

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. draft	re: Call to Senator Breaux (3 pages)	03/01/1999	P5

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Devorah Adler
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FOLDER TITLE:

Medicare Commission [Folder 4]

2012-0463-S

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RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
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- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

THE GREEN SHEET

News About the U.S. Department of Health and Human Services

Vol. 46 No. 42

Thursday, March 4, 1999

N.Y. Times; 3-4-99 p. 1

Court Says Schools Must Pay For Needs of Disabled Pupils

By LINDA GREENHOUSE

WASHINGTON, March 3 — Students with disabilities who require special care during the school day are entitled to that care at public expense, the Supreme Court ruled today, as long as the services can be provided by someone other than a doctor.

The 7-to-2 decision upheld lower court rulings that required an Iowa school district to provide a trained aide to monitor the needs of a quadriplegic boy who was dependent on a ventilator.

It was a substantial victory for families of children with disabilities, who have become increasingly assertive about their rights under Federal law and who in many cases have met resistance from school districts burdened by the mounting costs of special education.

Without someone available at all times, the boy, a bright student who was injured in a childhood accident, would not have been able to attend school. The question was whether the parents had to pay for the full-time aide or whether the school district had that obligation under a Federal law, the Individuals with Disabilities Education Act, which guarantees a "free appropriate public education" to students with disabilities. The law provides that in addition to special education, school districts must pay for "related services" but need not pay for "medical services."

In ruling for the family, the Court adhered to its view in a 1984 case that as long as a student's physical needs can be met by someone who is not a doctor, the required services do not fall within the excluded "medical services" category.

"A rule that limits the medical services exemption to physician services is unquestionably a reasonable and generally workable interpretation of the statute," Justice John Paul Stevens said in the majority opinion today.

The Cedar Rapids Community School District had argued that the question should be not whether a doctor or someone else provided the services, but rather how complex, continuous and expensive the services were, a "multifactor test" requiring a detailed analysis of each case. But "the district's multifactor test is not supported by any recognized source of legal authority," Justice Stevens said, adding, "The district may have legitimate financial concerns, but our role in this dispute is to interpret existing law."

Although the district argued that the cost would be over \$20,000 a year, the majority opinion disputed this, noting that the boy, Garret Frey, was

already entitled to an aide who turned pages for him and kept his desk in order. The district could hire an aide who could both perform those tasks and be trained to attend to the ventilator and other physical needs, Justice Stevens said.

See DISABLED, p. 18

Balt. Sun; 3-4-99 p. 1

Sparks fly over Medicare reform

Clinton assails GOP, is himself criticized

By JONATHAN WEISMAN
SUN NATIONAL STAFF

WASHINGTON — President Clinton used a Democratic pep rally on Capitol Hill yesterday to assail Republicans for failing to embrace his call to save 15 percent of the federal budget surplus to shore up the ailing Medicare program.

Clinton's failure to embrace specific structural reforms for Medicare is garnering criticism, too, not only from Republicans but from some moderate Democrats.

Those critics contend that drastic reform is the only way to maintain the expensive federal health care program for the elderly. They would force the existing fee-for-service Medicare program to compete with private insurers for Medicare patients, hoping that market forces would hold down costs.

The president hinted yesterday that he could accept such changes in a 1980s-era program that, if untouched, could go broke in 10 years.

See MEDICARE, p. 15

USA Today; 3-4-99 p. 1

Collegians lighting up Universities trying to extinguish smoking trend



By Tom Ichniowski USA TODAY

University of Maryland: Stacy Schwartz and Adam Chernoff at the student union.

Smoke-free zones spreading across nation's campuses

By Aaron Davis and Bree Fowler
USA TODAY

It's a fact of life on the nation's college campuses: the harder administrators try to discourage students from smoking, the more students smoke.

Today, more students are lighting up than at any time in the past two decades despite increasingly stringent attempts to stop them, from bans on smoking

in classroom buildings to a growing trend toward smoke-free dorms and apartments.

But even a casual stroll across just about any campus provides visual documentation of a recent study by Harvard University, which found that 28% more college students smoke than just six years ago.

Smoking students can be seen everywhere outside the halls of academe, standing on heating grates at the University of Wisconsin, lounging outside the communications building at the University of Texas and turning cigarettes into an accessory of coffee, fast food, binge drinking and late-night studying.

"Regardless of student type, college size or location," says Henry Wechsler, an author of the Harvard study, "wherever you look there has been an increase" in student smoking.

All told, nearly 30% of all college students, or



By Andy Meehan USA TODAY

Smoking bans on the way: Catherine Shuts at the University of Wisconsin at Madison

roughly 4 million students, smoke cigarettes, the Harvard study found. The rate troubles researchers because it means that, for the first time, smoking rates among college students — traditionally a cigarette-resistant group — are nearing smoking rates of young people who do not attend college.

College officials are taking notice. Fueled by a surge in student and parent complaints, colleges and universities across the country are rewriting smoking policies that have stood for decades.

The latest battleground has moved from class-

See SMOKE-FREE, p. 12

Clinton hands out, receives Medicare criticism

MEDICARE, from p. 1

But he stuck to his insistence that he could accept no proposal that did not reserve 18 percent of the surplus — or up to \$700 billion over 18 years — for Medicare. That provision would extend the solvency of Medicare's hospital fund until 2030, the White House says.

"I'm not opposed to responsible reforms that enable us to secure Medicare for an even longer period," Clinton told cheering Democratic lawmakers. "But I am telling you that we cannot deal with the Medicare problem without a greater investment of money."

That was far short of what Republicans and some Democrats on the national Medicare reform commission had hoped for. Sen. Bob Kerrey of Nebraska, a Democrat on the commission, expressed doubt about Clinton's contention that paying down the debt with 18 percent of the surplus would stave off Medicare's short-term insolvency crisis.

"What the president is doing with Social Security and Medicare is politically satisfying," Kerrey said, "but it is financially inadequate."

Deborah Steelman, a Washington lawyer who was appointed to the commission by Senate Majority Leader Trent Lott, urged the president to allow private insurers to compete with Medicare rather than throw money at a program whose costs might soon spiral out of control.

"What we have from the White House is all kinds of statements from the briefing room, like, 'I look forward to the report of the commission,' as if they're not involved," Steelman said. "This is not leadership. This is not what is needed."

The White House has made the saving of Social Security and Medicare top issues for the rest of the president's term, suggesting that shoring up the two programs would enhance Clinton's scandal-tarred legacy.

The prospects for Medicare changes have reached a critical juncture. The March 1 deadline for a report from the bipartisan commission, which was appointed to find Medicare solutions, came and went this week. The commission chairman, Sen. John B. Breaux, a Democrat from Louisiana, promised that his panel would complete its work this month.

A Medicare fix has been caught between the hopes for Clinton's legacy and the impulse to help the electoral prospects of congressional Democrats and Vice President Al Gore in 2000. Those Democrats stood loyally by the president throughout the Monica Lewinsky scandal and could be looking for a reward. Gore and congressional Democrats, especially in the House, regard their main concerns as preserving the Democratic hold on the White House and regaining control of Congress.

If Clinton and Congress agree on a long-term solution for the Medicare system, they will have effectively denied Democrats a key political issue in 2000 that is thought to favor Democrats: the safeguarding of Medicare.

"I would assume the president is being properly grateful to the people who rallied around him during the impeachment process, but I also assume he's sensitive to the vice president's prospects," said Will Marshall of the Progressive Policy Institute, a wing of the centrist Democratic Leadership Council, which supports the proposed Medicare reforms.

Asked whether Democratic leaders in Congress were resisting Medicare changes, Kerrey said, "It's not resistance but nervousness. This is a very important issue for Democrats."

Republicans say they detect outright resistance, and they are increasingly blaming the White House for the Medicare stalemate.

To gain the imprimatur of the Medicare commission, the reform plan needs the support of 11 of the 17 members. The proposal — floated by Breaux and Rep. Bill Thomas, a California Republican — has 10 supporters, and none of Clinton's four appointees on the commission has signed on.

"I do think it's interesting that when you look at the 10 votes — Democrats and Republicans, House members and senators, private sector and public sector — not one of them is a presidential appointee," said Thomas, who accuses the White House of keeping its appointees in check. "They stand out like a sore thumb."

Chris Jennings, the president's top health care adviser, responded that Republicans have not tried to address Clinton's desire to reserve part of the surplus for Medicare and to include prescription-drug coverage in any plan. He said Thomas and Breaux were asking commissioners to vote on a framework for Medicare reform without providing any of the details.

The latest iteration does not

include the surplus, a prescription-drug benefit, and there are not enough details," Jennings said. "This is one of those issues where details mean everything."

Thomas maintains there is not enough money for a Medicare prescription-drug benefit, that the surplus cannot help Medicare's long-term problems and that it is Congress' role, not the commission's, to flesh out details of the reform plan.

"If Chris Jennings throws up absolute positions in which there's no way to compromise, then I don't think we can get an agreement," Thomas said.

Breaux says the battle lines are

not as firm as they might seem. Next week Kerrey and two Clinton-appointed commissioners plan to introduce a proposal that would meet many of the White House's demands and could secure the votes needed to give momentum to a Medicare reform plan.

Yesterday, Breaux met with Clinton, riding in his limousine from the Library of Congress to the White House to discuss the latest proposals.

The president is "doing exactly what he ought to be doing, waiting for the commission to give him a report," Breaux said. "In the end, I think he'll be there for us."

Drug Benefits in Medicare

As a bipartisan commission wrestles with restructuring Medicare financing for the next century, it needs to modernize Medicare's benefits. That means adding a prescription drug benefit to the program. Liberal Democrats in Congress and on the commission consider a drug benefit crucial to Medicare reform. But Republicans are worried that expanding coverage to drugs could add upward of \$20 billion a year in costs to a program already headed for insolvency.

The political reality is that neither camp can achieve what it wants without the other. The commission is considering a plan drafted by Senator John Breaux, the group's chairman, that would replace the existing Medicare system with a market of private and government-run health plans. The hope is that competition will help control growth in Medicare costs over time. But radical restructuring will be a hard sell politically without adding drug coverage. Conversely, it is unlikely that the Federal Government can afford to cover drugs without making substantial changes to traditional Medicare, including injecting more managed care into the system.

The commission, which was supposed to produce final recommendations for Congress next Monday, is now expected to work past that date. Two swing votes on the commission, Stuart Altman, a professor at Brandeis University, and Laura

D'Andrea Tyson, the former chief economic adviser to President Clinton, have both said they cannot support the restructuring plan without a new drug benefit. They have good reason.

Prescription drugs are more important therapeutically than ever. New drugs can save money overall by keeping patients out of the hospital. When Medicare was created in the 1960's, prescription drug coverage was not a standard feature of private insurance policies. Now most employer-based health plans provide drug coverage because drugs have become an integral part of modern health care. Medicare has never caught up.

More than a third of Medicare beneficiaries have to pay for all drugs themselves. The rest have drug benefits through plans provided by former employers, Medigap plans they buy themselves, or through Medicaid. But employer-paid plans are becoming more rare, and Medigap plans that cover drugs are too costly for many low-income retirees to afford.

It is not uncommon for elderly patients to pay thousands of dollars a year for drugs. Many simply go without. That situation needs to change. The debate over the future of Medicare has focused on ways to control costs and shore up the finances. Equally important is revamping benefits to reflect the prescription drug needs of the elderly population.

Bringing the Dogs to Heel

When it comes to passion, few groups can compete with the animal lobby. Members of the New York City Council still shudder at the memory of the travails they went through over the rights of carriage horses. Given that history, the Giuliani administration deserves a bravery medal for its attempts to enforce the leash law and restrict due-process rights for dogs that bite people.

Parks Commissioner Henry Stern announced this week that he was increasing fines for dogs caught romping off their leashes and is stepping up enforcement of dog-control laws in Central Park and Riverside Park. The initiative will be popular with bicyclists, parents of small children and joggers who have been harassed by over-friendly (or under-friendly) dogs, and a relief to park preservationists who say the damage caused by unrestrained pets is their worst maintenance problem. This outrages some dog owners, who say that human beings cause far more damage in the parks, and that their pets are being deprived of their natural right to run free.

Doggie rights are also an issue in the Giuliani administration's attempt to streamline the process for destroying vicious dogs. The Mayor has proposed a bill that would put the burden of proof on a dog's owner to show there were extenuating circumstances when a pet takes a chunk out of another city resident. Right now, even if a veterinarian finds the dog is dangerous, it can be put down only if the city can demonstrate that the attack was unprovoked.

As a result, animals linger on the canine equivalent of death row for months, taking space needed for other animals.

Both these initiatives seem reasonable. Pets are important, but people must come first. Dogs that bite have no place in a crowded city. Neither do dogs that are so large or hyperactive that they cannot adjust to life on a leash. Owners have an obligation to keep their dogs licensed and under control. If they fail to follow those rules, they have no right to complain if they are ticketed. If a dog attacks someone while roaming on its own, the owner will have only himself to blame if the animal is put away.

These rules exist to protect other animals as well as people. Smaller dogs are the most frequent targets of unleashed dogs in the parks, and hundreds of homeless dogs that have not bitten anyone have to be killed every week because there is no room in the shelters. Given scarce resources, we would keep as much space as possible for the animals without a prior record.

We also recommend that the Mayor get behind a bill proposed by Councilwoman Kathryn Freed that would raise license fees for unspayed dogs and encourage the establishment of low-cost spaying and neutering clinics. Ms. Freed contends that the vast majority of dog bites are the work of unneutered males, and her measure could reduce unwanted strays in the city, as well as the number of dogs with an urge for nipping.

Sheinbein Can't Be Extradited

He's a Citizen of Israel,
Its Supreme Court Says

By LAURA BLOOMFIELD
and KATHERINE SULLIVAN
Washington Post Staff Writers

Israel's Supreme Court ruled yesterday that Samuel Sheinbein, charged with killing, dismembering and burning another Montgomery County teenager in September 1997, is a citizen of Israel and cannot be extradited to the United States.

Sheinbein, 18, who never lived in Israel but whose family sent him there three days after Alfredo Enrique Tello Jr.'s mutilated and charred torso was found, remains in custody, and Israeli officials said he will be indicted there within days on a murder charge.

The court's ruling disappointed U.S. officials and created a furor among some Israelis, who said the country should not provide a haven for murderers. Tello's mother, Eliette Ramos, speaking publicly for the first time since the death of her son, 19, denounced the court's decision as "ridiculous."

Montgomery County State's Attorney Douglas Gansler said Sheinbein's "guilt or innocence should be adjudicated here."

"He should be held accountable here," Gansler said. "Our view is that Mr. Sheinbein does not fit within [Israel's extradition] law. He shouldn't be able to hide himself under the law."

Attorney General Janet Reno, who had fought for Sheinbein's return, said, "We're disappointed with the response, but at the same time, we're going to be dedicated to doing everything we can to work with the local prosecutor and with Israeli authorities, if the case is tried there, to see that justice is done."



Samuel Sheinbein, front left, under guard in Israel's Supreme Court, smiled after the decision was announced. No trial date has been set.

Sheinbein claimed citizenship through his father, who was born in British-ruled Palestine before Israel became a country. Under a 1978 law, no Israeli citizen may be extradited.

A State Department official said the department recognized that the decision was made within a responsible judicial system, but added that U.S. officials might recommend that Israel consider amending its extradition law.

In its 3 to 2 decision, the court reversed the ruling last fall by a lower court and held that Samuel Sheinbein enjoys all the protections of citizenship despite his tenuous ties to Israel. The lower court in effect had sought to create a new level of Israeli citizenship by saying he was technically a citizen but could not be accorded all its protections and therefore could be extradited.

It was clear, however, that even the justices in the majority were not happy with their ruling. "One can wonder if there is any justification for protecting someone from extradition when that person is not a resident



Montgomery State's Attorney Douglas Gansler, left, talks to reporters while Eliette Ramos, mother of the man Sheinbein is accused of killing, is comforted by a friend, Eric Dawes. Story, Page A5.

See SHEINBEIN, A1, C4, 1

NRA Pushing To Block Gun Suits

Bills in 10 States
Would Bar Action
By Local Officials

By SHARON WALSH
Washington Post Staff Writer

NEW YORK, Feb. 25—Moving swiftly, the National Rifle Association has succeeded in getting legislative underways in at least 10 states that would preclude local governments from suing gun manufacturers and distributors. The latest bill, passed earlier this week in Florida, is the toughest so far, making it a felony for any local official to file such a lawsuit.

The Florida bill, expected to advance rapidly, would make it a crime punishable by up to five years in jail and a \$5,000 fine for any local government official or employee to file suit against gunmakers. The bill includes a retroactive provision that would quash a suit filed by Miami-Dade County in January that seeks to hold gunmakers liable for what the city spends on police and county hospital services because of gun violence. It would also prevent suits from at least two other Florida cities, Tampa and St. Petersburg, that are considering taking gun manufacturers to court.

"We are responsible for the Florida legislation," said James J. Baker, chief lobbyist for the NRA, which has joined hands with the gun industry to fight the lawsuits. "The point is to try to get rid of the suits that have been filed and to target as many as 25 or 30 states where local officials are overreaching, suing, or suing."

"We think this is an outrageous attempt to prevent Miami-Dade from asserting the legal rights of its citizens," said Dennis Henigan, legal director of the Center to Prevent Handgun Violence, a nonprofit organization that is helping Miami in its lawsuit. "We allow ordinary citizens and cities to assert their rights in court. If a suit is frivolous, the court has a right to sanction. ... But we don't threaten people with jail." He said, noting that, technically, the Florida bill could lead to jailing the mayor of Miami.

Guncontrol activists have said

See GUNS, A9, C4, 6

Yeltsin's Absentee Rule Raises Specter of a 'Failed State'

By DAVID HOFFMAN
Washington Post Foreign Service

MOSCOW, Feb. 25—When President Boris Yeltsin arrives in the Kremlin, a Russian tricolor flag is hoisted over the citadel of Russian authority to show he is there at work.

But the flag has not flown much lately. Yeltsin, suffering from a bleeding ulcer, has come to the Kremlin only sporadically. Although he was back at work today, his prolonged absences are contributing to what some prominent analysts believe is a

long slide toward the collapse of central authority in Russia and perhaps the crumbling of Russia as a federation.

Russians have long feared the country would shatter in a violent crack up, ignited by secessionist movements in its diverse regions. But a different model is now gaining currency among political economists who say Russia is in imminent danger of becoming a "failed state," not breaking up into pieces like the Soviet Union did, but simply ceasing to function as a cohesive federal government.

Many experts and Russian politicians say

the debasement of Moscow's authority—possibly leading to a long stagnation and drift in which no one rules—threatens to bring its own special dangers, opening the doors to even more corruption and lawlessness, weapons proliferation, health hazards and environmental pollution.

If Russia becomes a failed state, the risks are that individual regions and parts of Russian society will essentially go their own way—making it difficult, for example, for Russia to control factories making missile parts, or to reign in such problems as disease or massive piracy of intellectual property.

Prime Minister Yevgeny Primakov has become so concerned about the ebbing power of the central government that he suggested recently that Russia should scrap direct election of governors by voters, one of the major gains of the country's young democracy. Instead, Primakov proposed that regional chieftains answer directly to the Kremlin, as they did in Soviet days—which would require rewriting the constitution. Primakov lamented that the Kremlin's chain of command over the country is "not a

See RUSSIA, A23, C4, 2

'Greaseman' Fired After Protests Over Remark WARW Apologizes for Racist Comment

By FRANK AURENS
Washington Post Staff Writer

Doug Tracht, the radio shock jock known as the "Greaseman," was fired yesterday after a day of widespread protests over a racist remark he made during his Wednesday morning show.

Several of Washington's black-oriented radio stations devoted extensive parts of their morning shows to criticism of Tracht, 48, by both deejays and listeners. And Tracht was fired from his position as a volunteer deputy sheriff in Falls Church after the sheriff there said he had received numerous phone calls.

Shortly after 7 a.m. during the Wednesday show on Classic Rock 94.7 (WARW-FM), Tracht played a portion of a song by Grammy-

winning black hip-hop artist Lauryn Hill and commented, "No wonder people drag them behind trucks," referring to the Jasper, Tex., murder of James Byrd Jr.

Following his program, WARW suspended Tracht without pay. Late yesterday afternoon the station released the following statement:

"After review of Doug Tracht's remarks, we have decided to sever his relationship with WARW, effective immediately. While we will always strongly support the right of our on-air artists to express a wide range of opinions, even those that are unpopular or offensive to some, WARW cannot be associated with the trivialization of an unspeakable act of violence now at

See TRACHT, A10, C4, 1



Death Penalty in Racial Murder

James Byrd Sr. and granddaughter Renee Mullins listen as John William King, convicted in the beating and dragging death of James Byrd Jr., is sentenced to death by lethal injection in Texas. Story on Page A3.

Livingston Bids House Conciliatory Farewell

Almost-Speaker Pleads for Moderation

By JULIET EILPERIN
Washington Post Staff Writer

Rep. Bob Livingston (R-La.), largely silent in the two months since he shocked his colleagues by announcing plans to resign rather than stand for House speaker, emerged yesterday to make a final plea for moderation and consensus as he ended his 21-year legislative career.

"Politician is not a dirty word, and compromise is the glue that renders democracy possible," Livingston said in his valedictory address on the House floor.

"To my friends on the left, government left unwatched can lead to injustice. To my friends on the right, government is not inherently evil."

Livingston's conciliatory ad-

dress seemed to capture the mood of a Congress struggling to move past impeachment and forge at least some meaningful legislative compromises. His words also were strikingly bereft of the bitterness one might expect from this casualty of the impeachment process: Livingston resigned the same day the House impeached President Clinton in December, after admitting he had himself engaged in extramarital affairs.

Indeed, in an interview late yesterday, Livingston offered no regrets about his brief and tumultuous tenure as would-be successor to former House Speaker Newt Gingrich (R-Ga.).

"I really haven't let myself dwell on any of this stuff," he said. "I've

See LIVINGSTON, A12, C4, 1



Boston College teacher Mary Daly

Feminist Ethics Course: No Place for Men Boston College Teacher Chooses Leave Over a Coed Class

By PAMELA FERNANDEZ
Special to the Washington Post

BOSTON, Feb. 26—Putting her career on the line, a renowned feminist philosopher at Boston College is refusing to accept two male students for a course called "Introduction to Feminist Ethics."

Mary Daly, a 70-year-old tenured associate professor and self-described radical, contends the

distraction and disruptive to female students engaged in emotional and intellectual feminist debates. In the revolutionary spirit of the 1960s, when she began teaching at the Jesuit college, Daly refused to back down, opting for a leave of absence in the face of an ultimatum from the administration: Teach men along with women or stop teaching.

"Boston College has remained

right-wing pressure and depriving me of my right to teach freely and depriving them of the opportunity to study with me," she said today in a telephone interview. "I choose to stand my ground."

A pioneer in the field of feminist theology and philosophy, Daly has written seven books, all of them used as texts in universities. They range from "The Church and the

China Pursuing Missile Advantage

China is building up ballistic and cruise missile forces that will give it an "overwhelming advantage" over Taiwan by 2005, according to a Pentagon report to Congress. **WORLD, Page A20**

Free at Last

South Korea grants amnesty to a 69-year-old man believed to have been the world's longest serving political prisoner. **WORLD, Page A19**



The Post on the Internet:

DRAFT: REVIEW OF COMMISSION PROPOSALS

March 5, 1999

1. Any answers to yesterday's unresolved questions?
2. Structure of discussion / presentation; policy options and principles
 - Base package: What it is, any outstanding issues
 - Drug coverage
 - Income-related premium
 - Premium support

DRAFT

INCOME-RELATED PREMIUM

- HSA: (-\$16 billion over 5 years; -\$42 billion over 10 years)

Single beneficiaries: Begin increase at \$90,000 with full payment at \$100,000

Couples: Begin increase at \$115,000 with full payment at \$125,000

Percent of the elderly affected: 5% (about 2 million)

- BBA: (-\$18 billion over 5 years; -\$47 billion over 10 years)

Single beneficiaries: Begin increase at \$60,000 with full payment at \$110,000

Couples: Begin increase at \$90,000 with full payment at \$150,000

Percent of the beneficiaries affected: 8% (about 3 million)

- Chafee-Breaux: (-\$23 billion over 5 years; -\$58 billion over 10 years)

Single beneficiaries: Begin increase at \$50,000 with full payment at \$100,000

Couples: Begin increase at \$75,000 with full payment at \$150,000

Percent of the beneficiaries affected: 11% (about 4 million)

- Breaux plan: (-\$38 billion over 5 years; -\$95 billion over 10 years)

Single beneficiaries: Begin increase at \$24,000 with full payment at \$40,000

Couples: Begin increase at \$30,000 with full payment at \$50,000

Percent of the beneficiaries affected: 33% (about 13 million)

For subsequent years, the starting point would be indexed to general inflation and the subsidy would be phased down at the same rate as in the first year.

Issues:

- Income thresholds (start and end points, phase-out schedule)
- Administrative issues (e.g., IRS v SSA/HCFA)

Draft / Preliminary: DRUG ESTIMATES: UNCAPPED BENEFITS

(Calendar Years, Dollars in billions, 2000-04 / 2000-09)

	DEDUCTIBLE		Difference
	\$500	\$250	
COINSURANCE *			
25%	61 / 186	71 / 214	\$10 / 28 billion
50%	47 / 148	na	na
Difference	\$14 / 38 billion		
STOP-LOSS **			
\$2,000	61 / 186	71 / 214	\$10 / 28 billion
None	58 / 176	69 / 205	\$11 / 29 billion
Difference	\$3 / 10 billion	\$2 / 9 billion	

* Assuming \$2,000 stop-loss

** Assuming 25% coinsurance

Draft / Preliminary: DRUG ESTIMATES: CAPPED BENEFITS
 (Calendar Years, Dollars in billions, 2000-04 / 2000-09)

CAP ON BENEFIT	DEDUCTIBLE		Difference
	\$500	\$250	
\$1,500 *	na	43 / 120	na
\$1,250	29 / 85 **	39 / 106 *	\$10 / 21
Difference	na	\$4 / 14 billion	
\$1,250	29 / 85 **	39 / 106 *	\$10 / 21
\$1,000 **	na	29 / 87	
Difference	na	\$10 / 18 billion	

* \$7 copay for generics, \$15 copay for brand-name

** 10 percent coinsurance

Medicare Drug Benefit

Health Financing Branch

February 19, 1999

Medicare Beneficiaries Lack Drug Coverage and Consistency

- 35 percent of Medicare beneficiaries have no drug coverage
- Medicare does not provide coverage for fee-for-service beneficiaries
- Coverage is a function of supplemental insurance or managed care
- Absent Medicaid and Managed Care, there appears to be a relationship between coverage and income

Chart 1: Distribution of Medicare Beneficiaries, By Type of Supplemental Insurance and Presence of Drug Coverage, 1995

Type of Coverage	Percent Enrolled	Percent With Drug Coverage	Percent Without Drug Coverage
All Persons	100%	65%	35%
No Supplemental Coverage	8%	0%	100%
Supplemental Coverage	92%	71%	29%
Medicare HMO	7%	95%	4%
Medicaid	12%	90%	10%
Employer-sponsored	33%	86%	14%
Individually-purchased (Medigap)	29%	36%	64%
All other	3%	79%	20%
Switched coverage during the year	8%	80%	20%

Source: HCFA analysis of data from the Medicare Current Beneficiary Survey, 1995

Notes: Drug coverage includes primary and secondary coverage;

Columns may not add due to rounding; Other coverage includes other public programs including VA, DoD, and State Assistance Plans

Chart 2: Distribution of Medicare Beneficiaries, By Income Status And Presence of Drug Coverage, 1995

Income	Distribution	With Drug Coverage	Without Drug Coverage
All Persons	100%	65%	35%
Less than \$5,000	5%	63%	37%
\$5,001-10,000	25%	63%	37%
\$10,001-15,000	18%	59%	41%
\$15,001-20,000	14%	62%	38%
\$20,001-25,000	12%	68%	32%
\$25,001-30,000	8%	69%	31%
\$30,001-35,000	5%	74%	26%
\$35,001-40,000	4%	67%	33%
\$40,001-50,000	5%	77%	23%
Greater than \$50,000	6%	73%	27%

Source: HCFA analysis of data from the Medicare Current Beneficiary Survey, 1995

Chart 3: Average Prescriptions Per Person and Average Out-of-Pocket Expenditures Per Person by Type of Supplementary Insurance and Presence of Drug Coverage, 1995

Type of Coverage	Average Number of Prescriptions		Average Out-of-pocket Expend.	
	With Drug Coverage	Without Drug Coverage	With Drug Coverage	Without Drug Coverage
All Persons	20.3	15.3	\$ 232	\$ 432
No Supplemental Coverage	-	12.7	-	352
Supplemental Coverage	20.3	15.5	232	439
Medicare HMO	16.2	5.1	162	125
Medicaid	27.0	12.9	135	284
Employer-sponsored	18.6	16.9	224	484
Individually-purchased (Medigap)	19.8	16.8	361	480
All other	20.9	13.4	249	385
Switched coverage during the year	20.6	11.6	297	331

Source: HCFA analysis of data from the Medicare Current Beneficiary Survey, 1995

Notes: Drug coverage includes primary and secondary coverage;

Other coverage includes other public programs including VA, DoD, and State Assistance Plans

Additional Reasons for Deterioration of Coverage

- Medicare + Choice plans dropping out of Medicare decreases coverage
- Percentage of M+C plans offering drug coverage decreased from 1997 to 1998
- Anecdotal evidence that M+C plans are limiting benefit and implementing three-tiered cost-sharing

While 65% of Medicare Beneficiaries Have Drug Coverage, It Varies Across Different Supplemental Plans

Supplemental Plan Type (Typical Plan)	Deductible	Copayment	Out-of-Pocket Limit	Benefit Limit	Annual Premium
Employer-Sponsored	\$300 (For All Services)	\$5 (Generic) \$10-\$15 (Brand Name)	\$1,750	None.	\$1,910 (\$159 per month)
Individual Medigap	\$250 (Drugs Only)	50 Percent (for drugs only)	None	\$1,250 or \$3,000	\$2,300 (\$192 per month)
Medicare Risk HMO	Most plans have no deductible.	Varies, usually lower than Medigap plans.	Generally none.	Capped for 60% of enrollees (most commonly at \$1,000.)	Varies, but most plans have \$0 premiums.
Medicaid	Nominal (e.g. \$2 a month) at State Option.	Nominal (e.g. \$0.50 to \$3 per prescription) at State Option.	NA	States may limit # of prescriptions & refills and not cover certain classes of drugs (e.g. cosmetic drugs, smoking cessation).	None.

Other Components Differ from Plan to Plan

- Use of formularies
 - open, closed, managed, incentive-based
- Use of Drug Utilization Review
 - prospective, retrospective
- Use of Generic Substitution
- Disease Management
- Prior Authorization

Drug Benefit Design Involves Several Issues

- Possible Benefit Structures (Maximum out-of-pocket versus Maximum benefit)
- Variations in Cost-Sharing (copays, deductibles)
- Options for the Administration of the benefit (HCFA, Private)
- Possible Financing Mechanisms (Trust Fund, Capped Entitlement)
- Targeted Population (low-income, managed care)

Cost of a Benefit Would be High

- Cost Estimates
- Possible Savings to Medicare
 - Savings from better clinical management
- Possible Costs to Medicare
 - Increased Utilization
 - Crowd out
 - Extension of Life (?)

Current Working Model

- All beneficiaries eligible
- \$250 Deductible
- 20% Coinsurance
- \$1,000 Maximum out-of-pocket
- 50% Beneficiary premium
- No maximum benefit
- **Cost: \$92 Billion over five years**

Decreasing or Increasing Cost

- Lower range cost estimates limit coverage of limited populations
 - \$15 billion over 5 years for a low-income only benefit
- Higher range cost estimates have lower premiums and deductibles
 - \$139 billion over 5 years for a benefit with a 50% premium and a \$50 deductible

**The National
Bipartisan
Commission on the
Future of Medicare
Ph: 202-252-3380
Fax: 202-252-3397**

Fax

To: Medicare Commission Members

From: Bobby Jindal

Attn:

Pages: 3 , including the cover sheet

CC:

Date: February 26, 1999

Re:

CC:

☐ **Urgent**

☐ **For Review**

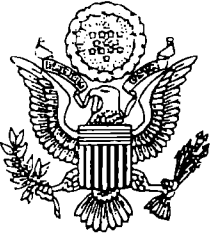
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• **Comments:**

For your information, we are transmitting copies of the letters sent on behalf of the Commission to the President and the Speaker of the House.



The National Bipartisan Commission on the Future of Medicare

February 26, 1999

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Hon. Bill Thomas
Administrative Chairman

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Bruce Vladeck, Ph.D.
Anthony L. Watson

Executive Director

Bobby Jindal

The Honorable William Jefferson Clinton
President of the United States
The White House
Washington, DC

Dear Mr. President:

We are aware that Section 4021 of the Balanced Budget Act of 1997, which created this Commission, directed it to report its recommendations to you on March 1, 1999. The issues the Commission was directed to consider are complex, difficult, and of great importance to every American – Medicare beneficiaries, future beneficiaries, and taxpayers.

We are pleased to report that after a year of intensive work and wide-ranging analysis, the Commission is in the final stages of its deliberations, and we are optimistic that we will be able to submit our recommendations shortly after March 1. We do not anticipate a need to extend the life of the Commission beyond its termination date of March 31, 1999.

Respectfully submitted,

John B. Breaux
Statutory Chairman

William M. Thomas
Administrative Chairman



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Bobby Jindal

The Honorable J. Dennis Hastert
The Speaker of the House of Representatives
H-232, The Capitol
Washington, DC 20515

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FAX COVER SHEETTO: Jeanne LambrewDATE & TIME: Friday 2/26FAX #: 202-456-7431PHONE #: 202-456-5377FROM: Steve Soumerai# OF PAGES FOLLOWING COVER SHEET: 19**COMMENTS:**

Jeanne,

Be sure to look at
graphs (figures) at very end of
packet and match them up to
"slide #'s" in testimony.

Great talking to you!
Tell us how we can be most helpful
in achieving something this year. SS

**ECONOMIC AND CLINICAL EFFECTS OF CHANGES IN DRUG COVERAGE
AMONG POOR, CHRONICALLY ILL PATIENTS**

**STATEMENT BEFORE THE JOINT MEETING OF THE HEALTH AND HUMAN
SERVICES COMMITTEE AND APPROPRIATIONS AND FINANCIAL AFFAIRS
COMMITTEE OF THE MAINE STATE LEGISLATURE**

MARCH 9, 1998

STEPHEN B. SOUMERAL, ScD

ASSOCIATE PROFESSOR OF AMBULATORY CARE AND PREVENTION

DIRECTOR, DRUG POLICY RESEARCH GROUP

HARVARD MEDICAL SCHOOL AND HARVARD PILGRIM HEALTH CARE, BOSTON

I AM PLEASED TO BE HERE ON THIS IMPORTANT OCCASION TO GIVE SOME RELEVANT HIGHLIGHTS OF 15 YEARS OF RESEARCH ON BOTH THE POSITIVE AND NEGATIVE ECONOMIC AND HEALTH EFFECTS OF CHANGES IN DRUG COVERAGE AMONG LOW-INCOME PATIENTS.

(SLIDE ONE)

I WILL FOCUS ON SEVERAL STUDIES OF THE IMPACTS OF TWO SUCCESSIVE POLICY CHANGES AFFECTING LOW INCOME PATIENTS ENROLLED IN THE NEW HAMPSHIRE MEDICAID PROGRAM -- FIRST, A CHANGE FROM FULL COVERAGE WITHOUT COPAYMENTS TO A THREE-PRESCRIPTION PER MONTH COVERAGE LIMIT (CAP); THEN, AFTER 11 MONTHS, REPLACEMENT OF THE CAP WITH FULL DRUG COVERAGE, EXCEPT FOR A \$1 PER PRESCRIPTION COPAYMENT. THUS, A NATURAL EXPERIMENT PROVIDED US WITH AN OPPORTUNITY TO STUDY THE IMPACTS OF BOTH REDUCING AND INCREASING DRUG COVERAGE IN LOW-INCOME PATIENTS, PROVIDING IMPORTANT DATA FOR CONSIDERATION IN CRAFTING THE PROPOSED MAINE LEGISLATION.

THESE STUDIES WERE PUBLISHED AS THREE CONSECUTIVE REPORTS IN *THE NEW ENGLAND JOURNAL OF MEDICINE* FROM 1987 TO 1994. THE FIRST PAPER REPORTS THE EFFECTS ON ACCESS TO ESSENTIAL AND NON-ESSENTIAL MEDICATIONS AMONG ALL MEDICAID ENROLLEES. THE SECOND AND THIRD STUDIES DESCRIBE THE EFFECTS OF THE DRUG BENEFIT LIMITS ON CHRONICALLY ILL ELDERLY AND PATIENTS WITH SCHIZOPHRENIA. (I HAVE REPRINTS OF THESE PAPERS AVAILABLE

FOR THOSE WHO ARE INTERESTED IN MORE DETAILS OF THESE STUDIES.)

SEE ATTACHED ABSTRACTS

(SLIDE TWO)

BEFORE WE BEGAN OUR STUDIES, WE ALREADY KNEW THAT INCREASED DRUG COST-SHARING REDUCES DRUG USE AND, CONVERSELY, THAT REDUCED DRUG CHARGES INCREASE MEDICATION USE, PARTICULARLY AMONG LOW-INCOME PATIENTS. HOWEVER, THERE WERE VIRTUALLY NO DATA ON THE EFFECTS OF LARGE CHANGES IN DRUG BENEFITS ON:

- ◆ POOR, CHRONICALLY-ILL POPULATIONS;
- ◆ ON USE OF ESSENTIAL DRUGS THAT SUBSTANTIALLY REDUCE MORBIDITY AND MORTALITY;
- ◆ ON CLINICAL OUTCOMES OF REDUCED OR EXPANDED COVERAGE, SUCH AS INSTITUTIONALIZATION;
- ◆ AND ON THE POTENTIAL COSTS OF EXPENSIVE HOSPITAL AND OTHER MEDICAL SERVICES REQUIRED TO TREAT SUCH ADVERSE CLINICAL OUTCOMES THAT MIGHT BE PREVENTED WITH INCREASED ECONOMIC ACCESS TO MEDICATIONS.

(SLIDE THREE)

ALL THREE STUDIES USED A VERY STRONG TIME-SERIES DESIGN.

- ◆ USING LARGE INSURANCE DATABASES, WE IDENTIFIED VULNERABLE PATIENTS IN THE STUDY STATE, NEW HAMPSHIRE, WHICH IMPLEMENTED THE THREE-DRUG BENEFIT LIMIT PER MONTH DURING THE SECOND YEAR OF A THREE-YEAR OBSERVATION PERIOD, AND WHICH THEN SWITCHED TO THE Milder ONE DOLLAR COPAYMENT. WE FOLLOWED PATIENTS FOR ABOUT A YEAR AFTER THIS SECOND POLICY CHANGE WHICH INCREASED DRUG COVERAGE.

- ◆ WE IDENTIFIED A MATCHED CONTROL GROUP IN NEW JERSEY AND LOOKED FOR SUDDEN CHANGES IN USE OF SPECIFIC MEDICATIONS OR ADVERSE CLINICAL EVENTS OCCURRING IMMEDIATELY AFTER THE DRUG BENEFIT LIMIT WAS IMPLEMENTED, AND, AGAIN, AFTER FULL DRUG COVERAGE WAS RESTORED.

(SLIDE FOUR) (SEE 1987-NEJM. FIG. 1 ATTACHED)

- ◆ THESE DATA, FROM OUR FIRST REPORT IN *THE NEW ENGLAND JOURNAL OF MEDICINE*, INDICATES A SUDDEN, STRONG EFFECT OF THE CAP POLICY IN NEW HAMPSHIRE. THESE EFFECTS WERE CONCENTRATED AMONG ELDERLY AND DISABLED PEOPLE WITH MORE THAN THREE PRESCRIPTIONS PER MONTH AT BASELINE, WHO EXPERIENCED A 43% DECLINE IN USE OF MEDICATIONS. FORTUNATELY, UTILIZATION REBOUNDED TO PRE-CAP LEVELS AFTER THE SWITCH BACK TO FULL COVERAGE.
- ◆ ALL OTHER PATIENTS (AT THE BOTTOM OF THE GRAPH), REPRESENTING ABOUT 92% OF PATIENTS, WERE ONLY IMPACTED MINIMALLY BY THE POLICY.
- ◆ THIS CONCENTRATED EFFECT ON THE ELDERLY AND DISABLED REMINDS US THAT IT IS ESSENTIAL TO TRACK THE EFFECTS OF COST-CONTAINMENT POLICIES IN THE MOST VULNERABLE PATIENTS.

(SLIDE FIVE) SEE 1987 NEJM FIG. 2
ATTACHED

- ◆ UNFORTUNATELY, HOWEVER, USE OF ESSENTIAL DRUGS LIKE INSULIN FOR DIABETES (SHOWN IN THE SLIDE), FUROSEMIDE FOR CONGESTIVE HEART FAILURE, BRONCHODILATORS FOR ASTHMA, AND LITHIUM FOR BIPOLAR ILLNESS, DECLINED SUBSTANTIALLY.
- ◆ A KEY FINDING FOR THE MAINE LEGISLATION IS THAT IMMEDIATELY AFTER DRUG COVERAGE WAS RESTORED, USE OF NUMEROUS ESSENTIAL MEDICATIONS LIKE INSULIN (SHOWN IN THE FIGURE) ALSO REBOUNDED TO BASELINE LEVELS.
- ◆ BECAUSE OF THE EXTREME POVERTY OF THIS POPULATION, THE ELDERLY AND DISABLED STUDY PATIENTS ONLY PAID FOR A SMALL PROPORTION -- ABOUT 10 PERCENT -- OF THE UNCOVERED MEDICATIONS OUT-OF-POCKET.

(SLIDE SIX) SEE 1991 NEJM FIG 1
ATTACHED

- ◆ WE FOUND THAT THE DRUG BENEFITS LIMIT **DOUBLED** THE RISK OF NURSING HOME ADMISSIONS AMONG CHRONICALLY ILL ELDERLY.
- ◆ THESE SURVIVAL CURVES SHOW WHO REMAINED OUTSIDE NURSING HOMES OVER TIME. SO A DOWNWARD MOVEMENT INDICATES AN INCREASE IN THE RATE OF INSTITUTIONALIZATION. AT BASELINE, ADMISSION RATES FOR THE CHRONICALLY ILL PATIENTS IN NEW HAMPSHIRE AND NEW JERSEY WERE ALMOST IDENTICAL, AT ABOUT TWO PERCENT.

- ◆ DURING THE DRUG BENEFITS LIMIT, THE CURVES IMMEDIATELY DIVERGED, AND THE RISK OF NURSING HOME ADMISSION WAS TWO TIMES HIGHER IN NEW HAMPSHIRE. THIS EFFECT WAS HIGHLY SIGNIFICANT.
- ◆ AFTER THE POLICY WAS DISCONTINUED AND COVERAGE WAS RESTORED, THE RISK OF ENTRY INTO NURSING HOMES BECAME EQUAL, [NOTE PARALLEL LINES], INDICATING THAT THE RESTORATION OF DRUG BENEFITS RESULTED IN NO FURTHER EXCESS RISK OF INSTITUTIONALIZATION.
- ◆ THESE EFFECTS WERE NOT SHORT TERM. ONCE PATIENTS WERE ADMITTED, THEY REMAINED IN THE NURSING HOME EVEN AFTER THE POLICY CEASED. THE EXCESS COSTS WERE GREATER THAN \$300,000 FOR THIS ONE SMALL STUDY GROUP -- WHICH WERE MANY TIMES HIGHER THAN THE MODEST DRUG SAVINGS.

NEXT WE STUDIED THE EFFECTS OF THE TWO CHANGES IN DRUG COVERAGE ON ANOTHER VULNERABLE POPULATION, THE CHRONICALLY MENTALLY ILL. SUCH INDIVIDUALS ARE OFTEN POOR, AND VERY DEPENDENT ON MEDICATIONS TO REMAIN OUTSIDE OF INSTITUTIONS.

(SLIDE SEVEN) SEE 1994 NEJM FIG. 1
ATTACHED

- ◆ THESE DATA INDICATE THE EFFECTS OF THE DRUG BENEFITS LIMIT ON USE OF ANTIPSYCHOTIC AGENTS IN PATIENTS WITH SCHIZOPHRENIA. EVEN THOUGH PATIENTS WITH SCHIZOPHRENIA IN NEW HAMPSHIRE RECEIVED LOWER LEVELS OF ANTIPSYCHOTIC AGENTS THAN SIMILAR PATIENTS IN NEW JERSEY, THE DRUG BENEFITS LIMIT CAUSED A FURTHER ABRUPT 15 % DROP IN THE USE OF THESE MEDICATIONS (SEE THE LOWER TREND LINE).
- ◆ AGAIN, A KEY FINDING WAS THAT AFTER COVERAGE WAS RESTORED, USE OF ANTIPSYCHOTIC AGENTS RETURNED TO BASELINE UTILIZATION LEVELS.

(SLIDE EIGHT) SEE 1994 NEJM FIG 1
ATTACHED

THESE DATA INDICATE A LARGER, 49% REDUCTION IN USE OF HIGHLY EFFECTIVE ANTIDEPRESSANTS AND LITHIUM AMONG THESE SAME PATIENTS WITH SCHIZOPHRENIA. AGAIN, NO CHANGE WAS OBSERVED IN THE CONTROL STATE WITHOUT THE DRUG BENEFITS LIMIT, AND RESTORATION OF DRUG BENEFITS INCREASED USE OF THESE ESSENTIAL AGENTS..

- ◆ WE HYPOTHESIZED THAT THESE REDUCTIONS IN MEDICATION USE WOULD CAUSE EXACERBATIONS OF SCHIZOPHRENIC SYMPTOMS THAT WOULD RESULT IN INCREASED USE OF EMERGENCY MENTAL HEALTH SERVICES AND DAY HOSPITALS. WE ALSO HYPOTHESIZED THAT RESTORING DRUG COVERAGE WOULD REDUCE THESE ADVERSE EVENTS.

(SLIDE NINE) SEE 1994 NEJM FIG. 1
ATTACHED

- ◆ THIS SLIDE INDICATES HIGHLY SIGNIFICANT INCREASES IN EMERGENCY MENTAL HEALTH SERVICES AT TWO OF THE LARGEST COMMUNITY MENTAL HEALTH CENTERS IN NEW HAMPSHIRE. BECAUSE THESE SERVICES WERE PROVIDED FOR HALF OR FULL DAYS, AND WERE DESIGNED TO TREAT PSYCHOTIC EPISODES, THEY WERE VERY EXPENSIVE, COSTING APPROXIMATELY \$180 EACH.
- ◆ WE ALSO OBSERVED LARGE INCREASES IN USE OF DAY HOSPITALIZATIONS WHILE THE DRUG BENEFITS LIMIT WAS IN EFFECT.
- ◆ IN MOST CASES, THE INCREASES IN THESE ADVERSE CLINICAL OUTCOMES CEASED OR REVERSED DIRECTION IMMEDIATELY FOLLOWING RESTORATION OF FULL DRUG COVERAGE, ACCOMPANIED BY A \$1 COPAYMENT.
- ◆ WHAT CAN WE CONCLUDE FROM THESE THREE STUDIES?

(SLIDE TEN)

- ◆ AMONG POOR, CHRONICALLY-ILL ELDERLY, WE FOUND THAT THE DRUG BENEFITS LIMIT RESULTED IN DECLINES IN BOTH APPROPRIATE AND INAPPROPRIATE MEDICATIONS;
- ◆ A 35% DECLINE IN USE OF ESSENTIAL DRUGS, SUCH AS INSULIN, CARDIAC MEDICATIONS, AND DRUGS FOR ASTHMA AND CONVULSIVE DISORDERS;
- ◆ A TWOFOLD INCREASE IN INSTITUTIONALIZATION IN NURSING HOMES, THAT WAS USUALLY PERMANENT;
- ◆ INCREASED GOVERNMENT COSTS FOR INSTITUTIONAL CARE OF \$311,000,

WHICH IS ABOUT 20 TIMES THE DRUG SAVINGS IN THIS POPULATION;

- ◆ A CESSATION OF ADVERSE OUTCOMES AFTER RESTORATION OF DRUG BENEFITS.

(SLIDE ELEVEN)

- ◆ AMONG PATIENTS WITH SCHIZOPHRENIA, THE DRUG BENEFITS LIMIT RESULTED IN A 15 TO 49% DECLINE IN USE OF ESSENTIAL PSYCHOACTIVE DRUGS, SUCH AS ANTIPSYCHOTIC AGENTS, ANTIDEPRESSANT AGENTS AND LITHIUM. [THESE DRUGS ARE WIDELY KNOWN TO KEEP SUCH PATIENTS OUT OF MENTAL HOSPITALS.] THESE AND THE FOLLOWING ADVERSE EFFECTS BEGAN TO DISAPPEAR WHEN DRUG COVERAGE WAS RESTORED:
 - ◆ A 50% INCREASE IN MENTAL HEALTH VISITS
 - ◆ LARGE INCREASES IN SCHIZOPHRENIC SYMPTOMS, USE OF EMERGENCY MENTAL HEALTH SERVICES AND DAY HOSPITALIZATIONS. ON AVERAGE, PATIENTS EXPERIENCED AN ADDITIONAL 1.3 EPISODES PER PATIENT PER MONTH.
 - ◆ GOVERNMENT COSTS FOR TREATING DESTABILIZED PATIENTS WERE AT LEAST 17 TIMES HIGHER THAN THE DRUG SAVINGS.

IN ADDITION, THESE ESTIMATES OF INCREASED GOVERNMENT COSTS ARE CONSERVATIVE BECAUSE THEY DO NOT CONSIDER UNQUANTIFIED COSTS OF PAIN AND SUFFERING, RISKS OF SUICIDE, AND COSTS IN THE CRIMINAL JUSTICE SYSTEM DUE TO CRIMES CAUSED BY UNTREATED PATIENTS WITH SCHIZOPHRENIA.

(SLIDE TWELVE)

- ◆ IN CONCLUSION, WHAT ARE THE IMPLICATIONS OF THIS RESEARCH FOR STATE PHARMACEUTICAL POLICY? FIRST, WE HAVE FOUND THAT EVEN RELATIVELY SMALL CHANGES IN DRUG COVERAGE CAN HAVE SUBSTANTIAL EFFECTS ON THE QUALITY AND COSTS OF CARE FOR LOW-INCOME, CHRONICALLY ILL PATIENTS.
- ◆ IN COMPARISON TO OTHER HEALTH CARE TECHNOLOGIES, MEDICATIONS REPRESENT THE MOST ESSENTIAL CARE FOR SUCH VULNERABLE POPULATIONS THAT CAN OFFSET INTENSIVE AND, OFTEN, EXPENSIVE SERVICES.
- ◆ OUR DATA INDICATE THAT COVERAGE OF MEDICATIONS IN THESE GROUPS CAN:
 - PREVENT MAJOR ACUTE ILLNESS;
 - CONTROL CHRONIC ILLNESSES;
 - AND MAINTAIN INDEPENDENCE OF FRAIL ELDERLY AND DISABLED PEOPLE IN THE COMMUNITY.
- ◆ MEDICATIONS ARE NOT WELL COVERED FOR NEAR-POOR ELDERLY WHO MAY NOT BE ABLE TO AFFORD TREATMENTS THAT ARE, FROM A SOCIETAL PERSPECTIVE, CLEARLY COST-EFFECTIVE.
- ◆ THE PROPOSED MAINE LEGISLATION TO EXPAND DRUG COVERAGE TO NEAR-POOR ELDERLY THUS REPRESENTS BOTH COMPASSIONATE AND INTELLIGENT, EVIDENCE-BASED HEALTH POLICY.

SPECIAL ARTICLE

PAYMENT RESTRICTIONS FOR PRESCRIPTION DRUGS UNDER MEDICAID

Effects on Therapy, Cost, and Equity

STEPHEN B. SOUMERAI, Sc.D., JERRY AVORN, M.D., DENNIS ROSS-DEGNAN, Sc.D.,
AND STEVEN GORTMAKER, Ph.D.

Abstract In an attempt to contain costs, 27 Medicaid programs have implemented patient-level payment limits for medications, but the effects of these restrictions on quality of care, costs, and health status remain largely unknown. We measured the effect of one state's limit of three paid prescriptions per month and its replacement a year later by a \$1 copayment. Using data on 48 months of claims in the study state (New Hampshire) and a comparison state (New Jersey), we employed time-series analysis to evaluate patient-level changes in the number of prescriptions filled for 16 drugs that varied in their clinical importance and cost.

Among 10,734 continuously enrolled patients, the limit of three paid prescriptions per month caused a sudden, sustained drop of 30 percent in the number of prescriptions filled (from 1.10 to 0.77 prescriptions per patient per month); no change was observed in the comparison state. The 860 recipients of multiple drugs, who were predominantly female and elderly or disabled, were most severely

affected; the number of prescriptions per month dropped from 5.2 to 2.8 (46 percent). The decrease was greatest for "ineffective drugs" (58 percent), but large drops were also observed for "essential" medications, such as insulin (28 percent), thiazides (28 percent), and furosemide (30 percent). Reductions in Medicaid prescriptions were minimally offset by increases in the size of the prescription or in out-of-pocket payments.

When a \$1 copayment replaced the three-prescription cap, prescriptions for most medications increased to just below precap levels. Medicaid's savings on drug costs resulting from both policies were comparable (\$0.4 to \$0.8 million annually), but the copayment policy had less effect on patients receiving multiple drugs. Because the clinical consequences of such policies cannot be assessed from prescription data alone, further study is needed to determine the effects of cost-containment strategies on health status and the use of other services among poor populations. (*N Engl J Med* 1987; 317:550-6.)

THE past several years have seen the implementation of diverse regulatory and financing changes aimed at reducing governmental costs for the health care of the poor and the elderly.^{1,2} In the Medicaid program, a variety of cost-limiting initiatives (e.g., curtailing eligibility for services, limiting coverage, and instituting copayments) have been put into effect by individual states since the Omnibus Budget Reconciliation Act of 1981. This act cut federal support for Medicaid programs but increased their administrative flexibility by allowing states to implement their own budget-reducing policies.³ Because of imperfections in the medical care marketplace,⁴ there is concern that such policies may result in reductions in essential as well as inessential care, adverse clinical outcomes, and increased costs, particularly among very ill and poor patients. One study demonstrated that when 186 patients with hypertension lost their Medicaid eligibility, their diastolic blood pressure increased by an average of 10 mm Hg.⁵ The Rand Health Insurance Experiment⁶⁻⁹ showed that cost sharing by patients who were not elderly reduced the number of medical care visits; this resulted in less favorable clinical outcomes only among patients with low incomes and hypertension

and those with poor vision.⁷ However, because the study sample excluded elderly persons with low incomes, its results cannot easily be generalized to the most vulnerable population. For example, among 1322 low-income adults in the Rand experiment, only 10 patients used insulin, only 8 were taking beta-blockers, and only 54 used a diuretic.⁸

Our investigation evaluated the effect of two cost-containment policies under Medicaid — one in which limits were placed on the number of drug prescriptions reimbursed per month (drug "caps"), and one that required copayments by patients of a portion of the cost of medication. Because these policies do not account for differences in the severity of illness, they are simple to implement and administer; not surprisingly, one or both strategies had been adopted by 27 states by 1984.¹⁰

As is true of other forms of therapy, there are great variations in cost and efficacy among the many pharmaceutical agents on the market.⁴ Because 60 percent of all visits to physicians result in the writing of one or more prescriptions,¹¹ it is possible to study a large sample of therapeutic decisions in computerized claims data bases.¹² Although there is broad agreement that overprescribing exists,¹³ it is clear that many drugs are highly cost effective in reducing both short-term and long-term morbidity and mortality.

The sudden implementation by New Hampshire Medicaid of a three-drug payment limit and its replacement 11 months later by a \$1 copayment policy provided a natural experiment in which to study the effect of these policies on access to medications by individual patients; their relative effects on the use of

From the Department of Social Medicine and Health Policy, the Program for the Analysis of Clinical Strategies, and the Division on Aging, Harvard Medical School, and the Department of Behavioral Sciences, Harvard School of Public Health. Address reprint requests to Dr. Soumerai at the Program for the Analysis of Clinical Strategies, Harvard Medical School, 643 Huntington Ave., Boston, MA 02115.

Supported by grants from the Health Care Financing Administration (Cooperative Agreement No. 18-C-98496/1-01) and the National Center for Health Services Research (HSO 5554), U.S. Department of Health and Human Services.

SPECIAL ARTICLE

EFFECTS OF MEDICAID DRUG-PAYMENT LIMITS ON ADMISSION TO HOSPITALS AND NURSING HOMES

STEPHEN B. SOUMERAI, Sc.D., DENNIS ROSS-DEGNAN, Sc.D., JERRY AVORN, M.D.,
THOMAS J. McLAUGHLIN, Sc.D., AND IGOR CHOUDNOVSKIY, B.S.

Abstract Background: Many state Medicaid programs limit the number of reimbursable medications that a patient can receive. We hypothesized that such limitations may lead to exacerbations of illness or to admissions to institutions where there are no caps on drug reimbursements.

Methods. We analyzed 36 months of Medicaid claims data from New Hampshire, which had a three-drug limit per patient for 11 of those months, and from New Jersey, which did not. The study patients in New Hampshire ($n = 411$) and a matched comparison cohort in New Jersey ($n = 1375$) were Medicaid recipients 60 years of age or older who in a base-line year had been taking three or more medications per month, including at least one maintenance drug for certain chronic diseases. Survival (defined as remaining in the community) and time-series analyses were conducted to determine the effect of the reimbursement cap on admissions to hospitals and nursing homes.

Results. The base-line demographic characteristics of the cohorts were nearly identical. In New Hampshire,

the 35 percent decline in the use of study drugs after the cap was applied was associated with an increase in rates of admission to nursing homes; no changes were observed in the comparison cohort (RR = 1.8; 95 percent confidence interval, 1.2 to 2.6). There was no significantly increased risk of hospitalization. Among the patients in New Hampshire who regularly took three or more study medications at base line, the relative risk of admission to a nursing home during the period of the cap was 2.2 (95 percent confidence interval, 1.2 to 4.1), and the risk of hospitalization was 1.2 (95 percent confidence interval, 0.8 to 1.6). When the cap was discontinued after 11 months, the use of medications returned nearly to base-line levels, and the excess risk of admission to a nursing home ceased. In general, the patients who were admitted to nursing homes did not return to the community.

Conclusions. Limiting reimbursement for effective drugs puts frail, low-income, elderly patients at increased risk of institutionalization in nursing homes and may increase Medicaid costs. (N Engl J Med 1991;325:1072-7.)

CONCERN has mounted that cost-containment policies implemented during the 1980s may be compromising the quality of care and the health of vulnerable populations, such as poor and chronically ill elderly people, although few studies have examined this question.^{1,2} Charges to the patient or monthly limits on medications and other "optional" services are characteristic of most Medicaid programs.³ Although such restrictions on specific services could increase admissions to hospitals and nursing homes among chronically ill elderly people, this has not been demonstrated in a controlled study. Decades of clinical research and experience document the effectiveness of many medications in treating both acute life-threatening illnesses and chronic debilitating conditions.⁴⁻⁶ Lack of compliance with drug therapy has been associated with increased admissions to hospitals and nursing homes.⁷⁻¹⁰ Logically, then, policies that reduce access to effective medications may increase the rate of adverse clinical outcomes and the accompanying costs.

In an earlier study¹¹ we examined the effects of a three-drug payment limit, or cap, on the use of med-

ications among 10,734 Medicaid patients in New Hampshire. Among 860 recipients of three or more drugs, the cap was associated with significant reductions in the receipt of several important medications (e.g., 28 to 30 percent reductions for insulin, thiazides, and furosemide) that were not offset by increased out-of-pocket purchases. When a copayment of \$1 per prescription replaced the cap one year later, the use of most agents quickly approached precap rates.

In that study, data were not available to measure possible changes in use of institutional services. One hypothesized effect of the cap was an increase in nursing home admissions, due either to deteriorating health or to a desire to shift to an environment exempt from the cap. If the loss of essential medications led to an acute deterioration in health, one might also expect increased hospital admissions. In the current study, we analyzed 36 months of additional nondrug claims and enrollment data from Medicaid to answer the following question: Among low-income, elderly Medicaid patients, is limiting access to medications associated with increased rates of admission to nursing homes and hospitals?

METHODS

Study Design

This study used survival (defined as remaining in the community) and interrupted time-series analyses to evaluate the effects of the drug-payment restriction. Outcome data included 36 months (July 1980 to June 1983) of patients' nursing home and hospital inpatient claims in two state Medicaid programs. We compared the rate of admission to nursing homes and hospitals before, during, and after the cap in a defined cohort of chronically ill elderly patients in the

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EFFECTS OF LIMITING MEDICAID DRUG-REIMBURSEMENT BENEFITS ON THE USE OF PSYCHOTROPIC AGENTS AND ACUTE MENTAL HEALTH SERVICES BY PATIENTS WITH SCHIZOPHRENIA

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Abstract Background. We examined the effects of a three-prescription monthly payment limit (cap) on the use of psychotropic drugs and acute mental health care by noninstitutionalized patients with schizophrenia. We hypothesized that reducing access to such drugs would increase the use of emergency mental health services and the rate of partial hospitalizations (full-day or half-day treatment programs) and psychiatric-hospital admissions.

Methods. We linked Medicaid claims data for a period of 42 months with clinical records from two community mental health centers (CMHCs) and the single state psychiatric hospital in New Hampshire, where Medicaid imposed a three-prescription limit on reimbursement for drugs during 11 months (months 15 through 25) of the study. For comparison, we used Medicaid claims for a period of 42 months in New Jersey, which had no limit on drug reimbursement. The study patients ($n = 268$) and the comparison patients ($n = 1959$) were permanently disabled, noninstitutionalized patients with schizophrenia, 19 through 60 years of age, who were insured by Medicaid. We conducted interrupted time-series regression analyses to estimate the effects of the cap on the use of medications and mental health services.

Results. The cap resulted in immediate reductions (range, 15 to 49 percent) in the use of antipsychotic drugs, antidepressants and lithium, and anxiolytic and hypnotic drugs ($P < 0.01$). It also resulted in coincident increases of one to two visits per patient per month to CMHCs (range of increase, 43 to 57 percent; $P < 0.001$) and sharp increases in the use of emergency mental health services and partial hospitalization (1.2 to 1.4 episodes per patient per month), but no change in the frequency of hospital admissions. After the cap was discontinued, the use of medications and most mental health services reverted to base-line levels (measured in the first 14 months of the study). The estimated average increase in mental health care costs per patient during the cap (\$1,530) exceeded the savings in drug costs to Medicaid by a factor of 17.

Conclusions. Limits on coverage for the costs of prescription drugs can increase the use of acute mental health services among low-income patients with chronic mental illnesses and increase costs to the government, even aside from the increases caused in pain and suffering on the part of patients. (N Engl J Med 1994;331:650-5.)

REQUIREMENTS for cost sharing by patients and limitations on coverage for primary medical care are popular cost-containment strategies in the United States and other countries¹⁻³; they may become more prevalent as a result of future health insurance reforms. Yet objective data on the effects of these measures on the use, costs, and outcomes of health care in vulnerable populations are limited.⁴⁻⁶ We examined the effects of limits on Medicaid payments for drug treatment on access to effective pharmacotherapy and on the use of acute mental health care services among low-income, noninstitutionalized patients with schizophrenia.

The economic, clinical, and personal burdens associated with schizophrenia make it a leading public health problem. The lifetime prevalence of schizophrenia is between 0.5 percent and 1.0 percent⁷⁻⁹; rates of mortality and somatic morbidity are much higher among patients with schizophrenia than in the general population¹⁰; and the total costs to society are estimated to equal half the total financial burden of myocardial infarction.¹¹ Patients with schizo-

phrenia are also highly likely to receive fragmented and uncoordinated care.¹²⁻¹⁵

Antipsychotic drugs, the most effective treatment for acute episodes or exacerbations of schizophrenic illness,^{16,17} allow many patients to leave institutions and live in the community.^{18,19} Rates of relapse among patients with schizophrenia who receive medication are two to three times lower than those among patients receiving placebo,^{16,20} and noncompliance increases the frequency of acute psychotic episodes and psychiatric hospitalization.^{16,17} Although antipsychotic drugs can have serious adverse effects,^{19,21} many clinicians prescribe them at moderate doses for as long as possible to prevent relapse. In addition to antipsychotic agents, patients with schizophrenia may receive lithium, antidepressants, or benzodiazepines for concomitant psychiatric disorders.¹⁶

Nine states limit the number of prescriptions per patient per month that are reimbursed by Medicaid, but there are no data on the effects of such caps on people with chronic mental illnesses. In September 1981, the New Hampshire legislature limited Medicaid reimbursement to three prescriptions per month as a cost-cutting measure during a budget crisis that was precipitated, in part, by reduced federal support for the Medicaid program.⁵ Patients who filled more than three prescriptions in any month were usually unable to pay for them out of pocket²²; this policy therefore reduced the use of essential medications (such as insulin and cardiac drugs) among elderly patients with

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month per recipient; "moderately expensive" drugs ranged in cost from \$6.50 to \$10.00; "expensive" drugs cost over \$10.00 per monthly supply.

Statistical Analysis

Mean monthly numbers of constant-size prescriptions and total milligrams per patient were plotted for the study groups. Regression models were fit to these time series with use of the SAS AUTOREG procedure.^{22,23} The models included a constant term, a linear time trend, and terms indicating changes in the mean level of prescribing during an "anticipatory" precap period (month 20) and the periods during which the cap (months 21 to 32) and the copayment (months 33 to 48) policies were in effect. Finally, terms were included for changes in linear time trend (slope) after the cap and the copayment policies were instituted. The statistical significance of the effects of the policy interventions was tested with *t*-statistics; correlated errors in the regressions were taken into account by assuming first-order autocorrelated errors. Because of the large number of patients and the reliability of the data, all effects reported are significant beyond the 0.05 level (and, in most cases, $P < 0.0001$).

RESULTS

Background Characteristics of Study Cohorts

We identified a total population of 10,734 persons who were continuously enrolled in New Hampshire Medicaid and not residing in nursing homes during the study period. Seventeen percent of this group received no prescriptions during the study period. Multiple-drug recipients (≥ 3 medications per month before the cap) represented only 8 percent of this group ($n = 860$), but had 47 percent of all the prescriptions filled in the base year (1980). As expected on the basis of their high use of medication, the members of this cohort were more likely to be elderly and disabled than other continuously enrolled patients. Their average age ($\pm$ SD) was 56 ± 19 years as compared with 33 ± 26 years for all other patients; the proportions over the age of 60 were 48 and 22 percent, respectively. The majority (81 percent) were female, as compared with 68 percent among other patients. The recipients of multiple drugs were eligible for Medicaid because of receipt of old-age assistance (36 percent), physical or mental disability (47 percent), or blindness (2 percent); 18, 20, and 1 percent, respectively, of all other patients were eligible for these reasons. Fourteen percent of multiple-drug recipients and 61 percent of all other patients received assistance from Aid to Families with Dependent Children. As expected, 87 percent of the high-use group were long-term recipients (≥ 4 prescriptions per year before the cap) of one or more of the following classes of drugs: hypoglycemics (17 percent), cardiovascular agents (56 percent), bronchodilators (26 percent), anticonvulsants (12 percent), anticoagulants (2 percent), and medications for affective disorders (27 percent) or psychoses (26 percent).

Effects on Total Prescriptions

Monthly averages of constant-size prescriptions are plotted in Figure 1 for the two subgroups within the total population of continuously enrolled patients ($n = 10,734$) before and after implementation of the

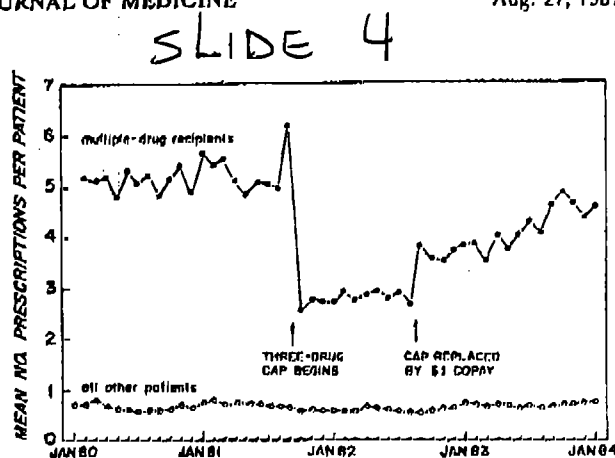


Figure 1. Time Series of Average Number of Constant-Size Prescriptions per Continuously Eligible Patient per Month among Noninstitutionalized Patients Receiving Multiple Drugs ($N = 860$) and Other Outpatients ($N = 8002$).

Patients with no prescriptions throughout the four-year period ($n = 1872$) were excluded from the denominator.

cap and copayment policies. As expected, the greatest effects of these policies were concentrated among multiple-drug recipients ($n = 860$; Fig. 1). In the 20 months before the policy changes, this group had an average of 5.2 prescriptions filled per person per month. The cap caused an immediate and sustained reduction in the number of constant-size prescriptions of 46 percent (2.4 prescriptions per person per month) to an average level of 2.8 during the 11-month cap period. There was no increase in medication use throughout the cap period. After the cap was replaced by a \$1 copayment, average prescription rates rose both in level and slope (Fig. 1) to approximately 4.7 constant-size prescriptions by the end of the 48-month period. The R^2 for the regression equation was 0.96, indicating a very good fit. All other patients had a much smaller, yet still significant, decrease of 17 percent in average number of Medicaid prescriptions filled, from their expected level of 0.7 per month; this rate increased significantly during the copayment period to approximately precap levels.

As shown in Figure 1, an anticipatory demand was observed for multiple-drug recipients in the month immediately before the cap was instituted; this effect was controlled for in all estimates.

In the New Jersey comparison series, drug-prescription rates among continuously enrolled outpatients remained stable at an average ($\pm$ SD) of 1.2 ± 0.07 prescriptions per patient throughout the entire study period, with very low month-to-month variations.

Effects on Prescription Size

Although the regulations allowed physicians to increase the number of units per prescription substantially in order to maintain the supply for their patients, the average prescription size among multiple-drug recipients increased by only 11 units per prescription (13 percent) during the cap period. There was no upward slope in prescription size during the cap period, sug-

gesting that there was no "learning curve" for providers who did not compensate in the first several months. Prescription size decreased by 16 units per prescription to approximately precap levels soon after the switch to the copayment policy. No such changes were observed for the comparison population.

Withdrawal of Essential versus Inessential Drugs

The cap policy had abrupt and significant downward effects on the rates of use of all 16 medications studied in the cohort of multiple-drug recipients, across all efficacy and cost categories. Among these patients, the switch to a copayment policy significantly increased prescription levels or trends for 9 of the 16 study-drug groups. During the cap period, essential drugs were relinquished at a somewhat lower rate than were less essential agents; within categories of efficacy, high-cost drugs were somewhat more likely to continue to be reimbursed than were the most inexpensive drugs. (All estimated effects reported below are in constant-size prescriptions per 100 patients per month.) The number of prescriptions filled for effective, essential medications declined from 67.0 to 48.6 (28 percent), that for effective symptomatic-relief drugs from 28.3 to 17.5 (38 percent), and that for drugs of limited efficacy from 5.5 to 2.3 (58 percent). Among essential medications, the number of prescriptions filled for inexpensive ones declined from 19.4 to 12.2 (37 percent), that for moderately expensive ones from 19.0 to 13.7 (28 percent), and that for expensive agents from 28.6 to 22.7 (21 percent).

The largest reductions in the actual numbers of prescriptions were for several commonly used essential medications; the reduction was from 11.6 to 8.4 prescriptions per 100 patients per month for insulin (28 percent), from 12.1 to 8.5 for furosemide (30 percent), from 9.0 to 6.5 for thiazide diuretics (28 percent), and from 10.4 to 5.7 for digoxin (45 percent). Across all efficacy categories, prescriptions for medications with the lowest cost declined from 30.2 to 16.4 (46 percent), prescriptions for moderately expensive agents decreased from 30.1 to 21.0 (30 percent), and those for expensive agents from 40.5 to 31.1 (23 percent). Prescriptions for aspirin and acetaminophen, which are available over the counter, dropped from 7.0 to 2.8 (61 percent), but the use of prescription analgesics fell only from 28.3 to 17.5 (31 percent). Thus, both increased drug cost and greater efficacy appeared to be independently associated with reduced effects of the cap.

Patient-Level Effects on Insulin Use

Because of the large decreases in the use of effective medications, we looked more closely at variations in patient-specific dosages of one expensive and essential agent, insulin, which was taken by 79 continuously enrolled patients who had more than four prescriptions for insulin filled in the year before the cap. These analyses also considered whether precap doses had been excessive, whether observed changes in aggre-

gate use were concentrated among a few patients, and the process by which reductions in prescriptions occurred. The average decrease in dose attributable to the cap was 28 percent, or 490 units per patient per month. Only 2 of the 79 patients completely stopped receiving insulin through Medicaid during the cap period, and 1 of these received insulin again after the cap was lifted. Among those who continued to receive some insulin through Medicaid, nearly half had decreases of more than 25 percent in their average monthly doses and a quarter had decreases of more than 50 percent.

Figure 2 shows the average monthly doses (top half) and prescription sizes (lower half) for two groups of patients: those ($n = 36$) whose doses of insulin were maintained (≤ 10 percent drop in average monthly dose), and those ($n = 32$) with large reductions in dose (> 30 percent drop; mean, 68 percent). Both groups had similar precap dosages, suggesting that a reduction in excessive doses was not an underlying explanatory factor. Changes in eligibility also do not explain these effects, since both groups were continuously enrolled in the Medicaid program during the

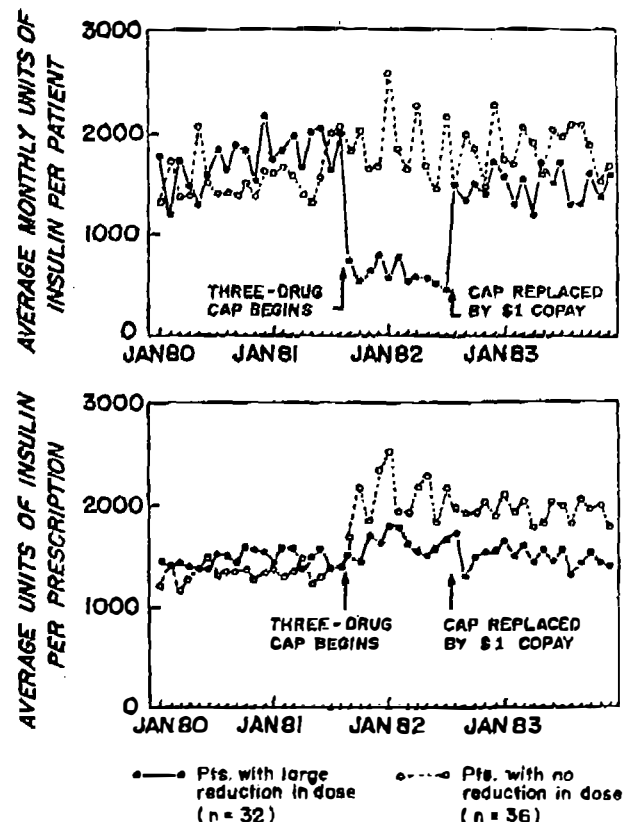


Figure 2. Changes in Average Monthly Insulin Doses (Top) and Prescription Size (Bottom) among Two Groups of Patients with Diabetes Receiving Multiple Drugs.

Patients with large reductions in reimbursed insulin (> 30 percent) are indicated by closed circles and patients whose reimbursement for insulin was maintained (< 10 percent drop) by open circles.

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ization and 95 percent two-sided confidence intervals in the study groups.¹⁰ We used segmented time-series regression models to estimate changes in drug use, including a constant term, a linear time trend, and terms to estimate changes in the mean level of use of core drugs during an "anticipatory" precap month (August 1981) and during the cap and copayment periods.¹¹

RESULTS

Background Characteristics of the Study Groups

The base-line demographic characteristics and rates of drug use were similar in the New Hampshire and New Jersey groups (Table 1). The high proportion of women in both cohorts (80 percent) reflects the predominance of women in frail, elderly populations. In the year before the cap policy was instituted, approximately four out of five patients in both cohorts were regular recipients of core medications indicated for heart disease; rates of regular use of medications for chronic obstructive pulmonary disease and asthma, diabetes, and seizures were all similar, as were rates of use of anticoagulant agents. The total number of classes of drugs taken regularly was slightly higher in the comparison cohort; we controlled for the potential effects of this difference through the stratified analyses reported below. Although patient-specific data on income were unavailable, both cohorts were very poor, with incomes substantially below federal poverty levels; at the time of the study, the monthly income of elderly recipients of supplemental security income who lived alone was about \$350 in both states.²⁰ During the follow-up period, similar proportions of patients (35 percent in New Hampshire and 28 percent in New Jersey) died or left the Medicaid program for other reasons.

Changes in the Use of Study Medications

During the base-line year the median number of standardized monthly doses of core drugs per month was stable at 2.8 in New Hampshire and 2.3 in New Jersey. There was no change in the use of these agents in New Jersey during the study period. In New Hampshire, however, the time series of drug use dropped by 35 percent, to 1.9 standardized monthly doses per patient per month after the cap was instituted (two-sided $P < 0.001$).

After the cap was replaced by the \$1 copayment, these rates rose almost to base-line levels.

Effects on Nursing Home Admissions

The most clearly observable effect of the payment cap in New Hampshire was an increase in nursing home admissions (Fig. 1). The proportions of patients entering nursing homes were similar in the study groups before the cap: 2.3 percent in New Hampshire and 2.1 percent in New Jersey. After the institution of the cap, there was a marked separation of the two survival curves showing the probability of remaining in the community; by the end of the 11-month cap

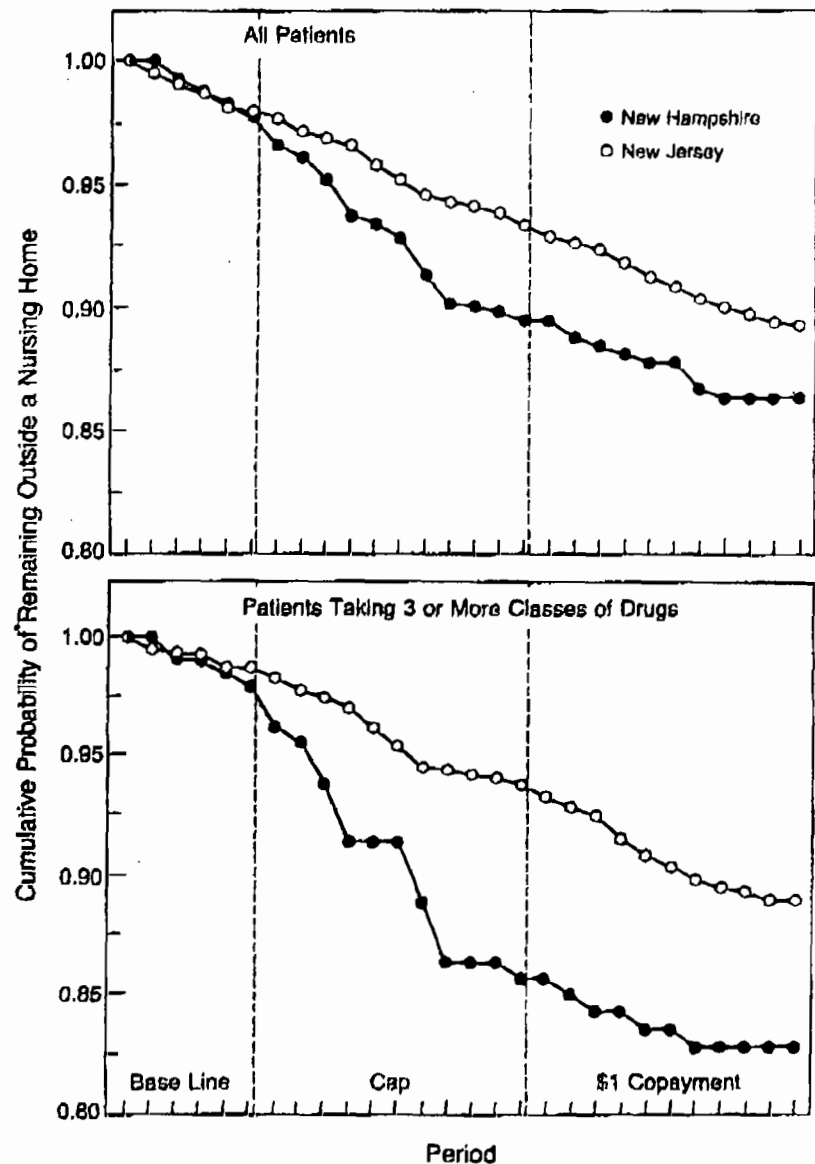


Figure 1. Cumulative Probability of Remaining outside a Nursing Home. The top panel shows the curves for all patients in the New Hampshire ($n = 411$) and New Jersey ($n = 1375$) groups. The bottom panel shows the curves for patients who regularly used drugs from three or more classes at base line ($n = 198$ for New Hampshire and 762 for New Jersey).

SLIDE 6

son) cohort, which received somewhat higher numbers of SMDs of antipsychotic drugs and anxiolytic and hypnotic agents. Before the cap was implemented, the use of antipsychotic agents was stable at approximately 1.4 SMDs per patient per month in New Hampshire; the level of use dropped abruptly by a mean ($\pm$ SE) 0.23 ± 0.08 SMD during the cap (a decrease of 15.4 percent, $P = 0.003$) but rose to a level slightly above pre-cap rates after the discontinuation of the policy. We also observed statistically significant reductions in the use of anxiolytic and hypnotic agents (a decrease of 0.07 ± 0.02 SMD per patient per month [37.3 percent], $P = 0.001$) and of antidepressants and lithium (0.13 ± 0.02 SMD [49.1 percent], $P < 0.001$). The use of these drugs returned nearly to base-line levels after the discontinuation of the cap.

Among regular recipients of antipsychotic drugs, the level of use of these medications dropped by 0.64 ± 0.15 SMD per patient per month after the cap was instituted (a decrease in the level of 21.2 percent, $P < 0.001$). The average monthly dose of antipsychotic drugs among regular recipients before the cap was 2.85 SMDs (415 mg of chlorpromazine or the equivalent per day),²⁰ well within the accepted range of maintenance doses.²²

Provision of Medications in CMHCs

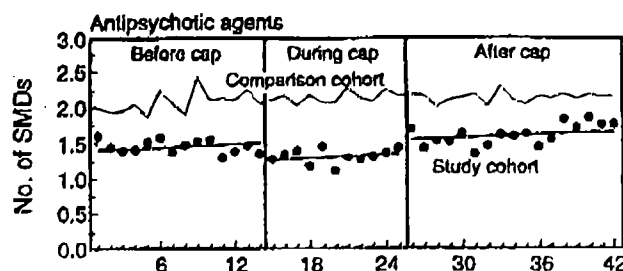
Figure 2 shows a substantial increase in the amount of antipsychotic drugs administered to members of the study cohort at CMHC 1 after the cap was instituted. This change shifted costs for medications to the state mental health system. When both Medic-

Table 1. Base-Line Characteristics of the Study and Comparison Cohorts.

CHARACTERISTIC	STUDY COHORT (NEW HAMPSHIRE) (N = 268)	COMPARISON COHORT (NEW JERSEY) (N = 1959)
Mean age (yr)	39.9	39.0
Age group (%)		
<30 yr	30.2	34.4
31-40 yr	19.8	20.5
41-50 yr	24.3	20.3
51-60 yr	25.7	24.8
Female sex (%)	61.2	59.2
Psychoactive drugs used (%) ^a		
Antipsychotic agents		
Any use	72.8	79.5
Regular use	43.6	46.4
Drugs for affective disorders		
Any use	29.8	31.3
Regular use	13.4	11.9
Anxiolytic and hypnotic agents		
Any use	26.5	39.4
Regular use	8.2	10.6
Use of ≥ 2 types of psychoactive drug (%)	78.3	74.2
No longer enrolled in Medicaid at end of follow-up (%)	7	8

^aAny use is defined as ≥ 1 prescription in the base-line year and regular use as ≥ 1 prescription per quarter in the base-line year (July 1990 through June 1991).

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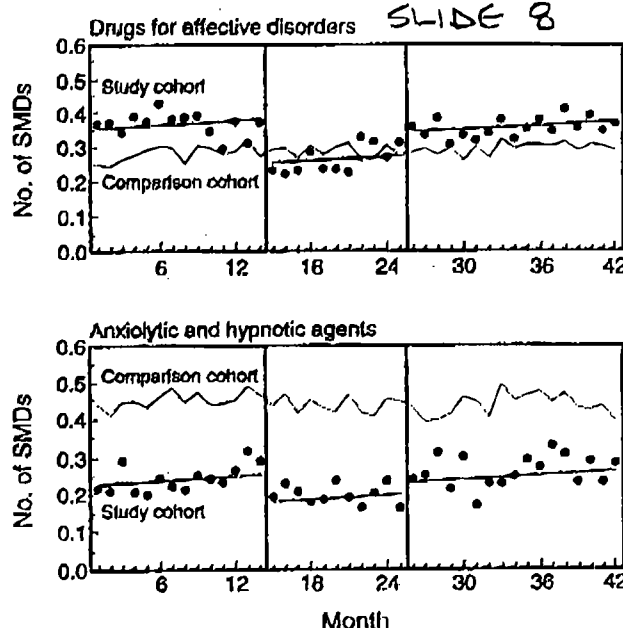


Figure 1. Standard Monthly Doses (SMDs) per Patient of Antipsychotic Agents, Drugs for Affective Disorders, and Anxiolytic and Hypnotic Agents Whose Cost Was Reimbursed by Medicaid in the Study Cohort (New Hampshire; N = 268) and the Comparison Cohort (New Jersey; N = 1959).

The fitted trend lines for the study cohort show predicted values for segmented time-series regressions. After the cap was discontinued, a copayment of \$1 per prescription was instituted.

aid-reimbursed and CMHC-provided antipsychotic agents were included, the average use per patient per month was 0.91 SMD before the cap was instituted, 1.24 SMDs while it was in effect, and 0.80 SMD after it was discontinued.

Use of CMHCs and Admissions to State Psychiatric Hospitals

As illustrated in Figure 3, after a moderate decline at CMHC 1 from 7.6 to 4.3 visits to the center per patient per month, the number of visits increased abruptly when the cap was put into effect, reaching 7.5 visits by the end of the cap period (increase in trend, 0.6 ± 0.1 visit per patient per month [57 percent], $P < 0.001$). When the cap was withdrawn, the number of visits declined to 6.4 per patient per month by the end of the 17-month follow-up period ($P < 0.001$). At CMHC 2, the institution of the cap was associated with an immediate increase in the number of visits

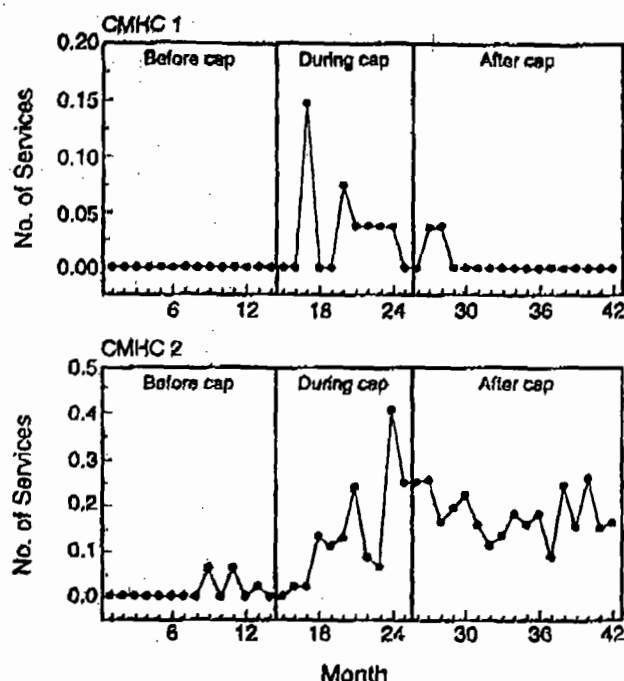


Figure 4. Emergency Mental Health Services per Patient per Month at CMHC 1 (N = 29) and CMHC 2 (N = 49).

more than 17. Moreover, we probably underestimated these costs because of the lack of data on administrative costs and the costs of the psychoactive drugs provided free at CMHCs, other unobserved expenditures (for example, cost shifting to Medicare, the criminal-justice system, family efforts to compensate for disruptions in care, and possibly increased cost of treating the approximately 30 percent of patients with schizophrenia not identified by our algorithm),³¹ and intangible costs, such as increases in pain, suffering, and the risk of suicide among patients, that were associated with exacerbations of schizophrenic illness.

DISCUSSION

We previously reported a direct relation between the New Hampshire Medicaid drug-payment cap and both the reduced use of essential therapies and increased institutionalization of frail elderly persons.³ In the present study, we examined the effects of this policy on another vulnerable population: low-income adult patients with schizophrenia who were living in the community. Our results strongly suggest that the restriction on payment for psychoactive medication caused immediate and sustained reductions in the use of antipsychotic drugs, antidepressants and lithium, and anxiolytic and hypnotic agents. The lower base-line use of antipsychotic agents among New Hampshire patients, as compared with patients in New Jersey, suggests that psychiatrists in New Hampshire were already reducing doses to minimize adverse effects, a finding that is consistent with recent positive evaluations of New Hampshire's public mental health system.³²

We detected no changes related to the cap in the rates of admission to the state psychiatric hospital. However, there was a significant increase in visits to CMHCs; an increase in the administration of antipsychotic agents at the CMHCs that were paid for by the state mental health system; and increases in the use of emergency mental health services, partial hospitalizations, and doses of antipsychotic agents given at the CMHCs. The sudden decline in the number of patients given psychoactive medications at the CMHCs and the downward trends in the use of most acute mental health services after the cap was discontinued further support the hypothesis that the limit on drug benefits increased patients' agitation or exacerbated schizophrenic symptoms, thereby increasing the use of expensive acute care services. Continued higher rates of partial hospitalization and increased numbers of outpatient visits at CMHC 2 suggest that some local effects of the cap continued even after its withdrawal. These consequences may be due to the need for continued surveillance to stabilize the condition of patients after relapse, the difficulty of changing administrative mechanisms once they are in place, and the effects of the newly required copayment.

Could some other factor have caused the increased use of acute mental health care services? This is unlikely, since such a confounder would have had both to increase use after the 14-month base-line period and to reduce it again 11 months later. In addition, none of the directors and staff members of New Hampshire CMHCs could suggest alternative explanations. The fact that admissions to the state psychiatric hospital did not increase is consistent with state mental health policies that strongly discouraged such admissions.

Could the observed changes merely reflect patients' efforts to gain access to medications rather than changes in their mental health status? This explanation is unlikely, because most patients received one-month supplies of medications and were already visiting the CMHCs about once a week before the cap was imposed (Fig. 3). Thus, additional visits were not needed to obtain medications. It is more likely that the increased use of services, especially the higher rate of use of partial hospitalization and emergency mental health services, represents a response to acute exacerbation of illness, although the exact reasons for the increases in acute care services remain unknown.

Case reports obtained from state mental health records corroborate these impressions. For example, during the period when the cap was in effect a middle-aged woman with schizophrenia was admitted to the New Hampshire Hospital on an emergency basis because of extreme agitation. At admission, her medication regimen included an antipsychotic agent, an antiparkinsonian drug, insulin, and a cardiac medication. The reasons for admission included diabetic ketoacidosis precipitated by her discontinuation of insulin in favor of continuing her other three medications.

DRAFT BACKGROUND: PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES

NEED AND USE AMONG MEDICARE BENEFICIARIES

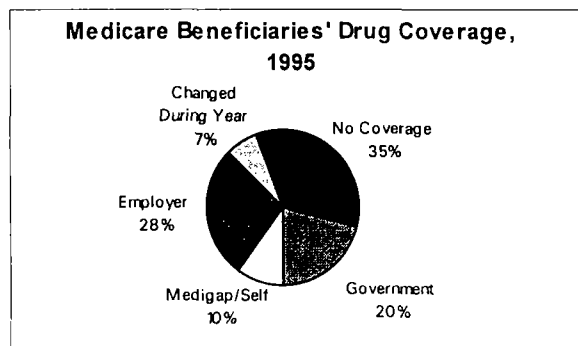
- Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. (Davis et al., 1999).
- Medicare beneficiaries with coverage for drugs used, on average, 20.3 prescriptions per year, compared to 15.3 per year for beneficiaries without coverage. (Davis et al., 1999)
- One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodilators) when their Medicaid drug coverage was limited. (Soumerai et al., 1987)
- Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. (Soumerai et al., 1991)
- The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. (Stuart & Grana, 1998)

SPENDING

- In the past 10 year, spending on prescription drugs has risen as a percent of total spending, by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs. (HCFA, 1998)
- Although the elderly comprise 12 percent of the population, they account for over one-third of all prescription drug spending. (Mueller, Schur & O'Connell, 1997)
- The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication. (Mueller, Schur & O'Connell, 1997)
- Spending on prescription drugs represents one-third of Medicare fee-for-service beneficiaries' out-of-pocket spending (excluding premiums payments). (AARP, 1998)
- About half of Medicare beneficiaries have prescription drug spending of more than \$500 per year; over one in ten have more than \$2,000. (HCFA Office of the Actuary, 1999)

INSURANCE COVERAGE

- **Only 38 percent of Medicare beneficiaries have private drug coverage.** Employer-based, retiree coverage is the largest source of private coverage, but recent studies show a dramatic decline in this coverage. About 10 percent of beneficiaries have Medigap or other private sources of coverage. Similarly, as the cost of Medigap insurance climbs, the proportion of beneficiaries who can afford it has been declining. (Davis et al, 1999)



- **Retiree health insurance:** The major source of drug coverage for the elderly -- employer sponsored retiree insurance -- is eroding. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent (from 40 to 31 percent). (Mercer/Foster Higgins, 1997).
- **Medigap:** 3 of the 10 standard Medigap plans offer prescription drugs. Their benefits includes: a \$250 deductible; 50 percent coinsurance; and a cap of \$1,250 or \$3,000.

Medigap premiums in general have been rising rapidly. One study of Medigap in 3 states found that premiums for the two most popular plans rose by 12 and 20 percent between 1995 and 1996. (Eppig & Chulis, 1997)

Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. (Medicare Commission staff analysis)

Medigap premiums range from \$402 to \$7,196, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage (Medigap Plan H) to one with virtually identical benefits except for drugs (Medigap Plan D) is well over \$1,000 or more than twice as costly (\$2,073 v 913 in 1998). (Medicare Commission staff analysis). According to experts, virtually all Medigap drug coverage plans are underwritten, meaning that the premiums that they charge are based on the person's health.

- **Medicare managed care:** Typical Medicare managed care plans have no deductibles and relatively low copayments, but caps on the benefit:

- 40 percent of enrollees are in plans with unlimited benefits
- 18 percent of enrollees are in plans with limits greater than \$1,000
- 17 percent of enrollees are in plans with a limit at \$1,000
- 24 percent of enrollees are in plans with limits less than \$1,000

[Note: these data are for 1998; expectations are that for 1999, the proportion of beneficiaries in plans with caps and deductibles will rise significantly; unpublished HCFA analysis]

BENEFICIARIES WITHOUT ANY INSURANCE COVERAGE

- **Not just a problem for low-income beneficiaries:** Over 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty.
- **Beneficiaries without drug coverage are not much healthier than those with coverage:** Although some argue that beneficiaries without coverage may not need it, 26 percent of beneficiaries without coverage report fair to poor health, compared to 29 percent of beneficiaries with drug coverage. Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs.
- **Older beneficiaries are less likely to have drug coverage:** The proportion of beneficiaries without drug coverage rises with age:
 - 38 percent of people ages 80 to 84
 - 41 percent of people ages 85 or older
- **Nearly half of rural beneficiaries have no insurance coverage for drugs:** 46 percent of rural beneficiaries do not have drug coverage

Source: Unpublished analysis of the 1995 Medicare Current Beneficiary Survey

SPENDING BY BENEFICIARIES WITHOUT DRUG COVERAGE

- Even after controlling for health status and income, elderly people with private insurance for drugs had half the financial burden for drugs as those without coverage. One percent of elderly households spend at least 25 percent of their household incomes on drugs. Rural elderly have costs that are 35 percent higher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income. (Rogowski et al., 1997)
- A recent study found that the average older American without insurance coverage for drugs pays twice as much as large insurers or HMOs. (Committee on Government Reform and Oversight, 1998)
- A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine. (Families USA, 1995)

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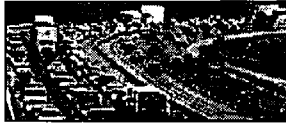
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February 26, 1999

Medicare Recommendations Delayed

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Filed at 5:20 p.m. EST**By The Associated Press**

WASHINGTON (AP) -- A commission that is supposed to recommend changes in Medicare will need to work past its March 1 deadline, the panel's leaders advised Congress and President Clinton on Friday.

"The issues the commission was directed to consider are complex, difficult and of great importance to every American," Sen. John Breaux, D-La., and Rep. Bill Thomas, R-Calif., said in a letter to Clinton and congressional leaders.

The co-chairmen of the National Bipartisan Commission on the Future of Medicare said they do not expect the panel's work to extend beyond March 31.

"The commission is in the final stages of its deliberations, and we are optimistic that we will be able to submit our recommendations shortly," their letter said.

The 17-member commission is just one or two votes shy of the 11 it needs to recommend a plan that would make the nation's health insurance program for the elderly and disabled more like the health benefits that many companies and the federal government offer to workers.

Under that plan, retirees would choose from a menu of health-insurance policies and get a Medicare subsidy to help cover the enrollment fee or premium. The government-run system that most retirees now use to get reimbursed for each medical bill would compete with private health plans, which would have to offer similar coverage.

Breaux has been a leading proponent of the proposal, which Republicans on the panel also support. But most of the commission's other Democrats say the plan lacks enough detail to demonstrate it would ensure adequate health care at reasonable

prices.

Democrats on the panel, who could cast deciding ballots, also say they are holding out for a provision recommending that Medicare help all beneficiaries pay for prescription drugs -- something the program does not now cover.

GOP commission members say the cash-strapped program can't afford drug coverage for everyone, and Breaux has suggested a compromise that would mainly help those with the lowest incomes.

The commission also is considering whether to recommend raising the Medicare eligibility age from 65 to 67, and if so, whether some younger people should still be able to get scaled-back coverage.

Another sticking point: whether to recommend more money for Medicare -- from tax increases or government surpluses, for example -- in addition to cost-cutting changes.

Without some action, Medicare is expected to run short of cash in about a decade -- just before the first of the huge baby boom generation begins to retire. Lawmakers have hoped that solid, bipartisan consensus from the commission would help neutralize some political dangers of making changes to the popular program.

The commission is expected to meet again sometime next week.



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Study Finds Agreement on Medicare Elusive

By Jane Bryant Quinn

Sunday, February 28, 1999; Page H02

Americans haven't even begun to think seriously about reforming Medicare. At current spending rates, the trust fund will run dry in 2008.

President Clinton proposed using part of the future budget surplus to shore up the system until 2020. But that's far from a done deal and wouldn't address the continuing medical needs of the giant baby-boom generation.

To find out what kind of reforms the public might accept, the League of Women Voters, together with the Henry J. Kaiser Family Foundation, sponsored 321 community talkathons: 11 focus groups, 300 small discussion circles and 10 large public meetings. More than 6,500 citizens were engaged.

To read the results is to find yourself on Fantasy Island.

Americans love their Medicare and say they're willing to do whatever is necessary to keep it going. But they're loath to raise payroll taxes or personal contributions.

They say that people should be responsible for themselves as much as possible, by paying as much as they can for their own health-care costs. Nevertheless, they think the government should cover long-term care in nursing homes so that they won't have to use their personal savings.

Americans know that Medicare is in serious trouble. But their major proposal for fixing it is to eliminate waste and fraud.

"Their feelings on this topic are so intense that they find it difficult to consider other reforms until they're assured that fighting waste, fraud and abuse will receive top priority," the League says.

But every overcharge isn't fraud; it might be a gray area, or an error. As important as error reduction is, it won't collect enough money to keep Medicare solvent.

Moving on to other ways of shoring up the system, the citizens groups quickly hopped on the thought of cutting payments to doctors and hospitals. They saw it as an antidote to their perception of overbilling.

But then they backed off. They're afraid that, if payments to providers

are reduced, fewer doctors and hospitals will take Medicare patients, reducing senior citizens' access to quality care.

What about raising Medicare premiums, co-payments and deductibles across the board? Absolutely not, the panels said. They think it would be unfair to lower-income people.

But the majority of those surveyed believe that contributions should be raised on a sliding scale, so that higher-income people would pay more. They didn't define "higher-income." Presumably, it means "anyone who makes more than I do." Some sort of means-testing contribution may well be part of the final package of reforms.

As for raising payroll taxes, most participants said that workers are already taxed enough. But they kept returning to this idea, as a "last resort."

They seem to feel that it's their "shared responsibility to ensure that Medicare is preserved, even if it means paying more in taxes," the League's report concluded.

Another proposed reform would gradually raise Medicare's eligibility age to 67, from 65 today. Most participants thought that a bad idea. It would push large numbers of people 65 and 66 into the ranks of the uninsured.

The citizens groups had mixed feelings about Medicare HMOs. Some supported them, others didn't, and they couldn't agree. At older ages, managed care continues to be a difficult sell.

Another tough sell is the Medicare privatization plan, expected next month from the National Bipartisan Commission on the Future of Medicare.

Under this approach, the government would allot every beneficiary a certain amount of money each year, which could be used toward the cost of traditional Medicare or private health insurance, most of which would be managed care.

No details have been provided yet, so people have no clue how such a radical revamping might affect their care or their out-of-pocket costs.

The panels and discussion groups fervently agreed on two things. Medicare should cover prescription drugs and the cost of long-term care. But they didn't offer to pay higher taxes or Medicare premiums to fund these new benefits.

As I said, Fantasy Island.

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March 1, 1999

Call to Senator Breaux

Chris Jennings has advised us that Senator Breaux may call to ask you to support the current Medicare proposal being considered by the Commission or indicate what modifications would need to be made to secure your support. Ron K. recommended that while you are apprised of the general status of the Medicare Commission, it would be useful to outline the major flaws in this proposal to help underscore why you cannot support his approach for Medicare reform.

Background. As you know, the Medicare Commission is coming to a close and Senator Breaux has currently has nine or ten votes (all eight Republicans, himself and likely Senator Kerrey) of the eleven that he needs to pass it out. As such, he is putting a great deal of pressure on the Administration and its appointees (particularly Laura Tyson and Stuart Altman) to vote for his plan to give him the necessary votes. Clearly, if Senator Breaux gets these additional votes, it would give this proposal a great deal of momentum (although regardless, he is likely to offer his proposal in the Senate Finance Committee). As such, our current strategy is to assure that we keep the bar high enough so that we do not have to endorse this proposal, while not appearing to be the roadblock for real Medicare reform.

Senator Breaux's proposal has so many serious shortcomings and major omissions that all of the base Democrats are urging us to avoid sending any positive signal about the Commission's work. Senator Breaux will no doubt say that he is open to changes in the proposal. However, to date he has not come close to modifying his proposal in any way that is acceptable to get the support of our Commission members or for that matter meets the basic principles the President has articulated. While he may be able to make some modifications to this proposal, we believe that it is highly unlikely that we will be able to reach the bar that we have set.

Major shortcomings in the Breaux proposal.

(1) No commitment to dedicate any of the surplus to Medicare. Senator Breaux has not agreed to the President's proposal to dedicate a portion of the surplus to the Medicare program. Virtually every independent health analyst agrees that it is simply not possible to extend the life of the Trust Fund significantly without unadvisable and unrealistic cuts. However, it is highly unlikely that Senator Breaux can get many Republicans to agree to this, in lieu of an across-the-board tax cut. (He may point out that the Administration's own actuaries are saying that his current premium support proposal saves \$347 billion over ten years. However, this is misleading because that includes not only his premium support proposal but a number of other controversial reforms listed below).

(2) No prescription drug benefit to all Medicare beneficiaries. Senator Breaux has only offered a prescription drug proposal that, by and large, cover beneficiaries in managed care plans as well as low-income beneficiaries. However, this proposal would no doubt leave out many in traditional fee-for-service, particularly those in rural areas that often only have access to fee-for--service. Base Democrats and our Commission members strongly believe that we must offer a drug benefit for all beneficiaries as well.

(3) An income-related premium for beneficiaries down to \$24,000 income threshold. This is an excessive proposal, even to those who are open to an income-related premium. It goes twice as low as the income thresholds proposed by Senators Chafee and Breaux during the Balanced Budget Act of 1997.

(4) An increase in age eligibility from 65 to 67 without any mechanism to ensure that these vulnerable hard-to-insure Americans would have access to coverage. We already know that Americans ages 55 to 65 are the most rapidly growing group of uninsured and those 65 to 67 would no doubt be vulnerable as well.

(5) No clear understanding of the impact of premium support on beneficiaries. We still have not seen sufficient details about Senator Breaux's proposal to understand how it would impact beneficiaries (e.g. increase in out-of-pocket costs, etc). If we are going to contemplate moving in this direction, we simply have to understand the implications of such reforms on beneficiaries.

Suggested Talking Points

- John, I believe your Commission is performing a constructive function and floating some important ideas.
- Having said this, our Commission members -- even those who are supportive of the premium support concept (Laura Tyson and Stuart Altman) -- have raised a number of very legitimate concerns.
- Your proposal does not dedicate any of the surplus to the Medicare program -- even though virtually every independent health analyst agrees that it is simply not possible to extend the life of the Trust Fund significantly without unadvisable and unrealistic cuts.
- It does not extend a prescription drug benefit to all Medicare beneficiaries. We believe that it is important that this benefit be for all beneficiaries. We are concerned that a benefits that is just for those in managed care plans or low-income beneficiaries would leave millions on beneficiaries out, particularly those in rural areas that may only have access to the traditional program.
- Your proposed income-related premium for beneficiaries down to \$24,000 income threshold is simply to low. It is twice as low as what you and Senator Chafee proposed during the Balanced Budget Act of 1997.
- Increasing the age eligibility to 67 without any mechanism to help those between 65 and 67. We already have too many uninsured in this country and we simply cannot support a proposal that will leave those 65 and 67 -- who will be quite vulnerable in the private insurance market --without coverage.
- More important, though, we are facing a real "melt-down" from many Democrats. While you may want to still try, I am not sure that you can produce the changes that they want, let alone the alterations Laura and Stuart want, without losing all or most of your Republican support.
- And, because of the strong feelings the Democrats have against your package, I don't think it would be advisable or productive for us to jump in this debate at this time to jam this proposal on Democrats. Therefore, recognizing the situation you face, it may well be best for you to move your package out with 10 votes out of the Commission.
- Doing so would avoid giving Democrats more time to analyze, criticize and undermine your work, since the only way you could even hope to attract Laura or Stuart would be through a prolonged discussion about important details.

Recommended Changes to the Breaux Medicare Reform Plan

Stuart H. Altman

The Medicare program which began in 1965 has been among the most successful programs developed by the Federal government. It has allowed millions of Americans, mostly over age 65, to have access to the best health care our nation offers, and provided critically needed funding to enable the health care system to support its ever changing structure and the use of increasingly expensive technology. But, Medicare has problems, problems which will grow much worse in the years ahead. To greatly simplify, these problems can be put into three categories:

- **1. Inadequate Benefits**

Medicare currently covers about 53 percent of the health care spending of Americans 65 years of age and over. Among the benefits not covered, the most important are outpatient prescription drugs and long-term care.

- **2. Future High Cost**

The combination of Medicare spending on a per capita basis growing faster than the growth in GNP and the number of Medicare beneficiaries doubling over the next 30 years, every projection indicates that spending under the current Medicare program will consume an ever larger proportion of our national income. With that said, it should also be emphasized that Medicare will be required to cover a much larger proportion of the US population and that Medicare spending per capita must be related to the medical cost growth in the general economy or the program will cease to provide adequate coverage for "mainstream" medical care.

- **3. Inflexible Program**

Medicare is a major federal program which is governed by the laws of Congress and administered by an agency of the federal government. As a result it is often restricted in its operation and the creation of new programs by political infighting within the Congress and between the Congress and the Administration. These political problems are compounded by the bureaucratic inertia of a large governmental program.

OUTLINES OF A REFORM PLAN

To address the problems listed above and still maintain the integrity and value of this vital program requires that we not replace three of Medicare's critical underlying principles:

1. A government guarantee that a specified set of benefits will be covered by any approved and financed Medicare plan.
2. A sufficient government contribution such that adequate coverage will be available and affordable to all beneficiaries regardless of their income or geographic location.
3. A premium and cost sharing structure that does not invalidate the social insurance aspects of Medicare such that it no longer is a preferred plan for all income groups.

A premium support plan with defined benefits and expanded coverage for outpatient prescription drug expenses that has limited income related premiums and/or co-payments can meet these requirements if it is designed correctly and is adequately financed.

The specifics outlined by Senator Breaux could be the foundation for such a plan but, I believe, they fail to include a number of important factors and include other components which could undermine the basic integrity of Medicare as a social insurance program. I have summarized these issues below along with proposed changes I believe are necessary to make the reform plan adequate for the 21st century and meet the high goals originally established for the Medicare program.

1. Lacks a specified and adequate set of benefits.

In order for adequate benefits to be available and affordable to all Medicare beneficiaries they must be specified in law and available in all approved Medicare plans including the one administered by the federal government. They also must include sufficient payments to providers that they will in fact be available and sufficient funds from the Medicare program that they will be affordable to all beneficiaries. To that end, I would propose the following additions to the Breaux plan.

A. All health insurers approved by Medicare including the program operated by the federal government must provide for beneficiaries to select as an option to basic coverage a plan which includes at least the following coverage for outpatient prescription drug expenses.

-- Following a special drug benefit deductible of \$500, the plan will pay 75 per cent of all outpatient drugs prescribed by an approved Medicare provider. After an individual reaches an out-of-pocket payment including the deductible of \$2500 per year, the plan would pay all additional drug expenses. For a couple living together the spending limit would be \$4000. For the basic Medicare plan, the federal government will contract with a limited number of private prescription drug benefit managers to administer the program. It is expected that such PBMs will use the same techniques developed by private health plans to help control spending including volume discounting, mail order dispensing and approved pharmacy formularies. The prescription drug option would require a special premium which would equal 50 percent of its expected costs. Beneficiaries would pay more or less than this average premium based on an income related schedule consistent with the design established for the basic Medicare plan. For low income beneficiaries, the deductible would vary from \$0 at 100% of poverty to the full \$500 at 200% of poverty.

B. A detailed set of benefits covered under all Medicare plans must be specified in law. All plans, including the one administered by the federal government, can establish their own rules as to how these benefits will be provided. Also permitted will be small variations requested by plans from the exact magnitude of the benefits subscribed in law. The Board which will oversee the operation of the premium support plan must approve all benefit designs and develop sufficient oversight competence that it can assure the Congress and the President that all plans comply with the law.

2. Income related payments could jeopardize social insurance aspects of Medicare

C. Any income related aspects of the reform plan will not consider family income below \$75,000 (\$50,000 for an individual) to be subject to a higher than average payment amount. The income related schedule should also recognize that some government payment amount is appropriate even for the highest income groups as they are also the groups which pay the largest tax amounts. Furthermore, any individual whose annual income is equal to or less than 135% of the poverty level will not be required to pay any premium or co-payment amounts.

3. Raising age could increase uninsured

D. The age when an individual becomes eligible for the full Medicare

program will gradually be raised from age 65 to age 67. In tandem with this change all otherwise eligible individuals could buy into the Medicare program at age 62. For those aged 65-67, the premium charged would be income related for the lowest income groups using the same schedule as discussed above.

4. The core Medicare program must continue to be affordable to all

E. The modernized Medicare plan operated by the federal government must continue to be primarily a fee-for-service plan open to all qualified and approved providers except for certain select high cost procedures and where clear quality differences are shown to exist. The basic Medicare plan should also be given the necessary authority to engage in the kinds of competitive bidding schemes used by private health plans for laboratory services, durable medical equipment and other similar services. Since this plan will retain much of its current character it should continue to have the power of federal government pricing and contracting authority.

F. The system used to allocate funds to different regions of the US and to price the national basic Medicare plan must not create a regional bias against particular regions or in favor of the non basic plan except where clear regional or plan inefficiencies exist. To this end, all extra legislated payments to providers beyond what the market for patient care requires should be calculated on a per patient basis (including both basic Medicare and private health plans) and paid by the government from the Medicare trust fund independent of the calculations used to determine beneficiary premiums and the regional payment to private health plans. Specifically, the extra payments for Indirect Teaching Costs and Disproportionate Share, or the special subsidies to rural providers should not be paid only by the Basic Medicare plan or required of patients of private plans who live in areas where such programs exist.

5. Need an adequate financing plan

G. The plan must include a detailed structure on how it will be financed. While the exact dollar amounts need not be included since predictions of future spending become increasingly suspect beyond 10 years, the proportions required from the different sources of funds should be specified and in general how such funds will be generated. Specifically, while the Breaux plan includes a number of provisions which will increase beneficiary liabilities, it does not mention how the additional governmental funds will be raised. This is a serious omission since the legislation which established the Commission required that we develop plans to restore the solvency of

the Federal Hospital Insurance Trust Fund and maintain the financial integrity of the Supplemental Medical Insurance plan. In that connection, the plan should include either the proposal stated by the President to use a portion of the expected federal surplus to help fund Medicare in the future or indicate how the needed federal revenues will be generated. Most importantly, the plan should indicate what proportion of the expected costs of the program should come from beneficiaries and the federal government, and how much should come from reduced payment growth to providers.

6. No discussion of Long-term care needs.

H. No mention is made in the Breaux plan for how the aged will pay for the increasingly expensive costs of long-term care in the future. At a minimum, recognizing the complex nature of this problem and its very high costs, the plan should contain some general statements about a preferred direction of future policy.



March 3, 1999

Letter to Vice-President Gore, Christopher Jennings, Donna Shalala, Nancy-Ann Min DeParle

Co-Chairs

David Harvey
AIDS POLICY CENTER FOR
CHILDREN, YOUTH AND FAMILIES

Miguelina Maldonado
NATIONAL MINORITY AIDS
COUNCIL

Executive Committee

Terje Anderson
NATIONAL ASSOCIATION OF
PEOPLE WITH AIDS

Julia Cohen
PLANNED PARENTHOOD®
FEDERATION OF AMERICA

Rose Gonzalez
AMERICAN NURSES
ASSOCIATION

Jeff Jacobs
AIDS ACTION COUNCIL

Seth Kilbourn
HUMAN RIGHTS CAMPAIGN

Jane Silver
AMERICAN FOUNDATION FOR
AIDS RESEARCH

Dear Friends:

We are writing to express our grave concern about proposals under development by the Bi-Partisan Commission on Medicare. On January 26th, 1999, Senator John Breaux (D-LA), Chairman of the Commission presented a skeletal draft of a possible majority Commission report. The proposal undermines the fundamental integrity of the Medicare program, does nothing to address the limitations of the program in providing comprehensive health care to beneficiaries, and fails to demonstrate the stated goal of restoring solvency to the Medicare program.

The National Organizations Responding to AIDS (NORA) coalition is a coalition of over 175 health, labor, religious and professional advocacy groups that represent a broad consensus on HIV and AIDS-related issues, policy, and funding levels.

Individuals living with HIV/AIDS comprise as many as 40,000 of the 5 million disabled beneficiaries currently in the Medicare program. As a result of new and more effective drug treatments, individuals with HIV/AIDS are increasingly becoming eligible for the Medicare program. It is clear that any major reform of the Medicare program will have a significant impact on the health care services available to people living with HIV disease as well as other individuals who qualify for Medicare on the basis of their disability status.

The Breaux proposal would essentially transform the Medicare program from a defined benefits program to a defined contribution program. Under the Breaux plan there would be two delivery systems-- fee-for-service traditional Medicare and the premium support or voucher system. The government would make a defined contribution toward the cost of an individual's health care in either system. If health care costs per person exceed what the voucher will buy, individuals will be liable for a greater and greater share of cost than is now the case. Sicker individuals, including people with HIV disease and other disabled beneficiaries would likely become concentrated in the traditional Medicare program because they will find it difficult if not impossible to find affordable private insurance plans. The very concentration of individuals with significant health care needs will likely drive up costs in the fee-for-service Medicare program--costs that will be passed on to beneficiaries in a system that caps the federal contribution per beneficiary.

NORA

A coalition convened by
AIDS Action Council

1875 Connecticut Ave., NW
Suite 700
Washington, DC 20009
202 986 1300
202 986 1345 fax

"A coalition of over 175 organizations responding to AIDS with resolve and action."

This proposal erodes the integrity of Medicare as a social insurance program. Healthy individuals with good incomes will do well; those with greater medical needs and lower incomes will not. Moreover, the Breaux proposal does not include any prescription drug coverage or any provisions to reduce out-of-pocket expenditures for beneficiaries. In fact, it is likely that beneficiary costs will rise significantly under this proposal, especially for those with limited incomes and significant health care needs.

We believe that our nation can do better in its efforts to guarantee health care to senior citizens and disabled beneficiaries. Given the ongoing commitment of this Administration to expand health care access for the nation's people, we urge you to clearly state your opposition to any Medicare reform proposal that reduces health care access and increases health care costs for some of our nation's most vulnerable citizens.

Thank you

AIDS Action
AIDS Legal Referral Panel
AIDS National Interfaith Network
AIDS Nutrition Services Alliance
AIDS Policy Center
American Association for World Health
Association of Nurses in AIDS Care
Center for Women Policy Studies
Committee for Children
HIV Managed Care Network
Legal Action Center
National Association of People with AIDS
National Association of Protection and Advocacy Systems
National Council on HIV Disease
National Health Care For the Homeless Council
The National Latina/o Lesbian, Gay, Bisexual & Transgender Organization

THE PRESIDENT HAS SEEN
3-4-99

C. Jennings
from Duigden

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Padasta
Jenning:

Projected 10-Year Savings

HCFA Actuary February 23rd Estimate of Commission Proposal -- Option 1

• Cutting Number of Seniors Eligible	-\$25 b
• Added Beneficiary Payments	-\$127b
• Extending Provider Cuts	-\$57 b
• Fee For Service Reforms	-\$22 b
• Removing DME from Trust Fund	-\$46 b
• Premium Support	-\$75 b
• <u>Interactions</u>	<u>\$ 5 b</u>
• Total	-\$347b

Cutting Number of Seniors Eligible: raising the age of Medicare eligibility from 65 to 67

Added Beneficiary Payments: includes increased cost sharing (including a 10% coinsurance on all home health services and 20% coinsurance on other services like laboratory services); and Medigap reforms prohibiting Medigap from 1st dollar coverage

Extending Provider Cuts: extends reductions in provider payments and updates from the Balanced Budget Act of 1997 for 5 years

Removing Direct Medical Education (DME) from the Trust Fund: this is not really a payment reduction, but a budget game. The government will presumably still pay for Direct Medical Education, but it will be moved to another part of the budget.

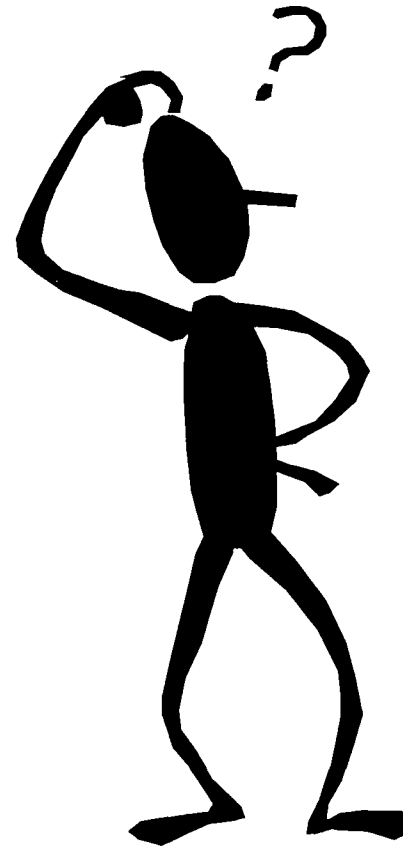
Premium Support: includes savings from managed care reductions in payments to providers; greater efficiencies through competition; and shifting of costs for fee for service beneficiaries.

Interactions: there is a cost to the government because of the way these provisions interact with other programs, like Medicaid.

Cuts to Beneficiaries

Total Cuts to Beneficiaries \$141b

- Added Beneficiary Payments
 - Cost Sharing Increases \$20b
 - Income Related Premium \$96b
- Cutting Number of Seniors
Eligible for Medicare \$25b



Extending Provider Cuts

Extending Provider Cuts **\$57b**

- Five year extension of payment reductions to providers in the BBA 97



Premium Support Savings

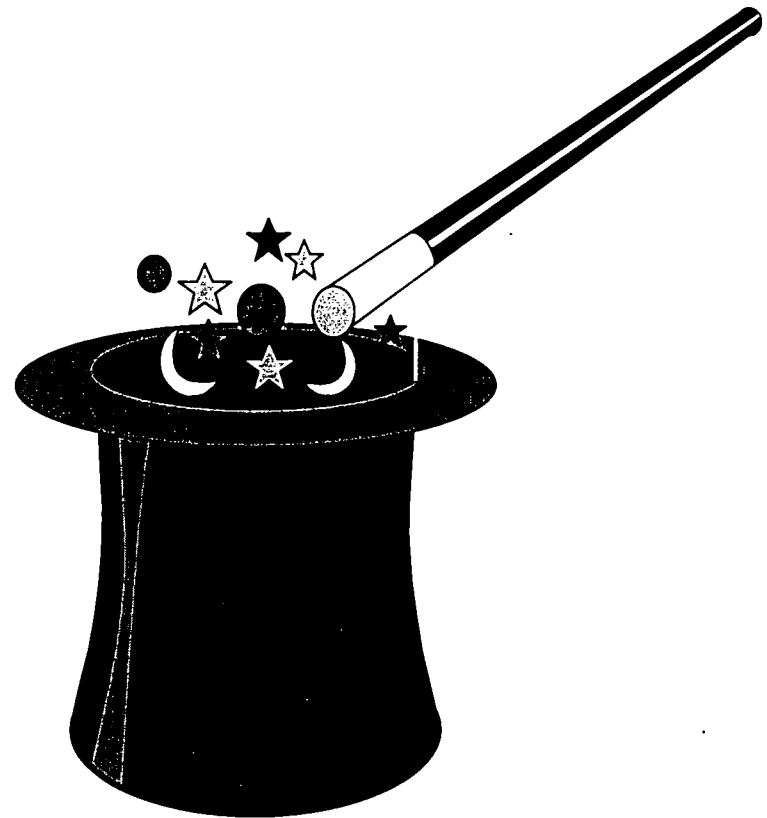
- **Premium Support Savings \$75b**

Commission says savings come from:

- greater efficiencies and
- competition

We believe real savings come from:

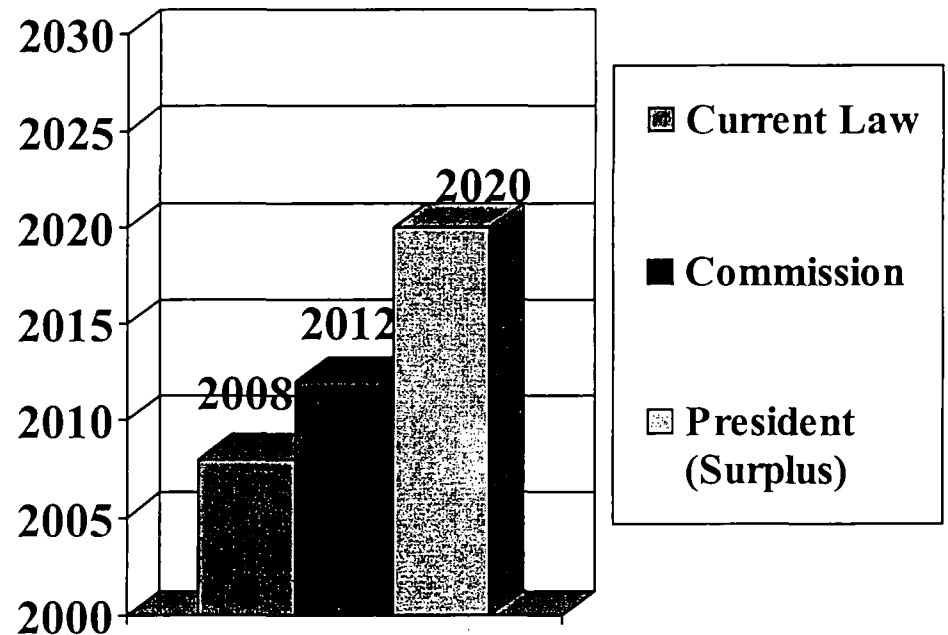
- managed care reductions in payments to providers
- raising premiums for beneficiaries in fee for service



Does Commission Proposal Save Medicare?

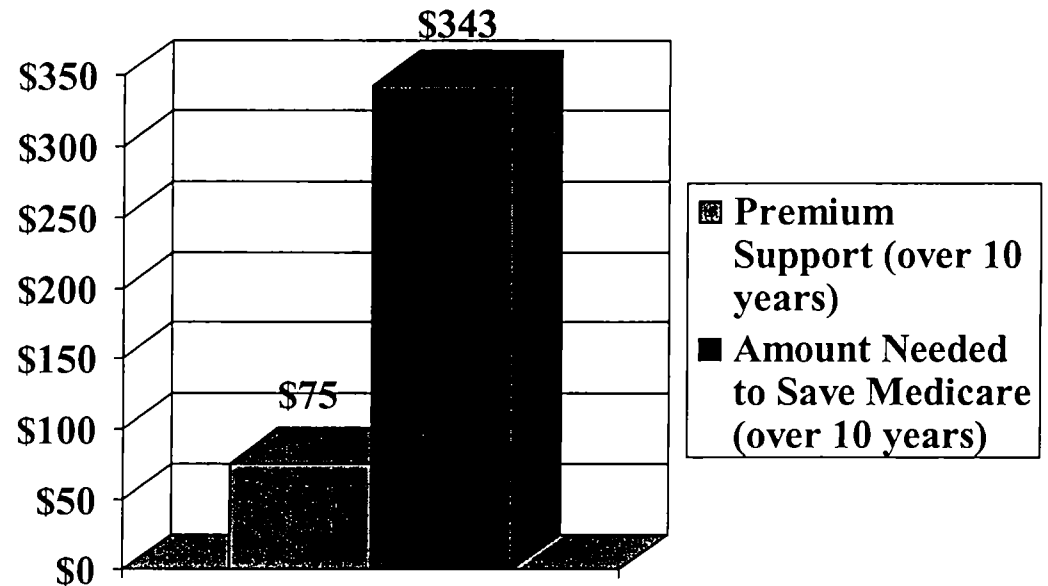
- **Trust Fund Expiration Date**

- Current Law 2008
- Commission (best estimate) 2012
- President's Proposal 2020



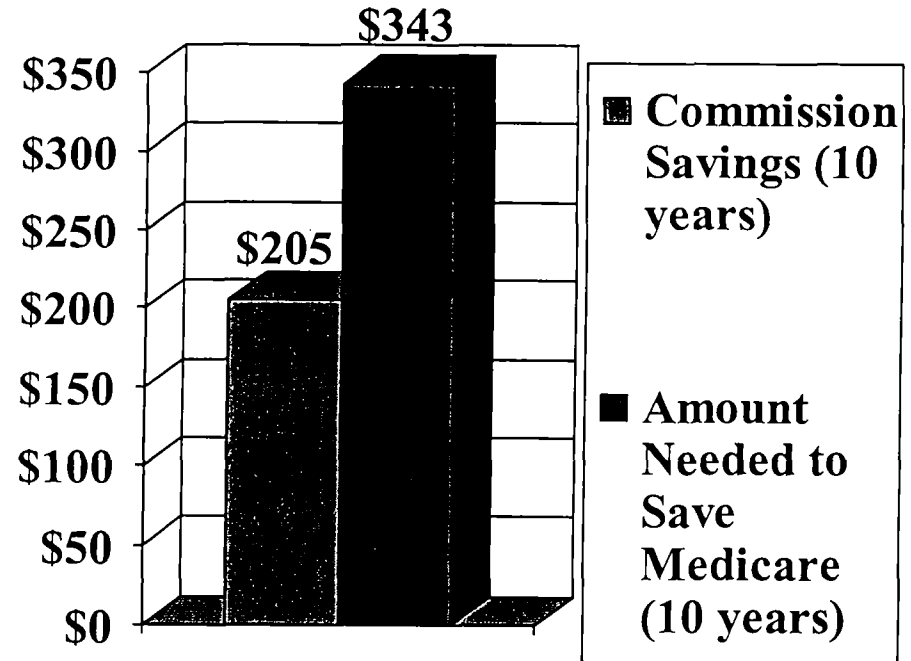
Premium Support Falls Short

- Savings from Premium Support (over 10 years) \$75b
- Amount needed to save Medicare (over 10 years) \$343b



Commission Proposal Doesn't Save Medicare

- Commission Savings
(10 years) \$205b
- Amount Needed to Save
Medicare (10 years) \$343b





THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 2 1999

MEMORANDUM FOR THE PRESIDENT

I am writing because of my deep concern about the direction of the recent Medicare Commission discussions as Senator Breaux and Representative Thomas continue to court support for their proposal. While I believe the Administration has and should continue to vigorously articulate specific recommendations for strengthening and modernizing Medicare, we should be extremely cautious about accepting the vague "premium support" model developed by the Commission without fully exploring the significant policy issues it raises. In my view, it would also be a tactical mistake to cede political leverage by validating a premium support approach in advance of the upcoming congressional debate.

Despite the very hard work of your appointees, your staff, and the other Democrats involved with the Commission, I think that we must conclude that the Commission has failed in its primary task, which was to engage the policy community and the public in an open process that could develop reasonably broad, bipartisan agreement on how to address the long-term financing issues facing Medicare. Instead, the work of the Commission has focused largely on recasting and dressing up the Republican's 1995 Medicare reform goal of privatizing Medicare under the guise of "premium support." While the Democrats (helped considerably by your budget proposal) have remained willing to engage on the primary mission of the Commission – long-term financial solvency – little progress has been made in this area. Indeed, at the last Commission meeting, Republicans sought to recast the solvency debate in terms of the "rate of program growth" rather than trust fund solvency – a fairly transparent attempt to dismiss your strong argument for dedicating a portion of the surplus to extend the life of the Medicare Part A trust fund.

As the Commission winds up its work, we are left with a vague proposal that enjoys no public credibility, that fails to address the long-term financing problem of Medicare, that fails to address the critical need for an outpatient prescription drug benefit, and that fails to achieve any true bipartisan consensus on the appropriate future direction for Medicare. These problems are fundamental. Even if some last minute maneuvering brings about some coverage for prescription drugs or some use of the surplus, it seems doubtful that, after a thorough review, the "deal" would long survive the Commission's end.

In addition, we have extraordinarily few details on many of the major elements of the proposal, leaving the door open for the Republican leadership and Commission members to later selectively invoke the Commission's endorsement for items they decide to include in their legislative proposals. Another serious problem is that we only last week received an objective analysis (from the HCFA actuary) of the financial impacts of the proposal, and we have yet to receive any information on the distributional consequences (the winners and losers). I do not see how we or the congressional Democrats can move forward on a bipartisan basis when there is no

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firm meeting of the minds about what this proposal is intended to do, who it affects, how it would be structured, and who would pay for it.

Although the proposal put forth by Senator Breaux and Representative Thomas lacks specificity in many areas, the information that has been provided raises significant policy concerns. These include:

- **A substantial portion of the savings from the proposal result from raising beneficiary costs.** The estimates from the HCFA actuary indicate that roughly 45 percent of the savings from the Breaux/Thomas proposal come from increasing costs to beneficiaries, including specific proposals that would increase cost sharing (particularly for home health care), delay program eligibility to age 67, and create a new income-related premium (although these savings may be spent on new low-income protections). The income-related premium would begin at \$24,000 for single beneficiaries and \$30,000 for couples, a threshold so low that it essentially changes the social insurance nature of the program. In contrast, the income related premium proposed in the Health Security Act began at \$90,000 for single beneficiaries and \$110,000 for couples. The change in the eligibility age will increase the number of uninsured Americans, whether or not a buy-in proposal is included in the package. I do not believe that these proposals, as currently specified, are good for Medicare or will be acceptable to most congressional Democrats.
- **The proposal places the traditional fee-for-service Medicare program and the beneficiaries that it serves at risk.** While the Breaux/Thomas proposal contains some improvements for fee-for-service Medicare, including the new authorities that you have regularly requested to make HCFA a more prudent purchaser, the premium support program that is being considered would increase costs for those beneficiaries who elect to stay in fee-for-service or who have no choice of plans (e.g., millions of beneficiaries in rural areas). According to the HCFA actuary, fee-for-service premiums will increase by roughly 18 to 30 percent under premium support, with somewhat lower increases, 10 to 20 percent, if BBA extenders are enacted at the same time. Such increases may force lower income beneficiaries into private plans; beneficiaries in rural areas with no private plan choices will be forced to pay much higher premiums.
- **The proposal does not guarantee that all beneficiaries will receive the Medicare defined benefits.** Although the Democrats on the Commission have repeatedly stated that the benefit package for private plans should be defined so that it includes all existing Medicare benefits, the proposal appears to allow a proposed Medicare Board to approve benefit variations. Without a defined benefit package, aggressive risk selection activities by private plans could lead to greater adverse selection against the fee-for-service program. Without perfect risk adjustment, which we do not have, fee-for-service costs and premiums will increase.

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- **Premium support, which is the most contentious element of the proposal, neither addresses Medicare's long-term financing problem nor produces sufficient savings to justify its adoption at this time.** According to the estimates of the HCFA actuaries, the inclusion of premium support will reduce Medicare spending in 2030 by just 2.5 to 3.1 percent. Over the 30-year period, premium support would provide only a little more savings than would be gained from the combination of the proposed fee-for-service modernizations and extending the BBA savings policies for about 5 years. While any method of improving the efficiency of Medicare should be seriously explored – and premium support has some positive attributes – it is clear that premium support has little impact on the long-term financial problems faced by the program.

As stated above, while we know something about the savings that may come about from premium support, we still do not have distributional analyses of who wins and who loses under different premium support approaches. Given the political controversy that premium support engenders, combined with its adverse impacts on beneficiaries without other choices, it would be premature for us to give any indication that premium support might be appropriate for Medicare.

We also need to be mindful that the premium support concept remains a moving target, despite the attempts of Senator Breaux and Representative Thomas to provide some direction. For example, at the last Commission meeting, three of the advocates of premium support suggested that their support was based primarily on the ability of private plans under premium support to provide substantial additional benefits to beneficiaries. However, the premium support specifications released by Senator Breaux either eliminate or substantially restrict (two options) the ability of private plans to offer additional benefits. Some members of the Commission and most of the public are not yet aware of this fact, and many potential supporters may have second thoughts when they understand the new direction. Again, I think that there is need for extreme caution in our public pronouncements until the details are written down and well understood by all of the relevant parties.

- **The proposal does not include a critically needed outpatient pharmaceutical benefit for all beneficiaries.** As you well know, prescription drug therapies are increasingly important to improving the health and well-being of our citizens, particularly those with chronic health conditions. Medicare simply cannot operate efficiently unless providers and health plans can use all of the tools available to improve the health of the elderly and the disabled.

Unfortunately, Senator Breaux and Representative Thomas have not agreed to support inclusion of a prescription drug benefit that would be available to all Medicare beneficiaries, instead suggesting a combination of different approaches for different segments of the Medicare population. Their stated reason for opposing a Medicare outpatient pharmaceutical benefit is a concern about substituting for existing prescription

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drug coverage, but much of this concern is misdirected. A substantial portion of existing spending is either in public programs (i.e., Medicaid) or government subsidized (i.e., employer-provided retiree benefits, Medicare+Choice plans). Further, all of the trends indicate that employers will be providing fewer retiree health care benefits in the future.

Another concern raised by some Commission members is that a Medicare pharmaceutical benefit would give HCFA too much power over the prices that the elderly pay for prescription drugs. I view this argument as saying that we should be putting the profit needs of the pharmaceutical industry above the needs of beneficiaries to have access adequate health care. We must assure that beneficiaries are provided an affordable prescription drug benefit and that HCFA and private plans have sufficient authority to procure needed drugs at the best possible prices for beneficiaries and taxpayers.

- **The new Medicare Board that would be created under the proposal would bifurcate federal responsibility for Medicare and significantly reduce executive branch influence over Medicare policy and spending.** The Breaux/Thomas proposal to create a new Medicare Board would result in a split of administrative responsibility for Medicare, with the new Board overseeing private plans, and HCFA continuing to have responsibility for fee-for-service Medicare. This split of responsibility would eliminate the single point of accountability for Medicare that we have today, and would make it much more difficult for the President and the Executive Branch to coordinate overall Medicare policy in a way that focuses on the needs of all beneficiaries. It also could diffuse our successful anti-fraud efforts, particularly the aggressive initiatives undertaken by the HHS Inspector General, by separating accountability over program finances. Such a change is not prudent given the important role that Medicare plays in the lives of millions of Americans as well as its significant impact on the federal budget.
- **Current beneficiaries may experience significant disruptions.** We also need to be cautious about the extent to which we cause large disruptions for current beneficiaries. Last year, when a large number of managed care plans left the program, there was a considerable backlash from beneficiaries who experienced changes in plans, benefits and providers. Significantly greater changes for beneficiaries are likely under the Breaux/Thomas proposal. For example, the proposal would significantly limit the extent to which private plans could offer additional benefits to beneficiaries, which would mean that most current beneficiaries in Medicare+Choice plans would lose many of the benefits that they have today. In addition, market shake-ups and plan withdrawals could well be more frequent and more extreme under premium support, particularly in the early years before the system stabilizes. These issues have received no attention by the Commission.

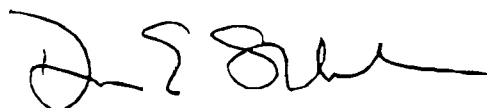
In raising these serious concerns, I am also reminded that the Administration has a vision for addressing Medicare's financial problems and for strengthening and modernizing the benefits and program operations. As your budget proposal demonstrates, the Administration, working with congressional Democrats and interested Republicans, can begin to address Medicare's

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problems without undermining the financial security of present and future beneficiaries. A thoughtful approach that includes dedication of a portion of the surplus to Medicare, the authority for HCFA to use more competitive purchasing practices, a responsible income-related premium aimed at truly higher income beneficiaries, an affordable prescription drug benefit, more rational cost sharing, and an extension of BBA savings proposals would be a package that could receive substantial support. These policies have been discussed before and are fairly well understood by the public and the Congress, and, unlike premium support, would not be considered radical change to the program.

We have an opportunity this year to make real improvements in Medicare that both secure the financing of the program for years and enhance the health care protection that we offer the elderly and disabled. But as we continue to put forth our vision for change, I believe that we need to be careful not to provide political cover to an untested, radical restructuring proposal that may be taken up in Congress this year. In my opinion, providing Administration validation of premium support would diminish our ability to control the details through the legislative process, potentially handing us a take-or-leave-it proposal for Medicare restructuring imbedded in a broader legislative vehicle at the end of this session. As we move forward, we need to protect the program from those whose ultimate goal is simply to privatize rather than improve Medicare.

The Commission process has been a trying one for all of us, and everyone who supports this program appreciates the effort that you personally and your appointees and staff have made to try and make the process a success. I hope that we can shift those energies now toward developing a proposal that is consistent with the values that underlie this program and which can garner broad public support and bipartisan support in Congress.



Donna E. Shalala

% respect retrospective

total retrospective
1998 spending