Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. schedule	Schedule of the President re: phone numbers (partial) (1 page)	07/22/12	P6/b(6)
002. manifests	re: Marine One and Air Force One (4 pages)	07/22/1999	P6/b(6), b(7)(C), b(7)(E), b(7)(F)
003. paper	re: medicare stories (2 pages)	07/22	P6/b(6)
004. paper	re: medicare stories (3 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:
Medicare Drugs Event [Folder 3]

2012-0463-S
rc697

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]
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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)]

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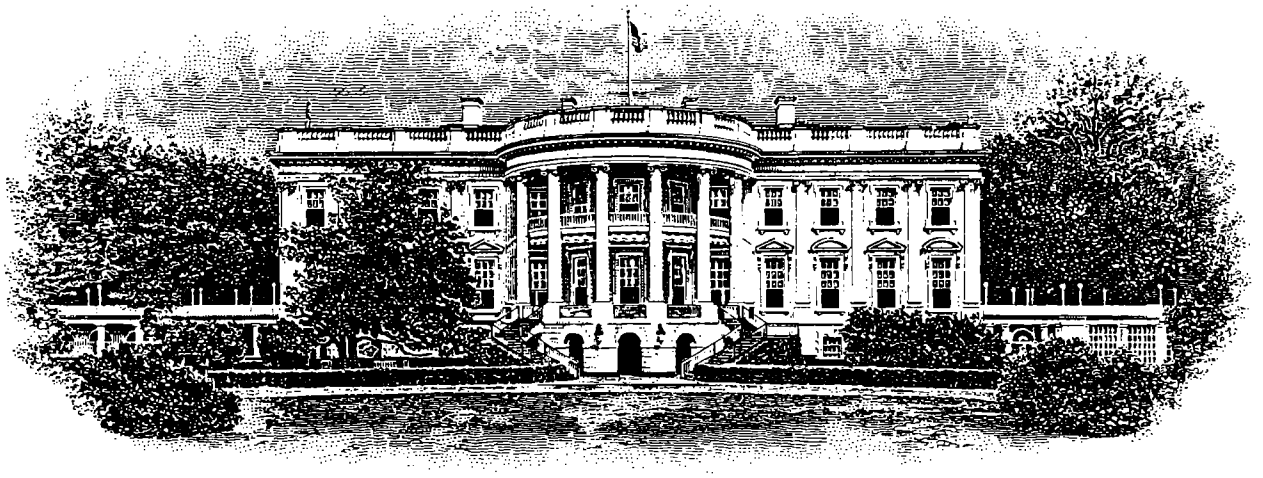
DPUB

The White House



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SCHEDULE OF THE PRESIDENT
FOR
THURSDAY, JULY 22, 1999

Final Schedule

[001]

SCHEDULING DIRECTOR:	**STEPHANIE STREETT**
HOME:	P6/(b)(6)
OFFICE:	**202-456-2823**
WHCA PAGER:	**4824**
PRESS DESK:	**DORI SALCIDO**
HOME:	P6/(b)(6)
OFFICE:	**202-456-5771**
WHCA PAGER:	**4844**
TRIP COORDINATOR:	**AVIVA STEINBERG**
HOME:	P6/(b)(6)
OFFICE:	**202-456-2920**
WHCA PAGER:	**4022**
ADVANCE LEAD:	**MOLLY BUFORD**
CELL PHONE:	P6/(b)(6)
STAFF OFFICE:	**39-220**
WHCA PAGER:	**4452**

WEATHER:

WASHINGTON, D.C.
Partly to mostly cloudy with isolated light showers and thunderstorms . Winds southeast at 5 to 10 knots. Low 70 to 75. High 86 to 91.

LANSING, MICHIGAN
Partly cloudy with isolated afternoon showers. Winds south to southwest at 8 to 12 knots. Low 62 to 67. High 85 to 90.

Schedule of the President
for
Thursday, July 22, 1999
Final Schedule

8:30	am		**THE PRESIDENT** departs The White House via motorcade en route Reflecting Pool [drive time: 5 minutes]
8:35	am		**THE PRESIDENT** arrives Reflecting Pool
8:45	am		**THE PRESIDENT** departs Reflecting Pool via Marine One en route Andrews Air Force Base [flight time: 10 minutes]
8:55	am		**THE PRESIDENT** arrives Andrews Air Force Base Greeter: Colonel Mike Wright, United States Air Force
9:10	am		**THE PRESIDENT** departs Andrews Air Force Base via Air Force One en route Capitol City Airport, Lansing, Michigan [flight time: 1 hour, 30 minutes]
9:40 10:00	am- am	(T)	**FOREIGN POLICY BRIEFING AND PHONE CALL** ABOARD AIR FORCE ONE Staff Contact: Samuel Berger

10:40 am **THE PRESIDENT** arrives Capitol City Airport, Lansing, Michigan

Greeters:
Jennifer Granholm, Attorney General
State Senator John D. Cherry, Jr., Senate Minority Leader
State Representative Michael Hanley, House Minority Leader
State Representative Laura Baird
State Representative Lynne Martinez
State Representative Lingg Brewer
State Representative Paul N. DeWeese
Antonio Benavides, Lansing City Council President
Joan Bauer, Lansing City Council Vice President
Louis H. Adado, Lansing City Council Member
Sandy Allen, Lansing City Council Member
The Reverend Michael C. Murphy, Lansing City Council Member
Mayor David C. Hollister, Lansing
Lansing County Commissioner Paul Pratt, Chair
Lansing County Commissioner Mary Stid, Chair Pro Tem
Lansing County Commissioner Wallace Juall, Vice-Chair Pro Tem
Betty Lee Ongley, President, National Board of Directors, Older Women's League
Judith A. Lee, Assistant Executive Director, Older Women's League
Steve Protulis, Executive Director, National Council of Senior Citizens
John D'Agistino, President, Michigan State Council of Senior Citizens
Martha McSteen, President, National Committee to Preserve Social Security and Medicare
Max Richtman, Executive Vice President, National Committee to Preserve Social Security and Medicare
Ann Greer (T)

10:55 am **THE PRESIDENT** departs Capitol City Airport, Lansing, Michigan via motorcade en route Lansing Community College
[drive time: 20 minutes]

11:15 am **THE PRESIDENT** arrives Lansing Community College

11:20 am **THE PRESIDENT** proceeds to Gymnasium

Greeters: Jim Anderton, President, Lansing Community College
Olga Holden, Trustee, Lansing Community College
Jim Byrum, Trustee, Lansing Community College
Brian Jeffries, Trustee, Lansing Community College
Paula Cunningham, Executive Director of Marketing, Communications, and Board Relations, Lansing Community College

11:25 am-
12:40 pm **CONVERSATION ON MEDICARE**
GYMNASIUM
Lansing Community College
Remarks: Paul Glastris
Staff Contact: Bruce Reed, Mary Beth Cahill
Event Coordinator: Aviva Steinberg
OPEN PRESS

Note: There will be 45 participants and 350 audience members.

-- Off-stage announcement of **the President**, accompanied by Jane Aldridge, Moderator.

-- **The President** proceeds to podium.

-- **The President** makes a statement.

-- **The President** proceeds to his seat on-stage.

-- Jane Aldridge, Moderator, begins the discussion.

-- **The President** makes a closing statement, works a ropeline and departs.

12:45 pm-
1:00 pm **HOLD**

1:05 pm **THE PRESIDENT** departs Gymnasium via motorcade en route Dart Auditorium
[drive time: 5 minutes]

1:10 pm **THE PRESIDENT** arrives Dart Auditorium

1:15 pm- **GREET OVERFLOW CROWD**
1:25 pm DART AUDITORIUM
Lansing Community College
Staff Contact: Bruce Reed, Mary Beth Cahill
Event Coordinator: Aviva Steinberg
CLOSED PRESS

1:25 pm- **POLICE/DRIVER PHOTOGRAPHS**
1:30 pm HALLWAY
Dart Auditorium

1:35 pm- **BRIEFING**
1:40 pm ROOM 251
Dart Auditorium
Staff Contact: Joe Lockhart

1:40 pm- **INTERVIEW FOR AARP'S *PRIME TIME RADIO* PROGRAM**
1:50 pm ROOM 252
Dart Auditorium
Staff Contact: Joe Lockhart, Megan Moloney
Event Coordinator: Aviva Steinberg
CLOSED PRESS

1:55 pm **THE PRESIDENT** departs Lansing Community College via motorcade en route Capitol City Airport, Lansing, Michigan
[drive time: 20 minutes]

2:15 pm **THE PRESIDENT** arrives Capitol City Airport, Lansing, Michigan

2:30 pm **THE PRESIDENT** departs Capitol City Airport, Lansing, Michigan via Air Force One en route Andrews Air Force Base
[flight time: 1 hour, 15 minutes]

3:45 pm **THE PRESIDENT** arrives Andrews Air Force Base

4:00 pm **THE PRESIDENT** departs Andrews Air Force Base via Marine One en route Reflecting Pool
[flight time: 10 minutes]

4:10 pm **THE PRESIDENT** arrives Reflecting Pool

4:20	pm	**THE PRESIDENT** departs Reflecting Pool via motorcade en route The White House [drive time: 5 minutes]
4:25	pm	**THE PRESIDENT** arrives The White House
4:30 6:00	pm- pm	**DOWN TIME**
6:00 6:30	pm- pm	**CONGRESSIONAL MEETING** OVAL OFFICE Staff Contact: Steve Ricchetti, Larry Stein
6:30 7:30	pm- pm	**HOLD**
7:50	pm	**THE PRESIDENT** departs The White House via motorcade en route Private Residence [drive time: 10 minutes]
8:00	pm	**THE PRESIDENT** arrives Private Residence Greeters: Bill Douglas Corinne Douglas
8:05 9:30	pm- pm	**DINNER** DINING ROOM Private Residence Staff Contact: Joe Lockhart Event Coordinator: Aviva Steinberg **CLOSED PRESS**
9:35	pm	**THE PRESIDENT** departs Private Residence via motorcade en route The White House [drive time: 10 minutes]
9:45	pm	**THE PRESIDENT** arrives The White House
BC/HRC RON		**THE WHITE HOUSE** **WASHINGTON, DC**

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THE WHITE HOUSE

WASHINGTON

July 21, 1999

CONVERSATION ON MEDICARE

DATE:	July 22, 1999
LOCATION:	Lansing Community College
EVENT TIME:	11:25am – 12:40pm
FROM:	Bruce Reed, Gene Sperling, Mary Beth Cahill Chris Jennings

I. PURPOSE

To participate in a discussion regarding the future of the Medicare program with Lansing and surrounding Michigan area community members.

II. BACKGROUND

You will participate in a conversation with approximately 45 Lansing and surrounding Michigan area residents. The Older Women's League, the National Council of Senior Citizens, and the National Committee to Preserve Social Security and Medicare have sponsored this forum. The audience consists of seniors from the three host organizations, senior organizations from Lansing and around the state, health care and consumer organizations, participants in senior programs across the community, and state and local elected officials.

Today, you will release a new report entitled, *"Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage,"* which describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. You will also underscore the importance of seizing this historic opportunity to strengthen and modernize the Medicare program by making it more competitive and efficient; modernizing and reforming its benefits, including the provision of a long-overdue prescription drug benefit; and making an unprecedented long-term financing commitment to Medicare that would secure Medicare's financing for the next quarter century. Today, you will:

UNVEIL NEW REPORT DOCUMENTING THE DANGEROUS TRENDS IN PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES.

Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. Today's report documents that the cost of purchasing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance, but is also an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

✓ **THREE OUT OF FOUR MEDICARE BENEFICIARIES LACK DECENT, DEPENDABLE, PRIVATE-SECTOR COVERAGE OF PRESCRIPTION DRUGS.**

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

- **Over three-fourths of beneficiaries have no coverage, inadequate Medigap coverage or public coverage for prescription drugs.** At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. Medicaid picks up 12 percent of the lowest income and sickest beneficiaries. The remaining 5 percent are in Veterans' and other public programs.

✓ **PRIVATE TRENDS: DECLINE IN COVERAGE AND AFFORDABILITY.**

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

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

✓ **PUBLIC DRUG COVERAGE TRENDS: MANAGED CARE BENEFITS REDUCED.**

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

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

✓ **MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE.**

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

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

✓ **PRESCRIPTION DRUG COVERAGE IS GOOD MEDICINE.**

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

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

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

I. PARTICIPANTS

Jane Aldrich, Moderator
See attached list of discussion participants.

II. PRESS PLAN

Open Press.

III. SEQUENCE OF EVENTS

- **YOU** will be announced, accompanied by Jane Aldrich, moderator, onto the stage.
- **YOU** will proceed to the podium and make a statement.
- **YOU** will proceed to your seat on stage.
- Jane Aldrich will begin the discussion.
- Upon conclusion of the discussion, **YOU** will make a closing statement, work a ropeline and depart.

VI. REMARKS

To be provided by speechwriting.

I. ATTACHMENT

Participants List
Conversation Talking Points

CONVERSATION ON MEDICARE
DISCUSSION PARTICIPANTS

MARY AIKEY, East Lansing, MI
Mary believes that while the Medicare program has been a godsend to America's elderly, we need to modernize the benefit package and cover new things like prescription drugs and other preventive benefits. She is concerned about the instability of Medicare+Choice drug coverage, and believes that her Medigap policy does not always cover the right thing – like prescription drugs.

BARBARA AMES, Brighton, MI
Because of the services Medicare provided when her mother became suddenly ill, Ms. Ames was able to concentrate on helping her mother recover, and not the financial cost of her mother's illness. She hopes that Medicare will be there for her, and her daughter, so that a serious illness will not financially devastate the family.

MARY ARCHART, Lansing, MI
Mary, 74, feels fortunate that her supplemental coverage and investments have taken care of her to this point. However, she is afraid of what will happen down the line when her coverage is too expensive and she can no longer afford prescription drugs, which cost her $100 monthly.

GREG BOVEE, Lansing, MI
Greg is a community pharmacist who counsels patients on their drug prescriptions and works with the appropriate caretakers to ensure that the medications are taken appropriately. He often encounters seniors who have to choose between purchasing drugs and necessities, such as food, and those who stretch out their medication because they can not afford to purchase their prescriptions regularly and end up in the hospital.

DERWOOD BOYD, Lansing, MI
Derwood, 77, has had no problems with his prescription drug coverage as he has supplemental insurance through the state. However, he does have many retired friends who are ill and have trouble keeping up with the cost of their prescription medications.

INEZ CAREY, Owoso, MI
Inez, 81, is has Medicare and supplemental coverage, which does not include prescription drug coverage. Paying for her prescriptions is very difficult for her, and last year she spent between $1600 and $2000 on her prescriptions. She has been forced to pay for some prescriptions with her credit card, and she worries about her accruing debt.

DAVE AND DOROTHY COBB, Delta Township, MI
Dave, 65, and Dottie, 63, have supplemental coverage, and Dave now has Medicare but has not had to use it yet. He feels thankful that Medicare is there for him in case he needs it.

DUBE COULTER, Lansing, MI
Dube, age 53, and her husband assist in the care of her mother-in-law, who has recently moved into a senior apartment building. Dube worries about her own future, as retirement age is rapidly approaching, and she is not counting on Medicare being there for her. With their expenses for their 2 daughters' college education and trying to assist Thomas' mother, they are not able to save much for their own retirement.

MARY CROSBY, Lansing, MI
Mary, aged 75, and her husband, have Medicare and retiree coverage, provided by General Motors, which includes prescription drug coverage.

KAY CRUMM, Lansing, MI
Kay Crumm, Executive Director, Rocking Chair Senior Center, sees firsthand the everyday experiences and struggles of those seniors that participate with her senior center.

CURTIS DUNN, Lansing, MI
Curtis, 71, spends approximately $120 per month on medications. He believes that the addition of a prescription drug benefit to the Medicare program is long overdue. He sees people at the grocery store and pharmacy paying for their prescriptions with their credit cards, and others who have had to take out home equity loans in order to pay their medication bills.

JOSETHINA ESTRADA, Lansing, MI
Josethina, a 69-year-old widow, is on Medicare, and has supplemental coverage, which helps pay her medical bills. With several health problems she must take many medications, and her daughter must help her pay for them.

HEATHER FRETELL, Lansing, MI
Heather is a pharmacist who has seen many seniors who have to go without their medications because they are too expensive. She has seen some patients almost walk out of the store without any medication at all, due to the high cost.

CYNTHIA GERSTENLAUER, Lansing, MI
Cynthia Gerstenlauer has been an advance practice nurse specializing in geriatrics for 17 years. She has seen seniors, who think that they feel well enough to do without their medications, ration their medication and end up in the hospital. She has also seen older women who request a mammogram or a bone density test, and leave without receiving one because they could not afford the copayment or deductible.

LAURIE GORDON, MSW, East Lansing, MI
Laurie has been a home health social worker for 8 years, and has seen firsthand how the lack of prescription coverage can result in negative medical consequences.

LOREN AND JANETTA GRAHAM, Lansing, MI
Loren and his wife Janetta, both have Medicare and supplemental coverage through their former employer. They are very happy with the Medicare program, and have both used it regularly as cancer survivors. While they do have some prescription drug coverage, Loren knows that their insurance is not guaranteed as part of their retirement, and is concerned that at any time they could be forced into an HMO.

JO GRUBBE, Lansing, MI
Jo, 57, has three children. The company she works for does not have a pension program, and Jo believes she may have to work well beyond retirement age to cover healthcare costs as she gets older. She worries about whether Medicare will be there for her, and about how expensive supplemental insurance and medication costs will be when she needs them the most.

PHYLLIS GUTHRIE, Diamondale, MI
Phyllis has a Medigap plan, which provides coverage for prescription drugs, but would like to see a guaranteed benefit for everyone. However, she is worried that we cannot afford the cost of a prescription drug benefit.

MARY JANE HOCK, Detroit, MI
Mary Jane, 72, has Medicare and supplemental coverage, but it does not cover prescription drugs. She has begun to spend her savings on her medications, which cost her about $250 a month.

ADONNA JORY, Haslett, MI
Adonna, 76, has Medicare and supplemental coverage. She has been happy with her Medicare coverage, but her one complaint is that there is no assistance with the cost of prescription drugs, which personally cost her $160 a month.

ALICE KOCEL, East Lansing, MI

Alice, 79, has Medicare and a retiree benefits program from her work as a state employee which includes prescription drug coverage. She is glad to see that Medicare has been expanding its preventive services, and would like to see more done for prevention.

OLIVIA LETTS , Lansing, MI
She has Medicare and a supplemental coverage plan that takes care of prescription drugs. She sees that her friends' costs are much higher than hers are. If she did not have her supplemental coverage she believes she would not be able to afford her medications costs, and she would likely not take all of her medications regularly.

BETTY LECLEAR, Holt, MI
Betty, 74, has Medicare and supplemental coverage which covers her medication costs, that would otherwise cost more than $300 monthly. However, she does find it difficult to afford this expensive supplemental coverage. Betty wonders whether Medicare will be there for her three children when they grow older.

BETH LOTT, Lansing, MI
Beth, 67, has Medicare and supplemental coverage, which pays for prescription drug costs. She knows that there are seniors out there that do not have the benefits she does, and believes that something must be done to add prescription drug coverage to Medicare.

PATRICIA LOWRIE, Okemos, MI
Patricia, 55, assists in the care of her parents, who live in Washington, D.C., as much as she can (flies to DC once a month. While Patricia knows her currently employer has a good retiree benefits package, she does worry about whether the employer will still be able to provide it when she retires. Patricia is married, and has one son.

FRED AND JANE PARKER, Lansing, MI
Both Fred, 72, and Jane, 70, have Medicare and supplemental coverage, which includes prescriptions. They are thankful for their healthcare coverage, which has been there for Jane through 2 breast cancer surgeries.

LORI PRENTICE, RN, Lansing, MI
Lori has been a home care nurse for 10 years. She works with seniors who, recently released from the hospital, go to the pharmacy to buy their medications and find they can not afford their prescriptions.

DONNA RILEY, Detroit, MI
Donna has studied Social Security, Medicare, and other social issues, and talks about the need to preserve social security and Medicare. She feels that Medicare is a program that should be there for the younger generation, as it has been for her grandfather's generation.

JUDY ROHM, Mason, MI
Judy, 59, and her sister-in-law help to pay for the health care costs of her mother, who lives in assisted living. While Grayce has Medicare and supplemental insurance, if her daughters did not help out with these costs she would not be able to make it. However, assisting her mother is a hardship for Judy herself, who takes expensive medications for her recovery from a bout with cancer, which forced her to retire.

DR. KRISHNA SAWHNEY, Detroit, MI
Dr. Sawhney has been a surgeon in Detroit for almost 20 years. He has seen a patient die because he could not afford to purchase his medication regularly. He has also encountered a patient who came in for a mammogram but could not afford the copayment or deductible and ended up leaving without the test.

MILDRED SCOTT, Detroit, MI
Mildred, 75, has Medicare and supplemental coverage which does not provide for prescription drugs. She has been lucky to have doctors who will provide her with medication samples, as she would not be able to purchase her medications on her own.

DOROTHY SILK, East Lansing, MI

She has been on Medicare for years, and has been very happy with it. She has a Medigap plan that has a good drug benefit, but she worries about those seniors who can not afford a Medigap plan like she can.

SUE SMITH, Lansing, MI
Sue, 76, and her husband, Norm, have Medicare and supplemental coverage through a retiree program. However, this coverage is very expensive for them, and Sue wonders how long they will be able to afford it as the cost is forcing them to start using their savings.

JANICE SOUTHWELL, Mason, Michigan
Janice's father and stepmother have a Medigap plan that does not cover prescription drugs, and their medication costs are approximately $2400 annually. She is 53 years old and is healthy, but does worry about what would happen if she and her husband lost the health insurance coverage her husband's employer is providing and she was solely dependant on the Medicare program.

GLORIA STAMBAUGH, Holt, MI
Gloria, 55, cares for her "adopted" grandmother, Annie, who is 71 years old. Annie has high prescription drug costs, and is only covered by Medicare. Annie is forced to scrimp to make it by, and Gloria does all she can to help her out.

DANIEL THOMPSON, Saginaw, Michigan
Daniel, 73, is a former GM worker of 53 years. He and his wife have Medicare and supplemental coverage, but have no prescription drug coverage and $300 in medication costs monthly. His wife, Cloteal, has cancer, and takes a cancer drug that is very expensive. They had to remortgage their home to pay for their escalating health care costs and their prescription drugs.

FLOYD WALLACE, Leslie, MI
Floyd, 81, and his wife, Rosemary, don't know what they would do without Medicare. Rosemary has had surgery, and uses medical supplies that would often be difficult to pay for out of their own pocket. They have Medicare and a supplemental insurance, but no prescription drug coverage, and have about $100 a month in medication costs.

FRANKIE WATTS, Lansing, MI
Frankie, 81, is on Medicare and supplemental coverage that includes a prescription drug benefit. However, due to her low income and the fact that a lot of small copayments eventually add up, she is often forced to let some of her bills go unpaid longer than she would like.

MARCIE WILSON, Mason, MI
Marcie and her husband have a Medigap plan, and say that it would have been impossible to pay their medical bills if they didn't. However, because their co-payments, premiums, and expenditures on prescription medications are all increasing, she does not know how long she will be able to sustain her current out of pocket costs.

SHERRY WILSON, Williamston, MI
Sherry has two sons, one in college, aged 18, and one aged 13 in the 8th grade. She is concerned about the funding gap of taking care of older parents, and knows that she can not afford to stop working if her elderly parents become ill. She saw her parents put her grandfather in a nursing home and she does not want that to happen to her parents.

JOHN AND BARBARA WILLSON, Delta Township, MI
John and Barbara have Medicare and supplemental coverage through his state employee retirement program. They do not have to sacrifice because they have good health insurance coverage, but know others that are not able to do as much as they do. He wonders whether Medicare will be there in the future, and has a son who has taken both Social Security and Medicare out of the equation when figuring out the finances for his future.

JACK WITT, Lansing, MI

Jack Witt, 75, spends approximately $100 per month in prescription drug costs with no prescription drug coverage. He feels very strongly that everyone should be able to access a prescription drug benefit, and that we have a social responsibility to address this problem. He knows that if he were to suffer a financial hardship, his children would probably not be able to help that much, and wants to be able to maintain his pride in his old age.

POINTS TO HIGHLIGHT AT THURSDAY'S CONVERSATION ON MEDICARE

There are many reasons to dedicate a portion of the surplus to the Medicare program. You should highlight that your plan:

- Extends the life of the trust fund for a quarter of a century from today;
- Eliminates the need for cuts equivalent to 60 percent below the private sector growth rate;
- Provides the opportunity to reinvest some of the surplus to mitigate excessive BBA 1997 cuts; and
- Helps offset the cost of a long overdue prescription drug benefit.

Medicare beneficiaries need access to a stable prescription drug benefit. You should stress that:

- Seventy-five percent of Medicare beneficiaries lack decent, dependable, private sector coverage of prescription drugs;
- Firms offering retiree health plans have declined by 25 percent over the last four years;
- Medigap coverage is inadequate, expensive, and increases with age – a particularly burdensome fact for older women, since over 70 percent of beneficiaries over the age of 85 are women;
- Medicare managed care plans are severely limiting their drug benefit packages;
- Over half the uninsured elderly are middle class individuals with incomes over 150 percent of poverty (approximately $17,000 for couples) and therefore would not be helped by proposals that would limit a new prescription drug benefit to low income individuals, as suggested by some in Congress;

The drug benefit is an option that is designed to support existing private retiree health coverage and encourage new coverage. AARP believes that beneficiaries are afraid that our proposal would require them to opt for the new Medicare drug benefit. Some seniors, such as many UAW retirees in Lansing, are fearful that their former employers will drop their retiree health coverage and that the availability of a new Medicare drug benefit might accelerate the current trend of employers eliminating their commitment in this area. You should highlight that your plan:

- Provides a purely optional prescription drug benefit, allowing beneficiaries to continue their current coverage if they so desire;
- Provides new subsidies to employers to retain or start offering retiree health benefits; and
- Allows retired beneficiaries who have been dropped by their employers to enter the Medicare program at any time.

Assuring the solvency of the Medicare Trust Fund is an essential component of your Medicare reform proposal. You should stress that your plan:

- Reduces the burden on the children of baby boomers assuming the health care costs of their parents;
- Reduces the need for excessive future cuts in the Medicare program; and
- Is fiscally prudent because it helps to buy down the debt.

Your Medicare buy-in proposal provides a new health insurance option. Your plan takes strong steps to address the issues facing uninsured older Americans. As you know, the 55 to 65 age group is most rapidly increasing cohort of the uninsured and this group faces excessively high premiums that makes access to affordable insurance impossible. You should stress that your plan

- Provides for a Medicare buy-in option that gives the near elderly the choice of buying into the program without burdening the program; and
- Providing Americans ages 55 and older whose companies reneged on their commitment to provide retiree health benefits the option to continue "COBRA" coverage until age 65.

Ensuring quality care and demonstrating sensitivity to provider concerns. Providers in Michigan, particularly the hospitals, are lobbying hard for relief from BBA 1997 provisions. While it remains unclear how much of the problem is caused by provider reimbursement in the Medicare program, mitigating some of the changes BBA made is viewed as the most likely solution. Your plan:

- Infuses a large portion of the surplus over 10 years into the Trust Fund, significantly reducing pressure to make large cuts in the Medicare program;
- Has no savings until 2003 and then significantly moderates provider reimbursement provisions currently in the BBA; and
- Provides for a $7.5 billion quality assurance fund for providers and initiates a series of administrative actions to relieve provider burdens.

Providing new protections for low income beneficiaries. Your prescription drug benefit provides cost sharing protections for low income beneficiaries, including:

- Waiving the plans' premium and copayments for beneficiaries with family incomes at or below 135 percent of poverty ($15,000 for a couple); and
- Providing for premium protections for beneficiaries up to 150 percent of the poverty level ($17,000 for a couple).

Choosing between a tax cut and strengthening the Medicare program. Dedicating the entire on budget surplus to an unnecessary, excessive, and regressive tax cut is totally unwarranted. A tax cut such as the one being suggested by the Republicans would mean:

- Failing to extending the life of the trust fund;
- Failing to protect against devastating cuts to health care providers, much worse than those in the BBA of 1997;
- Failing to dedicate any funds to mitigate the impact of BBA 1997;
- Failing to provide for any preventive benefits improvements; and
- Failing to provide a long overdue, meaningful, prescription drug benefit.

MEDICARE QUESTIONS AND ANSWERS

PRESCRIPTION DRUG BENEFIT

Q: Why are you providing coverage to the over two-thirds of beneficiaries who already have private insurance coverage for prescription drugs?

A: This charge is false. Less than one-third of Medicare beneficiaries have private insurance coverage – either retiree health coverage or Medigap. Over the last four years, the number of firms offering retiree health coverage has declined by 25 percent. Beneficiaries purchasing Medigap find it to be inadequate and excessively expensive. Beneficiaries choosing the publicly financed Medicare HMO option are finding that it less frequently provides for a drug benefit and, even when available, is increasingly limiting coverage for this essential need.

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

Means tested benefit excludes the middle class. The instability of private and Medicare managed care coverage has resulted in a growing number of uninsured throughout the income, demographic and geographic spectrum. Fully 40 percent of beneficiaries without drug coverage are middle class (with incomes above $16,000 for singles, $22,000 for couples). Means testing the benefit, as some suggest, would result in an inequitable and unfair system that would leave in an elderly widow with income of $19,000 without access to desperately needed prescription drug coverage.

The Republican approach, using tax deductibility of private drug coverage, excludes millions of middle-class beneficiaries. Recently, the Republicans on the Ways and Means Committee unveiled a proposal to attempt cover prescription drugs by allowing beneficiaries to take a tax deduction for premiums for private drug coverage. This approach has several critical flaws. First, tax deductions matter more the more income you have – helping Ross Perot and other wealthy seniors more than the majority of middle-class seniors. Second, over 55 percent of seniors have no tax liability at all and thus would not benefit from this policy. And, third, making all private Medigap plans offer drug coverage does not necessarily make it more affordable. In fact, it could lead to less access to private coverage as insurers raise premiums or drop out of Medicare altogether.

Q: Why should the Medicare program subsidize a drug benefit for Ross Perot and Bill Gates?

A: This issue is nothing but a red herring utilized by those who do not want to provide a prescription drug benefit to the vast majority of Medicare beneficiaries who are middle class. It is the same argument that was used by those people opposing enactment of the Medicare program in the first place. Medicare was created as a program where everyone who pays in gets a benefit upon retirement. We have never means tested Medicare's benefits and there is a very good reason for that. It would be inconceivable to have a Medicare program that would disqualify an 85-year old widow who has had a stroke from hospital coverage because she has an income of $25,000. Similarly, it is incomprehensible that prescription drug coverage in Medicare depends on how much income you have.

Equally as important is the fact beneficiaries who are sick – regardless of income – cannot access insurance in many places at any price. It is this sort of discrimination against the sick and the elderly that served as the rationale for creating the Medicare program to begin with.

Q: Will this new prescription drug benefit cover Viagra?

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

INVESTING 15 PERCENT OF THE SURPLUS IN THE TRUST FUND

Q: Aren't projections always wrong? Isn't your dependence on the yet-to-be fully realized surplus dangerous and irresponsible?

A: No. One of the hallmark achievements of this Administration is that it has reinstated the credibility of government economic forecasts. In each and every year of this Administration, our economic forecasts have been more conservative than the economy's actual performance. If the surplus turns out to be less than our forecasts projects, it will translate into a less significant extension of the trust fund. In contrast, if the surplus is fully spent on a tax cut, the consequence of misestimates means deficits and new taxes.

PROVIDER REIMBURSEMENT

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

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

POLITICS OF MEDICARE AND THE 2000 ELECTIONS

Q: Isn't your proposal just another political ploy to help Al Gore and the Democrats take back the Congress and entice the seniors back to the Democratic tent?

A: Of course not. I am committed to strengthening and modernizing both Social Security and Medicare. I believe that the surplus provides a golden opportunity for members of both sides of the aisle to contribute to the development of important reforms essential to these important programs. It serves no one's interest – Democrats or Republicans – to ignore challenges facing the programs. It is my hope and expectation that the majority of the members will come to that conclusion as well and take advantage of this extraordinary opportunity.

Q: Does Mrs. Clinton support the President's Medicare proposal?

A: Mrs. Clinton supports my Medicare proposal. Because of her concern about the impact of the Balanced Budget Act on health care providers across the nation, and her longstanding concerns about teaching facilities in America, she also particularly supported provisions in my package of administrative and legislative changes that will smooth out the impact of the Balanced Budget Act on health care providers across the nation, including those in New York. For this reason, she strongly supported the inclusion of the $7.5 billion quality improvement fund, and has made clear that she believes that we need to be particularly responsive to the concerns of academic health centers – the "crown jewel" of America's health care system. I explicitly raised concerns in this area and believes we need to work with the Congress to develop an approach to respond to these provider concerns.

TALKING POINTS FOR THURSDAY'S CONVERSATION ON MEDICARE

There are many reasons to dedicate a portion of the surplus to the Medicare program. You should highlight that your plan:

- Extends the life of the trust fund for a quarter of a century from today;
- Eliminates the need for cuts equivalent to 60 percent below the private sector growth rate;
- Provides opportunity to reinvest some of the surplus to mitigate excessive BBA 1997 cuts; and
- Helps offset the cost of a long overdue prescription drug benefit.

Medicare beneficiaries need access to a stable prescription drug benefit. You should stress that:

- Seventy-five percent of Medicare beneficiaries lack decent, dependable, private sector coverage of prescription drugs;
- Firms offering retiree health plans with prescription drug coverage (?) have declined by 25 percent;
- Medigap coverage is inadequate, expensive, and increases with age – a particularly burdensome fact for older women;
- Medicare managed care plans are severely limiting their drug benefit packages;
- Over half the uninsured elderly have incomes over 150 percent FPL (approximately $17,000 for couples) and therefore would not be helped by proposals that would limit a new prescription drug benefit to low income individuals, as suggested by some in Congress;
- The House Republicans' proposal to accelerate the tax deduction for retiree health insurance only helps the well-to-do, leaving out millions (sorry could not find number) of middle class beneficiaries from any coverage.

Providing an optional prescription drug benefit that supports existing private retiree health coverage. AARP believes that beneficiaries are afraid that our proposal would require them to opt for the new Medicare drug benefit. We have also heard that some beneficiaries who have generous retiree health insurance, such as many UAW retirees in Lansing, are fearful that they will lose their drug benefits. You should highlight that your plan:

- Provides a purely optional prescription drug benefit;
- Provides new subsidies to employers to retain or even start offering retiree health benefits; and
- Allows retired beneficiaries who have been dropped by their employers to enter the Medicare program at any time.

Assuring the solvency of the Medicare Trust Fund is as important as adding a new prescription drug benefit to the program. You should stress that your plan:

- Reduces the burden on the children of baby boomers assuming the health care costs of their parents;
- Reduces the need for excessive future cuts in the Medicare program; and
- Is fiscally prudent because it helps to buy down the debt.

Providing new health insurance options to Medicare beneficiaries. Your plan takes strong steps to address the issues facing uninsured older Americans. As you know, the 55 to 65 age group is most rapidly increasing cohort of the uninsured and this group faces excessively high premiums that makes access to affordable insurance impossible. You should stress that your plan:

- Provides for a Medicare buy-in option that gives the near elderly the choice of buying into the program without burdening the program; and
- Allows retirees whose employers have reneged on their commitment to provide coverage to buy-in to the Medicare program.

Ensuring quality care and demonstrating sensitivity to provider concerns. Providers in Michigan, particularly the hospitals, are lobbying hard for relief from BBA 1997 provisions. While it remains unclear how much of the problem is caused by provider reimbursement in the Medicare program, mitigating some of the changes BBA made is viewed as the most likely solution. Your plan:

- Has no savings until 2003 and then significantly moderates provider reimbursement provisions currently in the BBA;
- Redirects disproportionate share payments from managed care directly back to hospitals;
- Infuses a large portion of the surplus over 10 years into the Trust Fund, significantly reducing pressure to make large cuts in the Medicare program; and
- Provides for a $7.5 billion quality assurance fund for providers and initiates a series of administrative actions to relieve provider burdens.

Providing new protections for low income beneficiaries. Your prescription drug benefit provides cost sharing protections for low income beneficiaries, including:

- Waiving the plans' premium and copayments for beneficiaries with family incomes at or below 135 percent of poverty ($15,000 for a couple); and
- Providing for premium protections for beneficiaries up to 150 percent of the poverty level ($17,000 for a couple).

Choosing between a tax cut and strengthening the Medicare program. Dedicating the entire on budget surplus to an unncessary, excessive, and regressive tax cut is totally unwarranted. A tax cut such as the one being suggested by the Republicans would mean:

- Failing to extending the life of the trust fund;
- Failing to protect physicians and beneficiaries against program cuts, like those in the BBA;
- Failing to dedicate any funds to mitigate the impact of BBA 1997;
- Failing to provide for any preventive benefits improvements; and
- Failing to provide a long overdue, meaningful, prescription drug benefit.

GUIDANCE – SOCIAL SECURITY LOCKBOX

Q: What is your opinion of the Senate Republican lockbox proposal? Why won't you urge Senate Democrats to support it?

A: Again, I am committed to protecting Social Security and Medicare. In my State of the Union address, I introduced a budget proposal based on core principles. I called for dedicating the new surplus to a lock box that would lower the nation's debt and extend the solvency of both Social Security and Medicare.

The House-passed proposal was a positive step because it adopted my call to dedicate the surplus to debt reduction. But it fell short of my overall framework because it does not adopt my other core principles -- it does nothing to extend the solvency of Social Security or Medicare, and in fact would permit much of the surplus to be used first for a tax cut rather than Social Security or Medicare first.

The current design of the Senate proposal risks the possibility of exacerbating an economic downturn and needs to be changed. The proposal must also do more ensure that the money it sets aside for debt reduction today will actually be used for this purpose tomorrow. While the proposal is consistent with paying down the debt held by the public, it does nothing to ensure that the benefits of this debt reduction go to the Social Security and Medicare programs.

Background:

The lockbox legislation passed overwhelmingly (416-12) in the House on May 26, 1999. In the Senate, cloture on the lockbox has failed a number of times (at least five) because Senate Republicans are not allowing Senate Democrats to provide amendments.

7/20/99
1:23 AM

CONGRESSWOMAN STABENOW'S PARTICIPATION IN LANSING EVENT

Q: Is today's event merely a poorly camouflaged event to assist Congresswoman Stabenow in her efforts to run for the Senate seat in Michigan?

A: Absolutely not. The issues related to Medicare reform are of interest and concern to every member of Congress. Congresswoman Stabenow is no exception, and has indicated a great desire to highlight this issue because of her strong belief that we have an unprecedented opportunity to strengthen and modernize the Medicare program in this Congress. The President has done events in other areas of the country on Medicare, such as Chicago, and will no doubt do other events in different areas around the nation. The State of Michigan is one of those states that is broadly representative of the nation as a whole, and we chose it for that purpose. The event itself has been structured to be a conversation with members of the community, and Congresswoman Stabenow will not have a significant role. In fact, as of this morning, the Congresswoman was not even attending because her Congressional responsibilities precluded it.

Paul D. Glastris
07/21/99 10:50:47 PM

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PRESIDENT WILLIAM J. CLINTON
REMARKS AT MEDICARE CONVERSATION
LANSING COMMUNITY COLLEGE
LANSING, MICHIGAN
July 21, 1999

Acknowledgments:
Moderator-- Jane Aldridge
Sponsors-- National Committee to Preserve Social Security and Medicare Pres. Martha McSteen and Exec. VP Max Richtman; National Council of Senior Citizens Exec. Dir. Steve Protulis; Older Women's League nat. board Pres. Betty Lee Ongley,
Members—Rep. Debbie Stabenow's mother, Ann Greer, who is on Medicare

I want to thank you all for joining me today in a conversation on the challenges faced by Medicare, the challenges you face, and the choices we as a nation must make to secure and modernize Medicare for the 21st Century.

As our conversation gets underway here today, another debate is going on in Washington—a more heated debate than I suspect ours will be, but a debate crucial to the future of Medicare, and to the future of this nation. It is a debate over how best to use America's record-breaking budget surpluses.

That we can even have this debate is remarkable, when you consider that just six and a half years ago, when I first became President, we faced budget deficits that were $290 billion and rising. Incomes back then were stagnant. Unemployment was high—here in Michigan it was 7.4 percent.

But beginning in 1993, we put in place a new economic plan of fiscal discipline, coupled with greater investments in areas like education, training and technology. That strategy has helped to produce a private sector-led economic expansion of historic proportions. Unemployment here in Michigan, for instance, has been cut almost in half since 1993, to 3.8

percent, with nearly 600,000 new jobs.

At the same time, we not only balanced the budget; we produced budget surpluses of $99 billion this year, with substantial projected for years to come.

Now, as we debate what to do with our great prosperity, we face a critical choice: whether to move forward with the fiscal discipline that got us here, or return to the fiscal irresponsibility that crippled the economy and quadrupled the federal debt in the 12 years before 1993. We must decide whether to invest the surplus to strengthen America in the long term, or to squander it in the short term.

I think the right choice is to put first things first: invest the surplus to pay down the debt and meet our long-term obligations to secure Security and Medicare and modernize Medicare by providing a long-overdue prescription drug benefit. Last month, I set forth a plan to do that.

My plan would, first, devote $374 billion of the federal budget surplus over the next 10 years to strengthen Medicare to extend the life of the trust fund to 2027.

Second, my plan would use competition and the best practices now in the private sector to keep costs down without sacrificing quality.

Third, my plan will allow Americans between the ages of 55 and 65 who don't have health insurance on the job or in their retirement to buy into Medicare in a way that does not compromise the solvency of the trust fund

Fourth, my plan will modernize Medicare's benefits to match the advances of modern medical science. That means encouraging seniors and disabled Medicare beneficiaries to take greater advantage of preventive tests for cancer, osteoporosis, and other conditions, by eliminating the deductable and all copayments for such tests. And it means providing a voluntary, affordable prescription drug benefit.

Now, there are those who oppose providing secure, affordable, voluntary drug coverage for all Medicare recipients because they assume that most seniors already have private coverage. They're wrong, and today, I am releasing a report that shows why. According to this report, 75% of older Americans lack decent, dependable, private-sector coverage of prescription drugs. That's three out of every four seniors. To those who think prescription drug coverage isn't a problem for most Medicare beneficiaries, I say, think again.

In fact, the problem is getting worse. Fewer than one in four retirees has drug coverage from their former employers. And according to this new report, the number of corporations offering prescription drug benefits to retired employees has plummeted by 25 percent since 1994. Some 8 percent of seniors have Medigap policies with drug coverage. But premiums for these policies skyrocket as seniors get older, when they most need the benefits but can least afford to pay extra for them. Here in Michigan, seniors over 85 must pay

over $1100 per year in Medicap premiums for drug coverage, not counting the $250 deductable. These high costs are especially cruel to the women, who make up 72 percent of Americans over 85.

Some 17 percent of seniors have drug benefits through Medicare managed care plans. But three-fifths of these plans cap benefits at less than $1000 per year, and in just the last two years, the percentage that cap drug benefits at only $500 per year has grown by 50 percent.

What does this mean? It means that the vast majority of seniors either have no drug coverage at all or coverage that is unstable, unaffordable, and rapidly disappearing. And it means America needs a prescription drug plan that is simple, voluntary, and available to all. Anyone who says we don't is out of date, and out of touch.

Securing and modernizing Medicare is the right thing to do for our seniors. It is also the right thing to do for our economy. By setting aside most of the surplus for Social Security and Medicare, we will also be paying off the national debt. Under my plan, by the year 2015, we will be debt-free for the first time since 1835. And that would mean lower interest rates, more business investments, more jobs, higher wages, lower car payments, lower house payments, lower credit car payments, lower student loan payments.

My balanced budget would do this, while increasing investments in areas like education, technology, the environment and defense. It would also offer a quarter of a trillion dollars in targeted tax cuts to help middle-income families meet the crucial needs for child care, for long-term care for aging relatives, for saving for their own retirement, and tax cuts for inducing people to invest in building modern schools or rehabilitating those that exist now, and for investing in the areas of our country which have not yet fully participated in our recovery.

My plan puts first things first. It would protect Social Security. It would secure and modernize Medicare. It would pay off the debt to keep interest rates low. It would make the investments we need. And, finally, it will provide substantial tax relief.

Unfortunately, the Republican-led House of Representatives is voting today on a tax bill that does the opposite. Their bill would spend virtually the entire surplus on a tax cut, draining $3 trillion in national resources during the very years when the Baby Boomers start to retire, right when Social Security and Medicare feel the crunch. By failing to pay off the national debt, the Republican plan will lead to higher interest rates and a weaker economy down the road. It would force drastic cuts in areas where we should be investing more, like education, defense, the environment, and biomedical technology.

And, let me be clear about this: the Republican plan will put not one red cent towards extending the life of Social Security or Medicare. In fact, by devoting nearly all of the surplus to tax cuts, their bill would make it impossible to secure and modernize Medicare for the 21st Century. It would mean not extending the life of the trust fund. It would mean devastating cuts in the future no ability to cushion the blow to health care providers from excessive cuts in the 1997 balanced budget agreement. It would mean no improvement in

preventive care coverage. It would mean no prescription drug benefit.

If a bill like the current Republican plan comes to my desk, I will not sign it. And I will not sign it for the very reasons we are here to discuss today. Yes, we can have tax cuts. But tax cuts for the national interest, not the special interests. Tax cuts that leave room for investments in America's future. Tax cuts that come after we have secured and modernized Medicare. First things first.

The debate we're having in Washington is critically important. But the debate we are having here today is just as important--because the right thing will happen in Washington only if your voice is heard. That is why I am here today.

Thank you.

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Devorah Adler
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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]

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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]
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A CONVERSATION ON MEDICARE

SUGGESTED OPENING STATEMENT FOR JANE ALDRICH

Thank you, Mr. President. Next week is the 35th anniversary of the original Medicare law signed by President Johnson. (July 30th) Over the last 35 years, the Medicare program has provided vital health care services to tens of millions of older and disabled Americans. Since enactment, it has improved life expectancy, access to care, and reduced poverty.

But we now know that despite the recent improved status, the Medicare Trust Fund is currently scheduled to go bankrupt in 2015 – almost two decades before Social Security. It faces major demographic and health care challenges that many argue cannot be addressed without either new revenue or excessive cuts in program funding. There is a great deal of talk in Washington about the surplus. The President has framed the debate between the Republicans and the Democrats about the priorities related to the budget surplus. And we're here in Lansing today to hear from seniors, their families, and their health care providers about their personal health care challenges. We want to hear what they think about the choices that politicians in Washington are about to make and what their priorities are for the Medicare program.

I would like to begin with Janice Southwell.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. paper	re: medicare stories (3 pages)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:
Medicare Drugs Event [Folder 3]

2012-0463-S
rc697

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)]

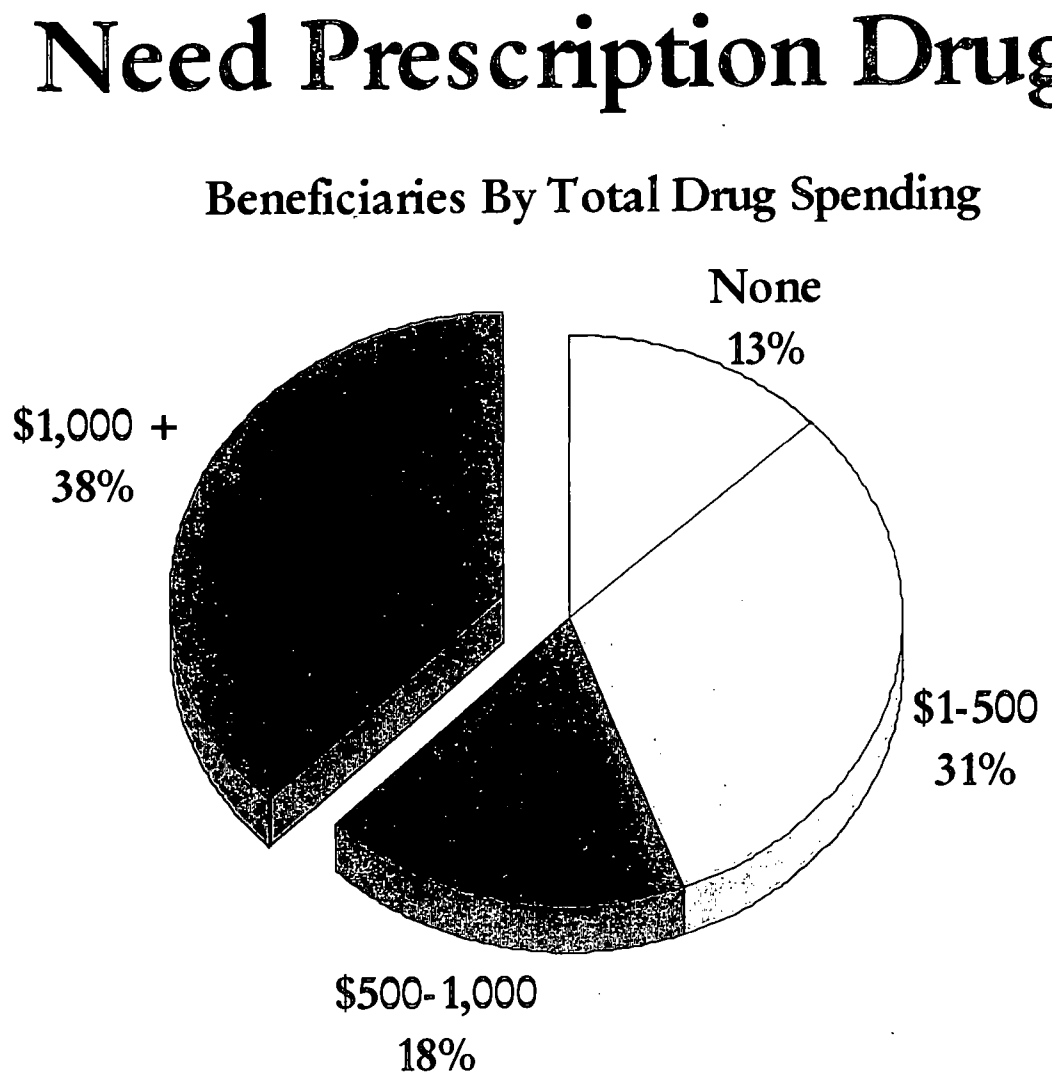
b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial 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]

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

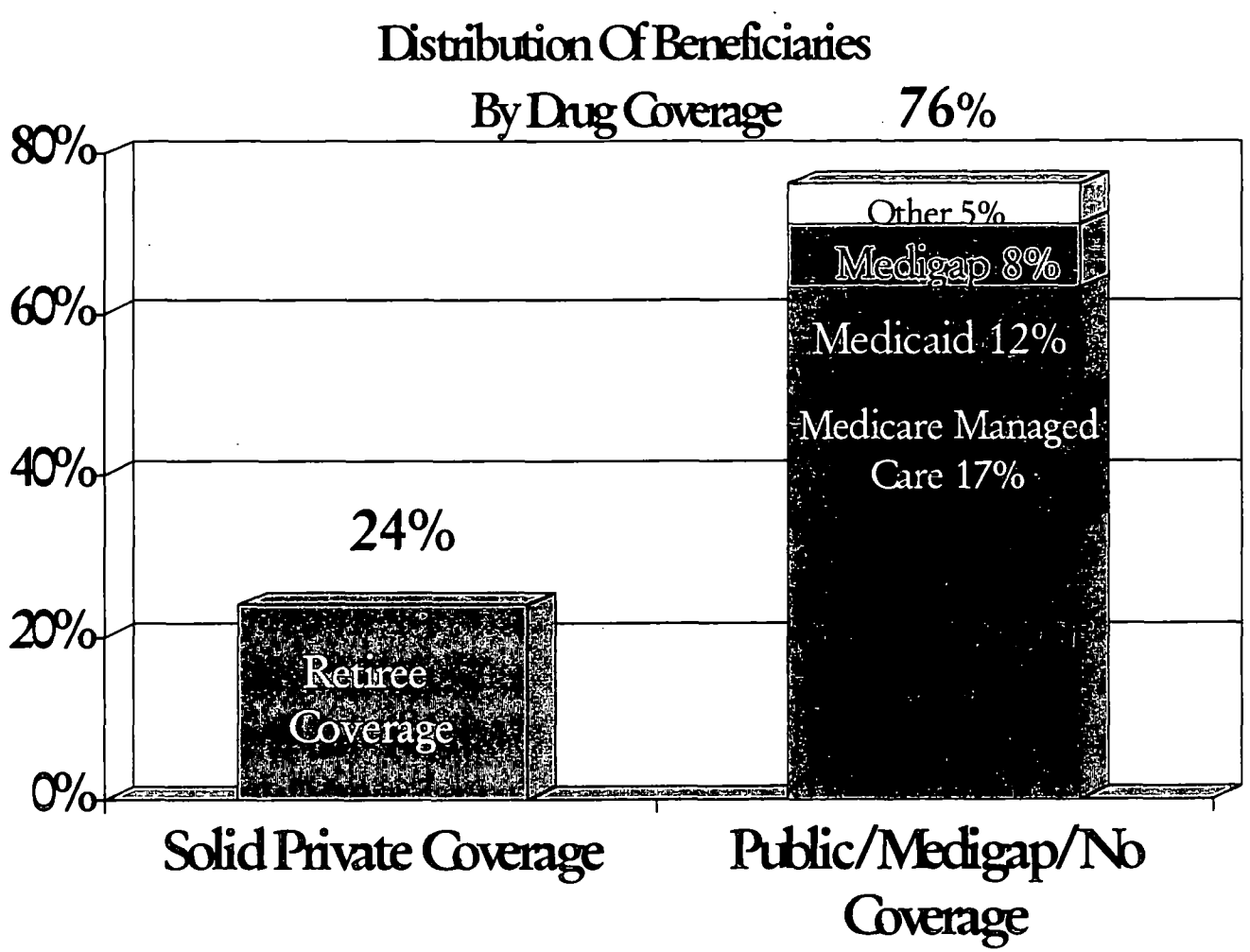
July, 1999

Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

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



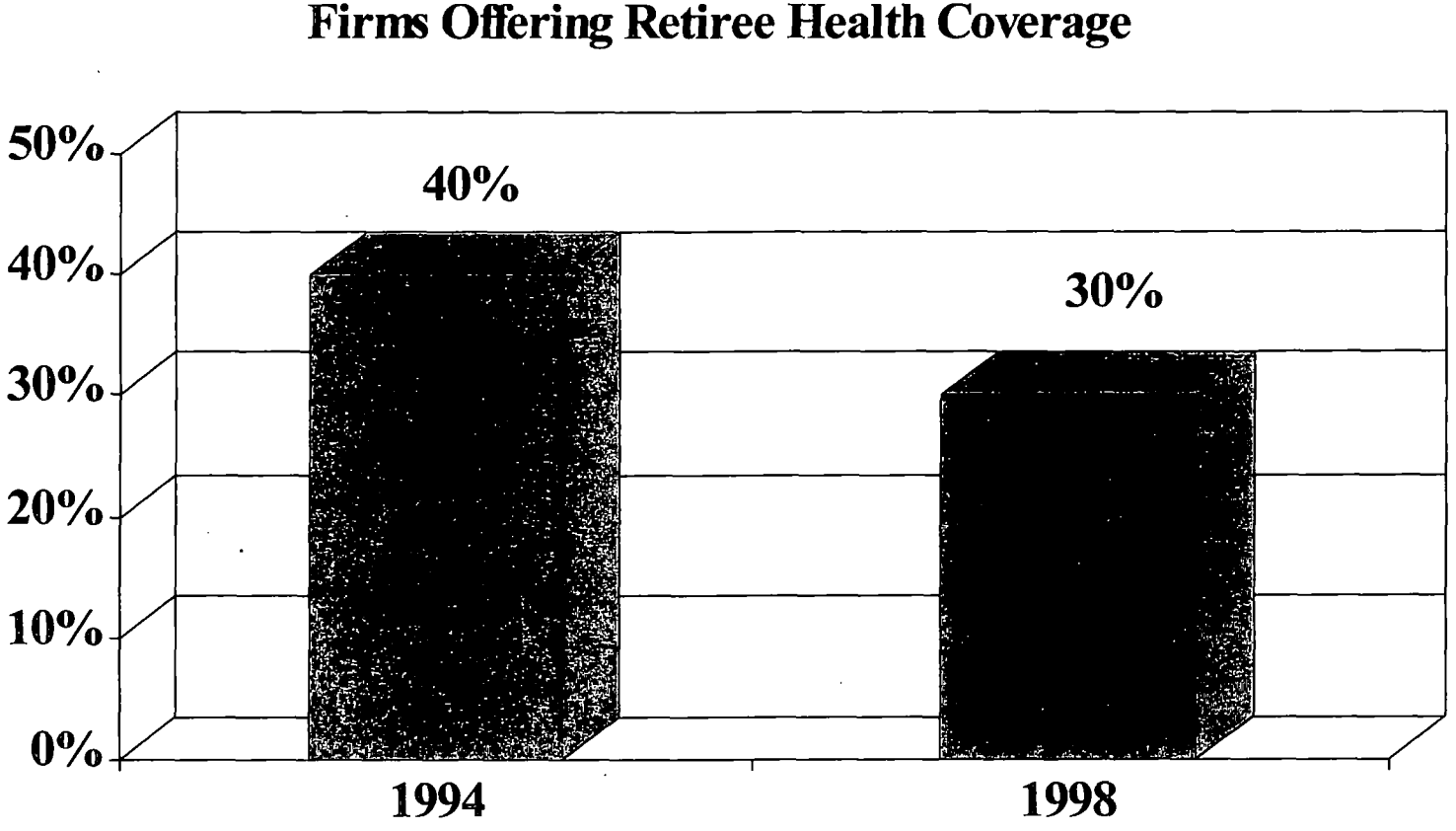
SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

PRIVATE DRUG COVERAGE:

Unstable and Declining

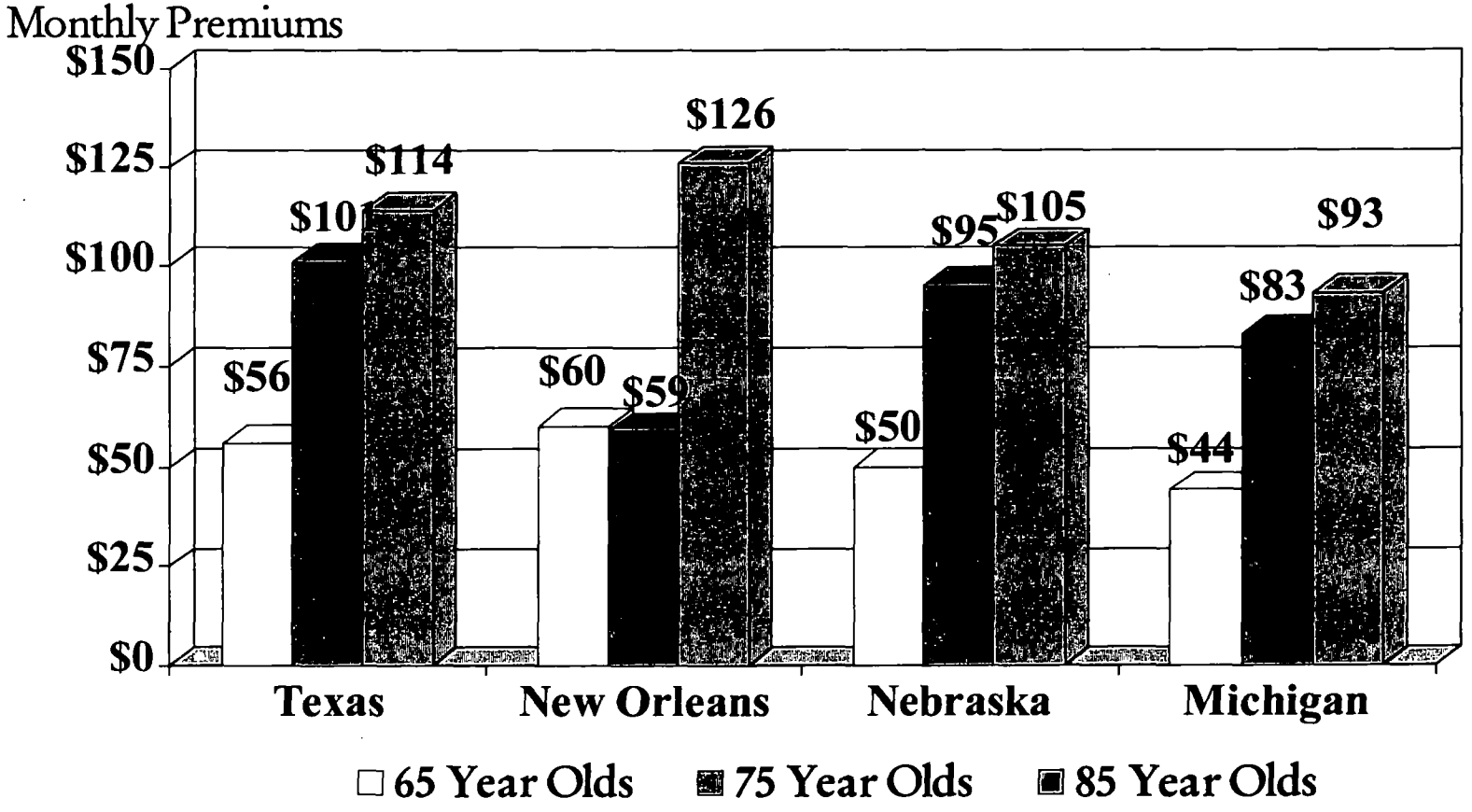
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

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

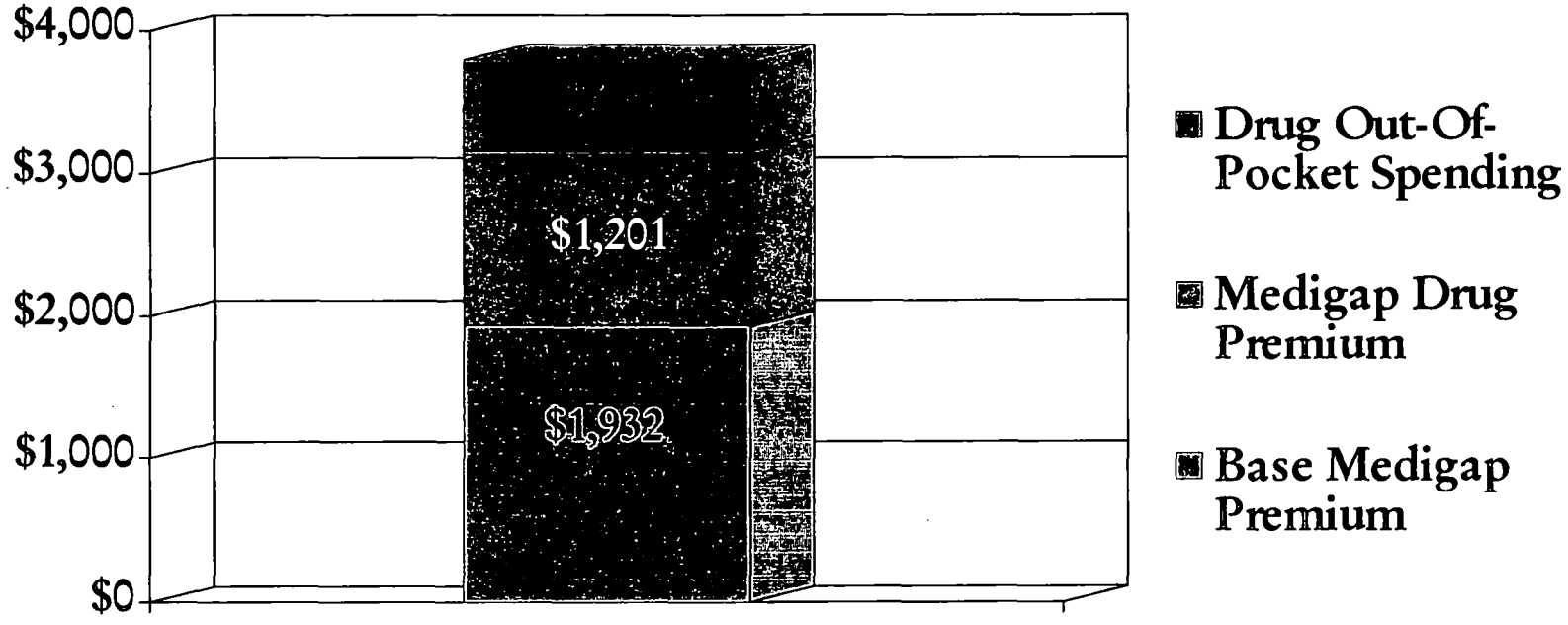


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

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

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

Medigap Annual Premiums And Out-Of-Pocket Spending

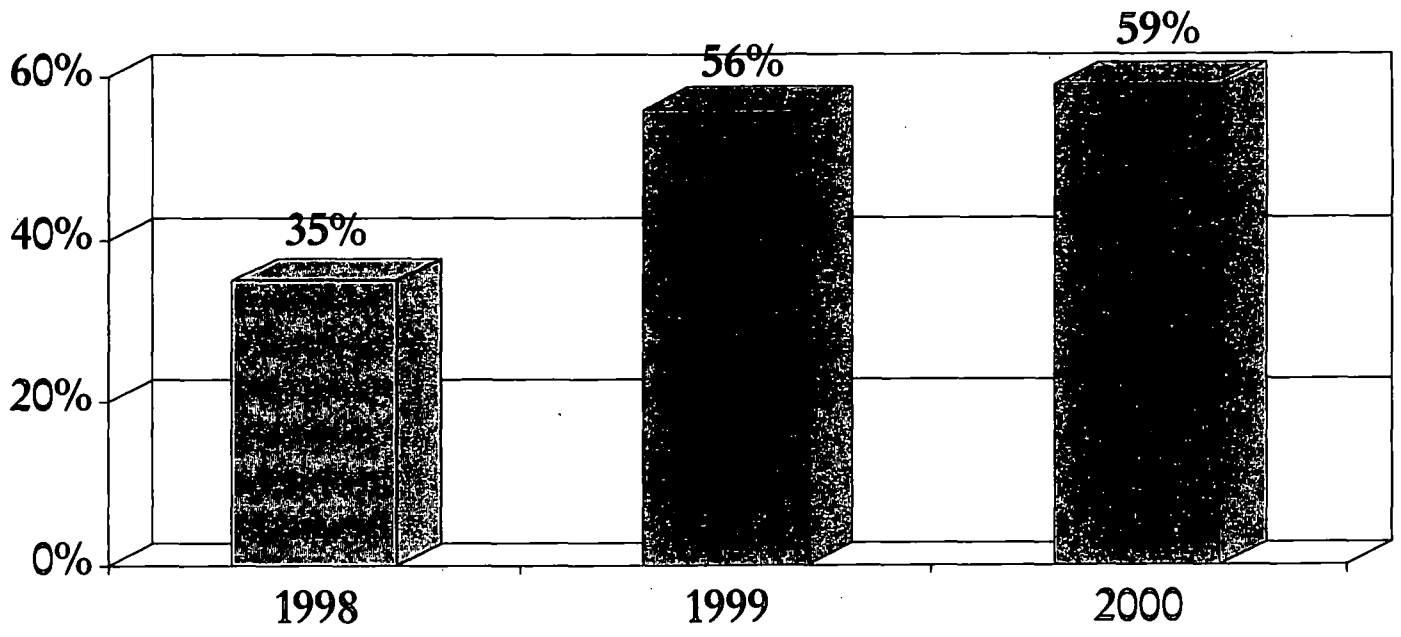


SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is $161 per month; drug addition is $101 per month

PUBLIC COVERAGE FOR PRESCRIPTION DRUGS

Value of Medicare Managed Care Drug Benefits Is Declining

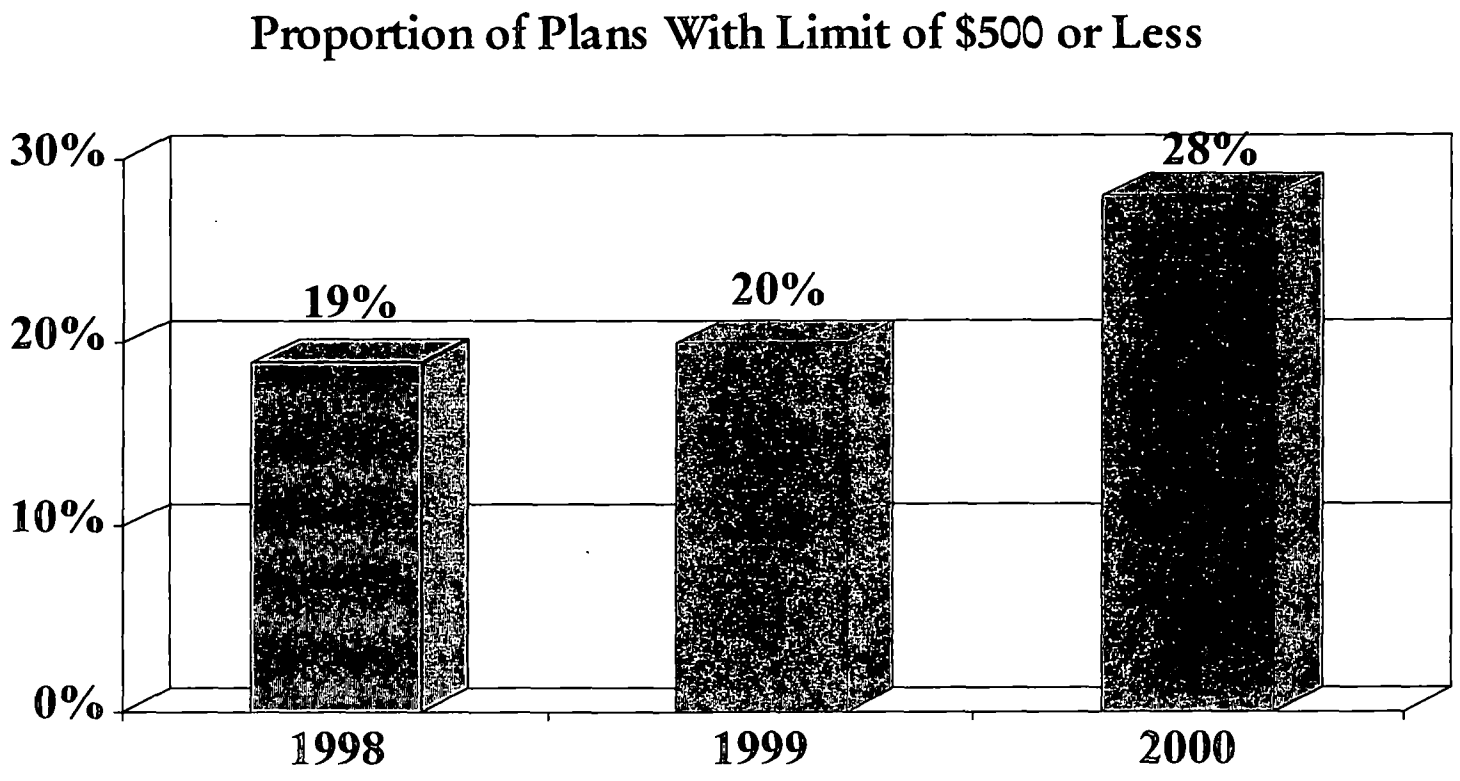
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

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

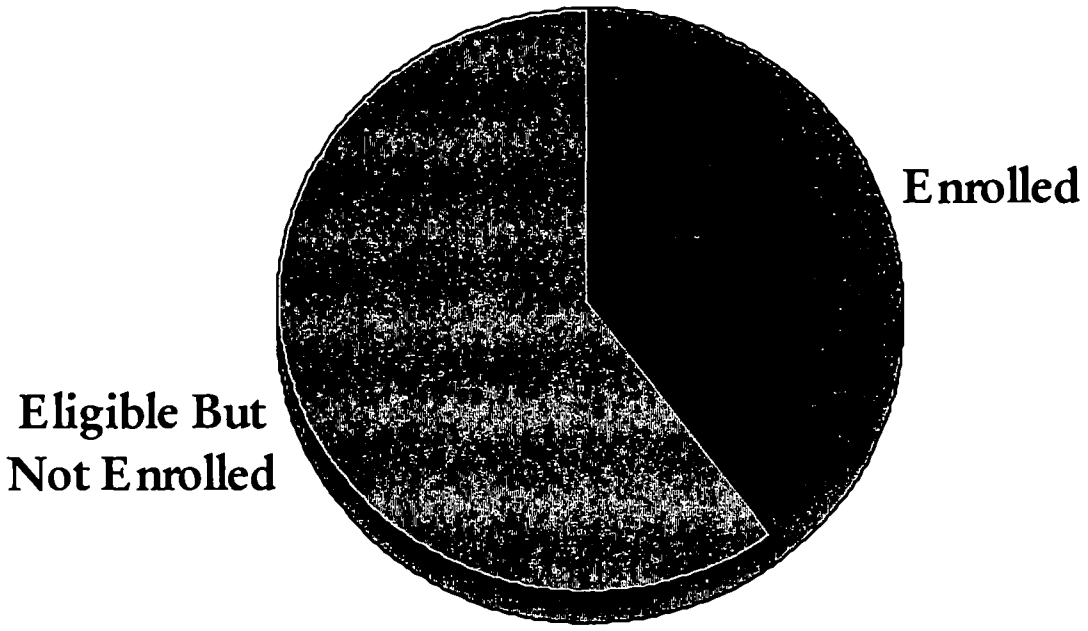


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



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

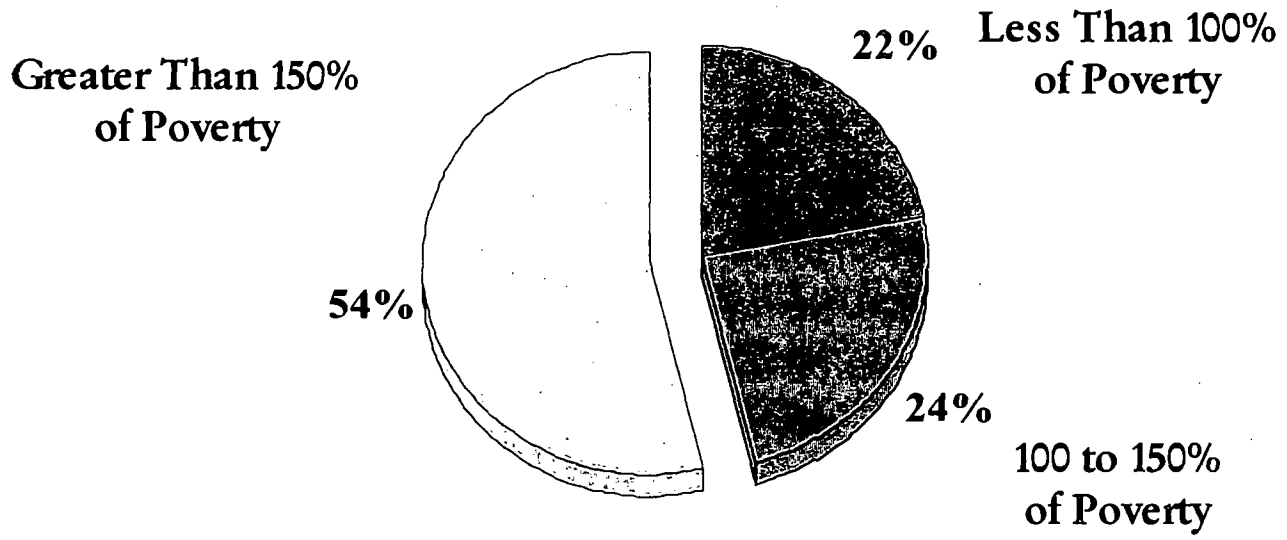
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

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

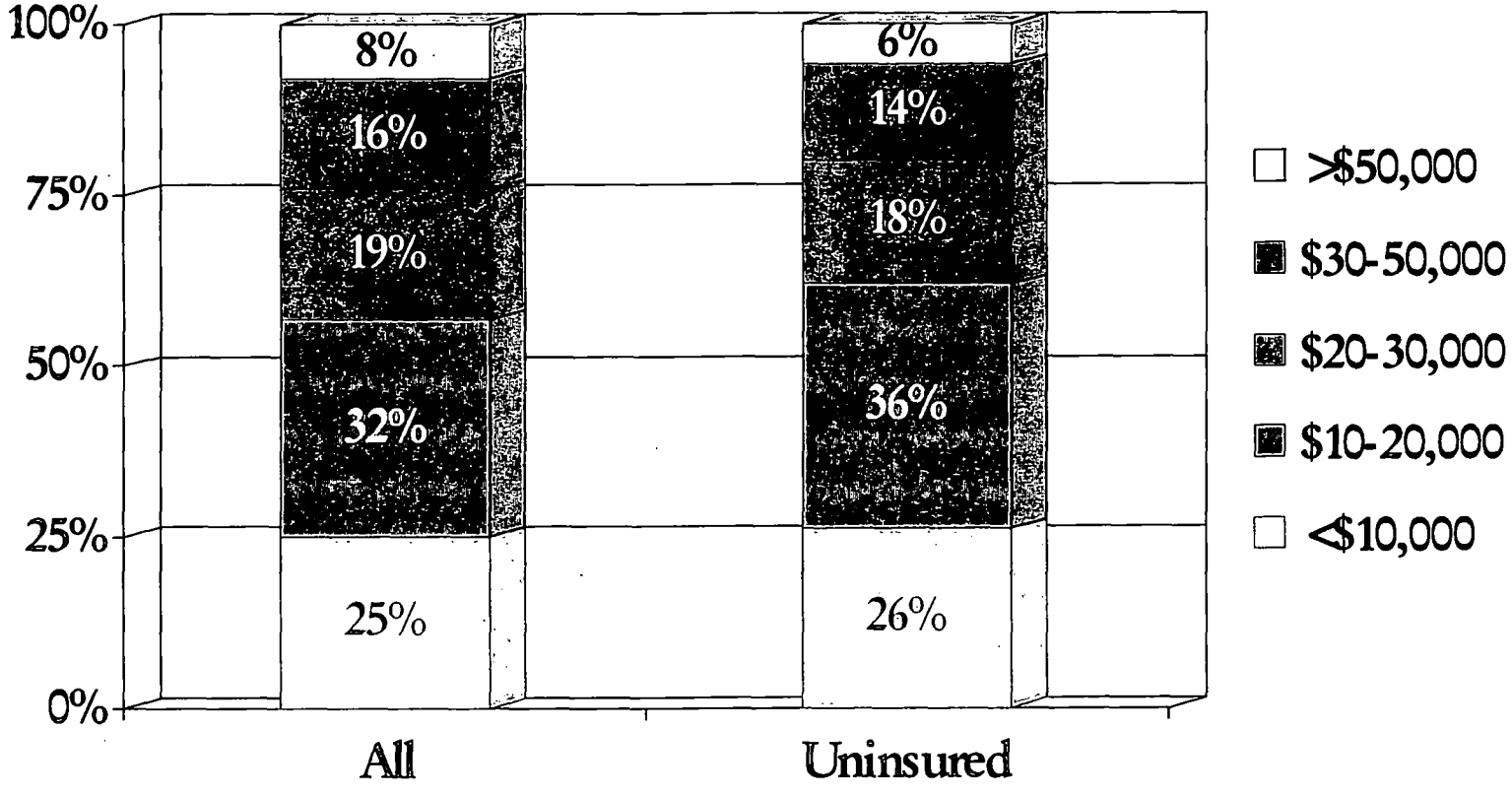
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



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

Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



SOURCE: Actuarial Research Corporation for HHS, 2000

Methodology

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