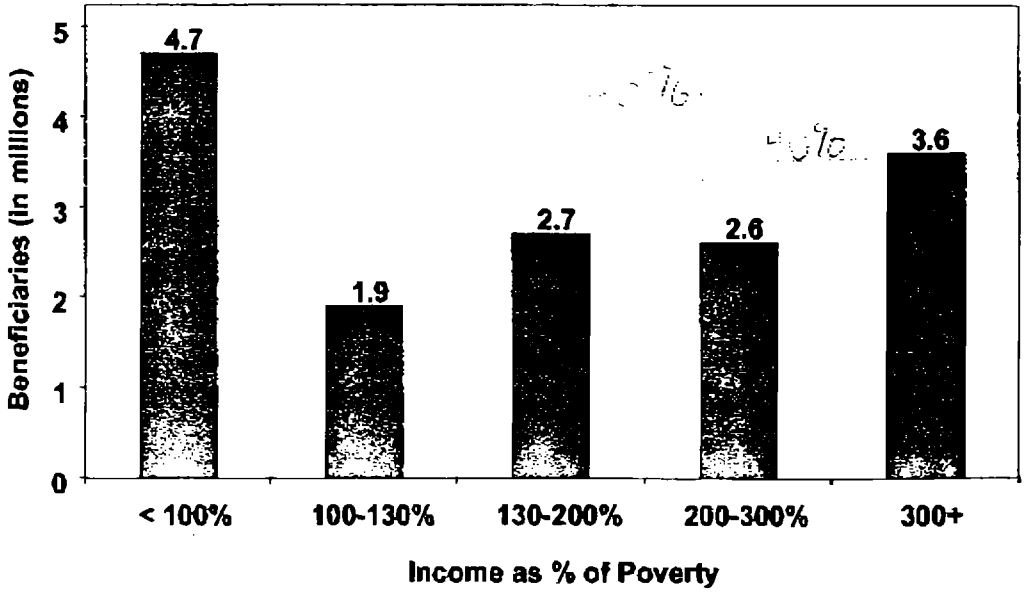
16 Million Beneficiaries Will Not Have Drug Coverage in 2000

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

Medicare Beneficiaries Without Any Drug Coverage by Income, 2000

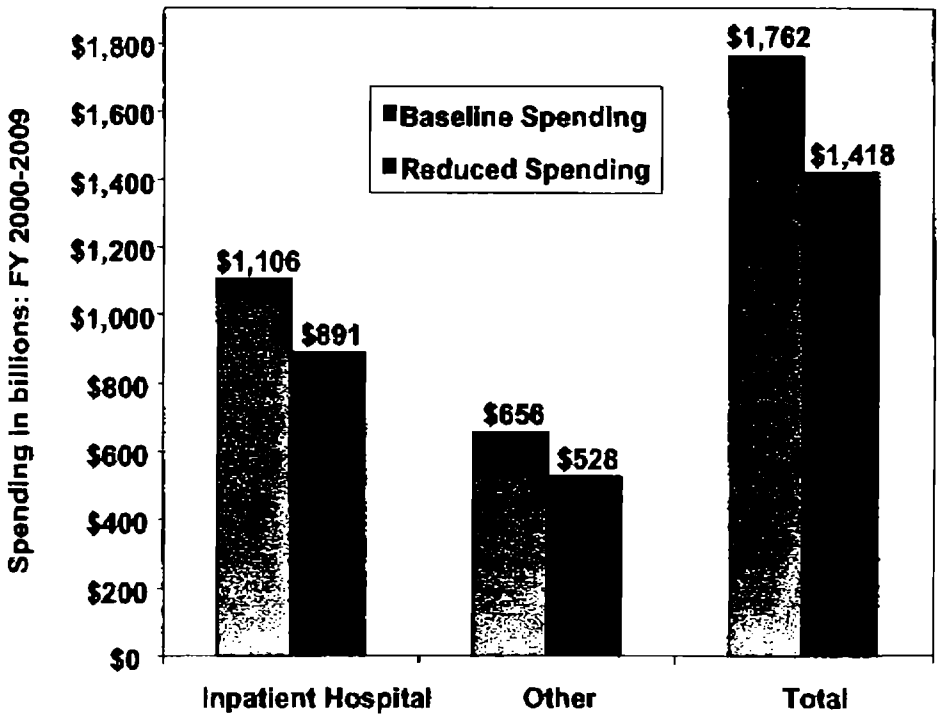


Source: HCFA (unpublished) analysis of 1995 Medicare Current Beneficiary Survey data

Large Medicare Cuts Necessary If No Transfer of Budget Surplus

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

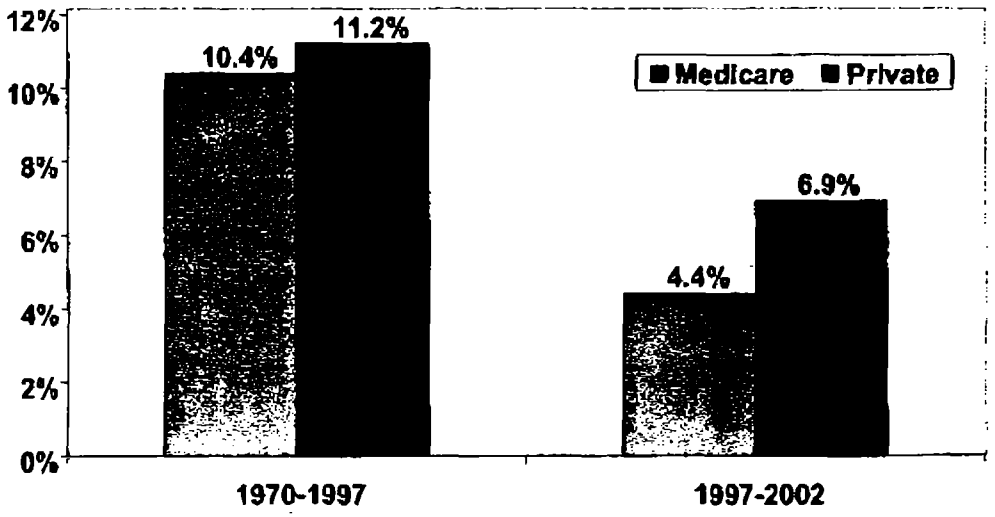
Part A Reductions to Achieve Same Impact as Surplus Transfer: FY 2000-2009 (20% cut)



Medicare As Efficient As Private Sector in Controlling Spending Growth

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

Medicare and Private Spending Per Capita

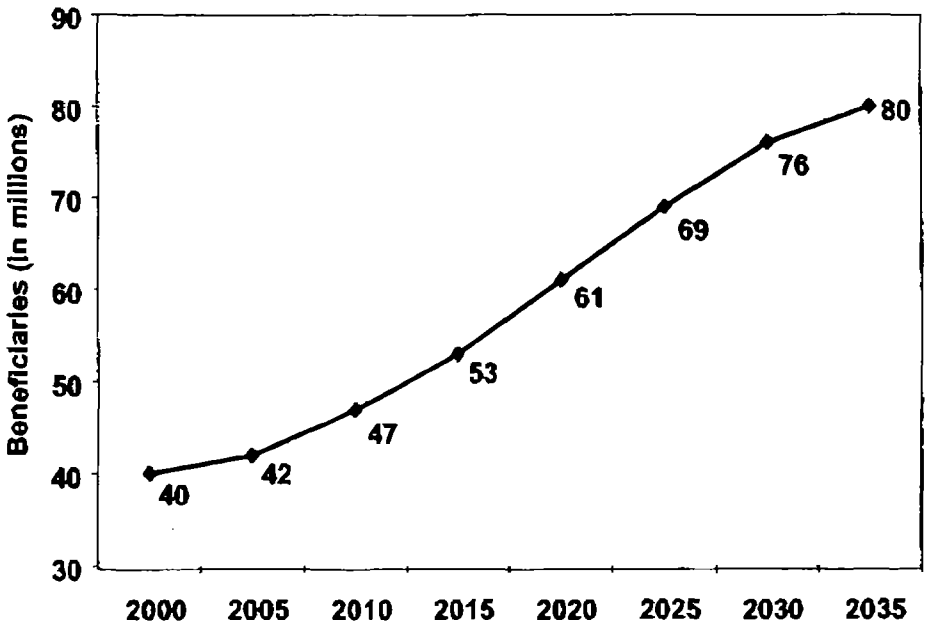


Source: Analysis of data from HCFA Office of the Actuary

Number of Medicare Beneficiaries Will Double by 2035

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

Medicare Hospital Insurance Enrollment, 2000-35



DATE: 8/16/99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-7450 *FAX: (202)690-8425*

FROM:

[ ] JANE HORVATH

TO: Dewsa

[ ] SHARON CLARKIN

OFFICE: _____

[X] BOB GUIDOS

[ ] JOANNE JEE

ROOM: _____

[ ] GREG JONES

PHONE: _____

[ ] ANDREA LEVARIO

FAX: _____

[ ] ROGER MCCLUNG

[ ] TANISHA PARKER

[ ] JON RETZLAFF

[ ] STEPHANIE WILSON

[ ]

(INCLUDING COVER): 5

REMARKS:

16 Million Beneficiaries Will Not Have Drug Coverage in 2000

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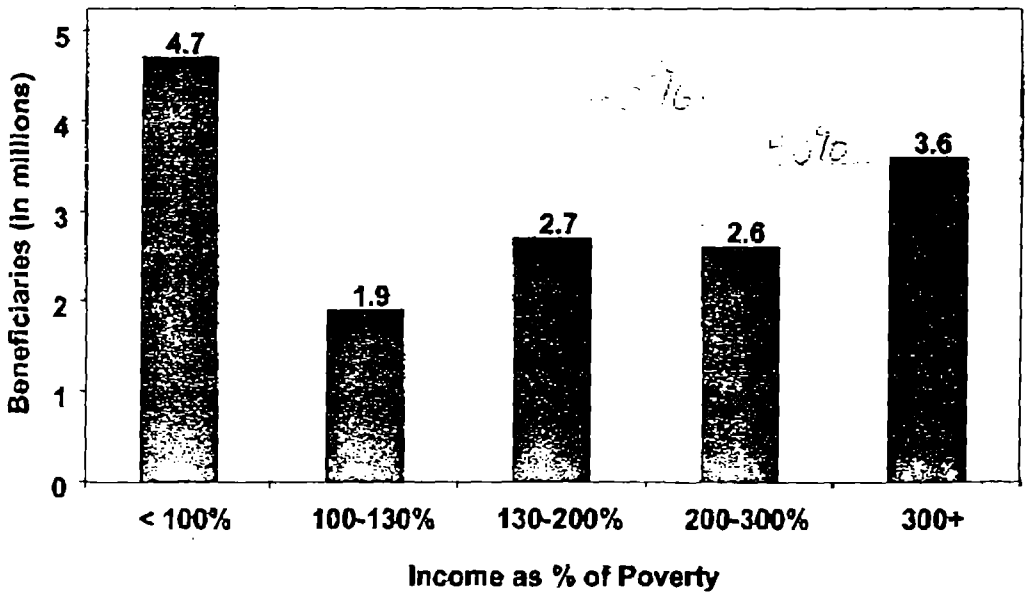

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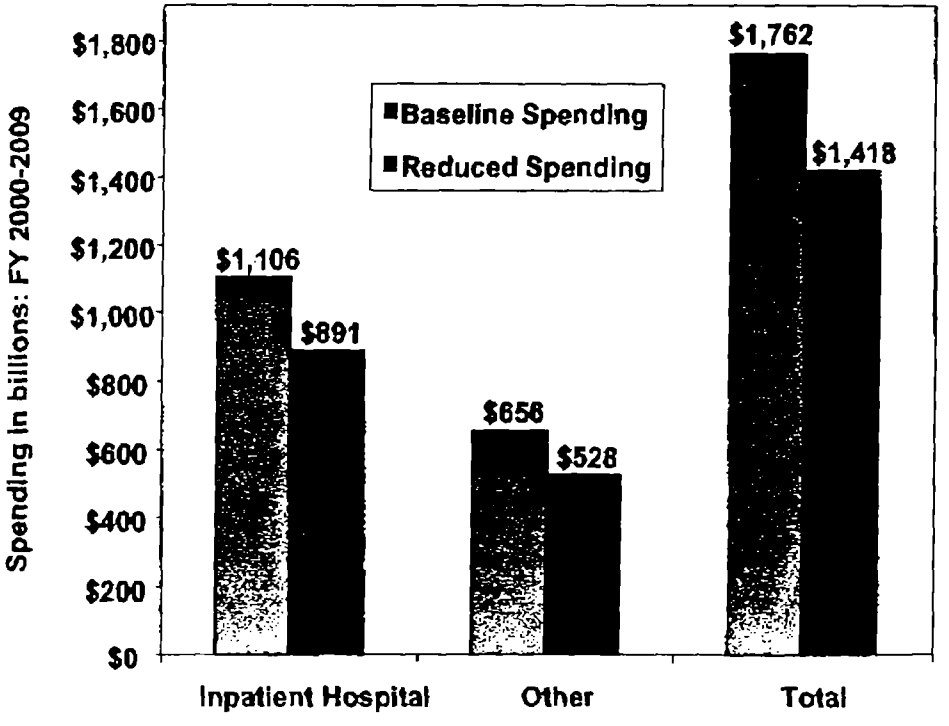

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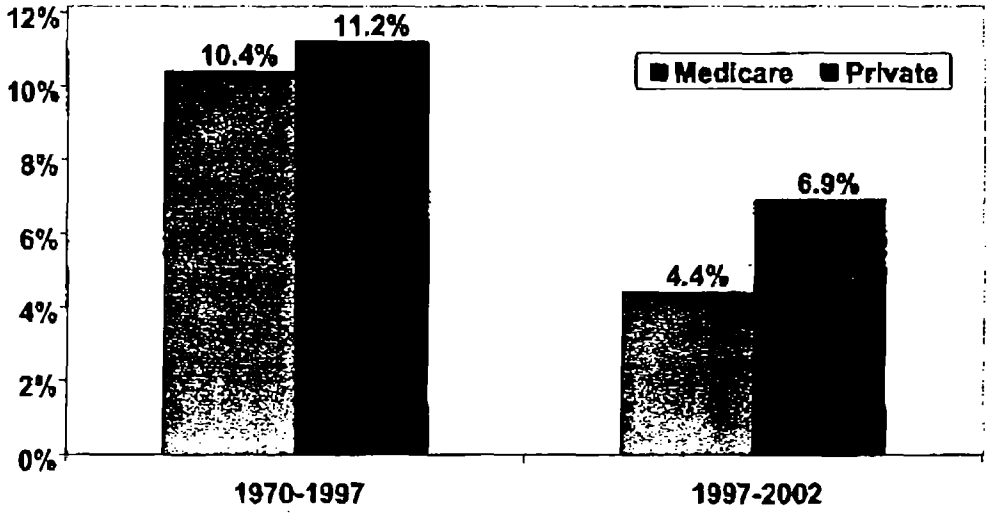

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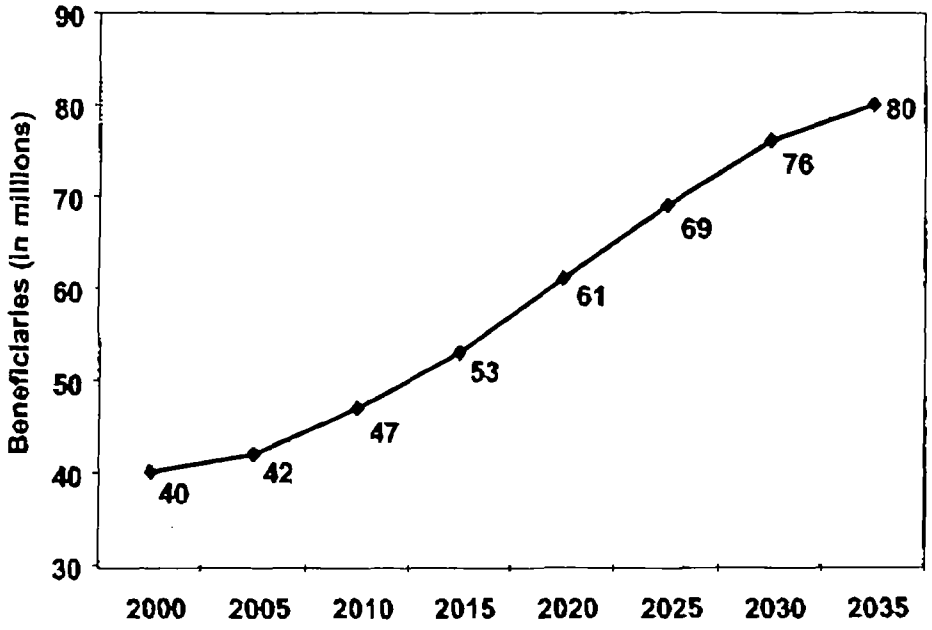

DATE: 8/16/99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
ROOM 405H, HUMPHREY BUILDING
200 INDEPENDENCE AVE, SW
WASHINGTON, D.C. 20201

PHONE: (202)690-7450 *FAX: (202)690-8425*

TO: Denisa

OFFICE: _____

ROOM: _____

PHONE: _____

FAX: _____

FROM:

[ ] JANE HORVATH
[ ] SHARON CLARKIN
[X] BOB GUIDOS
[ ] JOANNE JEE
[ ] GREG JONES
[ ] ANDREA LEVARIO
[ ] ROGER MCCLUNG
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[ ]

(INCLUDING COVER): 5

REMARKS:

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

August 4, 1999

The Honorable Thomas A. Daschle
United States Senate
Washington, D.C. 20510

Dear Senator Daschle:

This letter is in response to your request for information about the differences between the Administration and the Congressional Budget Office's (CBO's) cost estimate of the President's Medicare reform plan. CBO scored the President's proposal as having $111 billion in net costs over ten years compared to the Administration's estimate of $46 billion, a difference of $65 billion.

The Administration has consistently used conservative and realistic cost estimates and projections. This insistence has resulted in a track record of projections that are generally more conservative then actual experience. We are confident that our cost estimate for the Medicare Reform plan, which was produced independently by the Medicare actuaries using the best possible data and assumptions, is sound. Attached to this letter is a detailed explanation of the technical differences between the Administration and CBO's scoring of the President's Medicare reform plan. We have several overarching concerns regarding the differences between Administration and CBO estimates:

- **Reforms should be scored assuming that HCFA will be allowed to implement the law as enacted.** CBO scored $4 billion in savings for the fee-for-service modernization proposals, compared to the Administration's score of $25 billion. CBO agrees with the Administration that fee-for-service modernization can produce savings, but believes that HCFA will be prevented from implementing the legislation. The Administration has estimated the President's proposals as written and assumes that HCFA will implement the fee-for-service modernization proposals if Congress enacts legislation to modernize the Medicare program.

- **Fundamental reform challenges old estimation techniques and requires changes in assumptions and scoring methodologies.** The President's fee-for-service modernization proposals, such as Preferred Provider Organizations (PPOs), create new incentives for beneficiaries to seek and providers to offer more efficient care. In contrast, CBO's estimate does not recognize the incentives PPOs and other modernization proposals would create to reduce Medicare expenditures while improving the quality of care. CBO's unwillingness to score voluntary policies pushes decision-making towards compulsory options. While scoring this type of policy is challenging, HCFA actuaries worked through methodologies to score these policies.

- **The consistent use of objective data is crucial to producing sound estimates.** Each year HCFA's Office of the Actuary produces the National Health Expenditures (NHE) data. The data are widely recognized as neutral and are used by Congress, private businesses and researchers for many purposes. The Administration used the projected drug expenditure data available at the time of the estimate (i.e., 1998). The Administration depended on both this data and the estimates produced by the actuaries. CBO also depended on the latest available drug expenditure data (i.e., 1999) for their estimate, but assumed a higher drug cost inflation than the 1999 NHE projections in the early years.

No two estimators will score a given policy the same way, and there are additional assumptions where CBO appears to differ from the Administration. For example, there may be understandable differences between CBO and the Administration's assumptions about beneficiaries' reactions to different incentives. CBO assumes that the prescription drug benefit will result in an enrollment increase in the Medicaid programs that pay Medicare premiums and cost sharing for low income beneficiaries. In producing these estimates, the Administration did not assume this increase in enrollment. Although it is difficult to assess how beneficiaries will respond to incentives, the Administration believed that the incentives created by the drug benefit are not sufficient to induce enrollment into Medicaid beyond current outreach efforts that are underway. CBO assumes that the new drug benefit will induce more drug utilization, but not as much as the Administration assumed. CBO also assumes slightly less savings from discounts and management by pharmacy benefit managers and other entities. These assumptions made by CBO, as well as by others, were considered by the Administration and determined to be largely offsetting.

We are confident that our estimates are conservative and accurate, and hope that this letter clarifies the scoring differences. We look forward to working with you as we move forward with this important effort to modernize and strengthen the Medicare program.

Sincerely,

Jacob J. Lew
Director

Explanation of CBO Estimates of
Administration Medicare Proposals

The costs of the President's Medicare plan, $118 billion over 10 years, are fully offset by program savings of $72 billion and dedication of $46 billion in surplus. In contrast, CBO has scored the President's plan as costing $168 billion in over ten years with only $57 billion in program savings.

Prescription Drug Proposal

CBO scored a higher cost to the President's prescription drug benefit, estimating $168 billion over the ten-year budget window FYs 2000-2009 in contrast to the Administration's score of $118 billion. There appear to be two major reasons for CBO's higher estimate.

1. CBO differs in its assessment of the effect of the prescription drug proposal on Medicaid. The Medicare drug benefit includes Medicaid premium and cost-sharing coverage for low-income Medicare beneficiaries including those currently receive prescription drug coverage through Medicaid because they are eligible for both Medicare and Medicaid (i.e., dual eligibles). Medicaid would pay for the drug benefit's premium and cost-sharing for all beneficiaries up to 135 percent of poverty. Those beneficiaries between 135-150 percent of poverty would receive premium assistance on a sliding scale basis. The Federal government would pay 100 percent of the costs for these Medicaid protections for eligible beneficiaries above poverty.

   The Administration's estimates of the President's Medicare package assume that the drug benefit would not result in enrollment increase in Medicaid. We considered the extent to which the low-income protections included in the Medicare drug benefit would increase enrollment over existing outreach efforts, and concluded they would not for two reasons. First, the average Medicare beneficiary would be likely to save money on drug costs even without enrolling in the low-income program. Second, outreach efforts to enroll dual eligibles have been going on for some time and are currently being intensified and the addition of the drug benefit will not induce further enrollment, In contrast, CBO assumes that the drug benefit would result in an enrollment increase into the current Medicaid programs that provide full Medicaid coverage and pay Medicare premiums and cost-sharing. CBO also assumes that participation in the new Medicaid program for drug benefit cost-sharing would be higher than participation in current Medicaid programs covering Medicare cost-sharing.

2. CBO assumed a higher projected inflation in drug costs than the Administration. The Administration used the drug cost inflation (average growth over 10 years of 9.7 percent) available at the time that the drug costs were estimated (i.e., the 1998 National Health Expenditures (NHE) projections). CBO used a higher drug cost inflation reported in the 1999 NHE projections (average growth over 10 years of 10.6 percent), but then assumed that in the in-years drug cost inflation would be higher than that reported in the 1999 NHE. Historically both the Administration and CBO have relied on the NHE projections, and we see no basis for CBO's assumption of higher drug cost inflation.

Fee-for-Service Modernization Proposals

CBO also scored $48 billion of savings for the President's fee-for-service proposals (both BBA extenders and fee-for-service modernization) over the ten-year budget window FYs 2000-2009, compared to the Administration's score of $72 billion in savings. The majority of this difference results from CBO's lower estimate of the savings attributable to the President's fee-for-service modernization proposals. CBO scored $4 billion in savings for these fee-for-service modernization proposals, compared to the Administration's score of $25 billion. We believe that there are three primary reasons for this difference:

1. CBO believes that Congress and industry will not allow HCFA to implement the President's fee-for-service modernization proposals, even though CBO asserts that these proposals could produce significant savings. During his testimony to the Senate Finance Committee, the CBO Director stated, "the potential savings from these [fee-for-service modernization] changes are substantial. However, major impediments stand in the way of realizing those savings... In recent years, providers and elected representatives have voiced significant opposition in communities in which the Secretary has tried to reduce spending through competitive bidding and selective contracting." Contrary to CBO, the Administration assumes in its scoring that if Congress gives HCFA the authority to implement these policies, they will allow HCFA to use that authority.

2. CBO did not score any savings for the President's Preferred Provider Organization (PPO) proposal. The Administration believes that providers will agree to accept lower Medicare payments and offer lower beneficiary cost-sharing in exchange for the "preferred" provider designation. Further, the Administration believes that these preferred providers will be attractive to Medicare beneficiaries, particularly the 13 percent of fee-for-service enrollees who do not have any supplemental insurance. The Administration assumes that lower premiums will attract beneficiaries to PPOs, just as it assumes that lower premiums will attract beneficiaries to low-cost managed care plans. CBO does not believe that lower cost-sharing will be enough to attract beneficiaries to Medicare fee-for-service preferred providers which agree to accept lower Medicare payments. It believes that the proposal would have to require beneficiaries to use preferred providers in order to produce savings.

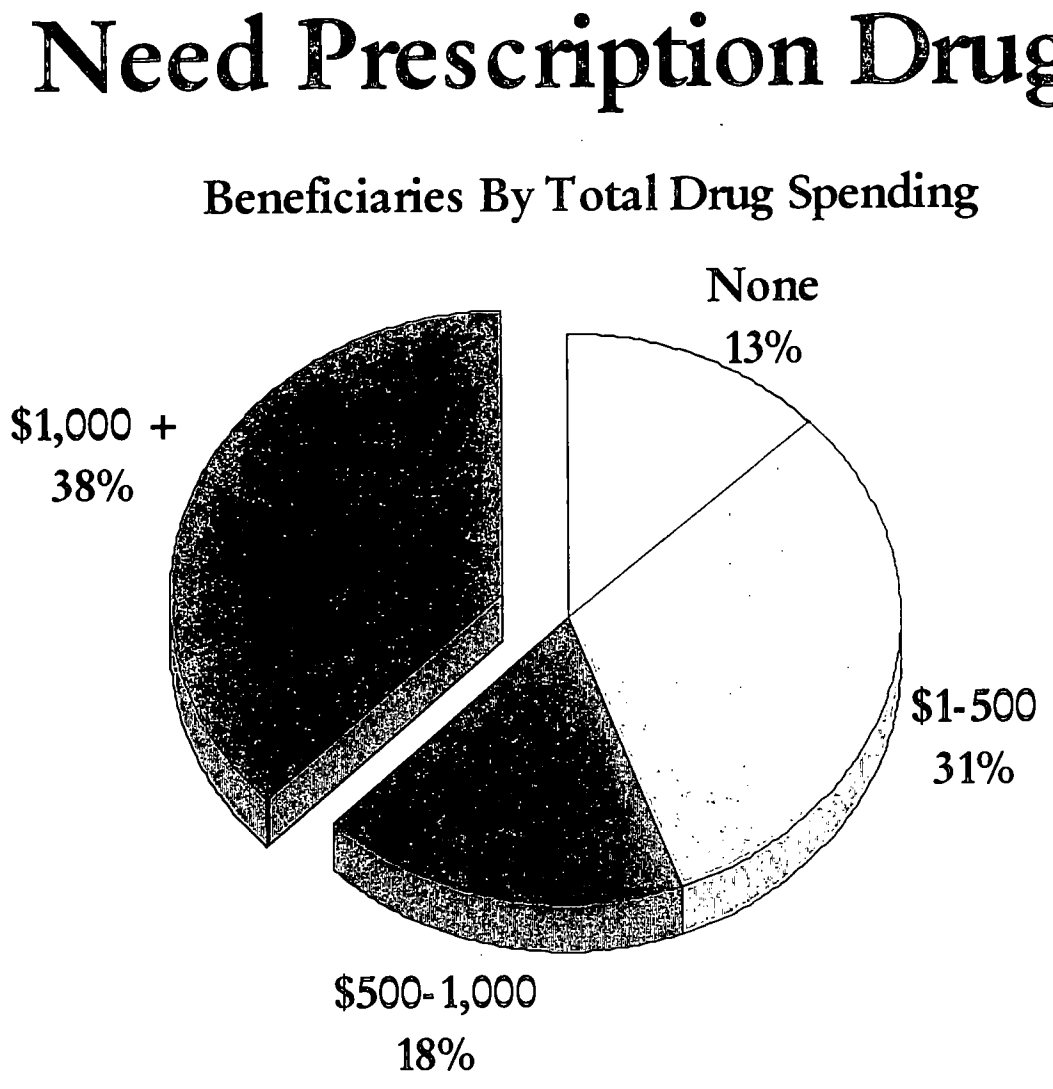
3. CBO scored only nominal savings for the President's proposal to expand the authorities of the Centers of Excellence. Centers of Excellence is a Medicare demonstration conducted during the early 1990's which was found to improve quality outcomes and reduce Medicare expenditures by 12 percent on average. The Administration is confident that expanded authority would increase savings. Both the Administration and CBO agree that expansions of this demonstration will produce additional savings to the Medicare program. In his Medicare reform plan, the President proposed to expand the Centers of Excellence proposal contained in his FY 2000 budget to include more hospital procedures. However, CBO has assumed that the President's proposal would grant HCFA the same authority to establish Centers of Excellence as his FY 2000 budget proposal, and therefore scored only nominal savings.

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

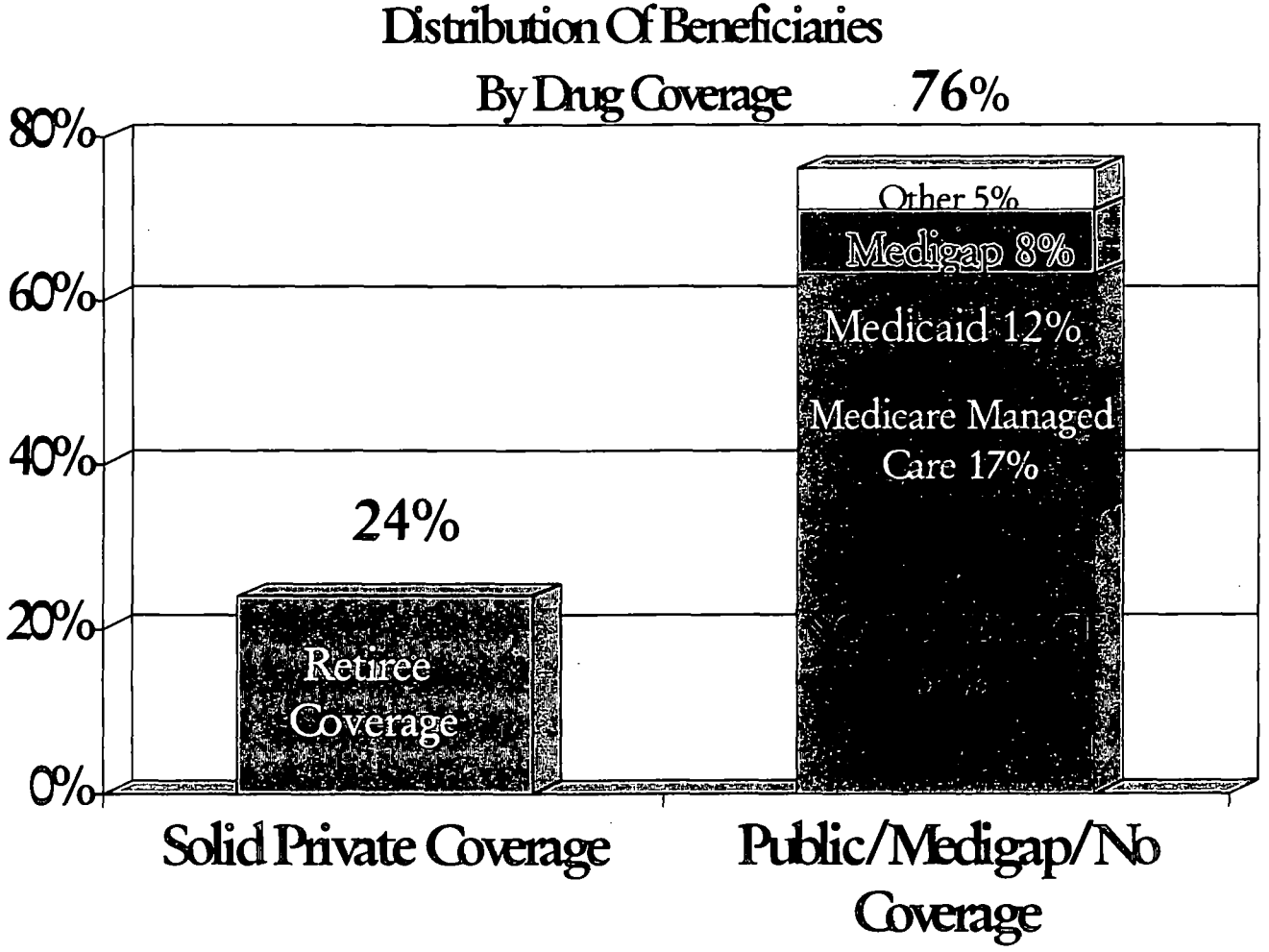
July, 1999

Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



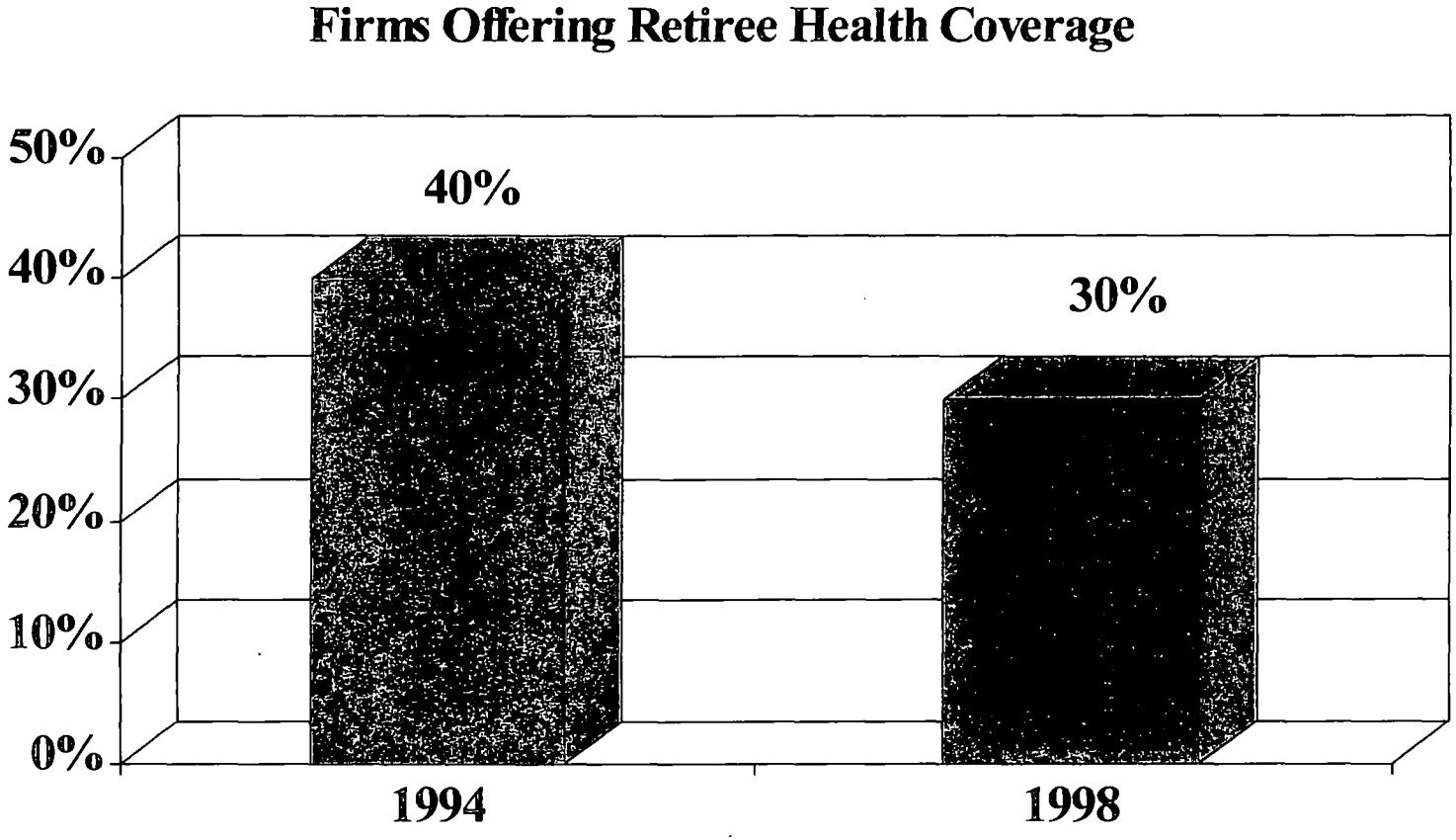
SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

PRIVATE DRUG COVERAGE:

Unstable and Declining

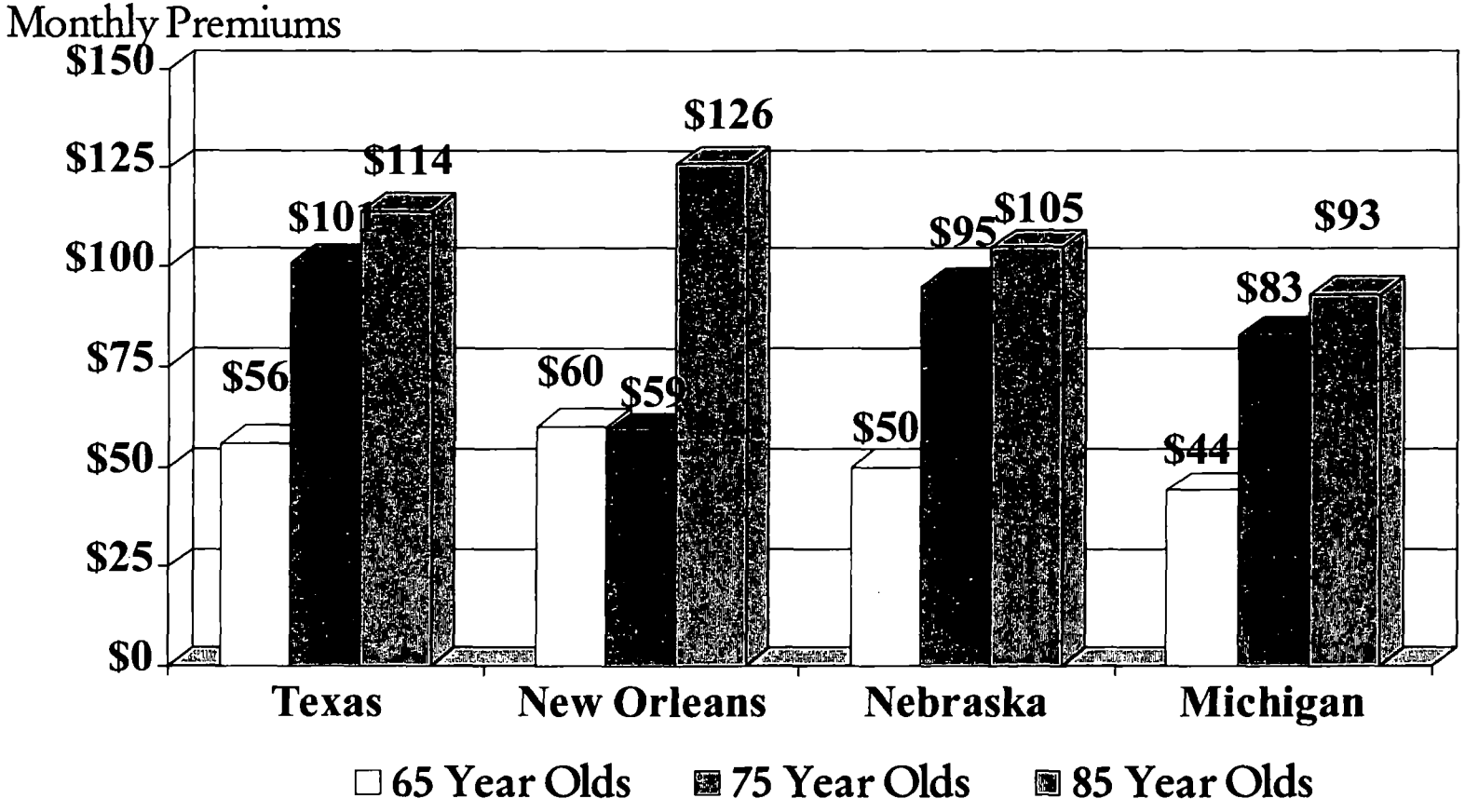
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

Medigap Premiums For Drugs Are High And Increase With Age, 1999

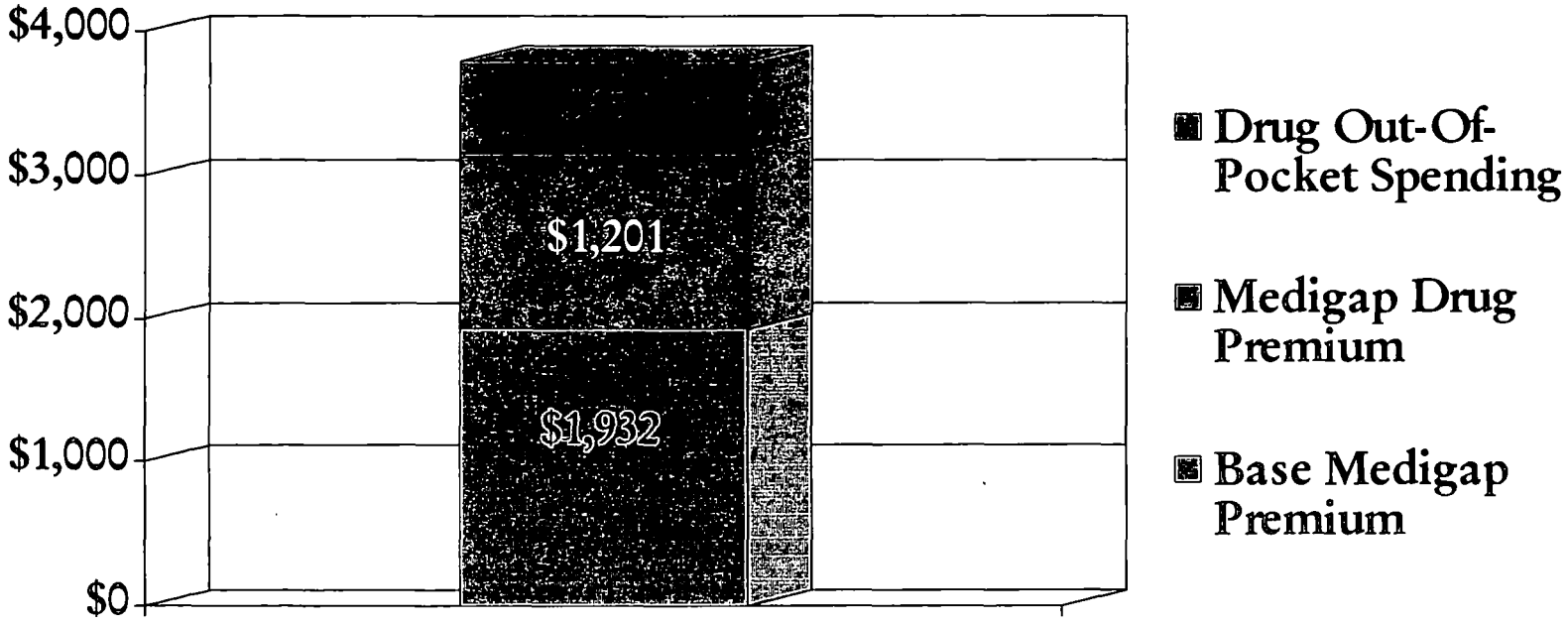


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

On Top Of The Premium For The Base Medigap, Beneficiaries Pay An Extra Premium For Drugs Plus Out-Of-Pocket Spending for Drugs

Medigap Annual Premiums And Out-Of-Pocket Spending

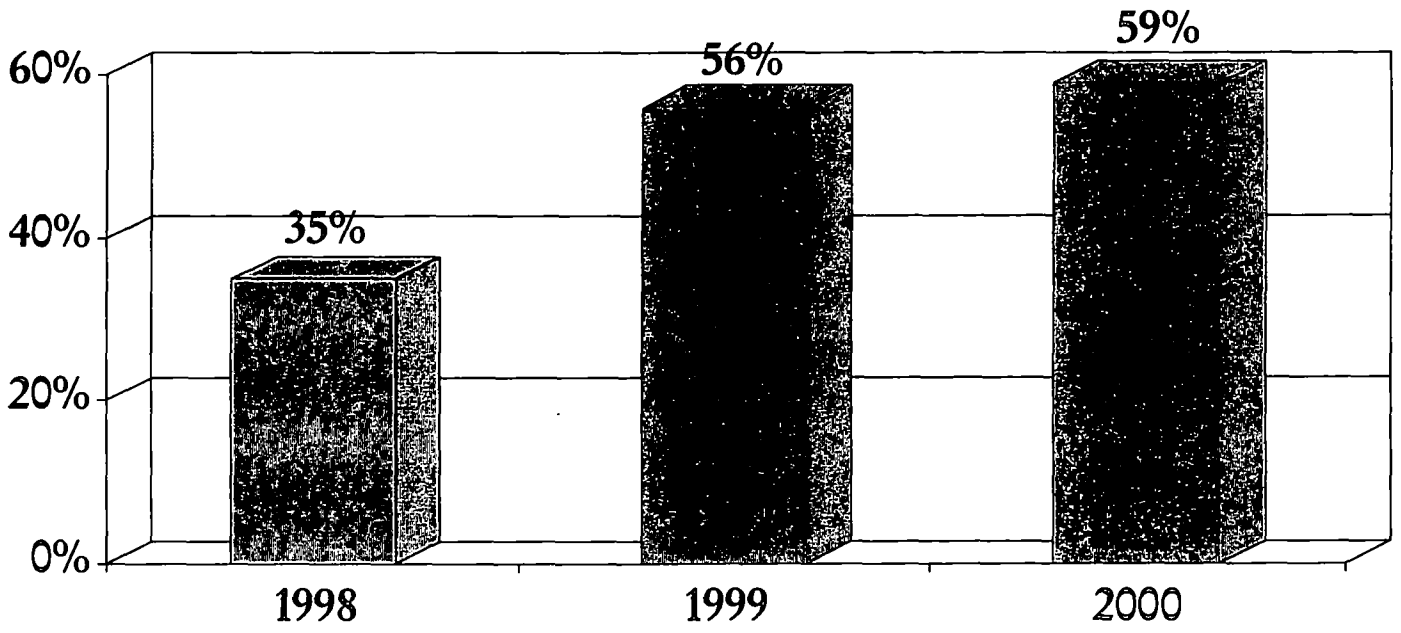


SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is $161 per month; drug addition is $101 per month

PUBLIC COVERAGE FOR PRESCRIPTION DRUGS

Value of Medicare Managed Care Drug Benefits Is Declining

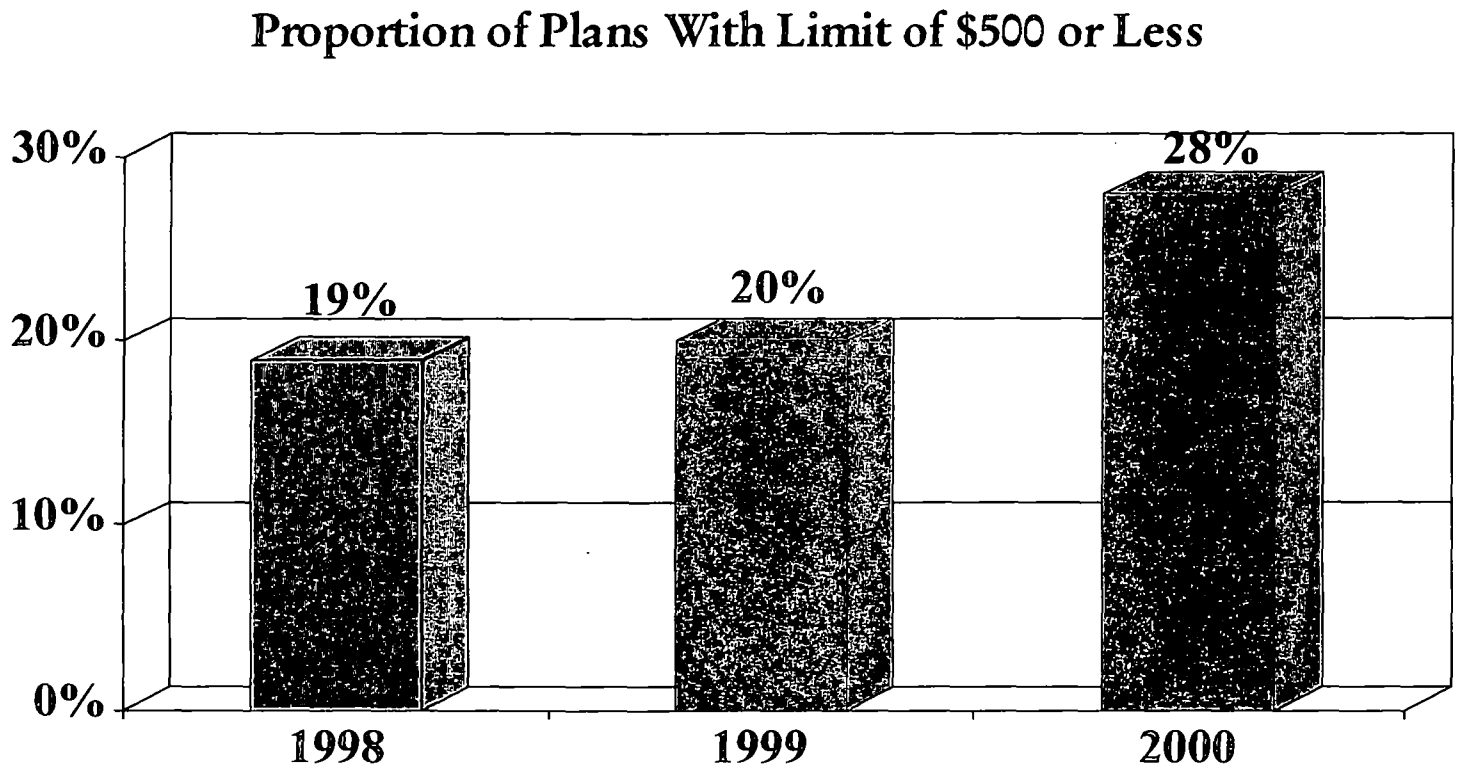
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

Proportion Of Plans With A $500 Or Lower Limit Has Increased By 50%



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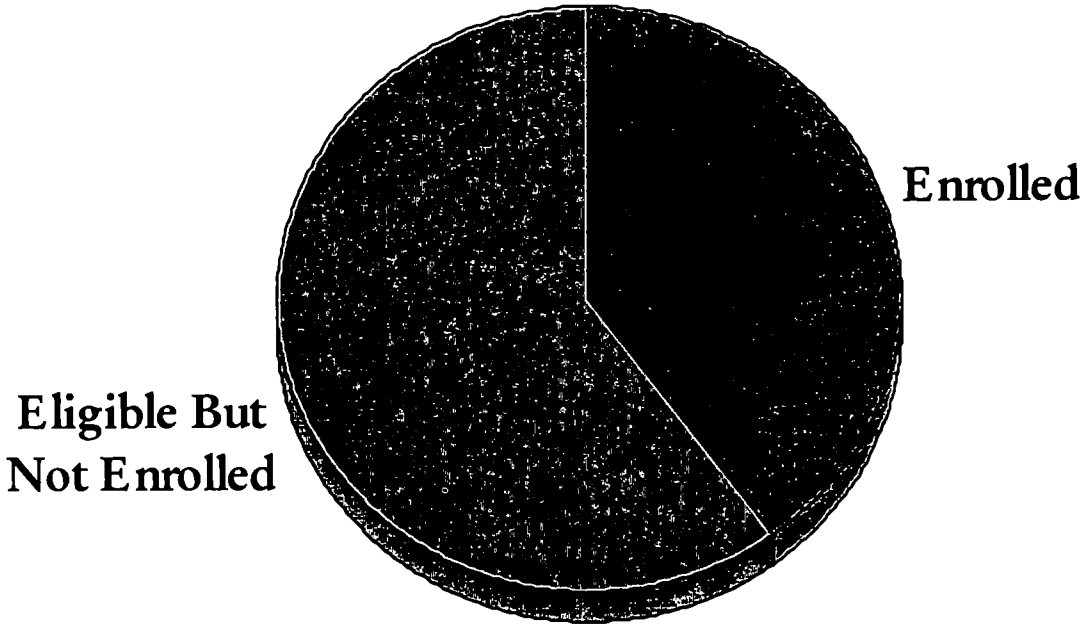
Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



SOURCE: Actuarial Research Corporation for HHS. Calculated assuming that beneficiaries below 73% of poverty are eligible for full Medicaid benefits through SSI (Kaiser Commission on Medicaid & the Uninsured, May 1999)

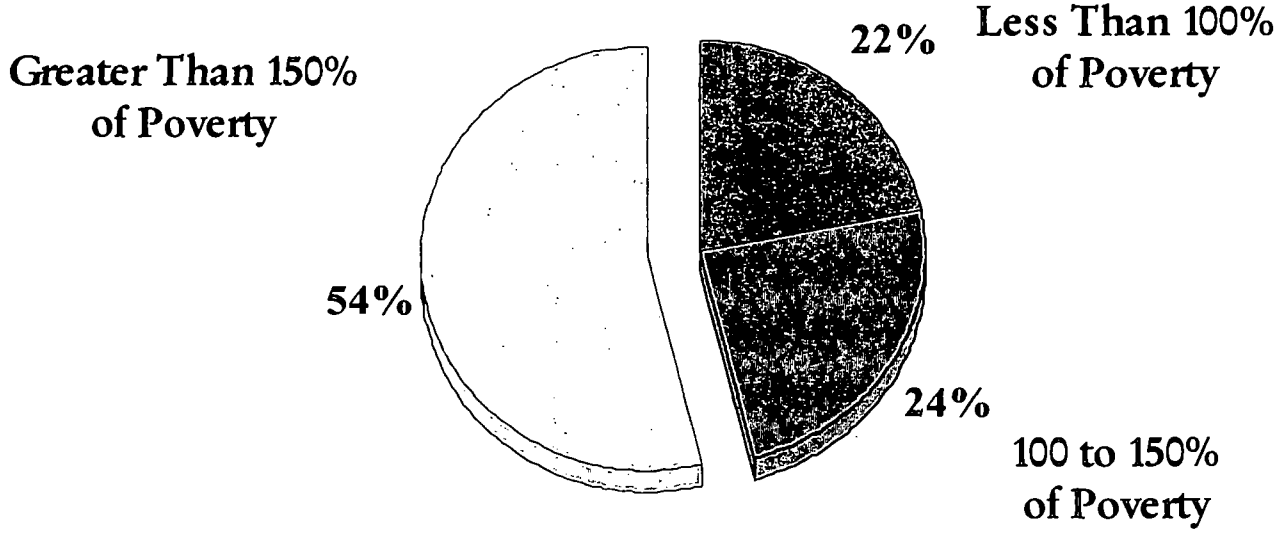
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

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

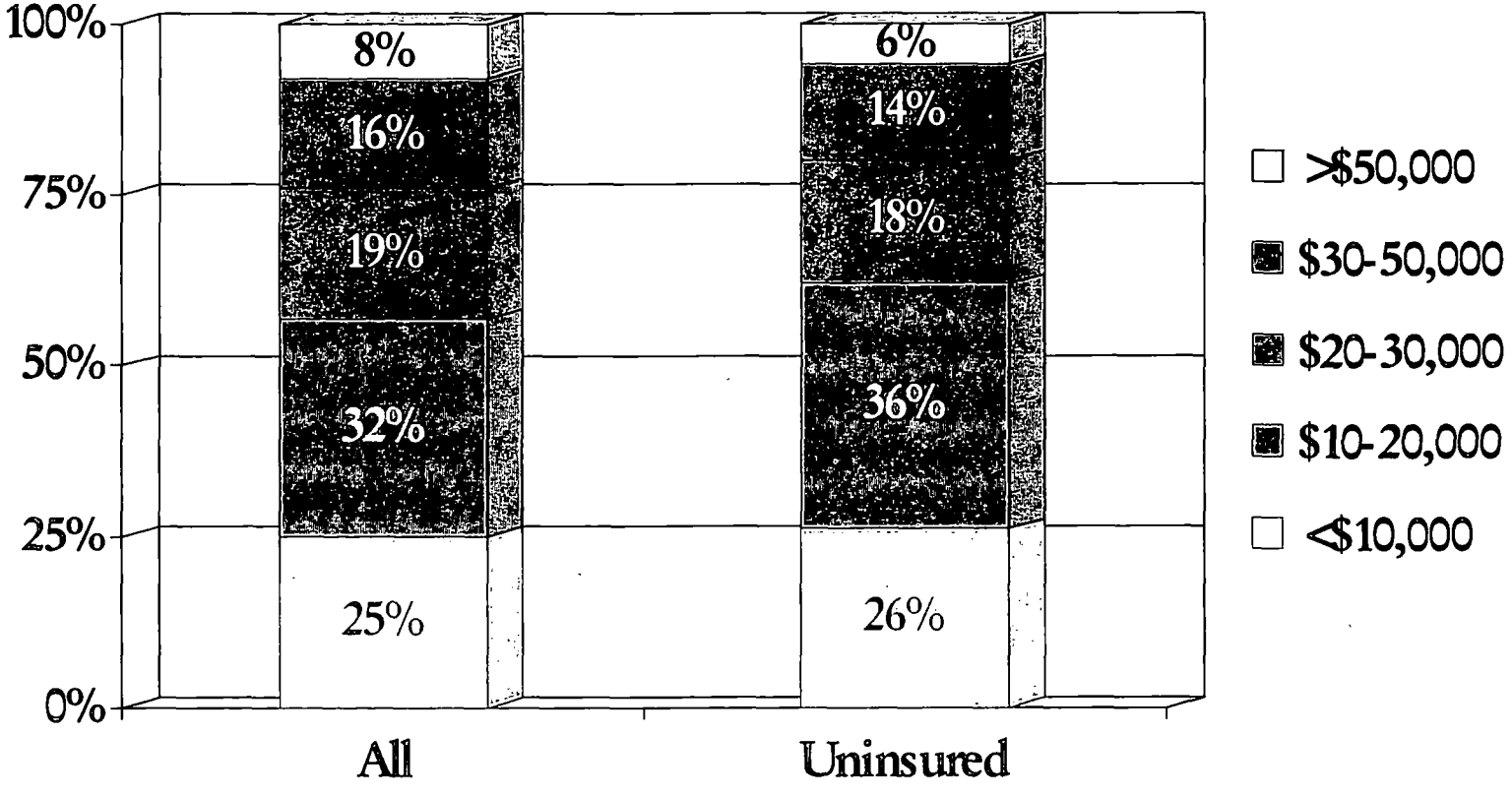
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, poverty for a single person is about $8,500, for a couple is about $11,400

Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



SOURCE: Actuarial Research Corporation for HHS, 2000

Methodology

The Actuarial Research Corporation under contract with the Department of Health and Human Services conducted most of the analysis. The basis for the estimates is the Medicare Current Beneficiary Survey (MCBS) for 1995. These data were aged to CY 2000, converted to a point-in-time estimate, and adjusted for the increase in managed care enrollment. This enrollment increase was estimated by moving beneficiaries from retiree health coverage, Medigap and the uninsured to managed care in proportion to their enrollment in those plans.

July 27, 1999

Health Division

Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

Route to:	Dan Mendelson	**ACTION:**	**Needed By:**
		Decision_____	Date:___/___/___
Through:	Barry Clendenin BC 8/2/99	Signature_____	Time:___:___am/pm
	Mark Miller MM	Comment_____	
		As requested___	**Copies to:** HD/HFB chrons.; Medicare exs, Dick Emery, Ellen Balis, Jack Smalligan, Chris Jennings, Gina Mooers
Subject:	HI Trust Fund Report for June 1999	Information XX___	
From:	Jonathan Blum JB	Phone: 202/395-7844 Fax: 202/395-7840 Room: NEOB #7002	Post this Document on HD Intranet? NO

The attached charts display data from the Monthly Treasury Statement on outlays, revenue, and change-in-balance of the Hospital Insurance (HI) Trust Fund. The charts include June 1999 data which were released on Monday, July 22 in the Monthly Treasury Statement for June.

Monthly Performance in June

HI outlays (summarized in Tables 1A and 1B) were 2 percent higher than the same time last year at $11,301 million. Revenues (summarized in Tables 2A and 2B) were 4 percent higher than the same time last year at $18,077 million. **The combination of outlays and revenues yielded a surplus in June of $6,776 million, compared to a surplus of $6,293 million a year ago.** Tables 3A and 3B illustrate this trend.

At the end of June 1999, the Trust Fund's balance was $139,591 million, compared to a balance of $122,736 million at this same time last year. Tables 4A and 4B illustrate the downward historical trend of the Trust Fund's balance.

Table 1A -- Gross HI Outlays: June 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

Actual Outlays	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	12,195	9,449	12,329	8,592	10,116	12,126	13,510	8,801	11,301				98,689
FY 1998	13,033	9,005	13,515	10,800	11,211	10,563	12,166	10,718	11,068	14,578	9,392	11,259	137,298
FY 1997	11,377	11,517	10,972	11,583	11,281	10,448	12,017	13,222	9,977	12,476	12,769	9,916	137,884
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 99 - FY 98	(838)	444	(1,186)	(2,208)	(1,095)	1,563	1,344	(1,917)	233				
% Difference	-7%	4%	-11%	-19%	-10%	15%	11%	-14%	2%				

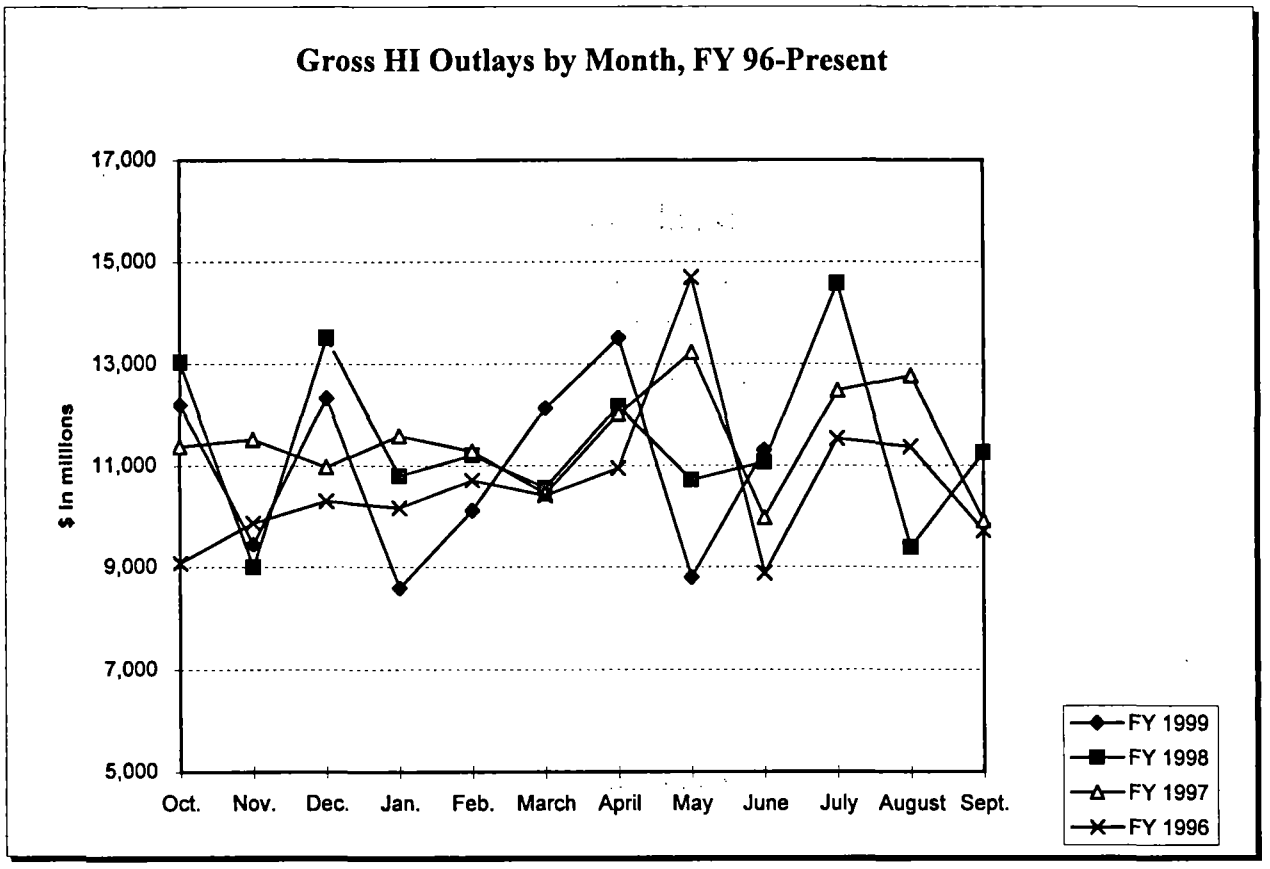


Table 1B -- Gross HI Outlays: June 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	12,195	9,449	12,329	8,592	10,116	12,126	13,510	8,801	11,301				98,689
FY 1998	13,033	9,005	13,515	10,800	11,211	10,563	12,166	10,718	11,068	14,578	9,392	11,259	137,298
FY 1997	11,377	11,517	10,972	11,583	11,281	10,448	12,017	13,222	9,977	12,476	12,769	9,916	137,555
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 99 - FY 98 Cumulative Difference	(838)	(394)	(1,580)	(3,788)	(4,883)	(3,320)	(1,976)	(3,893)	(3,660)				
Cumulative % Difference	-6%	-1.8%	-4.4%	-8.2%	-8.5%	-4.9%	-2.5%	-4.3%	-3.6%				

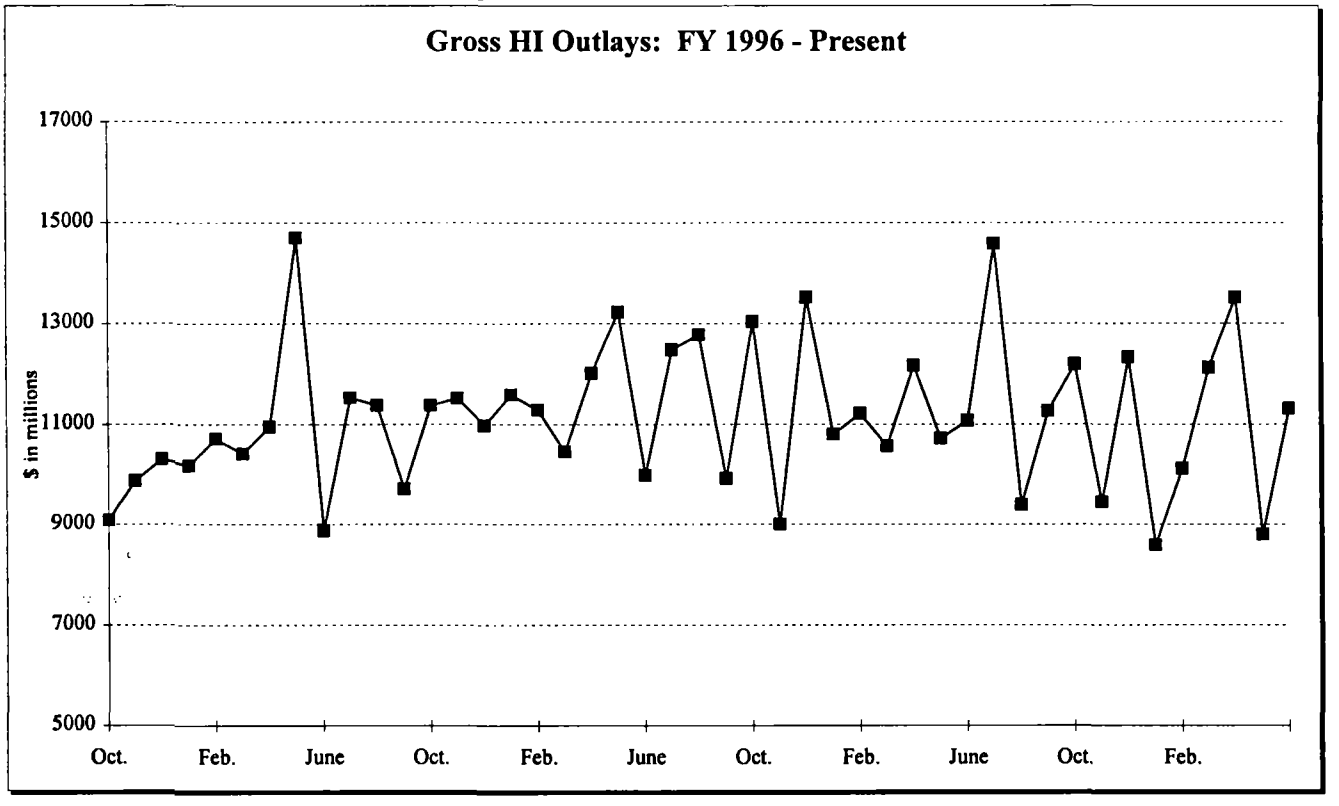


Table 2A -- HI Revenues: June 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

Actual Revenues	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	9,807	10,649	16,963	13,997	9,265	11,416	15,431	9,796	18,077				115,401
FY 1998	9,166	9,856	16,053	12,642	8,794	10,115	14,697	9,022	17,361	9,142	9,314	12,040	138,203
FY 1997	8,394	9,169	15,907	11,574	8,286	9,685	12,058	8,527	16,049	8,467	9,291	11,095	128,548
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 99 - FY 98	641	793	910	1,355	471	1,301	734	774	716				
% Difference	7%	8%	6%	11%	5%	13%	5%	9%	4%				

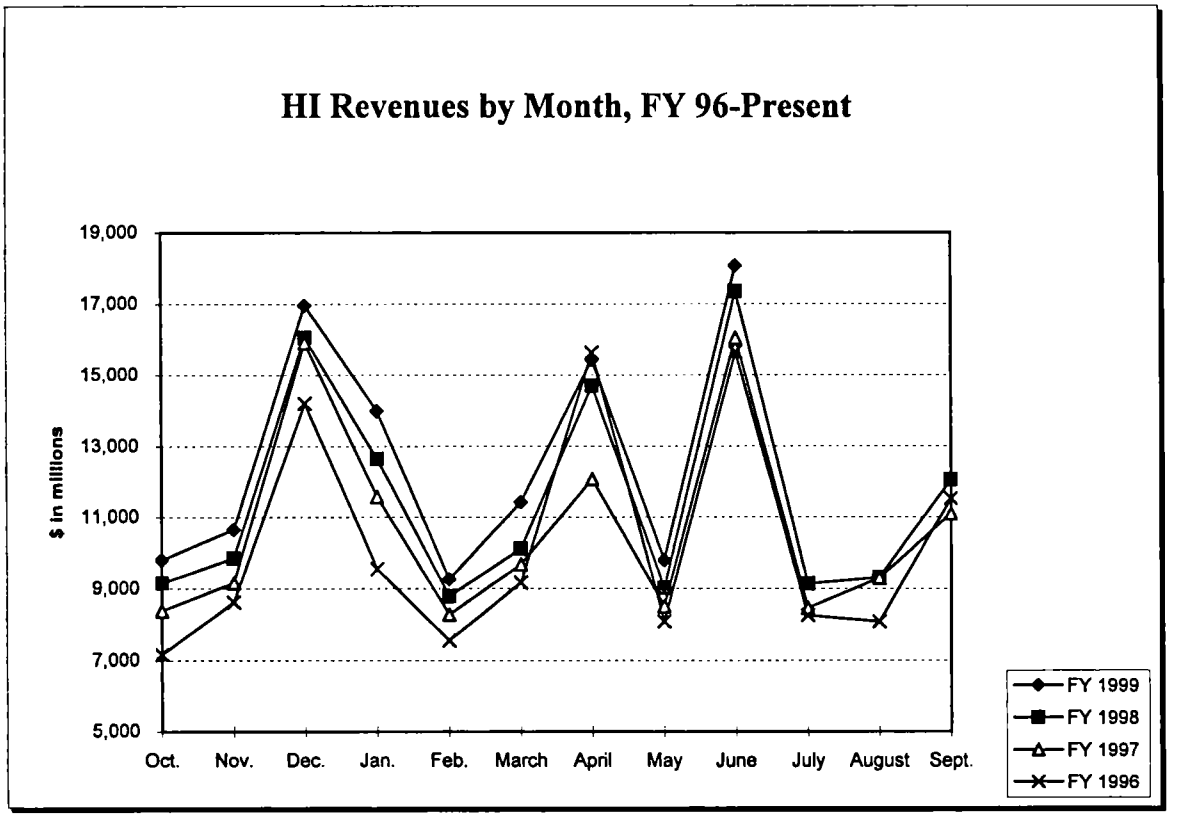


Table 2B -- HI Revenues: June 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	9,807	10,649	16,963	13,997	9,265	11,416	15,431	9,796	18,077				115,401
FY 1998	9,166	9,856	16,053	12,642	8,794	10,115	14,697	9,022	17,361	9,142	9,314	12,040	138,203
FY 1997	8,394	9,169	15,907	11,574	8,286	9,685	12,058	8,527	16,049	8,467	9,291	11,095	128,502
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 99 - FY 98 Cumulative Difference	641	1,434	2,344	3,699	4,170	5,471	6,205	6,979	7,695				
Cumulative % Difference	7%	7.5%	6.7%	7.8%	7.4%	8.2%	7.6%	7.7%	7.1%				

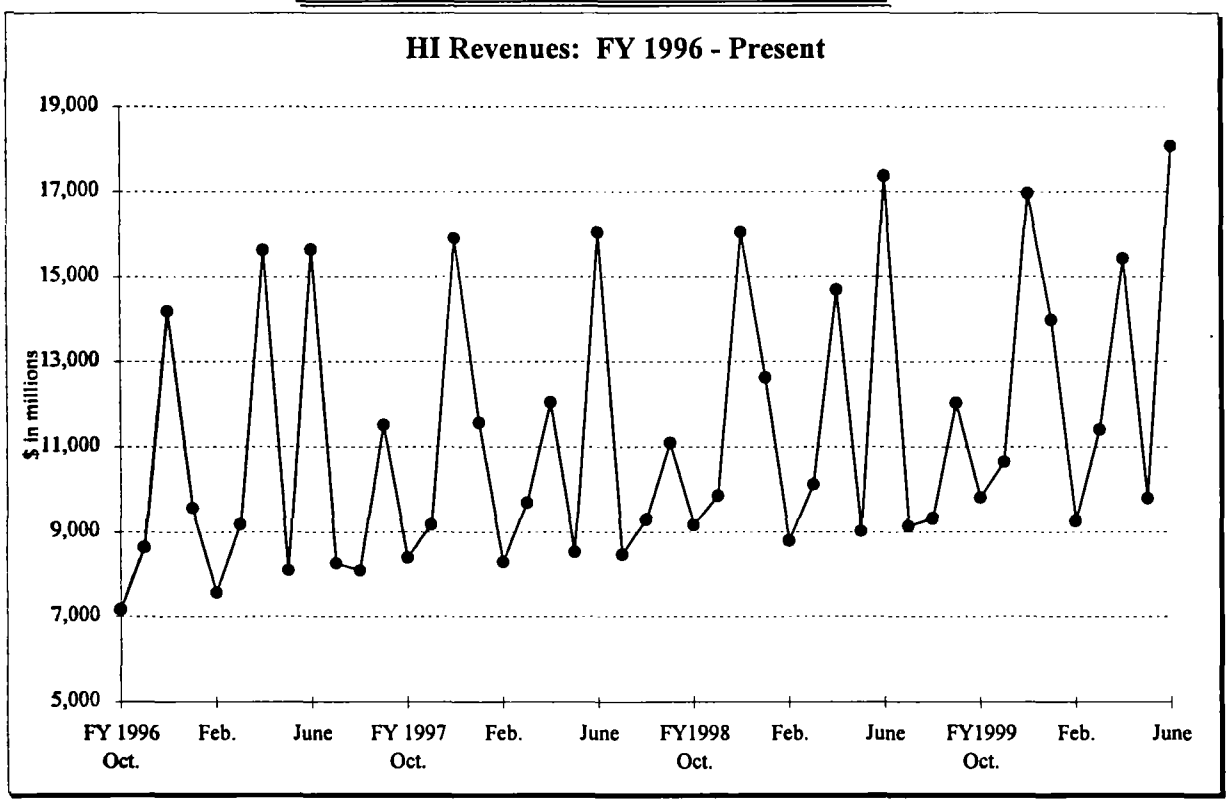


Table 3A -- Surplus (Shortfall) in HI Trust Fund: June 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

Actual Change	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	(2,388)	1,200	4,634	5,405	(851)	(710)	1,921	995	6,776				16,712
FY 1998	(3,867)	851	2,538	1,842	(1,734)	(448)	2,531	(1,696)	6,293	(5,436)	(78)	781	905
FY 1997	(2,983)	(2,348)	4,935	(9)	(2,995)	(763)	41	(4,695)	6,072	(4,010)	(3,478)	1,179	(9,336)
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 99 - FY 98	1,479	349	2,096	3,563	883	(262)	(610)	2,691	483				
% Difference	-38%	41%	83%	193%	-51%	58%	-24%	-159%	8%				

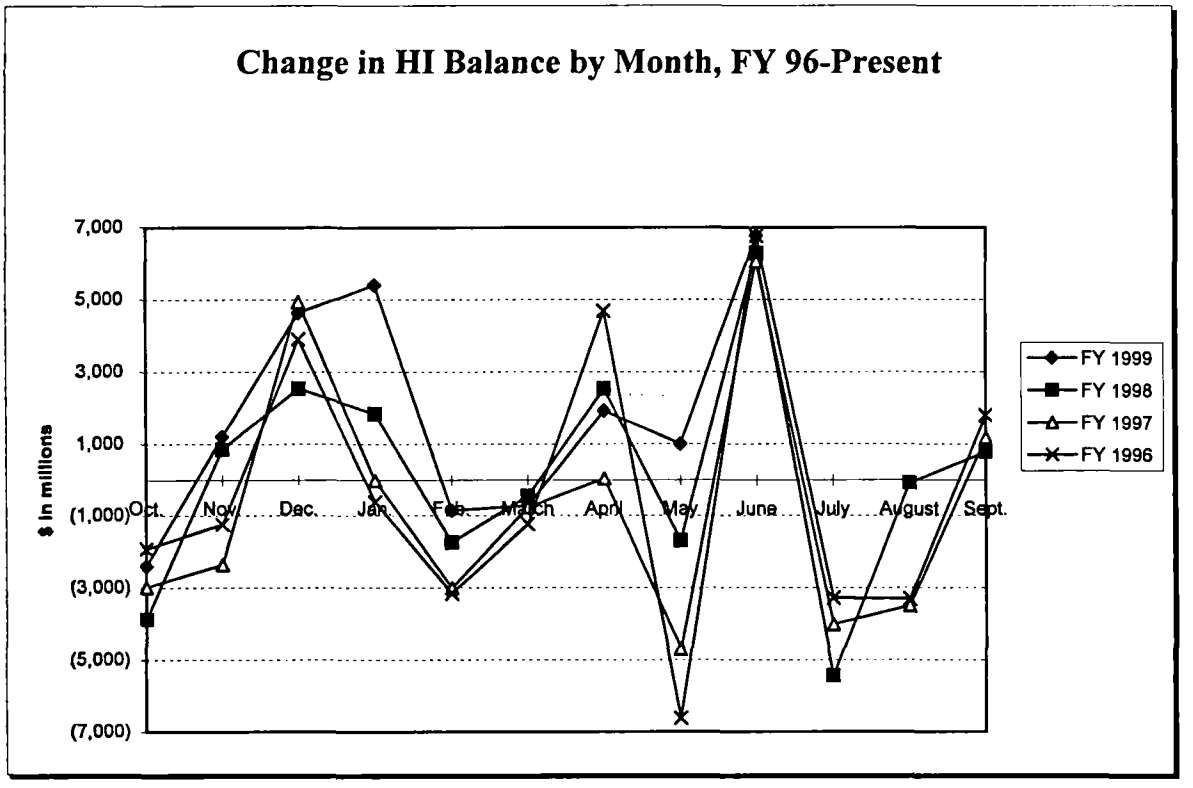


Table 3B -- Surplus (Shortfall) in HI Trust Fund: June 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years

($ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Total
FY 1999	(2,388)	1,200	4,634	5,405	(851)	(710)	1,921	995	6,776				16,712
FY 1998	(3,867)	851	2,538	1,842	(1,734)	(448)	2,531	(1,696)	6,293	(5,436)	(78)	781	905
FY 1997	(2,983)	(2,348)	4,935	(9)	(2,995)	(763)	41	(4,695)	6,072	(4,010)	(3,478)	1,179	(9,336)
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 99 - FY 98 Cumulative Difference	1,479	1,828	3,924	7,487	8,370	8,108	7,498	10,189	10,672				
Cumulative % Difference	-38%	-61%	-821%	549%	-2262%	-991%	438%	59935%	169%				

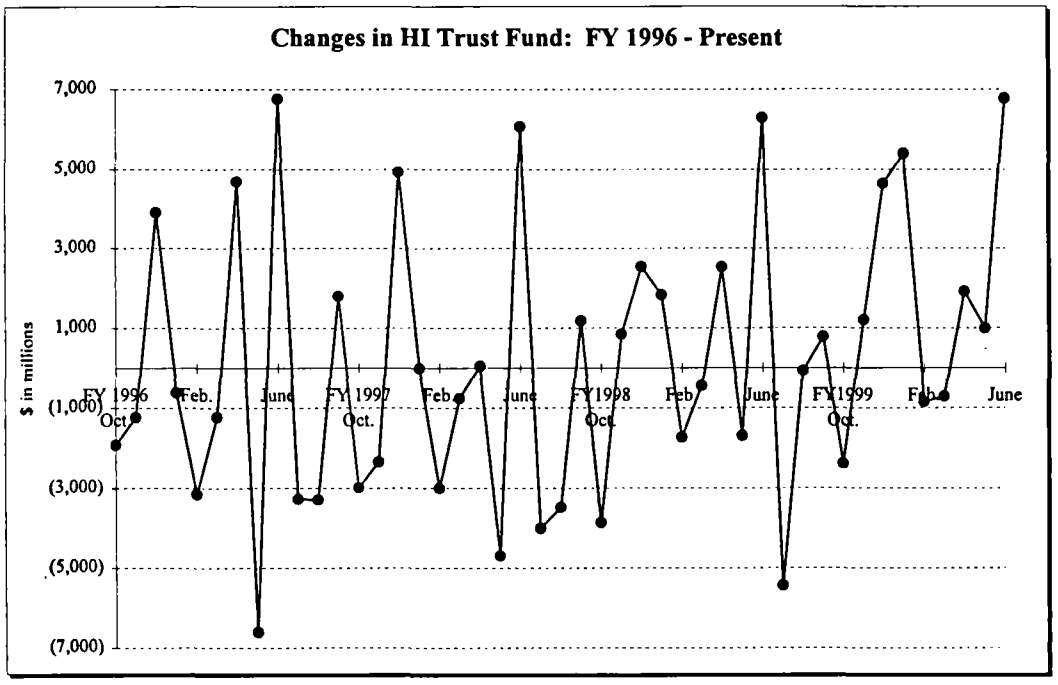


Table 4A – HI Trust Fund Balance: June 1999 Report
Comparison of FY 1999 Monthly Balance to Previous Years
($ in millions)

Actual Change	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Average
FY 1999	115,067	117,520	120,739	126,973	125,385	124,181	128,550	131,905	139,591				125,546
FY 1998	112,707	113,798	116,441	118,056	116,518	116,904	120,451	115,663	122,736	119,236	116,952	118,250	117,309
FY 1997	122,541	120,038	126,709	125,468	122,375	121,948	121,635	116,190	123,001	118,801	115,352	116,621	120,890
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610
FY 99 - FY 98	2,360	3,722	4,298	8,917	8,867	7,277	8,099	16,242	16,855				
% Difference	2%	3%	4%	8%	8%	6%	7%	14%	14%				

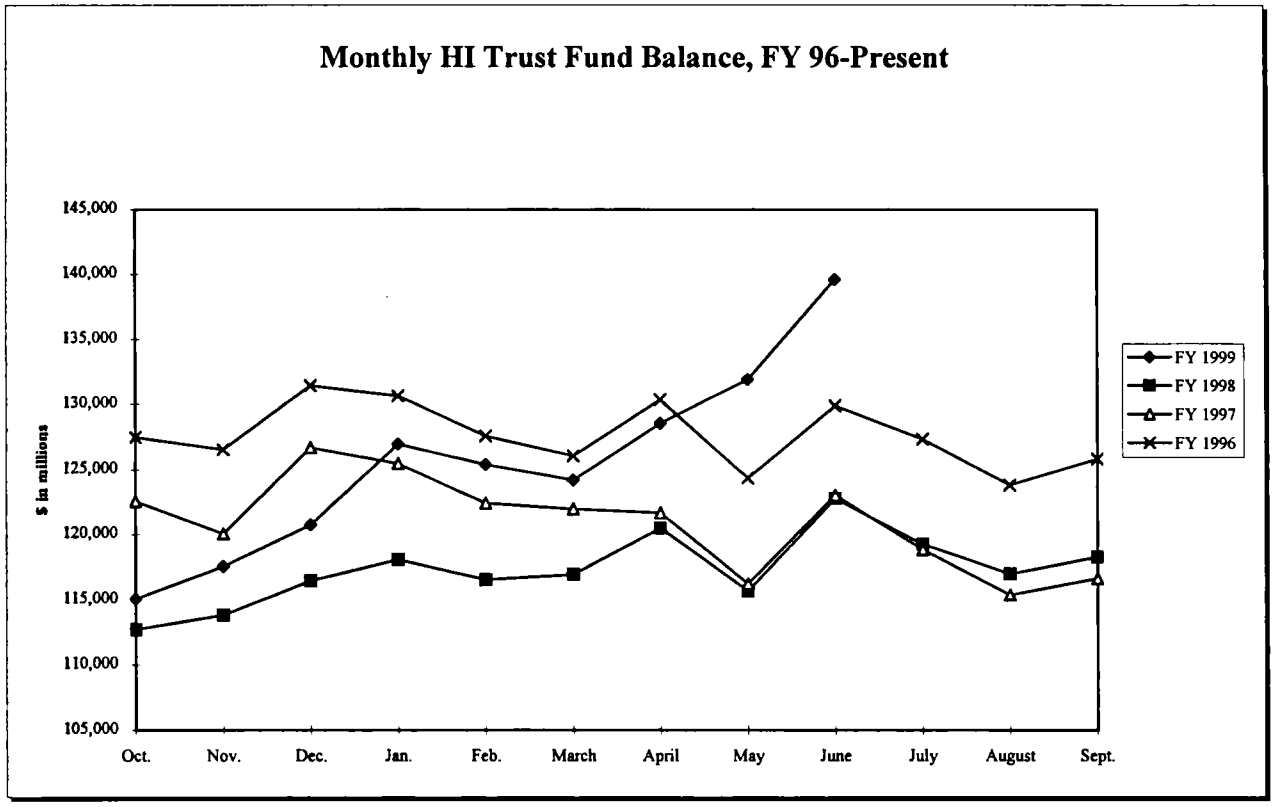
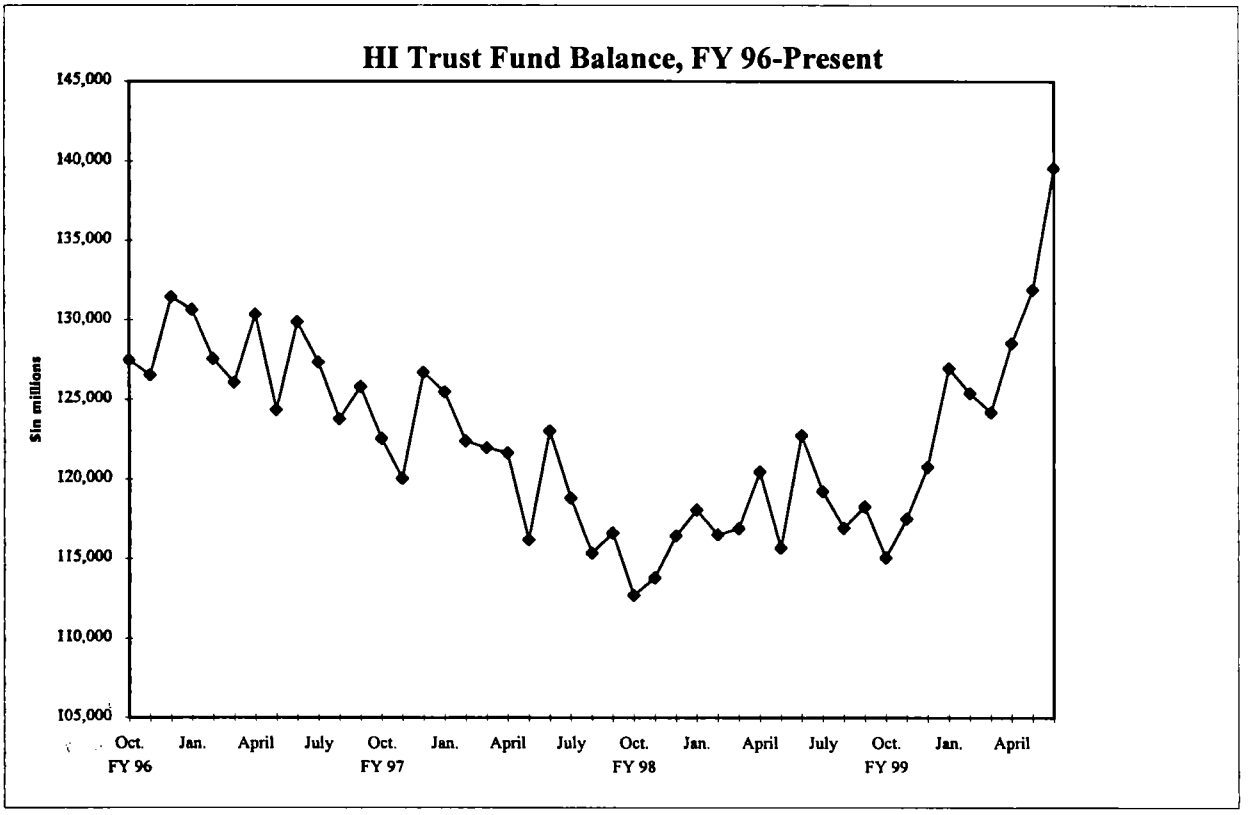


Table 4B -- HI Trust Fund Balance: June 1999 Report
Long-Term Comparison of FY 1999 Balance to Previous Years
($ in millions)

	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	August	Sept.	FY Average
FY 1999	115,067	117,520	120,739	126,973	125,385	124,181	128,550	131,905	139,591				125,546
FY 1998	112,707	113,798	116,441	118,056	116,518	116,904	120,451	115,663	122,736	119,236	116,952	118,250	117,309
FY 1997	122,541	120,038	126,709	125,468	122,375	121,948	121,635	116,190	123,001	118,801	115,352	116,621	120,890
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610



DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

National Economic Council
Domestic Policy Council

July 22, 1999

DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

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OVERVIEW

DISTURBING TRUTHS AND DANGEROUS TRENDS: The Facts About Medicare Beneficiaries and Prescription Drug

This report describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. This report shows that the accessing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance – it is an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

- **Prescription drug coverage is good medicine.**

  - Part of modern medicine. Prescription drugs serve as complements to medical procedures, such as anti-coagulants, used with heart valve replacement surgery; substitutes for surgery, such as lipid lowering drugs that reduce the need for bypass surgery; and new treatments where there previously were none, such as medications used to manage Parkinson's disease. In addition, as our understanding of genetics grows, the possibility for breakthrough pharmaceutical and biotechnology will increase exponentially.

  - Medicare beneficiaries are particularly reliant on prescription drugs. Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.

  - The lack of drug coverage has led to inappropriate use of medications which can result in increased costs and unnecessary institutionalization. Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. The consequence of inappropriate and underutilization of prescription drugs has also been found to double the likelihood that low-income beneficiaries entering nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.

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

  - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage.

- Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans' Affairs and other public programs.

- **Private trends: Decline in coverage and affordability.**

  - The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

  - Medigap premiums for drugs are high and increase with age. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the President. Moreover, unlike the President's proposal, premiums substantially increase with age as virtually every Medigap plan "age rates" the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach. This cost burden will particularly affect women, who make up 73 percent of people over age 85.

- **Public drug coverage trends: managed care benefits reduced.**

  - The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. This is part of a troubling trend of plans to severely limit benefits through low caps. In fact, the proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.

  - Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent. This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries. Inadequate outreach and welfare stigma contributes to these low participation levels and raise serious questions about the feasibility and advisability of using the Medicaid program to provide needed coverage for a population at higher income levels.

- **Millions of beneficiaries have no drug coverage.**

  - At least 13 million Medicare beneficiaries have absolutely no prescription drug coverage. The number of the uninsured is not concentrated among the low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels.

  - More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV and Parkinson's). Some of the major advances in public health – the near eradication of polio and measles and the decline in infectious diseases – are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

- **Greatest need for prescription drugs.** The elderly and people with disabilities are particularly reliant on prescription drugs. Not only do they experience greater health problems, but these problems tend to include conditions that respond to drug therapy. As a result, about 85 percent of beneficiaries fill at least one prescription a year. Some examples of common conditions include:

  - Osteoporosis: Over 1 in 5 older women have osteoporosis and about 15 percent have suffered a fracture as a result.[1] It is a leading risk factor for hip fractures, which affects 225,000 people over the age of 50. Estrogen replacement can reduce the risk of osteoporosis as well as that of cardiovascular disease. One commonly used drug costs $20 per month, $240 per year.

  - Hypertension: About 60 percent of people over age 65 have hypertension.[2] African Americans are more likely to have hypertension. For a person over age 55, hypertension increases the risk of a heart attack or other heart problem over 10 years by 10 percent.[3] Hypertension roughly doubles the risk of cardiovascular disease and is the leading factor for stroke. According to one study, treatment results in a one-third reduction in the probability of stroke and a one-quarter reduction in the probability of a heart attack.[4] ACE inhibitors which typically cost $40 per month, $480 per year are commonly prescribed to control hypertension, and are frequently used in combination with diuretics and /or beta-blockers.

  - Myocardial Infarction (Heart Attack): Heart disease is the leading cause of death for persons 65 and over. About 1.5 million Americans each year have heart attacks, which are fatal in about 30 percent of patients. Since people who survive heart attacks are much more likely to have subsequent attacks, disease management including drugs can significantly improve health and longevity. For example, a study of the use of a lipid lowering drug by people who had an acuate myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.[5] A common lipid reduction drug costs about $85 per month, $1,020 per year. A beta-blocker costs about $30 per month, $360 per year, and can reduce long-term mortality by 25 percent.[6]

  - Adult-Onset Diabetes: About 1 in 10 elderly have Type I or II diabetes.[7] Diabetes can lead to blindness, kidney disease and nerve damage. Glucose (blood sugar)

control can prevent or delay these conditions. Commonly used medications include cost around $60 per month, $720 per year.

- Depression: An estimated 1 in 10 to 1 in 20 community-based elderly experience depression.[8] Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.[9] New therapies can cost from $130 to $290 per month or $1,560 to $3,480 per year.

- **Many beneficiaries need drugs but do not use them as prescribed because they do not have well managed, affordable drug insurance.** Most research has found that drug coverage influences use of needed drugs:

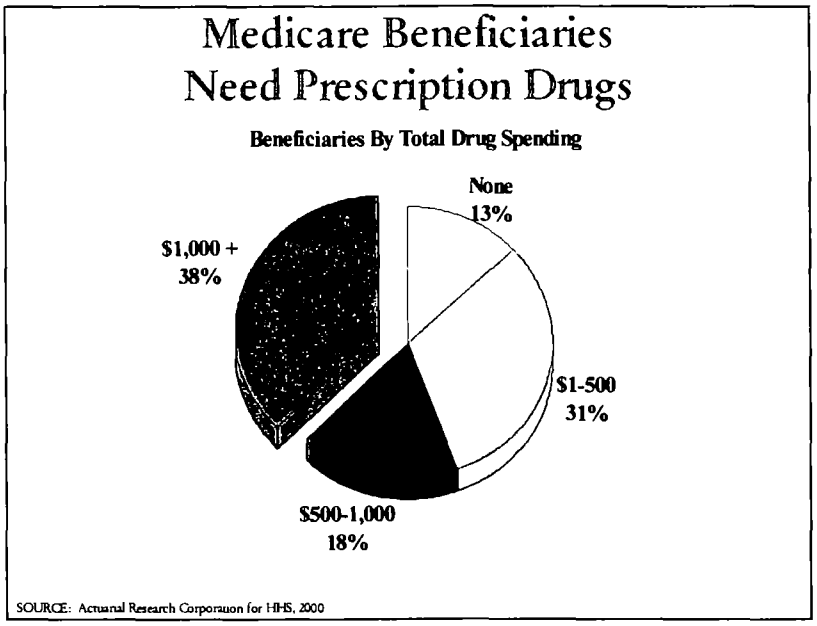
  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.[10] Many elderly must choose between prescriptions and other basic household needs.[11]

  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.[12]

  - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs. One study which classified the geriatric admissions to a community hospital found that drug-related hospitalization accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.[13]

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

- **Because of their greater need, the elderly and people with disabilities have greater health care costs.** The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug spending.



- **Over one-third (38%) of Medicare beneficiaries will spend more than $1,000 on prescription drugs.** Less than 5 percent will spend more than $5,000.

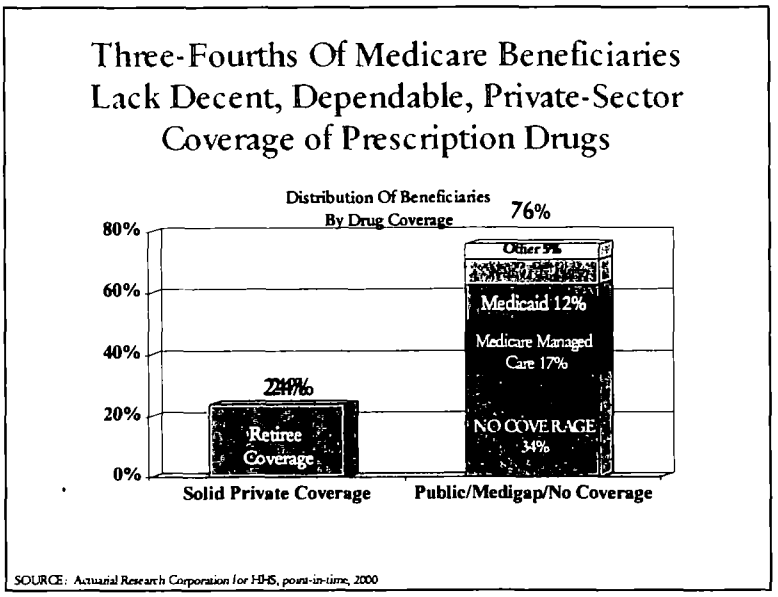
- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than $500.

- **Spending is higher for women.** Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.

- **Out-of-pocket spending is also high.** In 2000, Medicare beneficiaries are estimated to spend about $525 on prescription drugs out-of-pocket. This spending is linked to insurance coverage – it is much higher for those with no coverage ($800) and people with Medigap ($650) than those with retiree coverage ($400).

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

- **Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs.** As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.



- **Only one-fourth of Medicare beneficiaries have retiree drug coverage.** Employers provide health insurance for most Americans under the age of 65, but pay for supplemental coverage for only a fraction of their elderly retirees. When available, this coverage tends to have reasonable cost sharing and affordable premiums.

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs.** These beneficiaries include those with:

  - Medigap. About 8 percent of beneficiaries purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries.

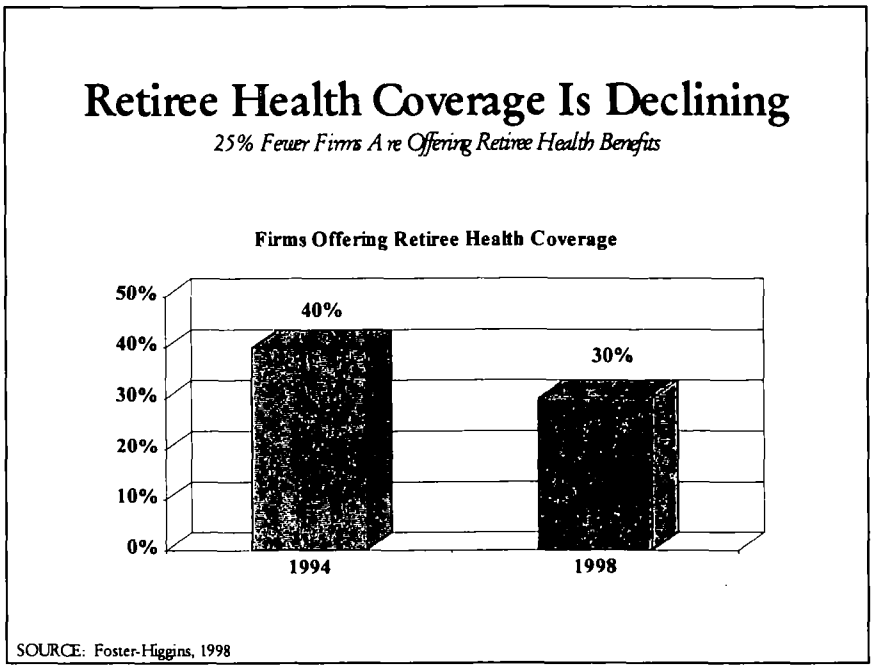
  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

  - Medicaid and other public programs. Medicaid covers about 12 percent of beneficiaries and programs like the Veterans' Administration cover another 5 percent of beneficiaries. Eligibility for these programs is very restrictive.

  - No coverage at all. 34 percent of Medicare beneficiaries has no drug coverage.

RETIREE HEALTH COVERAGE

- **About one in four Medicare beneficiaries has prescription drug coverage through their retiree health plan.** These employer-based plans offer decent, affordable coverage.



- **Firms offering retiree health coverage have declined by 25 percent in the last four years.**[14] Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage.

  - The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

- **Most serious effect will occur when the baby boom generation retires.** Although there are employers who are dropping health coverage for current retirees, most are restricting coverage for future retirees. This means that the access problems that are emerging now could be more severe in the future.

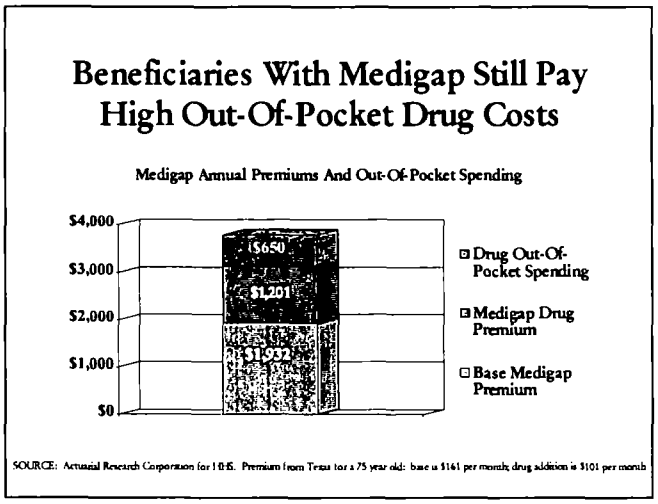
- **Firms are increasingly moving their retirees to Medicare managed care.** To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in 1996.[15]

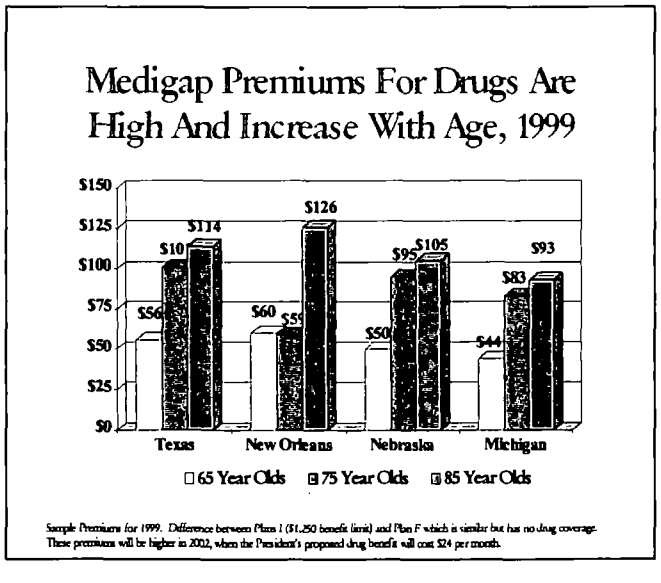
MEDIGAP PRESCRIPTION DRUG COVERAGE

- **Because of its high cost relative to its benefit, less than one in ten Medicare beneficiaries purchases a Medigap plan with prescription drugs.** Three of the ten standardized Medicare supplemental plans, (plans H, I, and J) include prescription drug coverage. All three plan types have a $250 deductible for the drug benefit and require 50 percent coinsurance. The H and I plans have a cap on drug benefits of $1,250 while the J plan caps the benefit at $3,000. The typical premium for a plan with the lower cap costs about $90 per month or $1,080 per year.

- **Medigap is expensive, inefficient, and often uses higher prices to discriminate against the oldest beneficiaries.**

  - Expensive. Medigap policies that cover prescription drugs are expensive relative to comparable policies that do not cover drugs. Additionally, premiums vary tremendously from place to place, and from beneficiary to beneficiary. Finally, a beneficiary cannot only pay for prescription drugs – they must also buy the other benefits in the package.





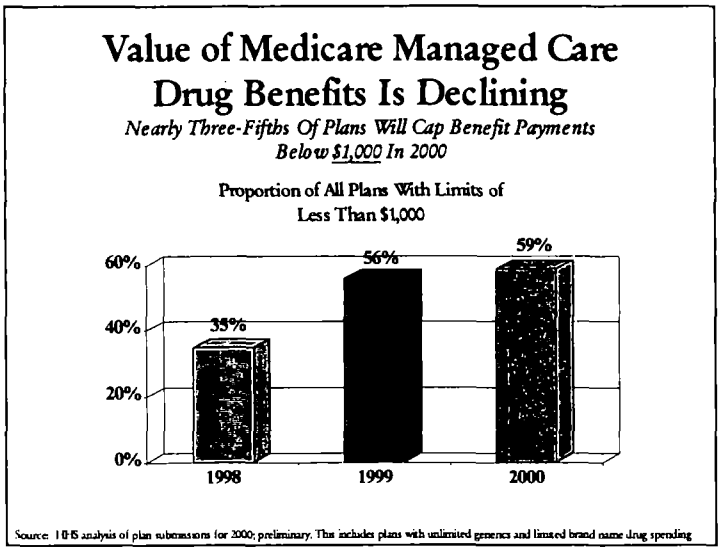
Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

Costs increase with age as well as health inflation. This "attained age" pricing practice causes excessive premiums for those who need it most – the very old. It also disproportionately affects women since they comprise nearly three-fourths of people over age 85.

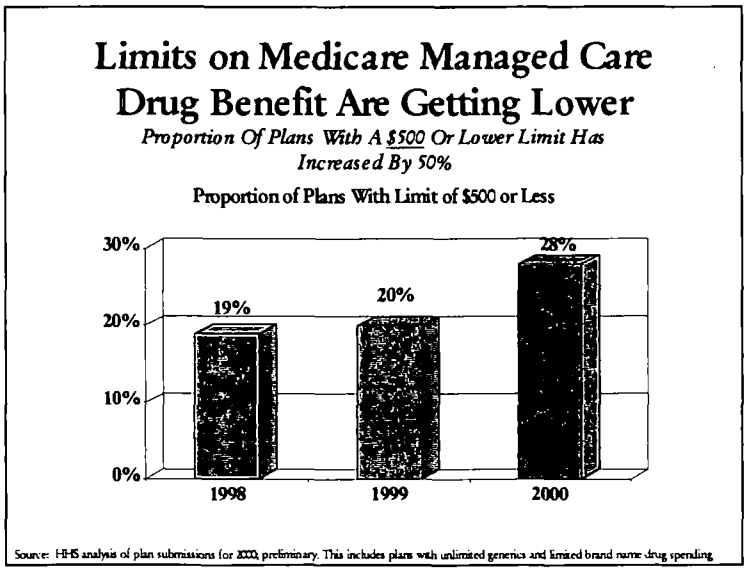
MEDICARE MANAGED CARE

- **The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent.** Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.

- **Drug coverage under Medicare+Choice is unstable.** Managed care plans are not required to offer a drug benefit, but can do so with any excess Medicare payments or by charging a premium. This results in wide variation across areas, since payments vary by area, and over time.



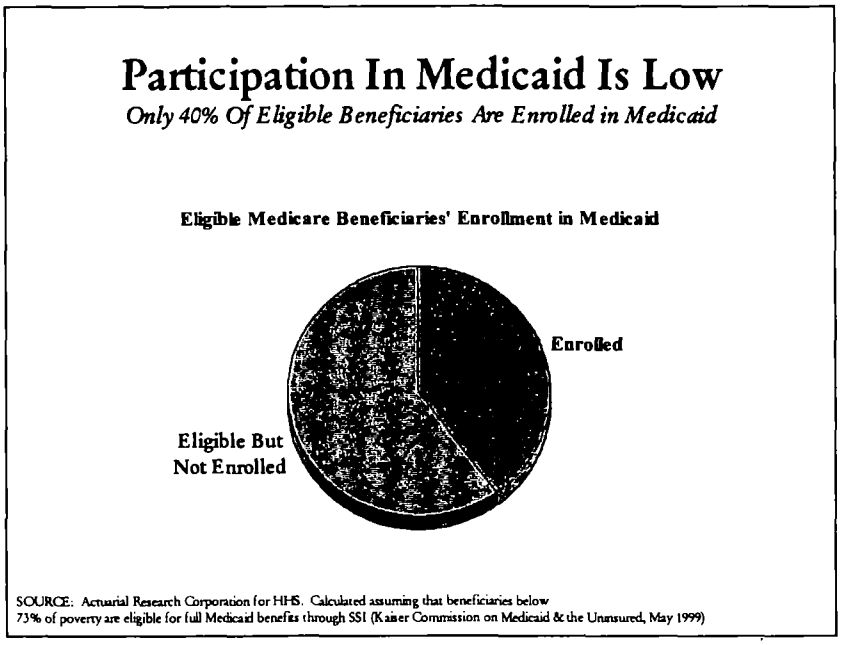
- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000. This is part of a troubling trend of plans to severely limit benefits through low caps.



- **Plans dropping out of Medicare limit access to drugs.** Nearly 80,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.

MEDICAID

- **About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit.** Most of these "dual eligibles" qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- $6,200 for a single, $8,300 for a couple in 2000). States have other options for covering the elderly and disabled, including "medically needy" or "spend-down" programs that extend eligibility to sick and/or institutionalized people.



- **Participation by Medicaid eligible populations remains low.** Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.

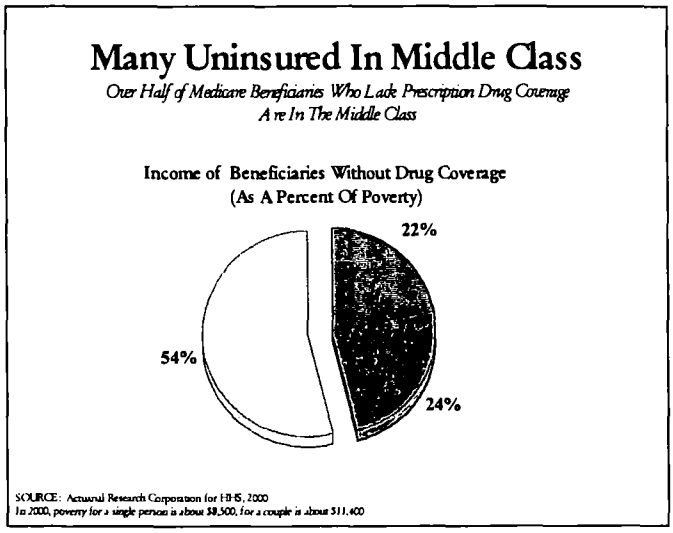
    - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.

    - This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries.

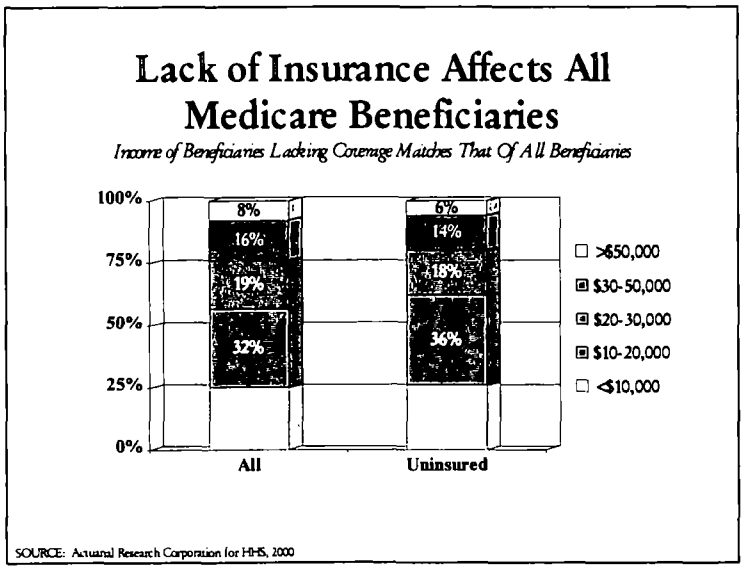
BENEFICIARIES LACKING DRUG COVERAGE

- **At least 13 million or 34 percent of Medicare beneficiaries have no insurance coverage for prescription drugs.** These beneficiaries pay retail prices for prescription drugs, which can often be significantly more expensive than what large firms or public programs pay for the same drugs.

- **More than half of Medicare beneficiaries without drug coverage are middle class.** Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This indicates that targeting a drug benefit only to the low-income cannot address even half of the problem.



- **The income distribution of beneficiaries lacking drug coverage closely parallels that of all beneficiaries.** This lack of difference suggests that everyone is at risk of losing their health insurance.



PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost the Federal government about $118 billion from 2000 to 2009. It would be fully offset, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare.

- **Meaningful coverage.** Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:

  - No deductible – coverage begins with the first prescription filled and

  - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

  The benefit would be limited to $5,000 in costs ($2,500 in Medicare payments) in 2008. It would phase it a $2,000 for 2002-2003; $3,000 for 2004-2005; $4,000 for 2006-2007; and $5,000 in 2008 (indexed to inflation in subsequent years).

- **Affordable premiums.** Beneficiaries who opt for Part D would a pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008 when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and, after an initial open enrollment for all beneficiaries in 2001, would occur when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would generally be deducted from Social Security checks.

  - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty ($17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty ($15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.

- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

APPENDIX: METHODOLOGY & ENDNOTES

Methodology. The Actuarial Research Corporation under contract with the Department of Health and Human Services conducted most of the analysis. The basis for the estimates is the Medicare Current Beneficiary Survey (MCBS) for 1995. These data were aged to CY 2000, converted to a point-in-time estimate, and adjusted for the increase in managed care enrollment. This enrollment increase was estimated by moving beneficiaries from retiree health coverage, Medigap and the uninsured to managed care in proportion to their enrollment in those plans.

Endnotes.

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