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OF THE UNITED STATES

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NEWS RELEASE
For Immediate Release

STATEMENT OF THE CATHOLIC HEALTH ASSOCIATION ON PRESIDENT CLINTON'S MEDICARE PROPOSAL

WASHINGTON (June 29) -- The Catholic Health Association of the United States (CHA) applauds President Clinton for his leadership in addressing the critical, but extremely complex, issue of reforming the Medicare program.

During the last 34 years Medicare has been highly successful in achieving affordable health coverage for hundreds of millions of elderly and disabled Americans. It is a government success story! Yet real reform of Medicare is needed to ensure financial stability and solvency and to modernize the program for the new millennium. In addition to necessary structural reforms in benefits and delivery of care, new federal revenues are essential.

"We strongly support efforts by the President to dedicate a portion of the federal budget surplus to Medicare," said Rev. Michael D. Place, STD, CHA's president and chief executive officer. CHA also supports expansion of the Medicare benefit package to reflect the current practice of medicine, which includes a greater reliance on prevention, prescription medications, and chronic care than was the case when the program was created in the 1960s. On a cautionary note, Fr. Place stressed that any new benefit must be balanced with the financial ability of Medicare to sustain the cost of both current and new benefits over time.

"The President's prescription drug benefit proposal is a significant contribution to the Medicare reform debate and would, indeed, respond to very legitimate needs of millions of America's seniors," added Fr. Place. "In particular, we support the President's efforts to make the new drug benefit affordable and available to all beneficiaries – especially to low-income seniors."

As for the President's proposal to reduce substantially Medicare payments to healthcare providers, Fr. Place explained that "CHA is not supportive of further reductions to providers and is, in fact, greatly disappointed in this aspect of the proposal."

Calling the proposal to cut payments to providers "ill-timed and ill-conceived," Fr. Place questioned "the wisdom of adding even more financial burden to the mission of the nation's healthcare providers." Healthcare facilities across the country, he pointed out, are currently experiencing the severe impact of provisions enacted as part of the Balanced Budget Act of 1997 (BBA). "The fact that the President has proposed a modest amount of additional funding to lessen the BBA impact is welcomed, but does not ameliorate the severity of the BBA reductions."

(MORE)

To provide *real* relief on the BBA, the President and Congress should immediately:

- Eliminate the additional 5.7 percent "across-the-board" reduction in payments to outpatient departments proposed by the Health Care Financing Administration (HCFA);
- Preserve Medicare Disproportionate Share Hospital (DSH) payments for safety-net hospitals; and
- Adjust the new prospective payment system (PPS) for skilled nursing facilities to reflect the costs of care for medically complex patients.

CHA looks forward to learning more details with regard to the President's proposal and pledges to work with him and Congress to enact true Medicare reform.

"Preserving Medicare is a test of our nation's commitment to the elderly and disabled," Fr. Place emphasized. "The President's proposal responds to that challenge." CHA calls on the President and Congress to act with the same urgency to achieve accessible and affordable healthcare for the nearly 44 million people uninsured.

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STATEMENT ON PRESIDENT CLINTON'S MEDICARE REFORM PLAN

Dick Davidson
President
American Hospital Association

June 29, 1999

For millions of Americans, Medicare is Social Security against illness and injury. That's why the President is right to dedicate a sizeable portion of the federal budget surplus to shore up the Medicare program. Unfortunately, President Clinton's prescription for Medicare reform potentially exacerbates a major ailment, the devastation inflicted by the Balanced Budget Act on those who care for our elderly, by proposing further cuts.

As caregivers, we recognize that prescription drugs are an important part of treating illness and enhancing wellness, and that many Medicare beneficiaries require assistance in purchasing these medicines. We believe the best course is to help those elderly most in need to purchase necessary medicines. But, before we expand benefits—and make new promises—to Medicare beneficiaries, it is essential that we keep our current promises by preserving access to existing benefits and the ability to deliver on our commitments.

The $71 billion in Medicare cuts to hospitals Congress enacted in 1997 have shaken the foundation upon which the Medicare program is built. These cuts are causing hospitals to reduce services to our elderly in communities across America. And the full impact of these cuts has yet

(more)

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AHA 100 YEARS

to be realized. That's why we are particularly concerned that the President's plan contains further Medicare reductions to hospitals and other caregivers -- chipping away at our ability to provide quality services that our elderly depend on. We are deeply disappointed that the President continues the pattern of cutting payment to hospitals for services when independent analyses have documented that Medicare is paying caregivers substantially less than the costs of providing services.

Instead of further reductions, we need to fix the unintended consequences of the Balanced Budget Act. We commend the President for taking administrative action today to address two major regulatory problems in Medicare. The President's willingness to allocate $7.5 billion to address the Balanced Budget Act is a start, but we ask that the President work further with Congress to provide additional legislative relief.

We also are concerned about the plan's call for "competitive bidding," which would give federal bureaucrats enormous decision-making authority to restrict the elderly's choice of providers. Giving government the ability to use the enormous economic power that Medicare has could disrupt health care in communities across the country, making the current market power of HMOs pale in comparison.

We call on the President to rethink the decision to cut Medicare payments and look forward to working with both the Administration and Congress to enact balanced Medicare legislation.

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MHA

Massachusetts Hospital
Association

Statement of Ronald Hollander, President, Massachusetts Hospital Association on proposed tax cuts July 29, 1999

At a time when hospitals in every community in the Commonwealth are feeling the devastating effects of huge cuts in Medicare, we urge Congress not to consider a major tax cut until they have repaired the damage to the health care system caused by the Balanced Budget Act of 1997. Instead, let us first use a portion of the growing federal surplus to reverse the unintended damage caused by the BBA. It would be a shame if we let this singular moment in our recent history pass us by without stabilizing the Medicare program for today's seniors and securing it for the future generations.

Decision-makers inside the Beltway must understand that they have gone too far in budget-driven health policy and are hurting health care programs and services. Hospitals are struggling to maintain access to quality care, and the worst of the cuts is yet to come.

We applaud the efforts of the entire Massachusetts Congressional delegation that has worked tirelessly to protect the health care system that is especially critical to the quality of life and economy of Massachusetts. For the most recent example, Senator John Kerry today offered an amendment to provide BBA relief that could mean millions of dollars for the services and programs of Massachusetts hospitals. We commend Senators Kerry and Kennedy and the entire House delegation for their steadfast support on this issue.

The BBA included the largest cuts in the history of the Medicare program. Under the BBA, Medicare payments to Massachusetts hospitals will be cut by $1.7 - $2.2 billion over five years. MHA's analysis shows that the typical community hospital will lose $1.3 million per year between 1998 and 2002, the life of the BBA; the typical teaching hospital will lose about $12 million per year. On average, one-third of total hospital revenue comes from the Medicare program.

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NEWS

Clinton Medicare Proposal

Statement From
Jordan J. Cohen, M.D.
President, Association of American Medical Colleges
June 30, 1999

As our nation's elderly population swells dramatically over the next three decades, the need for Medicare to be responsive to the increasing demands for the program's services is of paramount importance. President Clinton's Medicare proposal aims to create just such a program. However, while the Medicare proposal's long-term objectives are laudable, they fall short in their ability to repair the damage already inflicted by the Balanced Budget Act of 1997 (BBA). The Administration's proposal fails to recognize that Medicare beneficiaries need more than just prescription drug benefits, they also need a financially stable system of health care providers, including teaching hospitals, that offer a breadth of quality services.

Teaching hospitals, and many other providers, are hurting now. The BBA cut far more deeply than was originally anticipated. A competitive and efficient Medicare program that provides quality care and supports the training of the best doctors will never be achieved if teaching hospitals—the backbone of our health care system—do not remain strong. Teaching hospitals train most of the country's new physicians and provide over 40% of hospital uncompensated care. If the cuts called for in the BBA continue, some 40% of all major teaching hospitals, nearly 100 institutions, may actually be losing money by 2002. Where will the elderly turn for the latest and most sophisticated services if they are no longer provided at their nearby teaching hospital?

The financial troubles now facing many teaching hospitals, in part, are the unintended consequences of the BBA, which the new Medicare proposal needs to more aggressively address. While President Clinton's proposed provider set-aside of only $7.5 billion over 10 years is insufficient to ease even the most troublesome BBA provisions, we do appreciate the Administration's plans to pay hospitals directly for the uncompensated care they provide rather than to managed care organizations.

The Association of American Medical Colleges (AAMC) is also concerned that the Medicare proposal would extend some of the BBA provisions beyond 2002, the final year of implementation. The potential for additional Medicare cuts to teaching hospitals could be disastrous.

The AAMC applauds the Clinton Administration's continuing efforts to improve the Medicare program. The Administration's plan to provide long-term financing for Medicare advances this critically important debate. Likewise, the proposal to provide prescription drugs ensures this issue will be central to the ongoing Medicare deliberations. But providers cannot carry the cost burden of these new benefits at a time when they are struggling to maintain their existing services.

The AAMC plans to work closely with the Congress and Administration to create a Medicare program that improves the health of its beneficiaries but does so without jeopardizing the viability of health care providers.

For more information, contact John Parker at 202-828-0975.

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The Association of American Medical Colleges represents the 125 accredited U.S. medical schools; the 16 accredited Canadian medical schools; some 400 major teaching hospitals, including 74 Veterans Administration medical centers; 87 academic and professional societies representing nearly 88,000 faculty members; and the nation's 67,000 medical students and 102,000 residents.

Additional information about the AAMC and U.S. medical schools and teaching hospitals is available at www.aamc.org/newsroom.

NATIONAL
ASSOCIATION
OF PUBLIC
HOSPITALS &
HEALTH
SYSTEMS

June 30, 1999

The President
The White House
Washington, DC 20500

Dear Mr. President:

The National Association of Public Hospitals & Health Systems (NAPH) applauds your leadership in working to preserve and strengthen the Medicare program for future generations. We agree that Medicare must undergo fundamental reforms if it is to remain viable for the future; however, we believe that such reforms must be implemented in ways that continue to ensure access and quality of care for all our nation's elderly and disabled persons. We strongly support your proposal to dedicate part of the budget surplus to Medicare's trust fund to extend its life. We agree that shoring up the Medicare trust fund is a top priority in this time of budgetary surpluses.

NAPH represents over 100 metropolitan area safety net institutions which collectively comprise the essential infrastructure of many of America's urban health systems. These hospitals and systems are uniquely reliant on governmental sources of financing to support care to Medicare, Medicaid, and uninsured, low-income patients. Because of their role as the health care safety net in their communities, NAPH members also consider themselves to be strong advocates for the patients and communities that they serve. For both of these reasons, we are keenly interested in the future of the Medicare program and appreciate your efforts to ensure its continued viability.

We believe that your proposals to modernize Medicare's benefits package by providing a prescription drug benefit and eliminating cost sharing for preventive services are important steps in the right direction for the health of beneficiaries. Furthermore, as providers of care to large numbers of uninsured, we are pleased to see that your proposal includes your Medicare buy-in plan for certain individuals between the ages of 55 and 65. It is especially difficult for persons in this age group to obtain insurance and we appreciate your efforts to ensure that they do not join the growing ranks of the uninsured.

NAPH thanks you for recognizing the unique position of those hospitals that provide a disproportionate share of services to the poor and uninsured ("DSH hospitals") by providing some relief from the cuts of the Balanced Budget Act of 1997 (BBA) and requiring that payments intended for such hospitals be carved out of the payments made to managed care organizations. We are very concerned, however, that the overall impact of the Balanced Budget Act on the Medicare and

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Medicaid programs will seriously jeopardize the ability of our hospitals to continue to provide quality care to low income and uninsured individuals, particularly in 2001 and 2002 when the full effect of the BBA is realized. We fear that your relief package is not sufficient to address this problem and that extending BBA cuts is ill advised. Medicare does not become a more modern program if access to hospitals and other providers is lost in the process of adding other benefits.

We are anxious to learn more details about your proposal to make Medicare more competitive and efficient through the use of "private sector purchasing and quality improvement tools." While we agree that many improvements can be made in the traditional Medicare program, we caution you to proceed carefully to ensure that such tools do not harm providers who care for low income and uninsured populations. NAPH stands ready to assist you in working out these details so as to continue to ensure that Medicare remains accessible to all beneficiaries and that the fragile health care safety net remains intact.

Once again, we thank you for your work on these difficult issues. Your proposal is an important step toward ensuring that a meaningful Medicare program continues to be available into the future and NAPH looks forward to working with you as you continue to refine it.

Sincerely,

Larry S. Gage
President

PAYGO Sequester Calculation
(Dollar amounts in billions)

	2000	2001	2002	2003	2004
PAYGO Net Deficit Increase	2.4	0.2	34.5	51.9	61.7
Excess above total PAYGO sequester baseline	0.0	0.0	6.3	23.4	32.2
Sequester amount (constrained to baseline)	**2.4**	**0.2**	**28.2**	**28.5**	**29.5**
Programmatic Sequester Amounts:					
Special rules:					
ASI	0.0	0.0	0.0	0.0	0.0
GSL and Foster Care	0.2	0.2	0.2	0.2	0.2
Medicare	2.0	0.0	9.2	10.0	10.6
All other (across-the-board sequester):					
CCC	0.1	0.0	5.0	4.3	4.3
Child Support Enforcement	0.0	0.0	3.1	3.4	3.6
Social Services Block Grants	0.0	0.0	1.4	1.4	1.4
Immigration Support	0.0	0.0	1.3	1.3	1.3
Crop Insurance	0.0	0.0	1.6	1.7	1.8
Mineral leasing Act payments	0.0	0.0	0.6	0.6	0.7
Veterans Educ & Readj. Benefits	0.0	0.0	1.0	1.0	1.1
All other	0.1	0.0	4.4	4.4	4.4
Total, across-the-board seq. amounts	0.2	0.0	18.7	18.3	18.7
Sequester total	2.4	0.2	28.2	28.5	29.5

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POTUS remarks 6/29

when most of the cost containment measures put in place in 1997 are set to expire. And to make sure that health care quality does not suffer, my plan includes, among other things, a quality assurance fund, to be used if cost containment measures threaten to erode quality. And given the debates we're having now on the consequences of the decisions we made in 1997, I think that is a very important thing to put in this plan. (Applause.)

These steps will secure Medicare for a generation. But we should also modernize benefits as well. Over the years, as I said earlier, Medicare has advanced -- medical care has advanced in ways that Medicare has not. We have a duty to see that Medicare offers seniors the best, and the wisest, health care available.

One such rapidly advancing area of treatment is preventive screening for cancer, diabetes, osteoporosis, and other conditions -- screenings which, if done in time, can save lives, improve the quality of life, and cut health care costs. Therefore, my plan will eliminate the deductible in all co-payments for all preventive care under Medicare. (Applause.)

It makes no sense for Medicare to put up roadblocks to these screenings and then turn around and pick up the hospital bills that screenings might have avoided. No senior should ever have to hesitate -- as many do today -- to get the preventive care they need.

To help cover the cost of these and other crucial benefits and strengthen the Medicare Part B program, we will ask beneficiaries to pay a small part of the cost of other lab tests that are prone to overuse, and we will index the Part B deductible to inflation.

Nobody would devise a Medicare program today, if we were starting all over, without including a prescription drug benefit. (Applause.) There's a good reason for this: We all know that these prescription drugs both save lives and improve the quality of life. Yet, Medicare currently lacks a drug benefit. That is a major problem for millions and millions of seniors -- and not just those with low incomes. Of the 15 million Medicare beneficiaries who lack prescription drug benefits today, nearly half are middle class Americans. And with prescription drug prices rising, fewer and fewer retirees are getting drug coverage through their former employer's health programs.

My plan will offer an affordable prescription drug benefit to all Medicare recipients, with additional help to those with lower incomes, paid for largely through the cost savings I have outlined. It will cover half of all prescription drug costs, up to $5,000 a year, when fully phased in, with no deductible -- all for a modest premium that will be less than half the price of the average private Medigap policy.

It's simple: If you choose to pay a modest premium, Medicare will pay half of your drug prescription costs, up to $5,000. (Applause.) This is a drug benefit our seniors can afford at a price America can afford.

Seniors and the disabled will save even more on their prescription drugs under my plan because Medicare's private contractors will get volume discounts that they could never get on their own. By relying on private sector managers, I believe that my plan will help Medicare beneficiaries and ensure that America continues to have the most innovative research and development oriented pharmaceutical industry in the world. (Applause.)

With the steps I have outlined today, we can make a real difference in our people's lives. And I believe the good fortune we now enjoy obliges us to do so. In a nation bursting with prosperity, no senior should have to choose between buying food and buying medicine. But we know that happens. (Applause.) I'll never forget the first time I ever met two seniors on Medicare who looked at me and told me that they were choosing, every day, between food and medicine. That was almost seven years ago, but it still happens today.

At a time of soaring surpluses, no senior should wind up in the hospital for skimping on

POTUS press conference on 7/21

inclined to believe because of the circumstances here and because who's involved that we ought to go on a little more. And I said that I would support it and defend it. And I think it was the right decision.

Q Mr. President, if you'll allow me to ask about two different topics. On the Kennedy search, sir, there have been conflicting reports about whether or not Mr. Kennedy's body has, in fact, been recovered. I understand that based upon the answer you just gave, that might not be a question that you'd want to address, but, perhaps, given the fact that there is this conflicting information you could answer that question.

And, secondly, sir, on this notion of a drug benefit, prescription drug benefit, you chided the Republicans about targeting tax cuts at the wealthy, saying that they're too steered in that direction. How do you reconcile that philosophically with allowing rich Americans, rich older Americans, to get a prescription drug benefit which even you just said this new study will show one in four don't need?

THE PRESIDENT: Well, first of all, it's voluntary. And most wealthy Americans are well taken care of under the present program they have and won't exercise it. So that's the first point I want to make.

The second thing I would like to say is I don't think most people know this, even some of you may have forgotten, but in the 11th hour of the deficit reduction package negotiations in 1993, in order to get up to $500 billion in cuts in the deficit projected over five years -- we did much better, as all of you know -- the cap was taken off. The income cap was taken off of the Medicare tax, which means virtually every single upper-income person in America will pay far more into the Medicare program than they will ever draw out in health care or benefits.

They are making a net significant contribution today because, unlike Social Security taxes where there is still an earnings cap, there is no longer an earnings cap on Medicare. And I think a lot of folks have forgotten that -- so that in that sense, this is the most progressive program we have. The upper-income people, particularly once you get over about $250,000 in income, they're paying far more into this program over the course of their life than they could ever draw out if they were sick every day from the time they're 65 on.

Q Sir, a question --

THE PRESIDENT: I just don't think I should make an announcement about that. I am aware of what the Coast Guard has done and what they have found as of five minutes before I came out here. But I simply -- I just don't think it's appropriate for me -- I'll be glad to comment on whatever they want to say, but I think I should leave it for them to talk.

Q Sir, you talk about how expensive the Republican tax cuts would be. But the Congressional Budget Office has now just come out with a report saying that even with their tax cuts, almost $800 billion in tax cuts, they would save about $277 billion over a 10-year period, whereby your program would save only about $50 billion. That's about $227 billion difference. How do you reconcile that? And, you know, people on the Hill listen to the CBO.

THE PRESIDENT: They listen to the CBO except where it's inconvenient for them, like the patients' bill of rights. The Republicans have freed us all now to question the CBO, since they ignored the CBO in the patients' bill of rights; they have discredited their own CBO.

Let me say, I haven't seen that CBO accounting. All I can tell you is that all of our budget people were rolling their eyes and saying that it was a very creative study.

Let me just say this: You have six and a half years of experience with the numbers we have

given you and the estimates we have made. And every single year, our numbers have not only been accurate, but we have done better than we said we would do -- every single year, for six and a half years now.

Our studies show that their tax cut over the next two decades will cost, first, a trillion dollars and then $3 trillion in the second decade, and that -- then an enormous loss to the American people in interest savings. That is, we'll have to keep spending more and more of our tax money paying interest on the debt, and it will require huge cuts in education and defense and other things.

You cannot -- they simply cannot credibly make that statement. And they don't put any new money into the Medicare program. And they don't have a Medicare reform package out there. So unless they just simply propose to bankrupt all the teaching hospitals and a lot of the other hospitals in the country, and let the Medicare program wither away, as one of the previous leaders so eloquently put it -- they can't possibly finance this tax program without doing serious damage. I can't comment on the CBO study, but it doesn't make any sense to anybody I've talked to about it.

Q May I just follow up --

THE PRESIDENT: Yes.

Q The CBO estimates the cost of your Medicare reforms are more than twice what you say they are.

THE PRESIDENT: Well, again you have evidence. Let me just say this: In the 1997 Balanced Budget Agreement -- okay? -- and this is the reason all these teaching hospitals are in trouble today -- we agreed to a Medicare savings figure. And we said, okay, here is our health information -- this is what we do in the Executive Branch, we deal with these hospitals -- here are the changes you need to make in the Medicare program to achieve the savings that the Republicans and the Democrats in Congress and the White House agreed on.

And the CBO said, no, no, no, no, that won't come close; you need these changes plus these changes. And we said, okay, we're following the CBO, we put it in there. What happened? And that's one of the reasons the surplus is somewhat bigger than it otherwise would be -- the cuts in Medicare were far more severe, our numbers were right, their numbers were wrong and that's why you've got all these hospitals all over America, every place I go, talking about how they're threatened with bankruptcy.

So when it comes to estimating Medicare costs, again, we have evidence. And whenever there's been a difference between us and the CBO, we've been right and they've been wrong. That's all I can tell you. No serious person -- so what are they going to do about Medicare? They say our drug program will cost more -- they don't put a red cent into it. What are they going to do about it? Even if you don't have a drug program, if you adopt their tax cut program they won't be able to do anything to extend the solvency of Medicare and they will have to have huge cuts.

For them to produce those savings they are going to -- they can't even fund my defense budget, much less the one they say they want. They're going to have cuts in defense, cuts in education, cuts in the environment. That's all their savings assumed that they're going to stay with the present budget levels, which they, themselves, are trying to get out of even as we speak here today. So this is -- the American people are not -- I mean, this is not rocket science, this is arithmetic.

And we've been dealing with -- we went from creative supply-side mathematics to elemental arithmetic in 1993. And it has served us very well. And all I'm trying to do is

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other things, that we'll have, percentage-wise, relatively fewer people working and more people drawing Social Security and Medicare.

When you look at the Social Security system, it's slated to run out of money in about 34, 35 years. It ought to have a much longer life expectancy than that. Everybody -- it's fine for the next 35 years, but I've offered a plan to increase the life of the Social Security trust fund for at least 54 years and to go further if the Congress will go with me.

I have offered a plan to increase -- when I became President, the Medicare trust fund was slated to go broke this year. And we took some very tough actions in 1993 and again in 1997 to lengthen the life of the trust fund -- actions which, I might add, most hospitals with significant Medicare caseloads, and teaching hospitals which deal with a lot of poor folks, believe went far too far. And we're going to have to give some money back to those hospitals in Michigan and throughout the country. But we now have 15 years on the life of the Medicare trust fund. Under my proposal, we would take it out to 2027, and that will give plenty of time for future Congresses and Presidents to deal with whatever challenges develop in the Medicare program after that.

Now, to do that and to do it without cutting our commitment to education, to biomedical research, to national defense, we have to devote most of the surplus to Social Security and Medicare. We will still have funds for a substantial tax cut, but not as big as the one being offered in Washington today, which spends all the non-Social Security tax surplus funds on a tax cut.

I believe the wise thing to do is to take care of the 21st century challenge of the aging of America, to do it in a way that does not require us to walk away from the education of our children; and under my plan, because we would save most of the surplus, the side benefit we'd get is that in 15 years we could actually take the United States of America out of debt for the first time since 1835. (Applause.)

Now, why is that important -- and it's more important, I would argue, than at any time in my lifetime. I was raised to believe that a certain amount of debt for a country was healthy; that just like businesses are always borrowing money to invest in new business, a certain amount of debt was healthy. The structural deficit has been terrible. The idea that we quadrupled the debt in 12 years was an awful idea, because we were borrowing money just to pay the bills.

But I'd like to ask you all to think about this, because I don't think most Americans have focused on this part of the plan, the idea of being debt-free. We live in a global economy. Money can travel across national borders literally at the speed of light. We just move it around in accounts. Interest rates are set, therefore, in a global context. If we become debt-free and we, therefore, don't borrow any money in America just from the government, that means everybody else's interest rates will be lower. That means for businesses, lower business borrowing rates; it means more businesses, more jobs, easier to raise wages. For families it means lower home mortgage rates, lower credit card payment rates, lower car payment rates, lower college loan rates.

It means that we will secure the economic strength of America in ways that are unimaginable to us now. It means that if other parts of the world get in trouble, the way Asia did a couple of years ago, we'll be less vulnerable. And the people that are in trouble and need to borrow money will be able to get it at lower interest rates and they'll get up and go on again and be able to do business the us again.

This is a very good thing to do. But it can only be done if we set aside the vast majority of the surplus to fix Social Security and Medicare. You can still have a tax cut, focused on helping families save for their retirement or any number of the other things that have been discussed within the range we can afford, focused on helping people pay for long-term care, focused on helping working families pay for child care. And, I would hope, focused on

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to get us out of debt for the first time since 1835 -- to give the young people in this room a chance at a generation of prosperity. And I don't believe any thinking person, once they understand what the real numbers are -- let's get out of the rhetoric here, who's going to give it to whose friends and all that. What are the numbers? This is an arithmetic problem. You know, I told people when I got elected President -- I'd come from a state with fairly straightforward values and ways of doing things, and I thought we ought to have a radical new idea in Washington -- we'd bring basic arithmetic back to the budget. (Laughter.) And basic arithmetic has worked pretty well. This doesn't add up.

And so I ask you to help me send the word to the Congress that let's do first things first. Let's fix Medicare. The women of America especially need it. (Applause.)

You know, we have to work together. Every time we get in one of these fights people throw their hands up. But there's normally a process that goes on here. When we were doing welfare reform I vetoed two bills because it took away the mandate of health care and nutrition for children. We finally got a welfare reform that I thought was right, it carried by big majorities in both parties, in both Houses -- we have the lowest welfare rolls in 30 years. And we did it in an election year.

Then the next year we did the Balanced Budget Act and it has worked superbly. The only problem with it is that the Medicare cuts were too burdensome on certain groups, and we're trying to fix that. But I can tell you that if this tax cut passes there will be breathtaking cuts in every area of our national life that you would believe is important, over and above what it would do to totally rob us of any chance to stabilize and improve Medicare and save it for the baby boom generation.

We have big tests as a country: How are we going to deal with the aging of America? How are we going to give all of our kids a world-class education, especially since more and more of them come from families whose first language is not English? Those of us who expect to be alive in 20 years, or hope to be, better hope we do a good job of educating those kids.

How are we going to deal with all these other challenges? How are we going to bring economic opportunity to people who still haven't felt it? How are we going to stabilize the economy so that we'll still be growing even better 10, 15, 20 years from now? These are big challenges. But they are high-class problems in the sense that nations rarely get these opportunities. Once in a lifetime you get a chance to stand up with your country in good shape, bring people together, look down the road and say, yes, these are big challenges and we're going to check them off -- one, two, three, four -- because we have the money and the vision to deal with them.

So my appeal today is that we not get into a big fight, we just go back to basic arithmetic. These tax bills the majority is pushing could not get the support of their own members if we had a chart up on the wall that says, here is what we have to spend just to stay where we are today in education, defense, the environment, medical research; here's what every expert says it takes to stabilize Medicare; here is the interest savings you ought to be putting into the Social Security trust fund; here is what we have to do to fix health care. They agree we have to do some more for veterans care. They agree with these things -- the numbers don't add up. We cannot take the vacation without paying the home mortgage, the car payment, and the college loan bill. We can't do it. We can't eat the cake until the vegetables and the soup are out of the way. And we cannot defy the basic laws of arithmetic.

And contrary to some of the debate, we cannot forget the stories. This is about how millions upon millions upon millions of Americans will live. Will they live in dignity and health, or will they live in want and insecurity, imposing unconscionable burdens on their children, and limiting their children's ability to raise their grandchildren?

Or will we use this moment to build a more prosperous, more just, more decent society?

HRC remarks 7/27

For all these reasons, supported by new data that the President will talk about in a few minutes, women rely more on Medicare than men and are, therefore, more vulnerable to changes in Medicare policies.

Over the past six and a half years, and as recently as a few weeks ago, I've spoken with women around the country about their concerns about the future: Women living alone who worry about who's going to care for them when they can no longer live independently; women with limited incomes who are struggling to pay for their prescription drugs, who don't think they can afford to get regular check-ups or get screening tests for osteoporosis, or breast cancer; women who, in their 60s and their 70s, are taking care of their aging or disabled parents, and who rely on Medicare to help them meet their family responsibilities.

I'm sure each of us here today has a story to tell. And we have with us just one example of a devoted daughter: Mary Lee DiSpirito, whose mother came to live with her in Virginia after her father died. As her mother became increasingly frail, Mary Lee had to stop working to care for her mother full-time. Like so many elderly women today, Mary Lee's mother suffered from multiple health problems. And while she had Medicare, and even a Medigap policy, it did not cover prescription drugs.

Because her mother's sole source of income was a monthly $800 Social Security check, Mary Lee and her family paid $4,500 a year in out-of-pocket expenses for prescription drugs -- an amount that would have -- if her mother had been alone, without a devoted daughter and family -- would have depleted half of her mother's yearly income. Mary Lee's mother passed away last November. But her valiant efforts to care for her mother, often under very difficult circumstances, are a vivid reminder of why we must act now to protect and preserve Medicare. I'd like to ask Mary Lee to stand up, because she is emblematic, and symbolic, of women throughout our country. (Applause.)

We owe Mary Lee and all of us the commitment that goes not only to our parents and our grandparents, but to those of us in this generation who are the caretakers who will soon begin to age, may become disabled or chronically ill ourselves. And we owe it to our children and eventually our children's children -- because if we don't invest in our nation's priorities and dedicate the necessary funds to save and modernize Medicare, countless women, like Mary Lee and all of us, and her mother and ours, will be at even greater risk than they are today.

If we don't save and modernize Medicare, then women will continue to struggle to pay for out-patient prescription drugs, and the problem will only get worse as medical advances increasingly rely on drug treatments that even today are beyond the means of most ordinary citizens. If we don't save and modernize Medicare, then women will continue to skip regular screenings and check-ups that would enhance the quality of their lives and reduce Medicare's long-term costs.

And perhaps most importantly, if we don't take advantage of this time of prosperity that we have worked so hard to achieve, then we will look back at our generation as having missed a unique opportunity to make responsible decisions and we will instead have run the risk of becoming a great burden to our own children that none of us ever wanted to be.

That's why I believe that to meet these critical challenges we must take a responsible and balanced approach to tax cuts. Only then will we be able to meet our obligations to America's elderly and disabled, and extend the life of the trust fund for the next quarter century. Only then will we be able to modernize the benefit package to include prescription drugs and preventive care, and support the teaching hospitals that are so critical to serving America's poor and elderly. And only then will we be able to sustain and expand the investments we are making now in our schools, in our environment, in our cities and our country that are so critical to our future prosperity.

MHA

Massachusetts Hospital Association

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TO: Chris Jennings

ORGANIZATION:

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FROM: Chris Coats

TOTAL PAGES SENT (including cover sheet): 2

ADDITIONAL COMMENTS:

Tax cut statement that went out yesterday...

MHA

Massachusetts Hospital
Association

Statement of Ronald Hollander, President, Massachusetts Hospital Association on House and Senate votes on tax cuts

August 5, 1999

The action of the House and Senate today in voting for a massive $792 billion tax cut continues to ignore the urgent and real need to repair the damage to the health care system caused by the Balanced Budget Act of 1997. Until we do that, talking about this kind of massive tax cut is irresponsible.

The BBA included the largest cuts to health care providers in the history of the Medicare program. Hospitals in every community in Massachusetts are struggling to maintain access to quality care and services, and the worst of the cuts is yet to come. At the same time, we have a growing federal surplus. It would be a shame if we let this singular moment in our recent history pass us by without stabilizing the Medicare program for today's seniors and securing it for future generations. It is the right thing to do, and this is the right time to do it.

Contact: Judy Glasser (781) 272-8000 x161

PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

FOR THE 21st CENTURY

National Economic Council / Domestic Policy Council

The White House

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

TAB 1.

OVERVIEW: BUDGET PRIORITIES

BUDGET PRIORITIES:

Protect And Build On Our Prosperity? Or Threaten The Health Of Our Economy?

- We have the best economy in the world today. But remember, just six and a half years ago, the budget deficit was $290 billion and rising. Wages were stagnant, economic inequality was growing, social conditions were worsening.

  In the 12 years before President Clinton took office, unemployment averaged more than 7 percent. It's almost difficult to remember what it was like. No one really thought we could turn it around, let alone bring unemployment to a 29-year low, or turn decades of deficits, during which time the debt of our country was quadrupled in only 12 years, into a surplus of $99 billion. The keys to our prosperity have been fiscal responsibility and key investments in the American people.

- President Clinton has a responsible budget plan that *builds* on our prosperity, by putting *first things first*. The President's plan uses the surplus to strengthen Social Security and Medicare, including modernizing Medicare with a long-overdue prescription drug benefit. It provides targeted tax cutsfor childcare, long-term care and the President's USA Accounts proposal which helps middle-income Americans save for retirement. It provides for military readiness and strengthens our investment in domestic priorities like education, lawenforcement and the environment

  And, the President's plan continues down the path of fiscal responsibility – and would eliminate the national debt by 2015.

- Republicans would spend nearly the entire surplus on a risky tax cut scheme that would *threaten* the continued health of our economy. Their plan does nothing to strengthen Social Security. Nothing to strengthen and modernize Medicare. Nothing about providing prescription drug coverage for Medicare beneficiaries.

  Fifty economists, including six Nobel laureates, signed a statement on July 21st which said: *"[C]ommitting to a large tax cut would create significant risks to the budget and the economy."* And on July 22nd, Federal Reserve Chairman Alan Greenspan said: *"I would prefer to hold off on significant further tax cuts."*

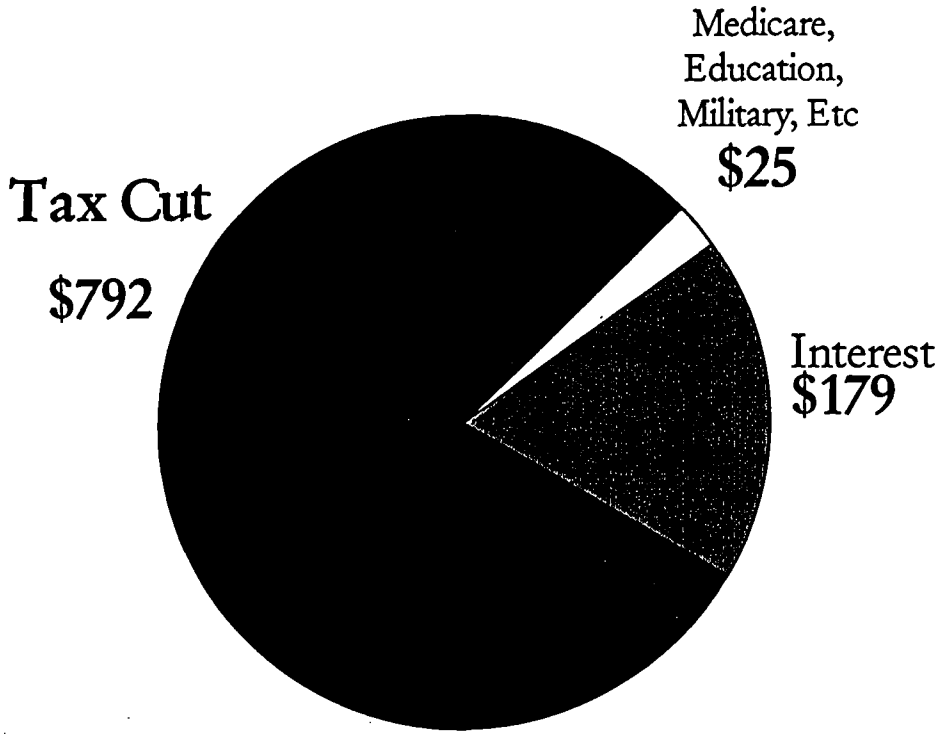
- Republican plans would lead to deep, across the boardcuts in domestic priorities. In order to pay for their risky tax cut and fund our military at the same level as the President, Republicans would have to cut *more than $700 billion* from domestic spending. In 2009, that would mean roughly a 50% cut in domestic programs across the board.

TAB 2.

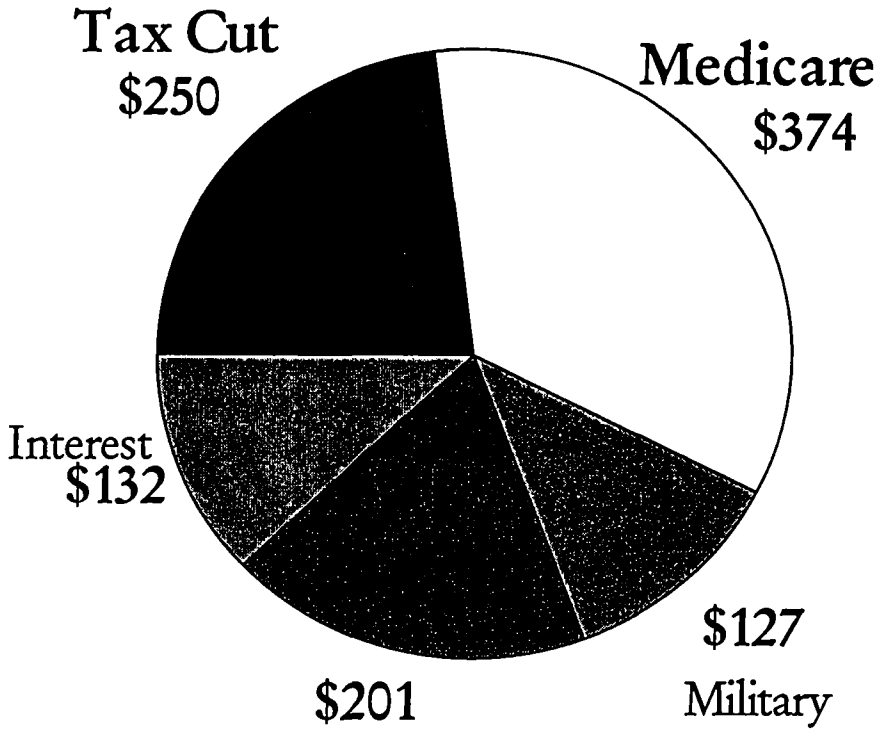
COMPARISON OF PRESIDENT'S AND REPUBLICANS' PRIORITIES

Plans For The On-Budget Surplus
(Dollars in Billions)

Republican Plan



President's Plan



FY 2000-2009; Republicans Use CBO, President Uses OMB Estimates

Impact of Republican Tax Plan

- Fails to extend Social Security Solvency
- Fails to dedicate surplus to Medicare to extend solvency for even one day
- Fails to fund adequately military readiness, education, environment, health, & other priorities

- **More than $700 billion cut** in domestic spending -- 50% in 2009. This means:
- Cutting services to 425,000 of 835,000 children in Head Start
- Reducing spending on bio-medical research by $9.8 billion
- Lowering NASA's budget to its 1984 level

Programmatic Impacts in FY 2009 of Republican Tax Cut
Assuming Defense is Equal to the President's Request

Education and Training

- A cut of this magnitude would force **Head Start** to cut services to **425,000** of the 835,000 children who would otherwise be served in FY 2009.

- About **306,000** summer **jobs and training opportunities** for low-income youth could be eliminated from the 577,700 that would otherwise be provided in FY 2009.

- **Title I, Education for the Disadvantaged** could be slashed, cutting more than **7.4** million children (from the total 14.6 million assumed in the baseline) in high poverty communities from key educational services necessary to improve their future prospects.

- The **Reading Excellence** program, which would otherwise help 1.2 million children learn to read by the 3rd grade, could serve **622,000** fewer students.

Environment and Health

- In FY 1999, the **VA Medical Care** budget projects providing treatment for 3,468,000 veteran patients, a figure that would drop by **1,622,00** should a cut of this magnitude take place.

- Funding for the **Health Resources and Services Administration** would be cut by **$2.5** billion from the current services baseline, resulting in the loss of health services for roughly **15** million women, children, uninsured people, and people living with AIDS from the total 30 million recipients assumed in the baseline.

- Funding for the **National Institutes of Health** would be cut by **$9.8** billion from the current services baseline, resulting in approximately **15,000** fewer biomedical research grants being funded from the total 31,000 assumed in the baseline. At this level, NIH might not be able to fund any new research grants, and support for research grants begun in previous years would have to be reduced.

- **Stopping Toxic Waste Cleanup** -- EPA's Superfund program would be cut by nearly **$1 billion,** eliminating funding for all new Federally-led cleanups due to begin in 2009. Major reductions would also be needed in emergency response actions, ongoing Superfund cleanups, negotiation and oversight of private party-led cleanups, cost recoveries, EPA's brownfields program, and support for other federal agencies and states. Over a thousand employees could lose their jobs, and Superfund contractors would be out of work.

Crime, Housing, and Other Priorities

- Cuts to the **Immigration and Naturalization Service** could result in a reduction of approximately **6,993** Border Patrol agents (from the total 8,947 assumed in the baseline). Cuts to the **FBI** could result in a reduction of approximately **7,187 FBI agents** (from the total 10,687 assumed in the baseline).

- Cuts of this magnitude to **HUD**'s housing rental subsidy could result in the termination of rent subsidies to approximately **1.5** million HUD subsidized low-income tenants in FY 2009.

- Cuts of this magnitude would reduce **NASA**'s funding to the lowest level since **FY 1984**. With this level of funding, NASA could support either a human spaceflight program or a science program relying on robotic missions, but not both.

- The **National Park Service** operating budget would be cut by **almost a billion dollars** below the FY 2009 baseline. Park rangers and other staff would have to be reduced through hiring freezes and RIFs. Seasonal workers could not be hired, resulting in widespread cutbacks in visitor services, seasonal programs, and hours of operations, as well as closures at many of the 378 park units serving almost 300 million visitors annually.

Source: Office of Management and Budget

TAB 3.

PRESIDENT'S MEDICARE PLAN

STRENGTHENING MEDICARE FOR THE 21st CENTURY

President Clinton has proposed to strengthen Medicare by making it more competitive and efficient; modernizing its benefits; and improving its financing. This plan would both offer a long-overdue prescription drug benefit to Medicare beneficiaries and use a portion of the surplus to secure the life of the Medicare Trust Fund for at least the next 25 years. It would also add structural reforms that constrain cost growth by making Medicare fee-for-service and managed care compete more effectively. Lastly, the plan would smooth out and moderate Balanced Budget Act provider payment changes that are excessive. *The New York Times* editorial board described the proposal as "well-considered" and said it would "constitute the most substantial change to Medicare since its creation in 1965."

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. In recent years, the President and Congress have worked together to extend the life of the Medicare trust fund from 1999 to 2015. Building on this success, this plan:

- Gives Medicare new private purchasing and quality improvement tools to improve care and constrain costs;
- Injects true price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices and saving money over time for both beneficiaries and the program;
- Reduces average annual Medicare spending growth, ensuring that program growth does not significantly increase after most of the Medicare provisions of the Balanced Budget Act expire in 2003; and
- Takes administrative and legislative action, including a $7.5 billion quality assurance fund, to smooth out provisions in the Balanced Budget Act which may be affecting Medicare beneficiaries' access to quality care.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefits package does not include all the services needed to treat health problems facing the elderly and people with disabilities. To address this, the President's plan:

- Establishes a new prescription drug benefit that is affordable and available to all Medicare beneficiaries. All beneficiaries would have the option to purchase this benefit that provides for privately-negotiated price discount and covers 50 percent of the costs from the first prescription for spending up to $5,000 when fully implemented. Premiums for this coverage would begin at $24 in 2002 and phase in to $44 per month in 2008;
- Eliminates copayments and deductibles for all preventive services covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, and mammographies;
- Rationalizes cost-sharing requirements to help pay for the prescription drug and preventive benefits by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation;
- Reforms Medigap policies by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and
- Includes the President's Medicare Buy-In proposal which provides an affordable coverage option for vulnerable Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. Medicare enrollment will double from almost 40 million today to 80 million by 2035, creating a need to strengthen Medicare financing. To address this, the plan dedicates part of the budget surplus to secure the life of the Medicare trust fund for the next quarter century.

- It is impossible to reduce provider payments enough to extend the life of the Medicare trust fund for any significant length of time. 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 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person.
- Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster, helping to eliminate public debt by 2015. This would make America debt-free for the first time in the 160 years

June 30, 1999

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*
ARTHUR OCHS SULZBERGER, *Publisher 1963-1992*

Improving Medicare

President Clinton's Medicare reform plan, if approved by Congress, would constitute the most substantial change to Medicare since its creation in 1965. Although no reform can instantly improve quality and increase cost-efficiency in the enormous program, Mr. Clinton has delivered a well-considered proposal that can shore up Medicare without heedlessly expanding costs or creating chaos for 39 million beneficiaries.

The plan takes a prudent, incremental approach in adding benefits and changing Medicare's structure. The proposal is premised on putting $794 billion into Medicare over the next 15 years from the projected $5.5 trillion Federal surplus. But any plan that does not greatly cut benefits or reduce eligibility through income tests or other means would need to put more money into Medicare in the next two decades as baby boomers reach retirement and technology makes it possible for more people to live longer. The Clinton plan would extend the solvency of the Medicare trust fund to 2027.

The Administration would spend $118 billion over 10 years to provide limited prescription drug coverage. That step is long overdue. A third of Medicare recipients have no drug coverage, even though drugs have become crucial to managing chronic illnesses and can help keep patients out of the hospital. The proposed voluntary program, beginning in 2002, would charge Medicare enrollees $24 a month. The Government would pay half the cost of prescription drugs for those who enroll, with a maximum Government payment of $1,000 a year. The monthly premium would gradually increase to $44 in 2008, with the maximum benefit cap rising to $2,500. Low-income people would receive help paying the monthly premiums and co-payments.

The drug plan, which would increase Medicare costs by about 5 percent in 2009, would not create an open-ended benefit. But it would enable Medicare to get volume discounts from drug companies, as large purchasers typically do, and to pass those discounts on to the elderly. The plan may also help staunch the decline in employer-paid retiree health benefits by covering some of the drug costs.

The Administration's package would also make it more attractive for beneficiaries to join managed care plans, a shift that is essential to future cost containment. Health plans bidding for Medicare patients would have to offer the same benefits as fee-for-service Medicare. If a plan could provide the same coverage for less money, enrollees would benefit directly from those savings, most likely through discounts off the current $45.50 monthly Medicare premium. That incentive could help pull more people into lower-cost plans. The proposal would increase competition and efficiency in the fee-for-service sector by enabling qualified, cost-efficient doctors to attract Medicare patients by offering patients lower cost-sharing than traditional Medicare, where patients usually pay 20 percent of the costs and the Government pays 80 percent.

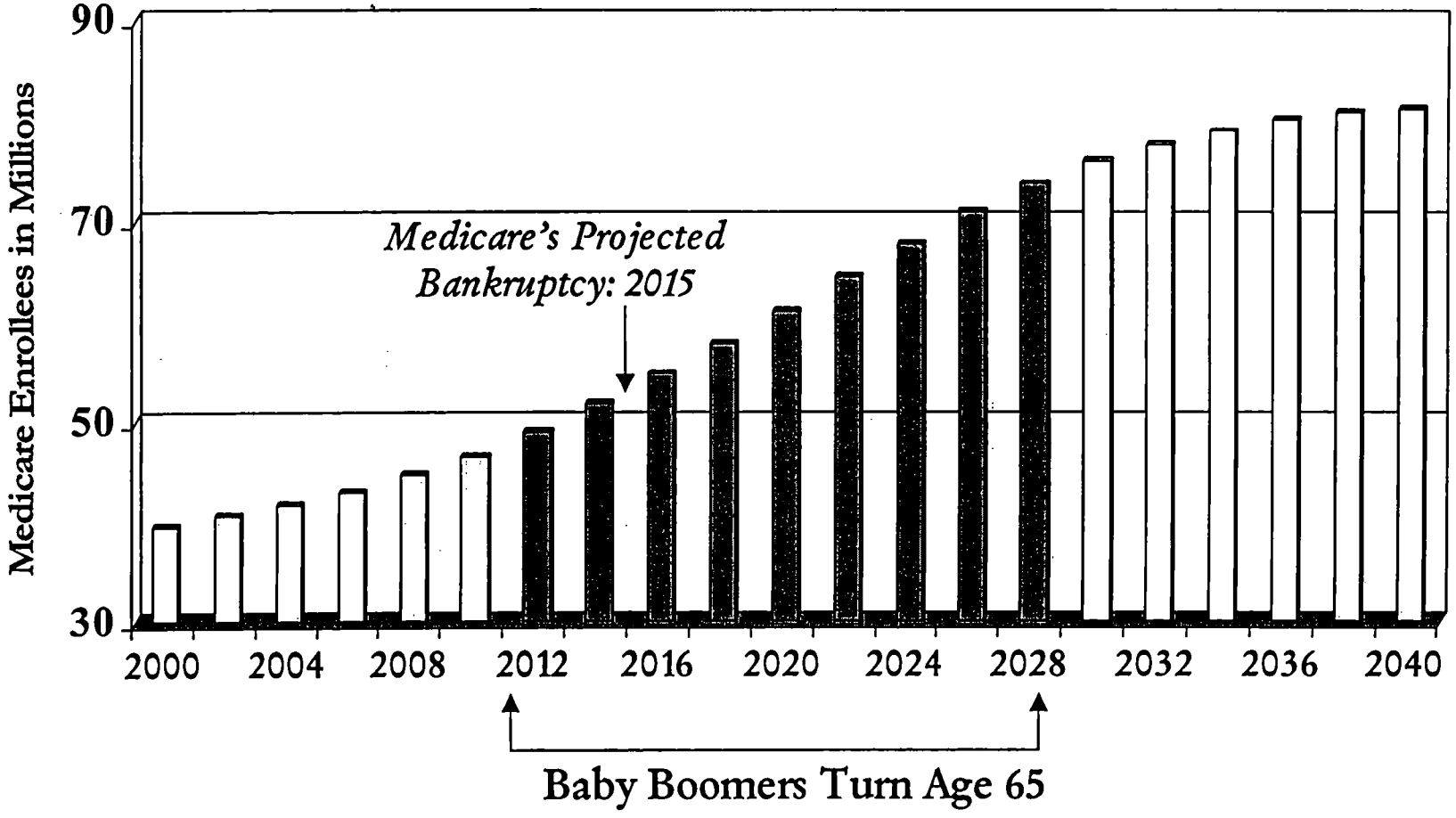
Reforming Medicare requires modernizing the benefits and improving cost controls. The Clinton proposal, made feasible by the surplus, offers some sensible ways to achieve those goals while keeping Medicare a broad-based social insurance program.

PRESIDENT'S PLAN TO MODERNIZE & STRENGTHEN MEDICARE

Plan To Modernize and Strengthen Medicare

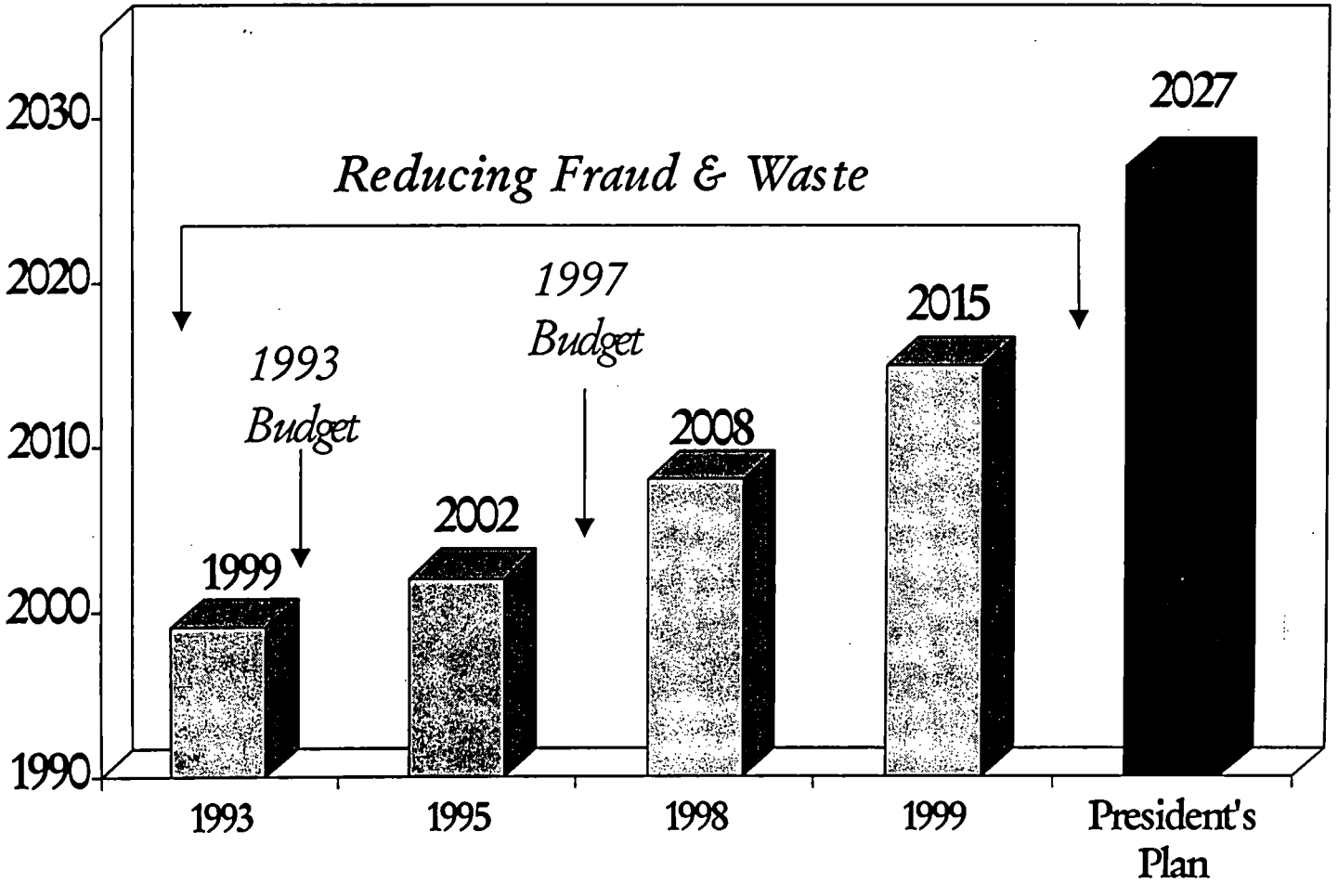
- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Financing for the 21st Century By Dedicating Part of the Surplus to Medicare

Medicare Enrollment Will Double As The Baby Boom Generation Retires



Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



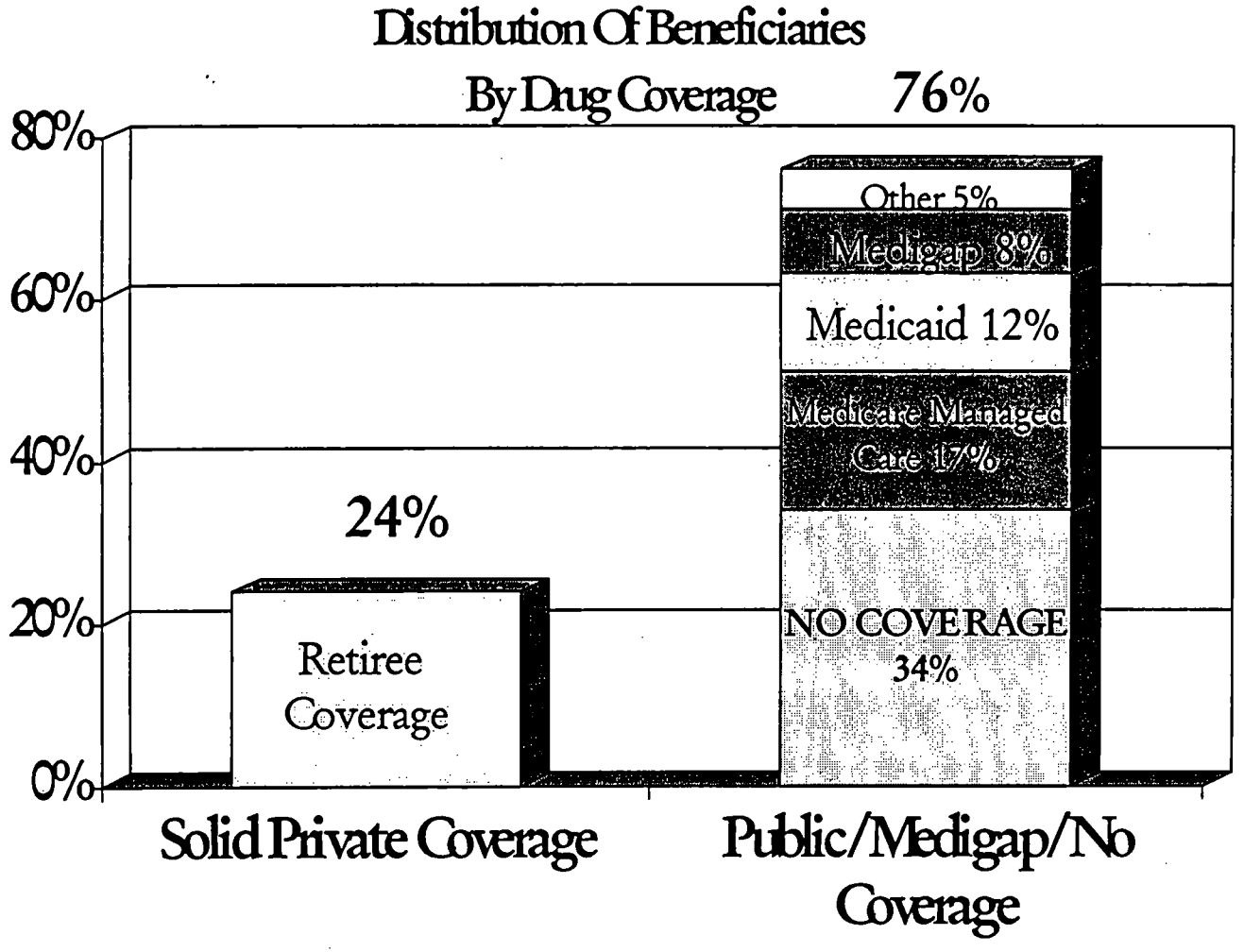
President's Proposal For Medicare Prescription Drug Coverage

- **Meaningful coverage:** Beginning in 2002, beneficiaries have the option to enroll in Part D:
  - No deductible -- coverage with first prescription
  - 50 percent copay with access to discounted prices
  - Benefit limited after $5,000 in costs (phased-in in 2008)

- **Affordable premiums:** $24/month, rising to $44/month when fully phased in. Includes low-income protections

- **Private management,** and incentives for retaining retiree health coverage

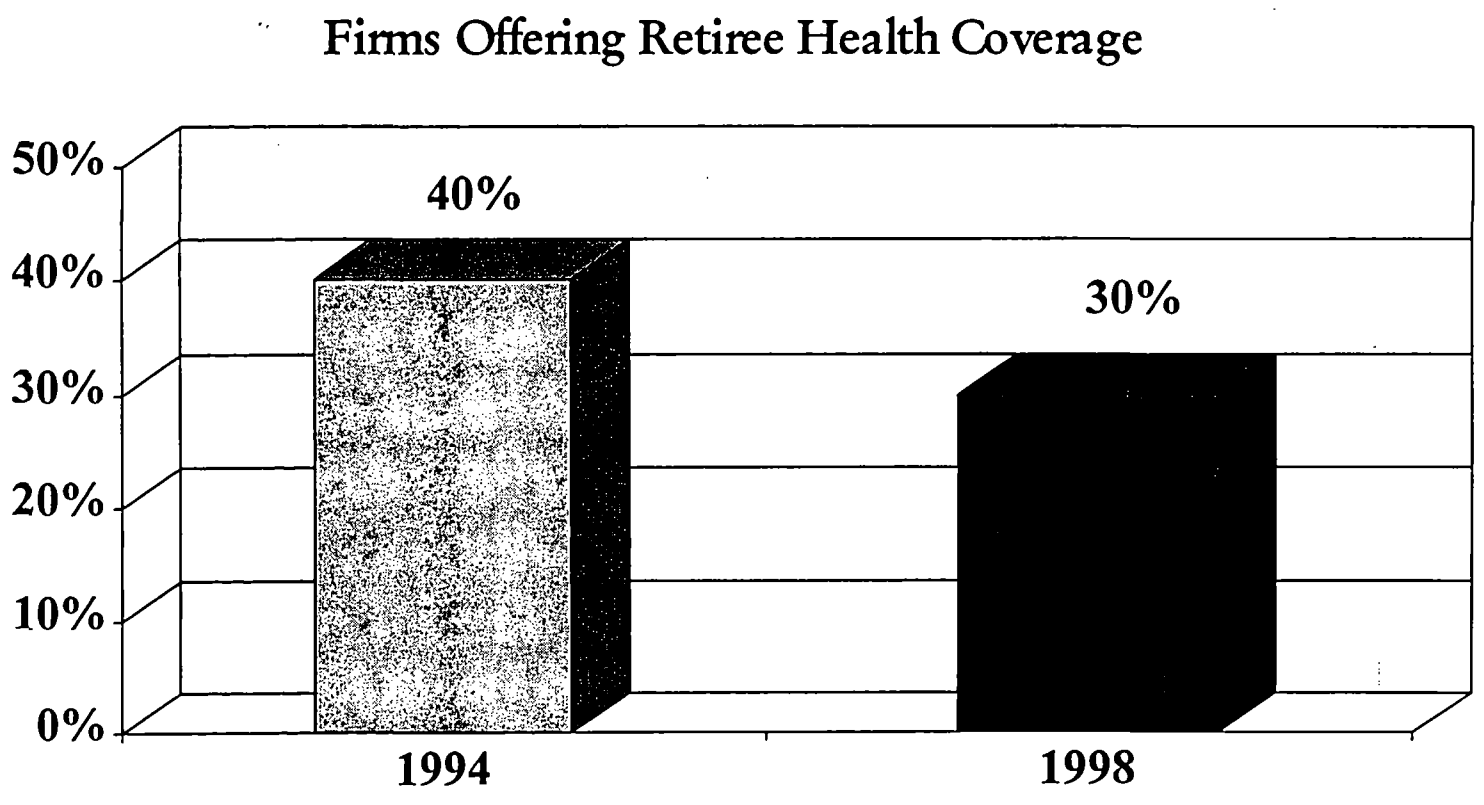
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



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

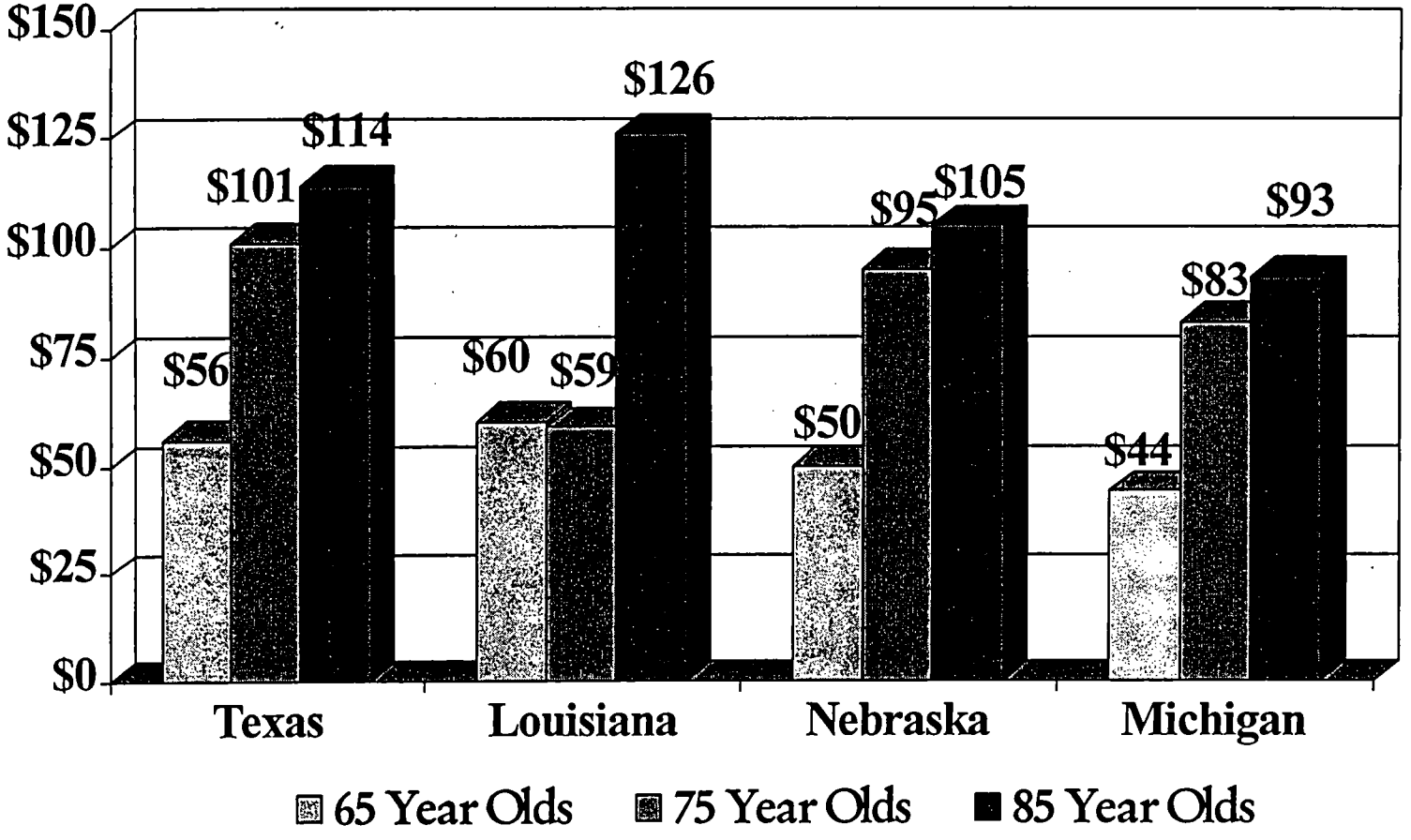
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

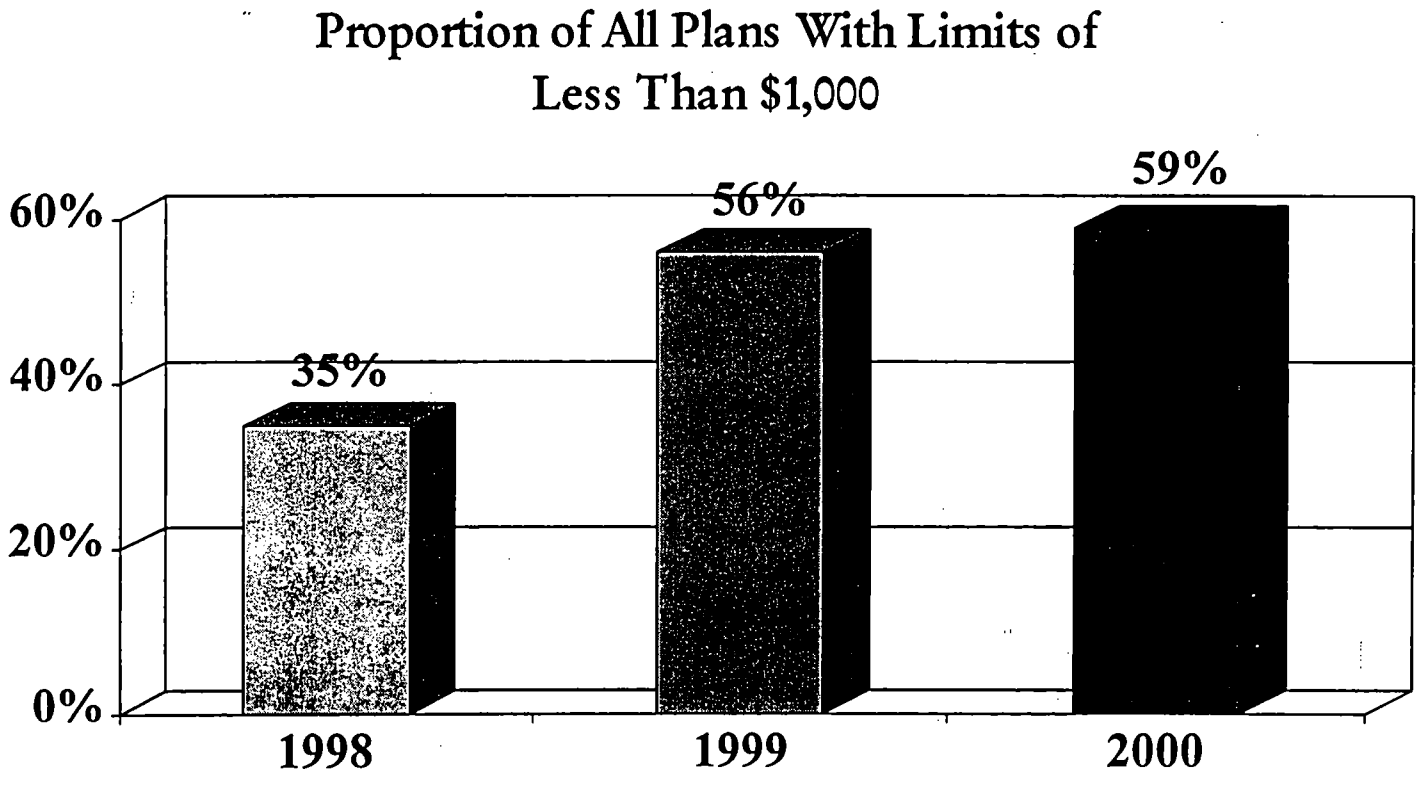
Premiums for Medigap, Which Only Covers 8% of Beneficiaries, Are High And Increase With Age



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

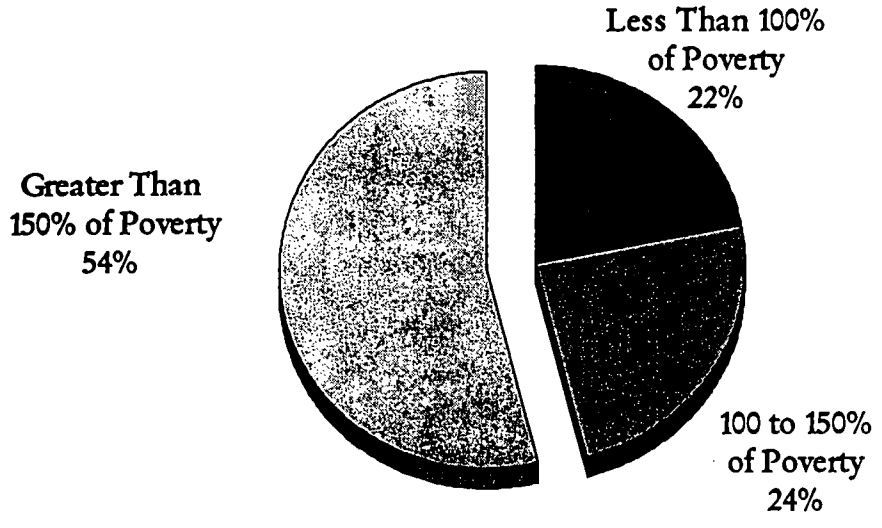
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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

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

Making Medicare Managed Care More Competitive

Current System	Competitive Defined Benefit
• No price competition	• Plans paid based on price and quality
• Plans compete by offering hard-to-compare benefits	• Plans compete by lowering premium & cost sharing for clearly defined benefits
• Over 1 in 4 beneficiaries do not have access to managed care -- or the extra benefits they offer	• Explicitly pays for drugs in managed care as well as traditional Medicare

Smoothing Out Balanced Budget Act Policies In The Short Run

- **Immediate Administrative Actions**, that moderate the impact on hospitals, academic health centers and home health agencies

- **Targeting Disproportionate Share Hospital Payments Directly to Hospitals**

- **$7.5 Billion Quality Assurance Fund**

TAB 4.

PRESCRIPTION DRUG BENEFIT

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

Table of Contents

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:

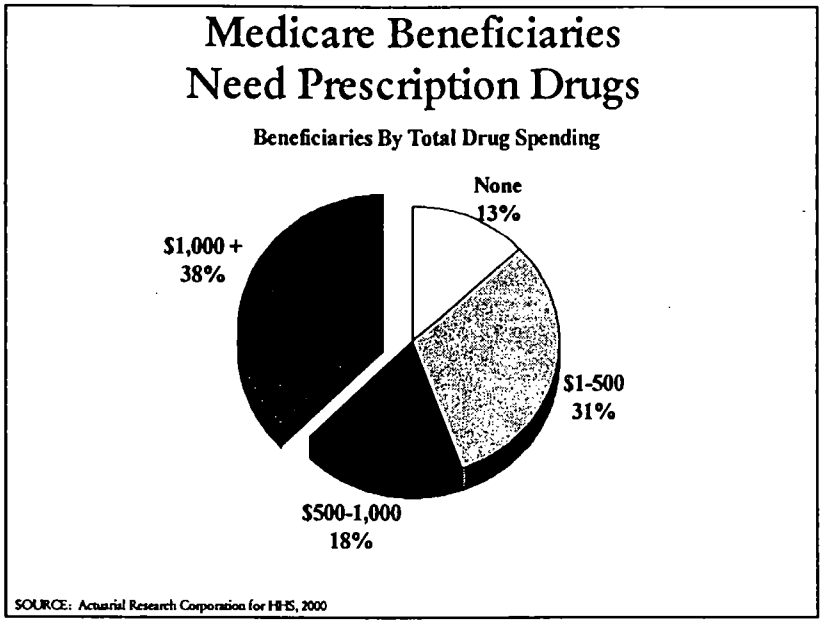
  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.[10] Many elderly must choose between prescriptions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

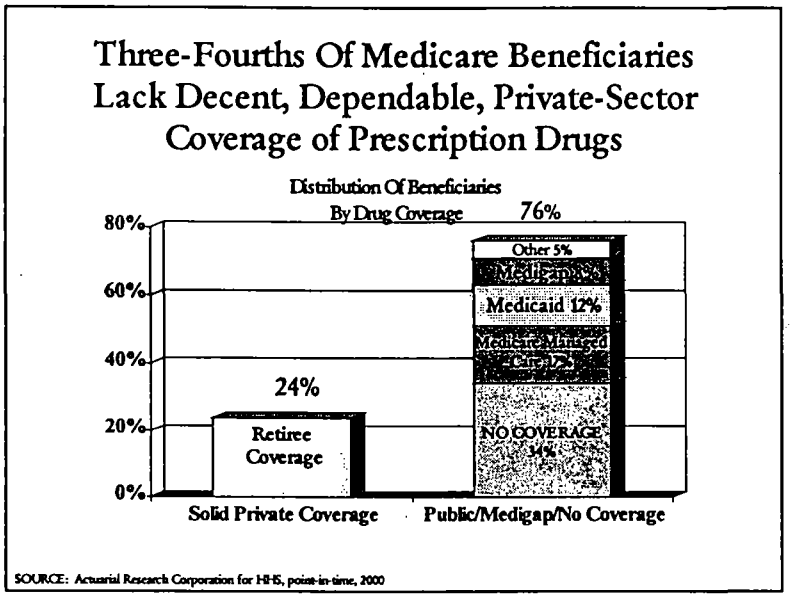
- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than $500.

- **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.

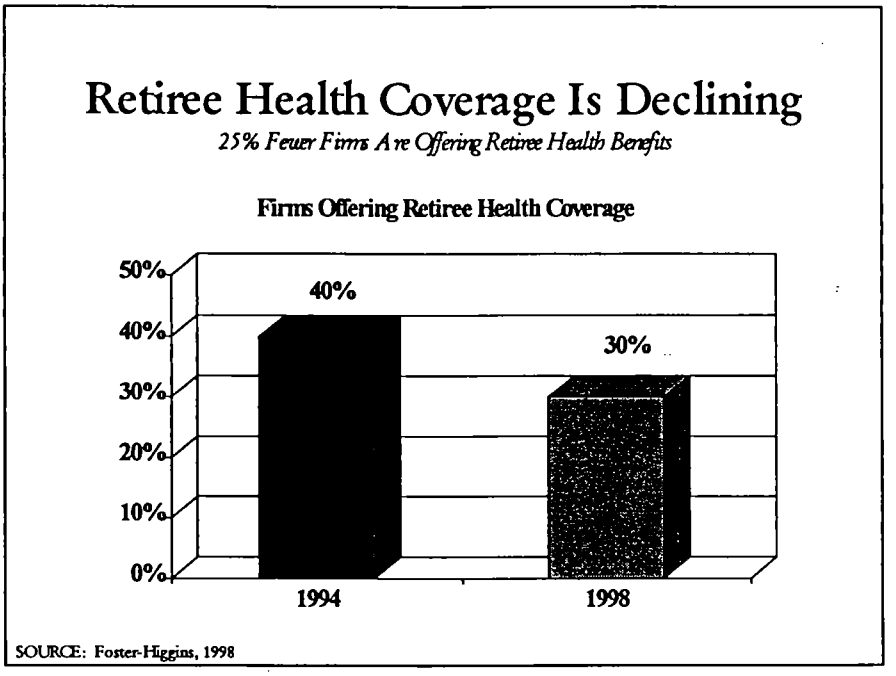
  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

  - 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.

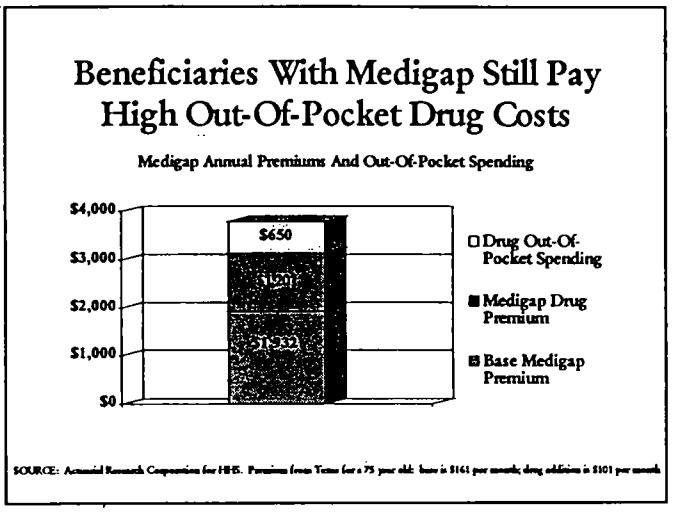
- Firms are increasingly moving their retirees to Medicare managed care. To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in 1996.[15]

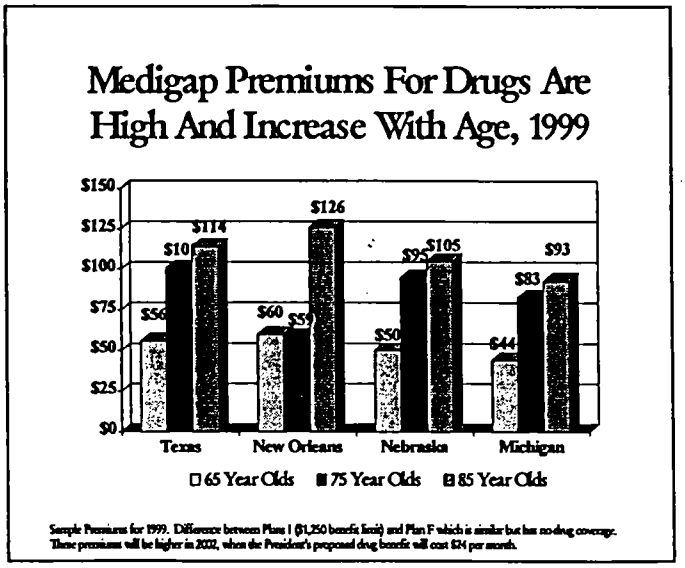
MEDIGAP PRESCRIPTION DRUG COVERAGE

- **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.





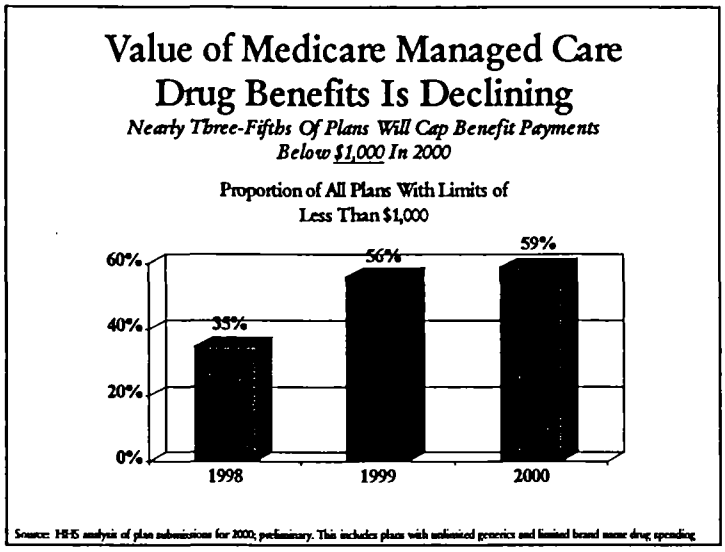
Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

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.

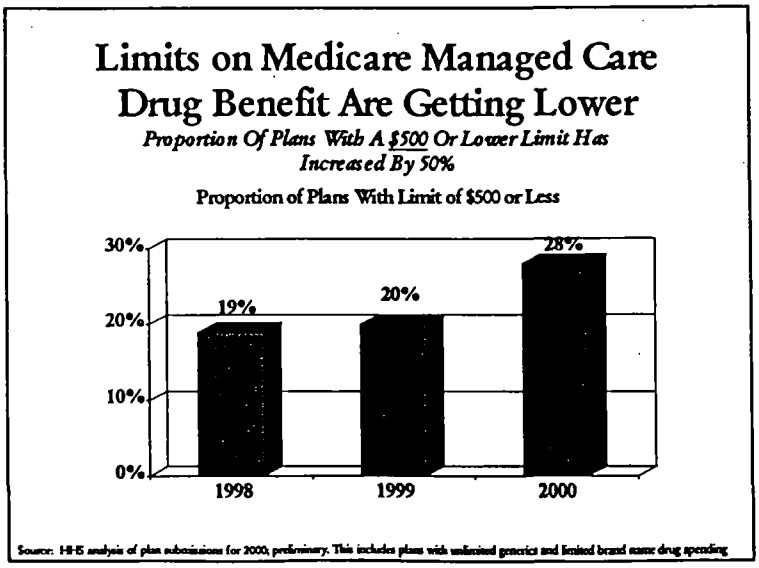
MEDICARE MANAGED CARE

- **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.



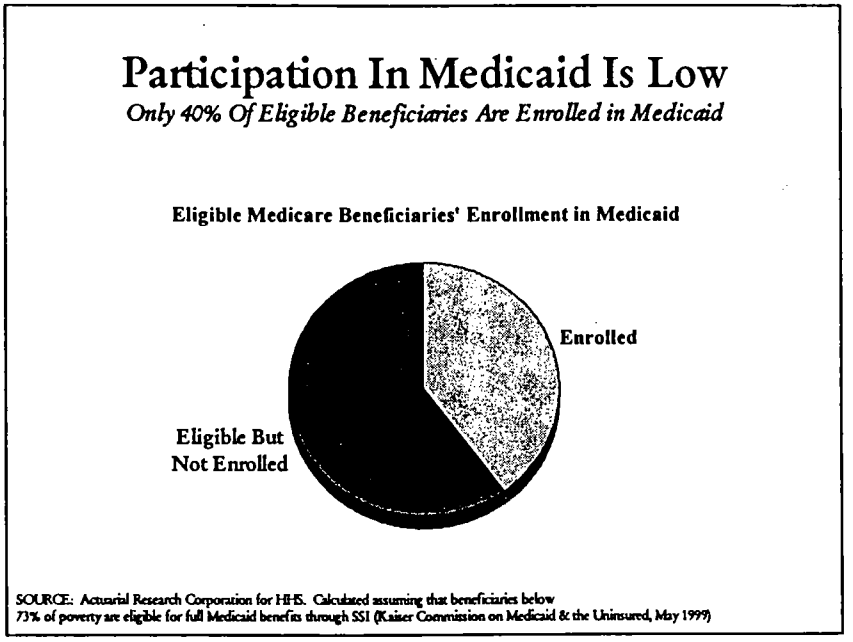
- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.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

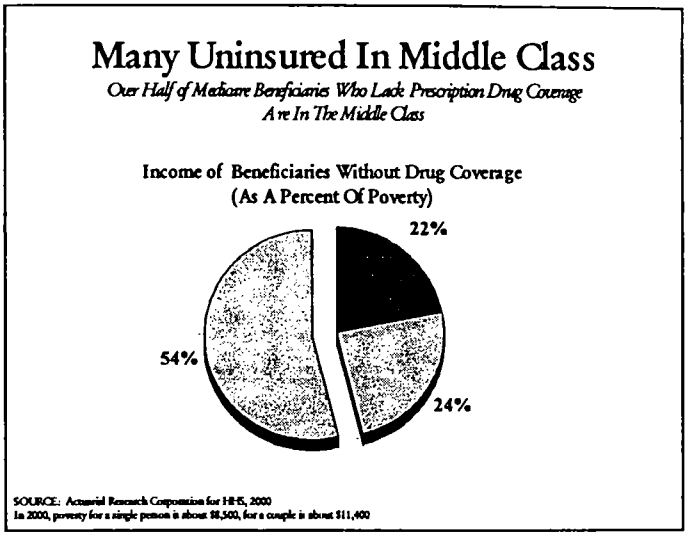
  - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.

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

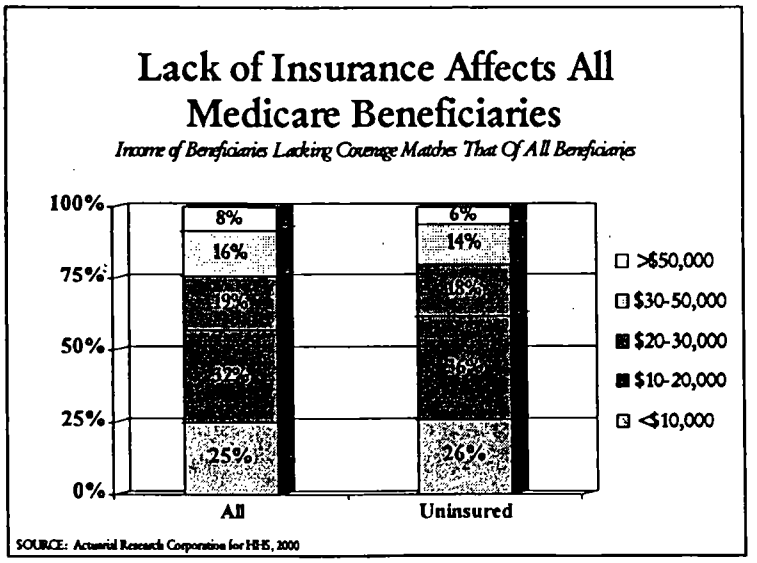
BENEFICIARIES LACKING DRUG COVERAGE

- 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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[1] Hazzard WR; Blass JP (Editor); Ettinger WH; Halter JB; Ouslander JG. (1998). *Principles of Geriatric Medicine and Gerontology.* New York: McGraw Hill.

[2] Centers for Disease Control and Prevention, National Center for Health Statistics. (1993). (National High Blood Pressure Education Working Group): Report on primary prevention of hypertension. *Archives of Internal Medicine.* 153: 186.

[3] Wilson PWF. (1991). Established risk factors and coronary artery disease: The Framingham Study. American Journal of Hypertension. 7: 75.

[4] SHEP Cooperative Research Group. (1991). Prevention of stroke by hypertensive treatment in older patients with isolated systolic hypertension. *JAMA*, 265: 3255-3264.

[5] Randomized trial of cholesterol lowering in 4444 patients with coronary heart disease: The Scandinavian Simvastatin Survival Study (45). Lancet 1994; 344: 1388-1389.

[6] The beta-blocker heart attack trial: Beta-Blocker Heart Attack Study Group. JAMA. 1981; 246: 2073-2074.

[7] National Health Interview Survey.

[8] Tierney LM; McPhee SJ; Papadakis MA (editors). (1998). *Current Medical Diagnosis and Treatment 1998.* Appleton and Lange.

[9] Tierney LM, et al.; ibid.

[10] Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1987). Payment restrictions for prescription drugs under Medicaid: Effects on therapy, cost and equity. *The New England Journal of Medicine,* 317: 550-556.

[11] Families USA, 1994.

[12] Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1991). Effects of Medicaid drug-payment limits on admissions to hospitals and nursing homes. *The New England Journal of Medicine,* 325: 1072-1077.

[13] Bero LA.; Lipton HL; Bird, JA.. (1991). Characterization of Geriatric Drug-Related Hospital Readmissions. *Medical Care,* 29 (10): 989-1003.

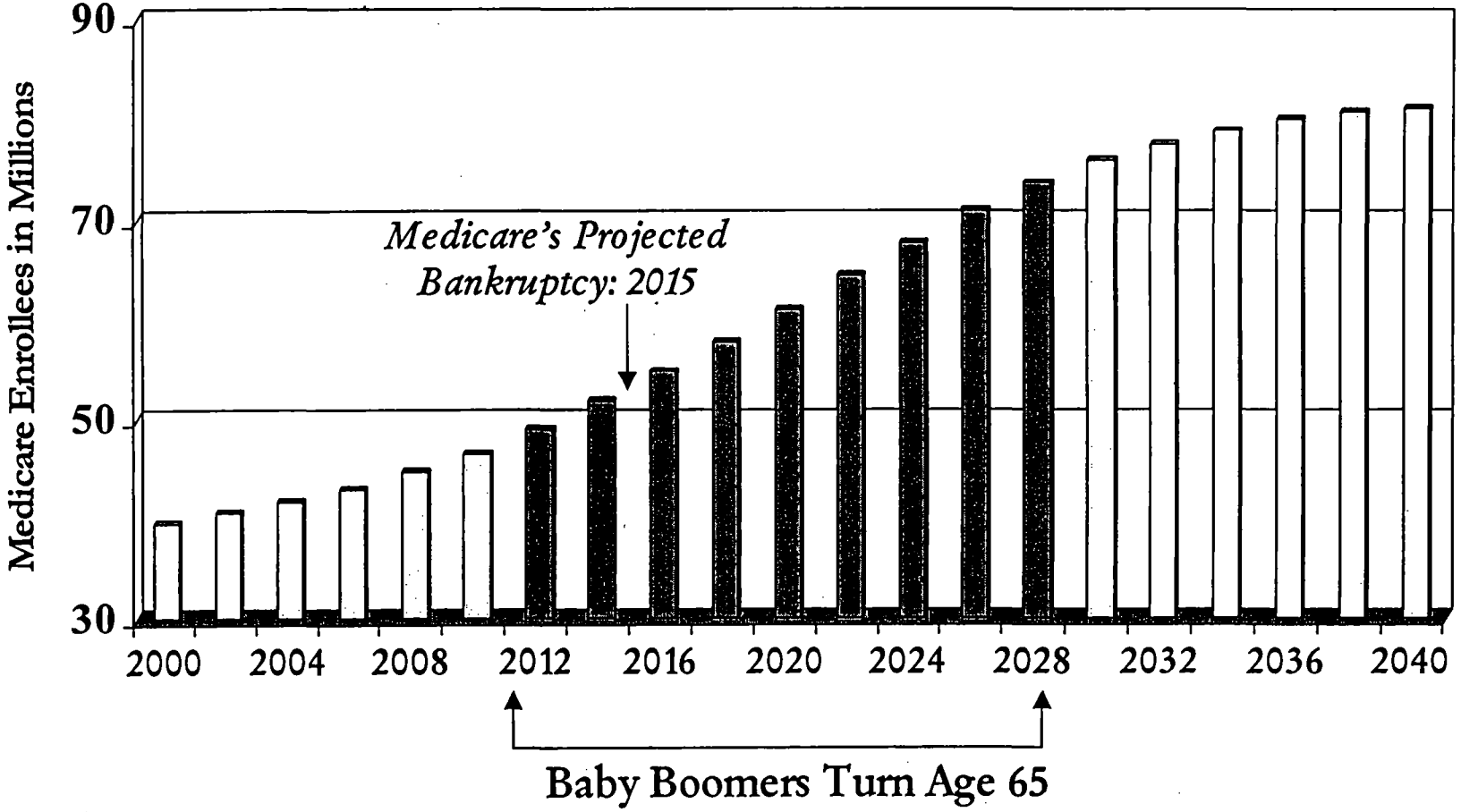
[14] Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.

[15] Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1996. As reported in Hewitt Associates. (1997). Retiree Health Trends and Implications of Possible Medicare Reforms. Washington, DC: The Kaiser Medicaid Project.

TAB 5.

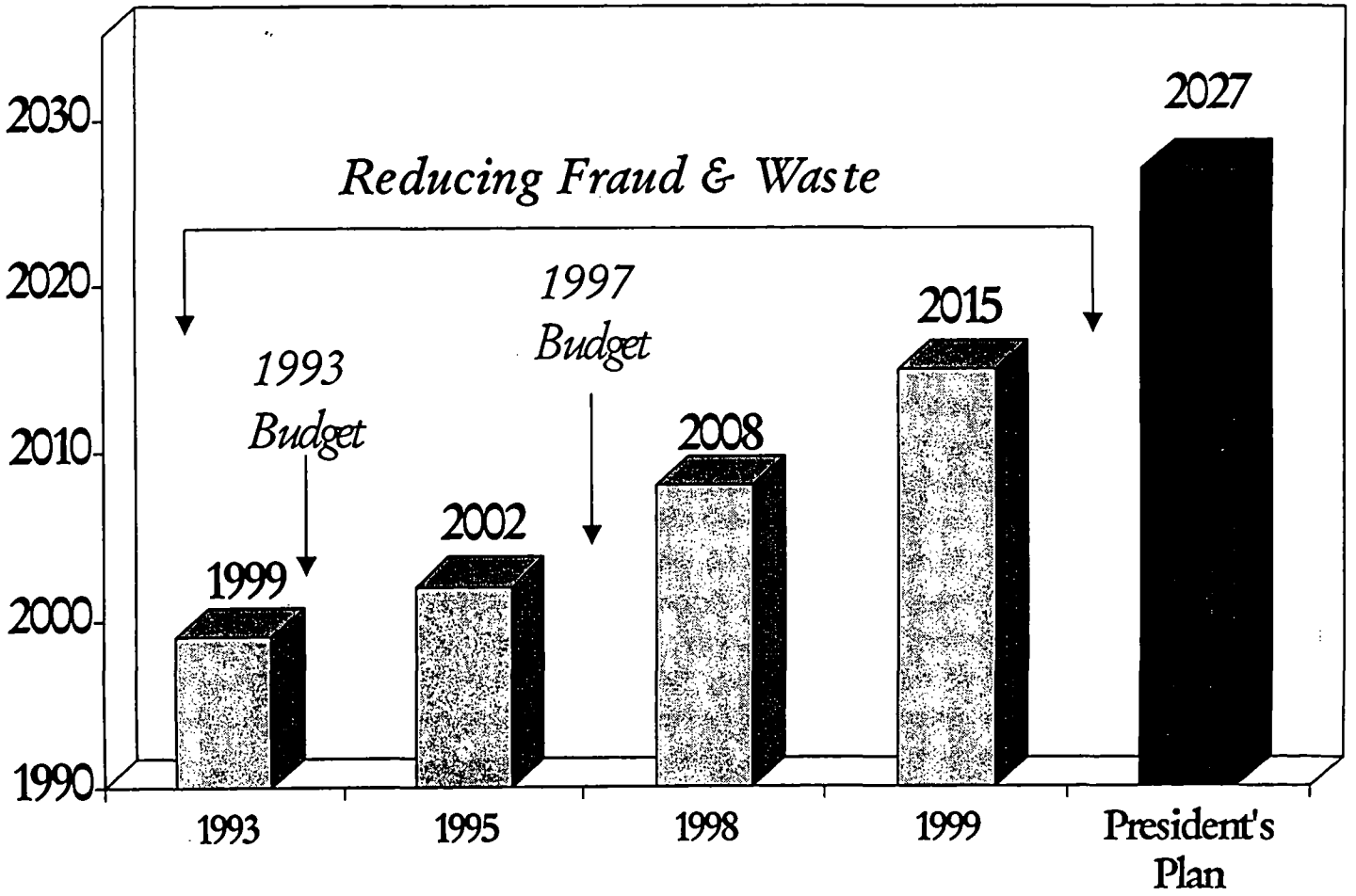
CHARTS

Medicare Enrollment Will Double As The Baby Boom Generation Retires

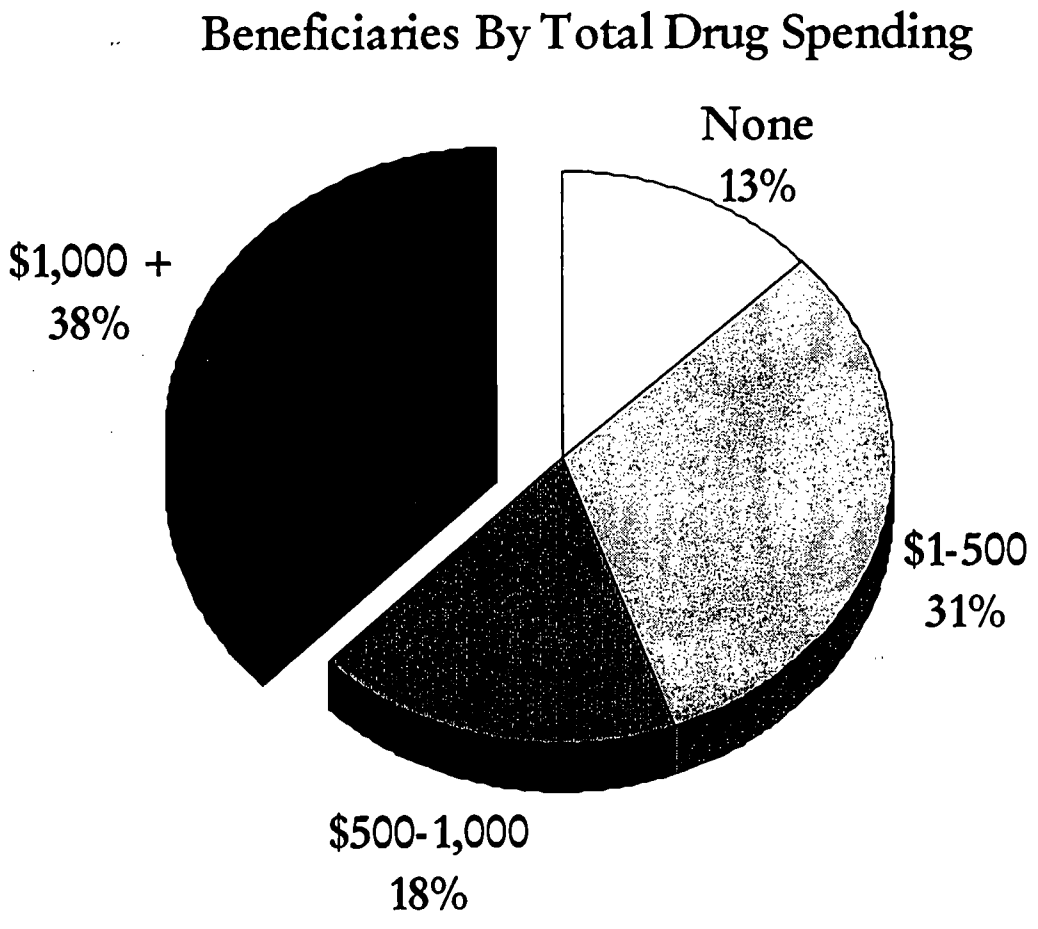


Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027

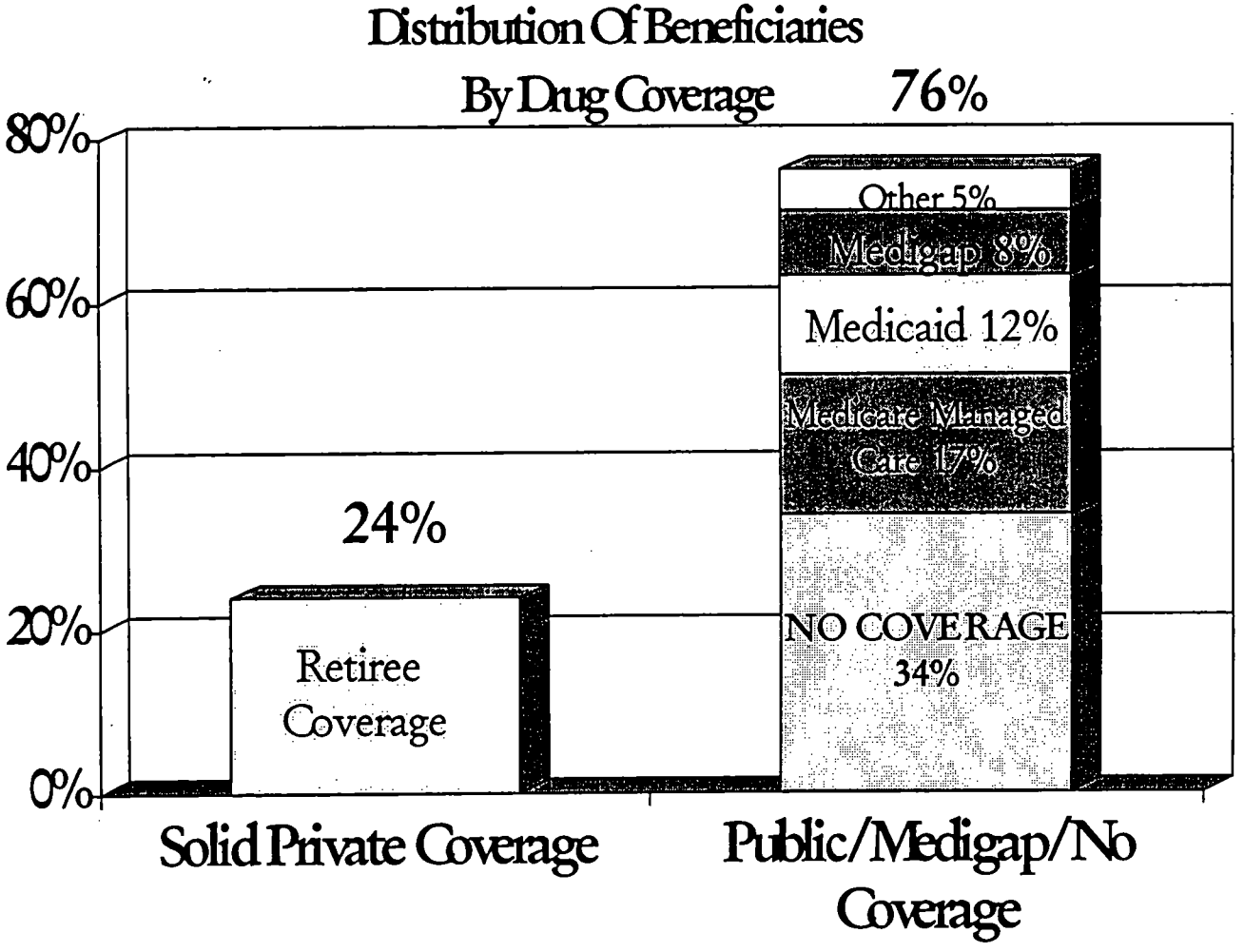


Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

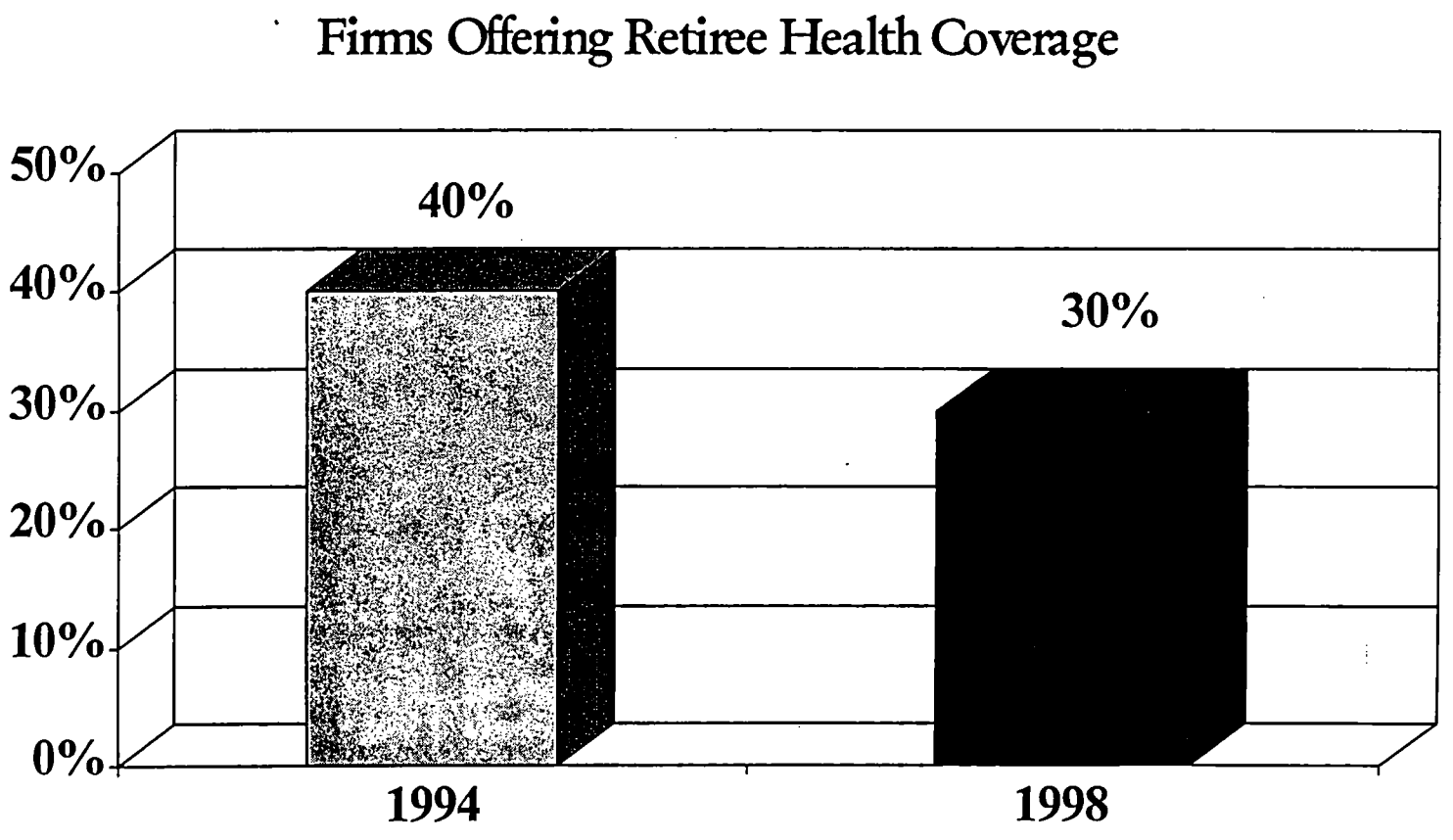
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



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

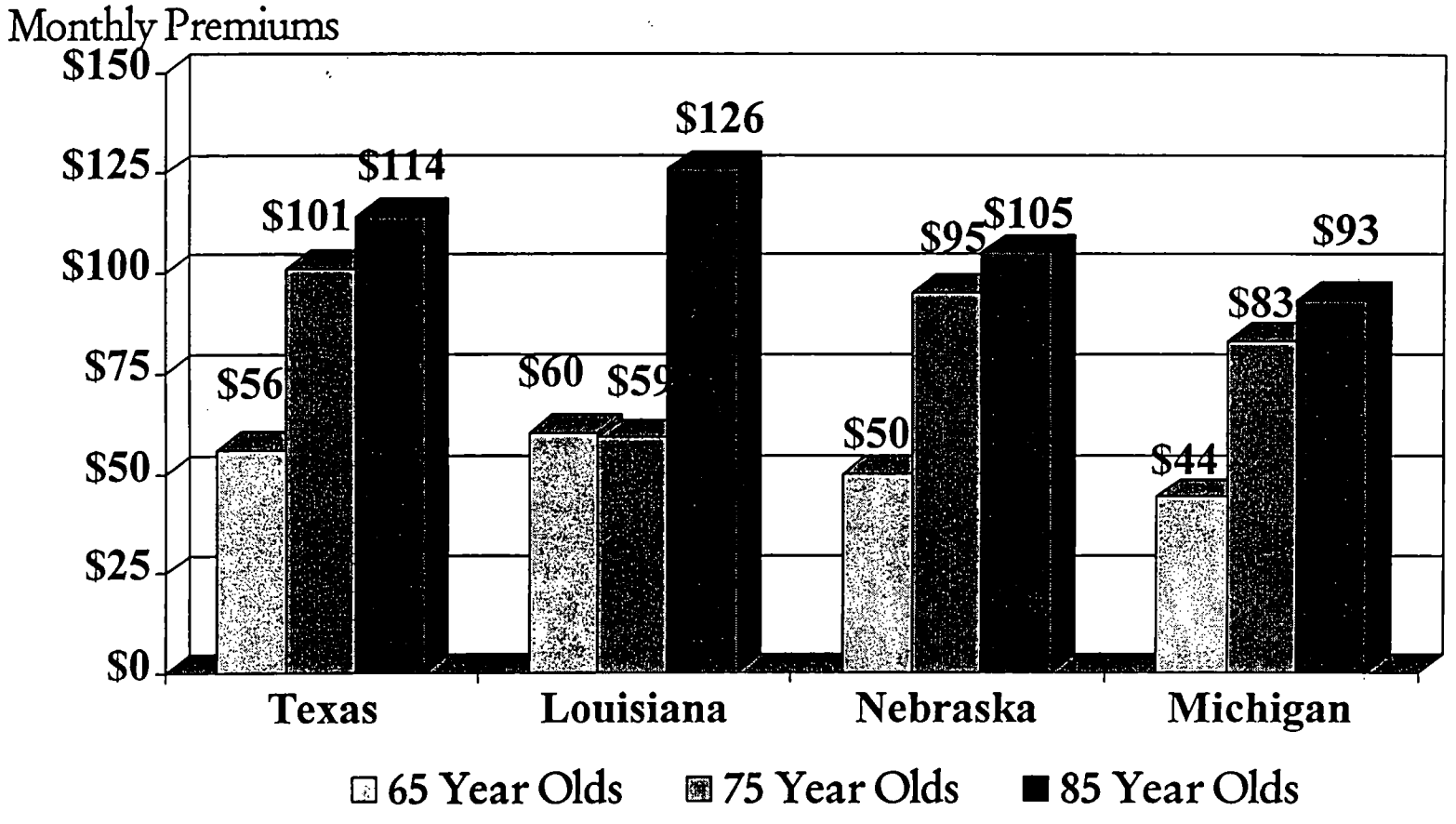
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

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

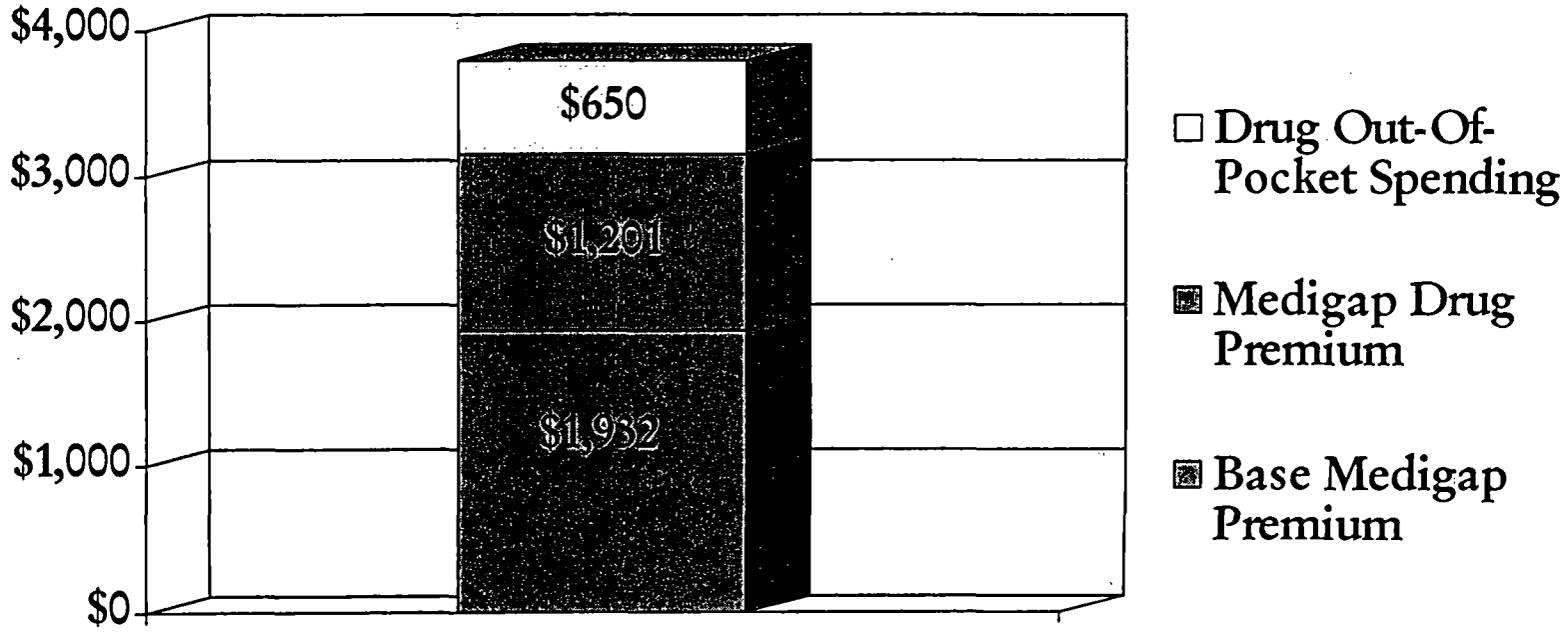


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

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

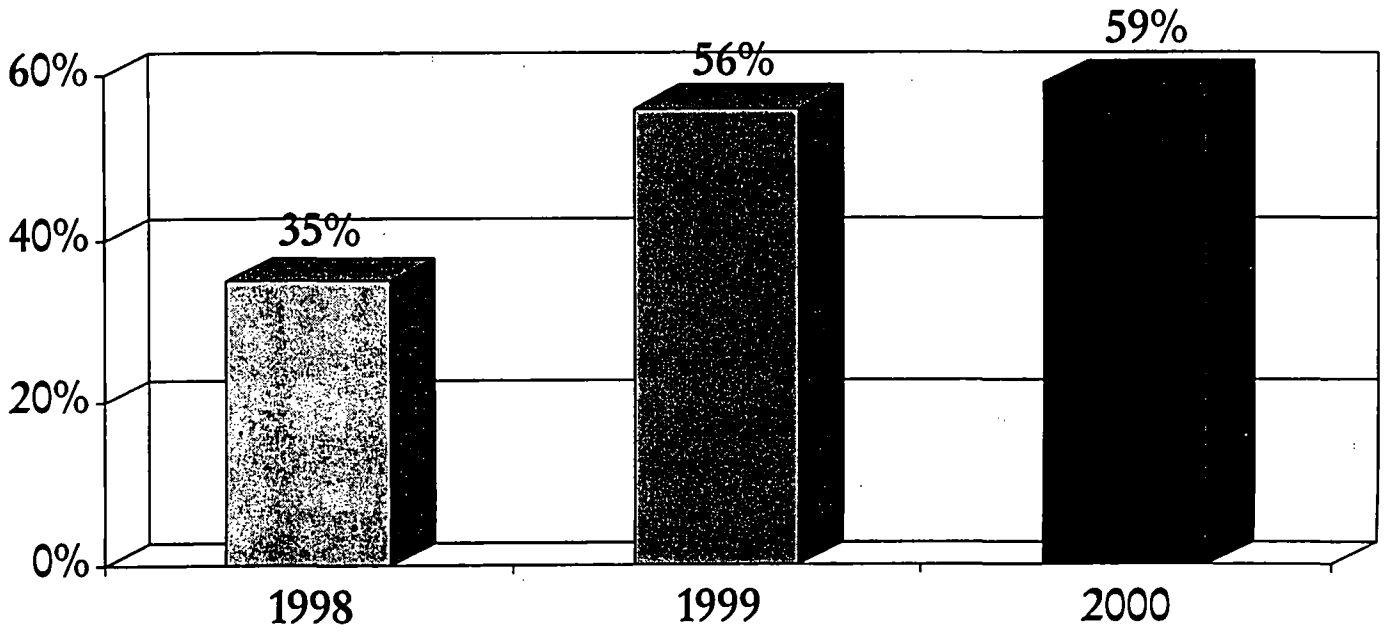
Medigap Annual Premiums And Out-Of-Pocket Spending



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

Value of Medicare Managed Care Drug Benefits Is Declining

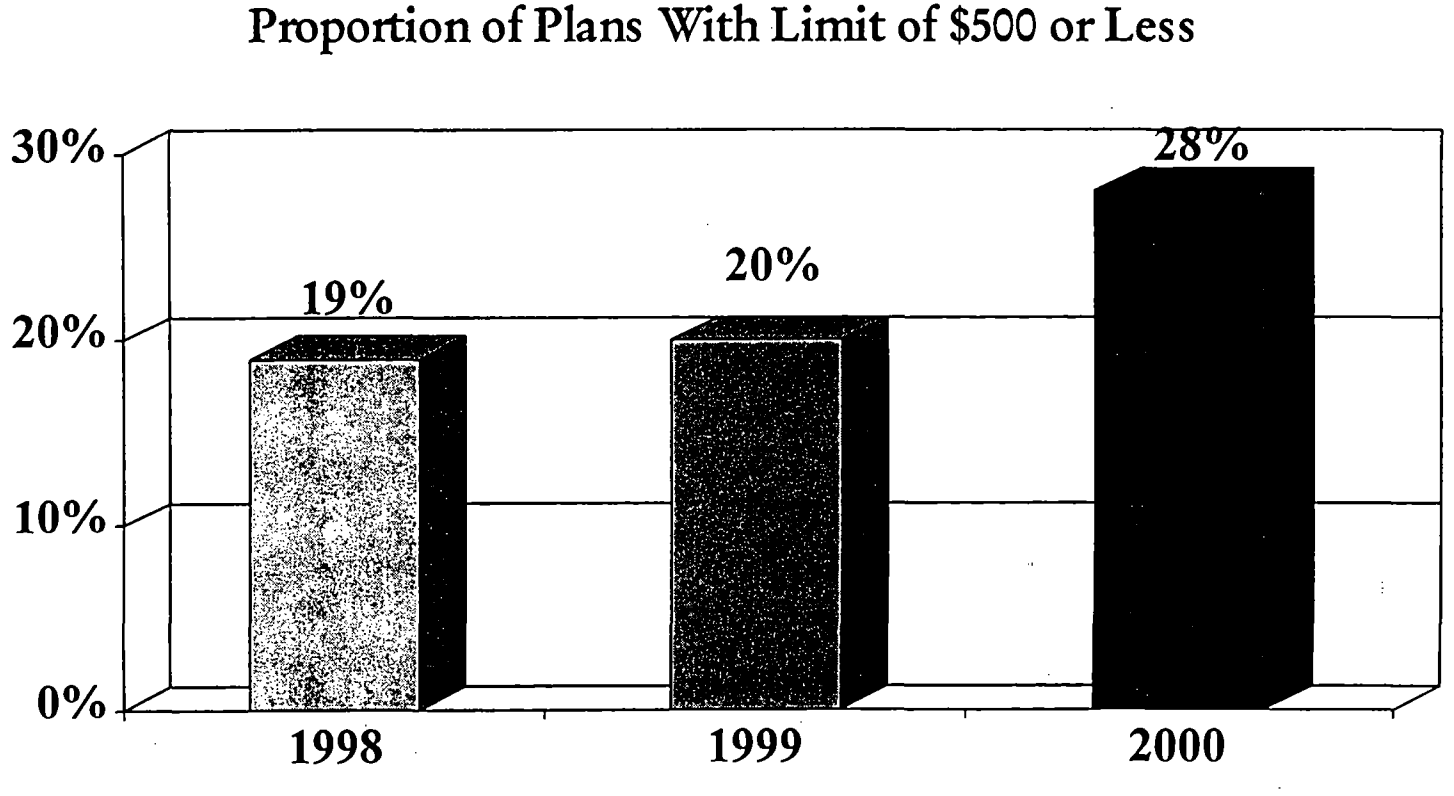
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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%

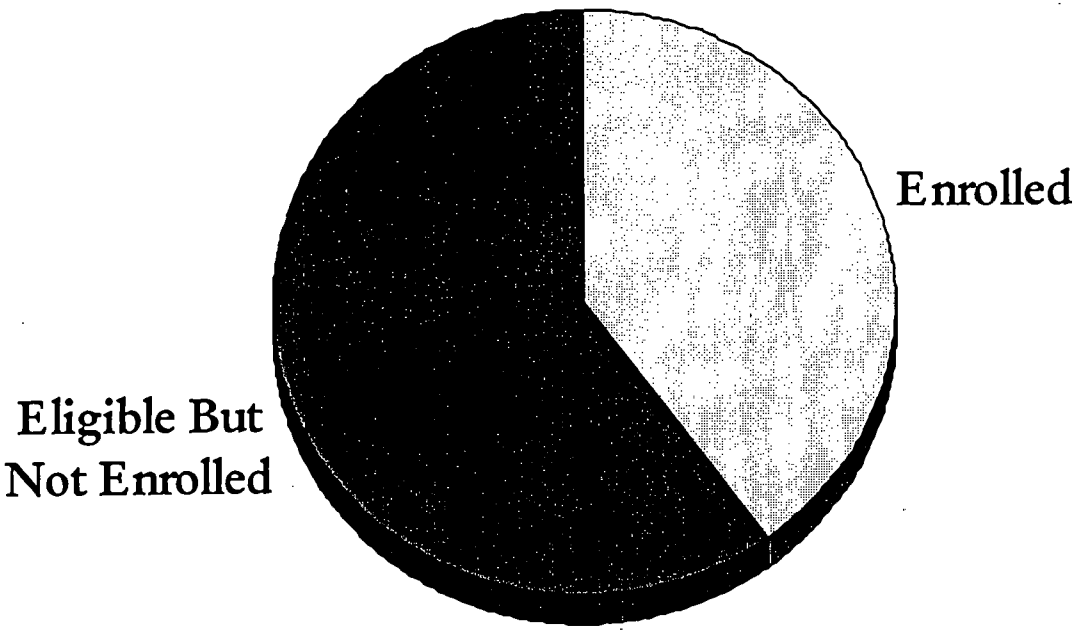


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

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)

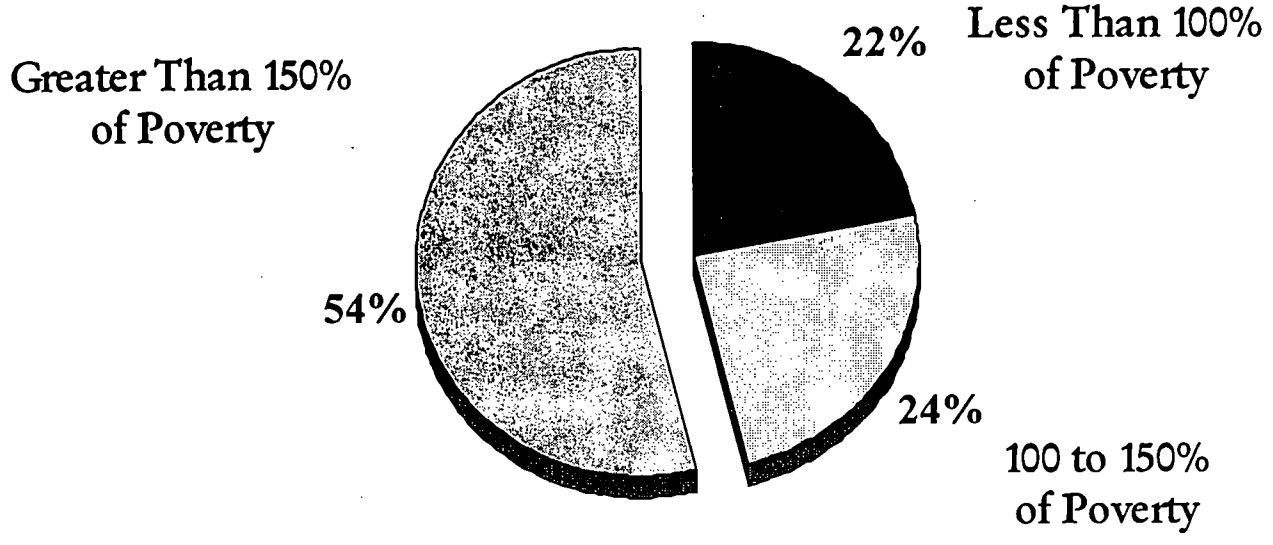
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

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

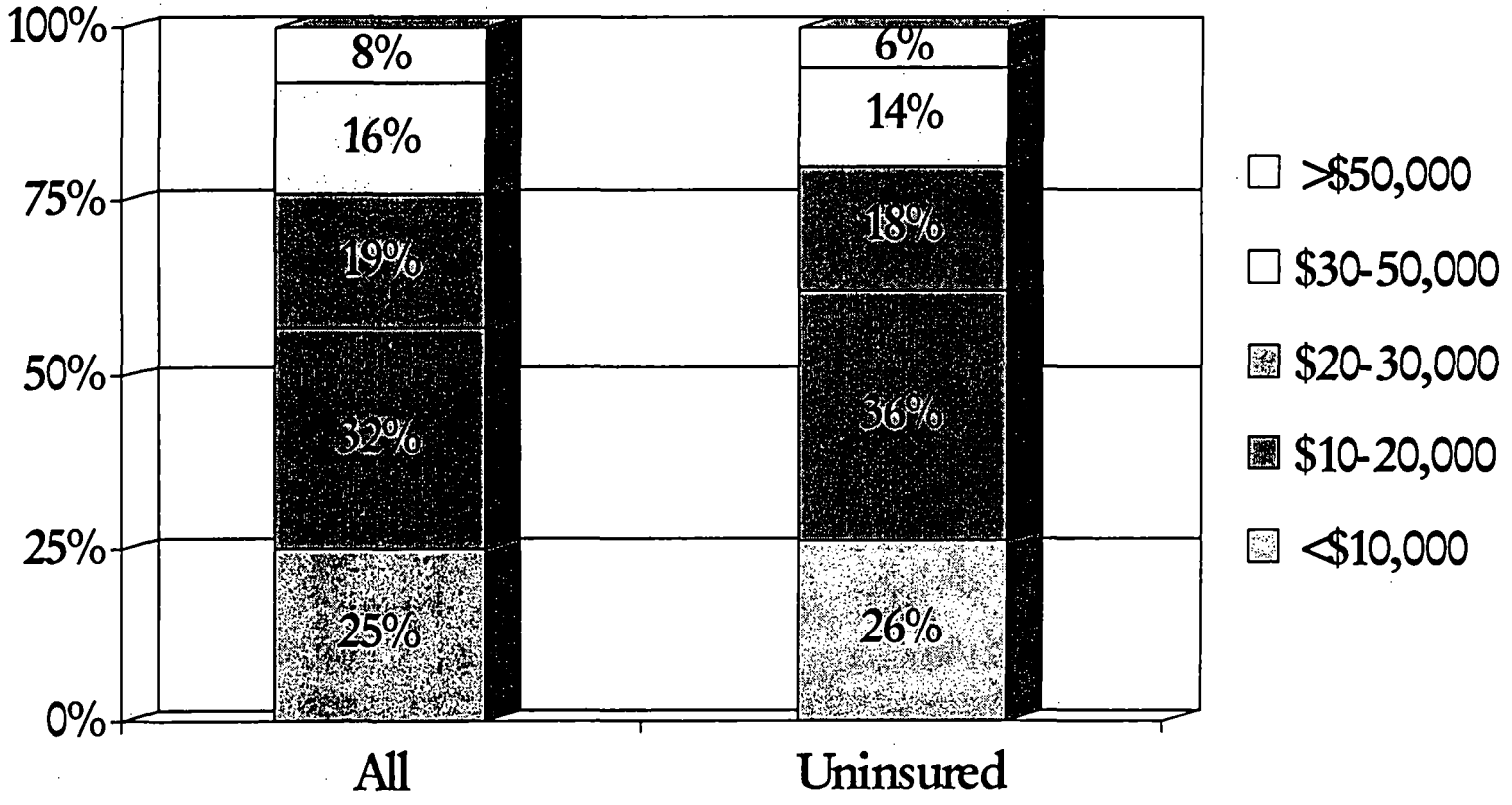
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



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

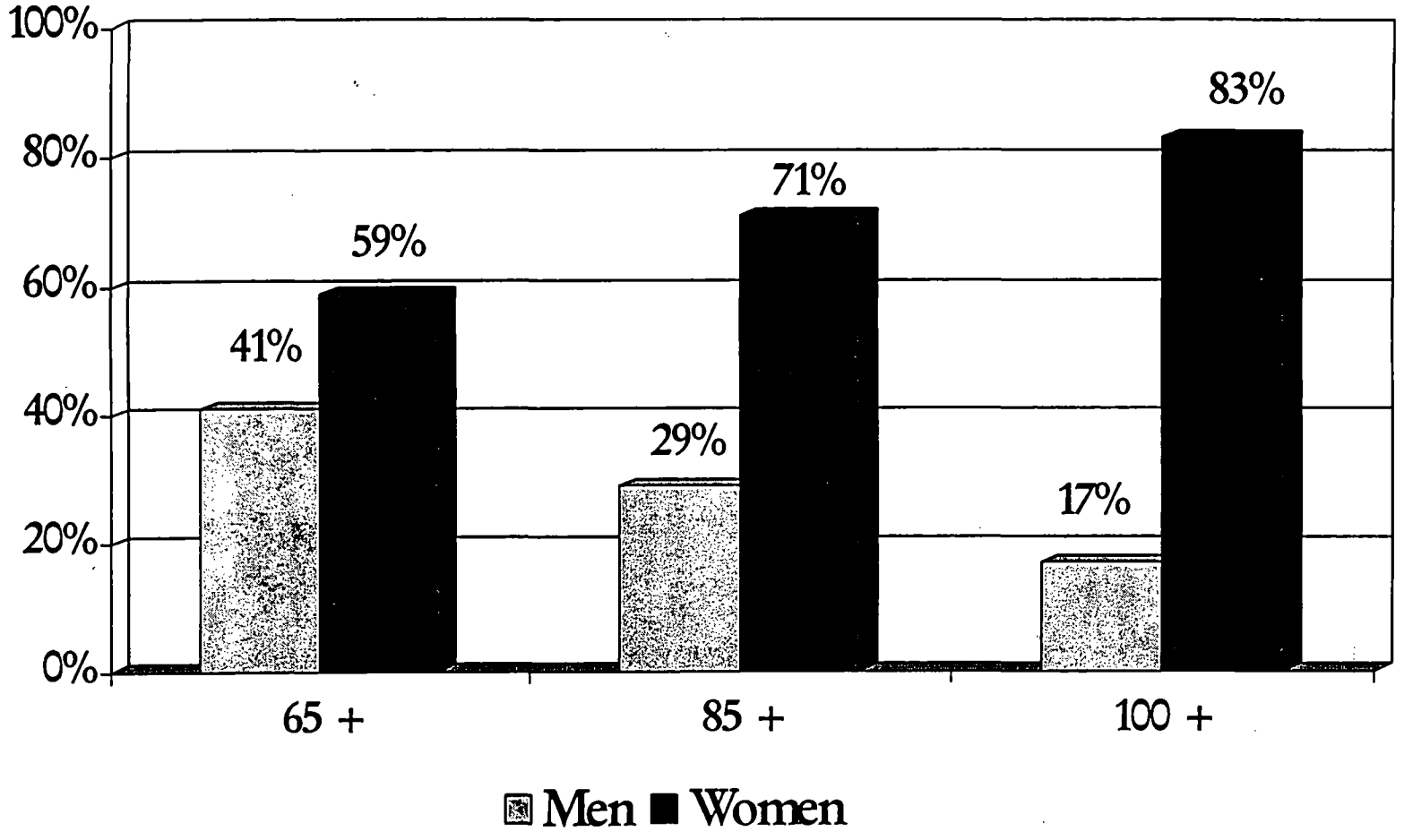
Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



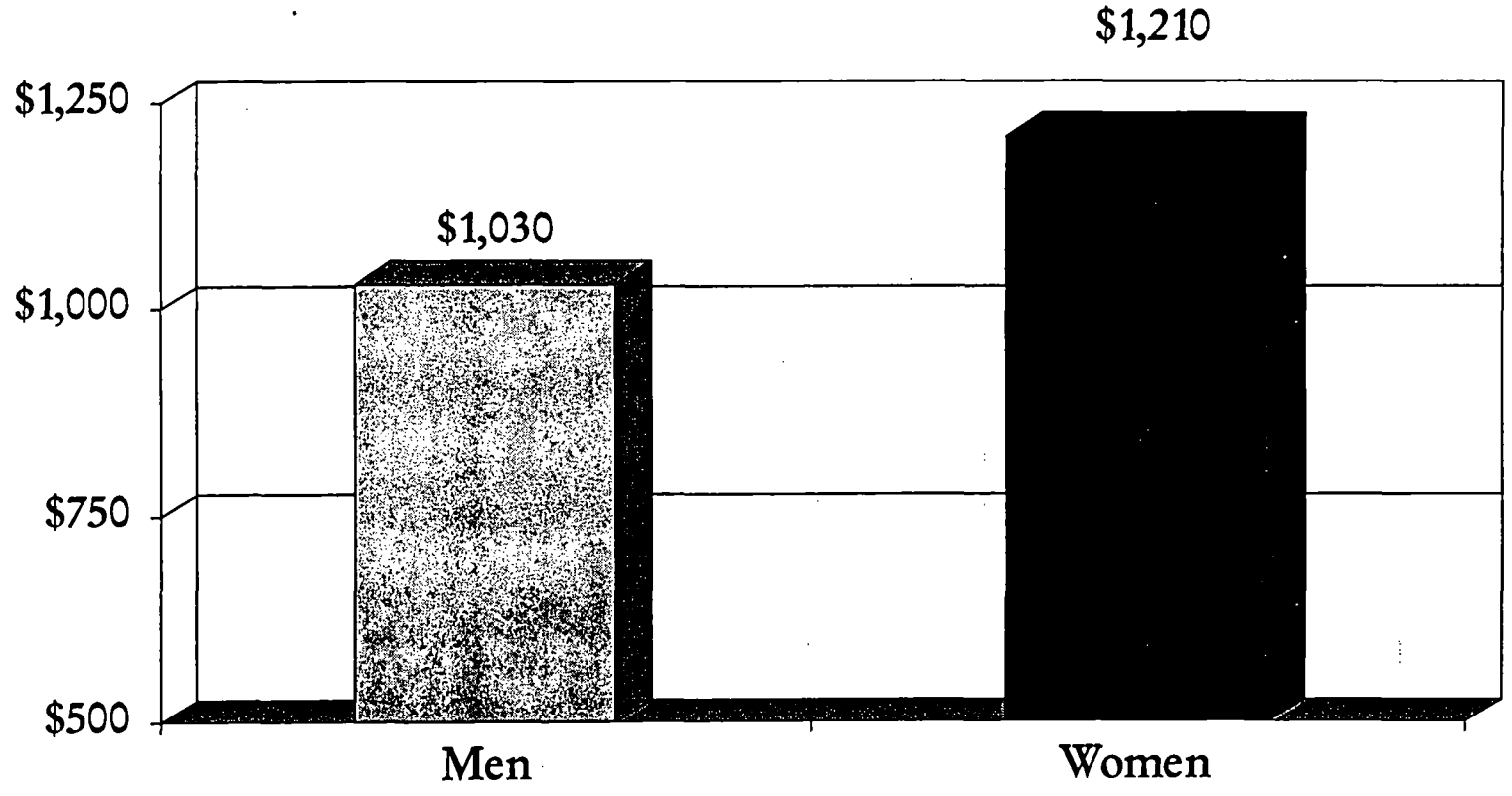
SOURCE: Actuarial Research Corporation for HHS, 2000

Most Medicare Beneficiaries Are Women



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

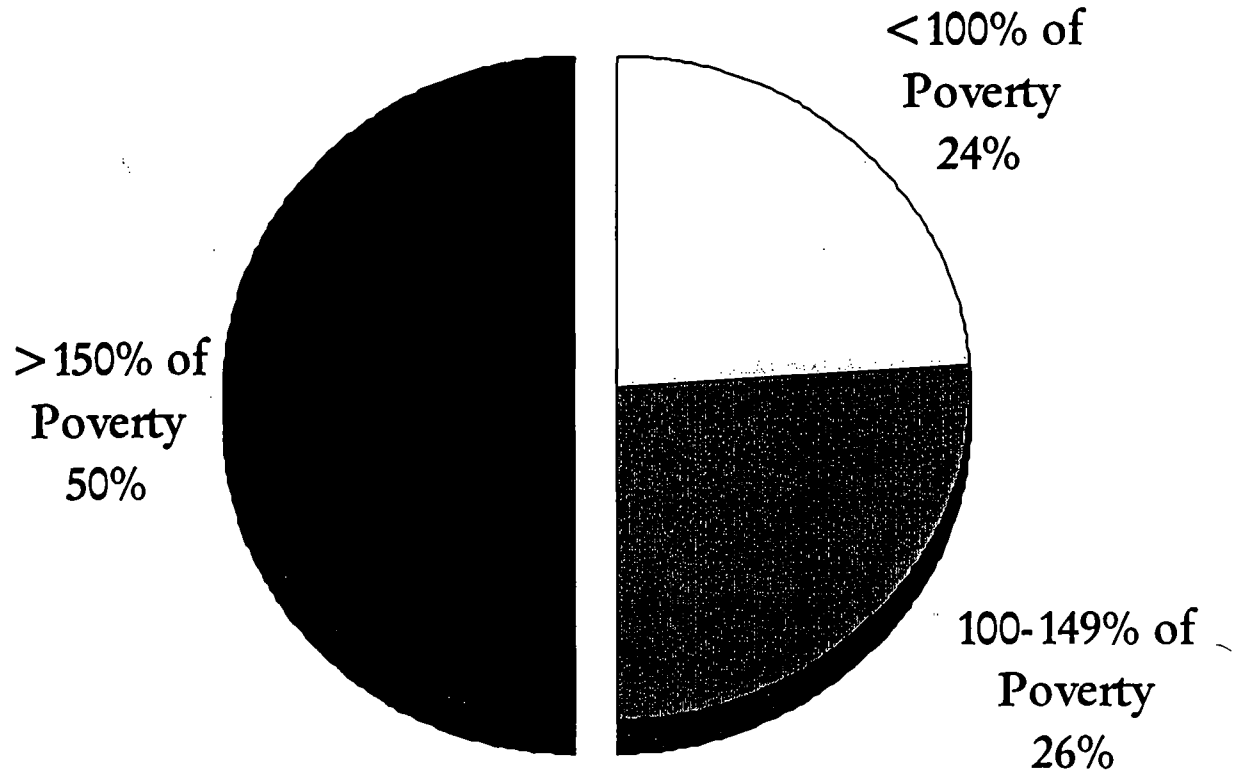
Total Prescription Drug Spending For Women On Medicare Is $1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

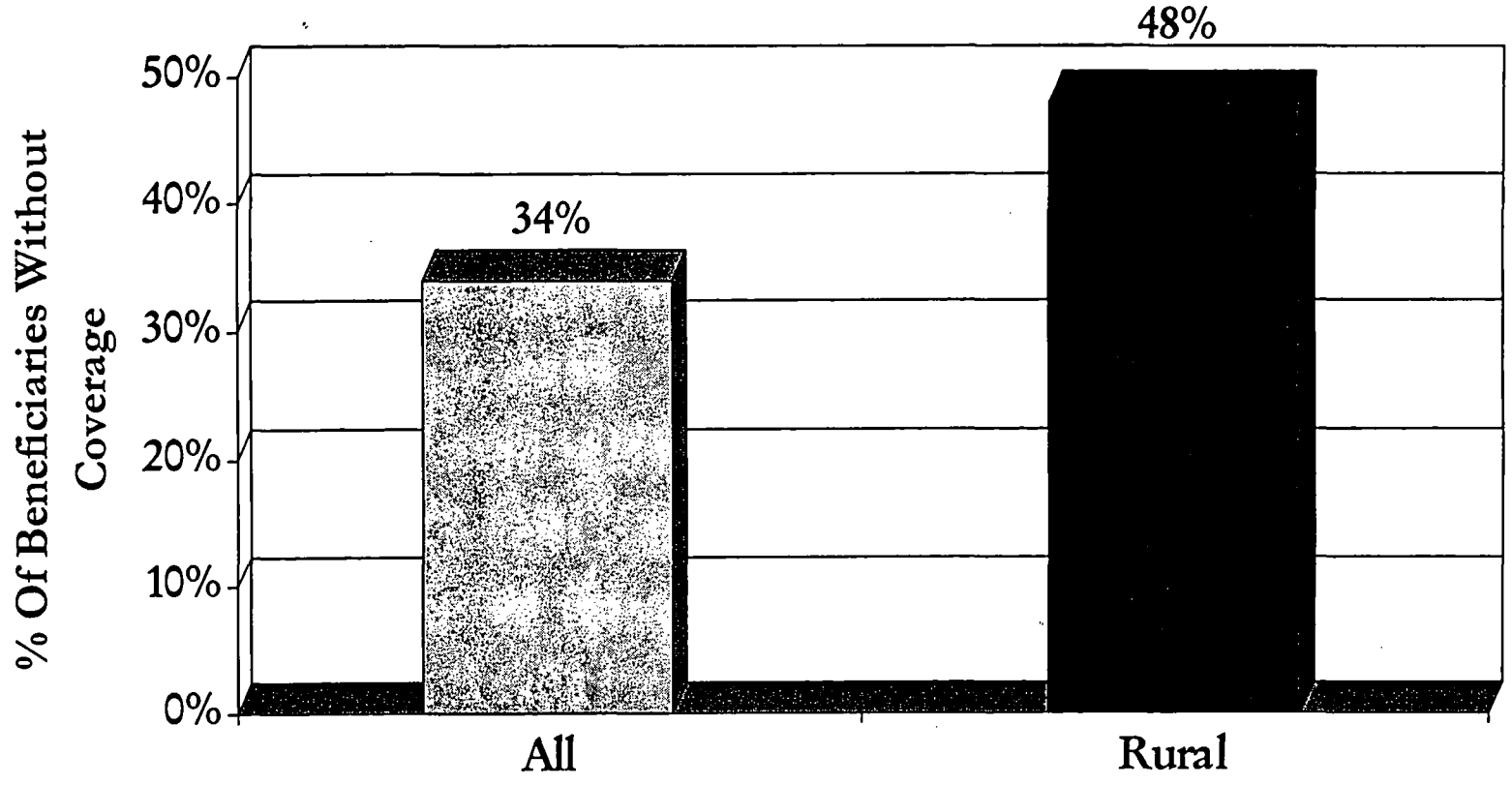
Source: Actuarial Research Corporation. As cited in OWL Report

Half Of Women on Medicare Without Drug Coverage Are Middle Income



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

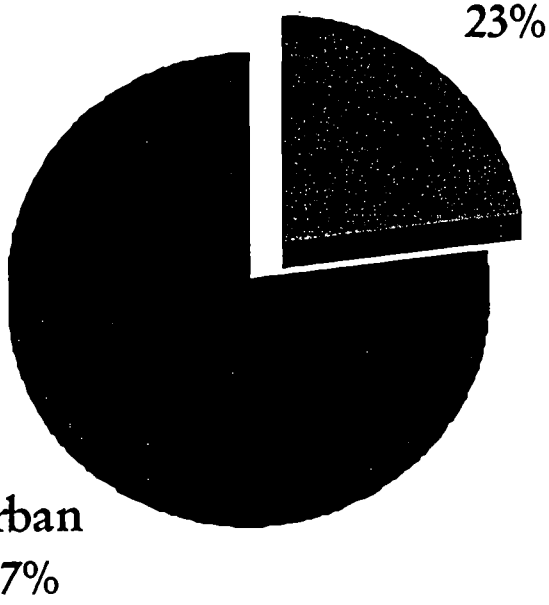
More Rural Medicare Beneficiaries Lack Prescription Drug Coverage



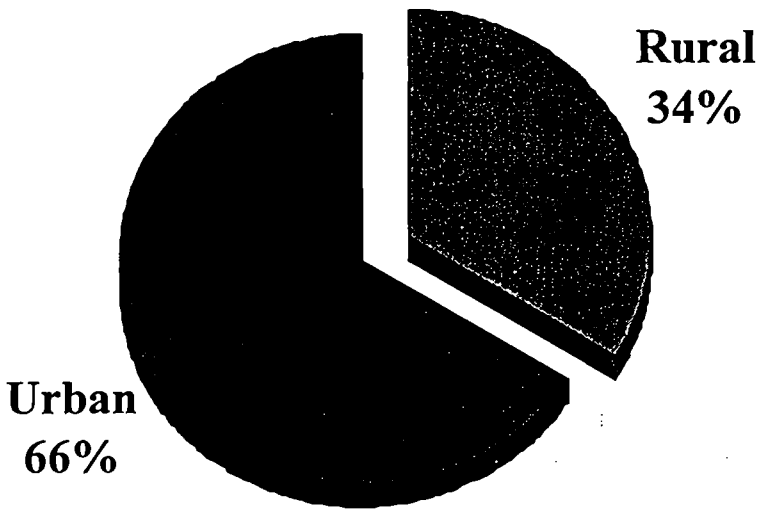
SOURCE: Actuarial Research Corporation for HHS, 2000

One In Three Beneficiaries Without Prescription Drug Coverage Lives In Rural America

All Medicare Beneficiaries

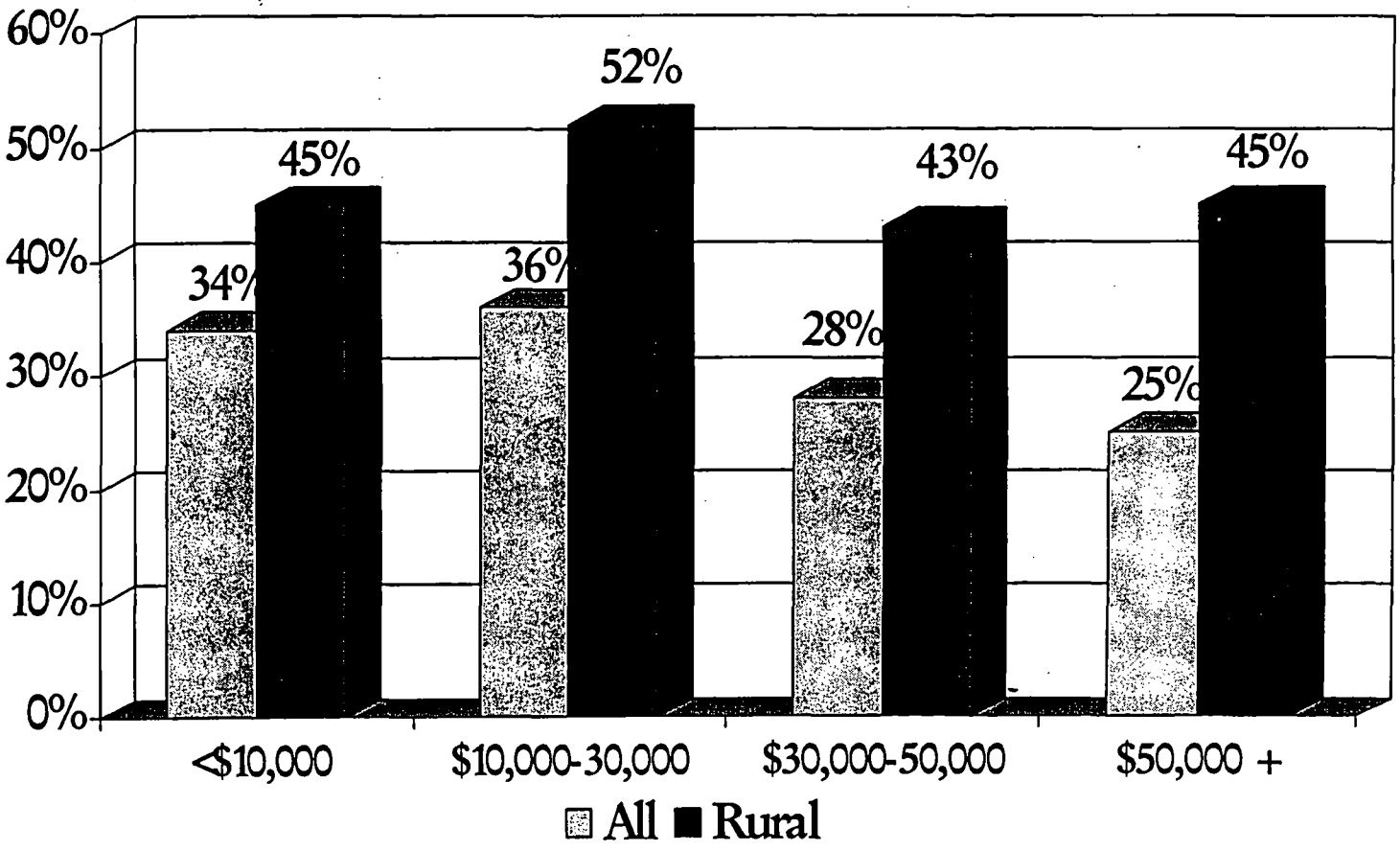


Medicare Beneficiaries Without Prescription Drug Coverage



SOURCE: Actuarial Research Corporation for HHS, 2000

Rural Beneficiaries Are Less Likely To Have Prescription Drug Coverage Across All Income Groups



SOURCE: Actuarial Research Corporation for HHS, 2000

TAB 6.

BREAUX-THOMAS MEDICARE REFORM PLAN

ISSUES WITH BREAUX-THOMAS MEDICARE REFORM PLAN

In recent weeks, the Republican Leadership has claimed it does have a Medicare plan -- the Breaux-Thomas Medicare reform plan. Under the leadership of Senator Breaux, the Bipartisan Commission on the Future of Medicare made significant contributions towards the Medicare reform debate. However, the final plan did not receive the necessary votes to formally report its recommendations and has several major flaws that need to be addressed, including:

- **No dedication of surplus to strengthen Medicare**: All experts agree that the doubling of Medicare beneficiaries in the next 30 years cannot be accommodated through spending reductions alone. Such cuts would be too deep to be absorbed by providers without sacrificing quality of care for beneficiaries. Waiting to address Medicare's financing makes the problem much harder to solve and shifts more of the burden to our nation's children.

- **"Premium support" proposal increases premiums for traditional Medicare, effectively financially coercing beneficiaries into managed care**: The Breaux-Thomas "premium support" proposal caps the government contribution to private plans and traditional Medicare based on the national average. Since traditional Medicare will be above an average that includes managed care plans, its premium will rise nationwide – 10 to 30 percent according to the independent Medicare actuary. This would have the effect of coercing beneficiaries into managed care. Despite this, a significant amount of the savings achieved by this proposal come from raising premiums for the beneficiaries who remain in traditional Medicare.

- **Inadequate prescription drug benefit:** The Breaux-Thomas proposal limits drug coverage to beneficiaries with incomes below 135 percent of poverty (about $11,500 a year for a single, $15,400 for a couple). This helps only a fraction of beneficiaries without drug coverage; over half of beneficiaries without any drug coverage would not qualify. For example, a widow with $19,000 in income would not qualify for assistance for coverage. Nor would millions more beneficiaries who have expensive and/or extremely poor coverage.

- **Raises the age eligibility to 67 for Medicare, increasing the number of uninsured**: The most rapidly growing group of the uninsured is aged 55 to 65. Raising the Medicare eligibility age without a policy alternative would exacerbate the problem of the uninsured.

- **Includes an unlimited home health and nursing home copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits – without any limits. The more than 1 million beneficiaries who need more than 60 visits per year – who tend to be older, sicker and widows – could pay more than $300. In addition, beneficiaries would pay about $60 per day for the first 20 days of nursing home care which, for those without supplemental coverage, could be a real burden.

- **Calls for continuation of Balanced Budget Act cuts for hospital, nursing home, and other providers:** Breaux-Thomas proposes to extend virtually every cut included in BBA.

- **Provides no immediate relief from BBA cuts:** Unlike the President's plan, Breaux-Thomas provides for no immediate moderation of the payment reductions in the BBA.

TAB 7.

TOP-TIER QUESTIONS AND ANSWERS ABOUT MEDICARE REFORM

TOP-TIER MEDICARE QUESTIONS AND ANSWERS

PRESCRIPTION DRUG BENEFIT

Q1: How do you respond to critics that charge that a new Medicare drug benefit available to all beneficiaries is not necessary because "two-thirds" of the population already have coverage?

A: **Those who use the argument that "two-thirds" of beneficiaries do not need a Medicare drug option are out of touch and out of date.** The two-thirds number -- inaccurately used by opponents of prescription drug coverage -- does not reflect current facts or trends in coverage of the elderly and disabled of this nation. All one has to do is go to any senior center around the nation to get a sense of the magnitude of this problem.

About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage. Less than one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage. About one-third of Medicare beneficiaries – at least 13 million beneficiaries – have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is expensive and inadequate. About 17 percent have it through Medicare managed care, but plans are severely limiting coverage. The remaining beneficiaries are covered through Medicaid and other public programs.

The limited private coverage that exists is declining and becoming more unaffordable. The number of firms offering retiree health coverage has declined by a staggering 25 percent in just the last four years. Premiums for Medigap prescription drug coverage are extremely expensive and increase with age. The most frequently purchased Medigap policy is typically priced at two to three times the President's option, has a $250 deductible, and limits plan payments to $1,250. Medigap premiums usually increase dramatically with age, just when beneficiaries need the coverage the most and are least likely to have the income to afford it. This is a particular problem for women who make up over 70 percent of those over age 85.

Public coverage is decreasing in value and becoming more unreliable. Nearly three-fifths of all Medicare managed care plans are reporting that they will cap their drug benefits below $1,000 in 2000. In fact, the proportion of plans with $500 or lower benefit caps will increase by 50 percent between 1998 and 2000. Medicaid coverage is meaningful, but is available only for those with the lowest incomes (generally less than about $6,200 for a single elderly person). And, because of "welfare" stigma and other reasons, this program only enrolls 40 percent of the low-income elderly who are eligible.

The President's proposed drug benefit offers all beneficiaries another option. Beneficiaries can choose to take it, choose to keep their current coverage, or choose to remain uncovered. The same critics opposing this proposal are usually the advocates of more health care choices. This benefit is simply a new option.

Q2: How do you respond to opponents' arguments that the proposal represents another step toward socialized medicine and a government takeover?

A: **The proposed drug benefit is purely voluntary. Beneficiaries can choose to take it, to keep their current coverage, or to remain uncovered.** No one can credibly argue this is a government take-over; it is simply another choice for beneficiaries. Since 75 percent of beneficiaries lack reliable, affordable, decent private sector coverage, this option is clearly needed.

Prescription drug coverage is essential to a modern Medicare program. No one designing the Medicare program today would exclude prescription drug coverage. It is as central to health care as hospital care was in 1965. The President's proposal simply provides an option to access this critically necessary benefit.

Those who oppose the President's proposal are making the exact same arguments that opponents of Medicare's creation did over 34 years ago. It is striking how similar the arguments against the new prescription drug option are to the arguments that many Republicans used against the passage of Medicare in the first place. Clearly, Medicare has not led to "socialized medicine."

Q3: Why not just target the benefit to the low-income beneficiaries who really need it?

A: **Over 50 percent of beneficiaries without prescription drug coverage are middle class.** Those who argue we should design a benefit for just the lower income ignore the fact that such an approach would leave out millions of beneficiaries in desperate need of help. Fully 54 percent of all beneficiaries without coverage have incomes over 150 percent of poverty -- over $17,000 a year for couples. And this number does not include the millions of middle-class seniors and Americans with disabilities who have excessively expensive, inadequate and declining drug coverage.

The President's proposal provides special assistance to low-income beneficiaries. Beneficiaries with income below 150 percent of poverty would not pay premiums, and those with income below 135 percent of poverty would not pay coinsurance for prescription drugs.

Ironically, some of the same Republicans who suggest that any drug benefit should be targeted to the poor just supported the House Ways and Means Committee tax deduction provision that provides the greatest assistance to wealthier beneficiaries. Despite their rhetoric of concern about the poor, the House Republicans just passed a bill that allows seniors to take a tax deduction for Medigap premiums. This helps higher income beneficiaries like Ross Perot, but would leave out millions of beneficiaries since over 55 percent of seniors have no tax liability and would be ineligible for this tax break. Indeed, while Republicans feel that the middle class should be denied help on drug coverage, its House plan would give 4 times more in tax relief to the top 1 percent (families making over $340,000) than to the entire bottom 60 percent of taxpayers.

Q4: Why should the Medicare program subsidize a drug benefit for people like Ross Perot?

A: This argument is nothing but a red herring used by those who are opposed to a prescription drug option for the millions of middle-class seniors who need it. People making this argument are seeking to cut off prescription drug assistance at only $12,750 for a single, $17,000 for a couple – leaving the millions in the middle class with no coverage or weak coverage out in the cold. This is the real issue: a debate between those who want to provide an option to all beneficiaries so that middle-class seniors have access to affordable prescription drug coverage and those who believe that seniors making over $17,000 are like Ross Perot and don't need any help.

Moreover, many beneficiaries who are sick -- regardless of income -- cannot access affordable insurance. Premiums in the private Medigap market increase with age and, except when beneficiaries initially turn age 65, are usually medically underwritten. As such, seriously ill patients without coverage today cannot get coverage at virtually any price. In the absence of a new Medicare prescription drug benefit option, we are sentencing too many seniors who have worked hard and played by the rules to a Medigap market that will not provide the coverage that they need.

Q5: How will beneficiaries who already have very good retiree health coverage be affected by this new proposal?

A: Since the new Medicare drug benefit is optional, the less than one-fourth of Medicare beneficiaries who are fortunate enough to have good retiree health coverage can -- and likely will -- keep their current coverage. The prescription drug benefit is simply another choice, but it is an important alternative to even those beneficiaries with retiree coverage. This is because, over the last 4 years, the numbers of firms offering retiree health coverage has declined by 25 percent. Under the President's plan, if a beneficiary chooses to stay in his or her current plan and the firm subsequently drops the coverage, he or she will have the ability to opt for the Medicare option.

Most importantly, the plan provides new financial incentives to firms to keep and increase their commitment to private retiree health coverage. The plan provides firms that are offering prescription drug benefits, which are at least as good as the Medicare option, an estimated $11 billion over 10 years in assistance if they continue or start to offer private health coverage. This policy is designed to slow down the trend of firms dropping their retiree health coverage and to provide incentives for employers not now offering to do so.

Q6: Will this new prescription drug benefit cover Viagra?

A: In general, the private sector contractors who will manage the Medicare drug benefit will be required to cover prescriptions that are determined to be medically necessary, including Viagra. However, as is the case in the Medicaid program and with other private insurers, the private contractors who manage the Medicare benefit could require doctors to get prior authorization before prescribing drugs for which there are documented abuses.

Q7: How do you reconcile a brand new entitlement with the need to constrain the growth of the Medicare program?

A: The prescription drug benefit is not a stand-alone initiative; it is part of a broader reform package that modernizes Medicare, makes it more competitive and efficient, and dedicates part of the surplus to Medicare to keep it solvent until 2027. It is simply not credible to suggest that the Medicare program can be modernized without adding the option for prescription drug coverage. Prescription drugs today are as important as hospital care was when Medicare was created. Having said this, the drug benefit is designed in a way that is affordable to both the program and the beneficiaries it serves.

Q8: Does the prescription drug benefit impose an unfunded mandate on states?

A: The prescription drug benefit both relieves states from their current coverage of very low-income elderly and asks states to share in paying for the premiums and cost sharing for poor elderly, as they do for Medicare Part B premiums and cost sharing. All states currently provide prescription drug coverage to Medicare beneficiaries who also qualify for Medicaid (known as "dual eligibles"). Some states cover prescription drugs for all poor elderly. Since Medicare will take over primary responsibility for drug coverage, the states will receive a windfall that will be used to pay for the prescription drug benefits' premiums and copayments for all poor beneficiaries. The Federal government would pay 100 percent of the cost of drug premiums and copayments for those beneficiaries with income between 100 and 150 percent of poverty.

Q9: Will a prescription drug benefit eventually lead to some form of price control?

A: No. The prescription drug benefit will be administered by contracting with private sector benefit managers just like virtually all private health insurers and employers do. There are no price controls. Pharmacy benefit managers (PBMs) and other entities have developed and successfully employed innovative management tools to offer affordable, high quality, prescription drug coverage. Recognizing that drug therapy holds great promise, the plan does not include price controls that would discourage research and development.

IMPORTANCE OF DEDICATING PART OF THE SURPLUS TO MEDICARE

Q10: Why don't you use structural changes rather than dedicating surplus to extend the life of Medicare?

A: Both structural reforms and new financing are needed to significantly extend the life of Medicare. We need to make Medicare a more competitive and efficient program – but all experts agree that it is impossible to rely only on provider payment reductions to extend the life of the Medicare trust fund for any significant length of time, given the doubling of Medicare enrollment that will occur as the baby boom generation retires. 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 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person. Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. Providers are already concerned that the BBA cuts were excessive, making it highly unlikely that significant additional savings could be achieved.

Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster – it contributes to eliminating public debt entirely by 2015. This would make America debt-free for the first time in the last 160 years.

UNCERTAINTY OF PROJECTED SURPLUS, SAVINGS, AND DRUG COSTS

Q11: What happens if the surplus doesn't materialize?

A: The uncertainty of projections is exactly why the most responsible approach to allocating the surplus is dedicating most of it to meet our existing obligations in Social Security and Medicare. If the surplus turns out to be less than our forecast projects, it will translate into a less significant extension of the trust fund. In contrast, if the surplus is fully spent on a tax cut, the consequence of misestimates means deficits and new taxes.

Q12: How do you respond to the Congressional Budget Office (CBO) testimony that concluded that the Administration underestimated the cost of the prescription drug benefit and overstated the plan's savings?

A: The Administration's economic team and the HCFA Actuary did a thorough and careful analysis in developing a cost estimate for the President's plan. The Medicare Actuary is the same independent and respected career expert who has been cited repeatedly by Republicans in the past for his estimates on the Medicare Trust Fund. The Clinton Administration's health and economic forecasts have been consistently more conservative than actual experience.

PROVIDER REIMBURSEMENT

Q13: How can you propose additional provider savings without restoring some of the excessive savings of the BBA?

A: We are certainly not ignoring the concerns that have been raised by providers in the wake of the implementation of the BBA. At the President's direction, HHS will implement administrative actions that would relieve unnecessary burdens that could undermine the ability of providers to deliver quality services. In addition, the proposal explicitly provides for a $7.5 billion quality assurance fund to help smooth out problems that Congress and the Administration decide, based on objective evidence, have resulted in harm to beneficiaries. Although the reform proposal includes proposals to constrain out-year spending, they are much more moderate than those included in the BBA and those recommended by the Republicans on the Medicare Commission. They do not include any hospital outpatient department savings, disproportionate share hospital payment reductions, nursing home savings, and new home health care provider savings.

Q14: How do you know that $7.5 billion is the right amount for correcting the overreach of the BBA? How should this fund be allocated?

A: The $7.5 billion set aside was designed to be responsive to legitimate provider concerns without opening the door to unsubstantiated complaints. It is based on a serious analysis of a range of provider concerns, but there is no one specific package of provider modifications that is linked to this amount. While there have been a number of concerns raised, we believe it is premature to assign any specific policy or funding amount to any one provider group. We need additional evidence to make informed decisions, and we look forward to working with the Administration in a collaborative and constructive manner.

STRUCTURAL REFORM

Q15: What do you say to those who say that this is about politics not substance?

A: The President's plan represents a serious proposal to strengthening and modernizing both Social Security and Medicare. The surplus provides a golden opportunity for members of both sides of the aisle to contribute to the development of important reforms essential to these important programs. It serves no one's interest – Democrats or Republicans – to ignore challenges facing the program.

Q16: Does this proposal qualify as real, structural reform of Medicare?

A: The proposal represents a bold initiative to strengthen and modernize the Medicare program and prepare it for the challenges of the 21st century. Its inclusion of traditional fee for service reforms, true competition between managed care plans, and savings from providers and beneficiaries alike, a new drug benefit, the elimination of all copayments and deductibles for all preventive services, and an explicit dedication of 15 percent of the surplus to extend the life of the trust fund can be defined as nothing short of comprehensive reform. This has been validated by experts such as Robert Reischauer, former director of the Congressional Budget Office, who says that the President's proposal will "restructure Medicare at its root." (New York Times, July 1, 1999).

Q17: Does your plan suggest that Medicare can be fixed without beneficiaries have to bear any burden?

A: The Medicare reform plan asks all affected parties to contribute to the solution. Both beneficiaries and providers will help offset the costs of the drug benefit through a new clinical lab copayments, indexing the Part B deductible to inflation, and outyear provider savings. The additional costs are financed through savings in the surplus that have been largely achieved through our aggressive efforts to curb waste, fraud and abuse in the program.

Q18: What is the problem with Senator Breaux and Congressman Thomas' proposal?

A: Although the plan outlined by Senator Breaux and Congressman Thomas in March has made an important contribution to the Medicare debate, it has serious flaws that must be addressed, including:

- No dedication of the surplus to strengthen Medicare, passing on the inevitable financing crisis to our children;
- Higher premiums for traditional Medicare in its so-called premium support program, which has the effect of implicitly, financially coercing beneficiaries into managed care;
- A totally inadequate, means-tested prescription drug benefit. More than half of beneficiaries without drug coverage today would not be eligible;
- Raising the age eligibility which would increase the uninsured;
- An unlimited home health and nursing home copay;
- Continuation of the Balanced Budget Act cuts without relief in the early years.

August 5, 1999 (1:50PM)

Sequester Impact of Tax Bill

- If the Conference Agreement on the Republican Tax bill were to be enacted in its present form, it would result in a sequester of mandatory programs in each year beginning in 2000. Mandatory spending would be cut by $2.4 billion in 2000. Beginning in 2002, Medicare would be cut by 4% each year. Mandatory programs subject to a full sequester would be eliminated, including CCC, child support enforcement, social services block grants, immigration support, crop insurance, mineral leasing payments and veterans education and readjustment benefits.

- The costs of the tax bill in 2002 and subsequent years exceed the savings that could be achieved by a sequester of mandatory programs. In 2002, the $28 billion cut in mandatory savings resulting from a sequester would still be $6 billion less than the costs of the tax bill

Medicare

- Medicare spending would be cut by $2 billion in FY 2000 and by $9.2 billion or 4% in FY 2002. Medicare payments to all providers (e.g., hospitals, physicians, home health agencies, skilled nursing facilities) would be reduced proportionally by the sequester.

- Any reduction in current Medicare spending will increase the pressure to "undo" the BBA and increase Medicare spending. It also will make it difficult to garner support for the reforms included in the President's Medicare reform plan, which includes important new initiatives (e.g., the prescription drug benefit) as well as justifiable reductions in spending.

Veterans Readjustment Benefits

- The Readjustment Benefits account provides education benefits and training to more than 450,000 veterans, reservists, and dependents through the Montgomery GI Bill and the Vocational Rehabilitation and Counseling Programs.

- The elimination of Readjustment Benefits in FY 2002 would mean that these veterans, reservists, and dependents would lose entitlement to the education and training programs many were promised (and paid into) when they enlisted. Programs like the GI Bill are the most potent recruitment and retention tools the military services have. Further, service members transitioning to civilian life would no longer be afforded re-training through college programs, work-study, or on-the-job training.

- If eliminated, the Vocational Rehabilitation and Counseling program, which helps 50,000 disabled veterans overcome employment handicaps sustained on active duty, would no longer assist veterans in finding jobs and becoming productive members of society again.

CCC Farm Programs and Crop Insurance

- The Senate has just passed a bill that provides over $7 billion in FY 2000 emergency assistance to the Nation's farmers and ranchers, to help them through these times of nationwide low commodity prices and regional droughts that are withering crops and livestock. Simultaneously, this bill would cut assistance to farmers funded through the Commodity Credit Corporation, through a small FY 2000 sequester, at a time when many farmers are hurting.

- The effect on farm programs in the outyears starting in FY 2002 would be catastrophic, and cause thousands of farmers and ranchers to go out of business. Farm income and price support programs would be devastated, and if today's commodity prices were to continue into the outyears, the "family farm" would become a historic relic. In addition, with U.S. agriculture heavily dependent on exports, such an outyear sequester would end USDA's export credit programs that guarantee billions of dollars of farm exports a year.

- Starting in FY 2002, the Agriculture Department's crop insurance program would shut down, and without insurance most farmers and ranchers could not secure the financing from banks needed to operate their farms and ranches.

Student Loans

- Guaranteed and Direct Student Loan Program borrowers would have their origination fees increased by one-half of a percentage point beginning in 2000.

- The average student loan borrower would pay an additional $28 in origination fees.
  A graduate student taking out the maximum $18,500 loan would pay an additional $93 in fees.
  A college junior or senior taking out the maximum $10,500 loan would pay an additional $53 in fees.

- Over 5.5 million beneficiaries would be affected.

Child Support Enforcement

- New Federal funding for Child Support Enforcement would be eliminated beginning in 2002 and many States would no longer be able to continue this critical program. In FY 1998 this program collected $14.3 billion on behalf of children and families, and helped many low-income families move from welfare to work.

Social Services Block Grants (SSBG)

- Beginning in FY 2002, SSBG would be eliminated. SSBG provides funding to States to support a wide range of programs including child protection and child welfare, child care, as well as services focused on the needs of the elderly and handicapped. The inherent flexibility of this grant permits States to best target funds to meet the specific needs in their communities.

Immigration Support

- Mandatory funding for immigration programs pays for the costs administering laws related to admission, exclusion, deportation and naturalization of aliens. These costs are funded principally from fees paid by aliens. Sequestering this entire amount in FY 2002 and subsequent years would bring the immigration services program to a halt, leaving millions of legal aliens stranded in the immigration process and stopping all new immigration actions. This untenable situation would have the further effect of stopping all new fee revenue collections, thereby increasing overall mandatory spending.

Mineral Leasing Act Payments

- The impact of a 100-percent outyear sequester starting in FY 2002 on Mineral Act Leasing payments would be devastating to many States. Under current law, these payments are made by the Interior Department to States as a percentage of Federal receipts received from the leasing and development of mineral resources (oil, gas, coal,) on Federal lands in those States. Most of the payments are made to the western States and to Alaska. The States, in turn, generally use these payments to help finance local elementary and secondary schools. Some of the lowest-income States would have outyear funding to schools substantially reduced as a result of such a large sequester.

PAYGO Sequester Calculation
(Dollar amounts in millions)

	2000	2001	2002	2003	2004
PAYGO Net Deficit Increase	2,388	245	34,531	51,935	61,700
Excess above total PAYGO sequester baseline	0	0	6,332	23,410	32,193
Sequester amount (constrained to baseline)	**2,388**	**245**	**28,199**	**28,525**	**29,507**
Programmatic Sequester Amounts:					
Special rules:					
ASI	24	38	39	40	41
GSL and Foster Care	180	191	203	215	228
Medicare	1,981	15	9,247	9,993	10,567
All other (across-the-board sequester):					
CCC	76	0	5,047	4,309	4,327
Child Support Enforcement	12	0	3,148	3,381	3,649
Social Services Block Grants	22	0	1,441	1,435	1,435
Immigration Support	14	0	1,319	1,319	1,319
Crop Insurance	14	0	1,642	1,708	1,786
Mineral leasing Act payments	6	0	630	644	656
Veterans Educ & Readj. Benefits	8	0	1,041	1,039	1,057
All other	50	0	4,443	4,443	4,443
Total, across-the-board seq. amounts	203	1	18,711	18,278	18,671
Sequester total	2,388	245	28,199	28,525	29,507

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