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Purchasing Medicare Prescription Drug Benefits: A New Proposal

It is possible for Medicare to offer an affordable prescription drug benefit without resorting to national price controls.

by Lynn Etheredge

PROLOGUE: Almost thirty-five years ago, Congress modeled Medicare's original package of medical benefits after those offered by Blue Cross and Blue Shield plans at the time. Few benefits have been added since then, although the nature of the illnesses that afflict Medicare's 38.4 million beneficiaries have changed considerably, as has the capacity of medicine to cope with them. On 1 July 1988, when President Ronald Reagan signed into law the Medicare Catastrophic Coverage Act, the federal government corrected what many elderly people believed was the program's most serious missing benefit: the coverage of outpatient prescription drugs. However, less than two years later Congress repealed the law in response to opposition vociferously expressed by some elderly people and some pharmaceutical companies. Now, as prescription drugs consume a larger share of the health care dollar, political pressure is building again for adding an outpatient drug benefit. Whether Congress takes definitive action may depend largely on whether it can forge a private/public collaboration that is acceptable to the competing parties.

In this lead paper Lynn Etheredge, an independent consultant widely respected for his policy acumen, proposes an approach that seeks to accommodate the concerns of both government and the private sector regarding a new drug benefit, and two leading stakeholders respond with perspectives that follow. Etheredge directed the professional health staff of the president's Office of Management and Budget during the administrations of Jimmy Carter and Ronald Reagan. He is now a consultant with the Health Insurance Reform Project at the George Washington University, a project that is supported by the Robert Wood Johnson Foundation.

NACDS

National Association of Chain Drug Stores

Facsimile Cover Sheet

To: CHRIS JENNINGS

Company:
Fax: 202-456-5557
Phone:

From: TINNIE CALDERWOOD
Fax: 703-739-6079
Phone: 703-549-3001
Date: Monday, Aug 30, 1999 10:30AM

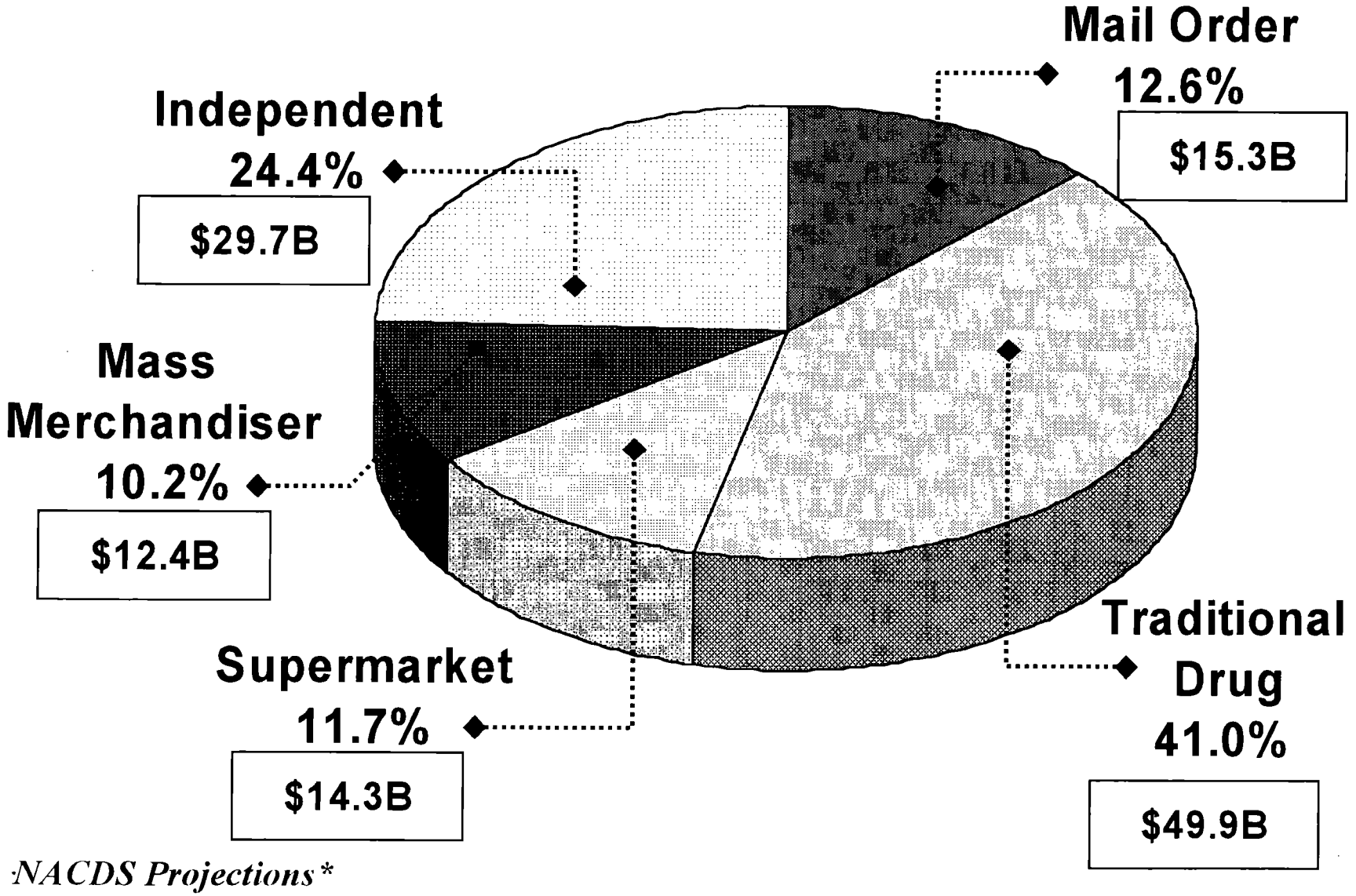
Total Pages: 7

Message:

1:30 conf call

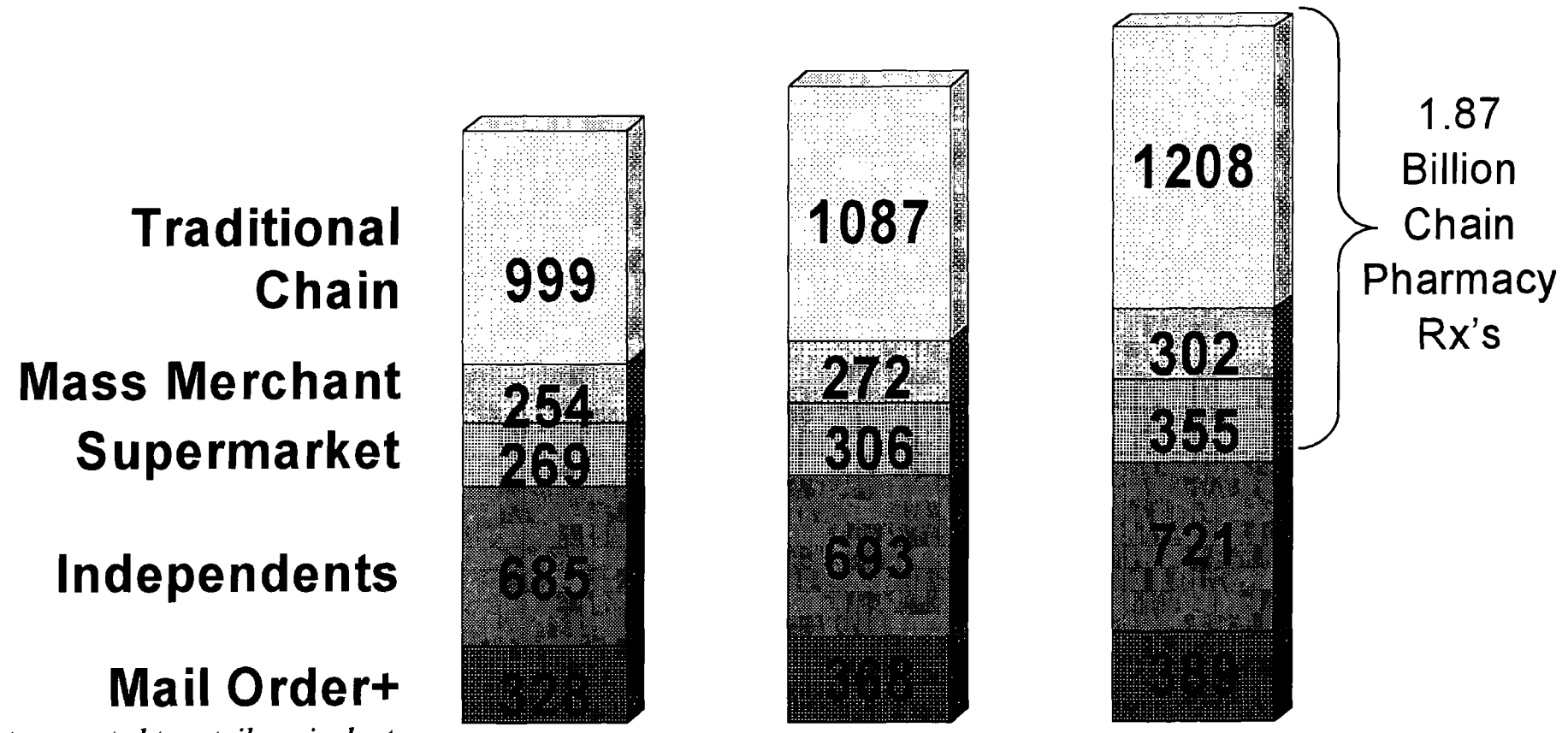
413 North Lee Street, P.O. Box 1417-D49, Alexandria Virginia 22313-1480 Phone: 703-549-3001 Fax: 703-836-4869

1999 Retail Pharmacy Sales Projections
$121.6 Billion*



*NACDS Projections**

Number of Scripts Dispensed



+converted to retail equivalents

*Source: IMS HEALTH and NACDS Projections**

OTC Medications

1999 Sales Projections vs. 1998

	1998	1999*	% Change
Traditional Chain	$ 9.7	$ 10.4	*7.1%*
Independent	1.3	1.3	*3.0%*
Mass Merchant	9.3	10.4	*11.1%*
Supermarket	9.2	9.9	*7.5%*
Total	$29.5	$ 32.0	*8.3%*

(in $ billions)

*Source: ACNielsen, NACDS Projections**

NACDS

NEWS RELEASE

National Association of Chain Drug Stores

Embargoed -- Not for Release Prior to 9:30 a.m. Aug. 29, 1999
August 29, 1999

For further information contact:
Phil Schneider
(703) 549-3001
pschneider@nacds.org

1999 Retail Rx Sales Projected to Rise 18%, Surpass $121 Billion On Volume of Nearly 3 Billion Prescriptions

San Diego – Total retail prescription drug sales for 1999 are expected to exceed a record $121.6 billion, according to projections released today by the National Association of Chain Drug Stores. In making its annual sales projection, NACDS also projects an 8 percent increase in the number of prescriptions dispensed in the retail pharmacy marketplace.

Industry sales and prescription volume projections were released by Robert W. Hannan, NACDS Interim President and CEO, at the 42nd NACDS Pharmacy Conference & Managed Care Forum meeting here August 29-September 1.

The NACDS estimate of 1999 year-end sales of $121.6 billion represents an increase of 18 percent over the 1998 year-end level of $103.5 billion. Chain community pharmacy will account for nearly 63 percent of these sales and will exceed $76.6 billion, up 22.6 percent from $62.6 billion in sales in 1998. There are approximately 31,000 chain owned and operated community pharmacies, including approximately 19,000 traditional chain drug stores, 7,000 supermarket pharmacies and 5,000 mass merchant pharmacies.

Additionally, sales of over-the-counter medications in community pharmacies are expected to reach $32 billion in 1999, an increase of 8.3 percent over the $29.5 billion in OTC sales in 1998. OTC sales in chain pharmacies are expected to exceed $30.7 billion, or 96 percent of OTC retail sales in stores with pharmacies.

"The chain pharmacy industry is very vibrant and continues to fill a key role in our healthcare system as an easily accessible source of high quality healthcare services and products," said Hannan. "With a highly diverse and innovative pharmacy infrastructure, chain pharmacy is well positioned to meet our health system's patient care needs well into then 21st century."

In announcing a projected 2.97 billion prescriptions by year-end, NACDS also estimates that of that total, chain pharmacies are expected to dispense 1.87 billion, with 1.2 billion from traditional chain drug stores, 302 million from mass merchant pharmacies and 355 million from supermarket chain pharmacies.

The NACDS projections are based on actual store experience for the first six months of this year, U.S. government sources of prescription sales data and data from IMS Health, which tracks pharmaceutical industry trends, as well as data from ACNielsen. The prescription volume projections include mail order prescription sales converted to retail pharmacy units.

Looking to the future, NACDS projects that continuing growth in prescription volume will lead to approximately four billion prescriptions being dispensed in 2005 by retail pharmacies.

"With an 8 percent increase in volume projected for this year, on top of last year's 6 percent volume increase, it's very likely retail pharmacy will reach the 4 billion level in prescriptions before 2005," Hannan noted.

Major factors contributing to the increase in prescription volume are increasing utilization of prescription drugs, especially by the elderly (those over 65) and the introduction of new medicines that enable treatment of more serious illnesses outside the hospital setting. Additionally, the growth in managed care and its growing utilization of prescriptions is

adding to overall prescription use, as well as increased consumer awareness of drug therapy options from direct to consumer advertising by prescription drug manufacturers and the availability of certain lifestyle enhancing medications.

Founded in 1933 and based in Alexandria, Virginia, the National Association of Chain Drug Stores (NACDS) membership consists of 136 retail chain community pharmacy companies. Collectively, chain community pharmacy comprises the largest component of pharmacy practice with over 97,000 pharmacists. The chain community pharmacy industry is comprised of more than 19,000 traditional chain drug stores, 7,000 supermarket pharmacies and nearly 5,000 mass merchant pharmacies. The NACDS membership base operates more than 31,000 retail community pharmacies with annual sales totaling over $158 billion including prescription drugs, over-the-counter (OTC) medications and health and beauty aids (HBA). Chain operated community retail pharmacies fill over 60% of the more than 2.73 billion prescriptions dispensed annually in the United States. Additionally, NACDS membership includes nearly 1,400 suppliers of goods and services to chain community pharmacies. NACDS international membership has grown to include 105 members from 26 foreign countries.

[Editor's Note: See accompanying charts on retail prescription sales and volume growth in number of prescriptions.]

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Share\public\releases.99\99est Rx-nr

DRAFT

For Release
September 3, 1999

Contact: Anne Montgomery
202-225-5065

STARK RELEASES LIST OF DRUGS WHERE MEDICARE BENEFICIARIES' 20% CO-PAY IS ACTUALLY HIGHER THAN THE COST OF THE DRUG TO THE PROVIDER

RENEWS CALL FOR MEDICARE DRUG REIMBURSEMENT REFORM

Rep. Pete Stark (D., CA), ranking Member of the Ways and Means Health Subcommittee, today released a list of pharmaceuticals on which the patient's 20% co-pay is actually higher than the wholesale cost of the drug to the Medicare provider. The list was provided to Stark by a pharmacist concerned about financial abuse of the Medicare program.

"Because of Congress's failure to reform the way we reimburse medical providers for drugs, we actually have cases where the patient's 20% copayment is more than the costs of the drug to the doctor or provider," said Stark. "This table is a testament to the rip-off of the Medicare taxpayer and patient. In some cases, the data shows profits of over 1000%–10 times the purchase price."

Medicare pays 95% of the Average Wholesale Price for most drugs.

"Unfortunately, the AWP is a joke on the taxpayer," said Stark. "It really stands for 'Ain't What's Paid.' The real price to doctors and others is much, much lower, yet Medicare blindly continues to pay this fictitious 'sticker price.'

In 1998, the President proposed paying for Medicare pharmaceuticals on the basis of actual acquisition cost (ACC). Heavy lobbying defeated the proposal–and taxpayers and Medicare continue to overpay at least $1 billion a year because of the phony Average Wholesale Price system.

"I hope ~~this~~ these data will enrage patients and taxpayers and that we can force Congress to legislate common sense reforms–paying for the actual acquisition cost plus a reasonable handling fee to the provider," concluded Stark.

Stark is sponsoring legislation to pay on the basis of ACC.

DRUGS WHERE MEDICARE BENEFICIARIES 20% CO-PAYMENT EXCEEDS THE TOTAL PRICE OF THE DRUG

Drug	HCPCS Code	1999 Florida Medicare Allowable	20% Co-Payment	1999 Wholesale Cost*
Leucovorin 50 mg	J0640	$ 19.50	$ 3.90	$ 1.48
Gentamycin 80 mg	J1580	$ 4.74	$ 0.95	$ 0.56
Sodium Chloride 0.9% 500 ml	J7040	$ 10.30	$ 2.06	$ 1.46
5% Dextrose/ Sodium Chloride 0.9% 500 ml	J7042	$ 10.75	$ 2.15	$ 2.00
Sodium Chloride 0.9% 250 ml	J7050	$ 10.90	$ 2.18	$ 1.33
5% Dextrose in Water 500 ml	J7060	$ 9.73	$ 1.95	$ 1.50
Lacted Ringers 1000 ml	J7120	$ 12.67	$ 2.53	$ 2.25
Doxorubicin 10 mg	J9000	$ 46.42	$ 9.28	$ 6.10
Cyclophosphamide Lyophilized 1.0 gm	J9096	$ 48.85	$ 9.77	$ 9.95
Etoposide 10 mg	J9181	$ 12.93	$ 2.59	$ 0.75
Etoposide 100 mg	J9182	$129.34	$25.87	$ 7.50
Vincristine 1 mg	J9370	$ 30.16	$ 6.03	$ 3.50
Vincristine 2 mg	J9375	$ 33.33	$ 6.67	$ 5.95

* Wholesale prices from Florida Infusion

20%.wpd

TO: **Christopher C Jennings**
Staff
Executive Office of the President

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Presented by the Mercatus Center at George Mason University

MEDICARE:

Republican Leadership's Latest Medicare "Reform" Plan

- IGNORES CHALLENGES FACING MEDICARE
- REPUBLICAN PLAN TO "WITHER MEDICARE ON THE VINE"
  - Premium Support Plan
  - Dedicate Surplus to Tax Scheme, Not A Penny To Medicare
- PRESIDENT'S PLAN TO STENGTHEN AND MODERNIZE MEDICARE

CHALLENGES FACING MEDICARE

- **Medicare population will double**: Enrollment in Medicare will increase by over 100 percent -- from 39 to 80 million by 2035 -- as the baby boom generation retires.

- **Cost growth will rise – as will need for more competition and greater efficiency in Medicare**: Although Medicare has recently reined in cost growth, increasing costs are projected to return after most of the Balanced Budget Act Medicare provisions expire in 2003.

- **Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security**. Just as the baby boom generation starts to retire, the revenues coming to the Medicare Trust Fund will not support this larger number of beneficiaries.

- **About 75 percent of beneficiaries lack decent, dependable, private-sector drug coverage.**

  - At least 13 million beneficiaries have absolutely no coverage at all.

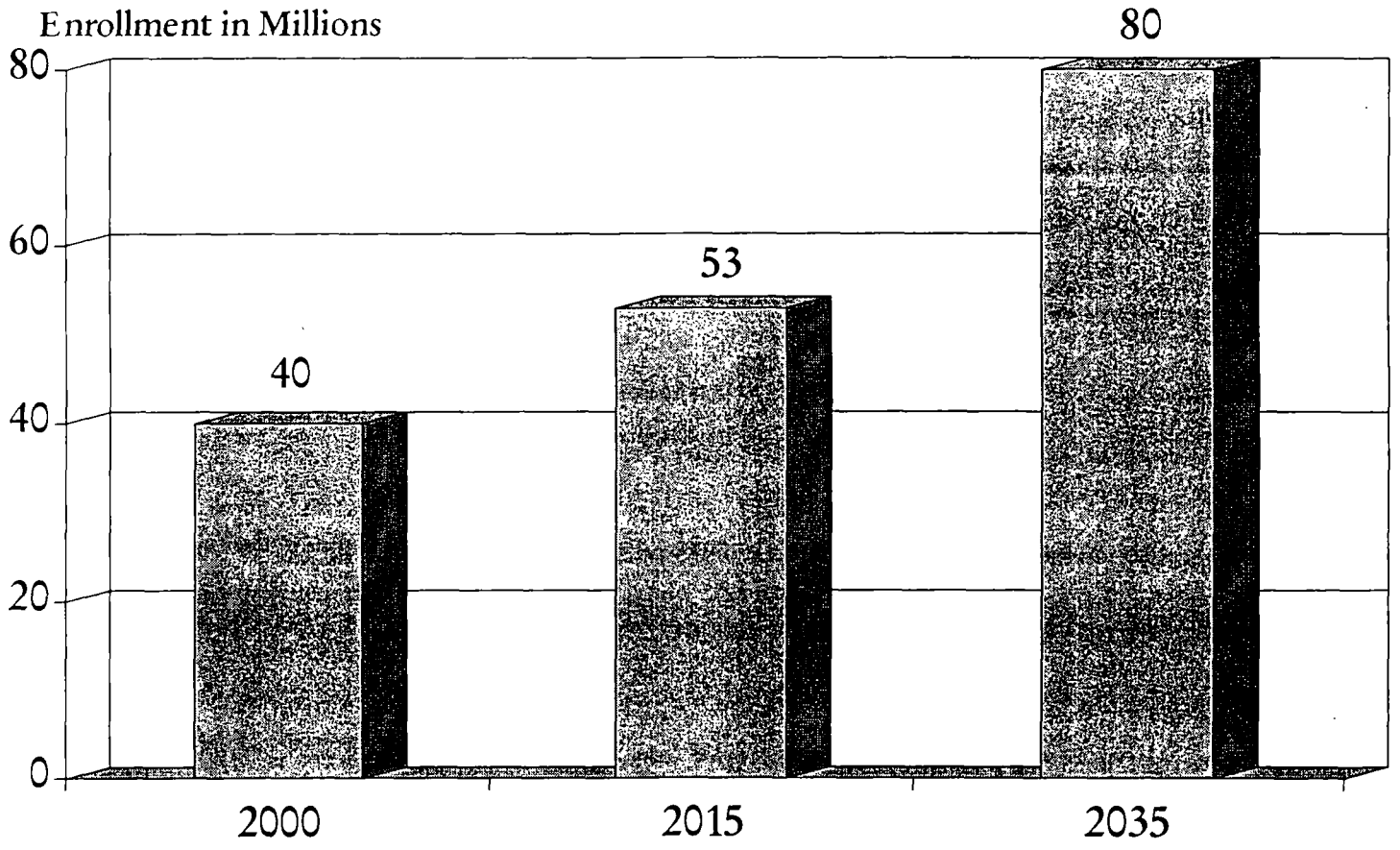
  - Medigap is inadequate, expensive, and increases with age.

  - Most Medicare managed care plans have inadequate and declining coverage. Nearly 3/5^{ths} of managed care plans will cap drug spending below $1,000 in 2000. The proportion of plans with caps of $500 or less will increase by 50 percent. However inadequate, at least 11 million Medicare beneficiaries have no managed care option at all.

  - Medicaid and other public programs cover another 17 percent of beneficiaries, but eligibility is restrictive and participation is very low (less than 50 percent).

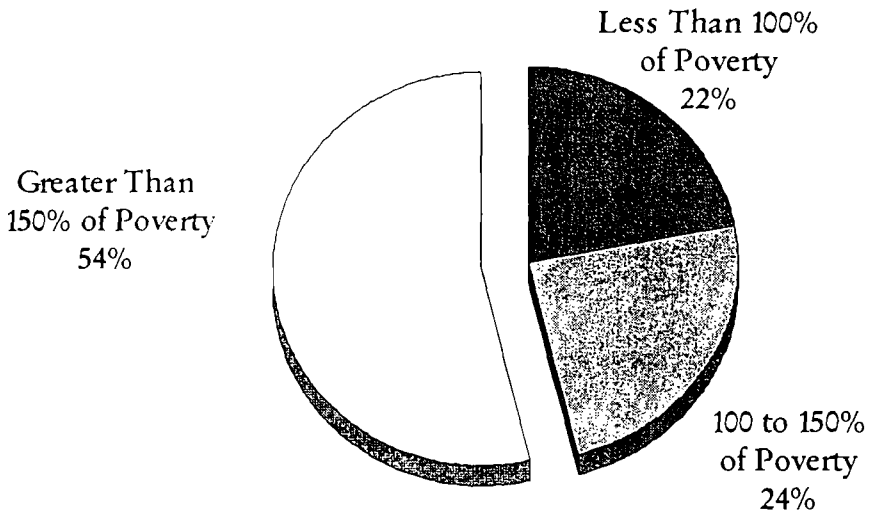
- **Private retiree health plans, which cover less than one-quarter of beneficiaries, are declining.** The number of firms offering retiree health insurance coverage dropped by 25 percent between 1993 and 1998. This trend will almost inevitably continue without new incentives to retain it.

Medicare Enrollment Will Double As The Baby Boom Generation Retires



Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

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



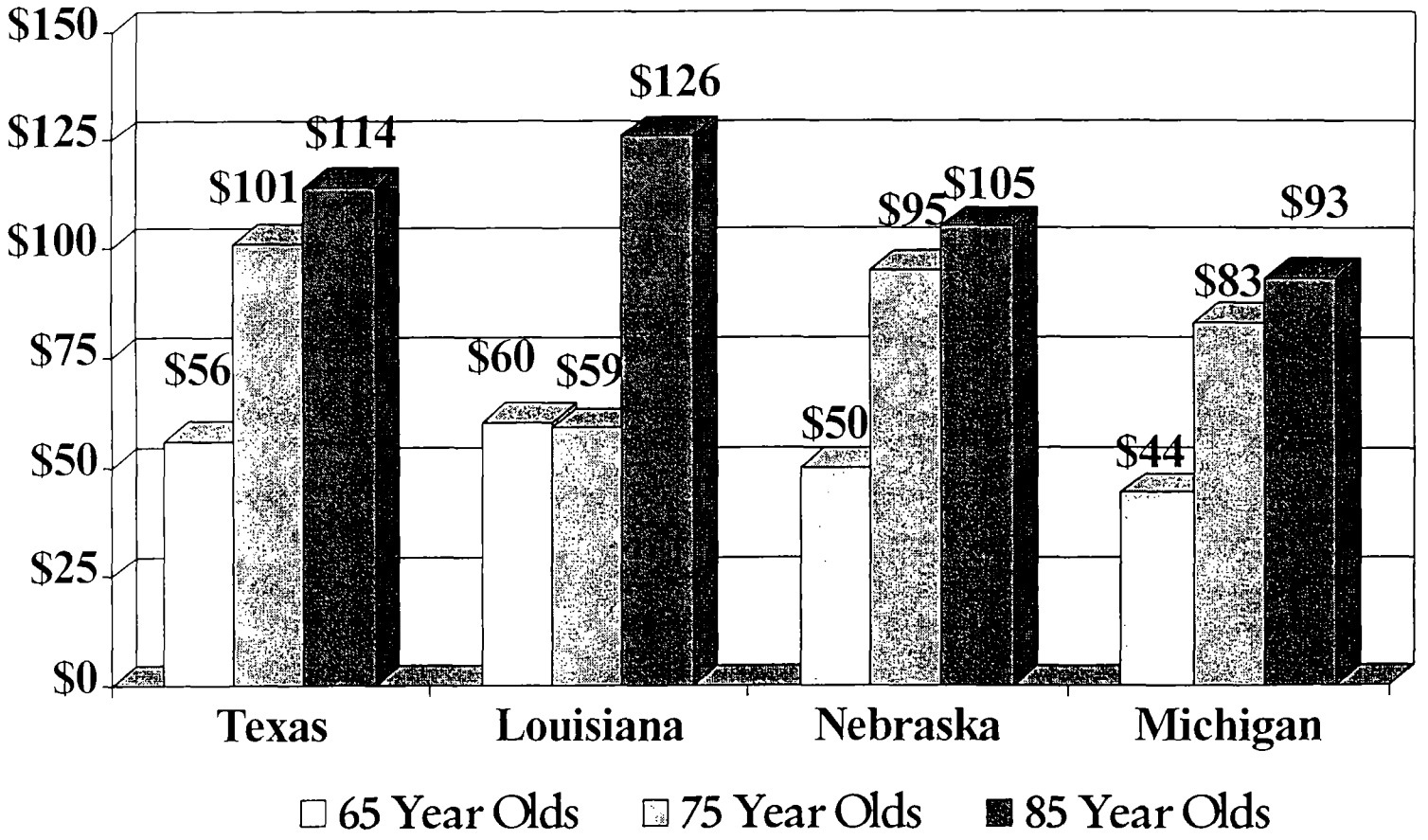
Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

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

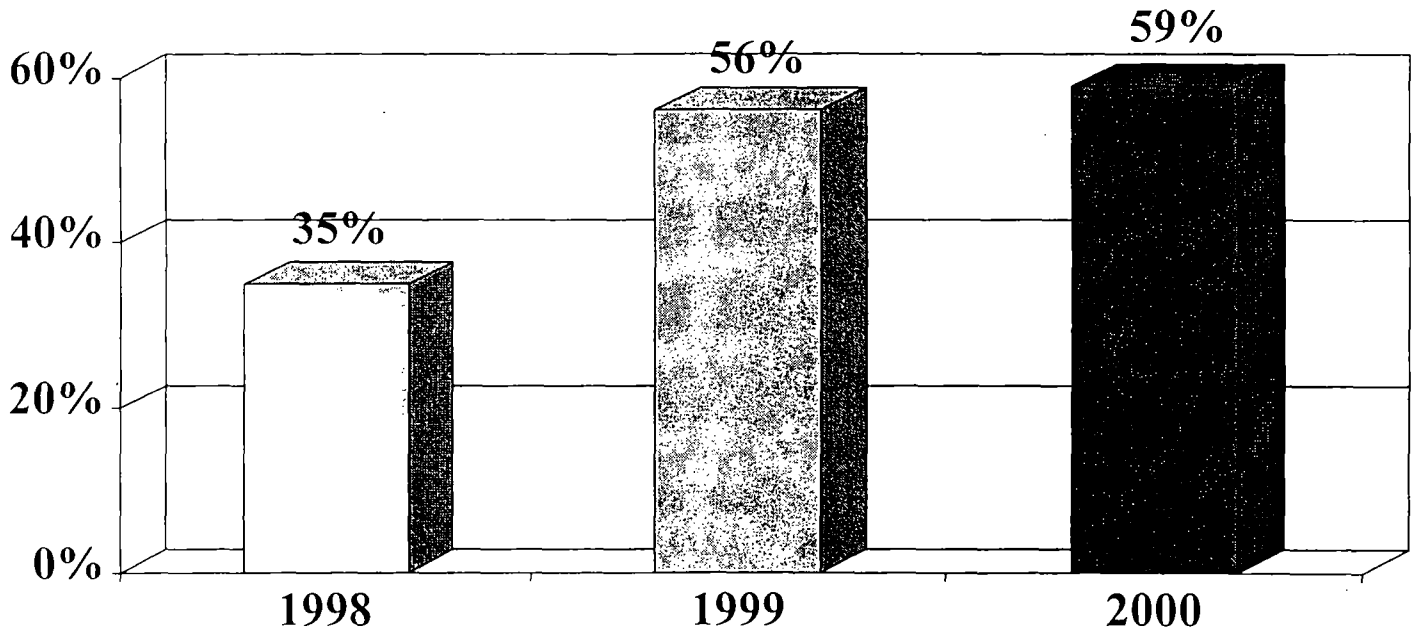


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

Value of Medicare Managed Care Drug Benefits Is Declining

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

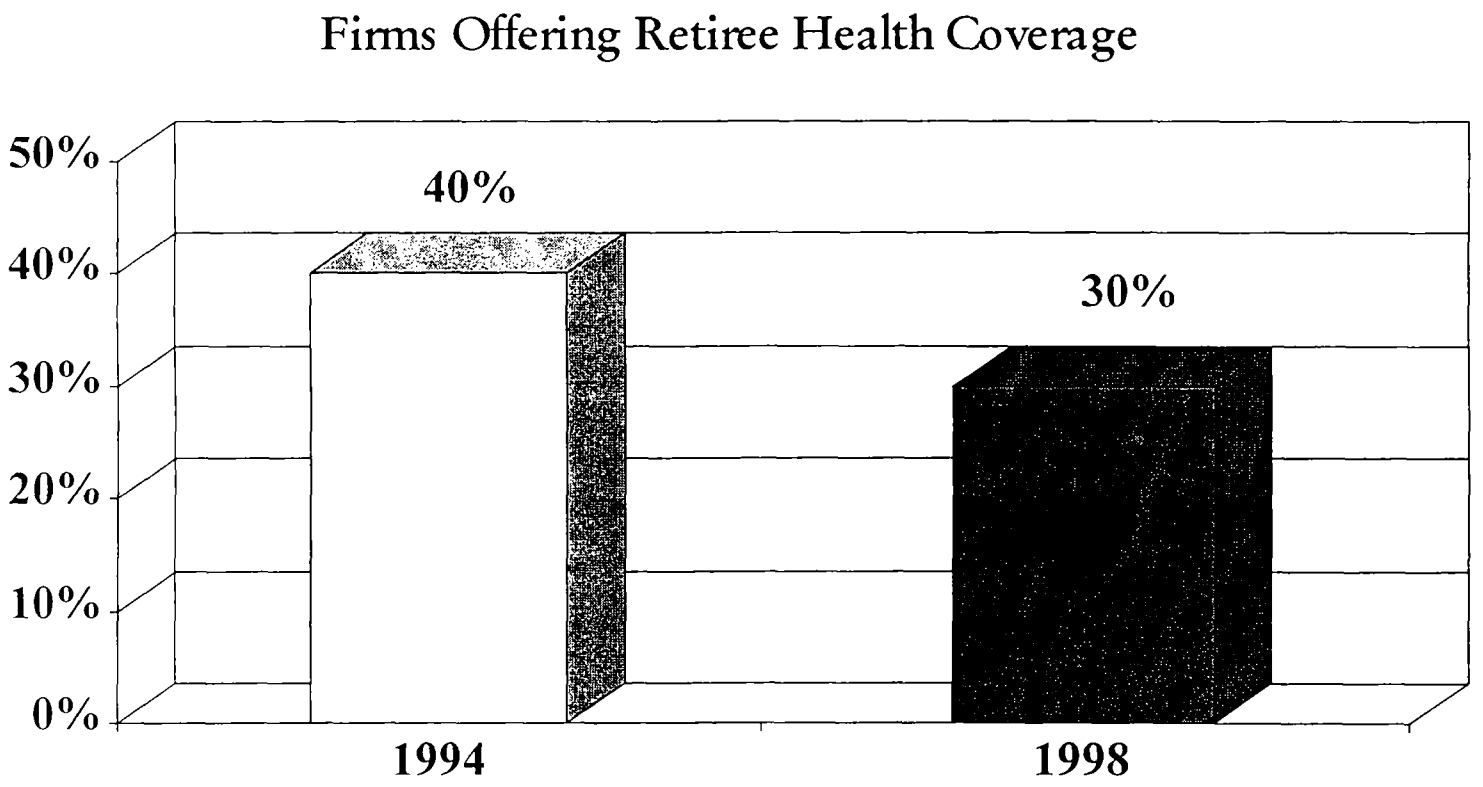
Proportion of All Plans With Limits of Less Than $1,000



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



SOURCE: Foster-Higgins, 1998

REPUBLICAN LEADERSHIP'S MEDICARE "REFORM" PLAN

- **Adopts "premium support" proposal that raises premiums and effectively coerces beneficiaries into managed care**: The Breaux-Thomas "premium support" proposal caps the government contribution for all plans. Since the cost of traditional Medicare will be above the cap, its premium will rise nationwide – 10 to 30 percent. This financial penalty for staying in traditional Medicare will force many beneficiaries to enroll in managed care.

- **Refusal to dedicate surplus to Medicare threatens Medicare's financing and ability modernize**: Reflecting their agenda to let Medicare "wither on the vine," the Republican Leadership's tax bill dedicates:

  - No new revenue to extend the life of the Medicare trust fund by a single day.

  - No funding for moderating the Medicare provider payment reductions in the Balanced Budget Act (BBA) of 1997 which are excessive.

  - No funding for a prescription drug benefit that is affordable and accessible to all beneficiaries.

- **Inadequate prescription drug benefit leaves out millions of middle-class Medicare beneficiaries:** The Republicans' plan gives a tax deduction to buy Medigap insurance with prescription drugs. About 55 percent of elderly do not have tax liability and thus would not qualify for a deduction and even those that do often lack access to Medigap because they are sick or have no plan options. It also limits additional coverage to those with incomes below 150 percent of poverty (about $12,750 a year for a single, $17,000 for a couple). This does not help the more than half of beneficiaries without drug coverage who are middle class nor the millions more who have expensive and/or poor coverage.

- **Raises the age eligibility for Medicare to 67, increasing the number of uninsured**: Since people ages 55 to 65 are the most rapidly growing group of uninsured, raising the eligibility age without a policy alternative will cause many of these seniors to become uninsured .

- **Includes an unlimited home health and nursing home copay**: The more than 1 million beneficiaries who need more than 60 home health visits per year (who tend to be older, sicker and widows) would pay more than $300. In addition, beneficiaries would pay about $60 per day for the first 20 days of nursing home care which is high for those without supplemental coverage.

ISSUES WITH MEDICARE "PREMIUM SUPPORT" PLAN

- **"Premium support" proposal increase premiums and coerces beneficiaries into managed care**: The cost of traditional Medicare will rise nationwide – 10 to 30 percent according to the independent Medicare actuary, forcing many beneficiaries to enroll in managed care.

- **Catch-22 for rural beneficiaries.** Medicare beneficiaries in rural areas would pay different premiums for the same traditional Medicare for the first time ever, and still have little or no access to prescription drug benefits.

  - Beneficiaries with one private plan option or more would have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their needs.

  - Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even just one plan enter the area. Since managed care plans with no competition tend to have lower benefits, rural beneficiaries – who rarely have more than one or two plan options – would still lack access to a meaningful drug benefit.

- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries would not be protected against higher traditional program premiums. They also would frequently pay more for private plans, since the government payments would not fully account for local costs, which are higher in most urban areas.

- **Encourages competition on extra benefits, not price and quality.** Premium support subsidizes extra benefits in managed care only. As a result:

  - Hard to make "apples-to-apples" comparisons, especially since few beneficiaries know the dollar-value of extra benefits.

  - Easy to manipulate benefits to attract healthy/discourage sick beneficiaries from enrolling. Managed care plans could offer subsidized benefits like travel emergency coverage or extra prevention to attract healthier seniors.

  - Discriminates against beneficiaries in low-cost or rural areas. Over 11 million beneficiaries, including 75 percent of rural Medicare beneficiaries, lack have access to Medicare managed care plan. Although these people pay the same Part B premium, they do not have access to extra benefits.

REPUBLICAN PLAN REPEATS EFFORT TO LET MEDICARE "WITHER ON THE VINE"

In 1995, the Republican Congress promised to let Medicare "wither on the vine" by cutting Medicare spending to impossibly low levels and forcing beneficiaries into Medicare. The 1999 Republican Leadership appears to share these goals.

- **Financially starves Medicare.** All experts agree that the doubling of Medicare beneficiaries in the next 30 years cannot be accommodated through spending reductions alone – new revenues will inevitably be needed. Without the surplus dedication, the Medicare program could not be sustained:

  - Spending growth 60 percent below private sector. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027.

  - Roughly a 20 percent cut in spending on hospital and other Part A services. Such cuts would be too deep to be absorbed by providers without sacrificing quality of care. They would dwarf the cuts in the Balanced Budget Act.

  - Tax increase for the next generation. Waiting to address Medicare's financing not only increases the size of the problem – since there are fewer years in which to address it – but would inevitably require a payroll (or any other) tax increase on the next generation of Americans.

- **Weakens traditional Medicare by coercing beneficiaries into managed care.** The Republican plan includes a number of provisions that make it more expensive and difficult for beneficiaries to remain in traditional Medicare:

  - "Premium support" that raises the premiums for those who remain in traditional Medicare. Rather than using incentives to encourage beneficiaries to join managed care, the Republican plan uses penalties for staying in traditional Medicare to implicitly, financially coerce b eneficiaries to join managed care plans.

  - Subsidies for prescription drug coverage only in managed care. The premium support plan would allow the government to pay for drug benefit in managed care but not in traditional Medicare.

CLINTON-GORE PLAN TO STRENGTHEN MEDICARE FOR THE 21st CENTURY

- **Makes Medicare more competitive and efficient – without premium increases.** The President's plan restructures Medicare to:

  - Give traditional Medicare new private-sector purchasing and quality improvement tools and constrains cost growth in the out-years.

  - Inject price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices and saving money for both beneficiaries and Medicare.

  - Moderate Balanced Budget Act. The plan also takes administrative and legislative actions, including a $7.5 billion quality assurance fund, to smooth out provisions in the Balanced Budget Act that may be too excessive.

- **Modernizes Medicare's benefits – including adding a long-overdue prescription drug benefit for all beneficiaries.**

  - Prescription drug benefit. All Medicare beneficiaries would have the option to purchase a drug benefit that provides for privately-negotiated price discounts and coverage of 50 percent of the costs from the first presription for spending up to $5,000 when fully phased in. Premiums would be $24 in 2002 and $44 per month in 2008.

  - Prevention initiative. Copays and deductibles for all preventive services would be eliminated and new services would be studied.

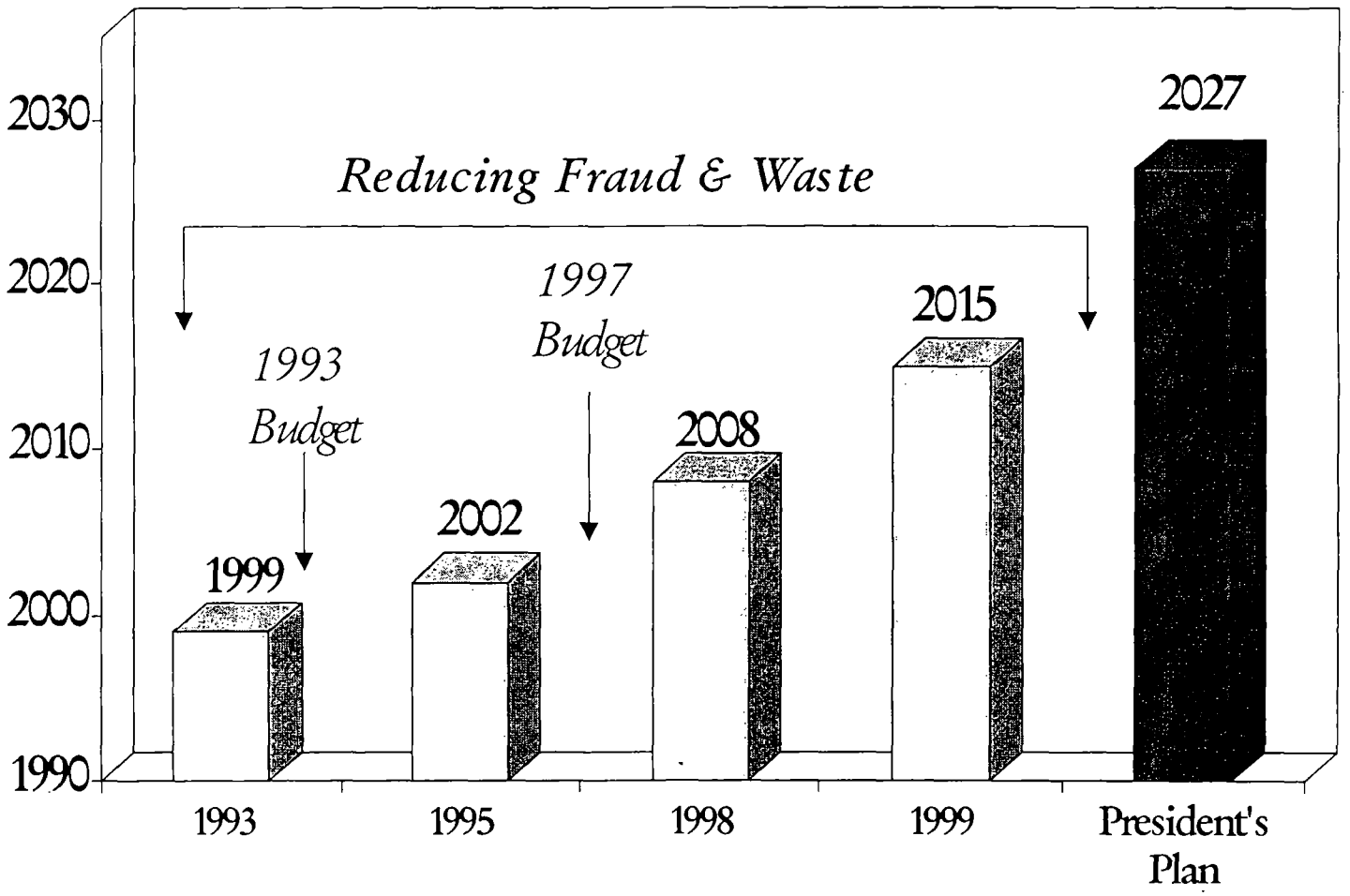
  - Rationalizes cost sharing. The plan would add a 20 percent lab copay and index the Part B deductible to inflation.

  - Medicare Buy-In. The plan includes a proposal to provide an affordable, coverage option for vulnerable Americans between ages 55 and 65.

- **Dedicates surplus to strengthen Medicare.** Over $300 billion over 10 years would be dedicated from the surplus to Medicare. These funds would contribute towards extending the life of the Medicare Trust Fund to 2027 and help offset the new prescription drug benefit and the $7.5 billion quality assurance fund for moderating excessive Balanced Budget Act provider cuts.

Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



DRAFT

Gene — Joel / Larry requested this for critique of "Republican Medicare plan." Not distributed.

MEDICARE: What do you think?

Republican Leadership's Latest Medicare "Reform" Plan

Need to talk to CJ

- **IGNORES CHALLENGES FACING MEDICARE**
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CJ

This is so "hot" right now does this gel with as want to work together on bipart Medic Rfm.? We need to cool it down + still make our point

GS 8/19

CHALLENGES FACING MEDICARE

1

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CLINTON-GORE PLAN TO STRENGTHEN MEDICARE FOR THE 21st CENTURY

(2)

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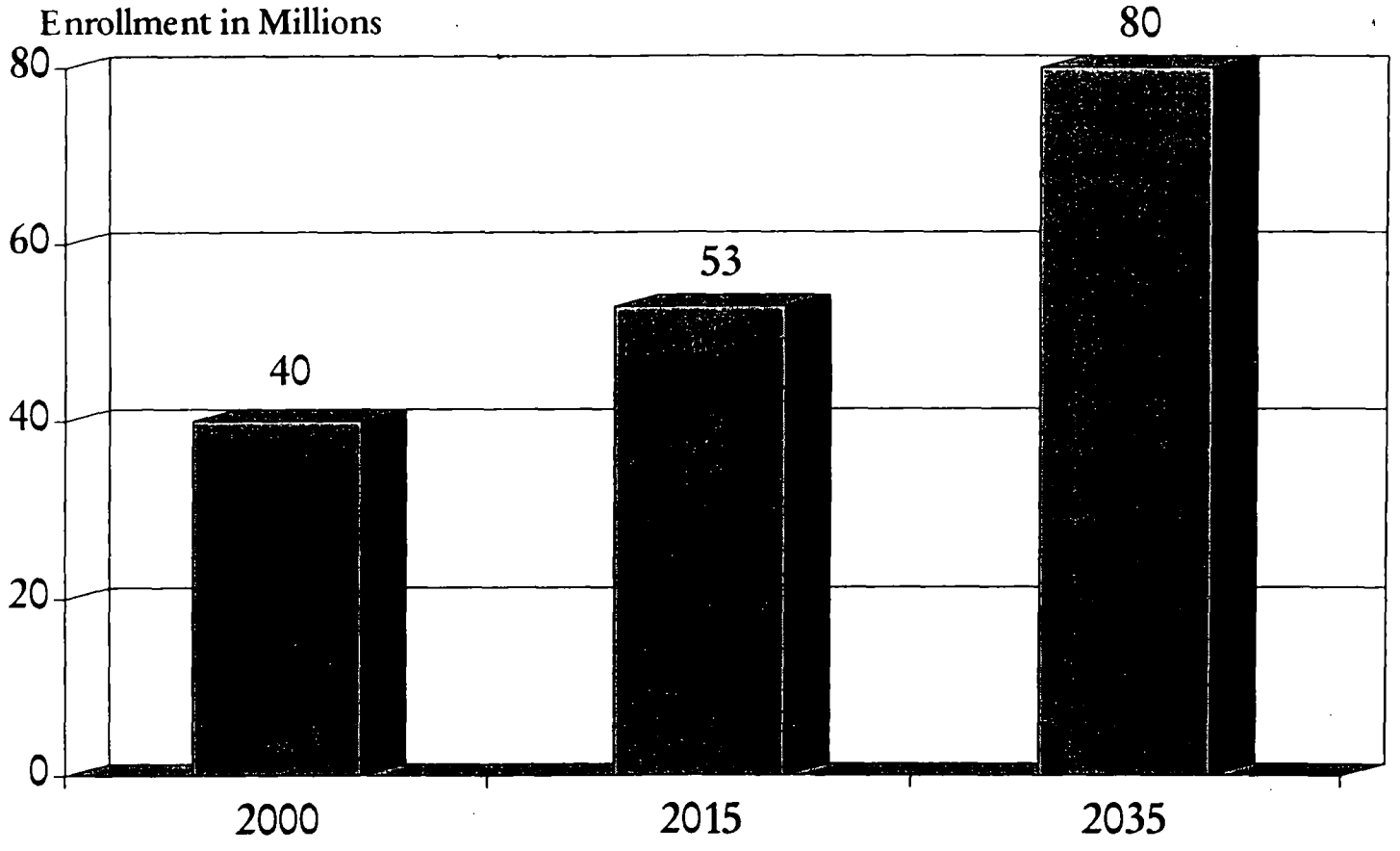
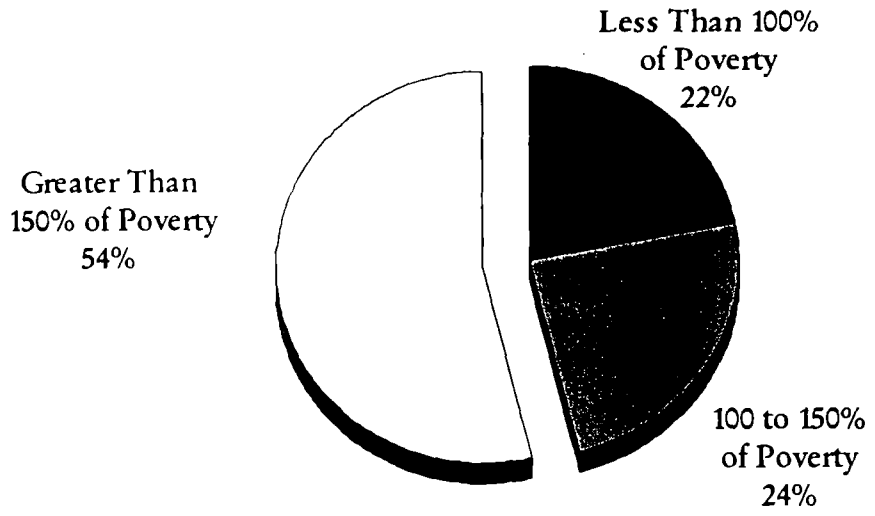


Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

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



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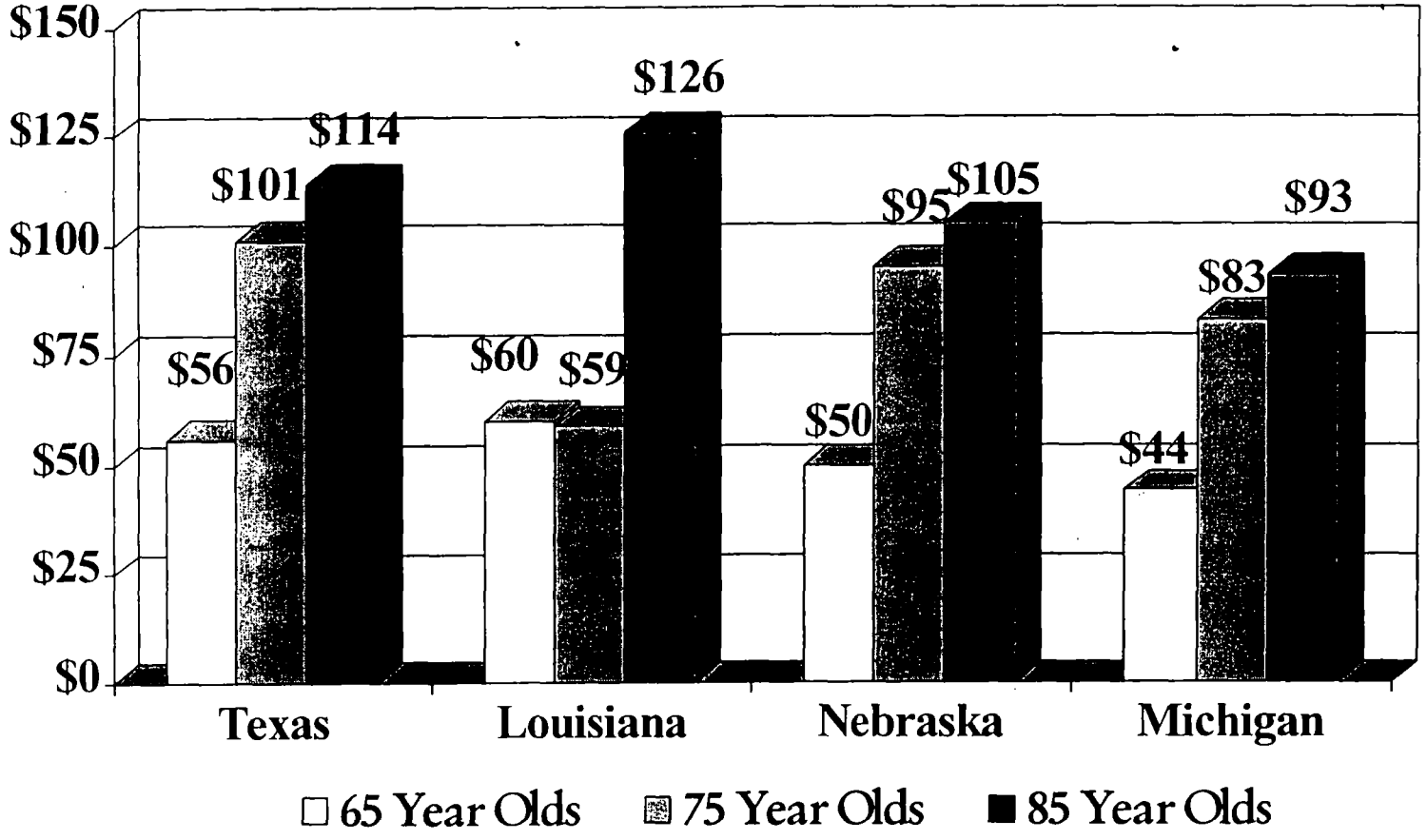
Disproportionately Affects:

- **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

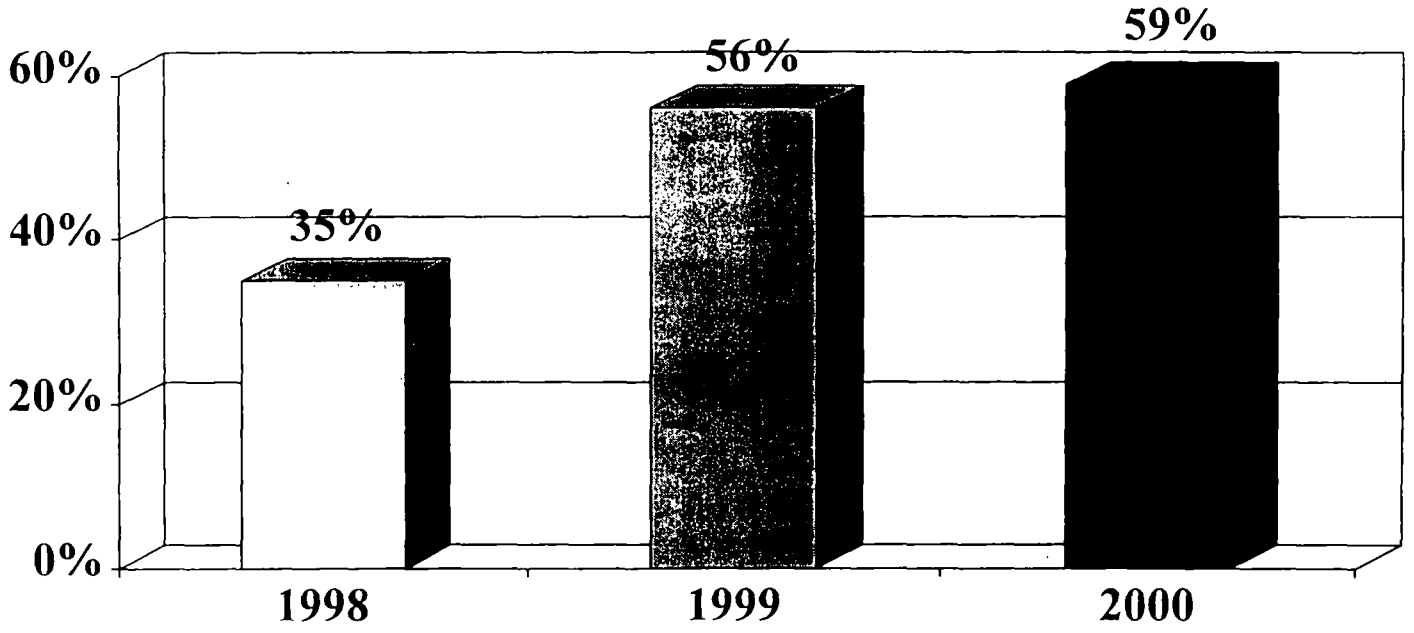
Premiums for Medigap, Which Only Covers 8% of Beneficiaries, Are High And Increase With Age



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

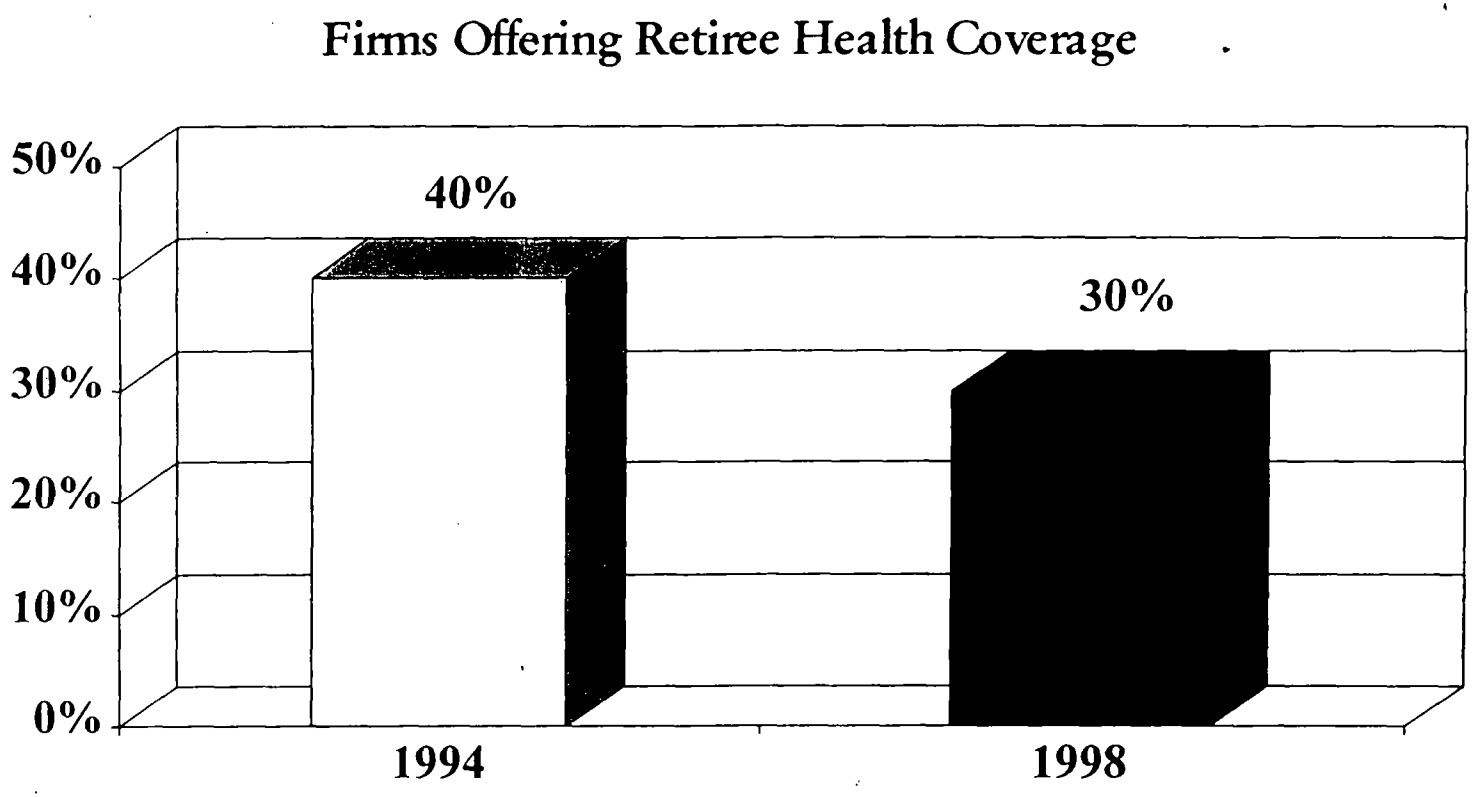
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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

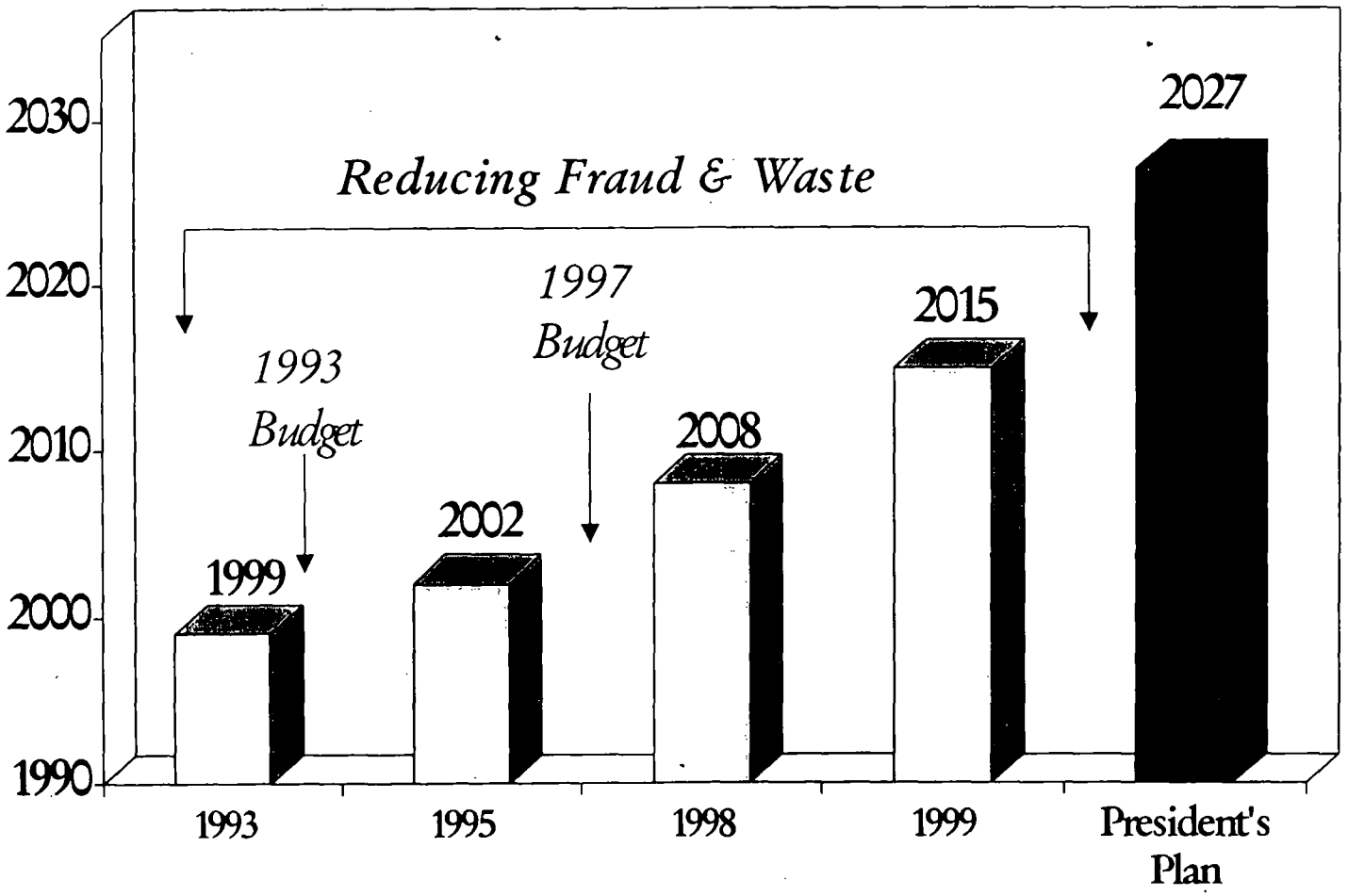
25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



REPUBLICAN LEADERSHIP'S MEDICARE "REFORM" PLAN

- **Adopts "premium support" proposal that raises premiums and effectively coerces beneficiaries into managed care**: The Breaux-Thomas "premium support" proposal caps the government contribution for all plans. Since the cost of traditional Medicare will be above the cap, its premium will rise nationwide – 10 to 30 percent. This financial penalty for staying in traditional Medicare will force many beneficiaries to enroll in managed care.

- **Refusal to dedicate surplus to Medicare threatens Medicare's financing and ability modernize**: Reflecting their agenda to let Medicare "wither on the vine," the Republican Leadership's tax bill dedicates:

  - No new revenue to extend the life of the Medicare trust fund by a single day.
  - No funding for moderating the Medicare provider payment reductions in the Balanced Budget Act (BBA) of 1997 which are excessive.
  - No funding for a prescription drug benefit that is affordable and accessible to all beneficiaries.

- **Inadequate prescription drug benefit leaves out millions of middle-class Medicare beneficiaries:** The Republicans' plan gives a tax deduction to buy Medigap insurance with prescription drugs. About 55 percent of elderly do not have tax liability and thus would not qualify for a deduction and even those that do often lack access to Medigap because they are sick or have no plan options. It also limits additional coverage to those with incomes below 150 percent of poverty (about $12,750 a year for a single, $17,000 for a couple). This does not help the more than half of beneficiaries without drug coverage who are middle class nor the millions more who have expensive and/or poor coverage.

- **Raises the age eligibility for Medicare to 67, increasing the number of uninsured**: Since people ages 55 to 65 are the most rapidly growing group of uninsured, raising the eligibility age without a policy alternative will cause many of these seniors to become uninsured .

- **Includes an unlimited home health and nursing home copay**: The more than 1 million beneficiaries who need more than 60 home health visits per year (who tend to be older, sicker and widows) would pay more than $300. In addition, beneficiaries would pay about $60 per day for the first 20 days of nursing home care which is high for those without supplemental coverage.

ISSUES WITH MEDICARE "PREMIUM SUPPORT" PLAN

- **"Premium support" proposal increase premiums and coerces beneficiaries into managed care**: The cost of traditional Medicare will rise nationwide – 10 to 30 percent according to the independent Medicare actuary, forcing many beneficiaries to enroll in managed care.

- **Catch-22 for rural beneficiaries.** Medicare beneficiaries in rural areas would pay different premiums for the same traditional Medicare for the first time ever, and still have little or no access to prescription drug benefits.

  - Beneficiaries with one private plan option or more would have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their needs.

  - Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even one plan enter the area. Since managed care plans with no competition tend to have lower benefits, rural beneficiaries – who rarely have more than one or two plan options – would still lack access to a meaningful drug benefit.

- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries would not be protected against higher traditional program premiums. They also would frequently pay more for private plans, since the government payments would not fully account for local costs, which are higher in most urban areas.

- **Requires beneficiaries to compare plans based on confusing benefits, not price and quality.** The premium support proposal does not alter the anti-competition status quo. As a result:

  - Hard to make "apples-to-apples" comparisons, especially since few beneficiaries know the dollar-value of benefits.

  - Easy to manipulate benefits to attract healthy/discourage sick beneficiaries from enrolling. Managed care plans could offer subsidized benefits like travel emergency coverage or extra prevention to attract healthier seniors.

  - Discriminates against beneficiaries in low-cost or rural areas. Over 11 million beneficiaries, including 75 percent of rural Medicare beneficiaries, lack have access to Medicare managed care plan. Although these people pay the same Part B premium, they do not have access to drugs and other benefits.

REPUBLICAN PLAN REPEATS EFFORT TO LET MEDICARE "WITHER ON THE VINE"

In 1995, the Republican Congress promised to let Medicare "wither on the vine" by cutting Medicare spending to impossibly low levels and forcing beneficiaries into Medicare. The 1999 Republican Leadership appears to share these goals.

- **Financially starves Medicare.** All experts agree that the doubling of Medicare beneficiaries in the next 30 years cannot be accommodated through spending reductions alone – new revenues will inevitably be needed. Without the surplus dedication, the Medicare program could not be sustained:

  - Spending growth 60 percent below private sector. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027.

  - Roughly a 20 percent cut in spending on hospital and other Part A services. Such cuts would be too deep to be absorbed by providers without sacrificing quality of care. They would dwarf the cuts in the Balanced Budget Act.

  - Tax increase for the next generation. Waiting to address Medicare's financing not only increases the size of the problem – since there are fewer years in which to address it – but would inevitably require a payroll (or any other) tax increase on the next generation of Americans.

- **Weakens traditional Medicare by coercing beneficiaries into managed care.** The Republican plan includes a number of provisions that make it more expensive and difficult for beneficiaries to remain in traditional Medicare:

  - "Premium support" that raises the premiums for those who remain in traditional Medicare. Rather than using incentives to encourage beneficiaries to join managed care, the Republican plan uses penalties for staying in traditional Medicare to implicitly, financially coerce b eneficiaries to join managed care plans.

  - Subsidies for prescription drug coverage only in managed care. The premium support plan would allow the government to pay for drug benefit in managed care but not in traditional Medicare.

Congress of the United States

Washington, DC 20515

August 18, 1999

The Honorable William J. Clinton
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President:

As the summer weather heats up, so too has the recent debate over tax relief. Throughout the year, Congressional Republicans have shown our commitment to strengthening Social Security and Medicare, and reducing the national debt. We commend you for recently agreeing to support our Social Security lock-box plan. As you know, the lock-box will save the *entire* Social Security surplus to be used only for Social Security and Medicare. This will accomplish two of our shared goals: it will pay down the national debt until we have implemented plans to secure Social Security and Medicare for future generations.

In recent weeks, you have vowed to veto common-sense tax relief, claiming that this money should be spent on other priorities. You have implied that we ignore Social Security and Medicare, yet our plan reserves $2.2 trillion for Social Security and Medicare reform over the next decade. You have said that the surplus should be used to pay down the national debt, yet our plan reduces the national debt by over $2 trillion in the next ten years – even more than your plan. Mr. President, there is no honest reason to veto this common-sense tax relief legislation.

Even if you believe that working Americans do not deserve tax relief, surely you must agree with us that issues of basic tax fairness must be addressed. The current tax code unfairly levies extra taxes on millions of Americans just because they are married. This is unfair. Tens of millions of Americans are investing money in the stock market to help finance their retirement. While our government often extols the importance of savings, it then turns around and punishes these investors with the capital gains tax. This is unjust. Family farmers and small business owners are stung by the death tax. They pay taxes on their income and property throughout their lives, yet the government again taxes them when they die. The tax code makes it impossible for them to pass their farm or small business on to their children. This is un-American.

Mr. President, our tax bill addresses basic American principles of common sense and fairness. In addition to the aforementioned proposals, our bill also expands Roth IRAs, 401 (k)s and education IRAs. If you are serious about encouraging Americans to save, then surely you must support this legislation. Furthermore, this legislation extends many important research and development tax credits. These credits encourage American businesses to develop new technologies that will help them better compete in the global marketplace.

Too often, partisan squabbles center on who deserves credit for this budget surplus. But the truth is that the American people are the ones who created it, and it is they who deserve fairness and tax relief. We hope you will join us in delivering both.

Sincerely,

Trent Lott
Senate Majority Leader

J. Dennis Hastert
Speaker of the House

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Trent Lott
Senate Majority Leader

J. Dennis Hastert
Speaker of the House

To: Deborah
Jeanne
Fl: Peter

HMO DRAFT

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MEDICARE+CHOICE PROGRAM TRENDS

Executive Summary

The Medicare+Choice program continues to grow despite challenges that parallel changes in the larger managed care market. About 45,000 Medicare beneficiaries have been choosing to join Medicare+Choice plans each month so far this year. But in both Medicare and the private sector, enrollees are finding that many plans are:

- raising premiums,
- restructuring benefits to avoid risk and increase costs to enrollees, and
- withdrawing from selected markets for a variety of management reasons.

Further analysis of Medicare+Choice plan business decisions to remain in or leave the program reveals that plans facing similar situations make different business decisions. Individual corporate strategies determine, for example, whether a plan chooses to leave rather than raise premiums or reduce extra benefits. There are, however, some noteworthy trends.

Plans leaving or reducing participation in Medicare+Choice tend to:

- Have more generous extra benefits, above and beyond the core Medicare benefits package, than plans that remain. They could easily have raised premiums or reduced the amount of extra benefits, as many plans remaining in the program are doing. But they instead chose to leave the program.
- Have problems maintaining provider networks. While this is especially true in outlying suburban and rural counties, it also is occurring in urban areas such as Suffolk County, New York, and Maricopa County, Arizona.
- Leave counties with payment rates lower than $500, and not primarily counties with the lowest payment rates. Only 4 percent of enrollees living in counties with the year 2000 floor payment rate of $401 per member per month were affected, vs 12 percent in counties with payments ranging from $450 to $500.
- Leave counties where payment increases are well above the national average. Plan withdrawals are affecting 7.2% of enrollees in counties where rates are rising by 10% or more but affecting only 2.4% of enrollees where rates are rising by 2%.

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- And they have less of an investment in the program, as measured by national enrollment rates.

Plans continuing participation in Medicare+Choice tend to be:

- In urban counties where increases in payment to plans are below the national average.
- Reducing and restructuring drug benefits in ways that increase enrollee out-of-pocket costs and may discourage enrollment by beneficiaries with greater health care needs. This is especially true for prescription drugs, which are the primary reason many beneficiaries enroll in Medicare+Choice plans. Plans are decreasing the dollar amount they cover, increasing use of formularies that limit choice, and increasing copayments.
- Increasing premiums. The national monthly average is nearly doubling from $21 in 1999 to $46 in 2000. And the number of plans charging no premium is dropping from 49 percent to 31 percent. The end result is that beneficiaries will pay more and get less.

Some of the most troubling trends disproportionately impact rural areas. Premiums are on average about 20 percent higher than in urban areas, drug coverage is less common, and far fewer beneficiaries have access to a Medicare+Choice plan; 21 percent vs 82 percent in urban areas. This is not surprising, as many rural counties also have no commercial managed care plans because of the difficulty in maintaining adequate enrollment and provider networks. However, the decline in rural access is occurring despite the fact that rural counties are receiving far greater payment increases than urban counties.

These trends underscore important lessons for Medicare reforms efforts.

Ongoing market volatility and regional disparities make it abundantly clear that managed care is not a reliable way to bring affordable access to prescription drug coverage to all Medicare beneficiaries.

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The best solution is to improve the Medicare benefit package by providing access to an affordable prescription drug benefit for all beneficiaries, and then paying Medicare+Choice plans explicitly for providing it to the beneficiaries they enroll. The President's Medicare reform proposal gives all beneficiaries the option to pay a modest premium for a benefit that covers half of all prescription costs up to $5,000 when fully phased-in in 2008, with no deductible and for less than half the price of the average Medigap policy. This will allow plans to provide additional benefits to their enrollees and help bring even more choices to Medicare beneficiaries.

Market volatility also makes clear that stronger protections are needed for beneficiaries affected by health plan corporate business decisions. The President's proposal will:

- give enrollees in departing plans access to all Medigap policies regardless of health status;
- expand Medigap open enrollment to newly disabled beneficiaries and those with end stage renal disease, and allow those with end stage renal disease to enroll in another plan;
- mandate a special Medigap open enrollment period for beneficiaries affected by a plan termination in January 1999; and
- increase penalties for violation of the Medigap open enrollment requirements.

The wide variation in what plans offer makes clear that payment reform is needed to ensure that all Americans get a fair and equitable deal for their tax and Medicare premium dollars, regardless of where they live. The President's reform proposal will establish a market-based payment system that uses competition, rather than an arcane statutory formula, to set truly fair prices in all markets. All plans will be paid their full price through a combination of government and beneficiary payments, with savings from low-priced plans passed directly onto beneficiaries, as in the Federal Employees' Health Benefits Program. Beneficiaries choosing plans that cost approximately 80 percent of traditional fee-for-service will pay no Part B premium.

All these changes are needed to strengthen and stabilize the Medicare+Choice program. They will secure cost savings for enrollees. And they will ensure fairness for all Medicare beneficiaries.

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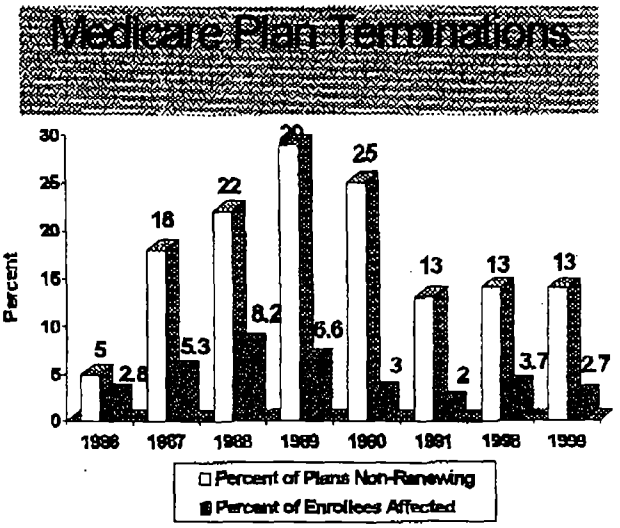
MEDICARE+CHOICE PROGRAM TRENDS

The Medicare+Choice program continues to grow. There are now more enrollees in the program than there were before some plans made business decisions last year to trim their participation. Program growth will likely continue despite similar decisions by some plans this year.

As of the July 1 deadline for plans to notify Medicare about participation in the year 2000, 99 Medicare+Choice plans have decided to reduce or drop participation in the program. This includes withdrawals from the program by 41 individual plans and cuts in the geographic areas served by another 58 plans. These changes affect about 327,000 beneficiaries in 329 counties in 33 States, or about 5% of all Medicare+Choice enrollees. The total is less than the 407,000 beneficiaries in 407 counties in 29 States who were affected in 1998. Of the 327,000 affected, 79,000 (1.3% of all Medicare+Choice enrollees), will return to traditional Medicare because they do not have any Medicare+Choice plan available in their county. This is more than the 51,000 enrollees left without access to another managed care plan in 1998.

Reductions in plan participation are still well below the rate seen a decade ago. In 1988, 22 percent of Medicare managed care plans withdrew from the program, affecting 8.2 percent of enrollees. In 1989, 29 percent of plans left, affecting 6.6 percent of enrollees. That compares to 13 percent of plans reducing participation in 1998 and again in 1999, with 3.7 percent and 2.7 percent of beneficiaries affected each year respectively. And, despite volatility in the marketplace, new plans continue to come into the program.



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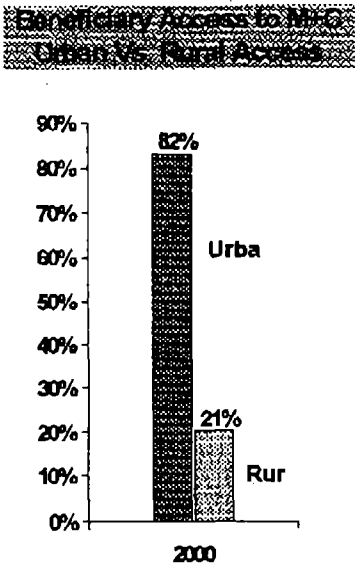
Since July 1998, 42 plans have been approved for participation or expansion in the program. As of August 1999, there are 13 pending applications for Medicare+Choice plans and 9 requests for service areas expansions. If approved, these applications would bring Medicare+Choice access to an additional 1.5 percent of beneficiaries over 50% of the counties in these applications now have no Medicare+Choice plans. For 2000, there will be at least 262 plan contracts with Medicare.

More than two thirds of beneficiaries continue to have access to a Medicare+Choice plan. However, the total will drop slightly, from 70 percent in 1999 to 68 percent in 2000, and the total number of counties with plans is dropping from 27 percent to 25 percent. This is largely because of the difficulty plans have in maintaining adequate enrollment and provider networks in outlying suburban and rural areas.

While 82 percent of urban beneficiaries will have access to Medicare+Choice plans in 2000, only 21 percent of rural beneficiaries will, down from 23 percent in 1999. This is not surprising, as many of these rural counties also have no commercial managed care plans.



However, the decline in rural access to Medicare+Choice is occurring despite the fact that rural counties are receiving far greater payment increases than urban counties.

Beneficiary Interest Continues to Grow

Despite volatility in the market, Medicare beneficiaries continue to express a strong and growing interest in the Medicare+Choice program. About one in every six beneficiaries is now in a Medicare+Choice plan. Enrollment losses resulting from reductions in plan participation last year were recouped within just two months.

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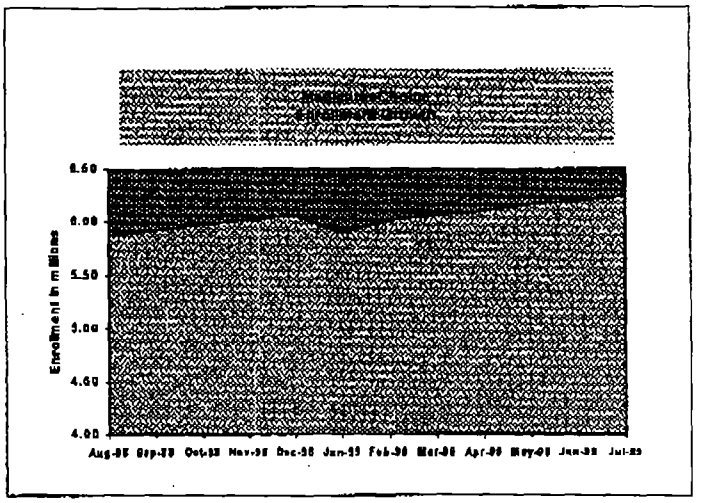
Total enrollment is rising, with about 45,000 new enrollees each month so far in 1999. Total Medicare managed care enrollment more than doubled in the past four years, from 2.7 million in 1995 to 6.2 million in 1999. The pace is down from its peak in 1997 of XX% growth.



Any leveling off in enrollment growth may reflect beneficiaries' greater awareness that plan participation and promises are subject to change each year. In fact, among beneficiaries affected by plan service reductions in 1998, half of those who could have chosen another managed care plan instead chose to return to the original fee-for-service Medicare program. There also is increased concern about plan restrictions on access to care throughout the general public, as reflected in broad support for Patients' Bill of Rights proposals.

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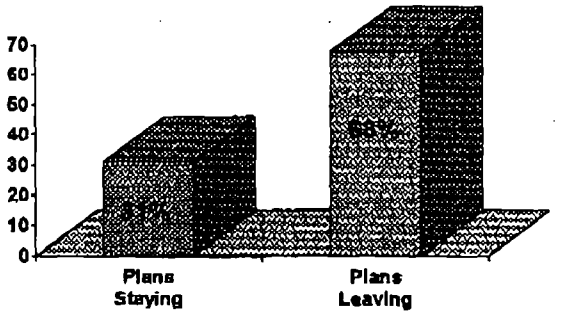
CHARACTERISTICS OF DEPARTING PLANS

Plans leaving or reducing participation in Medicare+Choice tend to offer more extra benefits above and beyond the core Medicare benefits package at little or no charge to beneficiaries -- than plans that are not leaving the program. In other words, they could have raised premiums or changed their benefits package, as many plans remaining in the program are doing, instead of choosing to leave the program.

Percent of M+C Plans with Zero Premiums



Among large national managed care firms, the size of the company's investment in the Medicare market, as reflected in the total number of enrollees nationwide, was strongly associated with decisions to remain or retreat. For example, less than one percent of beneficiaries in Pacificare, the largest Medicare+Choice company with nearly a million enrollees, were affected by service area reductions, while more than 12 percent of beneficiaries in CIGNA, with only 152, 000 enrollees, were affected.

National Enrollment + Plan Pull-Out Rates

Five Largest Plans That Withdrew	Total Medicare Enrollees	Percent of Enrollees Affected By Participating Decisions
Pacificare	997,953	0.9%
Kaiser	680,907	3.5%
Humana	483,998	5.7%
UHC	419,080	8.9%
CIGNA	152,073	12.1%

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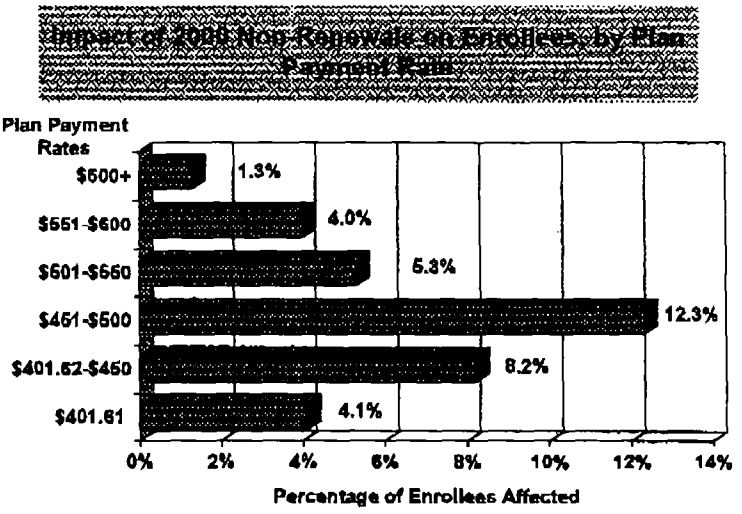
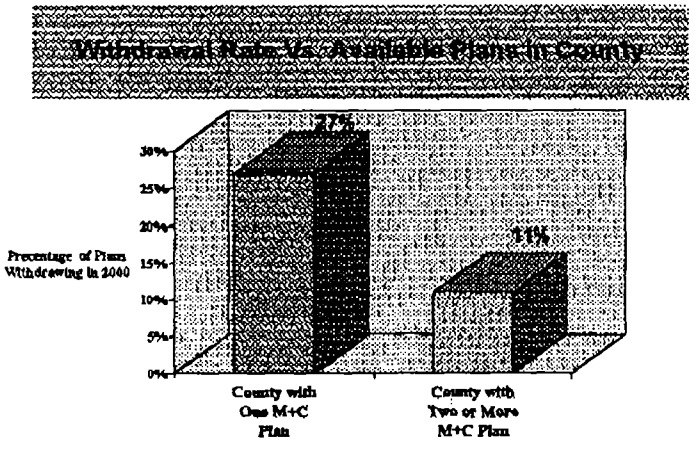
Problems maintaining provider networks were common among plans leaving high payment areas. For example, Oxford left 9,100 enrollees in Suffolk County, NY, despite a generous payment rate of $592, because of difficulty with providers. Similarly, Blue Cross and United Healthcare together left 15,000 beneficiaries in Maricopa County, Arizona, again because of difficulty maintaining provider networks, among other business factors.



Enrollees in plans with little or no competition were more likely to be affected. 11 percent of enrollees in plans with one other competitor were affected, while 27 percent of enrollees in plans with no competition were affected. And, in many cases, plans leaving the program had a much smaller market share than their competitors. Nationally, enrollees in plans with less than 5 percent of the market were twice as likely to be affected by non-renewals.



Plan Payment

Contrary to assertions by some industry sources, the rate of increase in payment to plans does not explain plan decisions to trim participation in the program.

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Payment is rising in all counties this coming year by an average of 5.1%, by at least 2 percent, and by as much as 13%. These increases result from Balanced Budget Act reforms designed to bring more plan choices to beneficiaries and level the playing field by increasing payment in counties that had the lowest rates and therefore the fewest number of plans.

Yet counties receiving some of the largest increases under the BBA payment system are experiencing the most disruption. Plan withdrawals are affecting 7.2% of enrollees in counties where rates are rising by 10% or more, but only 2.4% of enrollees where rates are rising by 2%.

Plans are primarily leaving counties where Year 2000 payment rates are lower than $500, and not primarily counties with the lowest payment rates. Only 4 percent of enrollees in counties with the Year 2000 floor payment rate of $401 were affected, vs 12 percent in counties with payments ranging from $450 to $500. Enrollees in counties with the highest payment rates, where plans are paid far more than the cost of providing Medicare benefits, were less likely to be affected. Only 1.3 percent of plans are leaving counties where payments are $600 or higher.

CHARACTERISTICS OF REMAINING PLANS

The majority of Medicare+Choice plans are remaining in the program. Plans remaining in the program tend to be raising premiums, as well as reducing and restructuring drug benefits in ways that increase enrollee out-of-pocket costs and may discourage enrollment by beneficiaries with greater health care needs. This is especially true for prescription drugs, which are the primary reason many beneficiaries enroll in Medicare+Choice plans.

Changes in Benefits

Most Medicare+Choice plans will continue to offer extra benefits beyond the basic Medicare package, such as coverage for prescription drugs. Because plan participation and enrollment are highest where payments are well above the cost of providing Medicare benefits, plans and beneficiaries in these areas often enjoy quite generous extra benefits beyond the Medicare benefits package at little or no cost to beneficiaries.

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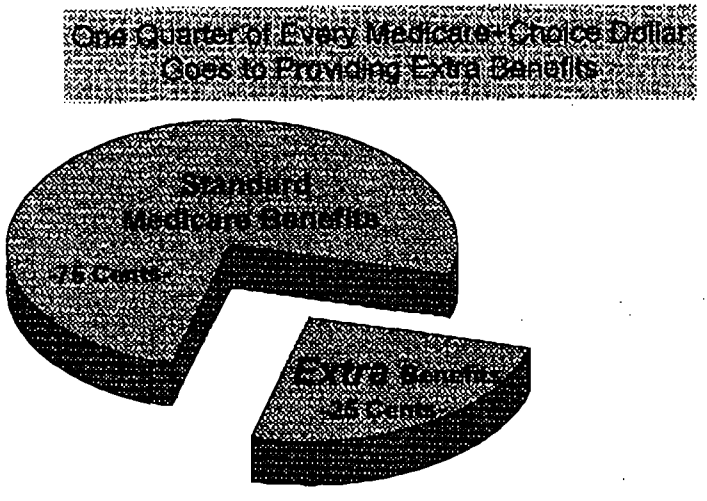
In fact, in 2000, only 75 cents out of every dollar Medicare pays to plans will be spent on providing the core Medicare benefit package. The other 25 cents goes for extra benefits above and beyond the core Medicare benefit package.

Yet plans are increasing what beneficiaries must pay for these extras. The overall average copayment for various benefits is rising from $29 to $32. The actuarial value of extra benefits is declining only slightly, from $52 per month in 1999 to $51 in 2000.

But, more importantly, the structure of these benefits, particularly prescription drug coverage, is changing in ways that limit plans costs,

increase enrollee out-of-pocket expenditures, and ultimately will discourage enrollment by beneficiaries with greater health care needs.

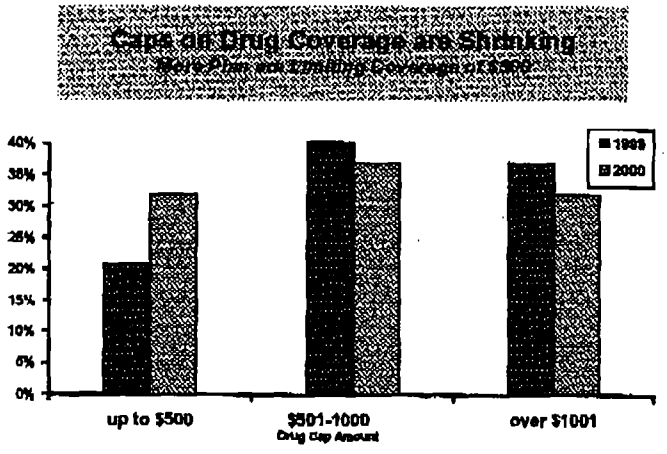
Drug Coverage: Most plans continue to offer drug coverage, 75 percent in 2000 vs 77 percent in 1999. The number of beneficiaries with access to a Medicare+Choice plan offering some drug coverage is dropping from 70 percent to 69 percent.



However, the total value to beneficiaries of these drug benefits is dropping by about 20 percent. That's because plans are decreasing the total amount of drugs they will pay for, raising premiums, increasing copayments for generics, and increasing use of formularies that limit drug choices. The actual value to beneficiaries varies dramatically

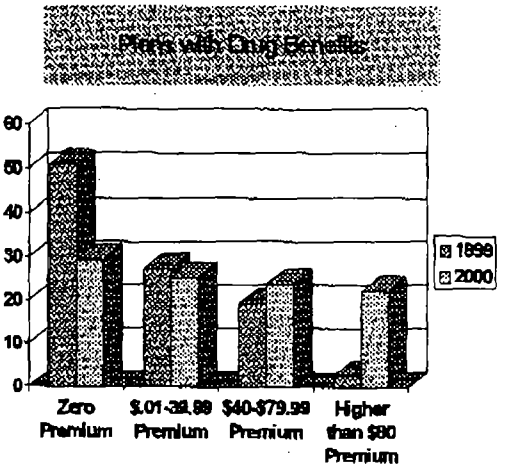
Plans have changed the structure of their drug benefits. A few more plans are offering unlimited drug benefits for both generic and brand drugs. However, a majority of plans (86 percent) will continue limiting drug benefits next year. Of those that have annual limits, 74 percent in 1999 had limits on both brand and generic drugs compared to only 45 percent in 2000. The remaining 55 percent will have limits on brand drugs but not annual limits on generics.

When plans do impose limits, the annual limits are smaller for 2000. For example, the proportion of plans with annual benefit limits of $500 or less is increasing from 21 percent in 1999 to 32 percent in 2000, and more than half of plans offering drug coverage will have annual limits of $1,000 or less. In fact, 82 percent of plans in 2000 will cap drug coverage below the $2000 level that is provided at the start of the President's Medicare reform plan. More plans are also putting special caps on brand name drugs vs generics. The number with such arrangements is increasing from 26 percent in 1999 to 55 percent in 2000.



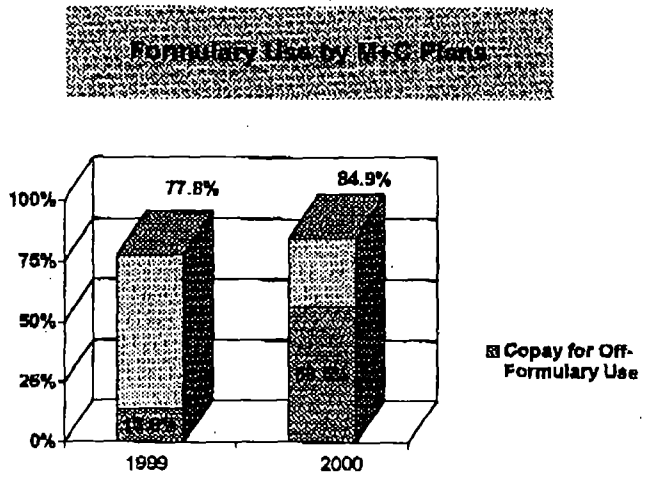
About 30 percent of plans with a drug benefit are not charging a premium, down from 51 percent in 1999. The number that offer drug coverage with premiums above $40 is increasing from 21 percent in 1999 to 46 percent in 2000. More plans are offering drugs in rural areas (33 in 200 vs 28 plans in 1999) but both the number of rural counties and rural beneficiaries with access to drugs is smaller in 2000. In rural areas, premiums for plans that offer drug coverage are even higher. In 2000, over one-third of rural plans with drug coverage will have a premium of $80 or more, up from fewer than 10 percent in 1999.

Plans are making greater use of drug formularies, meaning they encourage enrollees to use specific drugs, often in exchange for discounted prices from manufacturers. In 2000, 85 percent of plans with a drug benefit will have an established formulary, up from 78 percent in 1999. Of these, 57 percent may charge enrollees more for drugs that are not on the plan formulary, up from only 14 percent in 1999.



Plans are maintaining high copayments for brand name drugs, and raising copayments for generics. Nine out of ten plans with copayments continue to charge $15 or more for brand name drugs, with one in four charging $25 or more, as in 1999. For generics, however, the share of plans with copayments charging $10 or more is rising from 28 percent to 44 percent.

In 2000, plans in one in every eight counties where there is Medicare+Choice access are charging coinsurance for drugs. Plans also are sharply increasing the percentage that is being charged. And, while in 1999 no coinsurance rate was higher than 5 percent, in 2000 plans in 32 counties are charging coinsurance rates of 25 percent and higher.



Reducing and restructuring drug benefits in these ways may well discourage enrollment by beneficiaries with greater health care needs.

Beneficiary surveys show that drug coverage has been a primary reason for choosing to enroll in managed care. But higher premiums, increased use of higher charges for off-formulary drugs, and decreasing caps on total drug coverage substantially diminish the value for those with chronic conditions and greater pharmaceutical needs.

Drug coverage is weakening for Medicare beneficiaries outside Medicare+Choice plans, as well. Medigap plans with drug coverage are the most expensive, and are not guaranteed to beneficiaries who must return to original Medicare because of Medicare+Choice plan departures. Private retiree coverage is also unstable and declining, with now less than a third of firms offering it. And at least a third of all beneficiaries have no drug coverage at all.

Other Benefits: There are also moderate decreases in levels of coverage for other additional benefits not covered by Medicare, such as dental vision and hearing aid coverage.

- The number of plans offering dental benefits is dropping from 52 percent to 48 percent.
- The number of plans offering vision benefits is dropping from 95 percent to 91 percent.
- The number offering hearing aid coverage is dropping from 59 percent to 56 percent.

As with drug coverage, copayments and coinsurance are rising for office visits as well. The average copayment for a primary care office visit is rising from **$xx to $xx** and the average copayment for seeing a specialist is rising from **$xx to $xx**.

Changes in Premiums

As in the commercial and other managed care markets, premiums are going up in Medicare+Choice. The average premium, weighted by plan, is rising from $21.14 to $46.41. The number of plans charging no premium is dropping from 49 percent to 31 percent, **and the highest premium rate is rising from xx to xx**. And the proportion of plans charging premiums of more than $80 is rising from 2.9 percent to 18.4 percent.

Premium increases are most dramatic in urban areas, including many areas with large Medicare markets. For example, in New Jersey urban markets, premiums, weighted by eligibles, are more than tripling from an average of $22 to $80 per month. And in Florida urban markets, they are quadrupling from an average of $6 to$25.

Yet premiums remain much higher in rural areas, where substantial increases are also occurring, and extras like prescription drug coverage are less common and less generous. In 1999, half of plans in rural areas had premiums of $40 or less per month. In 2000, half of plans in rural areas will have premiums of $60 or more. Rural premiums, weighted by eligibles, will be about 20% higher than urban premiums for basic benefit plans ($42 versus $35). In Illinois, for example, premiums, weighted by eligibles, in rural areas will increase from $3 to $12, while in Wisconsin, premiums, weighted by eligibles, in rural areas will increase from $15 to $52.

Parallels in the Private Sector

Plan withdrawals, reduced benefits and premium increases are not unique to Medicare. They reflect the industry-wide difficulty plans face in controlling costs, continuing to maintain a primarily healthy mix of enrollees, adjusting to payment changes, and generating profits.

Industry analysts discussing these trends at a Salomon Smith Barney Health Care Investors Conference in New York February 9-11 noted that investors are demanding better profitability through increased premiums in the commercial sector, even at the expense of overall enrollment growth, and, through reduced benefits and additional payments from beneficiaries in Medicare. More

control is being sought over pharmacy costs, and plans are being told to do careful market analysis to determine the extent of their presence in given markets, and what a "disciplined" premium should be for the market.

Similar issues arose at the "4th Annual Wall Street Comes to Washington" session sponsored by the Center for Studying Health System Change June 9. Wall Street analysts noted that for many years, overly generous Medicare payments were used by managed care plans to subsidize their commercial business and keep private sector rates low. Now, however, because of the underwriting cycle, it is difficult for plans to engage in any cross subsidization.

As a result of these trends, there are many examples of health plans withdrawing from markets other than Medicare. Pacificare is withdrawing both Medicare and commercial service in several Washington State counties. Group Health Cooperative is pulling out of both Medicare and its private contracts in 14 counties in eastern Washington and northern Idaho, citing a variety of reasons for their decision. And in the northeast, Kaiser Permanente is withdrawing from Medicare, Medicaid, and its commercial business, affecting about 500,000 enrollees.

Over the last two years, the Federal Employees Health Benefits Program, which covers 9 million people, has seen the same kinds of changes that the M+C program has experienced. At the end of 1998, about 20 percent of participating HMOs withdrew from the FEHBP program. At the end of 1999, it is expected that about 13 percent of plans will withdraw from FEHBP. Premiums in FEHBP increased by slightly over 10 percent for 1999 and by 8.5 percent for 1998, and similar increases are expected next year.

There also are many examples of health plans raising premiums and reducing benefits in other markets. The California Public Employees Retirement System (CalPERS), which covers over 1 million people, agreed to an average premium increases of 7.3 percent for 1999 and more than 9.7 percent for 2000 -- the largest premium increases in CalPERS since 1991.

According to Towers-Perrin, large employers experienced a 7 percent increase in average health insurance premiums for active workers in 1999, owing to "unusually sharp increases in prescription drug costs and a health care market that continues to experience rising demand for services from an aging population." One finding in the survey was that rate increases for HMO products in 1999 equaled or exceeded the increases for traditional indemnity plans.

It is essential to note that the large increases now common in the private sector follow several years when private sector increases were quite small. In those same years Medicare increases were two to three times higher than private sector increases. Those years of excessive Medicare payment increases greatly contributed to plans' ability to provide generous extra benefit packages. They also greatly contributed to the fact that Medicare has lost, rather than saved, money on managed care, which was a primary reason for Balanced Budget Act payment reforms.

PRESIDENT'S PLAN WILL IMPROVE MEDICARE+CHOICE

Volatility in the Medicare+Choice market underscores the importance to enact the President's Medicare reform plan. It will increase protections for beneficiaries when plans withdraw from the program, ensure that plans receive full payment of market-based rates, and guarantee that all beneficiaries have access to affordable prescription drug coverage.

Clearly all beneficiaries need a more stable and reliable source of prescription drug coverage. And, if plans' primary problem is paying for benefits beyond the Medicare benefit package, the best solution is to improve the benefit package by providing all beneficiaries with access to an affordable prescription drug benefit, and paying plans explicitly for what most now offer only in areas where payments are excessive.

The President's plan gives all beneficiaries the option to pay a modest premium for a drug benefit. This benefit will cover half of all prescription costs up to $5,000 when fully phased in, with no deductible -- all for a premium that will be less than half the price of the average Medigap policy.

Medicare+Choice plans would be explicitly paid for providing a drug benefit under the President's plan. They would no longer have to depend on what the rate is in a given area to determine whether they can offer to do so. Thus, plans would continue to be able to expand the standard Medicare drug benefit if they choose to do so.

The President's plan also will modernize the way Medicare pays managed care plans. Rates would be set through competition among plans rather than through a complicated statutory formula, as they are today. All plans would be paid their full price through a combination of government and beneficiary payments. The lower the price, the less beneficiaries pay since the beneficiary contribution rate declines relative to the price of the plan, as in the Federal Employees' Health Benefits Program. Beneficiaries choosing plans that cost approximately 80% of traditional fee-for-service will pay no Part B premium.

The President's plan will preserve beneficiary options and strengthen protections when plans withdraw from Medicare by:

- giving beneficiaries access to all Medigap plans regardless of preexisting conditions, including those with prescription drug coverage;
- expanding the Medigap 6-month open enrollment period to newly disabled beneficiaries and those with end stage renal disease;
- allowing beneficiaries with end stage renal disease to enroll in another plan;
- mandating a special one-time additional Medigap open enrollment period for beneficiaries who were affected by a plan termination last fall; and
- increasing civil monetary penalties of up to $50,000 per violation plus $5,000 per day per violation of the Medigap open enrollment requirements.

All these changes will strengthen and stabilize the Medicare managed care market.

The President's plan also dedicates 15 percent of the budget surplus to Medicare for the next 15 years. This will assure the financial health of the Medicare Trust Fund through at least 2027, and help ensure that Medicare+Choice plan payment rates will be adequate well into the future.

National Association of
Community Health Centers, Inc.

MEMORANDUM

TO: Chris Jennings and Jeanne Lambrew

FROM: Dan Hawkins

DATE: August 31, 1999

RE: Data on the Impact of BBA for Federally Qualified Health Centers

Although I know we are not among the "interested parties" addressed in your memo of August 13, I would be remiss for not at least attempting to bring to your attention the very real problem facing Health Centers as a direct result of the BBA provision phasing out their Medicaid payment system, beginning on October 1st, and to appeal to you for support of an alternative to that phase-out.

As we have discussed several times over the past few years, we (NACHC and Health Centers generally) are not stuck on insisting that the Medicaid reasonable-cost payment system – under which Health Centers have been paid for the past 10 years – must continue indefinitely; in fact, we proposed and discussed possible replacements for that system as far back as 1995. On the other hand, I remember, however, that you (Chris) and I had a little mantra that went "no repeal without a replacement."

What will be the impact of the BBA's phase-out of Medicaid reasonable cost payments to Health Centers? The phase-out formula contained in the BBA penalizes even the most efficient Health Centers, and forces them to face revenue losses that are impossible to avoid or overcome no matter how much cost-cutting or other efficiencies might be attempted. Beginning with FY 2000, each Health Center will be paid first 95 cents of each dollar they spend on care for Medicaid clients, then 90 cents, then 85 cents, and so on. Thus, even if a Health Center were to cut its costs in half (say from $100 to $50 per visit), it would still receive only 95 percent of what it spends (in this case, $47.50). As the first chart (Attachment A) shows, total Medicaid payments reported by Health Centers in 1998 (not counting amounts that were for previous years' reconciliation or payments for non-FQHC services) were $898 million. Under the phase-out formula, then, the Health Centers will face an aggregate loss of at least $45 million next year – *equivalent to the cost of serving almost 130,000 people*, at their average per-patient annual cost of about $325. The following year, the losses double, to $90 million, then $135 million; in the fourth year, the losses reach $270 million (assuming no cost increases) – equivalent to the cost of serving nearly 800,000 people.

1330 New Hampshire Avenue, N.W. Washington, D.C. 20036 (202) 659-8008 FAX (202) 659-8519

Why do Health Centers need (and deserve) a different payment system in Medicaid? Because they are, in fact, very different from other ambulatory primary care providers, especially office-based physicians. As two charts from a recent report to the Kaiser Commission on Medicaid and the Uninsured (Attachment B) demonstrate, Health Centers have much higher concentrations of Medicaid-covered and uninsured patients than do private physicians – and thus cannot live on the marginal payment rates that most state Medicaid agencies (and most Medicaid managed care organizations) pay to private physicians. Equally important, the Health Centers serve a population that has much higher rates of serious and chronic conditions, thus requiring services of greater frequency and intensity. If Medicaid payments do not at least approximate the Centers' costs of serving their Medicaid clients, then they must cover those losses from the only other major, flexible revenue source they have – their federal grants that are supposed to cover the cost of caring for their uninsured clients. Under the phase-out, then, the real losers will be the uninsured families who today rely on Health Centers for the only locally-available, affordable, continuous health care they receive.

What about the cost-efficiency of Health Centers? Aren't their costs too high to begin with? A recent report prepared by American Express Tax and Business Services (Attachment C), a firm that provides financial services to dozens of Health Centers nationally, for presentation to HHS Deputy Assistant Secretary Gary Claxton, found that among some 40 Health Centers nationally, the average patient visit consumed 1.73 relative value units (RVUs) – nearly 50 percent more intensive than the MGMA average for private group practices. The report also found that, among a sample of Health Centers for which RVU data is available by payer source, the average cost per RVU was just above $60, about 50 percent higher than the current Medicare RVU conversion factor for primary care services. When the additional "enabling" services that Health Centers routinely provide – such as outreach, patient case management, transportation, or translation services – but which are not billed separately, are taken into account, Medicaid costs per RVU at Health Centers compare very favorably with costs per RVU for other payers and in other settings. Finally, the report found that, for each of the Centers studied, Medicaid revenues were consistently below total Medicaid costs – in one case (a Center in Tennessee, which does not pay costs under its 1115 waiver), less than 30 percent of costs.

While this last example is clearly excessive, we expect that – once the Health Centers' reasonable cost payment system is completely repealed (in FY 2004), Medicaid payments to Health Centers will average only 50 percent of their Medicaid costs. If correct, then Health Center Medicaid losses could approach $500 million annually, causing a potential loss of care for nearly 1.5 million people nationally – more than one-third of all uninsured people receiving care at Health Centers today – at a time when the uninsured population is growing by more than 1 million annually while other providers are shown to be cutting back dramatically on the level of charity care they provide.

For all the above reasons, we have come together nationally with a good contingent of Health Center supporters in the Congress, to lay out a most reasonable alternative that would avoid the disaster of a phase-out without returning to unfettered cost-based reimbursement. Introduced as the "Safety Net Preservation Act" (S. 1277, H.R. 2341), the bill calls for the establishment of a new Prospective Payment System under Medicaid for Health Centers (and rural health clinics). I would be more than happy to brief you or your staff on the bill (we have already done so with Gary and

other senior HHS officials). I don't know if we can gain your support for this vital measure, but I do hope that – unlike 1997 – when the final deals are being cut in the back room, Health Centers and rural health clinics, and the 15 million low income, mostly minority Americans they serve, will not be lost and forgotten as all the other so-called 'big ticket' issues are finalized.

I look forward to hearing from you at your earliest convenience.

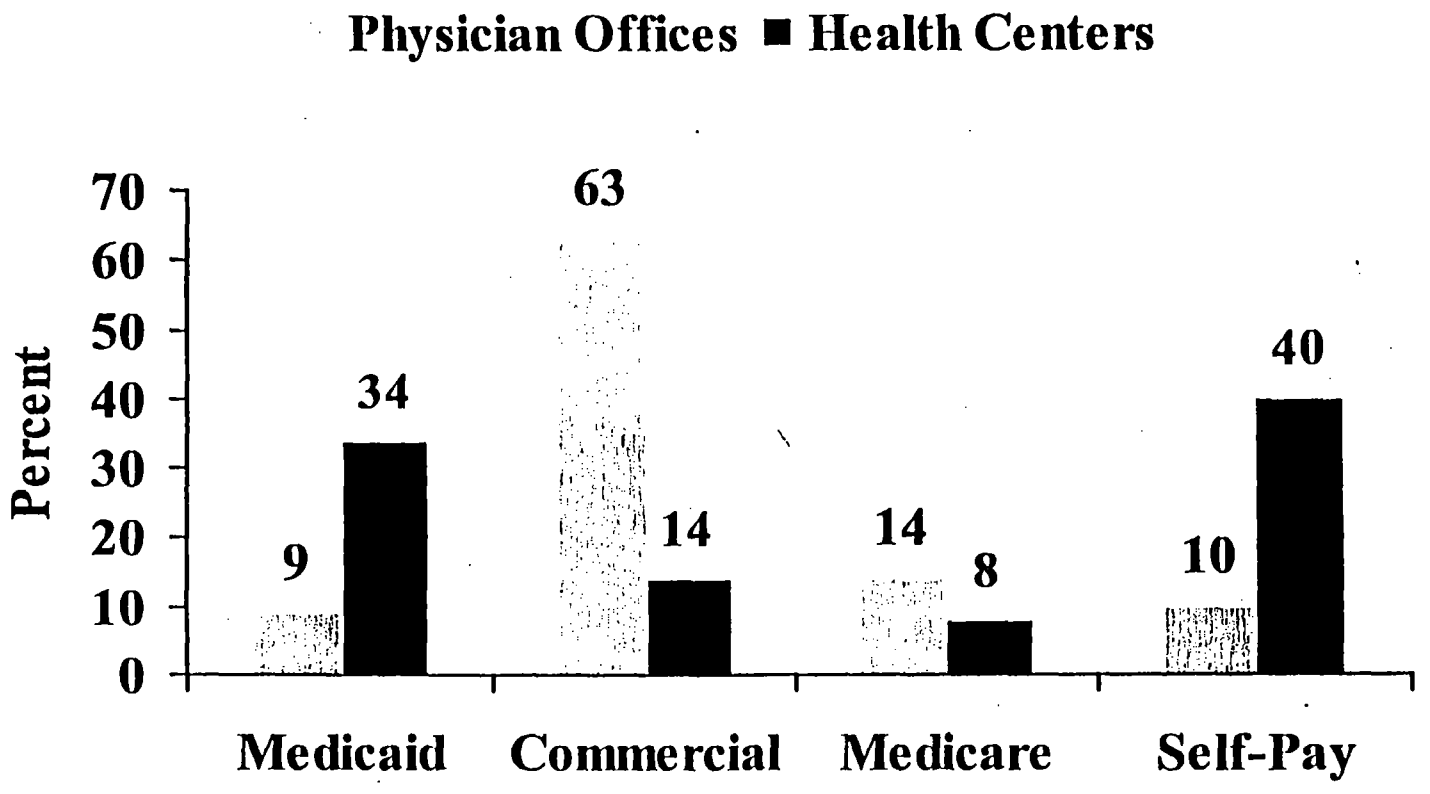
Attachments

Medicaid Payments to Health Centers

Total Medicaid Revenues, CY 1998	$996M
Reconciliation, previous years	-53M
Managed care payments, non-FQHC	-45M
Medicaid FQHC payments, CY	$898M
Medicaid Patients Served, CY	2.85M
Medicaid Cost per Patient, CY	$315
Total Medicaid Visits, CY (est.)	11.4M
Medicaid Cost per Visit, CY	$79

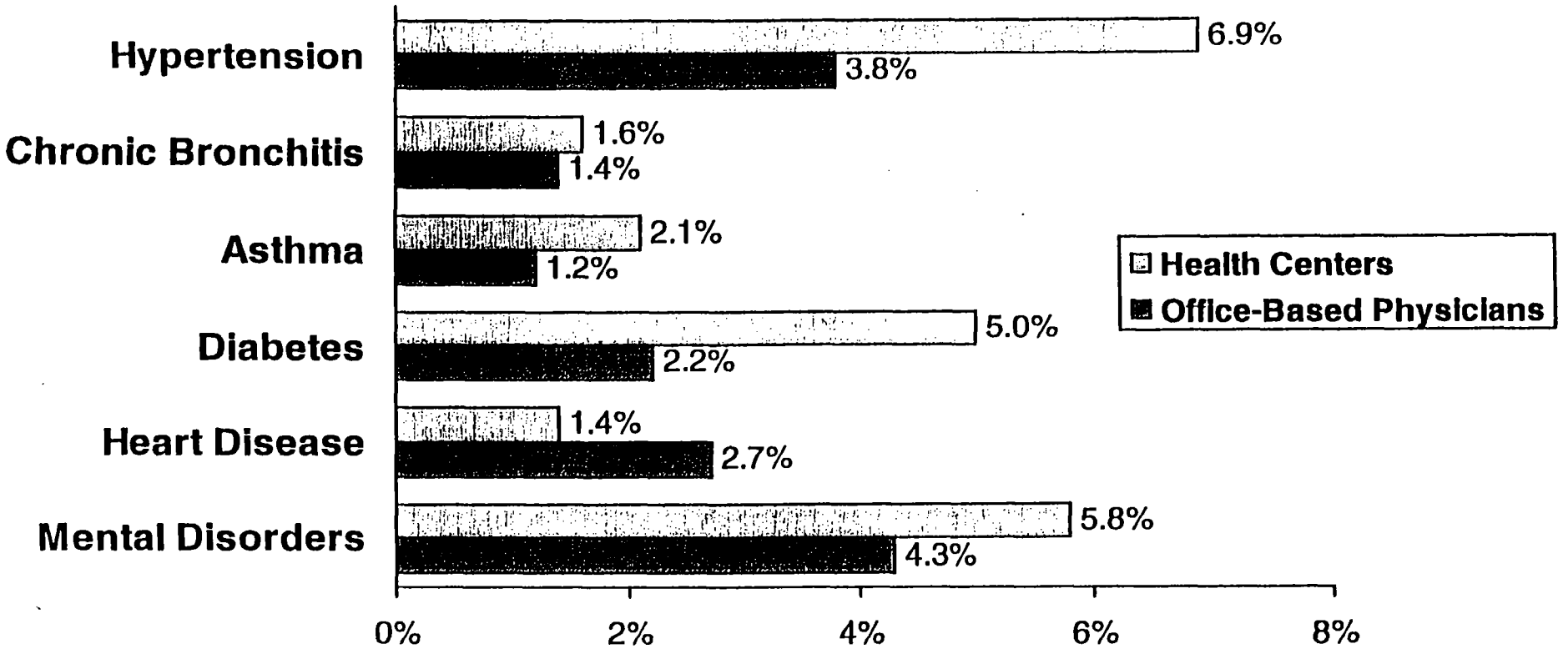
Source: Health Center UDS Reports to HRSA for CY 1998

Figure 7. Comparison of Health Center and Physician Office Patients by Payor Source



Source: 1995 National Ambulatory Care Survey; Center for Health Services Research and Policy Analysis of 1997 UDS.

Figure 8. Patient Visits for Selected Conditions Among Patients at Health Centers Compared to Office-Based Physician Practices



SOURCE: Center for Health Services Research and Policy analysis of 1997 UDS; U.S. Department of Health and Human Services, *Advance Data: National Ambulatory Medical Care Survey: 1996 Summary*, December 1997.

Attachment C

The National Association of Community Health Centers

Findings from Health Center Service Intensity Analysis

August 6, 1999

Presented by:

American Express Tax and Business Services Inc.

Tax & Business Services

Key Information Points

- American Express Tax and Business Services Inc. (TBS), has over twenty years of experience working with community health centers, providing a range of financial and operational services including Relative Value Unit (RVU) studies and diagnoses of organizational costs.

- TBS, in conjunction with the National Association of Community Health Centers, performed an analysis of Medicaid revenue based on data from five health centers across the country.

- The organizations selected for participation in the study represented health centers in different geographic settings (e.g. rural vs. urban, etc.) and experiencing various stages of managed care penetration among their Medicaid populations.

- Total Medicaid revenue per visit was consistently below the total Medicaid cost per visit for services among participating health centers.

Average RVUs per Visit

The following data is a partial selection from the TBS Health Center Database:

Health Center	RVUs per Visit (3)	Type	Geographic Area
Health Center A	2.20	Rural	Northwest
Health Center B	2.29	Urban	Northeast
Health Center C	1.99	Urban	Northeast
Health Center D	1.34	Rural	West
Health Center E	1.75	Rural	Northeast
Health Center F	2.25	Rural	West
Health Center G	1.57	Urban	MidAtlantic
Health Center H	1.94	Rural	Appalachia
Health Center I	2.05	Urban	Midwest
Health Center J	1.55	Rural	Northeast
Health Center K	1.83	Urban	West
National Median (1)	**1.75**		
Private Medical Group Practice (2)	**1.23**		

(1) National median calculated from 40 health centers in TBS Health Center Database; Based 1998 Data
(2) MGMA 1998
(3) Source: TBS Database of Health Centers nationally; Based on 1998 Data

Findings from Service Intensity by Payor

RVUs per Visit

	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center	Average
Medicaid	1.82	2.25	1.75	1.54	2.43	2.23
Medicare	1.45	1.45	1.97	1.22	2.66	2.32
Commercial	1.45	2.76	1.61	2.57	2.49	2.13
Self Pay	1.44	1.73	1.00	1.39	2.66	1.87

RVUs per User

	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center	Average
Medicaid	1.49	7.42	3.59	6.16	10.76	8.58
Medicare	4.00	6.15	5.85	6.33	21.18	15.91
Commercial	1.75	7.46	4.98	1.73	11.88	7.34
Self Pay	2.87	3.57	3.15	3.59	6.86	4.97

Findings from Service Intensity by Payor

Medicaid	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center	Average
RVUs per Visit	1.82	2.25	1.75	1.54	2.43	2.23
Cost per RVU	$ 63.22	$ 60.92	$ 75.91	$ 84.49	$ 59.51	$ 63.66
Cost per Visit	$ 115.06	$ 137.07	$ 132.84	$ 130.11	$ 144.61	$ 138.97

Medicare	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center	Average
RVUs per Visit	1.45	1.45	1.97	1.22	2.66	2.32
Cost per RVU	$ 63.22	$ 60.92	$ 75.91	$ 84.49	$ 59.51	$ 62.70
Cost per Visit	$ 91.67	$ 88.33	$ 149.54	$ 103.08	$ 158.30	$ 136.23

Commercial	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center	Average
RVUs per Visit	1.45	2.76	1.61	2.57	2.49	2.13
Cost per RVU	$ 63.22	$ 60.92	$ 75.91	$ 84.49	$ 59.51	$ 62.51
Cost per Visit	$ 91.67	$ 168.14	$ 122.22	$ 217.14	$ 148.18	$ 123.58

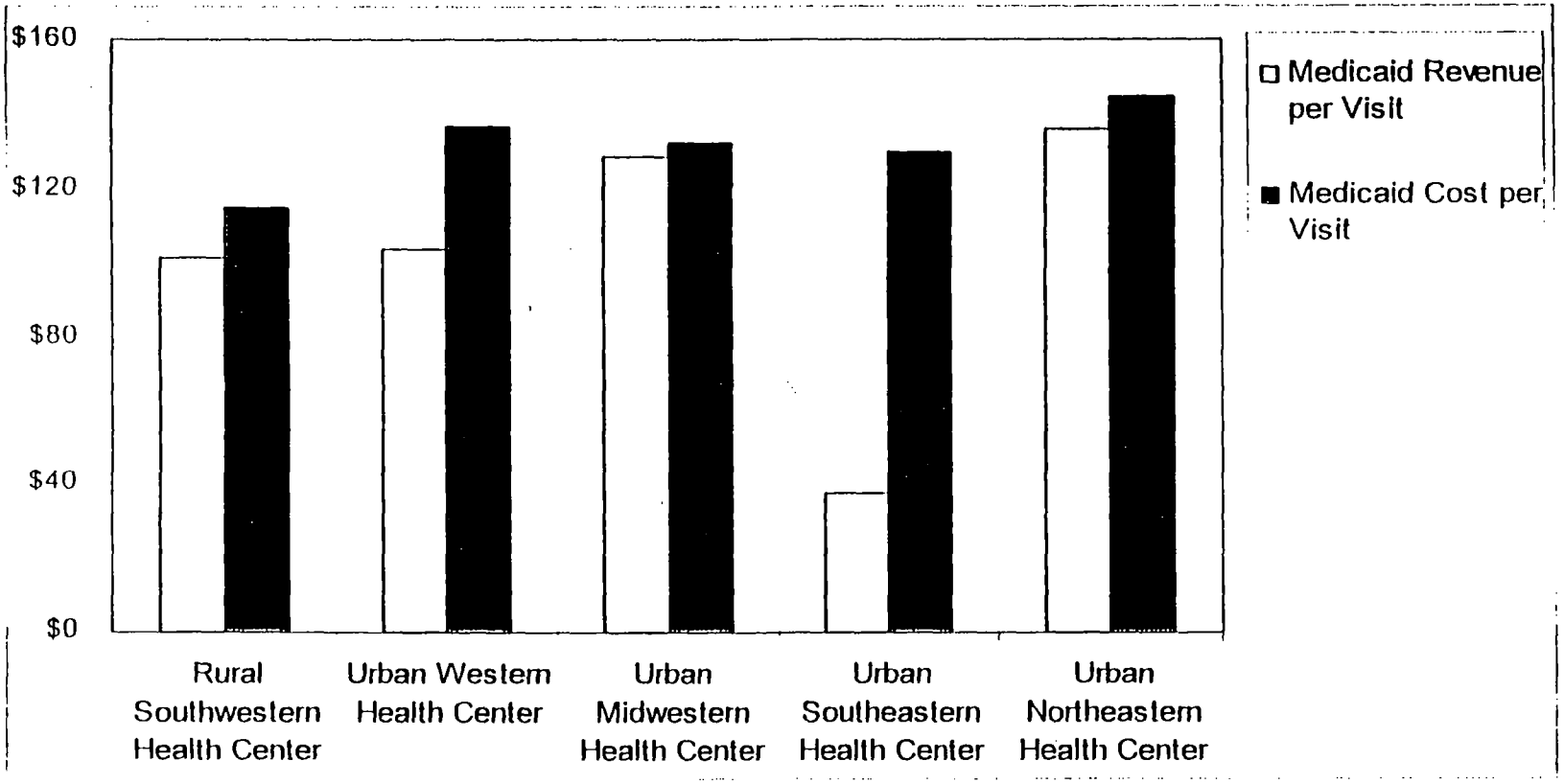
Self Pay	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center	Average
RVUs per Visit	1.44	1.73	1.00	1.39	2.66	1.87
Cost per RVU	$ 63.22	$ 60.92	$ 75.91	$ 84.49	$ 59.51	$ 67.23
Cost per Visit	$ 91.04	$ 105.39	$ 75.91	$ 117.44	$ 158.30	$ 106.22

Findings from Service Intensity by Payor

	Rural Southwestern Health Center	Urban Western Health Center	Urban Midwestern Health Center	Urban Southeastern Health Center	Urban Northeastern Health Center
Medicaid Revenue per Visit	$ 101.54	$ 104.18	$ 128.85	$ 37.67	$ 136.00
Medicaid Cost per Visit	$ 115.06	$ 137.07	$ 132.84	$ 130.11	$ 144.61
Loss per Medicaid Visit	$ (13.52)	$ (32.89)	$ (3.99)	$ (92.44)	$ (8.61)
Total Medicaid Visits	3,909	28,716	23,200	12,342	70,740
Loss on Medicaid Population	$ (52,850)	$ (944,469)	$ (92,457)	$ (1,140,894)	$ (609,071)

Findings from Service Intensity by Payor

For all participating health centers, the Medicaid Cost per Visit was higher than Medicaid Revenue per Visit.



Richard Durbin

UNITED STATES SENATOR ■ ILLINOIS

FAX

TO: Chris Jennings / Jere Lambrew

OFFICE: _____

FAX NO: (_____) _____

FROM: Anne Marie Murphy, Ph. D

PHONE: (2 0 2) 224-2152

DATE: Aug

PAGES *(including this cover sheet):* 13

NOTE: Illinois Hospital Data re BBA

They are working on the other data you requested.

364 Russell Senate Office Building • Washington, D.C. 20510 • (202) 224-2152 (202) 228-0400-fax

Illinois Hospitals Data on the Impact of the BBA

Contact: Barb Filliung: 630-505-7777 ext 286

Assumptions:
Constant Volume and constant case mix

Inflation assumption is the AHA estimate for market basket
BBA Impact = Pre-BBA law rates with inflation adjusters - BBA rate

BBA' Impact on Medicare Payments

TOTALS--STATE OF ILLINOIS

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	76,442,286	153,591,659	208,345,033	241,814,240	279,137,191	957,330,409
I) Transfer Provision		28,695,343	29,155,401	29,855,130	30,541,798	118,447,673
b) IME Payments	33,989,030	57,802,100	84,018,926	109,357,731	114,724,739	399,902,528
I) Applied to Outliers	14,983,157	13,602,870	12,368,245	11,242,041	10,220,037	62,394,350
c) DSH Payments	7,508,442	13,695,842	19,991,353	26,003,044	33,753,994	100,952,675
I) Applied to Outliers	9,292,224	9,106,379	8,833,188	8,479,880	8,055,867	43,767,519
d) Outlier Payments	5,155,174	6,081,662	6,867,062	7,448,037	8,065,006	33,596,941
2. Inpatient Capital	60,372,958	60,614,388	60,775,680	60,978,559	61,222,687	303,864,282
3. Bad Debt	22,510,485	38,661,160	42,528,552	43,634,393	44,858,140	190,410,730
4. Outpatient	59,416,968	60,843,090	107,244,643	116,759,791	126,856,128	471,117,619
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	3,274,139	4,807,892	6,395,971	8,176,739	10,095,870	32,750,611
b) Distinct-Part Rehabilitation Unit	3,339,310	4,903,590	6,523,279	8,339,493	10,296,823	33,402,495
c) TEFRA Inpatient Capital –Psych	2,088,388	2,098,739	2,103,029	2,109,334	2,117,782	10,515,272
d) TEFRA Inpatient Capital –Rehab	1,705,751	1,712,572	1,717,710	1,722,859	1,729,759	8,588,650
BBA Total Impact to Medicare Payments	**300,058,312**	**454,615,286**	**594,866,085**	**676,918,252**	**741,673,818**	**2,767,141,752**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA's Impact on Medicare Payments

LARGE URBAN

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	53,166,870	106,665,713	143,570,359	166,249,053	184,217,547	653,869,541
i) Transfer Provision		23,678,278	23,891,382	24,464,776	25,027,465	97,061,901
b) IME Payments	30,099,421	51,170,635	74,379,684	98,811,440	101,562,707	354,022,889
i) Applied to Outliers	13,149,418	11,954,016	10,667,288	9,879,352	8,981,230	54,631,304
c) DSH Payments	6,556,647	12,142,617	17,723,434	23,053,129	28,924,773	89,500,100
i) Applied to Outliers	6,012,447	7,852,198	7,616,632	7,311,967	6,946,369	37,739,614
d) Outlier Payments	3,574,664	4,203,235	4,761,710	5,184,585	5,592,379	23,298,554
2. Inpatient Capital	43,339,195	43,512,598	43,626,334	43,773,930	43,949,179	218,203,145
3. Bad Debt	16,654,686	27,614,672	31,843,142	32,671,138	33,585,917	142,569,535
4. Outpatient	38,444,880	38,387,610	72,397,358	78,600,144	85,169,752	313,999,722
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	2,748,545	4,033,149	5,365,325	6,859,141	8,469,023	27,473,183
b) Distinct-Part Rehabilitation Unit	2,685,632	3,943,701	5,246,332	6,707,016	8,281,196	26,863,879
c) TEFRA Inpatient Capital –Psych	1,708,771	1,715,604	1,720,751	1,725,910	1,732,822	8,603,857
d) TEFRA Inpatient Capital –Rehab.	1,361,727	1,367,172	1,371,274	1,376,385	1,380,893	6,856,449
BBA Total Impact to Medicare Payments	**221,819,864**	**339,420,610**	**444,383,004**	**506,648,947**	**564,841,250**	**2,067,111,675**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA's Impact on Medicare Payments

OTHER URBAN

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	13,676,622	27,881,602	37,457,958	43,896,711	50,671,971	173,784,864
i) Transfer Provision		3,349,089	3,379,231	3,460,332	3,539,920	13,728,571
b) IME Payments	3,783,877	6,433,008	9,350,775	12,170,823	12,769,136	44,506,620
i) Applied to Outliers	1,790,490	1,627,719	1,479,744	1,345,222	1,222,929	7,466,104
c) DSH Payments	811,462	1,460,154	2,150,531	2,810,234	3,647,905	10,910,286
i) Applied to Outliers	1,241,196	1,216,372	1,179,881	1,132,686	1,076,052	5,846,187
d) Outlier Payments	394,028	463,312	524,871	569,277	616,434	2,567,920
2. Inpatient Capital	10,550,633	10,592,825	10,620,992	10,656,467	10,699,130	53,120,047
3. Bad Debt	2,815,095	4,612,249	6,318,495	5,456,788	5,609,676	23,812,203
4. Outpatient	11,038,875	11,309,830	17,795,837	19,529,010	21,368,397	81,033,949
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	384,751	535,616	712,534	910,918	1,124,716	3,648,535
b) Distinct-Part Rehabilitation Unit	536,732	791,098	1,052,402	1,345,412	1,661,189	5,386,833
c) TEFRA Inpatient Capital –Psych	267,167	268,236	269,040	269,847	270,928	1,345,217
d) TEFRA Inpatient Capital –Rehab	303,680	304,895	305,809	306,726	307,954	1,529,064
BBA Total Impact to Medicare Payments	**47,776,607**	**70,860,004**	**91,508,101**	**103,860,453**	**114,563,237**	**428,568,402**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report FPS 13 compiled by Illinois Hospital & Health Systems Association

BBA's Impact on Medicare Payments

RURAL

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	9,378,795	18,844,343	25,316,716	29,668,477	34,247,673	117,456,004
i) Transfer Provision		1,867,976	1,684,788	1,930,023	1,974,413	7,457,200
b) IME Payments	116,732	196,457	288,469	375,467	393,894	1,373,019
i) Applied to Outliers	23,248	21,135	19,213	17,467	15,879	96,942
c) DSH Payments	40,333	73,570	107,388	139,681	181,317	542,288
i) Applied to Outliers	38,580	37,609	36,674	35,207	33,447	181,716
d) Outlier Payments	1,188,464	1,395,115	1,580,481	1,714,194	1,858,193	7,732,467
2. Inpatient Capital	6,483,130	6,509,056	6,528,364	6,548,162	6,574,378	32,841,090
3. Bad Debt	2,840,724	4,654,239	5,386,915	5,506,467	5,650,646	24,028,992
4. Outpatient	9,933,233	10,171,650	17,051,449	18,627,637	20,299,977	76,083,947
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	162,843	239,127	318,112	408,660	502,131	1,628,893
b) Distinct-Part Rehabilitation Unit	114,946	168,792	224,545	287,062	354,436	1,149,782
c) TEFRA Inpatient Capital –Psych	112,450	112,699	113,236	113,576	114,032	566,197
d) TEFRA Inpatient Capital –Rehab	40,344	40,505	40,627	40,749	40,912	203,136
BBA Total Impact to Medicare Payments	**30,471,841**	**44,334,672**	**58,874,980**	**65,410,862**	**72,249,330**	**271,341,675**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA's Impact on Medicare Payments

LESS THAN 100 BEDS

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	4,264,564	8,568,576	11,511,582	13,490,340	15,572,514	53,407,576
i) Transfer Provision		635,707	843,229	869,466	883,326	3,425,728
b) IME Payments	23,635	40,521	58,900	76,684	80,426	280,346
i) Applied to Outliers	924	840	764	694	631	3,853
c) DSH Payments	59,516	106,741	155,808	202,660	263,068	786,793
i) Applied to Outliers	30	29	29	27	26	141
d) Outlier Payments	285,102	348,993	393,098	426,355	461,673	1,923,221
2. Inpatient Capital	2,739,823	2,750,780	2,758,094	2,767,308	2,776,385	13,794,389
3. Bad Debt	1,341,435	2,197,805	2,534,343	2,600,241	2,673,047	11,346,872
4. Outpatient	4,626,689	4,737,739	9,972,396	10,739,033	11,565,103	41,630,960
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	24,329	35,726	47,527	60,760	75,020	243,362
b) Distinct-Part Rehabilitation Unit	0	0	0	0	0	0
c) TEFRA Inpatient Capital --Psych	7,482	7,512	7,534	7,557	7,587	37,672
d) TEFRA Inpatient Capital --Rehab	0	0	0	0	0	0
BBA Total Impact to Medicare Payments	**13,382,732**	**19,626,971**	**28,283,301**	**31,235,103**	**34,350,806**	**126,880,914**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

IHHA

BBA' Impact on Medicare Payments

100 TO 299 BEDS

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	34,258,032	55,626,933	92,469,266	108,384,085	125,089,572	429,007,888
i) Transfer Provision		15,686,363	15,728,656	16,106,146	16,476,587	63,899,753
b) IME Payments	5,345,337	9,037,662	13,203,478	17,193,252	18,037,054	62,872,782
i) Applied to Outliers	1,591,431	1,446,755	1,315,232	1,195,665	1,086,969	6,636,052
c) DSH Payments	3,644,584	6,647,936	9,703,765	12,621,830	16,384,127	49,002,242
i) Applied to Outliers	2,884,726	2,627,033	2,742,222	2,632,534	2,500,907	13,587,424
d) Outlier Payments	2,663,232	3,131,535	3,547,615	3,847,754	4,168,489	17,358,625
2. Inpatient Capital	26,288,769	26,393,916	26,464,102	26,552,492	26,658,795	132,358,096
3. Bad Debt	10,961,184	17,958,612	20,708,737	21,247,213	21,842,127	92,718,083
4. Outpatient	25,966,799	29,580,053	43,799,431	47,907,367	52,264,930	195,528,601
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	1,379,797	2,026,155	2,695,407	3,445,853	4,254,629	13,801,851
b) Distinct-Part Rehabilitation Unit	1,070,687	1,572,244	2,091,587	2,673,902	3,301,483	10,709,882
c) TEFRA Inpatient Capital --Psych	876,244	879,749	882,367	885,032	888,577	4,411,987
d) TEFRA Inpatient Capital --Rehab	569,103	571,379	573,093	574,811	577,113	2,865,501
BBA Total Impact to Medicare Payments	**117,497,967**	**183,550,525**	**235,930,960**	**265,247,945**	**293,529,359**	**1,095,756,747**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA's Impact on Medicare Payments

300 BEDS AND OVER

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	37,921,690	76,194,150	102,364,185	119,959,835	138,475,105	474,914,965
i) Transfer Provision		12,471,273	12,583,514	12,885,519	13,181,868	51,122,191
b) IME Payments	28,629,859	48,673,917	70,760,550	92,087,615	96,607,258	336,749,400
i) Applied to Outliers	13,370,602	12,155,275	11,050,250	10,045,681	9,132,438	55,754,445
c) DSH Payments	3,805,340	8,941,184	10,131,782	13,178,554	17,106,799	51,163,639
i) Applied to Outliers	6,407,468	6,279,317	6,090,937	5,847,300	5,554,935	30,179,953
d) Outlier Payments	2,196,840	2,569,134	2,926,349	3,173,926	3,436,844	14,317,095
2. Inpatient Capital	31,344,345	31,469,691	31,553,494	31,658,761	31,785,506	157,811,797
3. Bad Debt	10,207,856	16,724,543	19,285,472	19,766,939	20,340,985	86,345,775
4. Outpatient	28,623,479	29,515,298	53,472,817	59,110,371	63,036,093	232,958,058
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	1,870,013	2,746,011	3,653,036	4,670,116	5,766,221	18,705,397
b) Distinct-Part Rehabilitation Unit	2,288,623	3,331,346	4,431,712	5,665,591	6,995,340	22,692,612
c) TEFRA Inpatient Capital –Psych	1,204,882	1,209,479	1,213,108	1,216,745	1,221,618	6,065,613
d) TEFRA Inpatient Capital –Rehab	1,136,647	1,141,192	1,144,816	1,148,048	1,152,645	5,723,148
BBA Total Impact to Medicare Payments	**169,187,622**	**251,435,790**	**330,651,823**	**379,435,203**	**413,793,653**	**1,544,504,091**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA's Impact on Medicare Payments

TERTIARY CARE TEACHING

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	22,565,083	45,338,689	60,911,220	71,381,405	82,398,812	282,595,409
i) Transfer Provision		9,524,931	9,610,855	9,841,311	10,067,661	39,044,559
b) IME Payments	27,261,166	46,380,994	67,417,644	87,749,756	92,056,298	320,885,860
i) Applied to Outliers	12,490,949	11,355,405	10,323,098	9,384,635	8,531,486	52,085,576
c) DSH Payments	3,007,995	5,466,761	8,008,839	10,417,211	13,522,358	40,443,163
i) Applied to Outliers	5,484,519	5,374,829	5,213,584	5,005,040	4,754,788	25,832,760
d) Outlier Payments	0	0	0	0	0	0
2. Inpatient Capital	19,675,091	19,753,771	19,808,421	19,872,452	19,952,011	99,059,745
3. Bad Debt	6,539,087	10,713,635	12,354,149	12,675,388	13,030,291	55,312,548
4. Outpatient	17,517,095	17,937,539	34,410,340	37,259,356	40,287,886	147,412,216
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	1,035,772	1,620,973	2,023,361	2,586,705	3,193,621	10,360,632
b) Distinct-Part Rehabilitation Unit	1,208,212	1,771,255	2,356,313	3,012,359	3,719,377	12,065,514
c) TEFRA Inpatient Capital --Psych	687,315	690,063	692,134	694,208	696,989	3,460,709
d) TEFRA Inpatient Capital --Rehab	538,618	540,769	542,392	544,018	546,195	2,711,991
BBA Total Impact to Medicare Payments	**118,028,900**	**176,389,816**	**233,670,149**	**270,423,842**	**292,757,975**	**1,091,270,682**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA' Impact on Medicare Payments

PRIMARY CARE TEACHING

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	15,544,968	31,233,728	41,981,421	49,174,268	58,764,117	194,678,521
i) Transfer Provision		6,273,650	6,330,314	6,482,242	6,631,333	25,717,739
b) IME Payments	6,249,669	10,823,426	15,441,805	20,096,816	21,085,216	73,497,933
i) Applied to Outliers	2,331,154	2,119,231	1,928,573	1,751,430	1,592,209	9,720,598
c) DSH Payments	2,308,703	4,213,198	6,149,851	7,999,215	10,393,609	31,055,575
i) Applied to Outliers	2,231,853	2,167,218	2,121,599	2,036,735	1,934,899	10,512,302
d) Outlier Payments	0	0	0	0	0	0
2. Inpatient Capital	12,483,120	12,533,040	12,586,367	12,606,339	12,656,816	62,849,682
3. Bad Debt	6,080,547	9,962,361	11,487,840	11,786,550	12,116,570	51,433,889
4. Outpatient	11,018,884	11,283,339	17,837,617	19,569,832	21,404,242	81,112,693
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	914,951	1,343,555	1,787,340	2,284,972	2,821,289	9,152,089
b) Distinct-Part Rehabilitation Unit	1,041,352	1,529,168	2,034,282	2,600,642	3,211,028	10,416,452
c) TEFRA Inpatient Capital –Psych	491,363	493,327	494,807	498,291	498,278	2,474,066
d) TEFRA Inpatient Capital –Rehab	576,210	578,514	580,249	581,999	584,320	2,901,281
BBA Total Impact to Medicare Payments	**61,272,843**	**94,373,953**	**120,720,058**	**137,470,339**	**151,685,907**	**565,523,101**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

BBA's Impact on Medicare Payments

NON-TEACHING

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	38,332,235	77,019,042	103,472,391	121,258,548	139,874,262	480,056,478
i) Transfer Provision		13,096,562	13,214,431	13,531,578	13,842,804	53,685,375
b) IME Payments	469,193	797,661	1,159,478	1,509,159	1,583,224	5,516,735
i) Applied to Outliers	141,054	128,231	116,574	105,976	96,342	588,177
c) DSH Payments	2,190,655	3,995,883	5,832,654	7,586,619	9,846,027	29,453,837
i) Applied to Outliers	1,575,852	1,544,335	1,498,005	1,438,085	1,366,180	7,422,457
d) Outlier Payments	5,155,174	6,061,662	6,657,062	7,448,037	8,065,006	33,596,941
2. Inpatient Capital	28,214,746	28,327,577	28,402,903	28,497,769	28,611,860	142,054,854
3. Bad Debt	9,890,851	16,205,163	18,588,593	19,172,457	19,709,279	83,564,313
4. Outpatient	30,681,009	31,622,213	54,996,687	59,928,603	65,163,998	242,592,509
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	1,323,417	1,943,364	2,585,270	3,305,061	4,080,779	13,237,890
b) Distinct-Part Rehabilitation Unit	1,091,745	1,603,168	2,132,705	2,726,493	3,366,417	10,920,528
c) TEFRA Inpatient Capital --Psych	909,711	913,348	916,089	918,835	922,515	4,580,497
d) TEFRA Inpatient Capital --Rehab	590,926	593,289	595,069	596,853	599,243	2,975,378
BBA Total Impact to Medicare Payments	**120,766,568**	**183,851,518**	**240,475,879**	**268,024,071**	**297,229,935**	**1,110,347,970**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

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BBA's Impact on Medicare Payments

MEDICARE DSH

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	40,754,341	61,685,654	110,010,523	128,920,523	149,818,635	510,389,676
i) Transfer Provision		18,629,007	18,798,668	19,247,788	19,690,487	76,363,950
b) IME Payments	25,778,855	43,826,697	63,705,108	82,917,574	86,986,965	303,215,397
i) Applied to Outliers	12,302,461	11,184,055	10,167,323	9,243,021	8,402,746	51,299,606
c) DSH Payments	7,411,637	13,519,263	19,733,607	25,667,790	33,318,808	99,651,105
i) Applied to Outliers	9,197,342	9,013,395	8,742,993	8,393,273	7,973,610	43,320,613
d) Outlier Payments	0	0	0	0	0	0
2. Inpatient Capital	33,381,552	33,515,044	33,604,267	33,716,403	33,851,388	168,068,672
3. Bad Debt	16,330,081	28,755,192	30,652,055	31,654,280	32,540,588	138,132,197
4. Outpatient	29,651,705	30,383,403	57,970,253	62,786,439	67,909,849	248,683,648
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	1,912,375	2,608,217	3,735,790	4,775,910	5,896,845	19,129,136
b) Distinct-Part Rehabilitation Unit	2,089,190	3,038,491	4,042,125	5,167,535	6,380,387	20,697,729
c) TEFRA Inpatient Capital --Psych	1,103,729	1,108,143	1,111,468	1,114,800	1,119,264	5,557,403
d) TEFRA Inpatient Capital --Rehab	1,082,535	1,085,864	1,090,124	1,093,392	1,097,771	5,450,687
BBA Total Impact to Medicare Payments	**180,975,804**	**276,733,625**	**363,562,321**	**414,700,729**	**453,997,540**	**1,689,960,017**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

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BBA's Impact on Medicare Payments

NOT MEDICARE DSH

	FY '98	FY '99	FY '00	FY '01	FY '02	5 Year Total
1. Inpatient PPS						
a) DRG Payments	35,857,945	71,708,004	96,334,510	112,893,717	120,316,356	448,940,533
i) Transfer Provision		10,286,336	10,358,733	10,807,343	10,851,311	42,083,723
b) IME Payments	8,220,175	13,975,204	20,313,822	28,440,157	27,737,774	98,687,132
i) Applied to Outliers	2,660,696	2,418,815	2,199,922	1,999,020	1,817,291	11,094,745
c) DSH Payments	96,805	176,579	257,748	335,254	435,186	1,301,570
i) Applied to Outliers	94,682	92,984	90,195	88,587	82,258	446,907
d) Outlier Payments	5,155,174	6,051,662	6,857,062	7,448,037	8,065,006	33,598,941
2. Inpatient Capital	26,991,408	27,099,344	27,171,404	27,282,156	27,371,301	135,895,610
3. Bad Debt	6,180,403	10,125,968	11,678,497	11,980,113	12,315,552	52,278,533
4. Outpatient	29,765,283	30,479,697	49,274,391	53,968,352	58,946,277	222,433,971
5. PPS-Exempt Unit						
a) Distinct-Part Psychiatric Unit	1,361,764	1,999,675	2,660,181	3,400,829	4,199,025	13,621,474
b) Distinct-Part Rehabilitation Unit	1,270,119	1,665,099	2,481,154	3,171,958	3,916,436	12,704,766
c) TEFRA Inpatient Capital --Psych	984,659	988,596	991,582	994,534	998,517	4,957,888
d) TEFRA Inpatient Capital --Rehab	623,216	625,709	627,585	629,487	631,956	3,137,964
BBA Total Impact to Medicare Payments	**119,092,508**	**177,881,661**	**231,303,764**	**261,217,524**	**287,586,278**	**1,077,181,735**

Note: Above Does Not Include 5-Year Impact of BBA on Skilled Nursing Facilities and Home Health Agencies estimated to be over $300 million statewide

Source: Medicare Cost Report PPS 13 compiled by Illinois Hospital & HealthSystems Association

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Fax Transmission Sheet

To: **Chris Jennings**

Org: **White House**

From: **Dave Zook**

Date: **September 1, 1999**

Pages (including cover sheet): 3

If you have any problems receiving this information, please call 202-537-5471.

Notes: **FYI.**

ARTHRITIS FOUNDATION®
Your Source for Help and Hope®

Arthritis Foundation Statement on Prescription Drug Coverage for Medicare Beneficiaries

Summary
Because increasing numbers of individuals are living many years with chronic diseases such as arthritis, it is essential that older Americans have access to medications that can alleviate symptoms, modify disease and prevent disability. Approximately 35 percent of Medicare beneficiaries do not have prescription drug coverage, and many others have limited coverage that can prove inadequate for individuals often living on fixed incomes while facing a chronic disease. The Arthritis Foundation strongly endorses passage of legislation to make prescription drug benefits more widely available to Medicare beneficiaries. Any proposal enacted into law should support a defined and affordable benefit that covers all prescription drugs and biological therapies. In addition, given the continuing emergence of revolutionary arthritis treatments that present improved outcomes and potentially higher costs, the Arthritis Foundation believes that efforts to strengthen the Medicare program should address the special needs of these individuals. Finally, enhanced access to prescription drug coverage provided through a government response should emphasize assistance for Americans with lower incomes.

Full Statement
Arthritis is a painful and physically debilitating chronic disease. To reduce pain and disability, individuals with arthritis require access to comprehensive health care that can include preventive care, self-management programs, surgical interventions, rehabilitation services, and prescription drug, biological and medical device therapies. In view of the critical roles these elements play in confronting the social and economic burdens of arthritis, the Arthritis Foundation is committed to improving access to health care for all Americans.

Of the 43 million Americans living with arthritis, approximately 26 million are 65 years and older. This number will increase dramatically over the next two decades as the Centers for Disease Control and Prevention estimates that 60 million Americans will have arthritis by 2020. These demographics indicate that the Medicare program is and will remain a key aspect of ensuring the best possible medical care and quality of life for a large number of people with arthritis.

Moreover, because increasing numbers of individuals are living many years with chronic diseases such as arthritis, it is essential that older Americans have access to medications that can alleviate symptoms, modify disease and prevent disability. Timely and appropriate use of these interventions has been demonstrated to reduce both the direct and indirect costs of arthritis. As a result, pharmaceutical and biological therapies are playing an increasingly important role in our health care system. This accelerating development presents many challenges to available resources while holding the promise of both societal and individual benefits. A modern health care system must recognize this evolving reality through adequate insurance coverage for these technologies.

Aug. 20, 1999

At present, however, a significant percentage of seniors qualified for Medicare do not have prescription drug coverage. The Medicare program does not include prescription drug coverage unless the beneficiary has enrolled in a Medicare managed care plan or has purchased a private Medigap policy, both of which may offer such a benefit. Some seniors have access to a drug benefit through their former employer's health care plan for retirees. All told, approximately 35 percent of Medicare beneficiaries do not have prescription drug coverage, and many others have limited coverage that can prove inadequate for individuals often living on fixed incomes while facing a chronic disease.

For American seniors who presently do not have coverage, **the Arthritis Foundation strongly endorses passage of legislation to make prescription drug benefits more widely available to Medicare beneficiaries.** Any proposal enacted into law should support a defined and affordable benefit that covers all prescription drugs and biological therapies. In addition, given the continuing emergence of revolutionary arthritis treatments that present improved outcomes and potentially higher costs, the Arthritis Foundation believes that efforts to strengthen the Medicare program should address the special needs of these individuals. Finally, enhanced access to prescription drug coverage provided through a government response should emphasize assistance for Americans with lower incomes.

The Arthritis Foundation recognizes that improving access to appropriate care, including pharmaceutical and biological treatments, is a shared responsibility among the involved parties — consumers, providers, private insurance and plans, government programs and the manufacturers. In particular, designing and implementing adequate drug benefits for Medicare beneficiaries will require extensive collaboration that avoids placing a disproportionate burden on one market segment. The Foundation is committed to continuing its efforts to provide an open forum for dialogue, provoke fair and effective solutions and advocate for the best interests of people with arthritis in this key dimension of quality health care.

For More Information

Call the Office of Public Policy & Advocacy at (202) 537-5471 for additional information about the Arthritis Foundation position on prescription drug coverage for Medicare beneficiaries. Contact your local Arthritis Foundation chapter for free brochures about managing arthritis. To locate the chapter that serves your area, call (800) 283-7800 or write: Arthritis Foundation, P.O. Box 7669, Atlanta, Ga. 30357-0669. You may also find information on the Arthritis Foundation Web site at www.arthritis.org.

Aug. 20, 1999

THE WHITE HOUSE

OFFICE OF LEGISLATIVE AFFAIRS
HOUSE LIAISON
—FAX COVER SHEET—

DATE: 10/14

TO: Chris Jennings
D.P.C.

FAX: 6-5557

FROM:

___ BRODERICK JOHNSON	___ JOSH ACKIL
___ AL MALDON	___ ERICA MORRIS
_✓_ LISA KOUNTOUPES	___ LAUREN GILLESPIE
___ JANELLE ERICKSON	___ BRIAN MASON

(202)456-6620 (TELEPHONE)
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SUBJECT: Attached please find West letter on Allen bill. Would like to discuss our next steps on this/our response

1 OF 4

DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

AUG 13 1999

AUG 11 1999

In Reply Refer To:

The Honorable Cliff Stearns
Chairman, Subcommittee on Health
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter on the impact on the Department of Veterans Affairs (VA) of H.R. 684, which would extend favorable government prices for pharmaceuticals to the Medicare population.

We are very concerned that this proposed legislation would have an indirect, negative impact on VA pharmaceutical budgets. Section 3(c) of the bill would force covered outpatient drug manufacturers to sell to Medicare-affiliated pharmacies at the lower of the Medicaid reported best price or the "lowest price paid for [the drug] by any agency or department of the United States". The latter benchmark would include not only low Federal Supply Schedule (FSS) and FSS Blanket Purchase Agreement (BPA) prices negotiated by VA for the Government, but also large volume committed use national contract prices obtained by VA and/or Department of Defense (DOD) in head-to-head competitive procurements. Perhaps most importantly, the "lowest price paid" benchmark would include many Federal ceiling prices (FCPs) already imposed on manufacturers by the Veterans Healthcare Act of 1992. Section 603 (Public Law 102-585; 38 U.S.C. 8126).

By way of further information, through many recent inquiries by drug manufacturers regarding this bill, we have been informally informed that manufacturers may no longer offer lower-than-FCP prices to VA and DOD in BPA and national contract negotiations. They may also invoke 30-day cancellation clauses in FSS contracts and BPAs, to the extent allowed by Public Law 102-585, which would force Government healthcare agencies to buy drugs in the open market at much higher retail prices or AWPs (average wholesale prices).

The Honorable Cliff Stearns

In summary, we believe enactment of H.R. 624 would increase VA's annual pharmaceutical costs by $500-600 million. We would be pleased to discuss this matter further with you. If you have additional questions, please contact me or Mr. John Ogden, Chief Consultant for Pharmacy Benefits Management, at 202.273.8429/8426.

Sincerely,

Thomas L. Garthwaite, M.D.
Acting Under Secretary for Health

Bangor Daily News 10/5/99

VA calls Allen's prescription drug bill too costly

By Jill Carroll
States News Service

WASHINGTON — Rep. Tom Allen's measure to reduce the price of prescription drugs for seniors was criticized by the U.S. Veterans Affairs department for costing the VA millions of dollars, a key House panel announced Monday.

The measure would cost the Veterans Affairs department $500 million-600 million stated Thomas Garthwaite, VA acting undersecretary for health, in an August letter to Rep. Cliff Stearns, R-Fla., chairman of a House subcommittee on health.

But the Democrat from Portland, who attended the Veterans Affairs Subcommittee on Health hearing to answer questions with other House members about prescription drug benefits, said the numbers were baseless.

"There is no evidence in the letter of how they got that number," Allen said.

He also said there is no way to know the price for prescription drugs the government and drug makers will agree on, therefore the VA can't know they will lose a certain amount of money.

But Garthwaite said in the letter that drug makers have informally told the VA that because of the bill they may take actions that "would force government [health care] agencies to buy drugs in the open market at much higher retail prices."

Allen's measure is aimed at lowering the costs of medicines for the elderly on Medicare. It allows pharmacies to buy prescription drugs for Medicare recipients at the lowest rate given to the federal government.

The federal government purchases the medicines at half the retail price consumers pay, Allen said.

Allen expects the pharmacies to pass on their savings to the elderly on Medicare. But the House panel asked Allen how he could be sure the companies would choose to give Medicare recipients a lower price for drugs rather than beef up t bottom line.

"[Seniors] are checking around at pharmacies in their area to get the lowest price," Allen said, adding that pharmacies will be able to afford lower prices and will do so because of competition.

Sen. Olympia Snowe has also introduced a prescription drug measure that would benefit Medicare recipients.

The measure would allow seniors to have a choice in insurance plans with varying prescription drug benefits.

Medicare recipients would be covered for outpatient prescription drugs with co-payments and annual deductibles. Seniors will be able to choose between Medicare Choice or supplemental drug plans.

Money for the measure would come from tobacco taxes proposed in the president's budget.

Seniors making below 150 percent of the poverty level, $12,075 for a single person, won't have to pay any premiums for prescription drug insurance under the plan.

Those making between 150 and 175 percent of the poverty level, $14,088 for a single person, will have money helping with premiums lowered from 100 percent to 25 percent.

Seniors that don't fall in those ranges will have 25 percent of their premiums paid for by the government, under Snowe's measure.

Snowe's bill is still in committee.