

Group Reactions to President Clinton's Medicare Proposal

June 30, 1999

Seniors: Overall, the senior community is pleased with the proposal, particularly the prescription drug benefits.

-American Association of Retired Persons: Generally, pleased with proposal. However, they cannot endorse the plan because it is a "proposal" and their board does not meet until August. The quotes we are seeing are luke warm--"It's really hard to know whether or not it's going to be something that Medicare beneficiaries will deem affordable."

-National Council of Senior Citizens: Very pleased with our proposal. According to Steve Protulis, "A Historic Move."

-National Committee to Preserve Social Security and Medicare: Very Pleased.

-Families USA: Extremely pleased, no concerns. Very pleased that we have program at 150% of poverty.

-Older Women's League: Generally very pleased with the proposal. Expressed one caution: "We are concerned that the plan's efforts to control costs in the short run may create a precedent to alter fundamental social insurance principle on which the program was founded. OWL will be working to smooth these rough edges as the proposal makes its way through Congress."

-National Council on the Aging: Happy with proposal, with a few questions.

Disability Groups

-The Arc: Particularly pleased with the low-income protections included in the proposal for access to prescription drugs.

-Consortium for Citizens with Disabilities: Very pleased. Mentioned that "We will not rest, however, until a catastrophic drug benefit is added to protect the millions of people with disabilities with high cost drug needs in which this proposal would not reach."

Women Groups: Extremely happy with the plan. No particular complaints or concerns from these groups.

-National Women's Law Center: "The President's Medicare Reform proposal centers on two issues of special import to older women: the solvency of the Medicare Trust Fund and the need for prescription drug coverage."

-National Partnership for Women and Families: Especially pleased with creation of prescription drug benefit and its protections for low-income beneficiaries. "With the President's plan, women win."

Hospitals

-American Hospital Association: AHA tried to take a balanced approach, without being too critical or negative in their statement. Are positive towards the surplus, and other good news items. **However, their membership wants the association to be more critical than they currently are. Their biggest concern continues to be the OPD issue. We should see them become the association more aggressive.** "We are deeply disappointed that the President continues the pattern of cutting payment to hospitals for services when independent analyses have documented that Medicare is paying caregivers substantially less than the costs of providing services."

-Catholic Health Association: Issued a positive statement commending the President, then laid out their concerns about BBA reductions. "The fact that the President has proposed a modest amount of additional funding to lessen the BBA impact is welcomed, but does not ameliorate the severity of the BBA reductions."

-National Association of Public Hospitals: Pleased with proposal. Only caution is "to proceed carefully to ensure that such tools do not harm providers who care for low income and uninsured populations."

Nurses

-American Nurses Association: Pleased, strong supporters of the plan.

Nursing Homes: Are pleased with administration's proposal.

Home Health: Surprised and pleased that we didn't include home health co-payments.

Teaching Hospitals

-American Association of Medical Colleges: Much like the hospitals, talked positively about the surplus and other good news items for teaching hospitals in their statement. They continue to be disappointed with our proposal in that we did not include IME. Like the hospitals, are currently suffering financially as a result of the Balanced Budget Act's cuts. Therefore, they feel that the proposal's objectives "fall short in their ability to repair the damage already inflicted by the BBA."

Physicians: Generally applaud surplus and seem to be ok with proposal.

-American Medical Association: Looking forward to help build bipartisan support to enact these long over-due reforms.

Managed Care Industry: They are not with us. Some of their member companies seem to be ok with our proposal, however the following is a quote from the association.

-American Association of Health Plans: "The Clinton administration's Medicare proposal is bad news for both current Medicare+Choice beneficiaries and any beneficiary wanting to join a Medicare+Choice plan."

Pharmaceutical Industry

-Pharmaceutical Research and Manufacturers of America: The association said they would give the administration a few days of respect for our proposal. It is our understanding they will begin to express opposition to the proposal in the coming weeks. Have put together \$30 million and advertising boards, but not sure how to proceed. "We prefer a Medicare drug coverage that relies on a wide array of competing private health plans, a private marketplace solution. We want to see a break away from the large, government controlled program in which government dictates on a one-size-fits-all philosophy."

BIOTECH: Pleased that the proposal did not contain cost controls, but expressed disappointment that the proposal didn't include a special provision for patients with especially high pharmaceutical costs. They don't want us to do anything that will slow down the growth of these companies or be forced out of the system. Very interested in PBM issue. They say that a Medicare prescription benefit is "something that is much desired," but if the plan includes price controls, "it's death to investment and innovation"

"Before we take a position on the President's plan we'll have to see the details. It remains only an outline, complex, nuanced, blending policy and politics. The Clinton administration says it does not favor drug controls, but we have yet to find out how market-based competition will be maintained."

"Perhaps more troubling is the failure of the president's proposal to cover medicines for the sickest patients with the highest drug costs. It has capped expenditures without stop-loss coverage. Not to add a backstop for seniors' drug expenses leaves them without protection when they need it most."

Pharmacists

-National Association of Chain Drug Stores and National Community Pharmacists Association: They believe that the plan has great potential and are pleased with the proposal.

Insurance groups: The Health Insurance Association of America (HIAA) is ok.

What AARP is saying about the Medicare Proposal

"A few months ago, prescription drugs was a voice in the wilderness. Not it's the hot thing."—
John Rother, Chief Lobbyist

"Saying that the benefit has to be universal is a major contribution to the debate."

"There has not been a spontaneous outcry among beneficiaries, or an upsurge in complaints about denial of access to home care, nursing homes or hospitals."

"The fundamental problem is still whether there is enough trust within the institutions--and -- between the White House and Congress--to put together a deal."

--**Martin Corry, Director of Federal Affairs**

"Mr. Corry says he expects the industry at some point to attack the Clinton plan, saying he hasn't seen any evidence that the industry has "fundamentally changed" its position since a decade ago, when it aggressively opposed the inclusion of a catastrophic-drug benefit in Medicare.

--**Wall Street Journal, Monday June 28, 1999**

"It's really hard to know whether to not it's going to be something that Medicare beneficiaries will deem affordable."

--**Tricia Smith, chief federal health lobbyist**

DATE: 7/1/99**U.S. DEPARTMENT OF HEALTH AND HUMAN
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WASHINGTON, D.C. 20201****PHONE: (202)690-7450****FAX: (202)690-8425**TO: Chris Jennings

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FAX: 456-5557**FROM:**☒ JANE HORVATH☐ SHARON CLARKIN☐ BOB GUIDOS☐ JOANNE JEE☐ GREG JONES☐ ANDREA LEVARIO☐ ROGER MCCLUNG☐ TANISHA PARKER☐ JON RETZLAFF☐ STEPHANIE WILSON☐

(INCLUDING COVER): _____

REMARKS:

Attached for your review are new Q&As to be included in the Secretary's briefing materials. Please submit any changes or suggestions to be by 1pm tomorrow. Txs

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CONGRESSIONAL RECORD—SENATE

S3983

review and resolution of all complaints (including as use of formularies under by enrollment, or providers, or other individuals acting as individuals) (with the individual in accordance with requirements established by the Secretary) that able to such requirements for choice organizations under part C;

All beneficiaries are provided with information regarding the appeals process under this section at the time of enrollment.

(f) EDUCATIONAL REQUIREMENTS TO ENROLL APPROVED UTILIZATION.—

(1) **REQUIREMENTS OF PROGRAM UTILIZATION.**—The Secretary shall establish a model for comprehensive educational programs in order to assure the appropriate—

(A) prescribing and dispensing of covered outpatient drugs under this section; and

(B) use of such drugs by eligible beneficiaries.

(2) **ELEMENTS OF MODEL.**—The model established under paragraph (1) shall include the following elements:

(A) On-line prescriptive review available 24 hours a day and 7 days a week in order to evaluate each prescription for drug therapy problems due to duplication, interaction, or incorrect dosage or duration of therapy.

(B) Consistent with State law, guidelines for counseling eligible beneficiaries enrolled under a contract under this section regarding—

(i) the proper use of prescribed covered outpatient drugs; and

(ii) interactions and contraindications.

(C) Methods to identify and educate providers, pharmacists, and eligible beneficiaries regarding—

(i) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient drugs;

(ii) instances or patterns of substandard care;

(iii) potential adverse reactions to covered outpatient drugs;

(iv) inappropriate use of antibiotics;

(v) appropriate use of generic products; and

(vi) the importance of using covered outpatient drugs in accordance with the instructions of prescribing providers.

(g) **PROTECTION OF PATIENT CONFIDENTIALITY.**—Insofar as an eligible organization maintains individually identifiable medical records or other health information regarding enrollees under a contract entered into under this section, the organization shall—

(1) safeguard the privacy of any individually identifiable enrollee information;

(2) maintain such records and information in a manner that is accurate and timely; and

(3) assure timely access of such enrollees to such records and information.

(h) **DEFINITIONS.**—In this section:

(1) **COVERED OUTPATIENT DRUG.**—

(A) In general.—Except as provided in subparagraph (B), the term "covered outpatient drug" means any of the following products:

(i) A drug which may be dispensed only upon prescription, and—

(ii) which is approved for safety and effectiveness as a prescription drug under section 301 of the Federal Food, Drug, and Cosmetic Act;

(iii) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1988 or which is identical, similar, or related (within the meaning of section 312.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (iv) which has not been the subject of a final determination by the

Secretary that it is a "new drug" (within the meaning of section 301(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 303(a) of such Act to enforce section 302(c) or 303(a) of such Act; or

(iv) which is described in section 107(c)(5) of the Drug Amendments of 1988 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 312.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (v) for which the Secretary has not issued a notice of an opportunity for a hearing under section 304(c) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval or an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

(11) A biological product which—

(i) may only be dispensed upon prescription;

(ii) is licensed under section 361 of the Public Health Service Act; and

(iii) is produced at an establishment licensed under such section to produce such product.

(12) Insulin approved under appropriate Federal law.

(13) A prescribed drug or biological product that would meet the requirements of clause (i) or (ii) but that is available over-the-counter in addition to being available upon prescription.

(14) **EXCLUSION.**—The term "covered outpatient drug" does not include any product—

(i) except as provided in subparagraph (A)(iv), which may be distributed to individuals without a prescription;

(ii) when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title;

(iii) that was covered under this title on the day before the date of enactment of the Access to Rx Medications in Medicare Act of 1999; or

(iv) that is a therapeutically equivalent replacement for a product described in clause (i) or (ii), as determined by the Secretary.

(15) **ELIGIBLE BENEFICIARY.**—The term "eligible beneficiary" means an individual that is enrolled under part B of this title.

(16) **ELIGIBLE ENTITY.**—The term "eligible entity" means any entity that the Secretary determines to be appropriate, including—

(A) pharmaceutical benefit management companies;

(B) wholesale and retail pharmacy delivery systems;

(C) insurers;

(D) other entities; or

(E) any combination of the entities described in subparagraphs (A) through (D).

SEC. 4. OPTIONAL COVERAGE FOR CERTAIN BENEFICIARIES.

(a) **IN GENERAL.**—If drug coverage under a group health plan that provides health insurance coverage for retirees is equivalent to or greater than the coverage provided under section 1846 of the Social Security Act (as added by section 5), beneficiaries receiving coverage through the group health plan may continue to receive such coverage from the plan and the Secretary may make payments to such plans, subject to the requirements of this section.

(b) **REQUIREMENTS.**—To receive payment under this section, group health plans shall—

(1) comply with certain requirements of this Act and other reasonable, necessary, and related requirements that are needed to

administer this section, as determined by the Secretary;

(2) to the extent that there is a contractual obligation to provide drug coverage to retirees that is equal to or greater than the drug coverage provided under this Act, reimburse or otherwise arrange to compensate beneficiaries during the life of the contract for the portion of the part B premium under section 1846 of the Social Security Act that is identified by the Secretary of Health and Human Services as attributable to the drug coverage provided under section 1846 of that Act (as added by section 5); or

(3) for group health plans that are in existence prior to enactment of this section and provide drug coverage to retirees that is equal to or greater than the drug coverage provided under section 1846 of the Social Security Act (as added by section 5), reimburse or otherwise arrange to compensate beneficiaries for the portion of the part B premium under section 1846 of the Social Security Act that is identified by the Secretary of Health and Human Services as attributable to the drug coverage provided under section 1846 of that Act (as added by section 5) for at least 1 year from the date that the group health plan begins participation under this section.

(c) **PAYMENTS.**—The Secretary shall establish a process to provide payments to eligible group health plans under this section on behalf of enrolled beneficiaries. Such payments shall not exceed the amount that would otherwise be paid to a private entity serving similar beneficiaries in the same service area under section 1846 of the Social Security Act (as added by section 5).

SEC. 5. MODIFIED REQUIREMENTS.

(a) **COVERAGE OF OUTPATIENT DRUGS.**—Section 1846(p)(2)(B) of the Social Security Act (48 U.S.C. 1846(p)(2)(B)) is amended by inserting before "and" at the end the following: "including a requirement that an appropriate number of policies provide coverage of drugs which, although not covered by the plan, are otherwise entitled to under this title (with the Secretary and the National Association of Insurance Commissioners determining the appropriate level of drug benefits that each benefit package must provide and ensuring that policies providing such coverage remain affordable for beneficiaries)".

(b) **DEFERRED DATE.**—The Amendment made by subsection (a) shall take effect on July 1, 2001.

(c) TRANSITION PROVISIONS.

(1) **IN GENERAL.**—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform to the regulatory program to the amendments made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1846 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (2).

(2) **NAIC STANDARDS.**—If, within 6 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the "NAIC") modifies its NAIC Model Regulation relating to section 1846 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) **TRANSITION STANDARDS.**—If the NAIC does not make the modifications described in

FAX COVER SHEET

Congressman Sherrod Brown's Office
201 Cannon House Office Building
Washington, DC 20515
202/225-3401
202/225-2266 fax



To: *Chris Jennings*

Fax Number: *486-5557*

From: *Ellie Dehorsey*

Date: *7/2*

Pages to Follow:

Comments:

*Chris - Sherrod asked me
to fax this to you*

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Fax Transmittal Slip

Ohio State UAW-CAP Council**133 East Livingston Avenue****Columbus, Ohio 43215****Fax No. (614) 464-4330****Telephone No. (614) 484-2055****Date:** July 2, 1999**To:** Ellie Dehoney, Congressman Sherrod Brown's Office**Cc:****From:** James Harris, State Coordinator, Ohio State UAW-CAP Council**RE:** "Maintenance of Effort" Issue

☐ **FOR YOUR INFORMATION**☐ **NOTE AND RETURN TO ME**☐ **PER YOUR REQUEST**☒ **FOR YOUR ACTION**

COMMENTS:

I appreciate your agreeing to contact Christopher Jennings on behalf of the UAW on this issue.

Give my regards to Sherrod!

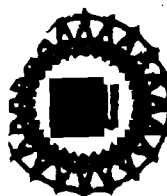
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Attachments 3 Not including cover page

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INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA—UAW
STEPHEN P. YOKICH, President**RUBEN BURKS, Secretary-Treasurer****VICE PRESIDENTS****ELIZABETH BURN • RON GETTELFINGER • BOB KING • JACK LABKOWSKI • RICHARD SHOEMAKER****June 23, 1999****IN REPLY REFER TO**
**1767 N STREET, N.W.
 WASHINGTON, D.C. 20038
 TELEPHONE: (202) 398-8900
 FAX (202) 398-3467**

**Christopher Jennings
 Deputy Asst. to the President
 for Domestic Policy
 Domestic Policy Council
 Rm. 216 Old Ex. Off. Bldg.
 Washington, D. C. 20500**

Dear Chris:

Thank you for meeting with representatives of various unions, including the UAW, to discuss the Administration's Medicare prescription drug proposal. I understand that during the meeting you requested that we provide you with additional information on the "maintenance-of-effort" issue, including why some provision is needed and how it would work.

The UAW urges the Administration to include maintenance-of-effort provisions for two reasons. First, we believe there is a danger some employers may attempt to use the establishment of a Medicare prescription drug benefit as an excuse to shift some of the cost of this benefit from themselves to Medicare beneficiaries. Although the Administration's proposal, as we understand it, contains an incentive for employers to continue their prescription drug programs, some employers may still decide it is in their interest to shift their retirees into the Medicare program and only provide wrap around drug coverage. For example, notwithstanding any subsidy and tax considerations, an employer might still wish to pursue this alternative because of FASB ramifications. If an employer pursues this approach, we believe this raises the question of who should be responsible for paying any beneficiary premium that Medicare charges for its drug benefit. The UAW submits that if the employer was previously paying for the drug benefit, then at least for a period of time that employer should be required to pick up the beneficiary's premium for the drug benefit. Otherwise, there will be a direct cost shift from the employer to the beneficiary. You should note that this type of maintenance of effort provision was included in Senator Kennedy's prescription drug bill (see section 4, which is attached). A similar maintenance of effort provision was included in the Medicare catastrophic legislation. I would suggest that this type of requirement could be drafted so as to extend for the longer of two years or the expiration of an existing contract. This would provide protection in situations where union contracts are expiring during the next two years. Also, it would help provide protection for non-union retirees.

Second, the UAW is concerned that some employers may use the establishment of the Medicare drug benefit as an excuse to ratchet their coverage down to the Medicare level. We encountered a similar type of problem when ERISA was enacted. Although some of our negotiated pension plans required stricter funding standards than those mandated by ERISA, when these contracts expired some unscrupulous employers used ERISA as an excuse to relax their funding requirements to the ERISA mandated level. They simply told unsophisticated local union officials that they were "ERISAifying" their pension plan. We are concerned that a similar dynamic could take place after the establishment of a Medicare drug benefit. In non-union situations, or in smaller unionized shops, employers might try to eliminate some of their retirees drug benefits by claiming they were simply conforming their plans to the Medicare "requirements". To prevent this type of abuse, we believe there should also be a maintenance-of-effort provision preventing employers from reducing drug benefits beyond those provided by Medicare, at least for a period of time (e.g. the longer of two years or the expiration of an existing contract).

Neither of these types of maintenance-of-effort provisions would entail significant problems in terms of drafting legislative language or implementation burdens. As previously indicated, a similar approach was adopted in connection with the Medicare catastrophic program. It is relatively easy for an employer to reimburse its retirees for the cost of the Medicare drug premium. It should also be easy for an employer to continue any wrap around drug benefits.

The UAW submits that these maintenance-of-effort provisions will help to ensure that beneficiaries are not inadvertently harmed by the establishment of the Medicare drug benefit. We believe that they are consistent with the purpose and thrust of the Administration's proposal.

I would be happy to discuss these issues with you in more detail.

Sincerely,



Alan Reuther
Legislative Director

AR:car
opelu484
C4085
cc Chuck Gayney
Mary Rouleau
Gerry Shea
Karen Tramontano

DATE: 7/07/99

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**OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
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TO: Jane Lowenson

OFFICE: _____

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PHONE: 456-5377FAX: 456-5557TOTAL PAGES
(INCLUDING COVER): 3☒ RICHARD J. TARPLIN☐ HELEN MATHIS☐ KEVIN BURKE☐ ROSE CLEMENT LUSI☐ ALICE ARTIS☐ HAZEL FARMER☐ EDWARD WHITLEY☐ FRANKIE MELTON

REMARKS:

*This is the TA we did for
Braham & Conrad.*

Rich

Medicare BBA Refinement Package*

IME 1/	\$1.2 bil
SNF 2/	0.9
Rural Hospital 3/	1.0
Therapy Caps 4/	1.5
Part B Premium Offset	- 0.4
Total	\$4.2 bil

* Estimated CBO Pricing.

1/ Change indirect medical education (IME) add-on payments to 6.5 percent for the last 6 months of FY 2000 (i.e., April 1, 2000 through September 30, 2000) (instead of 6.0 percent for all of FY 2000) and for all of FY 2001 (instead of 5.5 percent). Current law IME add-on payments of 5.5 percent would begin with FY 2002.

2/ Effective for services furnished beginning 4/1/00, increase the Federal portion of per diem payments by 1 percent for 6 specified RUGs associated with medically complex patients. This policy would be effective until the Secretary refined RUGs to deal with non-therapy ancillary costs/medically complex cases (expected to be 10/1/00) at which time this temporary add-on policy would end and the additional costs of it would be included within the SNF budget-neutrality calculation for the refined RUGs.

The six RUG groups cover the Extensive and Special Care Categories. These groups encompass approximately 17 percent of covered Medicare days and contain the patients with the highest level of medical complexity. Beneficiaries who classify into these groups have multiple complex medical conditions, very dependent functional status levels and require high levels of skilled nursing care and costly ancillary services and treatment regimens.

3/ BBA legislated the hospital update to be market basket minus 1.1 percentage points for each of FY 2001 and FY 2002. This proposal would give rural hospitals a 0.25 percentage point smaller reduction from the market basket in FY 2001 and FY 2002. The BBA policy would apply to urban hospitals in FY 2001 and FY 2002, and give rural hospitals would get an update of market basket minus 0.85 percentage points for FY 2001 and FY 2002.

4/ Create a third therapy cap, separating speech and physical therapy, with each having a limit of \$1,500 per year, effective 1/1/00.

Medicare BBA Refinement Package*

IME <u>1/</u>	\$1.2 bil
SNF <u>2/</u>	0.9
OPD Transition <u>3/</u>	1.0
Therapy Caps <u>4/</u>	1.5
Part B Premium Offset	- 0.4
Total	\$4.2 bil

* Estimated CBO Pricing.

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3/ Create a transition for hospitals to the Outpatient Department Prospective Payment System (PPS) by limiting reductions for individual hospitals. The transition would apply during the first 3½ years of the new system (July 1, 2000 through December 31, 2003). Additional payments would be made to individual hospitals so that a hospital's reduction under the PPS would be limited to 90 percent (during the first 18 months), 85 percent during 2002 and 80 percent during 2003, of their 1996 payment to cost ratio. In order to provide funds to hospitals during the transition, adjustments to interim payments would be made with a reconciliation after the end of each year.

4/ Create a third therapy cap, separating speech and physical therapy, with each having a limit of \$1,500 per year, effective 1/1/00.

QUESTION:

Clearly there is concern among members of Congress that a new universal prescription drug benefit will experience unsustainable cost growth in the future. Members of both parties have advocated for a more limited approach – either a back end catastrophic benefit or a benefit for only the most needy. Please explain why the Administration has chosen a universal benefit – especially since the majority of beneficiaries already have this coverage.

ANSWER:

We considered the whole range of options in developing our proposal. A variety of factors lead to our decision.

First, there are the demographic facts: about 34 percent of beneficiaries (about 15 million people) have no drug coverage. Not all of them are low income – 40% of them have incomes above 200% of poverty, so a low income benefit would not help them. We estimate that 50% of rural beneficiaries have no drug coverage, but we clearly have no way to target a benefit to this group.

Second, the hallmark of the Medicare program since its inception has been the universal nature of its benefit package – everyone regardless of income, is entitled to the same basic package of benefits. We believe the universal nature of the benefit package is a significant factor in the unwavering support for the program from the American public. A means-tested benefit within the program is inconsistent with what people like about Medicare.

Third, it's important to look behind the numbers – particularly to see the real story behind the 65% of beneficiaries who have drug coverage. Seven percent of beneficiaries are in Medicare HMOs, which generally provide drug coverage – this is publicly funded coverage. This coverage is in decline as HMOs claim they cannot sustain the cost of the benefit. Another 17% of beneficiaries are low income and enrolled in Medicaid – these people too receive publicly funded drug coverage. So, proposing a uniform benefit for these people who have have a range of publicly funded drug benefits -- we are not supplanting private coverage. Then there is the 8% or so of beneficiaries who have this coverage through Medigap. It is unstable, expensive coverage. The fact that only 8% hold such coverage speaks to its expense and inadequacy. Finally, there is the 28% or so who have drug coverage through their retiree health plans. The trend lines here are clear. Coverage is declining as employers decrease or eliminate drug coverage. Just two years ago, almost 35% of seniors had drug coverage through retiree plans.

As for catastrophic coverage, we estimate that about 4% of beneficiaries have drug expenses over \$2000 per year and only about 2% have expenses in excess of \$5,000. Catastrophic coverage is costly because only the sickest and most in need enroll – creating a skewed and expensive risk pool that leads to ever increasing costs.

Finally, I think we need to look to history. Before Medicare was enacted in 1965, people argued similar points: that the majority of elderly Americans had private insurance coverage which should not be supplanted. Medicare has been wildly successful since then – lifting generations of our seniors out of poverty, adding 3 years to the life expectancy of seniors and vastly improving the quality of their lives.

QUESTION:

How would your proposal help bring managed care and beneficiary choice to rural areas?

ANSWER:

Our proposal would change managed care incentives in a number of ways that, over time, would help bring more choices to people in rural areas.

Under our plan, health plans would compete based on price for a standard package of Medicare benefits.

The amount the government would contribute would be based on the average national per beneficiary cost of the traditional, or fee-for-service program, which would be adjusted geographically. We would maintain the progress made in the BBA of boosting the payment level in rural areas.

Prescription drugs would become part of the basic Medicare benefit package so that the amount bid by plans in rural areas would be higher than current payments to capture the costs of drugs. In contrast, plan payments in rural areas today generally are not high enough to permit HMO coverage of prescription drugs in rural areas which makes operation in rural areas unattractive.

QUESTION:

Your proposal calls for rationalizing cost-sharing and as part of that, you would institute a 20% coinsurance on clinical lab services. You justify this by citing seemingly excessive utilization of services. However, lab services involve very little beneficiary discretion in that physicians direct utilization in the course of treatment. Doesn't this unfairly burden beneficiaries?

ANSWER:

I think you can argue that most services are physician directed – even doctor visits where a patient has been referred to a specialist so, clinical lab services are not that different from other services.

We believe a modest copayment will reduce inappropriate utilization. Physicians do take beneficiary costs into account when ordering services or making treatment decisions, and this will help reduce overuse. A lab copay was also recommended by the Medicare Payment Advisory Commission.

QUESTION:

How much does your proposal to index the Part B deductible save and how much would the deductible increase?

ANSWER:

Indexing the deductible to the CPI as we propose would save about \$3 billion over 10 years. Please note we would index it to CPI – general inflation – not medical inflation. If the proposal is enacted this year, the deductible would rise \$2 or \$3 next year.

The deductible has only been increased twice in the history of the program, in ____ and _____. It is not currently structured to keep pace with inflation.

QUESTION:

Why is the President proposing to add an expensive new benefit to a program so beset with current troubles and problems that need to be addressed? Wouldn't it be more appropriate to fix current problems such as solvency and lack of managed care organizations in rural care areas rather than propose major new entitlement spending?

ANSWER:

There is much more to the President's proposal than just prescription drugs. The purpose of our proposal is to address many of the shortcomings of the current program.

The President's proposal extends the life of the Trust Fund until at least 2027 – adding 12 years to the current depletion date.

The proposal allows us, for the first time, to recognize and reward high quality providers.

Our proposal would allow the traditional program to use the same tools as the private sector to create greater efficiency and improve quality.

The proposal would allow managed care plans to bid competitively and compete for market share based on price.

Of course, the proposal includes an affordable prescription drug benefit. I believe this proposal puts Medicare on the proper footing for the 21st century.

DATE: 7-2-99



**U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES**

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**OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
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TOTAL PAGES

(INCLUDING COVER):

3

[] FRANKIE MELTON

REMARKS:

Conference Talking Points

- Yesterday, the President proposed his plan for Medicare reform. Now it is our turn to dispose of it.
- We need to be careful on how we approach this issue. In the latest polls, we have the lead among senior citizens. The President is trying to win seniors back by giving them free drugs. We shouldn't be too negative, but we can raise questions about the President's plan.
- Democrats want to put prescription drugs in conflict with tax relief. We shouldn't fall into that trap. We can have a responsible prescription drug program and provide tax relief to American families. We can do both.
- Tomorrow, the Congressional Budget Office will announce its new budget projections. It will track closely with OMB's projections. This gives us a great opportunity to celebrate our accomplishments and turn our attention to a big part of our agenda, tax relief.
- I would like you all to participate in our press event tomorrow morning that will help celebrate the first true balanced budget (without using the social security surplus) in modern history. The Conference will provide details to you all later today.

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515

SUBCOMMITTEE ON HEALTH

President Clinton's Medicare Announcement

June 30, 1999

Dear Colleagues:

We're pleased the President has finally decided to engage on the Medicare issue. Following are a few observations based on the President's four-page outline:

The President's Drug Benefit: Little Help to Those Who Need It Most

The President's proposal provides coverage for some drug costs but no coverage for high drug costs. Most people can afford the first dollar of pharmaceutical coverage, very few can afford the high costs of the latest, breakthrough drug therapies. Moreover, the average beneficiary consumes 18 prescriptions a year. Every Member of Congress has uncapped drug benefits and seniors should have access to the same kinds of plans we do.

The President's proposal gives a drug benefit to ^{Gov}everyone, regardless of whether they need it or not -- even retired millionaires. Two-thirds of seniors already have coverage. Why replace these private dollars with taxpayer dollars?

Is the President's plan worth buying? The benefit doesn't even start for over 3 years. Then, beneficiaries have to pay \$1,300 to get a \$1,000 benefit. And when the "benefit" is fully phased in, a beneficiary has to pay \$2,980 to get a \$2,500 benefit. No Member of Congress has a benefit that offers this little value for so much money.

Benefit Cuts: Rubbing Salt in the Wound

This President in the last 6 months alone has proposed \$100 billion in benefit cuts and tries to convince us he is "saving" Medicare. In this proposal, the President is cutting standard Medicare benefits by a staggering \$74.5 billion in order to mask the costs of the new drug benefit. Earlier this year, he proposed Medicare cuts of \$28 billion to fund still other programs. Instead of taking \$100 billion out of the program, Republicans think we need to put a little money back into the program.

Clinton's Plan Is Not More

We're pleased that the President thinks competition is a good thing. But why does he exempt the government-run HCFA plan from competing with private plans? This creates an unlevel playing field, with an unfair advantage given to the government-run plan. As a result, many private plans will be driven out of the market, stifling choices and enhanced benefits for seniors. In contrast, the Medicare Commission recommended that all plans -- public and private -- compete for the right to enroll Medicare beneficiaries.

Solvency: An Empty Promise

The President's "surplus" funding is nothing more than a giant punt to future generations, generations whose entitlement burden is already too great. How is he making Medicare a 21st Century program when the proposal merely increases 21st Century tax burdens? All the President has done is say that we will make fiscal discipline -- funding tied to payroll taxes -- irrelevant by pouring more and more general fund tax dollars into the program.

The GAO recently concluded that the President's proposal to dedicate 15% of the budget surplus to the HI (Medicare) trust fund is "more perceived than real. Specifically, while the HI trust fund will appear to have more resources as a result of the President's proposal, in reality, nothing about the program has really changed."

Bill Thomas
Bill Thomas



*The Architecture
of the*



West Wing of the White House





F O R E W O R D

Welcome to the West Wing of the White House, unquestionably the most important suite of executive offices in the world. The Oval Office is here, as are the offices of the President's immediate staff. In many ways the evolution of the design of this building represents the evolution of the Presidency since 1902, when Theodore Roosevelt directed its construction.

This document is intended to help you as you tour the West Wing. We hope you will find it informative and interesting.

The Architecture of the West Wing of the White House



C O N T E N T S

FOREWORD

i

PREFACE

1

ARCHITECTURAL HISTORY

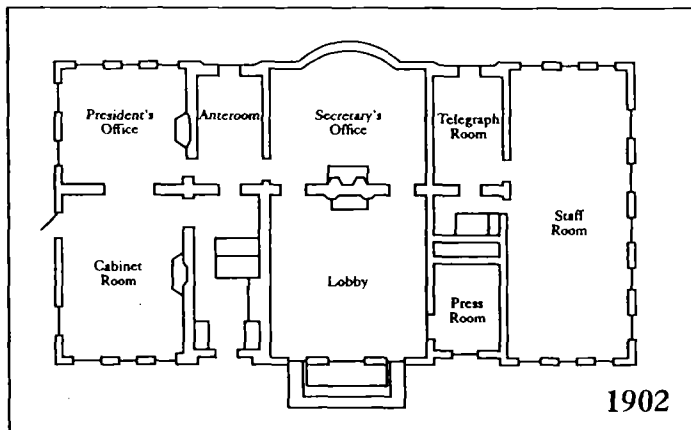
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ROOMS OF THE WEST WING

5

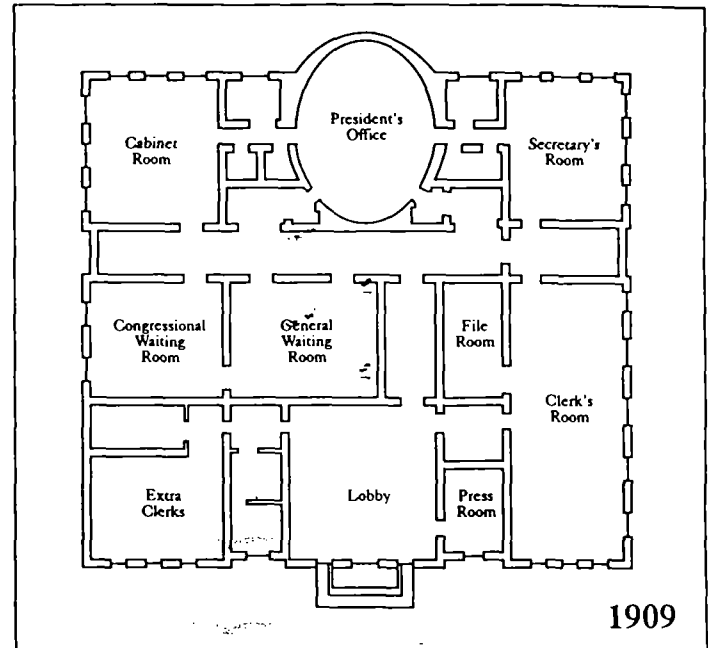
1902

The eminent architectural firm of McKim, Mead and White was commissioned by President Theodore Roosevelt to undertake a much needed renovation of the White House. To alleviate the problems caused by crowded conditions in the Executive Residence, an addition on the west side was designed to house the executive offices temporarily. Charles Follen McKim, the senior partner in charge of the project, was ever-mindful of the need to harmonize the proposed extension with both James Hoban's original design of the residence and the original Jeffersonian colonnade. The colonnade was to be left in place, while the complex of greenhouses built since 1857 was to be removed. President Roosevelt imposed a severe time constraint on the project; within six months the greenhouses were gone and the new office facility (called the Executive Office Building) was built at the end of the colonnade. Despite Congressional criticism of the project, McKim's design was a success in its architecturally subdued approach, which set a precedent for subsequent expansions of the West Wing.



1909

However successful McKim's design was architecturally, it was not long before the expanding role of the president again required a larger staff and, consequently, additional office space. Even before President Theodore Roosevelt left office in 1909, planning was initiated to meet the need. Under President William Howard Taft, a design



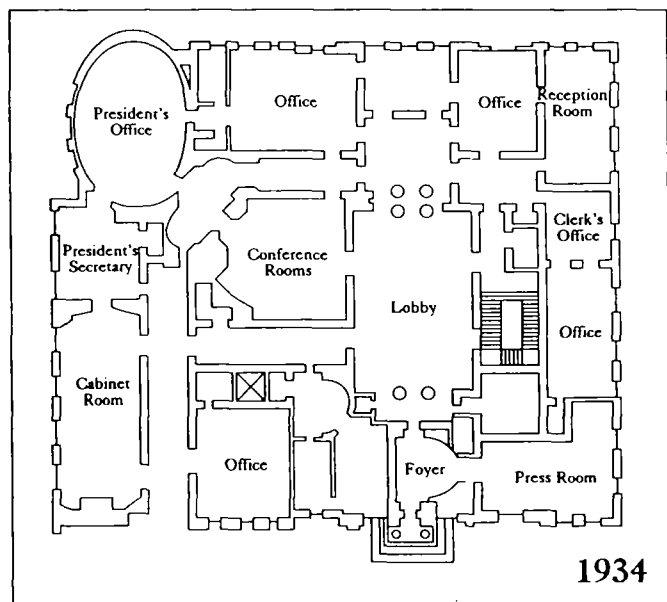
competition was held in 1909 for an addition to McKim's building. Obviously, the perception of McKim's design had gone beyond that of "temporary", and the issue was one of harmonizing the proposed addition not only with James Hoban's design for the mansion, but also with McKim's design of the executive office building. Eventually, President Taft selected the designs of Washington architect Nathan Wyeth which virtually doubled the available office space by the addition of a southern extension built on the site of the 1902 tennis court. Wyeth's floor plan moved the president's office from the southeast corner of the 1902 building to the center of the new south facade and changed its shape from a square to an oval, thus echoing the elliptical rooms designed by Hoban for the mansion. The Cabinet Room was moved from the northeast corner to the southeast corner of the building.

The additional office space provided by the 1909 construction proved sufficient for the time. In the spring of 1929, however, crowded conditions led President Herbert Hoover to order some changes, including the enlargement of the lobby. On Christmas Eve of that same year, President Hoover witnessed a fire which badly damaged the recently modified West Wing. During the fire, President Hoover's son and secretary rushed into the Oval Office to save the document-filled drawers of the President's desk. President Hoover was forced to move

his offices to the neighboring State, War and Navy Building (now referred to as the Old Executive Office Building or OEOB). The ensuing reconstruction of the West Wing, which included an attic and a new roof, provided an unexpected opportunity for the installation of a new technology: air conditioning.

1934

President Franklin Delano Roosevelt's Administration increased the number of presidential staff, necessitating another expansion of the West Wing. In 1934, planning was initiated to provide additional office space, and architect Eric Gugler was selected for this design commission. Rather than distort the proportions of the building by extending it further to the south, the architect convinced President Roosevelt that the addition of a second story would be appropriate. Setting the additional build-



ing volume behind the existing first floor parapet solved not only the problem of space, but also preserved the architectural integrity of both the Executive Residence and McKim's design. Because the plan included the further excavation and expansion of the basement, the entire structure was gutted, leaving only the northern, parts of the eastern, and western walls standing. President Roosevelt and his staff were relocated to the second floor of the Residence during the renovation.

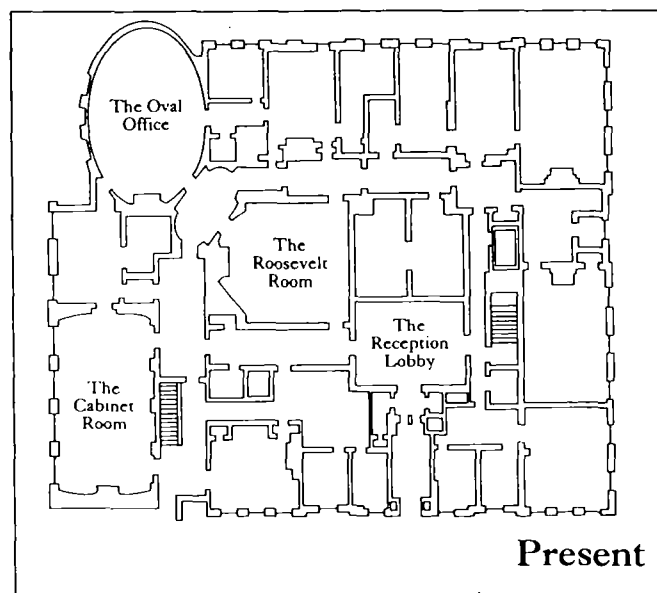
The 1934 renovation gave the West Wing floor plan the essential character that it retains today, with the Oval Office in its present location at the southeast corner of the building, the Cabinet Room to the north of the

Oval Office, and the Roosevelt Room diagonally across the hall from the Oval Office. The Reception Lobby and surrounding offices also retain approximately their original locations, although these spaces have been altered somewhat during succeeding administrations.

Present

The 1934 renovation marked the last substantial structural changes that have been made in the West Wing (the name which came into common usage after this time). In 1946, President Harry S. Truman favored a major renovation proposed by White House architect Lorenzo Winslow, a plan which would have changed the character of the building. This proposal was opposed by The American Institute of Architects, the organization President Theodore Roosevelt had entrusted to preserve and protect the architectural integrity of the White House and its adjuncts, and was never executed.

President Richard M. Nixon ordered a number of changes in the West Wing in 1969-70, including the creation of additional offices which resulted in a reduction in the size of the Reception Lobby, and the creation of the Press Center within the West Terrace. Even with the addition of the porte-cochere and circular drive that today serves as the northern entrance to the Reception Lobby, the exterior appearance of the building was not modified substantially. Alterations that have been made in the last 50 years have been matters of interior design and decoration.



The Reception Lobby

Visitors who come to the West Wing to meet with the President or his staff are welcomed in the Reception Room.

When the West Wing was erected in 1902, a rectangular lobby occupied the center of the north side of the building, opening directly to the driveway beneath a small porch. In 1929, under President Herbert Hoover, the lobby was elongated into a "T" shape.

In 1934, when the President's Oval Office and the Cabinet Room were moved into the eastern extension of the West Wing, a new lobby was created at the center of the building with access via a narrow foyer leading from the entrance on the north.

The somewhat informal character of this lobby, which was a general waiting room for both distinguished visitors and the press alike, was captured by artist Norman Rockwell in a four-panel illustration entitled *So You Want to See the President*, drawn for the November 13, 1943, issue of the *Saturday Evening Post*. The original artwork, showing a variety of people seated in red leather chairs and sofas around a massive center table carved with water buffalo heads, can be seen on the north wall of the ramp outside the Press Room.

With the construction of new press facilities in the west colonnade in 1970 by the Nixon Administration, the lobby was renovated to provide a smaller, more intimate reception room. The southern portion of the room was converted into two staff offices entered from the south corridor. The plaster cornice of the remaining north half of the room was retained and replicated on the new south wall. At the same time, the foyer was provided with a new marble floor and mahogany doors, and a porte-cochere was added to the north facade of the West Wing to provide a more formal, protected entry.

(For a description of the artwork in the Lobby, refer to the attached Brief Description of the Art supplement)

The Roosevelt Room

The Roosevelt Room presently occupies the site of the president's office and anteroom in the original West Wing design of 1902. The wooden mantel now in this room was, in fact, made for the 1902 President's Office. When the Wing was expanded to the south in 1909, this site became part of two waiting rooms. It now serves as a conference room across the corridor from the Oval Office which was relocated when the Wing was expanded to the east in 1934. At that time, a skylight was installed, lit from a shaft passing through the Wing's new second floor.

This room was first referred to as the "Fish Room" because of the aquariums and fishing mementos displayed by President Franklin D. Roosevelt. The tradition of this name continued into the early 1960's when President John F. Kennedy displayed a large mounted sailfish which he had caught near Acapulco, Mexico.

During the administration of President Lyndon B. Johnson, the room was called the Presidential Reception Room. It was given its present name by President Richard M. Nixon in 1969 to honor the contributions of President Theodore Roosevelt in initiating the construction of the West Wing and of President Franklin D. Roosevelt in enlarging the Wing to its present size. At that time, portraits of both Roosevelts were placed in the room, and the 1934 skylight was covered by a false ceiling.

The flags for each of the five uniformed services are displayed at the west end of the room along with the U.S. Flag. They are displayed in the order of official/ceremonial precedence of the services (Army, Marine Corps, Navy, Air Force, and Coast Guard). Attached to each service flag are a series of streamers depicting wars, campaigns, specific battles, etc. in which the particular service participated. Streamers may also represent foreign recognition of the U.S. military services as well as specific Presidential citations. They are awarded in recognition of heroism or meritorious service that is the result of a group effort.

In August 1988, the skylight was uncovered during the installation of new ceiling lighting. This eight-foot by eight-foot panel, framed by a classical Greek key motif, was replicated with the substitution of fluorescent backlighting.

(For a description of the artwork in the Roosevelt Room, refer to the attached Brief Description of the Art supplement)

The Cabinet Room

In 1902, President Theodore Roosevelt moved his office and Cabinet Room from the eastern portion of the second floor of the mansion to new quarters in the West Wing. The Cabinet Room was located in the northeast corner, and the President's Office, which was then a rectangular room, was in the southeast corner. The fireplace mantel in the room today was made for the 1902 Cabinet Room.

In 1909, President William Howard Taft expanded the wing to the south, constructing the first Oval Office at the center of this addition and moving the Cabinet Room to the southeast corner. In 1934, President Franklin D. Roosevelt, in an easterly expansion, moved the Oval Office to its present southeast corner location and returned the Cabinet Room to the northeast corner.

In August 1982, during the administration of President Ronald Reagan, architectural and decorative changes were made in the room. On the north wall, two niches which had been covered by doors, were restored to house pieces of sculpture. On the west wall, two false doors were removed. The entire room was painted a beige tone with the cornice and other architectural features highlighted in white. A green wool rug with a gold and green classical border, which had been ordered during the Johnson Administration but installed early in the Nixon Administration, remains in the room as do the table, chairs, and lighting fixtures acquired in 1970.

Traditionally, each new president selects portraits of favorite former presidents to be hung in the Cabinet Room. When the Cabinet meets around the large conference table, each Cabinet member is assigned a chair positioned at the table according to the seniority of the department represented. Traditionally, when Cabinet members conclude their terms of service, they are permitted to purchase their cabinet chairs, which bear brass plates indicating their cabinet position(s), and dates of service. The taller chair at the center of the east side of the table is occupied by the President.

(For a description of the artwork in the Cabinet Room, refer to the attached Brief Description of the Art supplement)

The Oval Office

The Oval Office is the President's formal workspace, where he confers with heads of state, diplomats, his staff, and other dignitaries; where he often addresses the American public and the world on television or radio; and where he deals with issues of the day.

The current Oval Office was constructed when the West Wing was expanded in 1934. Architectural features of the present Oval Office include: the Presidential Seal in plaster relief in the ceiling; the marble mantel designed in the classical order which was original to the 1909 Oval Office; the doors to the veranda and study, each with a pediment above a horizontal fasces, the classical symbol of the governing authority; and the window and shelf niches with shell canopies.

In August 1981, this room was painted in its current color scheme—off-white walls with the cornice and woodwork highlighted with a purer white.

In 1982, a new floor of walnut and white oak was added. This hardwood floor replaced a simulated wood-grain vinyl installed in 1969 during the administration of President Richard M. Nixon. That floor, in turn, had replaced a cork flooring installed in President Franklin D. Roosevelt's new office in 1934.

During August 1988, the cove lighting around the ceiling of the Oval Office was improved using the most recent developments in fluorescent lamp technology. These new fixtures, which are more compact and provide light of warmer color, replaced lights originally installed during the administration of President Richard M. Nixon.

While the architectural features of the Oval Office remain constant, the interior furnishings often change. On January 20, 1993, with the inauguration of President Clinton, new gold damask draperies were installed, consisting of a six-swag valance and three pairs of straight overcurtains in a popular 18th-century acanthus leaf pattern. At the same time, the two high-back armchairs before the fireplace, were reupholstered in a gold fabric. The changes to the Oval Office were completed in August 1993, under the direction of Little Rock designer, Kaki Hockersmith. An ornamental blue tape was added as trim to the drapery valance and panels. The two sofas acquired in 1990 were rebuilt and recovered in a red-and-cream striped silk with pillows of red silk decorated with gilt leaf medallions. The seats of the cane-backed armchairs around the room were recovered in a specially made blue silk called "Little Rock diamond".

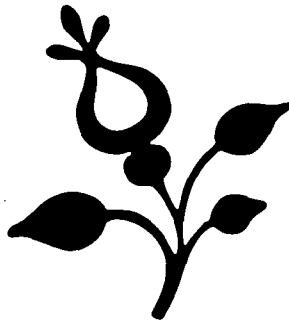
A new oval wool carpet was woven for the room. A dark blue field centers a full-color Presidential Coat-of-Arms encircled by fifty white stars and framed by a gilt rope band nestled into a plain red band. This framing band is repeated on the exterior of the rug's border which features green olive branches and gold laurel wreaths separated by red rosettes on a white field, framed on the interior by a gold rope band.

The President's desk, known as the "Resolute" desk, was made from the oak timbers of the British ship H.M.S. Resolute as a gift to President Rutherford B. Hayes from Queen Victoria in 1880. It has been used by every president since Hayes, excepting Presidents Johnson, Nixon, and Ford.

(For a description of the artwork in the Oval Office, refer to the attached Brief Description of the Art supplement)



*fine arts &
furnishings*



*The West Wing
Of The White House*

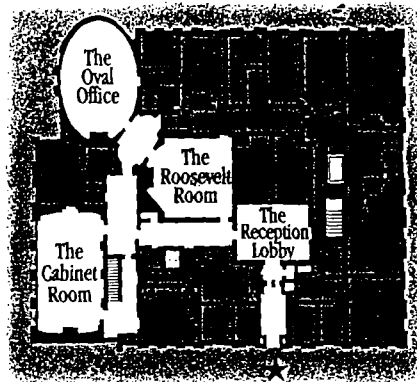


THE WEST WING OF THE WHITE HOUSE

fine arts & furnishings

F O R W A R D

Welcome to the West Wing of the White House, unquestionably the most important suite of executive offices in the world. The Oval Office is here, as are the offices of the President's immediate staff. In many ways the evolution of the design of this building represents the evolution of the Presidency since 1902, when Theodore Roosevelt directed its construction.



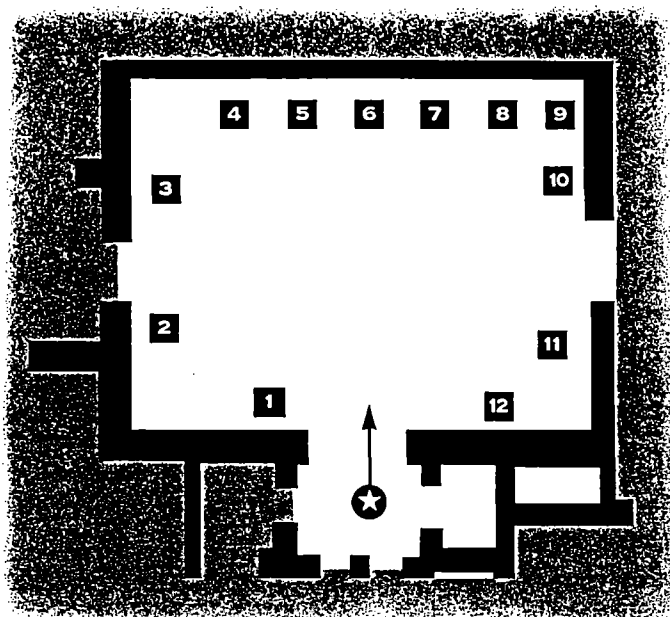
This document is intended to help you as you tour the West Wing. We hope you will find it informative and interesting.

WASHINGTON, D.C. 1996

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THE WEST WING RECEPTION LOBBY



WEST WING FOYER

NATHAN HALE

by Frederick William MacMonnies
(1863-1937), bronze, c.1890,
cast by H. Rouard, Paris.

Early in the American Revolution, Capt. Nathan Hale (1755-1776) was captured during an intelligence mission behind British lines in New York. A British officer attending his hanging on September 22, 1776, reported his immortal last words, "I only regret that I have but one life to lose for my country."

Gift of The Barra Foundation, Inc., 1991.

1 EMIGRANT SCENE

attributed to William Henry Powell
(1823?-1879), oil on canvas, c.1837.

Members of a wagon train on the Plains are shown receiving directions from a Native American guide. Powell is represented in the Rotunda of the U.S. Capitol by his painting of DeSoto discovering the Mississippi River.

Gift of the White House Historical Association, 1995.

2 JOHN TYLER

by James Reid Lambdin (1807-1889),
oil on canvas, 1841.

At the death of President William Henry Harrison after only one month in office, Tyler became the first Vice President to succeed to the Presidency, April 6, 1841. This portrait, completed in the same year, shows the U.S. Capitol as it looked, 1825-1856.

Gift of Mrs. Charles S. Payson, 1971.

3 ZACHARY TAYLOR

*by Eliphalet Frazer Andrews (1835-1915),
oil on canvas, 1879.*

When Rutherford B. Hayes became president in 1877, eight presidents were not represented by portraits in the White House, a deficiency which he proudly corrected during his term. Andrews painted four of these portraits, including this copy of a life portrait by John Vanderlyn at the Corcoran Gallery of Art. Taylor was the second president to die in office, serving 1849-1850.

4 THE FIRST NAVAL ACTION IN THE WAR OF 1812

*by William John Huggins (1781-1845),
oil on canvas, 1816.*

This large maritime painting depicts the naval division of Commodore John Rodgers pursuing the frigate H.M.S. Belvidera, five days after the United States had declared war on Great Britain in 1812. It was probably based on a sketch by James Stilwell, an officer on the Belvidera.

Gift of Mrs. Marshall Field, 1962.

5 TABLE LAMPS

The pair of ox-blood porcelain jars mounted as lamps was made in China, c.1800.

Gift of the White House Historical Association, 1971.

6 ENGLISH BOOKCASE

This mahogany bookcase was made circa 1770.

Anonymous Donation, 1976.

7 BOEHM BIRDS

Made by Edward Marshall Boehm, Inc., Trenton, New Jersey, these porcelain figurines include (from top) bob white and California quail, wood thrushes, blue jays and mockingbirds, and ruffed grouse. Such birds were a popular state gift during the Nixon administration.

Gift of Mrs. Edward Marshall Boehm, 1969.

8 WASHINGTON CROSSING THE DELAWARE

*by Eastman Johnson (1824-1906),
oil on canvas, 1851.*

The success of Emanuel Leutze's monumental life-size painting of this subject

(1850) led a New York publisher to commission a smaller version from which to produce an engraving. Leutze, working in Dusseldorf, assigned this project to one of his American students, Eastman Johnson. The circulation of the prints made from this painting increased the great popularity of this scene of the American Revolution.

*Lent by the Alex and Marie Manoogian Foundation,
1979.*

9 TABLE LAMPS

The pair of orange and blue Imari porcelain vases mounted as lamps was made in Japan, c.1830.

Gift of the White House Historical Association, 1971.

10 GALLERY CLOCK

This gilded-wood wall clock, a type used in public buildings, contains brass works made by Simon Willard, Roxbury, Massachusetts, c.1810.

Gift of Mr. and Mrs. Walter Welch, 1971.

11 RUTLAND FALLS, VERMONT

*by Frederic E. Church (1826-1900),
oil on canvas, 1848.*

Church was a major 19th-century American landscape painter best known for his panoramic views of exotic areas in North and South America. Painted early in his career, this painting already exhibits his special emphasis on light and cloud effects.

Gift of the White House Historical Association, 1976.

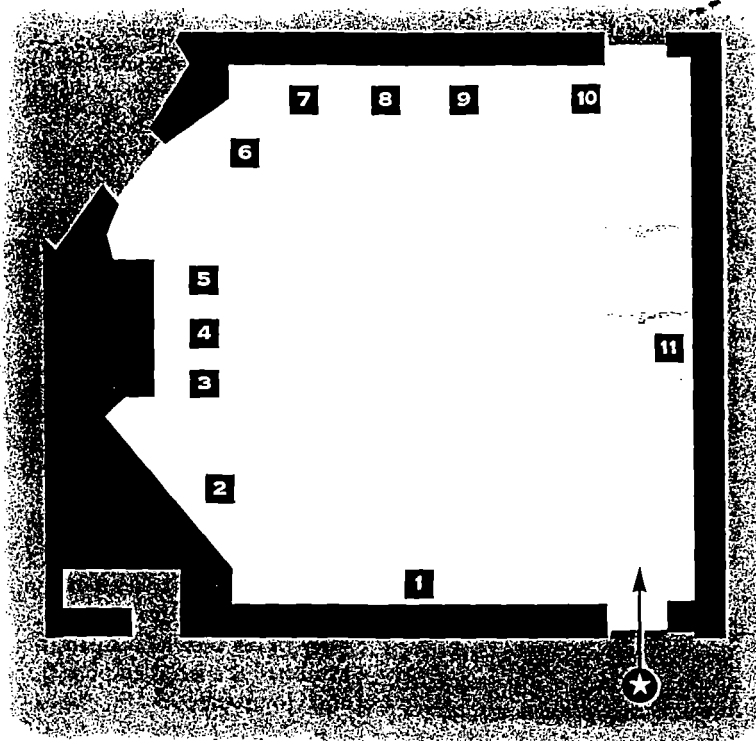
12 CANNONADING ON THE POTOMAC, OCTOBER 1861

*by A. Wordsworth Thompson
(1840-1896), oil on canvas, 1861.*

This Civil War scene was painted by Thompson from sketches which he made of the Battle of Ball's Bluff, on the Potomac River near Leesburg, Virginia, on October 21, 1861. Killed in the battle was Colonel Edward D. Baker, a longtime friend of Abraham Lincoln, after whom the president's second son was named.

Gift of the Edward and Mary Warburg Fund, 1962

THE ROOSEVELT ROOM



- 1 CROSSING THE RIVER PLATTE**
by Worthington Whittredge (1820-1910),
oil on canvas, c.1871.

Whittredge accompanied an 1865-66 military expedition across the Plains from Kansas to New Mexico. Back in New York he painted this scene of Indians fording the river in what is now eastern Colorado.

Gift of C.R. Smith, 1967.

- 2 THEODORE ROOSEVELT**
by James Earle Fraser (1876-1953),
bronze-finished plaque, c.1920.

Profile bust portrait with Roosevelt's quotation, "Aggressive fighting for the right is the noblest sport the world affords". The sculptor also designed the buffalo nickel.

Acquired by the General Services Administration in 1969.

3 ELEANOR ROOSEVELT

*after Victor Lamkay (?-?),
bronze-toned alvastone, c.1993.*

This commercial casting is taken from an original bust, copyrighted in 1963, at the Franklin D. Roosevelt Library.

*Gift of the Franklin and
Eleanor Roosevelt Institute, 1993.*

4 NOBEL PEACE PRIZE MEDAL

This gold medal, the first Nobel prize awarded to an American, was presented to President Theodore Roosevelt in 1906 for his mediation of the Russo-Japanese War peace settlement. Weighing about two pounds, it bears on its obverse a portrait of Alfred Nobel, the Swedish inventor of dynamite, whose fortune endowed the five prizes named for him. The reverse features three embracing figures and the Latin inscription, "For Peace and Fraternity among Mankind" in Latin.

*Gift of the Theodore Roosevelt Association, 1982,
on the 125th anniversary of the birth of
Theodore Roosevelt.*

5 THEODORE ROOSEVELT

*by Tade Szyka (1889-1954),
oil on canvas, c.1909.*

This equestrian portrait depicts Roosevelt in a tan uniform, possibly his Rough Rider outfit. It is believed to have been painted at the time that Roosevelt visited the artist's studio near Paris after his term of office.

Gift of the White House Historical Association, 1974.

6 FRANKLIN D. ROOSEVELT

*by John DeStefano (1915-?),
bronze plaque, c.1933.*

Sculpted in 1933 at the beginning of Roosevelt's first term, with a profile bust portrait and a quotation from the Roman statesman Seneca - "I shall hold my rudder true".

Lent by the Franklin D. Roosevelt Library, 1969.

7 FRANKLIN D. ROOSEVELT.

*by Alfred Jonniaux (1882-?),
oil on canvas, 1958.*

This portrait was painted from photographs under the supervision of Basil O'Connor, a close personal friend of President Roosevelt, and is considered to be one of the best likenesses.

Lent by the Franklin D. Roosevelt Library, 1978.

**8 VIEW OF THE CITY OF
WASHINGTON FROM THE
VIRGINIA SHORE**

*by William MacLeod (1811-1892),
oil on canvas, 1856.*

The artist, who painted himself at work in the lower right, executed this view of Washington from across the Potomac near his native Alexandria, Virginia. The most prominent structures of the somewhat distant city are the unfinished Washington Monument at the left, the U.S. Capitol with its earlier dome at center, and the Washington Navy Yard at the right.

Gift of Mr. and Mrs. Richard M. Scaife, 1971.

9 OUR VANISHING WILDLIFE

*by Alexander Pope (1849-1924),
bronze, c.1915-1924.*

The original sculpture of a bison battling wolves, from which this bronze was cast, was acclaimed at the 1915 Panama-Pacific Exposition in San Francisco.

Gift of The Barra Foundation, Inc., 1991.

10 TALLCASE CLOCK

Housed in a simple Federal-style mahogany case, the works of this clock were made by Charles Canby, Wilmington, Delaware, c.1830.

Gift of Dr. and Mrs. William A. Cobain, 1971.

11 BOOKCASE

This early 20th-century mahogany case is probably English.

Gift of Mr. and Mrs. A. Conger Goodyear, 1951

OUTSIDE *the* OVAL OFFICE

EAST WALL

ABRAHAM LINCOLN

by Augustus Saint Gaudens (1848-1907),

bronze, late 19th century, cast by the Roman Bronze Works, Corona, New York.

In 1887, Saint Gaudens, one of America's foremost sculptors, created a standing figure of Lincoln for Lincoln Park in Chicago, an especially expressive and successful memorial portrait. The head of that statue was the model for this later bust portrait.

Gift of the White House Historical Association, 1975.

MARBLE PEDESTAL

This dark green 19th century American pedestal features a circular fluted shaft on an octagonal base.

White House Acquisition Fund, 1976.

COMANCHE CHIEF, HIS WIFE & A WARRIOR

by George Catlin (1796-1872), oil on cardboard, 1857-1869.

Catlin was one of the greatest recorders of the life of the American Indian, becoming very adept at quickly capturing portraits and events in oils, preferring such on-site works to studio pictures created from sketches. From a collection of over 350 donated to the National Gallery by Paul Mellon in 1965.

Lent by the National Gallery of Art, 1982.

WEST WALL

GILDED BRONZE SCONCES

For the Theodore Roosevelt Renovation of the White House in 1902, many handsome classically-styled gilded bronze lighting fixtures were purchased from Edward F. Caldwell & Co., New York, for the Residence and the new West Wing office building. At least eight of this three-armed type were installed in the President's Room and Cabinet Room in 1902, although they were moved to other spaces when the West Wing was enlarged in 1909.

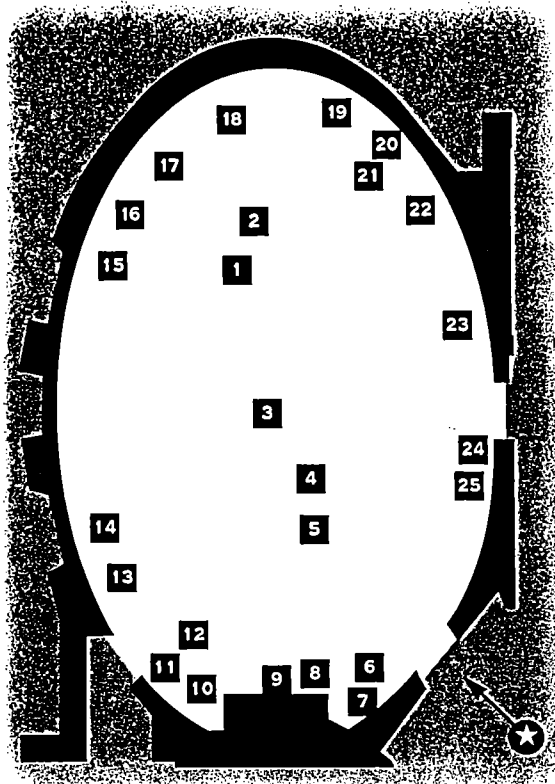
CEILING

EAGLE LANTERN

This English lantern, c.1800, features a spread-winged gilded wooden eagle over a diamond-cut glass bowl with four gilded double-dolphin chain mounts.

Gift of the White House Historical Association, 1972.

THE PRESIDENT'S OVAL OFFICE



1 "RESOLUTE" DESK

This double pedestal desk, usually called the "Resolute desk", was made from the oak timbers of the British ship H.M.S. Resolute as a gift to President Rutherford B. Hayes from Queen Victoria in 1880. It has been used by every president since Hayes, excepting Presidents Johnson, Nixon, and Ford, 1964-1977.

It was used in the President's Office on the Second Floor of the Residence from 1880 until 1902, at which time the office was moved to the newly constructed West Wing. This desk remained, however, on the Second Floor of the Residence in the President's Study. President Franklin D. Roosevelt requested that the rear kneehole be fitted with a panel carved with the

presidential coat-of-arms, but he did not live to see it installed in 1945.

After the Truman Renovation of the White House, 1948-1952, it was placed in the Broadcast Room on the Ground Floor where it was used by President Dwight D. Eisenhower during radio and television broadcasts. It was first used in the Oval Office in 1961 at the request of President John F. Kennedy. After President Lyndon B. Johnson selected another desk for his office, it was lent to a Kennedy Library traveling exhibition, 1964-1965, and then to the Smithsonian Institution for exhibition, 1966-1977.

In January 1977, President Jimmy Carter requested that this historic desk be returned to the White House for use again in the Oval Office. In 1981, President Ronald W. Reagan also chose to use this

desk in the Oval Office. President George Bush used it in the Oval Office for five months in 1989 before having it moved to his Residence Office in exchange for a partner's desk which he had used in his West Wing office as Vice President. On January 20, 1993, this historic desk was returned to the Oval Office for use by President Clinton. A brass plaque fixed to the desk records the history of its creation: "H.M.S. 'Resolute', forming part of the expedition sent in search of Sir John Franklin in 1852, was abandoned in Latitude 74°41' N. Longitude 101°22' W. on 15th May 1854. She was discovered and extricated in September 1855, in Latitude 67° N. by Captain Buddington of the United States Whaler 'George Henry'. The ship was purchased, fitted out and sent to England, as a gift to Her Majesty Queen Victoria by the President and People of the United States, as a token of goodwill & friendship. This table was made from her timbers when she was broken up, and is presented by the Queen of Great Britain & Ireland, to the President of the United States, as a memorial of the courtesy and loving kindness which dictated the offer of the gift of the "Resolute".

2 CANED-BACK ARMCHAIRS

Purchased for the new West Wing in 1902 from A.H. Davenport Co., Boston, five of the caned-back mahogany armchairs have been in use in the Oval Office since 1930. The sixth is a reproduction.

3 RUG

A new oval wool carpet (30'3" x 23'2") was woven in the United States by Scalandre for the 1993 redecoration of the Oval Office. A dark blue field centers a full-color Presidential Coat-of-Arms encircled by fifty white stars and framed by a gilt rope band. The border features green olive branches and gold laurel wreaths separated by red rosettes.

4 FEDERAL PEMBROKE TABLES

The two drop-leaf breakfast or "pembroke" tables were made in New York, circa 1785-1800.

Gift of the White House Historical Association, 1973, and the National Society of Interior Designers, 1960.

5 TABLE LAMPS

The pair of French Empire neoclassical porcelain urns mounted as lamps was made in Paris, c.1810.

White House Acquisition Fund, 1974.

6 HARRY S. TRUMAN

by Charles Keck (1875-1951), bronze, 1947, cast by Roman Bronze Works, Corona, New York.

Presented to President Truman in the Oval Office, where he had posed for the sculptor.

Gift of the American Legion, 1947.

7 CITY OF WASHINGTON FROM BEYOND THE NAVY YARD

by George Cooke (1793-1849), oil on canvas, 1833.

View across the Anacostia River, the White House at left center.

Gift of The Morris & Guendolyn Cafritz Foundation, 1972.

8 CHINESE JARS

The pair of tall porcelain jars was made in China in the K'ang Hsi period (1662-1722). The dogs on the lids are a Buddhist guardian symbol.

White House Acquisition Fund, 1973.

9 GEORGE WASHINGTON

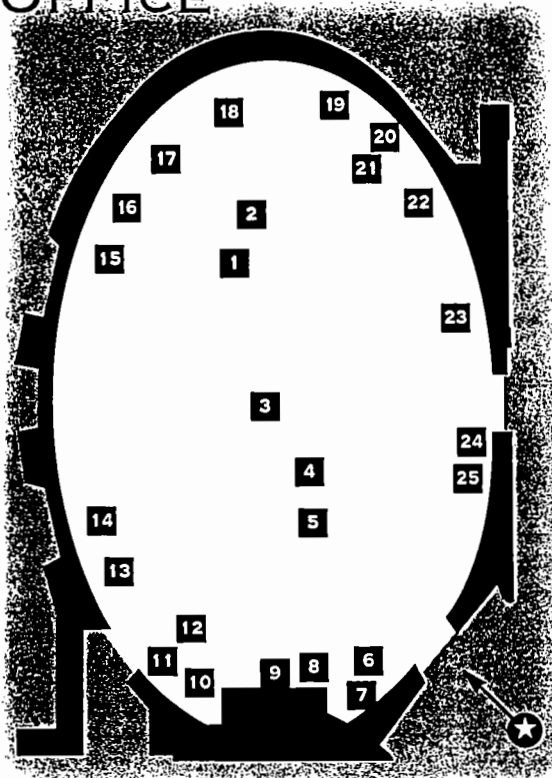
by Rembrandt Peale (1778-1860), oil on panel, c.1823.

Peale's original "porthole" likeness, begun in 1823, is believed to be the one which now hangs in the Old Senate Chamber of the United States Capitol. From it, Peale painted 79 similar portraits, some in civilian dress, some in uniform.

Gift of Mrs. John N.M. Howells, 1962.

THE PRESIDENT'S OVAL OFFICE

continued



10 BENJAMIN FRANKLIN

*by Jean-Antoine Houdon
(1741-1828),
bronze, c.1778-1828.*

Probably the most familiar depiction of this famous American statesman, largely because so many other artists copied it.

*Gift of J. William Middendorf, II, and the
White House Historical Association, 1980.*

11 THE THREE TETONS

*by Thomas Moran (1837-1926),
oil on canvas, 1895.*

Some of Moran's watercolors of the Yellowstone region helped to convince the U.S. Government to establish Yellowstone National Park in 1872. This view of the Idaho or western side of the Grand Teton Range was apparently executed from sketches made in 1879 during his only visit to those mountains.

Gift of C.R. Smith, 1966.

12 FEDERAL CARD TABLES

The pair of mahogany folding-top card tables was made in New England, possibly in Connecticut, 1790-1810.

Gift of Mrs. Francis B. Crowninshield, 1946.

13 TALL CASE CLOCK

The richly veneered case was probably made by John and Thomas Seymour, prominent Boston cabinetmakers, in the early nineteenth century. Although the dial is not marked, the works are possibly by James Douell of Charlestown, Massachusetts.

Gift of the White House Historical Association, 1972.

14 THE BRONCO BUSTER

*by Frederic Remington (1861-1909),
bronze, c.1903, cast by the
Roman Bronze Works, Corona, N.Y.*

*Gift of Miss Virginia Hatfield and Mrs. Louise Hatfield
Stickney in memory of their father,
James T. Hatfield, 1974.*

THE PRESIDENT'S OVAL OFFICE

continued

15 THE AVENUE IN THE RAIN

*by Childe Hassam (1859-1935),
oil on canvas, 1917.*

During and shortly after World War I, the streets of New York City were often hung with flags and banners in support of the Allied war effort, a subject often painted by Hassam.

Gift of T.M. Evans, 1963.

16 THE THINKER

*by Auguste Rodin (1840-1917), bronze,
cast by Alexis Rudier Foundry, Paris,
early 20th century.*

*Lent for President Clinton's Oval Office by
the B. Gerald Cantor Collection, 1993.*

17 FEDERAL CHEST OF DRAWERS

This simple mahogany chest is a mid-19th-century country version in the late-18th-century Federal style.

White House Acquisition Fund, 1962.

18 SOFA TABLE

This reproduction walnut table was acquired for the Oval Office in 1969.

19 CHINESE FISH BOWLS

The pair of large, circular porcelain bowls, originally used for gold fish but presently used as planters, was made in China, circa 1800.

Gift of Mrs. Lamont duPont Copeland, 1980.

20 THE PRESIDENT'S HOUSE

*by an unknown artist,
oil on canvas, mid-19th century.*

Based on engravings from a drawing by English artist, William Henry Bartlett (1809-1854), c.1836-37. Shows Tiber Creek, along which now runs Constitution Avenue.

Gift of Mr. and Mrs. Hawley S. Simpson, 1967.

21 APPEAL TO THE GREAT SPIRIT

*by Cyrus Dallin (1861-1924), bronze,
c.1916, cast by Gorham Co., New York.*

Dallin was an eloquent defender of the American Indian, particularly through four great equestrian statues which were later also executed in reductions such as this.

Gift of The Barra Foundation, Inc., 1991.

22 FEDERAL CHEST OF DRAWERS

The mahogany chest was made in Massachusetts, circa 1790.

Gift of the White House Historical Association, 1977.

23 GEORGE WASHINGTON, THOMAS JEFFERSON, AND ABRAHAM LINCOLN

sapphire miniature busts, 1950s.

After life portraits; carved from some of the world's largest sapphires found in Queensland, Australia - Washington (1056 carats), Jefferson (1381), and Lincoln (1318).

Gift of the Kasanjian Foundation, 1988.

24 ANDREW JACKSON

*by Thomas Sully (1783-1872),
oil on canvas, c.1824.*

From this likeness, or prints made after it, was engraved the image on the \$20 bill.

Lent by the National Gallery of Art, 1976.

25 EAGLE CARD TABLE

The mahogany folding-top card table with the gilded eagle pedestal is attributed to Salem, Massachusetts, circa 1810.

Gift of the White House Historical Association, 1972.



WEST WALL

FRENCH PORCELAIN PITCHER

The late-19th-century pitcher made for the American market is decorated on one side with an American eagle and crossed flags.

Gift of Mr. and Mrs. Joey Bishop, 1962.

CLEVELAND DINNER PLATES

The pair of Wedgwood plates, red-edged with gilt swags, is from a set of 60 purchased by Mrs. Frances Cleveland in 1893.

GILDED SILVER BASKETS

The pair of baskets made by London silversmiths John Wakelin & William Taylor, 1780-1788, bear the coat-of-arms of the British Order of the Garter.

From the collection bequeathed to the White House by Mrs. Margaret Thompson Biddle, 1958.

FRENCH PORCELAIN VASE

The small cobalt blue and gold vase was made c.1800-1810.

Gift of Miss Pauline Herrmance, 1961.



FIREPLACE

MANTEL

The classical white marble mantel was installed in the original Oval Office in 1909 and retained when the room was moved during the 1934 expansion of the West Wing.

FEDERAL ANDIRONS

The urn-finished brass andirons are American, c.1780.

Gift of the White House Historical Association, 1973.

FEDERAL FIREPLACE FENDER

The serpentine fender was probably made in New York, c.1800.

Gift of Sotheby-Parke Bernet, Inc., 1973.



CENTER

CHIPPENDALE-STYLE ARMCHAIRS

The pair of modern tall-back chairs was acquired for the Oval Office in 1981.

PAIR OF SOFAS

The pair of modern sofas was acquired for the Oval Office in 1989.

COFFEE TABLE

The oval coffee table, with a central inlaid star, was specially designed for the 1993 redecoration of the Oval Office.

OUTSIDE *the* CABINET ROOM

WEST WALL

FORDING THE HORSE HERD

by Charles Marion Russell (1864-1926), oil on canvas, 1900.

Russell strongly identified with the Indians he painted and sculpted. This early morning scene of Blackfoot Indians was painted in the year that Russell built his Montana home as his reputation was increasing.

Gift of Dr. and Mrs. Armand Hammer, Dr. and Mrs. Ray Irani, Mr. and Mrs. John Kluge, Mr. and Mrs. Carl Lindner, the Milken Family Foundation, and the Armand Hammer Foundation, 1987.

TABLE LAMPS

This pair of Chinese porcelain Ming Dynasty vases, c.1522-1566, now mounted as lamps, feature blue decoration of beaded strings over seahorses among waves.

Gift of Mrs. W. Murray Crane, 1955.

NORTH AND EAST WALLS

EXCAVATING A CANOE - NASS; VIEW ON THE LOWER MISSISSIPPI TWO PAWNEE CHIEFS; COMANCHE CHIEF WITH THREE WARRIORS OJIBWA INDIANS; THREE NAVAJO INDIANS

by George Catlin (1796-1872), oil on cardboard, 1857-1869.

Catlin was one of the greatest recorders of the life of the American Indian, becoming very adept at quickly capturing portraits and events in oils, preferring such on-site works to studio pictures created from sketches. From a collection of over 350 donated to the National Gallery by Paul Mellon in 1965.

Lent by the National Gallery of Art, 1982.

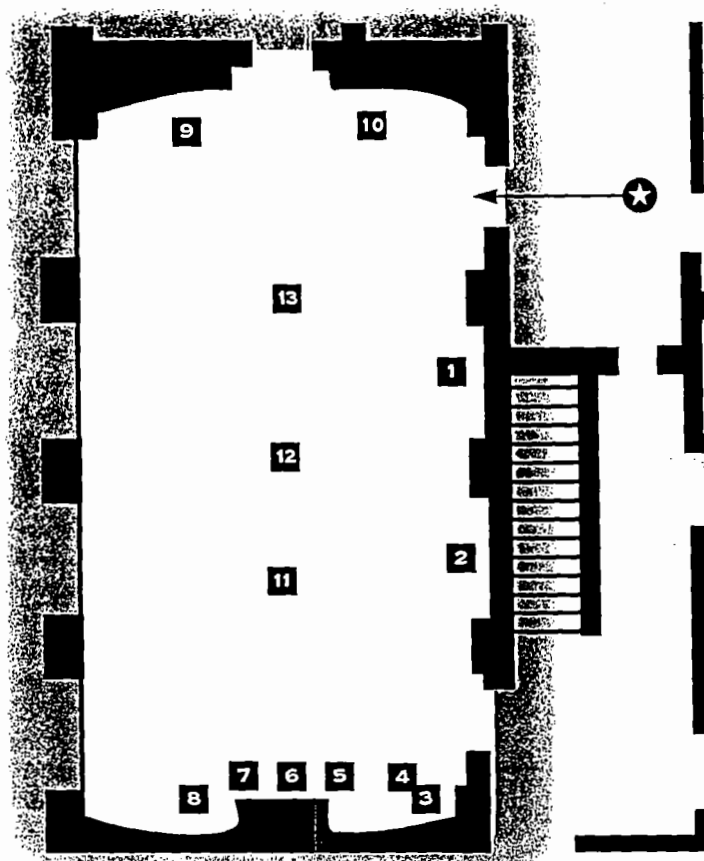
SOUTH WALL

TALL CASE CLOCK

Philip Garret, a Philadelphia clockmaker and silversmith, made or marketed, c.1802, the brass weight-driven works which he placed in this handsome Federal case, with its scrolled pediment, fluted columns, fan inlays, and painted dial.

White House Acquisition Fund, 1971.

THE CABINET ROOM



1 ABRAHAM LINCOLN

by George Henry Story (1835-1922),
oil on canvas, c.1915.

After sketches Story made of President Lincoln in his White House office (now the Lincoln Bedroom) in June 1861.

Gift of the White House Historical Association, 1981.

2 THOMAS JEFFERSON

by George P. A. Healy (1813-1894),
oil on canvas, c.1842-1860.

Based on a life portrait by Gilbert Stuart; part of a series of presidential portraits commissioned in 1842 by Louis Philippe, King of the French, for the gallery at Versailles but never delivered as the King was overthrown in 1848.

Lent by the Corcoran Gallery of Art, 1982.

3 GEORGE WASHINGTON

by Hiram Powers (1805-1873),
marble, 1860.

Many prominent Americans, including Presidents Andrew Jackson and Martin Van Buren, posed for Powers early in his career. This white marble bust of Washington, not a life portrait, was created after commissions for statues of Franklin and Jefferson, for the U.S. Capitol.

Gift of the White House Historical Association, 1981.

4 COMMODO PEDESTALS

The tall mahogany pedestals, made c.1805, probably in England, are each fitted with a drawer and cabinet.

Gift of Andrew P. Fuller, 1969.

5 CLOCK-BAROMETER

This combined instrument was used on the U.S.S. Williamsburg when it served as the presidential yacht during the Truman administration and was probably transferred when the ship was decommissioned in 1953.

6 THE DECLARATION OF INDEPENDENCE OF THE UNITED STATES OF AMERICA, JULY 4, 1776

by Charles-Edouard Armand-Dumaresq (1826-1895), oil on canvas, c.1873.

This depiction of the Second Continental Congress adopting that historic document on July 4, 1776, was a preliminary oil sketch for an painting that the artist exhibited at the 1876 Centennial Exposition in Philadelphia.

Gift of Sam Salz, 1961.

7 MANTEL

The large white-painted wooden mantel has been situated in the West Wing Cabinet Room since its creation in 1902, having been moved each time the room was repositioned. It was made by the Norcross Brothers, Worcester, Massachusetts, the builder of the West Wing.

8 BENJAMIN FRANKLIN

after Jean Jacques Caffieri (1725-1792), marble, early 19th century.

After an original terra-cotta bust modeled from life in 1777, when Franklin was the American emissary to the French court.

Gift of Joseph H. Hennage, 1976.

9 THEODORE ROOSEVELT

by Philip Alexius de Laszlo (1869-1937), oil on board, 1910.

De Laszlo first painted Roosevelt in 1908 from sittings at the White House. This second portrait was painted, as inscribed, in Paris in 1910, during a post-presidential tour of Europe.

Gift of Dr. and Mrs. W. Benjamin Bacon, 1971.

10 GEORGE WASHINGTON

by Charles Willson Peale (1741-1827), oil on canvas, 1776.

General Washington, dressed in the buff and blue uniform of the Continental Army, was painted in 1776 for John Hancock; this is believed to be Peale's only full-size replica of that portrait. The background shows the port of Boston, commemorating Washington's successful siege of that city in 1775.

Gift of Mr. and Mrs. Lansdell Christie, 1979.

11 CABINET TABLE

This large oval mahogany table (22 1/2 x 7 feet) was made by the Kittinger Company of Buffalo, New York, and donated for use in the Cabinet Room by President Richard M. Nixon.

12 CABINET CHAIRS

Traditionally, when Cabinet members conclude their terms of service, they are permitted to purchase their cabinet chairs, which bear brass plaques marked with their offices and dates of service. The taller chair at the center of the east side of the table is occupied by the President.

The Queen Anne style was selected in 1970 and was modeled after chairs in the Council Chamber at Colonial Williamsburg.

13 RUG

The blue-green wool rug made by Carpet Masterpieces, Inc., New York, N.Y., was ordered during the Johnson administration but installed early in the Nixon administration in 1969.

HALLWAY to RECEPTION LOBBY

NORTH WALL

ENGLAND AND AMERICA. THE VISIT OF HER MAJESTY QUEEN VICTORIA TO THE ARCTIC SHIP RESOLUTE-DECEMBER 16TH, 1856

after W. Simpson, engraved by G. Zobel,

published by P.D. Colnaghi & Co. and E. Gamber & Co., London, engraving, 1859.

This scene shows Captain Henry Hartstene, U.S. Navy, greeting Queen Victoria and family aboard H.M.S. Resolute after its return to Great Britain in 1856. An Arctic exploration ship abandoned in the Canadian ice pack in 1854, the Resolute was extricated in 1855 by an American whaler. The U.S. Government purchased, refitted, and returned it to Great Britain as a gesture of goodwill. When it was dismantled in 1878, a desk was made from her timbers, at the request of Queen Victoria, and presented to President Rutherford B. Hayes in 1880. This is the desk now in the Oval Office.

Gift of Miss Marion Pixley, 1961.

WHITE HOUSE, WEST TERRACE

by Jules Guerin (1866-1946), pencil and gouache on canvas, 1903.

The 1902 Theodore Roosevelt Renovation of the White House by noted New York architects, McKim, Mead & White, included the construction of an office building at the end of the colonnaded terrace built under Thomas Jefferson, 1805-1808. Prior to 1902, the President's offices had been located on the Second Floor of the Residence. Illustrations which Guerin drew for an article about the renovation in the April 1903 issue of Century Magazine were also used by the U.S. Government in the official published report of the renovation. This drawing shows the terrace and the new "West Wing", with the State, War & Navy Building (now the Old Executive Office Building) in the background.

*Gift of the Class of 1965, Maine East/Maine South High Schools, Park Ridge, Illinois,
in honor of Hillary Rodham Clinton, 1995.*

SOUTH WALL

ARCHERY OF THE MANDANS: O=JIB=BE=WAY=S

*after George Catlin, drawn on stone by McGahey, lithographed by Day and Haghe, London;
hand-colored lithographs, 1844.*

From Catlin's North American Indian Portfolio, these two prints were derived from paintings Catlin executed while traveling on the Great Plains - up the Missouri River in 1832 (Mandans) and up the Mississippi River in 1835 (Ojibways).

Gift of Mrs. Jacob M. Kaplan, 1963.

SOUTH FRONT OF THE WHITE HOUSE

by Jules Guerin (1866-1946),

pencil on canvas, 1903.

In 1902, the White House was renovated for President and Mrs. Theodore Roosevelt by the noted New York architects, McKim, Mead & White. Illustrations which Guerin drew for an article about the renovation in the April 1903 issue of Century Magazine were also used by the U.S. Government in the official published report of the renovation. This drawing is a variation of one which was published.

Gift of the White House Historical Association in memory of T. Sutton Jett, 1990.

DRAFT OP ED: MEDICARE FIRST

September 3, 1999: 7:00pm (749 words)

Neema - This is
a draft of ed
that Gene's
working on, but
it's the way we've

Medicare -- like virtually every other aspect of the American economy -- has prospered from the robust growth and fiscal discipline of the Clinton-Gore Administration. Strong management has slashed fraud and abuse has returned more than \$1.2 billion to the Medicare trust fund in the last two years alone. Policies in 1993 and 1997 reformed outdated payment systems and helped reduce Medicare spending growth to 5 percent per capita for the next 5 years. And, low unemployment and higher wages have shored up the revenue in Medicare's trust fund [revenue in 1998 was \$9 billion or 7 percent higher than predicted in 1997]. When President Clinton took office in 1993 the Medicare trust fund was expected to become insolvent by [1999]. As a result of these changes, expected solvency has been extended to 2015. *(talking about solvency)*

However, there should be no false sense of complacency. Medicare becomes insolvent nearly 20 years before Social Security -- and perhaps sooner. Its projected prognosis has worsened 8 times in the last 29 years, meaning that 2015 may be optimistic.

The uncertainty about the Medicare insolvency date sharply contrasts the inevitable and indisputable challenges it faces. Medicare's enrollment will double from 39 to 72 million by 2032 as the baby boom generation retires. By 2030, the proportion of Americans who are elderly will rise from 12 to 20 percent. And, as medical breakthroughs continue to lengthen lives, Medicare will have to adapt to caring for people longer and addressing the unique needs of people age 90, 100 and older.

As certain as the demographic change is the fact that Medicare savings alone cannot fund the doubling of its enrollment. Its growth per beneficiary would have to be held at a rate that is more than 60 percent below that of the private insurance projections -- below inflation in every year -- to extend solvency to 2027. [get Donna's chart / add HHS new fact on spending cuts needed]

To put the size of these reductions into perspective, compare these reductions to the Balanced Budget Act (BBA) of 1997. Hospital spending would need to be cut x percent more than the BBA to keep Medicare solvent to 2027. Given the concerns about BBA itself, which the President has proposed to address in his plan, this would be devastating.

President Clinton not only recognizes the urgency of Medicare's challenges but has proposed a plan to address them. As part of this reform package, the President's budget proposes to dedicate over \$300 billion of the non-Social Security budget surplus over 10 years. His plan, which includes policies to make Medicare more competitive and efficient and add a long-overdue prescription drug benefit, is projected to keep Medicare solvent for the next 25 years.

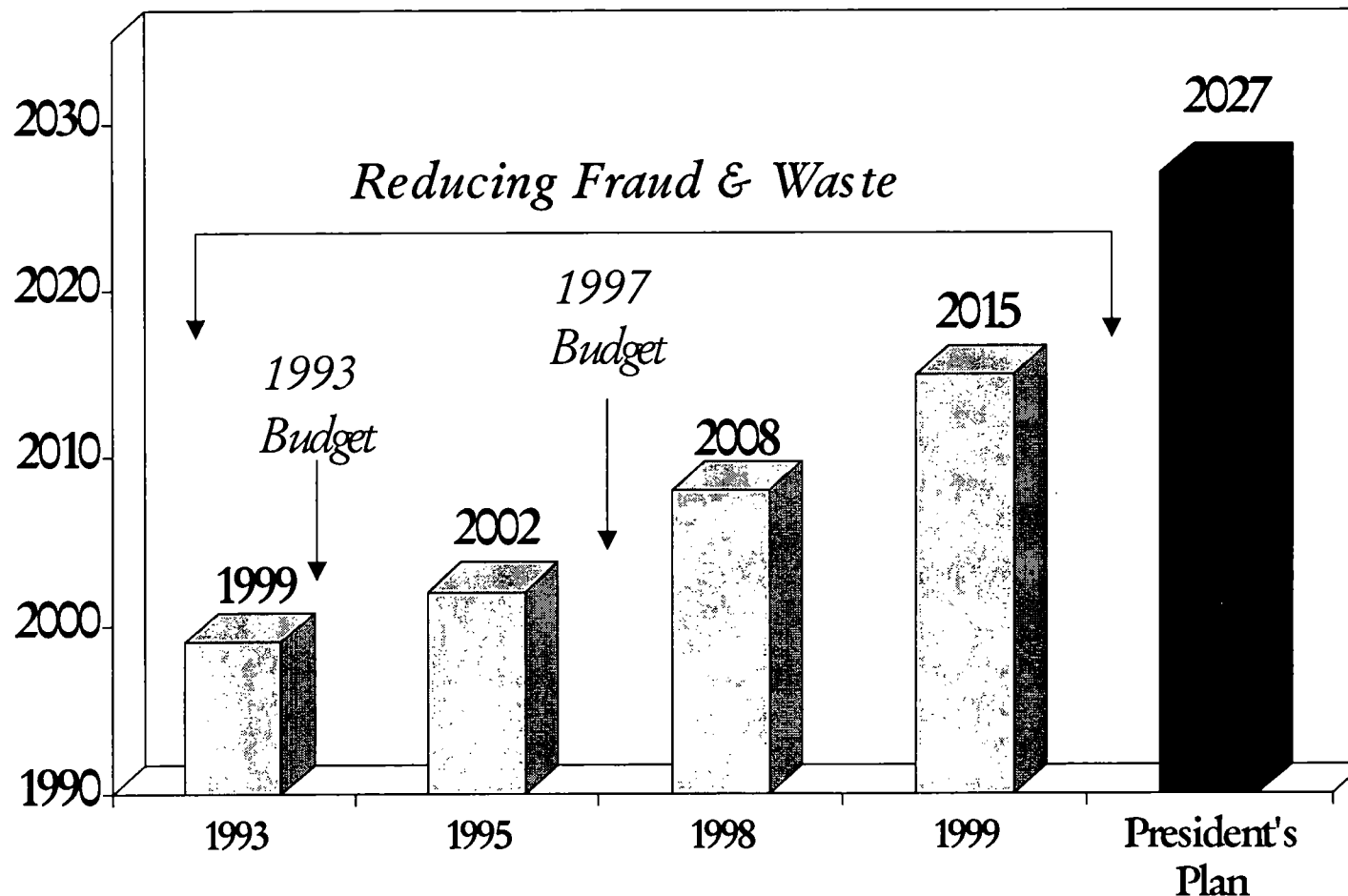
Locking a large part of the on-budget surplus in the Medicare trust fund is good policy in several respects. It solidifies our commitment to pay for basic health care for our seniors and people with disabilities. It helps reduce debt faster since if Medicare's trust fund it will not be needed for over a decade. Paying down a dollar of debt today will help the government afford to pay benefits when they are needed. This dedication of the surplus to solvency alone reduces interest payments by about \$200 billion over 15 years. Buying down debt also helps the Nation prepare for the retiring baby boomers, helping to boost national savings which leads to lower interest rates, a larger capital stock, a more productive workforce, a higher standard of living, and an enhanced ability to finance future Medicare [and Social Security?] obligations.

In contrast, if the entire on-budget surplus were used for a tax cut, then there would be less certainty about Medicare's future, less debt reduction, and, perhaps most importantly, no margin of error. Mistakes in the projected surplus today would lead to a larger tax cut than we can afford. This would require future generations to implement additional program cuts, raise taxes or return to deficit spending.

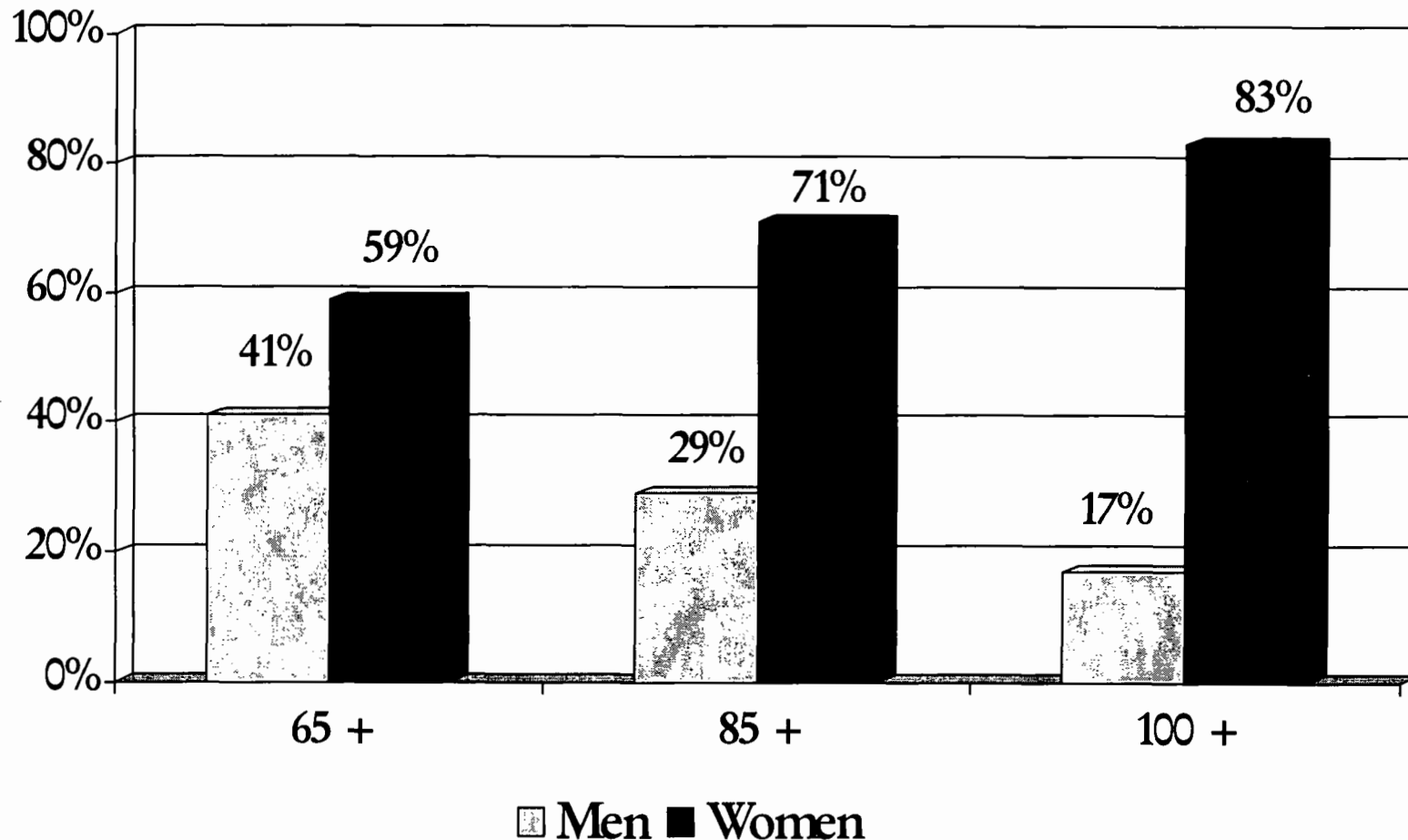
This is a decisive moment in our history: how, as a nation, will we choose to manage the unprecedented surplus that our strong economy and policies have generated? Will we stow it away to ensure that Medicare is strong and debt is reduced? Or will we immediately dissolve the surplus through a tax cut, leaving our children to deal with our parents' health care needs? [add something about bipartisanship] From an economic perspective, the answer is clear: save Medicare first.

Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027

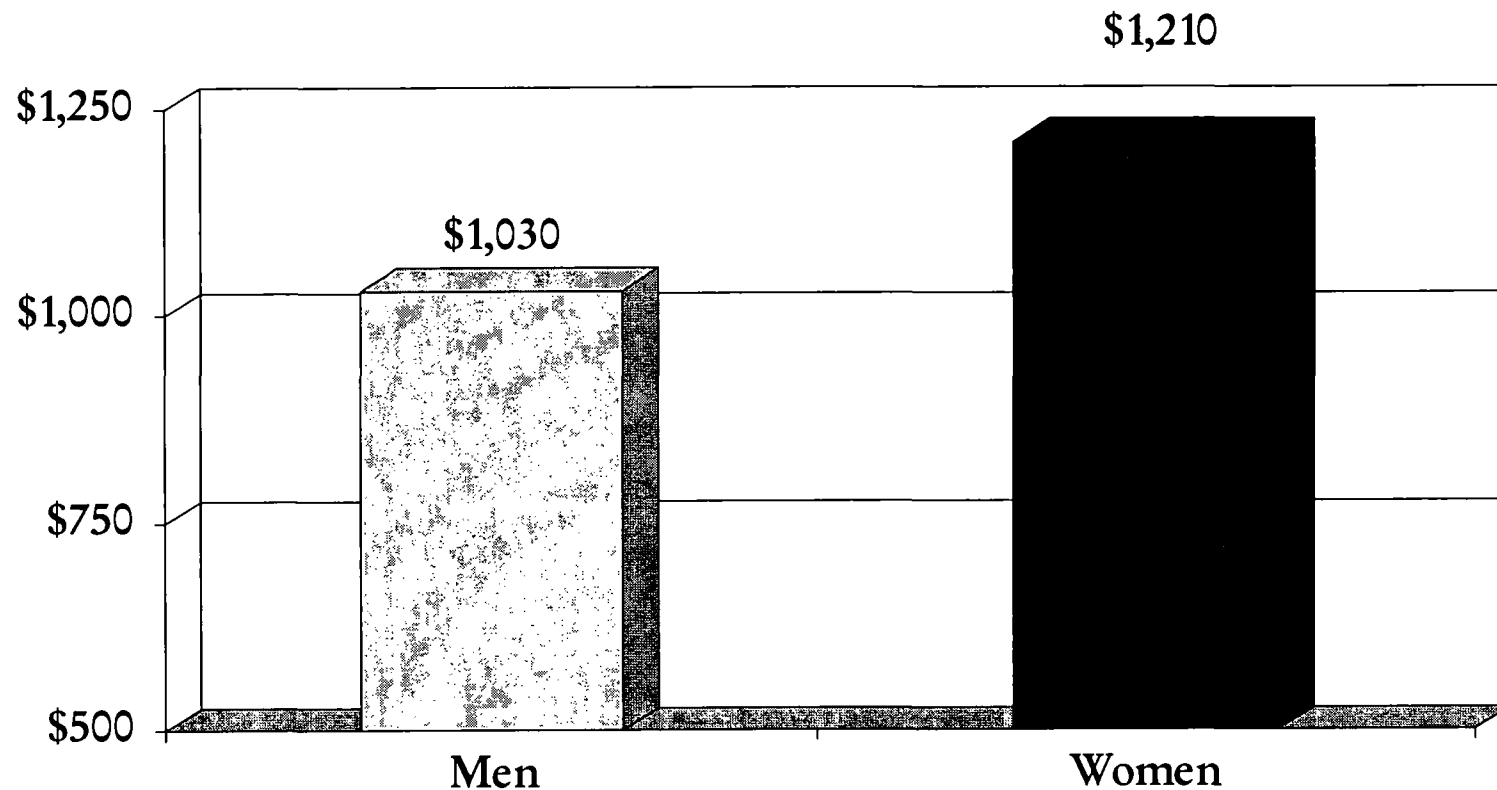


Most Medicare Beneficiaries Are Women



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

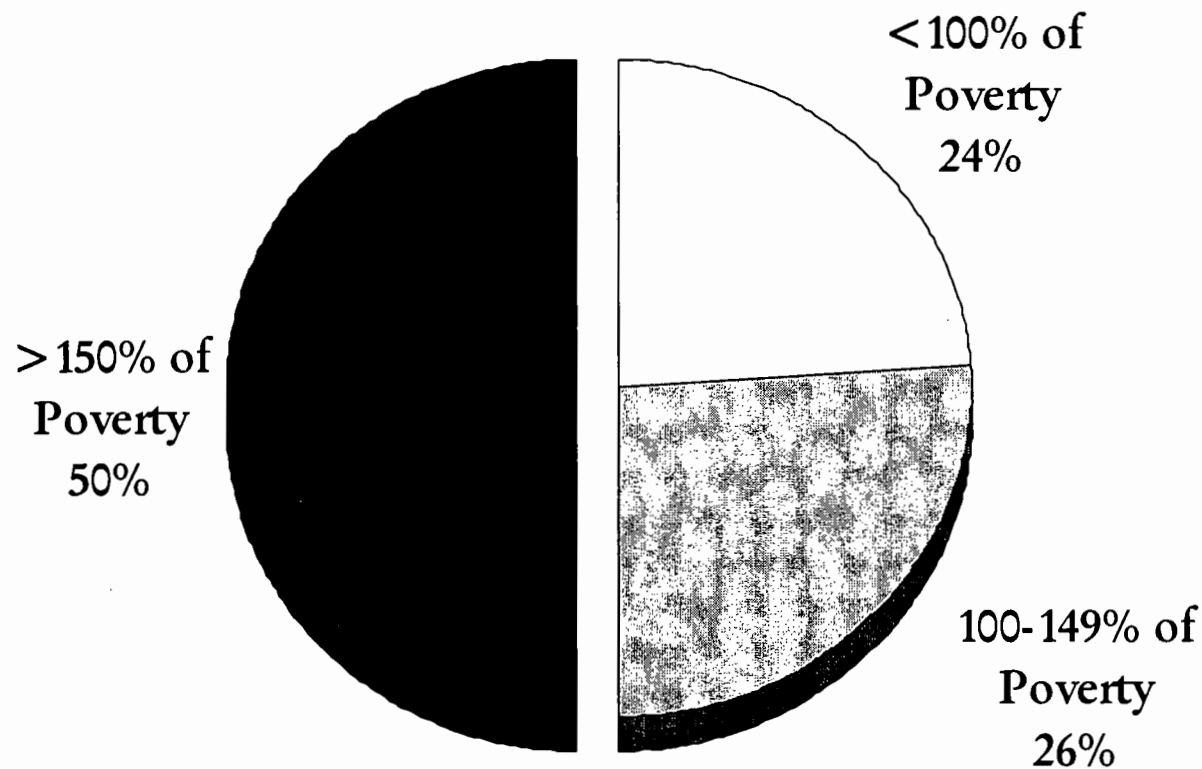
Total Prescription Drug Spending For Women On Medicare Is \$1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

Source: Actuarial Research Corporation. As cited in OWL Report

Half Of Women on Medicare Without Drug Coverage Are Middle Income

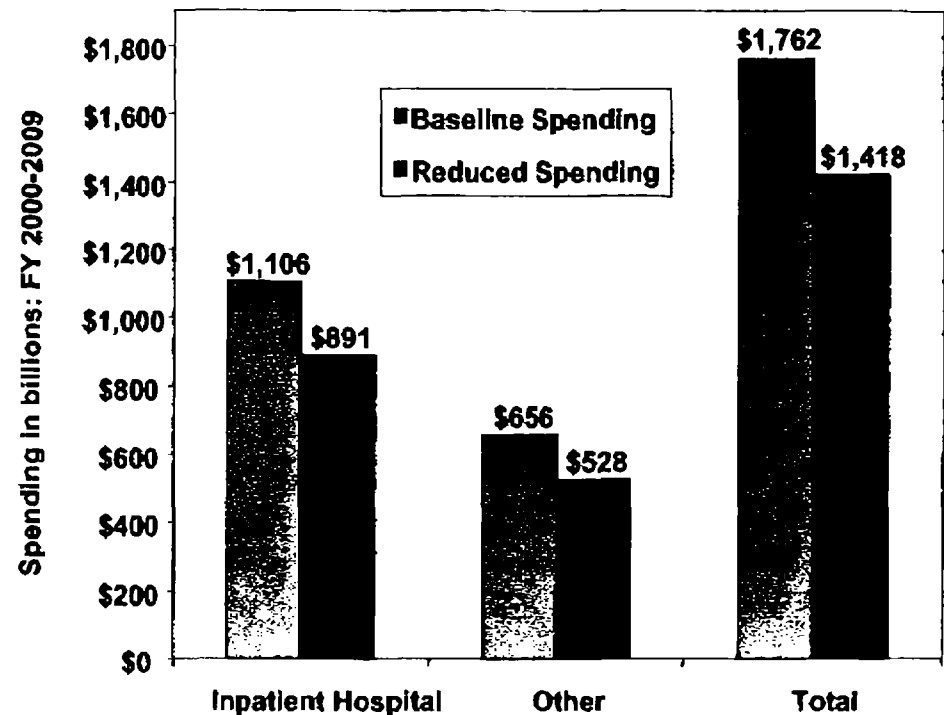


Source: Actuarial Research Corporation. As cited in OWL Report
150% of poverty is about \$12,750 for a single, \$17,000 for a couple in 2000

Large Medicare Cuts Necessary If No Transfer of Budget Surplus

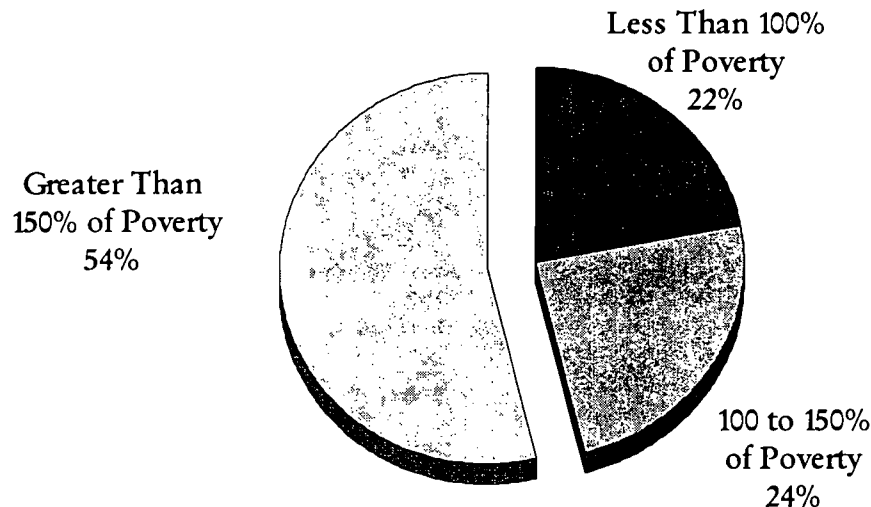
- President's proposal to transfer 15% of budget surplus would extend life of Trust Fund
- Without transfer and other Medicare changes, 20% cut in Part A spending would be required for same effect on Trust Fund
- Inpatient hospital spending would need to be cut \$215 billion over 10 years

**Part A Reductions to Achieve
Same Impact as Surplus
Transfer: FY 2000-2009 (20% cut)**



Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

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



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

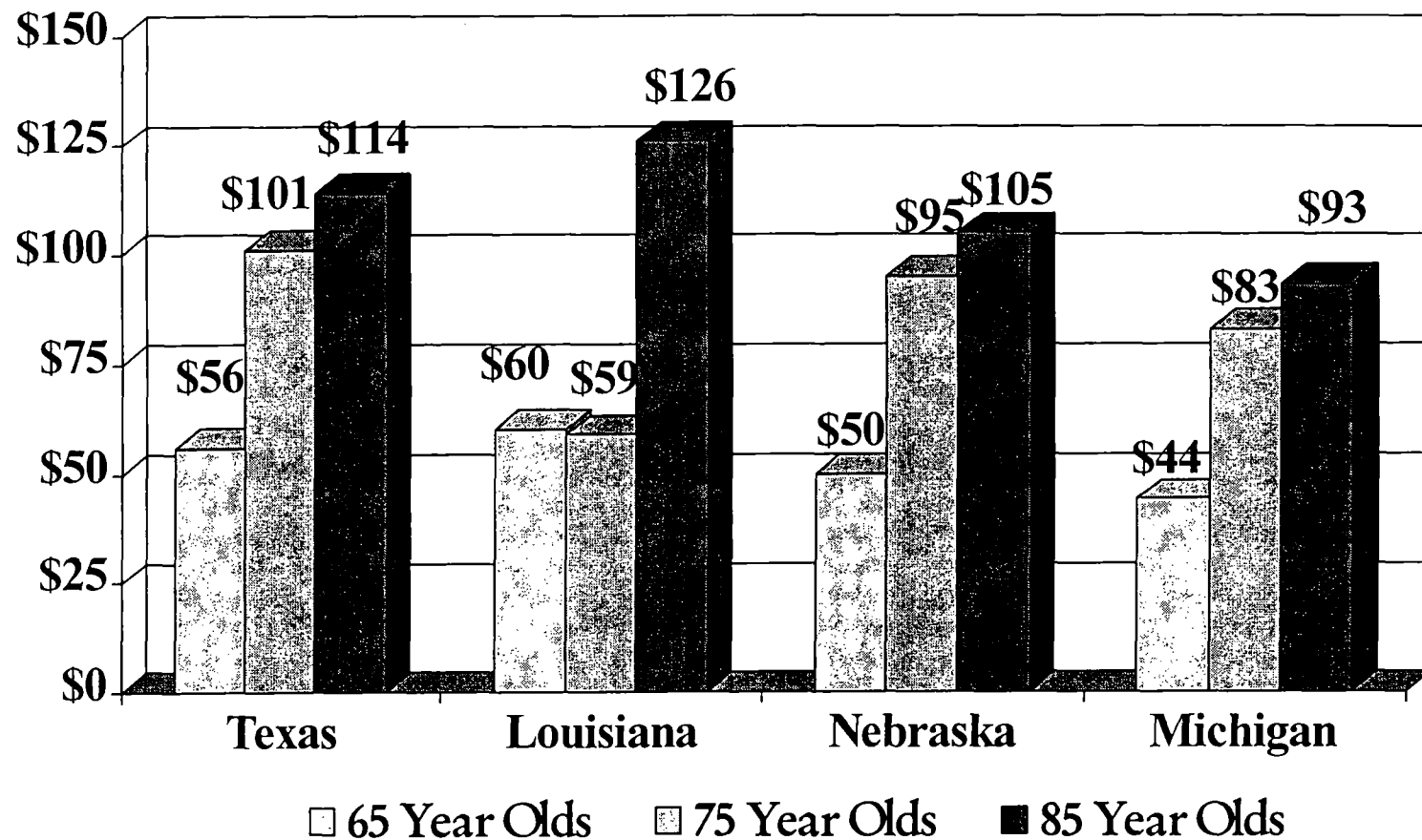
Disproportionately Affects:

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

SOURCE: Actuarial Research Corporation for HHS, 2000

In 2000, 150% of poverty for a single person is about \$12,750, for a couple is about \$17,000

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

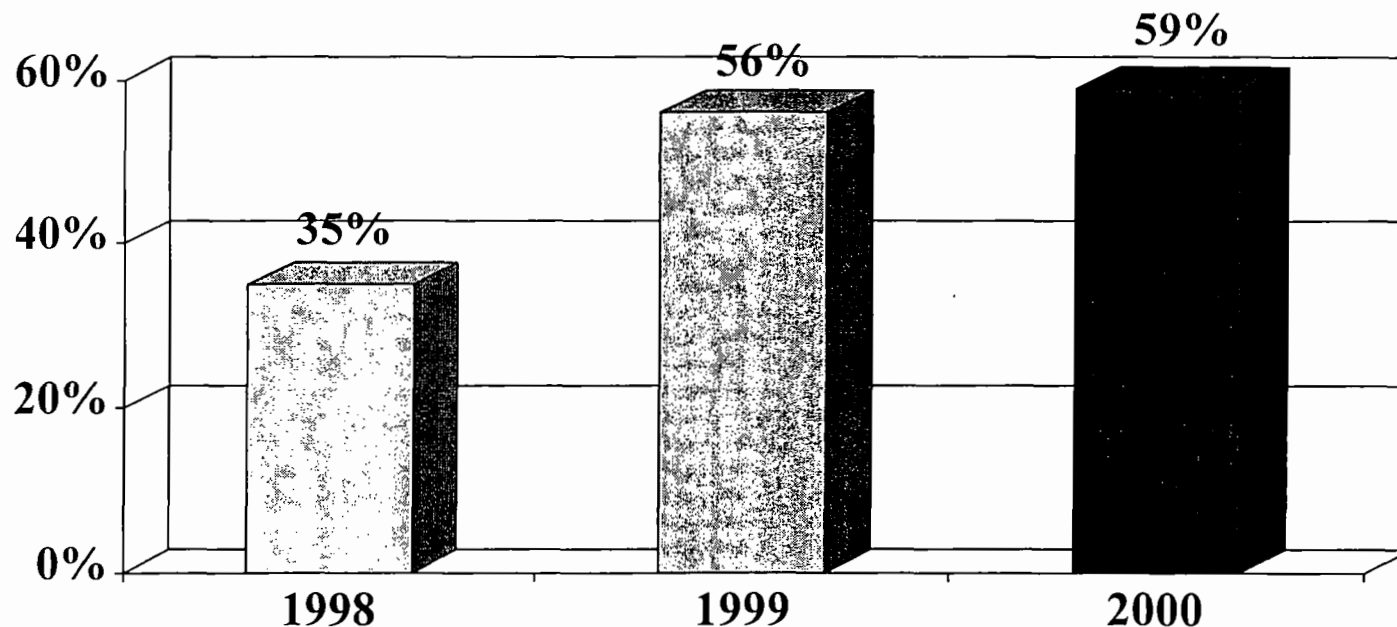


Sample Premiums for 1999. Difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost \$24 per month.

Value of Medicare Managed Care Drug Benefits Is Declining

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

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

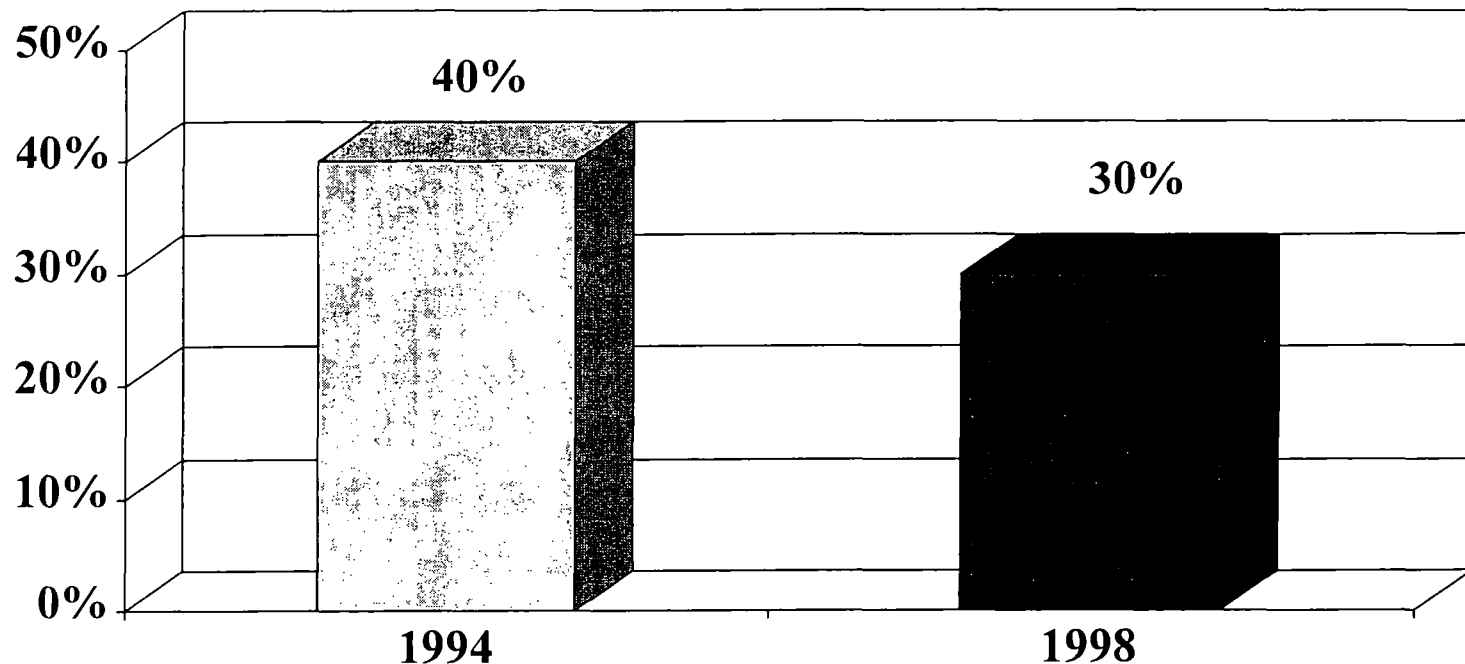


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits

Firms Offering Retiree Health Coverage



SOURCE: Foster-Higgins, 1998

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FAX COVER SHEET



OFFICE OF LEGISLATION

Number of Pages: 6Date: 9/10/99To: Chris Jennings
DevoraFrom: Paul CottonFax: 456-5557Fax: 202-690-8168 or 205-5157

Phone: _____

Phone: 690-6277REMARKS: _____

_____**HEALTH CARE FINANCING ADMINISTRATION**200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

**Medicare Rights Center****Medicare Rights Center's Cases and Policy Options
Monthly HCFA/Advocates Meeting
September 9, 1999**

*Copies for Paul C.
Nancy DeLee
Sharman
Don
Jennifer B
Anne Scott
Ira
ous: BW*

MRC helps seniors and people with disabilities on Medicare through telephone counseling, public education, and public policy work. MRC, under a contract with the New York State Office for the Aging, with funding from the Health Care Financing Administration, operates New York State's Health Insurance Assistance Program (HIICAP) hotline. Each year, we field approximately 50,000 hotline calls from people with Medicare questions and problems and provide direct assistance on a variety of Medicare issues to more than 7,000 individual callers.

MRC has heard from many clients who have reached caps on Medicare payments for physical and occupational therapy and both a large and an increased number of clients who are having trouble getting and maintaining home health care. MRC has not heard from a large or increased number of consumers who are having trouble gaining admission to a skilled nursing facility.

Physical and Occupational Therapy

MRC has received more than thirty-five calls in the past few months from clients who have been denied continued coverage for their physical or occupational therapy and who called the MRC-HIICAP hotline to find out why.

MRC Case Study: Mr. M's son is on Medicare because of a disability that requires on-going physical therapy. He contacted MRC after receiving bills for physical therapy that exceeded the \$1500 cap. He could not understand "how they could bill his son so much."

Home Health Care

Since October 1997, when the Interim Payment System (IPS) was implemented for Medicare home health care, callers have been contacting the MRC-HIICAP hotline on a regular basis when their home health care or the home health care of a relative or client is reduced or terminated. The number of callers experiencing home health reductions or terminations increased 300% after implementation of IPS. Frequently, these callers are confused about their rights under Medicare and do not understand the system for appealing.

Based on our clients' experiences, MRC believes that IPS has rendered the Medicare home

health benefit inadequate for clients with serious and chronic conditions. In the past year, we have seen certified home health agencies (CHHAs):

- 1) Reduce or terminate services prematurely on the grounds that Medicare does not cover "chronic care" or "maintenance therapy."
- 2) Screen out potential clients and refuse to do assessments for clients with expensive illnesses and chronic conditions, such as Multiple Sclerosis, chronic kidney failure, Parkinson's Disease, and diabetes.

Numerous callers, including those with chronic conditions, have told MRC-HIICAP counselors that their CHHAs have incorrectly told them that Medicare no longer covers people with chronic conditions. Perhaps even more worrisome is the resignation expressed by our clients that the Medicare home health benefit no longer exists as a meaningful benefit.

MRC Case Studies:

- 1) MRC recently received a call from a social worker in Philadelphia who was worried about a client being terminated by a CHHA. A CHHA representative told the social worker that she needed to find a new home health agency for her client because the current agency had exhausted its payments from Medicare and was no longer willing to provide services. The CHHA representative told the social worker that if she found a new agency, Medicare would start payments again.
- 2) Mr. F had two strokes which left him blind and paralyzed on one side of his body. He was unable to get home health care when discharged from the hospital because the CHHAs in his area claimed they were short-staffed.
- 3) Mrs. P had been receiving home health care for Multiple Sclerosis when her CHHA terminated service, claiming that Medicare would no longer cover the services. Although Mrs. P's physical therapist wanted to extend therapy because of the improvement she was making, the CHHA coordinator decided to terminate services. The coordinator informed Mrs. P that Medicare would no longer pay because she only needed maintenance therapy, but refused to put anything in writing. MRC contacted the CHHA and, after considerable effort, got them to extend care. During the next six months the CHHA threatened Mrs. P with termination several more times. Finally, Mrs. P switched CHHAs.
- 4) Ms. P has a disabling stenosis of the spine and arthritis. She contacted MRC after a CHHA representative told her that Medicare was "turning off" her home care. Ms. P never received a formal letter of discharge. MRC was eventually able to get her home health care extended.

Policy Options:

These cases are a few examples of people on Medicare who are having trouble getting the physical therapy and home health care they need. Often, consumers receive incorrect information from health care providers about the BBA regulations. To address these problems, MRC recommends the following actions:

- 1) **HCFA should create an identified unit in each regional office of HCFA that investigates allegations of CHHA misconduct.** This unit of HCFA would sanction CHHAs that illegally refuse care for patients because of the high cost of their care, or give people on Medicare incorrect information about their rights and benefits in Medicare.
- 2) **HCFA should do an analysis of the payment system to certified home health agencies.** CHHAs should not have a financial incentive to "cherry pick" and to refuse to give care to high cost clients and clients with serious or chronic conditions.
- 3) **HCFA should required CHHAs to issue a standardized Advance Beneficiary Notice (ABN) whenever services are reduced or terminated.** The ABN should developed with a literacy expert and should be focus-group tested for readability and usefulness. The ABN should prominently explain the patient's right to appeal.
- 4) **Medicare's physical therapy cap must be increased.** \$1,500 is an unrealistic cap for people with chronic conditions or serious injuries. By 2020, there will be 12 million people age 65 and over with a limitation in a major activity due to a chronic condition. Adequate physical therapy could keep some of these people out of the hospital at a greater cost for Medicare.

MEMO

To: Vicki Gottlich

From: Ellen Lang
Brad Plebani
Judy Stein

Re: Your Inquiry Regarding Increase in Beneficiary Contacts

Date: September 8, 1999

We have reviewed the Center for Medicare Advocacy's telephone call logs and can report the following increase in contacts from beneficiaries:

Home Health Contacts:

In February 1998, telephone calls from beneficiaries increased by 300% from the previous month. This increase was attributable to the IPS and the change in coverage for venipuncture. Home health calls stayed at a significantly higher level (on average about twice the normal level) through August, 1998, after which they returned to normal levels (normal = about 100 home health calls per month).

Our logs and other records indicate that during the period from February, 1998 through August, 1998, home health calls were from beneficiaries in 12 states and the District of Columbia. In 1999, thus far, we have received calls from beneficiaries in 34 states and the District; most, although not all, such calls are attributable to home health issues (some are SNF cases and other issues as well).

SNF Contacts:

SNF telephone calls stayed within the normal range from July, 1998 through January, 1999. However, beginning in February, 1999, SNF calls nearly doubled and that rate remains the same to date. (normal = about 35 SNF calls per month). Most of these calls are attributable to SNF access problems. In fact, we have made four referrals to the State regarding SNF waiting list violations, something we have not done for years.

Physical Therapy Contacts:

We have had two contacts in 1999 from beneficiaries who reported that they were told they had reached a "cap". Both beneficiaries have diagnoses of multiple sclerosis. After being terminated from home health services, one ceased receiving therapy services altogether; the other began receiving PT as an outpatient, but reached the \$1500 cap and **then** ceased receiving therapy services. Of course, prior to the institution of IPS our office never received calls from beneficiaries saying they had been told that they reached a "cap" on services.

DATE: 9-8-99

**U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES**
ROOM 416G, HUMPHREY BUILDING
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WASHINGTON, D.C. 20201

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

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☐ ALICE ARTIS

TOTAL PAGES

(INCLUDING COVER):

2

☐ FRANKIE MELTON

REMARKS:

*Per our conversation
about Roth's commitment*

FOR IMMEDIATE RELEASE Press Release #106-167

June 25, 1999

**ROTH ANNOUNCES INTENTION TO MOVE BIPARTISAN MEDICARE REFORM BILL
WITH
PRESCRIPTION DRUG BENEFIT**

WASHINGTON -- Senate Finance Committee Chairman William V. Roth, Jr. (R-DE) today announced that he intends to put together a bipartisan Medicare reform bill with a prescription drug benefit.

"I believe very strongly that the Finance Committee has the opportunity now to address the challenges facing Medicare. This year alone, we have held half a dozen hearings where we have heard from 70 witnesses, including compelling testimony from Senator John Breaux and Congressman Bill Thomas on the work of the Bipartisan Commission on Medicare reform. The missing piece, that I hope will be unveiled soon, is the President's Medicare reform plan.

"It is critically important that we not squander this opportunity to work together in favor of pursuing self-serving, partisan, and short-term advantages. Our efforts should be focused on a bipartisan pursuit of real solutions to Medicare's real problems. We must remember that this is a shared responsibility, and that the American public has every right to demand the best from us.

"Toward this end, as Chairman of the Senate Finance Committee, I will be listening to the views of those who have ideas about Medicare reform and prescription drug coverage that should be taken into consideration. Over the next two months, I will develop a Medicare reform proposal based on testimony from our hearings and members' input. I intend to put this proposal before the Committee in the fall for consideration. The Finance Committee will work together in a bipartisan manner, as we always do, to reach a consensus on this important issue.

"One of the key issues that we must address in any reform proposal is ensuring that the poor and sick elderly have access to prescription drugs. I fully intend to include a prescription drug benefit in our bipartisan package to address this problem in a serious way, without disrupting the U.S. pharmaceutical industry's laudable efforts in research and development."

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Tate

202

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Benny

Pat
Bancro
2244853

Sarah
Wilson
62144

US Department of the Treasury

Office of Legislative Affairs

September 9, 1999

FAX

7 pages to follow

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	Jeanne Lambrew		456-5557
	Rich Tarplin		690-7380

From: Lara Muldoon

622-6773

622-0534

Attached are the final copies of the statements given today by Secretary Summers and Deputy Secretary Eizenstat.

Here is Dept. Sec's EIZENSTAT STATEMENT AGAIN.

Chris, here's the statement again,



TEXT AS PREPARED FOR DELIVERY

OPENING STATEMENT OF DEPUTY SECRETARY EIZENSTAT

Urban Institute Panel on Medicare Reform
September 9, 1999

Secretary Summers made clear in his remarks why the President's proposal will create real competition among all plans in Medicare while protecting beneficiaries and ensuring that competitive reform does not mean a new increase in Medicare premiums. For any who might remain skeptical about our commitment to use well-designed competitive reform to strengthen Medicare, I just wanted to emphasize how widely we applied principles of competition in developing the entire proposal. Indeed, we followed the President's charge to build on the best ideas of the Medicare Commission to produce a proposal that is suffused with competition – but would foster the right kind of competition that does not put the most vulnerable at risk.

Competitive Drug Benefit - No Potential for Price Controls

First, in our proposed drug benefit we categorically and unequivocally reject price controls in favor of competitive bidding by private-sector pharmaceutical benefits managers. Price controls reduce incentives for research and development and are difficult to administer. Instead, under our proposal, benefit managers would be selected through a separate competitive bidding process in each region of the country, and the bidding will be opened every few years to keep competition vigorous. This is the same approach used in the private sector. It is a system that will be administered entirely by private companies, just as is the case in large firms and the health plans for Federal employees today, and so it is in no way conducive to price controls. Private benefit managers would submit bids to provide the defined drug benefit, and these private managers would do all of the negotiation with drug manufacturers and pharmacies.

LS-88

It is also important to note that under our competitive reform proposal, if private plans can provide this benefit at a lower premium or can add to the drug benefit, it would provide another competitive incentive for Medicare beneficiaries to switch to more competitive plans. At a time when employers are dropping drug benefits, they would receive a new subsidy to continue coverage. Competition will be further enhanced because all private plans participating in Medicare will have to offer a drug benefit that is at least as generous – and unlike current law will receive a direct subsidy for doing so.

It is also important to recognize that effective competition could not take place unless an affordable and meaningful drug benefit is available to all beneficiaries. Currently, private plans often attract beneficiaries by offering some drug coverage – though recent data also suggest that these benefits are being designed to attract only healthier beneficiaries. By providing a defined prescription drug benefit to all those in Medicare, the President's plan levels the playing field – which permits competition only on price and quality. This approach should also help private plans since they would be explicitly subsidized to provide drug benefits – the same subsidy that an enrollee in traditional Medicare would receive. As a result, beneficiaries should gain greater confidence in managed care plans, since they would not have to worry – as they do now – that their plan will drop its drug benefit or make it less generous.

Competitive Reform of Traditional Medicare Plan

Second, the President's proposal would not only generate more competition between private plans and traditional Medicare; it would also make the traditional program itself more competitive. No longer would Medicare pay all the managed care plans the same flat rate regardless of actual cost; payment would be based on their competitive bid price. If beneficiaries chose lower cost plans they would receive 75% of the savings with Medicare retaining the balance – a win-win situation for both. To attract beneficiaries, the traditional Medicare program would thereby have powerful new incentives to control costs appropriately. All of us on the panel have endorsed the idea of traditional Medicare competing head-to-head with private plans on price and quality. We – and most experts – believe that competition works better when plans are all competing to provide the same defined set of benefits; beneficiaries can then compare apples to apples and don't need to purchase benefits they do not desire.

For such competition to work, though, and to move away from the current system of regulated prices, we need to give the administrators of the traditional plan more latitude to negotiate payment arrangements and make purchases based on competitive bids -- just as "preferred provider organizations" and "point of service" plans do today in the private sector. Thus our proposal follows the recommendation of the Breaux-Thomas plan – and of my fellow panelist Stuart Butler – and gives the traditional Medicare program more flexibility to use some of these innovative purchasing tools.

While there are many points of agreement about competition, there are some differences. The major difference between our plan and Breaux-Thomas is in the types of incentives used, the balance between choice and penalties, and the mix of carrots and sticks. Under our system, if traditional Medicare does not keep up with private plans then these private plans can attract

beneficiaries with lower premiums. This is because we key the level of government payments to costs in the traditional program. Breaux-Thomas would tie support to the average cost of all plans, with beneficiaries left to pay 100% of the difference in higher-cost plans. Since traditional Medicare program is expected to cost slightly more than the average, this has the unfortunate effect of raising their premiums sharply. In order to assure that all beneficiaries gain from competition, it is important to provide protection to the large percentage of Medicare beneficiaries on fixed incomes. The Administration's price competition provides incentives to join efficient managed care plans – not by raising the premiums of traditional Medicare beneficiaries, many of whom do not have good private plan alternatives, but by letting private plans offer lower premiums for the same defined benefits. We must not forget that two-thirds of beneficiaries live in households with annual income of less than \$25,000 per year, and that many are on fixed incomes. Moreover, about one-third of Medicare beneficiaries are seriously disabled or impaired. It is too risky for this population to implement competitive reforms without keeping a safety net of traditional Medicare.

Competition Alone Can't Solve Medicare's Financing Problems

I also want to make sure that as we discuss the many important aspects of bringing more effective competition on Medicare, we do not lose sight of this fact: Even if we enacted all of the sensible reforms to Medicare that all of us could reasonably support, every independent actuarial and economic projection about the fiscal future of Medicare reaches a clear conclusion: Medicare will need additional resources to meet our commitment to provide high-quality medical care to The Baby Boom when it retires, if we are to do so without indebting future generations. The number of Medicare beneficiaries will double over the next 30 years, and medical breakthroughs are likely to continue to lead to effective new treatments for diseases. To extend Trust Fund solvency by even a decade through reductions in provider payments would require drastic cuts. To prepare for these challenges, we must take difficult but necessary steps now to enact Medicare reform that modernizes the program and helps control its costs. But we must also take the fiscally prudent step of securing Medicare's finances for the upcoming demographic shift.

That is why the President's "first things first" approach to the budget includes the dedication of a substantial amount of the budget surplus to the Medicare trust fund. Not only will this help us eliminate the public debt by 2015 – reducing government interest payments along the way, and freeing up resources for private-sector investments that will strengthen our economy for the 21st century. It will also extend the solvency of Medicare for the next quarter century.

DRAFT

"Preparing Medicare for the 21st Century"
Remarks by Lawrence H. Summers
Secretary of the Treasury
The Urban Institute, Washington, DC
September 9, 1999

Thank you. It's a pleasure to be here this morning with such a distinguished group of experts to discuss Medicare reform. Let me start by thanking the Urban Institute — and Marilyn Moon in particular — for organizing this event. As we work together to strengthen and modernize Medicare, discussions like this one will make a significant contribution to the fulfillment of that goal.

The remarkable advances in medicine of the last several decades — borne of technological progress, scientific advancements, and investments in research and development — have given us a health care system at the end of this century that is dramatically different from the one that existed in 1965, when Medicare was introduced. Clearly, a health care program that was right for beneficiaries 34 years ago is unlikely to be right for Americans today. But I think we can all agree that having the right Medicare system — one that guarantees America's senior and disabled citizens high-quality, affordable health care — is today more important than ever.

In that context, let me commend both Representative Thomas and Senator Breaux for their leadership on the bipartisan Medicare Commission. That group has significantly advanced the debate over how to improve the health care social safety net for older and disabled Americans. Their efforts, and those of others, including Senate Finance Committee Chairman Roth and Ranking Member Moynihan, have given rise to an atmosphere where meaningful, bipartisan reform seems possible.

Yesterday I gave a speech reflecting on the factors that have been most responsible for the strength of our domestic economy in recent years. Among the themes I highlighted are our commitment to fiscal responsibility and to harnessing market forces to address the economic challenges that we as a country face. I believe that it is these same themes that need to be considered as we debate how best to modernize Medicare.

Indeed, the central pillar of the Administration's approach to Medicare reform is grounded in basic economics: that enhancing the level of competition within Medicare can improve the quality and efficiency of health care for senior and disabled Americans without resulting in higher premiums. I would like to focus my remarks this morning on this point, before briefly discussing the fiscal virtues of our proposal and the importance of adding a Medicare prescription drug benefit.

A Competitive Approach to Medicare Reform

The collective efforts of the President, the Medicare Commission, and others have given rise to an emerging bipartisan consensus — a consensus that there is a need to act to strengthen and

modernize Medicare, that now is the time to act, and in particular that injecting more competition into Medicare is the right way to act. The Administration is committed to an approach to Medicare reform that relies on sound economic principles to protect patients and keep costs down, while ensuring that the health care system has the flexibility to efficiently address future developments — foreseen or unforeseen.

That is why the Administration believes that the proper approach to Medicare reform would have the participating plans in the program engage in head-to-head competition, with the beneficiaries reaping the rewards in the form of lower prices, higher quality, or even both. The current Medicare system fosters some competition — both between private health plans and the traditional fee-for-service program, and among private plans — but it also regulates payments to private plans. And since each beneficiary pays the same basic premium — now about \$45 per month — whichever plan they choose, providers compete primarily by offering extra benefits, making it difficult for seniors to make apples-to-apples comparisons between plans.

Under the President's approach, private health plans participating in Medicare would submit a competitive bid at the price at which they are willing to cover an average senior citizen. These bids would then be compared to the costs in traditional Medicare to determine the cost to a beneficiary of enrolling in that plan. As under current law, a participant choosing a private plan which costs about the same as traditional Medicare will pay the same premium. But under our proposal, someone who opts for a plan that is less expensive than the traditional fee-for-service plan would pocket three-fourths of the savings, with the remainder accruing to the Medicare Trust Fund. As a result, market forces would steer beneficiaries to providers offering the best value for their dollar.

This is expected to result in \$9 billion in savings for the government over the next 10 years, and \$22 billion in savings to beneficiaries. Indeed, participants might be able to select a plan that entirely eliminates their monthly premium.

At the same time, the Administration's proposal includes a \$7.5 billion "quality assurance fund" to smooth out provisions in the Balanced Budget Act of 1997 that may be affecting Medicare beneficiaries' access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and appropriate policy solutions.

A Commitment to Protecting the Elderly and Disabled

The Administration firmly believes that adequate protections must be afforded to beneficiaries as we move into a more competitive environment. Traditional Medicare now provides essential care for 84 percent of all beneficiaries, and it should not become less affordable for our most vulnerable citizens even as we are enacting a fundamental change in the program. Perhaps a third or more of the elderly and disabled have serious chronic illnesses and impairments, and their very survival may depend on continuing to have access to specialized care.

That is why we consider it critical that any reform allow beneficiaries to stay in traditional Medicare for the same monthly premium as under current law. While this would protect the elderly and disabled against further premium increases, in no way would it exempt traditional Medicare from competition. Let me be clear: *it is not necessary to raise the premium in*

traditional Medicare in order to have real competition. Instead, private plans would be able to attract beneficiaries by offering them lower premiums. And if private plans are more efficient than traditional Medicare, they would gain a competitive advantage.

Regardless of the changes we make to Medicare, beneficiaries will continue to enjoy the protections of the Patient's Bill of Rights — which the President extended to Medicare by Executive Order last year. For the elderly in particular, access to the specialists they need and prohibitions on "gag orders" so that doctors can discuss all treatment options are essential. As Vice President Gore said earlier this week: "Americans have the right to have their medical decisions made by them and their doctors, not by bureaucrats sitting behind a computer screen hundreds of miles away." Indeed, the Administration is committed to passing a similarly meaningful Patients Bill of Rights to cover all Americans.

Clearly, there is much in common between the President's plan and the proposal put forward by the Breaux-Thomas Commission, including the central role assigned to competition. At the same time, one of the greatest concerns that the Administration has about their plan and some of the other Medicare reform proposals that have been put forth is that the benefits of competition might be obtained at too high a cost in terms of exposure of beneficiaries to increased risk. Monthly Medicare premiums are already expected to increase substantially over the next decade, simply because growth in health care costs is expected to continue. Against this backdrop, it is especially important that we prevent an extra premium increase from accompanying a transition to a more competitive system. We believe it is critical to select an approach that encourages robust competition among health care providers in the Medicare system, while preserving the vitality of the social safety net that is so important for some of our most vulnerable citizens.

A Fiscally Responsible Approach

The President's approach recognizes that — important as they are — structural reforms alone cannot realistically generate enough savings to meet the costs of caring for the Baby Boom generation when it retires. As the members of this audience know all too well, the demographic challenge that we face with the greying of the Baby Boomers makes immediate action to strengthen Medicare imperative. With the elderly population set to double from almost 40 million to 80 million over the next three decades, it is clear that additional financing will be necessary to maintain basic health care services and quality for any length of time.

In order to meet these obligations without burdening future generations, we would dedicate more than \$300 billion of the on-budget surpluses over the next 10 years to the Medicare Trust Fund, thereby extending its solvency beyond 2025. Investing the surpluses in this way would also reduce the Federal debt held by the public — helping to eliminate it entirely by 2015 — and lower the government's net interest costs, further reducing its future obligations. At the same time, it would help limit the need for future cuts and restructuring. Importantly, therefore, the new resources we would commit to Medicare are fully pre-funded. The monies we commit to the Trust Fund are taken off the table, and not available for other purposes. We may not always have the chance before us today to provide stability to the nation's fiscal picture for several decades to come. We should not squander this opportunity.

A Prescription Drug Benefit

If we are going to harness the same competitive forces that make private health care plans operate efficiently, then we should also extend the same type of meaningful prescription drug benefit that is a part of any such plan. As President Clinton has said: "Nobody would devise a Medicare program today, if we were starting all over, without including a prescription drug benefit."

Indeed, adding a drug benefit is not just good health policy, it's good economics. This investment in improved and lengthened lives should yield benefits that easily justify its costs. And the peace of mind that all current and future seniors will have — knowing that they have a reliable source of meaningful insurance — must also be counted as a welfare gain to society.

Drug therapies have become an integral part of modern medicine, providing more effective and lower-cost treatments for many illnesses that used to result in disability, hospitalization, and death. But prescription drugs are only as effective as they are utilized, as the case of osteoporosis shows. Of the estimated 20 million women in this country who could benefit from treatment for this disease, only about 3 million are being treated, even though hormone replacement therapies and other drugs that help bones maintain their strength are currently available.

The President's plan makes needed drugs more accessible to the three-fourths of seniors and disabled who do not have dependable and affordable drug coverage today. When fully implemented, the Administration's drug benefit would cover half a beneficiary's drug expenses up to \$5,000 a year, at a cost to them that is one-half to one-third as much as a typical Medigap drug plan. The President's plan does so without price controls, instead adopting the best private-sector practices. It also provides new subsidies to encourage employers to provide or retain high-quality coverage for their retirees. And most of the drug benefit's costs to the government would be offset by sensible reforms, including the proposal to create true price competition between traditional Medicare and managed care plans.

Conclusion

In the weeks and months ahead, we have an historic opportunity to reform Medicare in a way that will strengthen our country, our economy, and the security of current and future disabled and elderly Americans. The Administration is looking forward to working with Representative Thomas and other members of Congress to enact Medicare reform that we can all support. I think we can all agree that increasing competition in Medicare can strengthen the program and reduce its costs in the long run, and that competitive reform should be implemented with an adequate safety net so as not to put beneficiaries at risk. Using some of the surpluses to stabilize the Medicare Trust Fund, and putting competitive forces to work to reduce costs has the potential to strengthen this crucial health care program in a way that would not have seemed possible only a few years ago. By seizing this opportunity, we can enact Medicare reform that makes all of us — beneficiaries and taxpayers alike — better off.

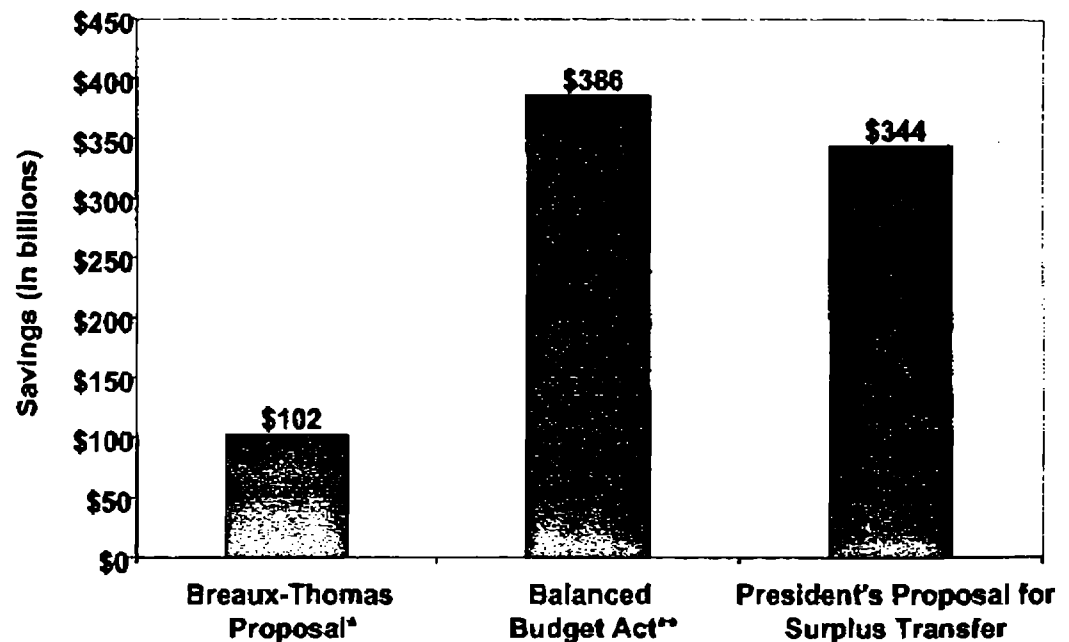
Shortcomings of Breux-Thomas Proposal

- **Increases premiums for millions of beneficiaries and achieves \$35 billion in savings from other cost shifts to beneficiaries -- increase cost sharing, raising eligibility age**
- **Ignores need for new revenues to finance growing numbers of beneficiaries**
- **Raises eligibility age for Medicare without policy to protect against increases in number of uninsured**
- **Proposes inadequate drug benefit that helps few beneficiaries**
- **Unclear commitment to a defined guarantee of benefits**
- **Creates dilemma for rural beneficiaries once one private plan enters area**

Savings Under Breaux-Thomas Have Small Impact on Medicare

- \$102 billion in net savings* over 10 years less than one-third of savings produced by Balanced Budget Act
- Net savings only one-third of amount produced by President's proposal to commit 15 percent of the surplus to Medicare
- More than 35% of net savings not budget savings, simply shift of GME to funding outside Medicare

10-Year Savings under
Various Medicare Proposals

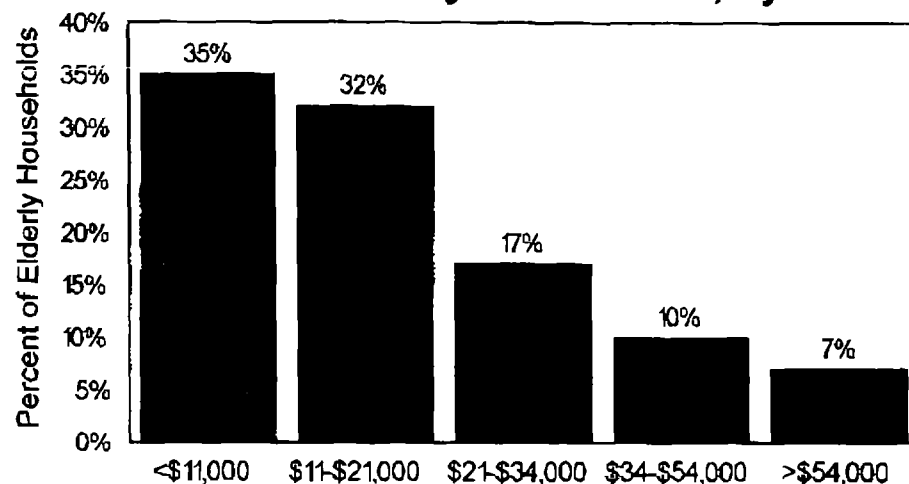


* Commission staff estimates of Breaux-Thomas proposal, March 16, 1999

** CBO estimate of savings at time of enactment

SPENDING FOR HEALTH AS A PERCENTAGE OF INCOME, 1994

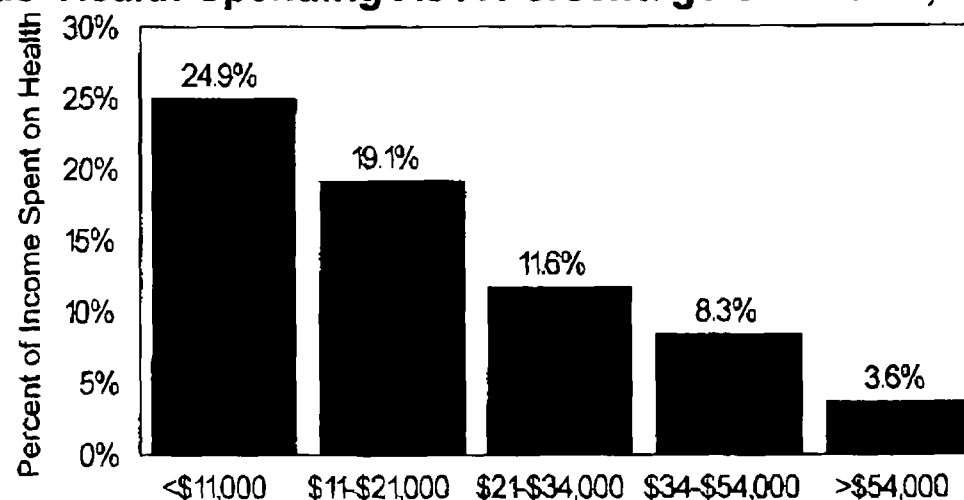
Distribution of Elderly Households, by Income Quintile, 1994



**Most Elderly Households
Have Income Below
\$21,000**

Elderly Households' Health Spending As A Percentage of Income, 1994

**The Elderly Poor Spend
a Greater Proportion of
their Income on Health**

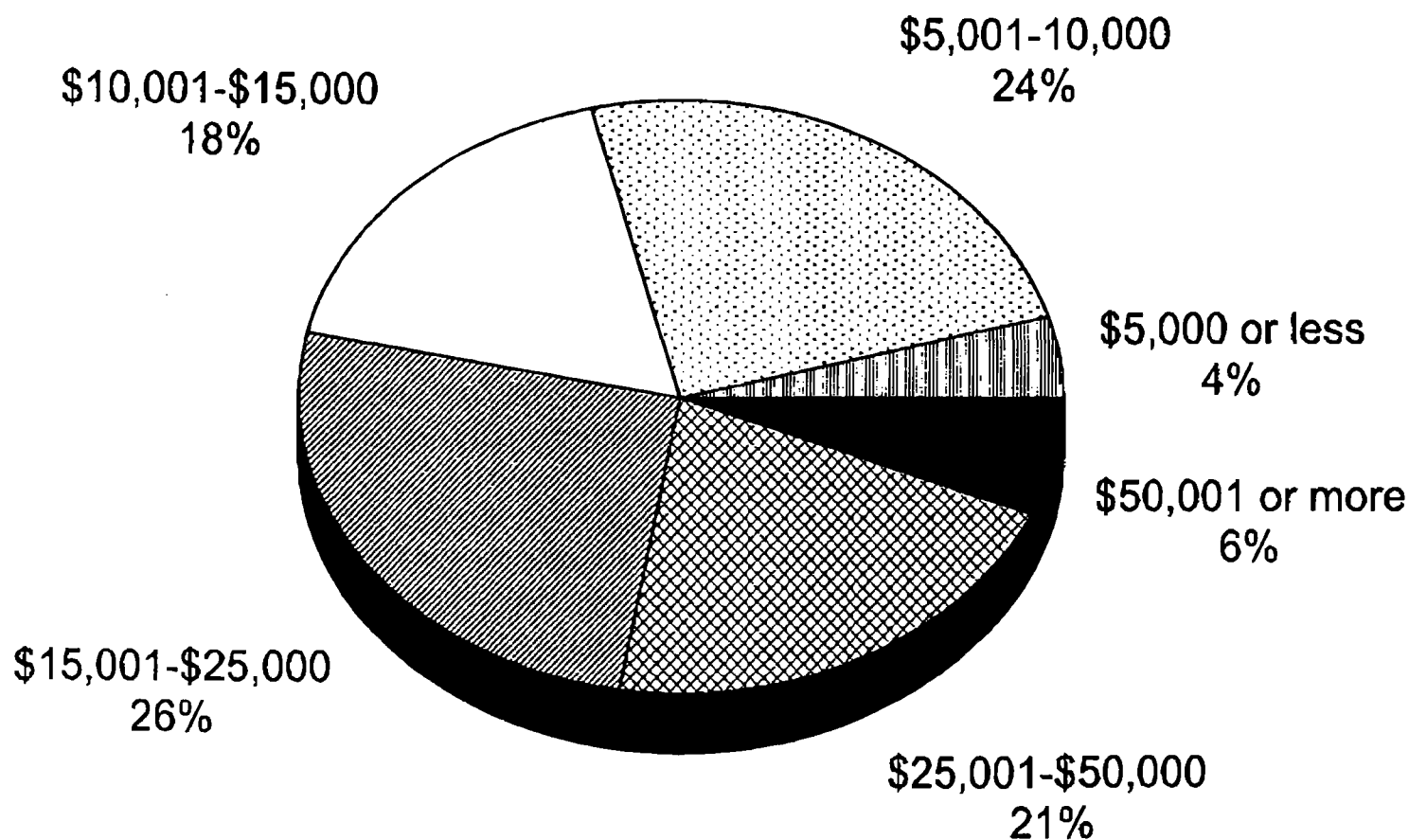


Source: HCFA/Office of Strategic Planning: data from the Bureau of Labor Statistics, Consumer Expenditure Survey.

Figure 34

INCOME DISTRIBUTION OF ELDERLY MEDICARE BENEFICIARIES, 1995

Over seventy percent of elderly beneficiaries reported income of \$25,000 or less.



Note: Income represents total gross income, and includes pensions, Social Security, Railroad Retirement and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and Workers Compensation benefits; interest, dividends, and work-related income. Data includes the income of the beneficiary and spouse, if applicable.

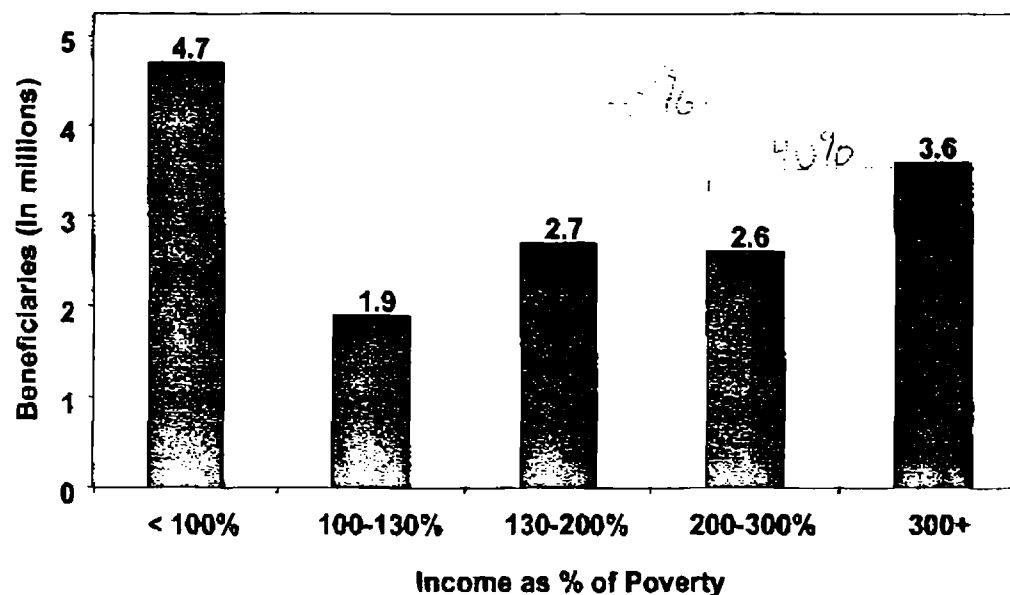
Source: HCFA/Office of Strategic Planning; data from the Medicare Current Beneficiary Survey.

Figure 9

16 Million Beneficiaries Will Not Have Drug Coverage in 2000

- 40% of beneficiaries without drug coverage have incomes above 200% of poverty
- Almost 50% of rural beneficiaries do not have drug coverage
- Private insurance for drug coverage through Medigap or employer-sponsored retiree coverage is declining
- Medigap for drugs is expensive and coverage is declining

Medicare Beneficiaries Without Any Drug Coverage by Income, 2000

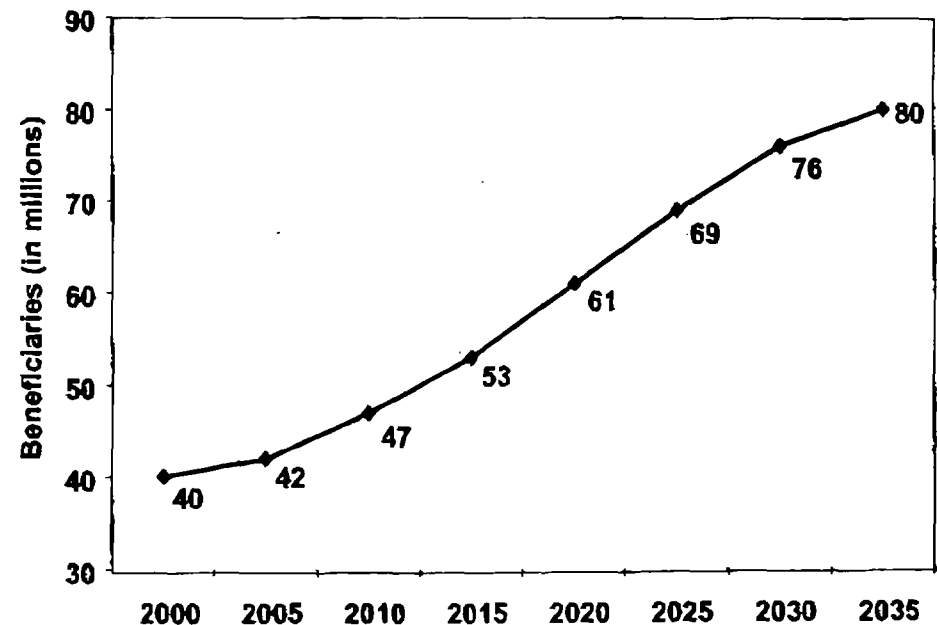


Source: HCFA (unpublished) analysis of 1995 Medicare Current Beneficiary Survey data

Number of Medicare Beneficiaries Will Double by 2035

- By 2035, Medicare beneficiaries will grow from 14% to 22% of U.S. population
- Over one-half of long-term HI growth attributable to demographics, not excessive health care cost growth
- To support increasing beneficiaries, new financing sources will be needed

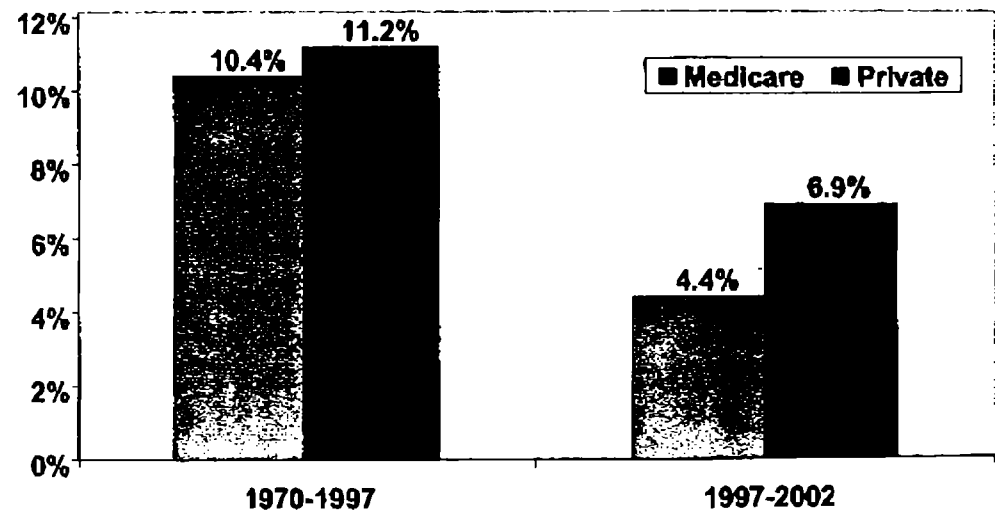
Medicare Hospital Insurance Enrollment, 2000-35



Medicare As Efficient As Private Sector in Controlling Spending Growth

- Over long-term, per capita Medicare spending growth has been similar to private sector
- Growth rate in Medicare spending will be less than private sector from 1997 to 2002

Medicare and Private Spending Per Capita



Source: Analysis of data from HCFA Office of the Actuary

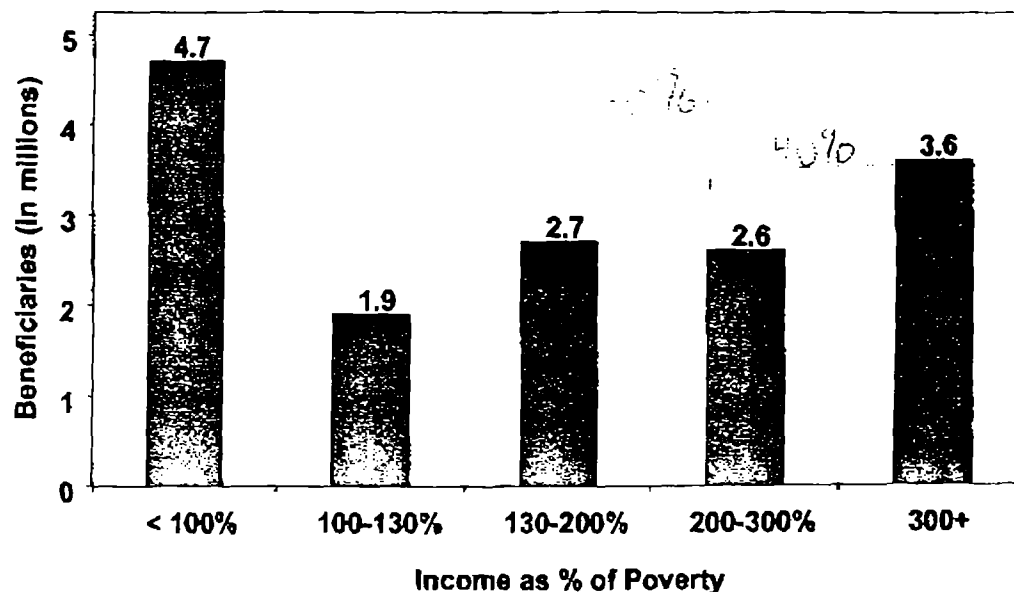
Contributions of the Medicare Commission

- **Focused attention on challenges facing Medicare**
- **Breaux-Thomas proposal advanced debate**
- **Several recommendations merit consideration:**
 - **Increasing competitiveness of Medicare's traditional plan**
 - **Recognizing need for prescription drug coverage**

16 Million Beneficiaries Will Not Have Drug Coverage in 2000

- 40% of beneficiaries without drug coverage have incomes above 200% of poverty
- Almost 50% of rural beneficiaries do not have drug coverage
- Private insurance for drug coverage through Medigap or employer-sponsored retiree coverage is declining
- Medigap for drugs is expensive and coverage is declining

Medicare Beneficiaries Without Any Drug Coverage by Income, 2000

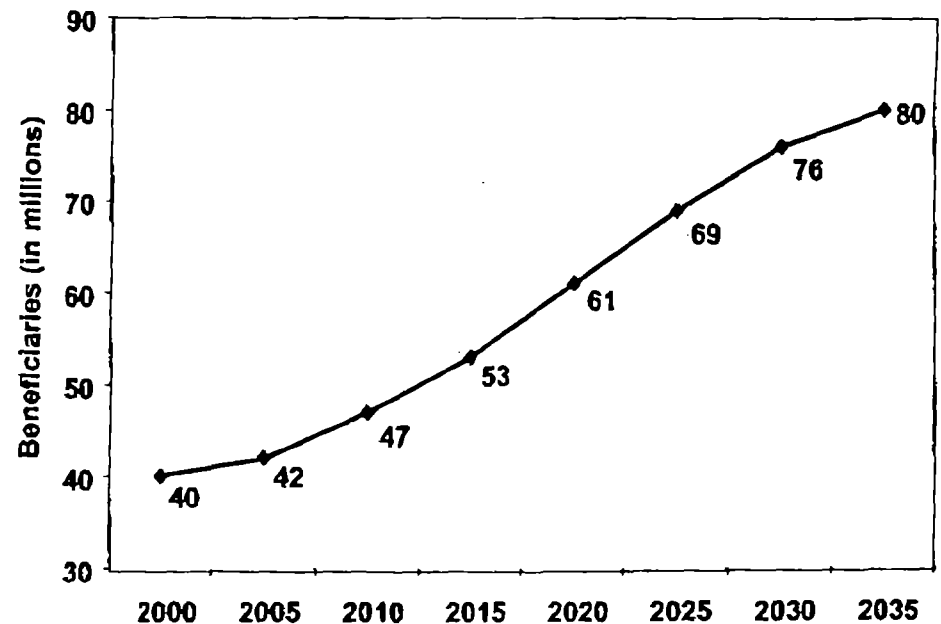


Source: HCFA (unpublished) analysis of 1995 Medicare Current Beneficiary Survey data

Number of Medicare Beneficiaries Will Double by 2035

- By 2035, Medicare beneficiaries will grow from 14% to 22% of U.S. population
- Over one-half of long-term HI growth attributable to demographics, not excessive health care cost growth
- To support increasing beneficiaries, new financing sources will be needed

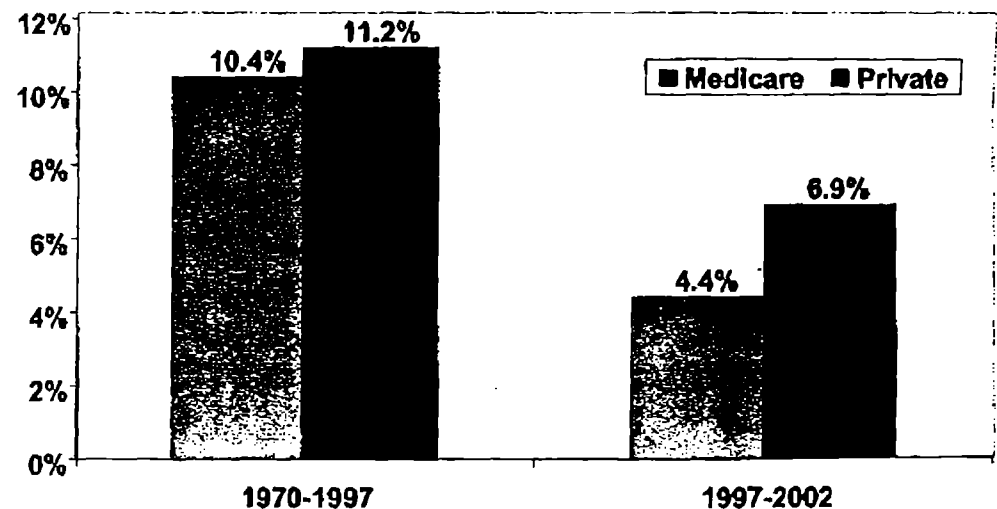
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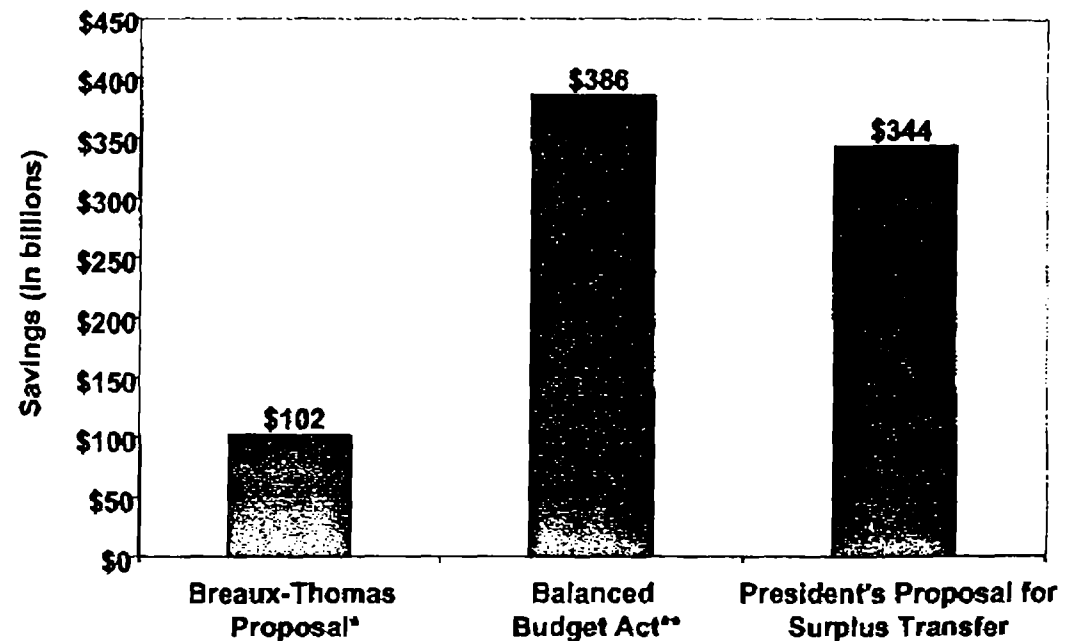
Shortcomings of Breux-Thomas Proposal

- **Increases premiums for millions of beneficiaries and achieves \$35 billion in savings from other cost shifts to beneficiaries -- increase cost sharing, raising eligibility age**
- **Ignores need for new revenues to finance growing numbers of beneficiaries**
- **Raises eligibility age for Medicare without policy to protect against increases in number of uninsured**
- **Proposes inadequate drug benefit that helps few beneficiaries**
- **Unclear commitment to a defined guarantee of benefits**
- **Creates dilemma for rural beneficiaries once one private plan enters area**

Savings Under Breaux-Thomas Have Small Impact on Medicare

- \$102 billion in net savings* over 10 years less than one-third of savings produced by Balanced Budget Act
- Net savings only one-third of amount produced by President's proposal to commit 15 percent of the surplus to Medicare
- More than 35% of net savings not budget savings, simply shift of GME to funding outside Medicare

10-Year Savings under Various Medicare Proposals

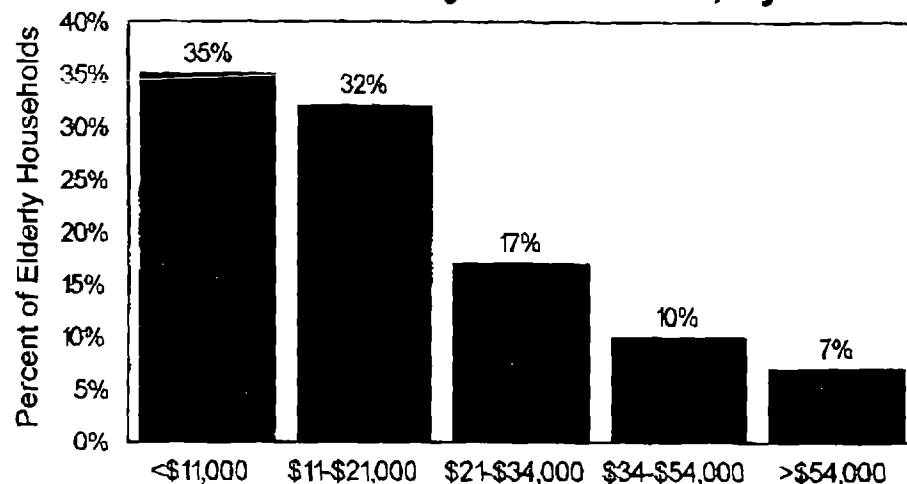


* Commission staff estimates of Breaux-Thomas proposal, March 16, 1999

** CBO estimate of savings at time of enactment

SPENDING FOR HEALTH AS A PERCENTAGE OF INCOME, 1994

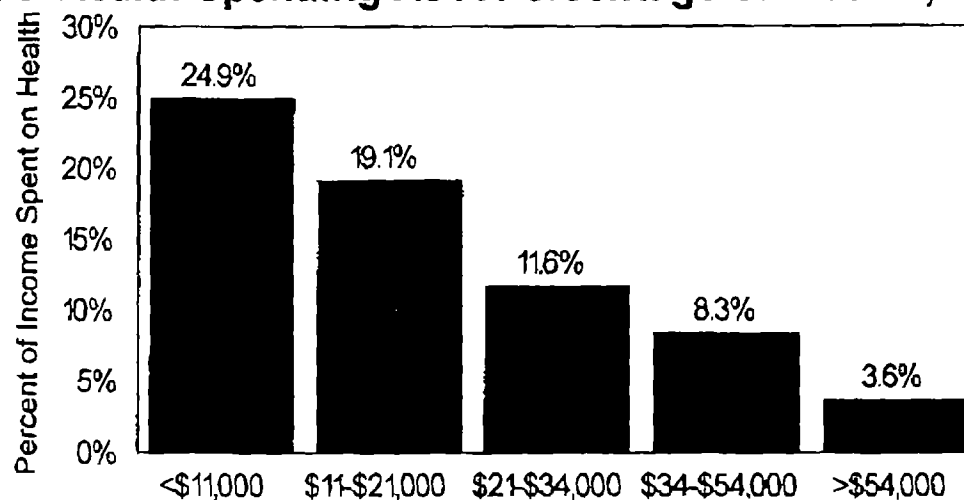
Distribution of Elderly Households, by Income Quintile, 1994



**Most Elderly Households
Have Income Below
\$21,000**

Elderly Households' Health Spending As A Percentage of Income, 1994

**The Elderly Poor Spend
a Greater Proportion of
their Income on Health**

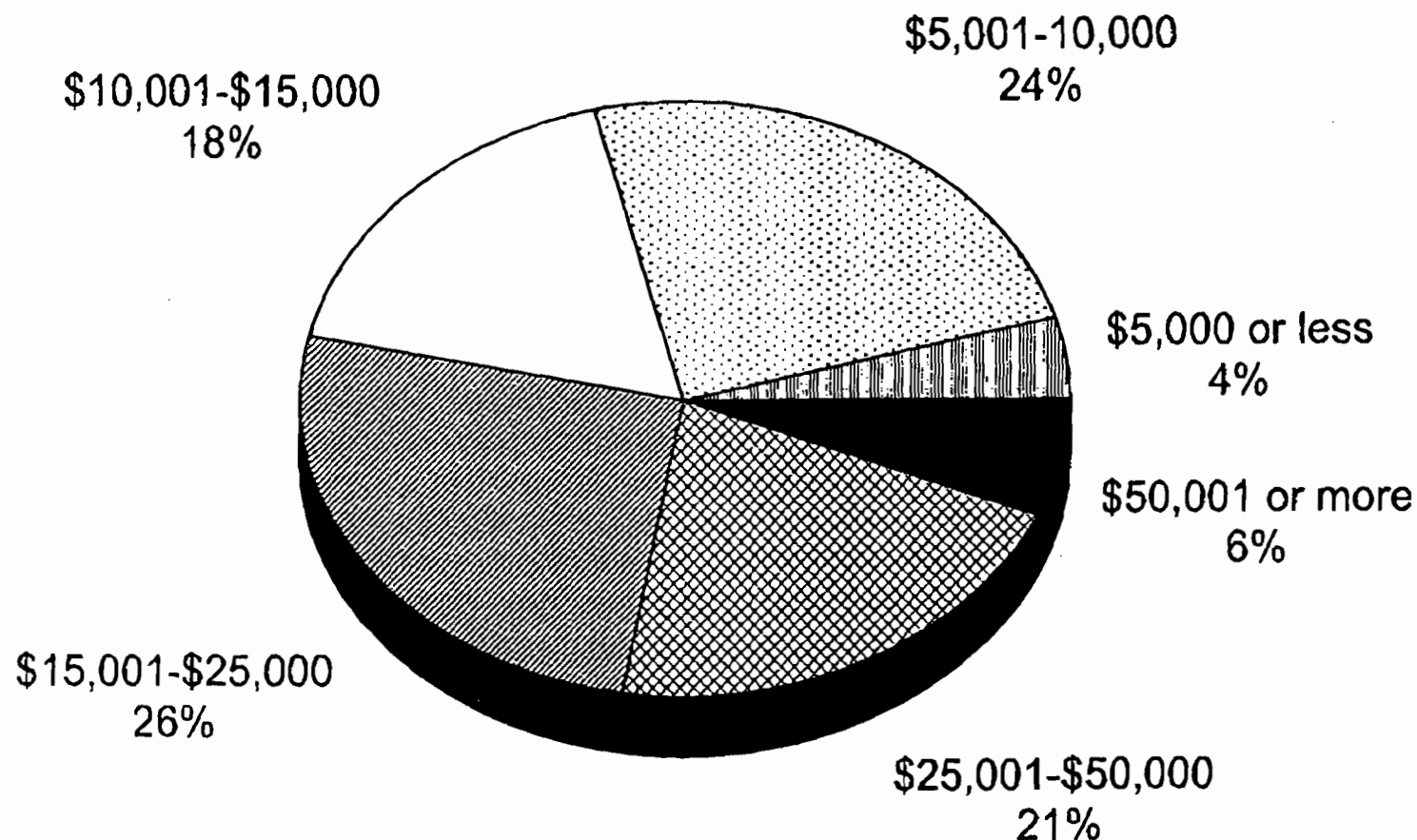


Source: HCFA/Office of Strategic Planning: data from the Bureau of Labor Statistics, Consumer Expenditure Survey.

Figure 34

INCOME DISTRIBUTION OF ELDERLY MEDICARE BENEFICIARIES, 1995

Over seventy percent of elderly beneficiaries reported income of \$25,000 or less.



Note: Income represents total gross income, and includes pensions, Social Security, Railroad Retirement and disability payments; the cash value of food stamps and public assistance payments; capital gains, annuities, VA and Workers Compensation benefits; interest, dividends, and work-related income. Data includes the income of the beneficiary and spouse, if applicable.

Source: HCFA/Office of Strategic Planning; data from the Medicare Current Beneficiary Survey.

Figure 9

Large Medicare Cuts Necessary If No Transfer of Budget Surplus

- President's proposal to transfer 15% of budget surplus would extend life of Trust Fund
- Without transfer and other Medicare changes, 20% cut in Part A spending would be required for same effect on Trust Fund
- Inpatient hospital spending would need to be cut \$215 billion over 10 years

**Part A Reductions to Achieve
Same Impact as Surplus
Transfer: FY 2000-2009 (20% cut)**

