "Medicare Board" which would negotiate with health plans and prevent plans from cherry picking only the healthy individuals and turning away unhealthy individuals. The Board would also provide beneficiaries unbiased information about their plan choices. This has the benefit of getting HCFA out of the inherent conflict-of-interest of regulating its competition.

Premium support does not force seniors into managed care. To the contrary, under the Breaux-Thomas bill, seniors can choose to remain in the government-run FFS plan, and they will have more options for open-network private plans because the new payment structure will permit these plans to compete.

Advantages of Premium Support

More Choices for Beneficiaries: Some allege that premium support may not work because 7 out of 10 counties do not have Medicare+Choice plans and that a number of plans have recently pulled out of the Medicare market. I think these problems are the very reason we must move to a premium support system. Currently, we pay plans based on the arbitrary, county-wide administered prices determined by government policy. Then we wonder why many private plans, acting in the real world, find payments in many areas insufficient. Our attempts to address this issue in the BBA through "blended rates" and payment floors can only help at the margins.

In contrast under FEHBP, every enrollee in every state of the country has a choice of at least 10 different plans. While Medicare has many states with no plan choices, enrollees in FEHBP in West Virginia have 23, South Dakota: 17 and Nebraska: 19. This is because the plans are paid on the rates that they bid. Under premium support, plans will bid for the real costs of health care. This will expand choices for seniors, particularly in rural areas.

Quicker Beneficiary Access to Innovation: I was proud to work with my Democratic Colleague, Ben Cardin, to assemble a package of preventive benefits, which became the core of the Medicare changes in the 1997 Balanced Budget Act. This package included important new benefits such as mammographies, diabetes self-management, colorectal screenings and others. While this was a great improvement to Medicare, most private plans had already adopted these benefits more than a decade earlier. This illustrates that Medicare's current statutory and regulatory structure simply cannot keep pace with the changes in the marketplace. As long as Congress must be relied on to legislate and

micro-manage the program, Medicare will always be behind the curve and seniors will have to wait for new benefits and innovative health delivery systems. My first attraction to premium support was the long-overdue flexibility and responsiveness it will provide so that the program becomes more self-correcting.

Produces Significant Savings Through Greater Efficiency: Shortly after the HI trust fund is scheduled to go broke, 77 million baby boomers begin to retire and the number of workers to beneficiary will drop from a ratio of about 4:1 today to about 2:1 in 2030. At the same time, health care costs are anticipated to grow at a far higher rate than the economy. This leaves Congress with an enormous challenge and three fundamental choices: cut benefits, raise taxes or make the program more efficient. Obviously, the most preferable course is increasing efficiencies.

Premium support makes the program more efficient by giving seniors incentives to make more rational choices and plans more incentive to provide high quality care at the greatest economy. Data from the FEHBP show that enrollees chose less expensive plans every year, even when the average premiums *decreased*. The Medicare Commission estimated that the Breaux-Thomas plan will slow the Medicare growth rate 1 to 1.5% a year. Any manager of a mutual fund will tell you that 1.5% compounded over time produces enormous results. We expect this savings to amount to \$800 billion *a year* by 2030. The sooner we can begin to moderate these growth rates, the better off we will be as savings compound over time.

Reduced Costs for Beneficiaries: Under Premium Support, seniors will have incentives to choose more efficient plans because they can share in the savings. This is unlike the current Medicare+Choice program, in which seniors can never reduce their premiums by choosing less expensive plans. In fact, our proposal allows seniors to choose zero premium plans. By reducing the growth rate, the Commission estimated that beneficiary premiums would be 17-24% lower than under current law.

Making Prescription Drugs Accessible and More Affordable

One key feature of premium support is integrating prescription drugs in Medicare in a responsible way. Over the past 5 years, the FDA has approved more than 200 new innovative pharmaceuticals, half of which are targeted to seniors. But 35% of seniors currently lack prescription drug coverage. Our goals were to 1) target assistance to those who need it most – low income beneficiaries; 2) permit seniors to insure against the risk of high pharmaceutical expenditures and benefit from the market discounting common in the employer market; and 3) design a program that would permit employers a greater ability to integrate their retiree coverage with Medicare.

Comprehensive Coverage for Low-Income: The neediest beneficiaries, those with incomes up to \$10,500, will get comprehensive prescription drug coverage. This is a significant commitment to improving the safety net, costing \$30 billion over 10 years for the prescription drug coverage and an additional \$31 billion for the expected increased participation in the low income programs that cover premiums and cost-sharing.

Restructured market for all seniors: The 35% of seniors that lack drug coverage and millions of others that have inadequate coverage through Medigap, are now faced with high retail prices for drugs and no way to insure against the risk of high pharmaceutical expenditures. This is a particular problem when many seniors take 10 or more prescriptions a year. The Breaux-Thomas plan restructures the market to address these problems. All plans, including the government-run FFS plan, must offer a high-option plan, which includes prescription drug coverage and stop loss protection. Secondly, all Medigap plans must include prescription drug coverage as a core benefit, and one Medigap plan must be a prescription drug only plan. These plans will now be in a position to negotiate discounts on seniors' behalf and permit seniors to insure against large pharmaceutical expenditures.

Encouraging Employer Participation: Finally, employers who are finding it increasingly difficult to maintain open-ended retiree plans, can easily add their dollars to these integrated high-option plans for their retirees. Thus, we can maintain and even increase employer participation for retirees. Many other Medicare prescription drug proposals displace employer-sponsored coverage, rather than integrating it.

Conclusion

In short, Premium Support brings Medicare into the 21st century as a stronger, improved health program for today's and tomorrow's retirees. I look forward to working with you and Democrats and Republicans in the House in improving this proposal and modernizing the Medicare program. Thank you.

306640

United States Senate
WASHINGTON, DC 20510

May 27, 1999

President Bill Clinton
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

As you develop your plan to ensure the solvency of the Medicare program, we would like to share our thoughts with you on the importance of this program to our constituents. Further, we would like to suggest some changes that we believe would strengthen traditional Medicare.

We are in strong agreement with you that Medicare must continue to guarantee benefits for all our nation's seniors and individuals with disabilities, as it has since 1965 when it was created to provide universal health insurance coverage to these populations. As you know, before the passage of Medicare, 85 percent of seniors lacked health insurance. Tragically, we already have 43 million uninsured individuals in our nation and adding to that number would be disastrous. Today, about 60 percent of Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL) and ten percent have incomes below 100 percent of the FPL. Eliminating the current guarantee of benefits will erode the safety net relied on by our elderly and disabled constituents.

The Bipartisan Commission on the Future of Medicare's plan contained a number of proposals which we strongly oppose. These concepts, such as "vouchering out" Medicare, raising the eligibility age from 65 to 67 and imposing a copayment on home health care, would be a disaster for millions of seniors and individuals with disabilities and have an especially negative impact on minorities and women.

While we were pleased that the Medicare Commission's plan did not receive the needed super-majority, we are concerned that elements of that plan will reappear in specific legislation. We hope you will join us in opposition to these disastrous "reforms" and hope that as you develop your Medicare reform plan that you will give serious thought to the suggestions we are offering:

1) Eliminating the Medicare guarantee and replacing it with a "voucher" system will hurt current and future beneficiaries. This proposal must be rejected. A premium support or "voucher" plan - by moving healthier and wealthier beneficiaries into private health plans - will destroy the guarantees that Medicare beneficiaries have relied on for 34 years.

A "voucher" model lacks effective cost control mechanisms for the Medicare program. It assumes that competition among private health plans will keep costs down. There are several problems with this assumption. First, as we have seen in the case of prescription drugs,

To: President Clinton
Re: Medicare Reform
May 27, 1999
Page 2

competition does not always keep costs down. Second, from 1997 to 1998, Medicare expenditures increased by only 1.5 percent compared with a 6.1 percent increase for the private health plan competitive marketplace. Medicare does a much better job controlling costs than the private insurance marketplace.

Premium support plans will be a form of corporate welfare for the private insurance industry, and particularly HMOs. Tens of billions of dollars currently paid by the government to health providers each year will instead be paid to HMOs and other private insurers.

Private health care plans are not available in many parts of the country. Of America's 3,100 counties, seven out of ten - nearly 2,200 - do not currently have Medicare managed care. Because of the lack of providers, these areas are unlikely to ever develop HMO-type programs.

Rural communities will be particularly hard-hit. The 11 million Medicare beneficiaries in rural areas make up 30 percent of the Medicare population. They will be left behind under a "voucher" plan. In those areas where managed care is available for Medicare, only 21 percent of beneficiaries have chosen to leave traditional Medicare to join managed care plans. Additionally, many managed care plans have pulled out of the Medicare program since 1997, leaving more than 400,000 seniors with no health insurance.

Even in areas that have managed care available, most low-income seniors will not be able to afford to purchase these plans. Women and minorities are disproportionately harmed by a "defined contribution" plan because they tend to be poorer and less able to pay additional costs for a good health plan. The average Medicare beneficiary spends about one-fifth of income on out-of-pocket health costs, but beneficiaries at or below the poverty line spend over a third of their income on health care out-of-pocket expenses. Low-income women and minorities will be most hurt by a "voucher" program.

It is also troubling that, at a time when Congress is concentrating on fixing the problems of managed care programs, some in Congress and the Medicare Commission are willing to subject our Medicare beneficiaries to problematic HMOs. Speaker Dennis Hastert has promised a vote on managed care reform legislation this year. We have concerns about moving seniors and individuals with disabilities into managed care and certainly do not support subjecting them to the risks of the current managed care system before any patient protection legislation is passed.

The Medicare Commission's premium support model is not the same as the Federal Employees Health Benefits Plan (FEHBP), which covers federal workers and Members of Congress. Many supporters of a "voucher" plan compare it to the FEHBP. However, the FEHBP population is far more healthy and wealthy, on average, than the Medicare population. Median pay for federal employees is about twice that of seniors. Thus, it is easier for federal workers to afford more expensive plans than Medicare beneficiaries. Most Members of Congress choose Blue

To: President Clinton
Re: Medicare Reform
May 27, 1999
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Cross/Blue Shield, which most resembles traditional Medicare, as their plan. However, this choice might not be an option, due to its higher cost, for many beneficiaries under a premium support model.

Additionally, the eight national plans open to all federal employees are PPOs with broad access to providers. The only Medicare plan with that same availability is traditional Medicare. While the 1997 Balanced Budget Act opened up participation to a wide variety of health plans, only HMOs have chosen to participate. Converting traditional Medicare to a premium support model would seriously limit beneficiaries' choice of providers and plans.

Interestingly, the FEHBP saw premium increases of 8.5 percent in 1998 and is looking at an increase of 10.2 percent in 1999. This dwarfs the 1998 Medicare increase of 1.5 percent.

2) We must not increase the eligibility age for Medicare. Raising the eligibility age from 65 to 67 is a very dangerous idea. Many older Americans will become uninsured under this plan. Under this proposal, one and one-half million Americans will be needlessly added to the rolls of the uninsured at an extremely vulnerable time in their lives.

We find it rather extraordinary that in this period of economic "boom," some in Congress would force seniors to work and wait for an additional two years until they can receive full medical benefits. Many employers are cutting back on workers' health insurance or eliminating it completely. How will we provide for individuals who lose their coverage and then must wait an additional two years to enroll in Medicare?

Additionally, many minority populations will be particularly hard-hit by this proposal as they tend to have shorter life expectancies and less retirement savings than other seniors.

3) We must not impose any copayment on home health care. The proposal offered by the Medicare Commission included a 10 percent copayment for home health care, which would mean that the average Medicare beneficiary needing home health care would have to pay \$470 a year out-of-pocket. Nearly one-half of seniors live on less than \$15,000 a year and about 12 percent live in poverty. Forcing them to pay hundreds of dollars more annually for a benefit that is currently provided at no cost to them will force even more seniors into poverty.

It is also ironic that at a time when you and many Members of Congress are supporting access for long-term care for the elderly, some members of the Medicare Commission supported cutting home health care, a vital source of long-term care. Past efforts to institute a copayment for home health care have failed repeatedly in Congress and we hope you will join us in rejecting this misguided proposal.

Elderly women are especially affected by home health copayments. In fact, the Medicare home

To: President Clinton
Re: Medicare Reform
May 27, 1999
Page 4

health population is mostly old and poor, predominantly female, and likely to live alone. Two-thirds of home health beneficiaries are women.

Seniors with medically complex needs require more home health visits per year than other beneficiaries. These Americans have disproportionately low-incomes, and with 200 visits per year, which is not uncommon for medically complex patients, their home health "tax" would be \$1,760 per year if the Medicare Commission had adopted the recommendation of its co-chairs. That sort of cost would make home health care prohibitive for many minorities, women, and other low-income Americans. The bottom line is that any copayment for home health care is counterproductive and a health care disaster.

Thus far we have discussed with you some of the proposals which the Bipartisan Medicare Commission considered and failed to adopt. We urge that you also reject these proposals as you formulate your recommendations for improving Medicare. Some of our suggestions as to how Medicare should be improved follow:

1) We agree with you that we need to commit 15 percent of the projected budget surplus to Medicare. Under the proposal which you have advocated, Medicare would remain solvent for the next 28 years. This would enable us to continue to provide strong guaranteed benefits for a prolonged period of time, as well as sufficient time to take a hard look at our entire health care system.

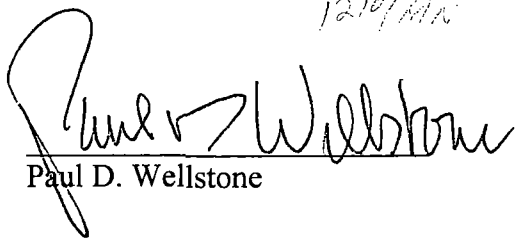
2) We must provide an outpatient prescription drug benefit for all Medicare beneficiaries. Thirty-five percent of seniors currently lack any kind of prescription drug benefit. Seniors are charged outrageously high prices for their needed medications. They are forced to pay much more than drug companies' favored customers, such as hospitals, HMOs, and even the federal government. Often, seniors and Americans with disabilities go without groceries or without paying their heating bills to afford their prescription drugs. It is disgraceful that our elderly and disabled Medicare beneficiaries are getting sicker and even dying because they cannot afford their drugs. We must provide a comprehensive drug benefit under Medicare.

3) We should automatically enroll eligible Medicare beneficiaries into the Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary (SLMB) Program, and Qualified Individuals Program and improve their protections. Low-income beneficiaries whose incomes are slightly higher than the Medicaid eligibility limit benefit greatly from these programs, which cover Part B premiums and, in some cases, other Medicare costs. Millions of Americans who are eligible for these programs are not taking advantage of them because they do not know they are eligible. We should also increase the eligibility limits above the current 135 percent so that more low-income beneficiaries can benefit.

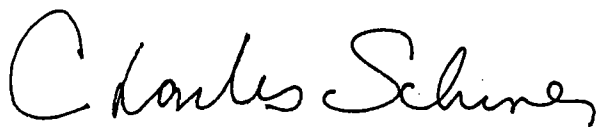
To: President Clinton
Re: Medicare Reform
May 27, 1999
Page 5

In conclusion, we want to thank you for your strong support of Medicare and look forward to working with you to make certain that all elderly and disabled Americans continue to receive guaranteed high-quality health care. In our great and wealthy nation, no senior or individual with a disability should be denied access to this very basic necessity of life.

Sincerely,

1210/MN

Paul D. Wellstone


John D. Rockefeller IV


Charles E. Schumer

cc: Members of the Ways and Means Committee
Members of the Finance Committee



National Committee to
Preserve Social Security
and Medicare

10 G Street, NE, Suite 600
Washington, D.C. 20002-4215 202 216-0420
Contact: Kris Geddings 703 709-6680

NEWS

FOR IMMEDIATE RELEASE:
Tuesday, January 19, 1999

For More Information:
Kris Geddings 703/709-6680

President Is Right In Rejecting Privatization And Focusing On Real Needs of Seniors

WASHINGTON, D.C. -- President Clinton was applauded tonight by the nation's second-largest seniors organization for rejecting privatized individual accounts as a reform for Social Security and, instead, focusing on several of the real needs faced by America.

"The President has been under great pressure for months by critics of Social Security to abandon the system and partially replace it with privatized investment accounts," said Martha McSteen, president of the National Committee to Preserve Social Security and Medicare.

"He is 100 percent right to have resisted the call for privatization at the expense of Social Security," McSteen said. "There no doubt will be proponents on Capital Hill who will continue to press for privatizing the system, but it's increasingly clear that their plans would jeopardize the retirement security of millions of Americans."

McSteen said the President's proposal to create a new retirement savings account outside the Social Security system deserved serious consideration by Congress and would stimulate personal savings without harming Social Security.

"The National Committee is also pleased by the President's focus on shoring up the Medicare trust fund and addressing the too often punitive cost of many prescription drugs," McSteen said. She added that her organization is a long-standing supporter of eliminating the income limit on what seniors may earn before facing reductions in their Social Security benefits.

"These are the real, kitchen-table issues -- how to earn a few extra dollars, how to make ends meet and pay for medications, how to afford long-term care - that so many of America's seniors and their families confront and struggle with every day," McSteen said.

"With today's population of seniors growing and with the baby boom retirement rapidly approaching, these are matters that deserve to be foremost on the country's attention and front and center on Congress's agenda," she said.

FOR COMMENTS TONIGHT: Call Max Richtman, NCPSSM executive vice-president, at 301/765-1164

APR 20 '99 01:56PM CONSUMERS UNION - DC

P.1/4

Phone: 202-462-6262
Fax: 202-265-9548

Consumers Union

Fax

To: Chris Jennings**From:** Gail Shearer**Fax:** 456-5542**Date:** April 20, 1999**Phone:****Pages:** 4**Re:** Medicare Letter**CC:**☐ **Urgent**☐ **For Review**☐ **Please Comment**☐ **Please Reply**☐ **Please Recycle****~~Comments:~~**

Chris,

Attached is a letter we sent yesterday, to Members of Senate Finance and House Ways and Means.

Hope that you are well!

Gail



Publisher of Consumer Reports

April 19, 1999

The Honorable William V. Roth, Jr.
Chairman, Senate Finance Committee
United States Senate
Washington, D.C. 20150

Dear Senator Roth:

We urge you to oppose high-risk "reform" of the Medicare program that is based on the Breaux-Thomas proposal considered (though not officially recommended) by the National Bipartisan Commission on the Future of Medicare. We believe that this "premium-support" model presents major risks for the Medicare program. We oppose the Breaux-Thomas "premium support" plan for the following reasons:

1. Medicare beneficiaries need a *standard benefits package* so that they can make informed comparisons among plans.

While the proposal pays lip service to the need for a standard benefits package, the details of the plan undermine the principle of uniformity. Health plans would be able to offer additional benefits, and would be able to vary the copay and deductible levels. Allowing this variation (with *no* requirements for uniformity) would prevent consumers from making apples-to-apples comparisons among plans. Even slight variation between plans – when multiplied by numerous plans in the marketplace – will serve to confuse consumers. The pathbreaking Congressional reforms of the *medigap* market, enacted in 1990, recognized the need for consumers to make apples-to-apples comparisons. Without standard benefits packages, the proposed new Medicare system would flunk the "kitchen table test" – in which consumers can make an informed choice after an analysis of policies spread out on their kitchen table.

2. *All* Medicare beneficiaries need coverage for prescription drugs.

The Breaux-Thomas proposal would provide some drug coverage (with *unspecified* deductibles, co-pays, maximum benefits, drug restrictions) for those with income up to 135 percent of poverty. The National Association of Insurance Commissioners would be required to include "basic coverage for prescription drugs" in all medigap plans. The traditional fee-for-service Medicare program *could* offer an unspecified prescription drug benefit. *This proposal is inadequate.* Only individuals with income below \$10,568 and couples with income below \$13,334 would be assured

Washington Office
1666 Connecticut Avenue, Suite 310 • Washington, D.C. 20009-1039 • (202) 462-6262

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coverage, and even for them required co-payments could be burdensome. "Basic" coverage in medigap could continue to require burdensome copays (e.g., 50 percent) and have low coverage limits (e.g., \$1,250). There is no assurance that Medicare HMO's will offer comprehensive coverage for prescription drugs. Furthermore, many seniors have income too high for the low-income coverage, but too low to allow them to afford a medigap policy.

3. Medicare beneficiaries need a cap on their out-of-pocket health care spending.

57 percent of people 65 and over pay 10 percent or more of their income out-of-pocket for health care expenditures (including premiums).¹ Medicare beneficiaries need the same kind of protection that many people with employer-based coverage now have: a cap on their out-of-pocket health care spending. This benefit redesign would help reduce the number of *underinsured* seniors. Like the addition of prescription drugs, it is the type of benefit design recommended by Robert Reischauer and Henry Aaron in their paper supporting a premium support model for Medicare.²

4. Congress should *lower* not *increase* the age of eligibility for Medicare.

The proposal would increase the age of Medicare eligibility, so that it "conformed to that of Social Security." We are very troubled by this proposal, which would gradually increase the age of eligibility to 67, because it will translate to hundreds of thousands of newly uninsured people, 65 and 66 years old. The proposal provides for "non-subsidized buy-in" at age 65, but with income levels often decreasing (when people retire, either voluntarily or involuntarily), Medicare coverage will remain out-of-reach for many. The proposal does not call for subsidy, or for buy-in before age 65 – two steps that could help to increase coverage at a time when income is decreasing and chronic health conditions are increasing.

5. Consumers need a Medicare system that is accountable to them, not bottom-line profitability of health plans.

The Medicare program has a long history of low administrative costs (between two and three percent per year). While it is certainly the case that the government needs to continue and expand its efforts to cut waste and fraud, there is no guarantee that costs will decrease in the long run by turning Medicare over to the private sector. Not only do private companies put upward pressure on costs because of their marketing costs and profits, but they have a strong incentive to find ways to enroll the healthy, but not the sick. This week, a new GAO study found that nearly half of Medicare

¹ *Hidden from View: The Growing Burden of Health Care Costs*. Consumers Union, January 22, 1999, p. 50.

² See "The Medicare Reform Debate: What Is the Next Step?" *Health Affairs*, Winter 1995.

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P.4/4

3

HMOs surveyed misstated benefit coverage. Another recent GAO report found that health plans often fail to inform Medicare beneficiaries of their right to appeal benefit denials. Before rapidly increasing the role of private insurance companies in Medicare, Congress must be clear about the need to keep Medicare accountable to the public interest, not the private interest. Allowing plans to vary benefits is just one way that the Breaux-Thomas proposal introduces confusion that is more likely to serve the interests of insurance companies rather than the interests of beneficiaries. As Reischauer and Aaron noted in *Health Affairs*, strong regulation from Washington is a key ingredient of a successful premium support model. ("The nation should not gamble with health care for the aged and disabled, many of whom are unlikely to be able to do well in an unregulated market.")³ The poorly defined roll of the Medicare Board offers no assurance that it will meet this need. In fact, it seems designed to undermine a strong federal government regulatory presence.

We urge you to enact legislation that will modernize the Medicare benefit package, strengthen the Medicare program, and build in assurances that Medicare will serve the interests of its millions of beneficiaries, today's and tomorrow's. We believe that the Breaux-Thomas proposal would move Medicare in the wrong direction, and we urge you to oppose it.

Thank you for your consideration.

Sincerely,

Gail Shearer
Director, Health Policy Analysis
Washington Office

Adrienne Hahn
Legislative Counsel

³ Reischauer and Aaron, p. 26.

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Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	re: SSN and DOB (partial) (1 page)	04/19/1999	P6/b(6)

COLLECTION:

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RESTRICTION CODES

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- 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.

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Meeting with Chris Jennings

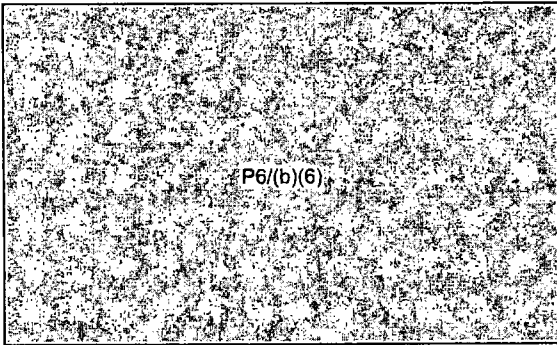
Old Executive Office Building
17th & G Streets, N.W., Room 216
Washington, DC

Monday, April 19, 1999

~~3:30~~ p.m.

4:30 pm

AAHP Attendees:

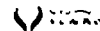
	<u>SS#</u>	<u>Birthdate</u>
Diana C. Dennett		[001]
Colette C. Desmarais		
Julie L. Goon		
Richard I. Smith		

P6(b)(6)

[001]

M+C Payment For Each County Was Calculated

- Using FFS growth rates from CBO's preliminary baseline (Jan. 1999)
- Taking into account BBA provisions such as floor, minimum update, blend, and budget neutrality
- Starting from 1997 published rate (Published 1998-2000 rates were successfully replicated.)



Projecting FFS Spending Per Capita

- To produce conservative estimates, FFS and M+C per capita payment rates were assumed to be equal in 1997.
- FFS per capita spending in each county was projected by applying the national growth rate to each county's 1997 level.
- M+C enrollment figures pertained to Dec. 1998



Impact Of Risk Adjustment Was Calculated

- Using the ratio of
 - Average demographic factor for enrollees and
 - Average risk factor for enrollees.
- Taking into account
 - The scheduled phase-in of PIPDCGs
 - But NOT the additional cut (13%?) projected for 2004.



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facsimile transmittal

To: Chris Jennings

Fax: 456-5557

From: Adrienne Hahn

Date: 04/28/99

Re: Speaking to Kennedy about External Appeals Pages: 5

CC: Gail Shearer

☒ X Urgent

☐ For Review

☐ Please Comment

☐ Please Reply

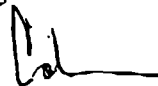
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Dear Chris:

Thanks so much for meeting with us today on Medicare, we really look forward to working with you on this issue. As promised, attached are the materials outlining the problem with the Patients' Bill of Rights Act (PBRA) external appeals structure. Simply put, PBRA allows a state to decide whether it will select the external entity or permit the plan to select the external entity. Under the PBRA, the plans pay for the appeals and can select the reviewer, this structure creates an inherent conflict of interest: reviewers could jeopardize future business if they decide against the plan. A whole host of organizations including the AFL-CIO, AARP, Consumers Union, and others have advised against this approach and even went further advocating for ONLY the state to select the reviewer. (Please see attachments.)

The Department of Labor recognized this shortcoming in the PBRA as well and advised Democratic staff to at least require a randomized process if the plan selects the reviewer to ensure that the appeal is truly independent. We would really appreciate it, if you could speak to Senator Kennedy about this matter and urge him to adopt DOL's suggested change for the selection of the reviewer which is a compromise between consumer, senior, and labor organizations and Democratic staff's approach. We understand Congressional staff are considering redrafting the medical necessity language in the bill and this might be a good opportunity to fix the external appeals process as well.

If you have any questions, please do not hesitate to give me a call. Thanks for your consideration on this matter.



PROCESSED



March 31, 1998

The Honorable Edward M. Kennedy
315 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

Dear Senator Kennedy:

AARP is deeply committed to assuring quality and consumer protections in managed care. We commend you for your leadership in the effort to develop effective consumer protections in managed care through legislation. It is our hope that you will continue your efforts and that meaningful bipartisan legislation that sets enforceable standards will be enacted this year.

"The Patients' Bill of Rights Act" is a good step toward assuring that Americans can rely on quality health care no matter what type of plan they use. We believe this bill includes several basic safeguards for the nation's managed care consumers. Among these are: improved access to emergency services; prohibiting "gag clauses" and providing consumers with information to make appropriate treatment decisions; and increased disclosure of information to consumers about plans, health care professionals, and facilities.

AARP is especially pleased with the attention given to the grievances and appeals process and the inclusion of both a rigorous system of internal review and an independent system of external review. An external appeals process will provide an objective review of denials, terminations, and reductions of care; and it will help to ensure that consumers have a fair and efficient process for resolving differences with their health plans and health care providers.

While your bill addresses several important standards, more will need to be done. In particular, we believe consumers would benefit from: a strong quality assurance provision that includes external review; a requirement that States choose the outside reviewing entity for external appeals; and, a meaningful framework for enforcement of national standards to assure that the rights and protections will apply to all consumers no matter what type of plan they use.

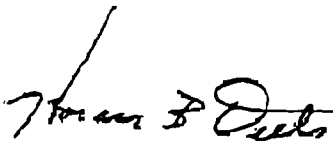
The Honorable Edward M. Kennedy

March 31, 1998

Page 2

We look forward to your continued leadership in the effort to win adoption of effective and enforceable consumer protection standards. If there is anything we can do to move the debate forward, do not hesitate to call me or have your staff call Tricia Smith or Mila Becker of our Federal Affairs Department at 202/434-3770.

Sincerely,



Horace B. Deets



Publisher of Consumer Reports

Independent External Appeals A Necessary Ingredient for Managed Care Reform

Approximately 161 million Americans are currently enrolled in a form of managed care. All of those patients deserve patient protections, enforceable through a fair external review process. An impartial external grievance and appeals system is necessary for all other consumer protections aimed at providing the delivery of quality care.

Today, many consumers are trapped *within* their health plan, which is totally in control of treatment decisions. The result: consumers risk *not* getting the medical care they need when bottom-line considerations, not medical appropriateness, have undue influence on decision-making. A truly independent external appeals process acts as a safety valve to ensure that consumers receive the appropriate care when a plan wrongly denies care. It also gives plans an incentive to improve their internal decision making processes (since they will be subject to external review).

Below are the elements necessary for a truly independent external appeals process:

Request for an Appeal

- *An external appeal should be available upon written or oral request.*

An enrollee (or doctor/individual acting on behalf of the enrollee with the consent of the enrollee) who desires to have an external appeal shall have an external review made available upon oral or written request for the review.

Scope of the Appeal

- *An external appeal should be available for the denial of any medical service or payment.*

A managed care enrollee who has had an adverse determination (of any grievance or appeal under the issuer's internal review process), should have the right to an external appeal if that decision denies, reduces, limits, terminates or delays a covered benefit or if the decision denies payment for a covered benefit (with no monetary or treatment threshold).



Selection of the Reviewer

- *The external appeal entity should be appointed by the State or through a random process conducted by the State.*

For an external review process to be truly independent, the entity selecting the reviewer must not have a stake in the outcome of the decision-making process. If plans pay for the appeal and select the reviewer, there is an inherent conflict of interest: reviewers could jeopardize future business if they decide against a plan. Having the State select the reviewer eliminates the financial incentive for the outside entity to be biased in resolving the dispute.

Washington Office

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Safeguards to Ensure Fairness

- ***The external appeals process should provide safeguards against any conflict of interest by an entity or individual selected to conduct an external review.***

Within the external appeals process, a mechanism must exist to identify all real or apparent conflicts of interests, and to disqualify all individuals or entities with any such conflict.

- ***The external appeals process must provide for a de novo review.***

A managed care enrollee's right to an external appeal must provide for a fair, de novo, evidence-based review by a neutral review entity of the internal appeals decision.

Rule of Construction

- ***The external appeals process must provide for an expedited review.***

The external appeals process must provide for an expedited review process in the event of a medical emergency or where speed is essential to the medical treatment. Most treatment decisions should be made within a few weeks, and some within a few days or even hours.

- ***The external appeals process must be binding on the plan.***

The determination of a review panel must be binding on the plan to ensure that the process is not an exercise in futility. The final decision of the external reviewer should neither limit nor prevent the managed care enrollee from bringing a civil action based upon the coverage involved.

- ***The plan must pay for the cost of the external appeals process.***

The health insurance issuer must be financially responsible for any and all reasonable costs associated with the conduct of an external review, including those incurred by the applicable State authority – except any filing fee (which should be minimal, and waivable for hardship). If the enrollee (or an individual acting on behalf of the enrollee) prevails in the external review, the issuer shall also pay the enrollee's reasonable preparation costs, including attorneys' fees for the representation during the review process.

Reporting By Review Entity

- ***A review entity must submit information for an annual report.***

A review entity should submit information for an annual report to the appropriate State body containing the number of reviews performed, the health plans involved, and their outcomes. The information contained in the annual reports, excluding any personally identifying patient information, shall be made accessible to the general public. The State shall have a duty to review these annual reports and take appropriate action.

For further information contact Adrienne Hahn or Gail Shearer at 202-462-6262.



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Mannique Singleton
Population-based
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Constituency Chair

March 3, 1999

Senator John Breaux, Chairman
National Bipartisan Commission on the Future of Medicare
Adams Building, Library of Congress
101 Independence Avenue, S.E.
Room 144
Washington, D.C. 20540

Dear Senator Breaux:

On behalf of the millions of rural Medicare beneficiaries the National Rural Health Association's provider community serves, we are writing to express our serious concerns with the "premium support" proposal being considered by the National Bipartisan Commission on the Future of Medicare. The NRHA would also like to express its strong opposition to any extension of Medicare fee-for-service payment constraints contained in the Balanced Budget Act of 1997 (BBA) beyond 2002.

Any dependence on choices among Medicare risk plans in a competitive market as the strength of the Commission's proposal cannot be extended to rural and frontier areas. As of September 1998, only 2.62 percent of rural Medicare beneficiaries were enrolled in Medicare risk plans. It should also be noted that 70 percent of the plans that dropped out of the Medicare+Choice program last year were serving rural Medicare beneficiaries, leaving many without any choice other than traditional fee-for-service. 33.6 percent of Medicare beneficiaries whose HMO withdrew from their county with no other managed care option available reside in rural counties. This clearly indicates the problem of Medicare risk plans not renewing is disproportionately affecting rural beneficiaries. At the same time, rural health researchers have concluded that it is highly unlikely, even given the recent reforms to Medicare capitation payments, that Medicare managed care will be a viable option for rural beneficiaries anytime soon.

The reality of the "premium support" model is that rural Medicare beneficiaries will be left with little or no new choice. Furthermore, under "premium support," the cost of staying in traditional fee-for-service will immediately increase to \$708 a year, a 30 percent increase for rural Medicare beneficiaries. It is also vital to have a clear understanding of the types of services that will be included in a minimum federally-

Peter
Fy1
Let's discuss
p-28

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NATIONAL OFFICE

Donna M. Williams
Executive
Vice President
One West Armour Boulevard, Suite 203
Kansas City, Missouri 64111
Telephone (816) 756-3140
Fax (816) 756-3144
E-mail: mail@nrharural.org

Internet:
<http://www.NRHA rural.org>

WASHINGTON, D.C., OFFICE

1320 19th Street, N.W., Suite 350
Washington, D.C. 20036-1610
Telephone (202) 232-6200
Fax (202) 232-1133
E-mail: ac@nrharural.org

sponsored Medicare benefits package. Without increasing the types of health care services covered by the fee-for-service benefits package, such as prescription drug coverage, most rural Medicare beneficiaries will still have to purchase supplemental insurance, further driving up their out-of-pocket cost. A single national premium will inevitably result in reallocation of beneficiary payments toward that premium. Under current patterns that would result in a rural to urban reallocation. The Commission should also take into serious consideration that sicker beneficiaries will likely become concentrated in the fee-for-service program. This currently occurs in urban areas with higher Medicare enrollment in risk plans, because these beneficiaries find it almost impossible to access affordable Medicare risk plans. The concentration of individuals with significant health care needs will likely drive up costs in the fee-for-service Medicare program which will continue to predominately serve rural Medicare beneficiaries.

A recent report by the Rural Policy Research Institute (RUPRI) states that “given low enrollment into managed care and limited use of any Medicare risk plans in rural areas for the foreseeable future, the impacts of changes in traditional Medicare are of vital concern for the welfare of rural beneficiaries.”

As the Commission considers recommending to the Congress that it should extend certain Medicare reforms and reductions contained in the BBA, it must be understood that any extension of current reductions in Medicare payments will threaten the financial viability of many rural health care providers and systems of care. The current proposal would continue payment reductions to health care providers that are widening the gap between Medicare’s payment for services and the actual cost of providing those services. Any change or extension of payment reductions must, at a minimum, include a rural differential that accounts for different impacts on providers as a function of size and geographic location.

The RUPRI report also cited that “constraining Medicare spending by imposing continuing and significant reductions on small, rural providers could jeopardize access to care for rural beneficiaries.” In fiscal year 1995, 15.9 percent of rural hospitals experienced negative total margins, as compared to 9.8 percent for urban hospitals. The Medicare Payment Advisory Commission’s December 1998 report shows that small, rural hospitals with fewer than 50 beds experienced an operating margin for Medicare inpatient services of 8.9 percent in 1997 compared to an operating margin of 17.2 percent for urban hospitals. These facts must not be ignored as the Commission considers extending provisions of the BBA that are cumulatively threatening rural providers ability to provide Medicare services.

In closing, the NRHA urges you and your fellow commissioners to take into serious consideration the impact of your recommendations on rural and frontier Medicare beneficiaries and providers. Any proposal set forth by the Commission must guarantee that Medicare beneficiaries living in rural areas have equity in benefits, choice in the delivery of those services, and premiums that are in-line with those available to Medicare beneficiaries where choice currently exists. At the same time, the Commission must not extend Medicare payment reforms and reductions contained in the BBA that will put access to such services in jeopardy in rural communities.

Enclosed is a copy of the RUPRI report which we have cited throughout this correspondence. If you have questions regarding the concerns we have expressed, please feel free to contact either of us at (202) 232-6200.

Sincerely,

Gail R. Bellamy, Ph.D.

Gail R. Bellamy, Ph.D.
President

A handwritten signature in black ink, appearing to read 'Darin E. Johnson', with a long horizontal flourish extending to the right.

Darin E. Johnson
Government Affairs Director

Enclosure

cc: Members of National Bipartisan Commission on the Future of Medicare

RITE AID CORPORATION

P. O. BOX 3165
HARRISBURG, PA 17105

Date: June 10, 1999
of pages including cover sheet 6

FAX

To: The Honorable Christopher Jennings
Deputy Assistant to the President
For Health Policy
FAX: 202-456-5557

From: William A. K. Titelman
Executive Vice President,
Managed Care & Public Affairs
Phone #: 717/975-3740
FAX #: 717/975-3760

Message:

Following is our letter with our recommendations concerning the design and structure of the Medicare drug benefit as promised. The original will be forwarded via Federal Express today. Thank you.

If you do not receive all pages indicated, please call 717/731-6580. Thank you.

CONFIDENTIALITY NOTE: The documents accompanying this facsimile transmission contain information from Rite Aid Corporation which is privileged and confidential and/or proprietary. The information is intended for the individual or entity named on this facsimile cover sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action on the contents of this information is strictly prohibited and that the documents must be returned to us immediately. In this regard, if you have received this telecopy in error, please call the above phone number immediately so that we can correct our error and direct the message to the proper destination. **THANK YOU.**



RITE AID Corporation

WILLIAM A.K. TITELMAN
Executive Vice President
Managed Care & Public Affairs

• **MAILING ADDRESS**

P.O. Box 3165
Harrisburg, PA 17105

• **GENERAL OFFICE**

30 Hunter Lane
Camp Hill, PA 17011

• **(717) 975-3740**

• **(717) 975-3760 Fax**

• **wtitelman@riteaid.com**

June 9, 1999

The Honorable Christopher C. Jennings
Deputy Assistant to the President
For Health Policy
Old Executive Office Building
17th Street & Pennsylvania Avenue, NW
Room 216
Washington, D.C. 20500

Re: Medicare Rx Drug Benefit

Dear Chris:

Thank you for the opportunity to meet with you briefly on June 1, 1999 and discuss the content of an Administration proposal to create a Medicare drug benefit. Rite Aid and our pharmacy benefits management subsidiary, PCS Health Systems, together have considerable expertise and experience in all aspects of prescription drug management and dispensing, as well as cost and other aggregate prescription data that we would be pleased to make available to you as you refine your proposal. We look forward to furthering our discussion on June 15, 1999.

When we met, you requested that we provide you with recommendations concerning the design and structure of a Medicare drug benefit. The attached document is offered in response to that request. It focuses on fundamental design elements which we believe are essential to get right if a Medicare drug benefit is to work and be meaningful to the elderly. We believe it is important that these basic elements be spelled out at the outset, so that there is less risk that they will be overlooked or incompletely considered later.

Thank you for your continued consideration. Please call us with any questions and if we may be of further assistance.

Best personal regards.

Sincerely,

William Titelman

WT:gr

Enclosure

MEDICARE DRUG BENEFIT PLAN DESIGN SUGGESTIONS

In order to provide a meaningful and effective drug benefit for the elderly, it is critical that the plan (a) works for seniors, i.e. is simple, convenient, and does not impose barriers on access, but instead encourages seniors to seek out, use and remain compliant with appropriate drug therapy; and (b) allows the flexibility necessary to manage utilization and costs while preserving and enhancing the quality of care. The following suggestions are offered with these goals in mind:

- **Private sector delivery mechanism should be utilized.** Private entities, such as pharmacy benefit management and other companies with similar capabilities, which have the expertise, operational capacity and sophistication and, most important, experience in managing pharmacy benefits on a large scale, should be utilized to provide the benefit. These entities already have in place the mechanisms necessary to deliver of a cost effective drug benefit, and have proven themselves able to manage utilization through innovative programs which do not sacrifice clinical quality or consumer choice. Successful mechanisms include online claims adjudication, formulary management, pharmacy network contracting, rebate negotiation, generic substitution and therapeutic interchange, physician drug utilization review, utilization management (including drug limits, prior authorization, step therapy) and disease management.
- **Standard basic benefit package with ability to offer variations.** To ensure adequacy of the benefit and a basic level of uniformity, there should be a standard core benefit package. This core package should cover all FDA-approved drugs determined to meet essential clinical needs, but should not mandate coverage of every FDA-approved drug. Discretionary or lifestyle drugs excluded from the basic benefit package could be covered in supplemental benefit packages and options, which should be permitted to be offered so as to increase consumer choice and encourage competition.
- **Use Flexible Methods to Control Costs Without Discouraging Appropriate Utilization.** There are several ways in which this can be achieved:
 - **Separate plan design for low-income beneficiaries.** While every senior paying into the Medicare system should be eligible for a drug benefit, the benefit's costs should be lower for low-income beneficiaries. This is critical to ensure that those most in need have affordable access to the benefit. In addition to lower premiums, low-income beneficiaries could pay a minimal deductible with a lower, or even zero, copayment. This system would promote accessibility and better manage program costs.

- **Minimize deductible and utilize fixed copayments rather than percentage coinsurance.** The willingness and ability of the elderly to access and utilize the drug benefit will depend upon its affordability and simplicity. A high deductible (which requires that the initial drug costs up to a fixed dollar limit be borne by the consumer) and percentage coinsurance (where a fixed percentage of the cost of every prescription is borne by the consumer) act as barriers to appropriate drug use. Fixed copayments (where a set dollar of the cost of the prescription is paid by the consumer), indexed as necessary to drug cost increases, are preferred by the elderly because they are predictable, simpler to budget for, and easier to remember. Copayments could also vary based on a clinical classification of different prescriptions, with those meeting core clinical needs requiring the lowest, or even a zero, copayment. In addition, as mentioned above, the plan for low-income beneficiaries could be designed with no deductible or copayment required for the core benefit package.
- **Beneficiary drug purchases for covered drugs up to any deductible or beyond any dollar cap should be at contract price.** If a deductible or dollar cap is imposed, beneficiaries should be entitled to the same contract price as the government for covered drugs they are required to purchase to meet the deductible or that exceed the cap. This will ensure that there is no cost shifting to the elderly to the extent they bear their own basic drug costs.
- **Use flexible drug utilization management techniques instead of arbitrary dollar benefit caps.** Dollar caps, which limit the total annual reimbursement per patient, impose arbitrary and inflexible ceilings on drug use. Historically, caps have distorted utilization patterns and/or increased noncompliance (e.g. pill-splitting, skipping year-end refills). Today there exist many more sophisticated, flexible and clinically-based formulary and drug utilization management tools that contain drug costs without sacrificing the quality of care afforded to the elderly, such as:
 - a clinical-needs based formulary that excludes certain discretionary or lifestyle drugs;
 - three-tiered copayments (generic, preferred, non-preferred);

- mandatory generic substitution and voluntary therapeutic interchange;
 - prior authorization, managed drug limits and step-therapy;
 - drug utilization review;
 - disease management;
 - case management for high-cost beneficiaries.
- **Require pharmacy networks to meet minimum accessibility standards, and permit the development of performance-based networks.** At a minimum, a national pharmacy network which meets Medicaid accessibility standards should be required. Subject to these standards, plans should have the flexibility to develop performance-based networks, i.e. networks of pharmacies which undertake, and are proven, to meet higher service and cost containment standards such as higher generic dispensing rates.
 - **Allow beneficiaries equal choice of their local community pharmacist or mail order.** Plans offering incentives to use mail should be required to offer a retail maintenance option to beneficiaries. This option would allow the elderly to obtain drugs at their community pharmacies on the same terms and in the same quantities as they would obtain these drugs through the mail. This would allow the elderly, who more than any other group, need, seek out and benefit from the personal contact and counseling available from community pharmacists, the flexibility to choose the delivery channel most convenient and appropriate for them. Internet pharmacies should also be permitted as an additional delivery channel option for the elderly.
 - **Employers must receive incentives to maintain retiree drug benefits.** Currently, a significant portion of the elderly population receives good, often generous, drug coverage through employers. However, increasing drug costs are causing many employers to reduce or eliminate these benefits. Employers should be encouraged, through economic incentives such as tax credits or other tax preferences, to continue to offer these benefits. Preserving existing employer plans in this way will reduce the government outlay for a Medicare drug benefit without imposing an economic penalty on those employers who have chosen to provide this benefit to their retirees.
 - **Preemption from conflicting state laws.** In order to provide the benefit in a consistent and efficient manner, it is essential that the program be allowed to operate free from the myriad of often conflicting and inconsistent

state laws regulating every aspect of pharmacy practice and benefit management, from provider networks to formularies to the details of plan design.

- **Mandatory beneficiary education and information.** Educating and advising beneficiaries about their drug benefit, and about drug use and compliance in general, is an integral part of any benefit, and is especially critical for the elderly. Some elements of an appropriate education program might include:
 - information to help beneficiaries evaluate their drug benefit choices;
 - an explanation of how to use the drug benefit, from what to ask the doctor, going to the pharmacy, differences between brands and generics;
 - compliance and drug usage information, such as directions for use, dosage and administration, drug interactions and precautions, and disposal of old medications.
- **A mechanism to evaluate the impact of the program on the healthcare system.** The program should establish funding to research the impact of improved drug usage and compliance on the healthcare system, including any reductions in medical costs and improvements in the quality of life of beneficiaries.

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Validator List on Competition - Preliminary

Groups based on expected statements; *=I can trust them not to talk to press.

FRIENDLY ("Good policy")

Tyson*
Altman*
Reinhardt
Davis



LUKEWARM ("Right direction, too incremental")

Newhouse*
Wennberg
Aaron/Reischauer (? - may be Friendly)

LIKELY NEGATIVE BUT WORTH CALLING ("Too little")

Enthoven
Wilensky
Pauly
Feldstein

CLAXTON ("Too much/ Should do a demo")

Moon
Feder (?)

AMERICAN HOSPITAL ASSOCIATION
325 7TH STREET, N.W.
WASHINGTON, DC 20004
TELEPHONE: 202-626-4625
FAX: 202-626-2355

DATE: June 11, 1999

FAX TO: Chris Jennings

FROM: Rick Pollack

NUMBER OF PAGES: 3 (including cover sheet)

COMMENTS:

United States Senate

WASHINGTON, DC 20510

June 10, 1999

Dear Colleague,

We ask you to join us in sending the attached letter to Nancy Ann Min DeParle, Administrator of the Health Care Financing Administration, to make sure that hospital outpatient departments do not suffer an unintended \$850 million per year cut in payments.

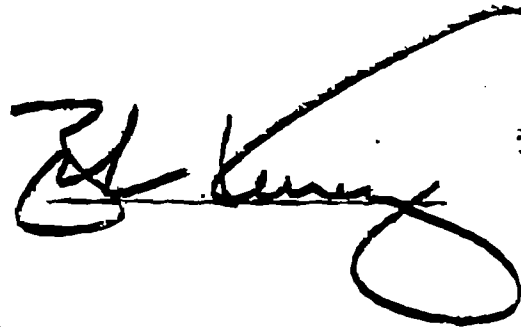
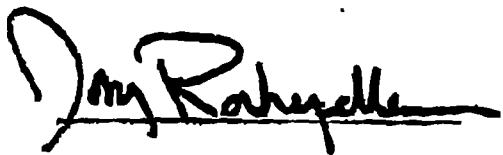
The attached letter opposes the Department's Notice of Proposed Rulemaking for implementation of the outpatient prospective payment system, as required by the 1997 Balanced Budget. Congress must clarify that an unintended minor technical change in the statutory language will impose an additional 5.7 percent, \$850 million per year cut on top of the fully contemplated \$7.2 billion reduction in outpatient payments. We need to send a strong message to HCFA that the NPRM is inconsistent with Congressional intent. The attached letter more fully explains how this problem arose.

The Balanced Budget Act of 1997 imposed tough cuts on providers. The BBA included intended reductions in outpatient payments through implementation of outpatient PPS. This additional \$850 million per year cut, however, was not anticipated or intended by the House or Senate. Its inclusion in HCFA's proposed rule will only unnecessarily threaten the continued viability and quality of hospital outpatient services.

We hope you will join our efforts to stop one of the Balanced Budget Act's unintended consequences. If you have any questions please call Ellen Doneski in Senator Rockefeller's office at 4-5663, Brad Prewitt in Senator Cochran's office at 4-3063, Karen Davenport in Senator Kerrey's office at 4-9280.

Because this issue is time-sensitive, we appreciate your response by June 15, 1999. Thank you for your consideration.

Sincerely,



United States Senate

WASHINGTON, DC 20510

Draft Letter to HCFA Administrator
The Honorable Nancy Ann Min DeParle

Dear Madame Administrator:

We are concerned about the Department's Notice of Proposed Rulemaking (NPRM) for the implementation of the outpatient prospective payment system (PPS) enacted in the 1997 Balanced Budget Agreement (BBA).

With the encouragement of Congress, HCFA, seniors' representatives and providers cooperatively developed the outpatient PPS policy. The new policy was designed to address a longstanding flaw in outpatient payment policy and to gradually rationalize Medicare's outpatient copayments, without imposing unmanageable outpatient payment cuts on hospitals. This policy change was accomplished in the Balanced Budget Act, which contained a \$7.2 billion outpatient payment reduction. No additional payment reductions were contemplated, analyzed or scored.

We strongly support the outpatient PPS approach. However, HCFA's proposed rule contains an additional, unintended 5.7 percent "across the board" reduction in payments to hospital outpatient departments. This \$850 million per year reduction represents a misinterpretation of Congressional intent and threatens the integrity of a broadly supported compromise. Total outpatient hospital payments were to be budget neutral to a clearly identified new baseline in the law. No additional reduction was contemplated.

Congress clearly intended that these changes to outpatient copayments be achieved on a budget-neutral basis - the identical language that originally passed the House and the Senate clearly precluded any payment reduction for this policy. While a minor technical drafting change in the Conference agreement resulted in confusion over the outpatient payment formula, we believe the Department has the flexibility under the statute to implement Congress' clear intent.

We urge that HCFA not implement an outpatient PPS rule which is inconsistent with Congressional intent.

Sincerely,

United States Senate

WASHINGTON, DC 20510

May 27, 1999

President Bill Clinton
1600 Pennsylvania Avenue
Washington, DC 20500

Dear President Clinton:

As you develop your plan to ensure the solvency of the Medicare program, we would like to share our thoughts with you on the importance of this program to our constituents. Further, we would like to suggest some changes that we believe would strengthen traditional Medicare.

We are in strong agreement with you that Medicare must continue to guarantee benefits for all our nation's seniors and individuals with disabilities, as it has since 1965 when it was created to provide universal health insurance coverage to these populations. As you know, before the passage of Medicare, 85 percent of seniors lacked health insurance. Tragically, we already have 43 million uninsured individuals in our nation and adding to that number would be disastrous. Today, about 60 percent of Medicare beneficiaries have incomes below 200 percent of the federal poverty level (FPL) and ten percent have incomes below 100 percent of the FPL. Eliminating the current guarantee of benefits will erode the safety net relied on by our elderly and disabled constituents.

The Bipartisan Commission on the Future of Medicare's plan contained a number of proposals which we strongly oppose. These concepts, such as "vouchering out" Medicare, raising the eligibility age from 65 to 67 and imposing a copayment on home health care, would be a disaster for millions of seniors and individuals with disabilities and have an especially negative impact on minorities and women.

While we were pleased that the Medicare Commission's plan did not receive the needed super-majority, we are concerned that elements of that plan will reappear in specific legislation. We hope you will join us in opposition to these disastrous "reforms" and hope that as you develop your Medicare reform plan that you will give serious thought to the suggestions we are offering:

1) Eliminating the Medicare guarantee and replacing it with a "voucher" system will hurt current and future beneficiaries. This proposal must be rejected. A premium support or "voucher" plan - by moving healthier and wealthier beneficiaries into private health plans - will destroy the guarantees that Medicare beneficiaries have relied on for 34 years.

A "voucher" model lacks effective cost control mechanisms for the Medicare program. It assumes that competition among private health plans will keep costs down. There are several problems with this assumption. First, as we have seen in the case of prescription drugs,

To: President Clinton
Re: Medicare Reform
May 27, 1999
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competition does not always keep costs down. Second, from 1997 to 1998, Medicare expenditures increased by only 1.5 percent compared with a 6.1 percent increase for the private health plan competitive marketplace. Medicare does a much better job controlling costs than the private insurance marketplace.

Premium support plans will be a form of corporate welfare for the private insurance industry, and particularly HMOs. Tens of billions of dollars currently paid by the government to health providers each year will instead be paid to HMOs and other private insurers.

Private health care plans are not available in many parts of the country. Of America's 3,100 counties, seven out of ten - nearly 2,200 - do not currently have Medicare managed care. Because of the lack of providers, these areas are unlikely to ever develop HMO-type programs.

Rural communities will be particularly hard-hit. The 11 million Medicare beneficiaries in rural areas make up 30 percent of the Medicare population. They will be left behind under a "voucher" plan. In those areas where managed care is available for Medicare, only 21 percent of beneficiaries have chosen to leave traditional Medicare to join managed care plans. Additionally, many managed care plans have pulled out of the Medicare program since 1997, leaving more than 400,000 seniors with no health insurance.

Even in areas that have managed care available, most low-income seniors will not be able to afford to purchase these plans. Women and minorities are disproportionately harmed by a "defined contribution" plan because they tend to be poorer and less able to pay additional costs for a good health plan. The average Medicare beneficiary spends about one-fifth of income on out-of-pocket health costs, but beneficiaries at or below the poverty line spend over a third of their income on health care out-of-pocket expenses. Low-income women and minorities will be most hurt by a "voucher" program.

It is also troubling that, at a time when Congress is concentrating on fixing the problems of managed care programs, some in Congress and the Medicare Commission are willing to subject our Medicare beneficiaries to problematic HMOs. Speaker Dennis Hastert has promised a vote on managed care reform legislation this year. We have concerns about moving seniors and individuals with disabilities into managed care and certainly do not support subjecting them to the risks of the current managed care system before any patient protection legislation is passed.

The Medicare Commission's premium support model is not the same as the Federal Employees Health Benefits Plan (FEHBP), which covers federal workers and Members of Congress. Many supporters of a "voucher" plan compare it to the FEHBP. However, the FEHBP population is far more healthy and wealthy, on average, than the Medicare population. Median pay for federal employees is about twice that of seniors. Thus, it is easier for federal workers to afford more expensive plans than Medicare beneficiaries. Most Members of Congress choose Blue

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May 27, 1999
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Cross/Blue Shield, which most resembles traditional Medicare, as their plan. However, this choice might not be an option, due to its higher cost, for many beneficiaries under a premium support model.

Additionally, the eight national plans open to all federal employees are PPOs with broad access to providers. The only Medicare plan with that same availability is traditional Medicare. While the 1997 Balanced Budget Act opened up participation to a wide variety of health plans, only HMOs have chosen to participate. Converting traditional Medicare to a premium support model would seriously limit beneficiaries' choice of providers and plans.

Interestingly, the FEHBP saw premium increases of 8.5 percent in 1998 and is looking at an increase of 10.2 percent in 1999. This dwarfs the 1998 Medicare increase of 1.5 percent.

2) We must not increase the eligibility age for Medicare. Raising the eligibility age from 65 to 67 is a very dangerous idea. Many older Americans will become uninsured under this plan. Under this proposal, one and one-half million Americans will be needlessly added to the rolls of the uninsured at an extremely vulnerable time in their lives.

We find it rather extraordinary that in this period of economic "boom," some in Congress would force seniors to work and wait for an additional two years until they can receive full medical benefits. Many employers are cutting back on workers' health insurance or eliminating it completely. How will we provide for individuals who lose their coverage and then must wait an additional two years to enroll in Medicare?

Additionally, many minority populations will be particularly hard-hit by this proposal as they tend to have shorter life expectancies and less retirement savings than other seniors.

3) We must not impose any copayment on home health care. The proposal offered by the Medicare Commission included a 10 percent copayment for home health care, which would mean that the average Medicare beneficiary needing home health care would have to pay \$470 a year out-of-pocket. Nearly one-half of seniors live on less than \$15,000 a year and about 12 percent live in poverty. Forcing them to pay hundreds of dollars more annually for a benefit that is currently provided at no cost to them will force even more seniors into poverty.

It is also ironic that at a time when you and many Members of Congress are supporting access for long-term care for the elderly, some members of the Medicare Commission supported cutting home health care, a vital source of long-term care. Past efforts to institute a copayment for home health care have failed repeatedly in Congress and we hope you will join us in rejecting this misguided proposal.

Elderly women are especially affected by home health copayments. In fact, the Medicare home

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health population is mostly old and poor, predominantly female, and likely to live alone. Two-thirds of home health beneficiaries are women.

Seniors with medically complex needs require more home health visits per year than other beneficiaries. These Americans have disproportionately low-incomes, and with 200 visits per year, which is not uncommon for medically complex patients, their home health "tax" would be \$1,760 per year if the Medicare Commission had adopted the recommendation of its co-chairs. That sort of cost would make home health care prohibitive for many minorities, women, and other low-income Americans. The bottom line is that any copayment for home health care is counterproductive and a health care disaster.

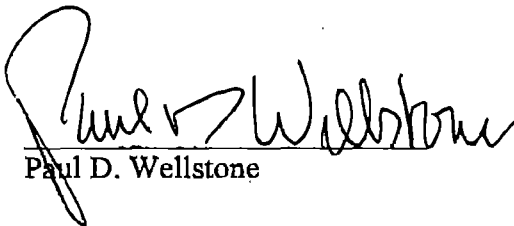
Thus far we have discussed with you some of the proposals which the Bipartisan Medicare Commission considered and failed to adopt. We urge that you also reject these proposals as you formulate your recommendations for improving Medicare. Some of our suggestions as to how Medicare should be improved follow:

- 1) **We agree with you that we need to commit 15 percent of the projected budget surplus to Medicare.** Under the proposal which you have advocated, Medicare would remain solvent for the next 28 years. This would enable us to continue to provide strong guaranteed benefits for a prolonged period of time, as well as sufficient time to take a hard look at our entire health care system.
- 2) **We must provide an outpatient prescription drug benefit for all Medicare beneficiaries.** Thirty-five percent of seniors currently lack any kind of prescription drug benefit. Seniors are charged outrageously high prices for their needed medications. They are forced to pay much more than drug companies' favored customers, such as hospitals, HMOs, and even the federal government. Often, seniors and Americans with disabilities go without groceries or without paying their heating bills to afford their prescription drugs. It is disgraceful that our elderly and disabled Medicare beneficiaries are getting sicker and even dying because they cannot afford their drugs. We must provide a comprehensive drug benefit under Medicare.
- 3) **We should automatically enroll eligible Medicare beneficiaries into the Qualified Medicare Beneficiary (QMB) Program, Specified Low-Income Medicare Beneficiary (SLMB) Program, and Qualified Individuals Program and improve their protections.** Low-income beneficiaries whose incomes are slightly higher than the Medicaid eligibility limit benefit greatly from these programs, which cover Part B premiums and, in some cases, other Medicare costs. Millions of Americans who are eligible for these programs are not taking advantage of them because they do not know they are eligible. We should also increase the eligibility limits above the current 135 percent so that more low-income beneficiaries can benefit.

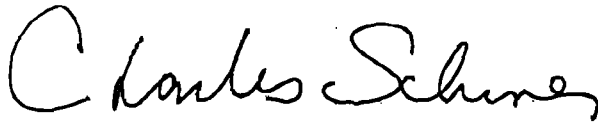
To: President Clinton
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In conclusion, we want to thank you for your strong support of Medicare and look forward to working with you to make certain that all elderly and disabled Americans continue to receive guaranteed high-quality health care. In our great and wealthy nation, no senior or individual with a disability should be denied access to this very basic necessity of life.

Sincerely,


Paul D. Wellstone


John D. Rockefeller IV


Charles E. Schumer

cc: Members of the Ways and Means Committee
Members of the Finance Committee