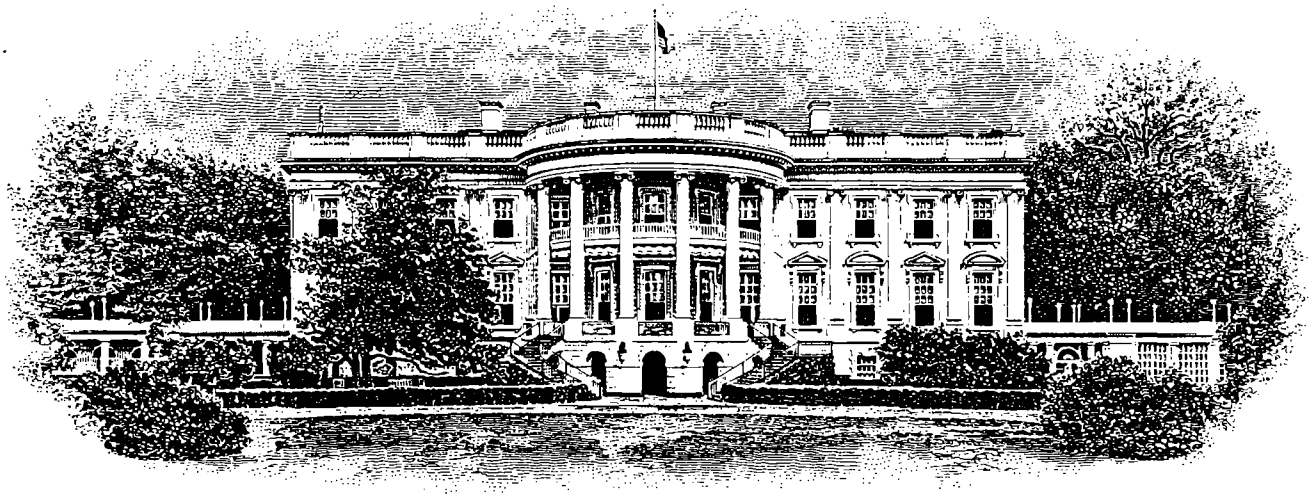
The White House



March 29, 1999

BRIEFING AND REMARKS ON ANNUAL REPORT ON THE STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS

DATE: March 30, 1999
TIME: 2:15-3:00pm
LOCATION: Rose Garden
FROM: Gene Sperling

I. PURPOSE

To review and comment on the Annual Report of the Social Security and Medicare Trustees. There will be audience of approximately 60 guests (Staff from Treasury, HHS, Labor, OMB and SSA).

II. BACKGROUND

Each year, the Trustees of the Social Security and Medicare trust funds report in detail on their financial condition. The reports describe their current and projected financial condition, within the next ten years (the "short term") and over the next 75 years (the "long term.") Tomorrow morning, the Trustees vote out the report and release it to the public.

We do not receive any advance notice of the conclusions in these reports until they are made public tomorrow. The Administration Trustees will brief you on the conclusions of the report before you speak. For Social Security, we expect that the continued strong economy and the incorporation of recent BLS methodological changes in the CPI will produce a modest improvement in the 75-year actuarial imbalance and in the trust fund exhaustion date. For Medicare, based on recent CBO re-estimates, we expect a more substantial improvement. The robust economic performance has resulted in higher-than-expected payroll tax revenues. In addition, there were lower-than-expected expenditures due in part to the continuing implementation of the Balanced Budget Act of 1997 reforms, low increases in health care costs more generally, and the success of efforts to combat waste, fraud and abuse in the Medicare program.

III. PARTICIPANTS

Event Briefing
-Secretary Rubin
-Secretary Shalala
-Secretary Herman
-Deputy Secretary Larry Summers
-Ken Apfel

-Gene Sperling
-Jack Lew
-Sylvia Mathews
-Chris Jennings
-John Podesta
-Ron Klain
-Larry Stein
-Paul Glastris

IV. SEQUENCE OF EVENTS

- **YOU** will be briefed in the Oval Office by the Trustees on their annual report.

- **YOU** will be announced into the Rose Garden and the trustees will take their place behind you on the steps.

- **YOU** will make your remarks to the guests and press corps

- **YOU** and 4 Trustees depart.

V. PRESS COVERAGE

Open

VI. REMARKS

To be provided by speechwriting.

MEDICARE 1999 TRUSTEES' REPORT

March 30, 1999

SUMMARY: MEDICARE'S FINANCIAL OUTLOOK

- **Life of the HI Trust Fund**:
  Spending exceeds income: Improved from 1998 last year to 2007 this year
  Trust Fund exhaustion: Improved from 2008 last year to 2015 this year

- **Actuarial deficit**: Improved from 2.1 last year to 1.46 this year -- a 30 percent decline

MESSAGE TO THE PUBLIC FROM THE TRUSTEES

"Income exceeded expectations as a result of robust economic growth and expenditures declined due to implementation of the Balanced Budget Act of 1997, low increases in health care costs generally, and continuing efforts to combat fraud and abuse."

"Despite the improvement in the financial outlook of Medicare, the projected increases in medical care costs still make solutions to Medicare's problems more complex than those for Social Security."

"In this regard, we are encouraged by the high priority the President and the Congress are giving to the resolution of the Social Security program's projected long-range financing shortfall. We strongly recommend that similar urgency be attached to the task of addressing Medicare's long-term financial situation."

1999 ANNUAL REPORT: THE FEDERAL HOSPITAL INSURANCE TRUST FUND

"Finding good solutions to providing medical care for the elderly and disabled will be a continuing and difficult challenge as our population ages and medical care evolves. The legislative action taken in 1997 was a significant first step in meeting that challenge." (Summary of the Annual Reports: p. 9)

"In 1998, HI income exceeded expenditures by $4.8 billion -- the first time in 4 years that the trust fund has experienced a positive cash flow." (P.11)

"These changes, substantial as they are, are only sufficient to enable payment of HI benefits over roughly the next one and a half decades. More far-reaching measures will be needed to prevent trust fund depletion as the baby boom generation reaches age 65 and starts receiving benefits." (P. 16)

"The projections shown in this report, while encouraging in comparison to prior estimates, continue to demonstrate the need for timely and effective action to address the remaining financial imbalance facing the HI trust fund." (P. 17)

HISTORY OF THE MEDICARE HI TRUST FUND

Year of Report	Date of Insolvency	Years Until Insolvency	75-Year Deficit
1970	1972	2	na
1971	1973	2	na
1972	1976	4	na
1973	--	--	na
1974	--	--	na
1975	"Late 1990s"	--	na
1976	"Early 1990s"	--	na
1977	"Late 1980s"	--	na
1978	1990	12	na
1979	1992	13	na
1980	1994	14	na
1981	1991	10	na
1982	1987	5	na
1983	1990	7	na
1984	1991	7	na
1985	1998	13	- 2.79
1986	1996	10	- 3.02
1987	2002	15	- 2.30
1988	2005	17	- 2.35
1989	--	--	--
1990	2003	13	- 3.26
1991	2005	14	- 3.35
1992	2002	14	- 4.20
1993	1999	6	- 5.11
1994	2001	7	- 4.14
1995	2002	7	- 3.52
1996	2001	5	- 4.52
1997	2001	4	- 4.32
1998	2008	10	-2.10
1999	2015	16	-1.46

Sources: Annual Trustees Reports for 1978 and subsequent years; Reischauer & Aaron, 1995 for early years.
Note: All estimates assume the "intermediary" or, when applicable "intermediary B" assumptions

MEDICARE Q&As ON THE TRUSTEES REPORT

Q: The President said his goal was to extend the life of the Trust Fund until 2020. Are you now suggesting that you are raising the bar and making the Congress go further than 2020 to meet the President's desires on Medicare?

A: The President always has and will continue to firmly believe that we should dedicate 15 percent of the surplus to Medicare. The fact that the Trustees are now projecting that the program is in better shape does not in any way alter the need for the President's proposal. The demographics and the costs are still overwhelming. It is important to recall that even with the new changes in estimates, Medicare remains in worse financial shape than Social Security (2xxx vs. 2xxx as it relates to projected exhaustion dates). The new projections simply mean that we can use the surplus to extend the life of the Trust Fund longer than 2020 and, in the context of broader reform, help pass a long-overdue prescription drug benefit for some of our most vulnerable the nation's citizens.

Q: FOLLOW-UP: At the State of the Union, the President said that we only needed to make Medicare solvent to 2020. Now that the numbers are better, aren't you just raising the bar to ensure that it is impossible for the Republicans to pay for their tax cut?

A: No. The President has said he is committed to dedicating 15 percent of the surplus to Medicare as part of a broader effort to strengthen Medicare. Even though the Trustees' report's projections have improved, they also underscore the fact that " INSERT SOMETHING FROM REPORT THAT HELPS MAKE CASE." The President does believe, however, that we should not be tapping any part of the surplus until after we have significantly bolstered the financial health of the Medicare program. Adding only 5 years to the life of the Medicare Hospital Insurance program, which is the most that the plan by Senator Breaux and Congressman Thomas produced, is inadequate. We can and must do better; the President's insistence on a 15 percent surplus dedication to Medicare in the context of broader reforms will assure that we do.

Q: Now that you can get to 2020 solvency without using all of the 15 percent of the surplus, are you now going to use some of the surplus for prescription drugs?

A: Our primary goal is to dedicate the surplus to improving Medicare solvency while also taking steps to strengthen and modernize the program. The exact details of the financing we'll be announcing with our plan, and I don't want to say exactly what the financing structure will be until we put our plan out.

Q: FOLLOW-UP. So prescription drugs will be financed at least in part through the surplus?

A: We are not going to get to details of the President's plan before it has been completed. Again, he has made no decisions on this provision --or any other provision --at this time.

Q: When is the President going to release his plan?

A: There is no set date, but it certainly will be soon enough for the Congress to have a realistic opportunity to review and consider it this year.

Q. Is it true that raising the age eligibility is off the table?

A. Raising the eligibility age will not be in the President's package. The President believes that raising the eligibility age for Medicare without policies to prevent the uninsured from increasing is going in the wrong direction.

Q: How do you respond to the health providers who point to the significant decline in baseline spending as evidence that BBA reforms went too far and much further than orginially projected at the time of enactment?

A: There are numerous reasons that explain baseline changes. Some relate to the low inflation rate in the economy, some relate to our success in combating fraud and abuse, and some relate explicitly to provider reimbursement changes. It is impossible to tell how much of the change results from BBA reforms. Moreover, the new baseline is only one source of information that should be used in evaluating the appropriateness of provider payments.

FOR RELEASE UPON DELIVERY
TUESDAY, MARCH 30, 1999

REMARKS BY

DONNA E. SHALALA

U.S. SECRETARY OF HEALTH AND HUMAN SERVICES

PRESS CONFERENCE TO RELEASE

1999 ANNUAL REPORT

SOCIAL SECURITY AND MEDICARE BOARDS OF TRUSTEES

WASHINGTON, D.C.

*THIS TEXT IS THE BASIS OF SECRETARY SHALALA'S ORAL REMARKS. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING PRESENTATION.

Good afternoon. Thank you Secretary Rubin.

In this Easter and Passover season, it's worth remembering that Medicare brings freedom from fear – and hope for renewal – to every member of our national family. That's why I'm pleased that for the second year in a row, we have very reassuring news.

Last year, we announced that the Medicare reform package that was part of the Balanced Budget Act extended both the short term and long term outlook for Medicare. The solvency of the Trust Fund was pushed back 7 years to 2008, and the Medicare actuarial deficit – in other words, where we will be 75 years down the road – was cut in half.

This year we are announcing that the solvency of the Trust Fund has been pushed back another 7 years. The Medicare Trust Fund is now solvent to 2015. And the Medicare actuarial deficit – where we will be 75 years from now – has been cut an additional one-third.

The groundbreaking achievements I noted last year – combined with the dramatic performance of the economy – brought us to where we are today. It's a place few people would have predicted just two short years ago.

In the last two years, we extended the life of the Trust Fund by a full 14 years – and cut the actuarial deficit by 66-percent. This means we have more time to work together. More time to plan. More time to build on the amazing progress we've already made.

We got here not by luck or guesswork. It took hard work, courage and skill. What are the reasons for our success?

Number one: We stopped the river of red ink and balanced the budget for the first time in 30 years – ending the deficit and strengthening a robust economy.

Number two: We passed – and began implementing – the bipartisan Balanced Budget Act, which reformed the way Medicare payments are made.

Number three: We cracked down big time on waste, fraud and abuse – and in just the last two years returned over 1.2 billion dollars to the Trust Fund. This is the first time in the history of Medicare that an Administration's effort to end waste, fraud and abuse has been identified as having a positive impact on the Trust Fund. The leadership and hard work of the Department's Inspector General, the Health Care Financing Administration and the Department of Justice have been outstanding.

Number four: We modernized the benefit package by adding important prevention services – including flu shots, mammograms and prostate cancer screening.

And maybe most important: We vigorously managed Medicare. I'm talking about management that is hands on; holds people accountable; introduces new systems; and responds to changing conditions. This Administration has had the toughest management team in the history of Medicare.

We still have a lot of work ahead of us. But today's Trustee report is a roadmap for getting us where we need to go.

As the President said in his State of the Union Address, Congress must set aside 15 percent of the surplus for Medicare. Setting aside 15 percent of the surplus would extend the life of the Trust Fund another 12 years, to 2027. We are heading for doubling our 65-and-over population by 2030 – from 39 million to 78 million beneficiaries. That means we need both new revenues and new reforms.

Program reforms are very important. But we have principles that shape our modernization strategy. We must keep our compact with the American people.

We will not approve a plan that leaves people sicker or poorer.

We will not shift significant costs to beneficiaries – or put them at undue risk for future costs.

We will continue to add competitive reforms.

In addition, with seniors living longer – and often in the grip of chronic diseases – we must continue to modernize the benefit package to improve the quality of health care, and offer some relief from the burdensome cost of prescription drugs. Health care is changing. Because of scientific breakthroughs, we are now substituting drugs for hospital stays, operations and other procedures. Drugs are an integral part of a modern American health care system – and must be part of a modern Medicare benefit package.

Finally our reform plan must be clear, understandable – and have the broad support of the American people.

I already noted that today's great news means we have a little more breathing space. But even though we have more time – we don't have a minute to waste. We must keep working for a consensus on how to protect and modernize Medicare. We must keep the promise we made 33 years ago to America's senior citizens. And we must keep faith with our children and their children – that Medicare will be strong, solvent and affordable for them in the future.

That may seem like a lot to ask for. A lot to work for. Even a lot to hope for. But by preserving Medicare for our national family – we are acting in the best tradition of every family – we are taking care of our own. Thank you.

DATE: 3-30-99

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 INDEPENDENCE AVE., SW
WASHINGTON, D.C. 20201

PHONE: (202) 690-7627 **FAX: (202) 690-7380**

OFFICE OF THE ASSISTANT SECRETARY FOR LEGISLATION
ROOM 416-G HUMPHREY BUILDING

TO : Chris Jennings

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FAX NO : 456-5557

TOTAL PAGES
(INCLUDING COVER): _____

FROM:

[X] RICHARD J. TARPLIN

[ ] HELEN MATHIS

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[ ] SANDI EUBANKS BROWN

[ ] ROSE CLEMENT LUSI

[ ] ALICE ARTIS

[ ] HAZEL FARMER

[ ] EDWARD WHITLEY

REMARKS:

See asterisked names for proposed recess mtgs with staff.

Initial Consultations RE: Medicare

Leadership
Gephardt -
Daschle -
House Medicare Task Force
(Senate Leadership Group - none yet. Do we want to suggest Daschle set one up?)

Committees
House Ways and Means - Staff mtgs during
House Commerce - recess.
Senate Finance -

Caucuses/Groups
Congressional Black Caucus -
Congressional Hispanic Caucus -
House Budget Task Force -
Blue Dogs -
New Democrats -
Chafee/Lieberman Group (staff) -

Individual Members

Moynihan
Breaux
Rockefeller
Conrad
Graham
Bryan
Robb
Kerrey
Lieberman
Kennedy
Bayh
Feinstein
Landrieu
Lincoln
Lautenberg
Chafee
Grassley
Hatch
Jeffords
Snowe
Collins

Dingell
Rangel
Stark
Cardin
McDermott
Kleczka
Tanner
Thurman
Waxman
Brown
Spratt
Johnson (CT)
Houghton
Bilirakis
Upton
Greenwood
Ganske
Lazio

* Indicates Recess meeting with Staff.

THE WHITE HOUSE

WASHINGTON

March 30, 1999

BACKGROUND MEMORANDUM ON PRESCRIPTION DRUGS

FROM: Chris J. and Jeanne L.

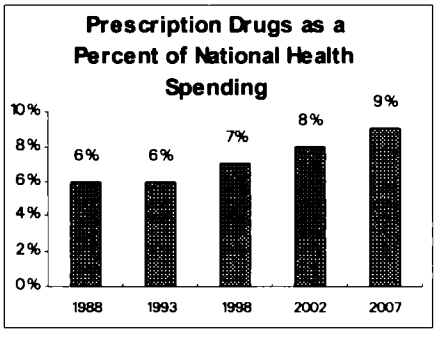
This memo provides background for tomorrow's discussion on a Medicare prescription drug benefit. It describes the need for coverage, expenditure patterns, and the various moving parts of a new benefit. We have also attached an article by Laura D'Andrea Tyson on the topic.

BACKGROUND

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

Increasing reliance on drugs. Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

Rising share of national health spending. The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 years, 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.



New drugs and growth in the pharmaceutical industry. Although the need for drugs is growing, the rapid spending increase is also driven by the number of new drugs, which are introduced at high prices, particularly if there is no therapeutical alternative. Between 1994 and 1998, the FDA approved nearly 150 new drugs (a 140% increase from the 1960s), and one of the leading pharmaceutical associations estimates that over 350 biotechnology medicines are now in development. Also, in the last several years, the industry has made unprecedented investments in advertising, increasing demand for drugs. Sales by research-based pharmaceutical companies were $125 billion in 1998, a 12 percent increase over 1997. Profits are expected to continue to grow.

MEDICARE BENEFICIARIES: GREATEST NEED FOR PRESCRIPTION DRUGS

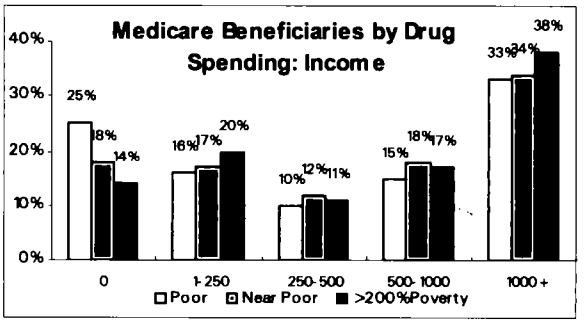
Elderly and people with disabilities rely more on prescription drugs. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. 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.

COMPARISON OF PRICES FOR DRUGS

Drug	Use	Price for Preferred Customers	Regular Price
Prilosec	Ulcers	$56.38	$111.94
Zocor	Cholesterol	$42.95	$104.80
Procardia	Heart	$67.35	$126.86
Zoloft	Depression	$123.88	$213.72

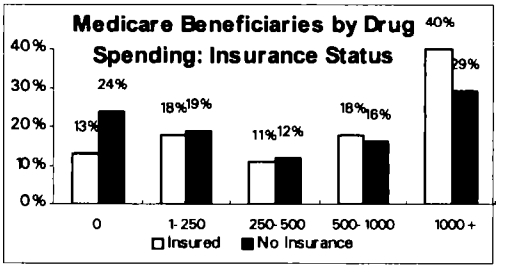
Source: Minority staff report to Committee on Gov't reform

Despite their higher use of drugs, many Medicare beneficiaries pay higher prices for them. Beneficiaries without drug coverage pay significantly more than large HMOs, employers and the Veterans' Administration pay for the same drugs. Moreover, American senior citizens pay higher prices for drugs than citizens in other nations. For example, the average retail price for the top ten drugs for seniors are 72 percent higher in the U.S. versus Canada (use is higher in Canada as well).



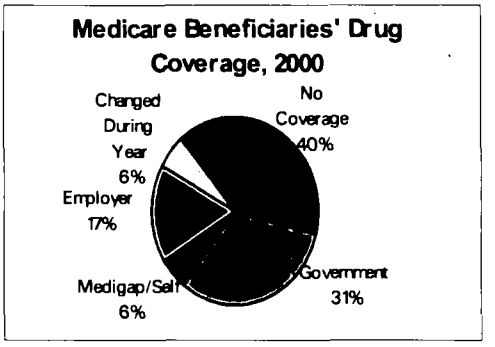
Distribution of beneficiaries' spending on drugs. According the HCFA actuaries' projections for 2000, over 50 percent of beneficiaries will have prescription drug spending of $500 or more -- about 13 million have spending that is greater than $1,000. This expenditure distribution varies somewhat by income. About one in four poor beneficiaries have no drug spending, compared to 14 percent of middle to high income beneficiaries.

Drug spending also varies by whether beneficiaries have insurance coverage. In general, those with some type of insurance coverage (private or public) have higher spending and utilization than those with no insurance coverage for prescription drugs. Although beneficiaries with drug coverage are somewhat less healthy and thus may need more drugs, there appears to evidence that the lack of coverage discourages use of prescription drugs.



The distribution of drug spending also varies by what type of insurance coverage beneficiaries have. Nearly half (47 percent) of beneficiaries with employer-sponsored retiree coverage have more than $1,000 in annual expenditures, versus 33 percent of those in Medicare managed care.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES



Private supplemental drug coverage: Only 23 percent of Medicare beneficiaries are expected to have private insurance for drug coverage (retiree coverage or Medigap) -- down from 38 percent in 1995. Whereas most people under age 65 have employer-based coverage, only about 17 percent have employer-sponsored retiree coverage. Another 6 percent of beneficiaries have Medigap or other private insurance that pays for prescription drugs. Both sources of coverage have been declining rapidly as the cost of coverage rises.

Retiree health insurance: Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. 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). The actuaries project that, by 2000, only 17 percent of beneficiaries will have this type of coverage in the absence of a new Medicare benefit.

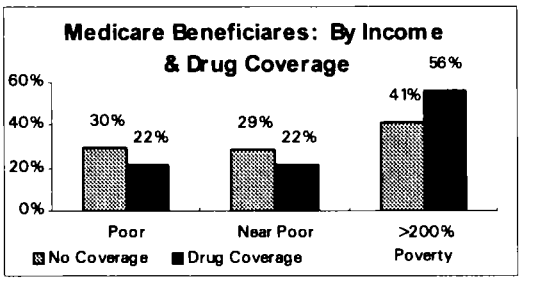
Medigap: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in 3 of its 10 standard plans. The standardized Medigap benefit includes a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Medigap premiums are expensive, ranging from $402 to $7,196 per year, depending on the state and type of coverage. The median premium for a 65-year old choosing a plan with prescription drug coverage is well over $1,000 more than a Medigap plan without drug coverage ($2,073 v $913 in 1998). 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.

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. At the same time, Medigap coverage has declined from about 40 percent in 1984-87 to 30 percent in 1996. The actuaries project that only 6 percent of beneficiaries will have Medigap drug coverage in 2000.

Public coverage: About 30 percent of beneficiaries have some type of government coverage.
Medicare managed care: About two-thirds of plans offer some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, 58 percent had coverage that is greater than $1,000 and 42 percent had coverage limited to $1,000 or less. Increasing costs and reducing Medicare overpayments could reduce coverage in the future.

Medicaid: Only Medicare beneficiaries who are eligible for Medicaid through the Supplemental Security Income program or a medically needy (spend down) option are eligible for prescription drug coverage. These dual eligibles typically have income at or below 60 percent of poverty.

Beneficiaries without coverage for drugs. About 16 million beneficiaries (40%) are projected to have no drug coverage in 2000. Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $17,000 for a single, $23,000 for a couple in 2000). 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, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



CONSEQUENCES OF THE LACK OF DRUG COVERAGE

Less use of needed prescription drugs. The odds that Medicare beneficiaries use drugs to treat their health problems increases by 60 percent if they have insurance. Although it is difficult to distinguish appropriate from over-utilization, virtually all researchers acknowledge that the lack of insurance coverage for drugs results in underutilization of drugs, even essential drugs.

Greater institutionalization. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited. The increased cost of institutionalization exceeded the savings from reduced use of drugs by 20 fold. Another study found that elderly, ill Medicare beneficiaries whose Medicaid coverage was limited were twice as likely to enter nursing homes. A different study of stroke patients found that those treated promptly with drugs to thin clots had significantly lower health care costs.

Larger financial burden. Even after controlling for health status and income, elderly people with private insurance for drugs have 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. A 1993 survey found that 13 percent of elderly Americans reported having to choose between buying food and buying medicine.

Shorter lives. Given the importance of prescription drugs to modern medicine, the actuaries suggest that under-use of them by Medicare beneficiaries can reduce life expectancy. Ironically, this means that adding a prescription drug benefit could raise -- not lower -- costs of hospitalization and other services, since beneficiaries would live longer.

DESIGN PARAMETERS FOR A PRESCRIPTION DRUG BENEFIT

There are a number of major design features that affect the costs and coverage of a Medicare prescription drug benefit. These are outlined below.

Eligibility: One of the basic questions about a new drug benefit is who is eligible. Medicare benefits have never been limited to subsets of beneficiaries or means tested. However, the costs of a new Medicare drug benefit and concerns about substituting for existing private coverage were major reasons why some Medicare Commission members opposed a drug benefit. The Breaux-Thomas proposal did not include a new Medicare benefit. Instead, it recommended a new Medicaid (not Medicare) subsidized benefit for those with income below 135 percent of poverty (about $11,000 for a single, $15,000 for a couple). It would also require Medicare plans and Medigap to offer an unsubsidized drug option. The lack of a significant subsidy would raise major selection issues that would destabilize this insurance, since healthy beneficiaries would consider it unaffordable and mostly sicker beneficiaries would participate, driving up costs.

Providing low-income beneficiaries with a fully subsidized benefit is important -- and would, in fact, happen automatically if a new Medicare benefit were created. This is because, under current law, Medicaid pays for Medicare premiums for all beneficiaries with income below 135 percent of poverty. Unless this provision is changed, Medicaid would also pay for the Medicare premium for prescription drugs for low-income beneficiaries (note: in our cost estimates).

However, a low-income drug benefit will leave most beneficiaries vulnerable. Nearly 3 out of 5 beneficiaries who lack drug coverage have income above 135 percent of poverty. About 30 percent of these beneficiaries have drug expenditures that exceed $1,000. This represents a considerable expense for beneficiaries with income between $15,000 and $20,000. Moreover, private coverage for drugs is unstable. The actuaries project that the proportion of beneficiaries with retiree coverage will decline from 28 to 17 percent between 1995 and 2000, and with Medigap from 10 to 6 percent. Although these declines are offset by increased enrollment in Medicare managed care, managed care plans are increasingly wary of offering a drug benefit.

For these reasons, Laura Tyson and other economists argue that the only efficient option is to extend drug coverage to all beneficiaries. Not only does this ensure that beneficiaries that need this coverage get it, but it limits the need for inefficient, expensive supplemental coverage.

Optional versus mandatory: Today, the Part B premium for Medicare is voluntary but, since the government pays 75 percent of the premium, virtually all beneficiaries take this option. In contrast, in 1988, when a catastrophic drug benefit was added to Medicare, all beneficiaries were required to pay the new premium. This mandatory premium was unpopular, particularly with beneficiaries with other, less expensive, and typically more generous coverage. This contributed to the subsequent repeal of this benefit.

Although proponents of a drug benefit would prefer that it be optional, there is one compelling reason to consider a mandatory benefit: costs. As with most insurance, a new optional drug benefit would create a "moral hazard", meaning that beneficiaries with high drugs costs are more likely to purchase the option. This results in a high average cost of the insurance which translates into higher premiums. Over time, healthier beneficiaries will be less willing to pay the higher premiums, causing the risk pool to shrink and the premiums to rise even more.

There are ways to reduce risk selection in an optional drug benefit. The most important would be to subsidize the premium for the benefit. Since nearly all beneficiaries use drugs, a reduced-price premium would encourage healthy beneficiaries to participate. The actuaries assume that even those with employer-sponsored retiree coverage would participate (employers would pay for the beneficiaries' share of the premium, and wrap around the Medicare benefit if their current benefit is more generous). Another way to ensure that an optional benefit is viable is to limit when beneficiaries can enroll. If beneficiaries can wait until they are sick to enroll, even a subsidized option could be subject to risk selection. Our actuaries assume that if there is at least a 50 percent premium subsidy and a one-time option to participate (when a beneficiary enrolls in Medicare), than all beneficiaries will participate in an optional benefit. It may also be possible to create transition rules for beneficiaries who lose their retiree coverage.

Premium subsidy: As described above, premium subsidies are important to participation in an optional drug benefit. At the same time, while they reduce the cost per beneficiary, they raise Federal spending in aggregate. The level of the premium subsidy was discussed extensively in the last days of the Medicare Commission. Laura Tyson and Stuart Altman, following logic of the actuaries, argued for at least a 50 percent subsidy. At one point, it appeared that the Commission would agree to a 25 percent subsidy for all beneficiaries, but in the end rejected it -- both on cost grounds and because of a reluctance to subsidize higher income beneficiaries.

One option that could address these concerns is an income-related premium for the optional drug benefit. It would have to be designed carefully, to avoid selection, but could both lessen the cost of the benefit and reduce government assistance for those who could afford it. It would make even more sense if there were an income-related Part B premium, simplifying the administration.

Cost sharing: In additional to the premium subsidy, the cost of a Medicare drug benefit depends on its cost sharing structure. There are four major moving parts of a drug benefit: its (1) deductible, (2) coinsurance or copayments, (3) limits on out-of-pocket spending or stop-loss protection, and (4) cap on benefit payments. The cost sharing for Medicare beneficiaries with drug coverage varies dramatically. Employer-sponsored coverage is probably the most generous. Mirroring coverage for their under-65 workers, it typically has no separate deductible for drugs, low copayments, stop-loss protection, and no limit on benefit payments. Medigap, in contrast, has a separate, $250 deductible, 50 percent coinsurance, and a cap on how much the plan will pay. Medicare managed care usually has low to no deductible and copayments, controlling costs by limiting the amount that plans pay.

EXAMPLES OF DRUG BENEFIT COST SHARING

Option	Deductible	Copay	Stop-Loss	Benefits Cap
FEHBP*	$50	20%	($3,750)	None
Retiree **	($300)	$5/15	($1,750)	None
Medigap	$250	50%	None	$1250/3000
Kaiser DC:	$0	$5/20	None	$1,000

Limits in parentheses are for all services, not just drugs
* Blue Cross/Blue Shield standard option
** Typical retiree plan

These different design features affect who benefits the most from each policy. The table shows the illustrative effects of two policies. It assumes that beneficiaries are not now paying premiums -- those who now pay premiums for drug coverage would see even greater savings. For the most part, the table shows that even with a $250 deductible, the combination of the deductible and the premium suggest that a beneficiary must have a sizable amount of drug spending to benefit from the new coverage. At the same time, capping the benefit at $1,000 versus $2,000 makes a substantial difference for a person with high expenditures. Benefits that help the sickest beneficiaries tend to be the most costly, since most of drug expenditures are associated with high users.

ILLUSTRATION OF DRUG BENEFIT OPTIONS

NO DEDUCTIBLE, 50% COPAY, $1,000 BENEFITS CAP

CURRENT	NEW BENEFIT			
SPENDING	Premium	Copays	Total	Change*
$0	$300	$0	**$300**	+$300
$250	$300	$125	**$425**	+$175
$500	$300	$250	**$550**	+$50
$1,000	$300	$500	**$800**	-$200
$2,000	$300	$1000	**$1,300**	-$700
$3,000	$300	$2000	**$2,300**	-$700

$500 DEDUCTIBLE, 20% COPAY, $0 BENEFITS CAP

CURRENT	NEW BENEFIT			
SPENDING	Premium	Copays	Total	Change*
$0	$300	$0	**$300**	+$300
$250	$300	$250	**$550**	+$300
$500	$300	$500	**$800**	+$300
$1,000	$300	$600	**$900**	-$100
$2,000	$300	$800	**$1,100**	-$900
$3,000	$300	$1000	**$1,300**	-$2700

* "+" indicates new spending; "-" indicates savings

Management of the benefit: The last major parameter of a drug benefit is its management. There are a number of ways that a new Medicare benefit could be administered and its costs constrained. The two major options are a HCFA-administered versus privately managed benefit. The Federal government has experience with both models through its health programs. Both Medicaid and the Veterans' Administration purchase prescription drugs for a large number of people. Medicaid has mandated a rebate for drugs. For drugs not covered by patents that prevent generic manufacturing, this discount is 11 percent of the average manufacturer price (AMP); for drugs covered by patents ("innovator drugs"), the discount is the greater of 15.1 percent of the AMP or the difference between a the AMP and a "best price" (defined in regulations). The Veterans' Administration uses a national formulary to negotiate lower prices for its members. Both use of a rebate program and formulary have served as effective price controls for drugs.

In contrast, most Federal employees get their prescription drugs through private managed care. Pharmacy benefit managers (PBMs) typically use computer networks and electronic card systems to link patients to the plan's formulary or list of drugs that are generic or reduced cost. PBMs also usually get discounts from drug companies for putting their drugs in their formularies and negotiate with pharmacies over the retail prices charged for prescriptions. Some studies suggest that the management tools used by PBMs can save up to 25 percent However, questions that arise with this approach to a Medicare benefit are more complicated (e.g., how much liability does the PBM and/or beneficiary bear; how would the PBM be selected).

During the Medicare Commission, strong arguments were made against a HCFA-administered benefit -- in particular, the adverse market effects if HCFA engaged in rate setting and regulation. Yet, others argued that it would be irresponsible to not use the leverage to get the best discounts. This is a complicated issue that staff will continue to examine.

BY LAURA D'ANDREA TYSON

WHY MEDICARE MUST DO MORE AT THE DRUGSTORE

ROBERT HOLMGREN

BIG GAP: Prescription drugs are more important than ever for the elderly, but the private insurance system isn't working well

Laura D'Andrea Tyson is dean of the Haas School of Business at the University of California at Berkeley and was President Clinton's chief economic adviser.

Dramatic breakthroughs in prescription drugs have fundamentally altered the treatment of virtually every major illness over the last few decades. Thirty years ago, patients who survived a heart attack might be sent home with advice to take it easy; today they are sent home with prescriptions for medications that improve the quality and length of life. Four out of five senior citizens are prescribed at least one drug treatment every day, and one in five take five prescribed drugs daily. These trends will only strengthen as new gene research produces advances in pharmaceuticals.

But such progress carries a hefty price tag. According to the National Bipartisan Commission on the future of Medicare, of which I am a member, some 12% of the population is elderly but these people account for more than one-third of all spending on prescription drugs. Per capita spending on drugs by the elderly is more than three times that of other adults and nearly 10 times that of children. On average an elderly American spends more than $600 a year on drugs, with 1 in 10 spending more than $2,000 a year. At a time of little inflation, drug spending by the elderly is projected to grow at more than 8% per year.

When the Medicare program was enacted more than 30 years ago, drug coverage was not included. Drugs were not as important in medical treatment as they are now, and drug coverage was not the norm in private health insurance plans, as it is today. Consequently, as both the effectiveness and the cost of drug therapies have increased, elderly Americans, the majority of whom have annual incomes of $25,000 or less, have been forced to find sources other than Medicare to cover their prescription drug bills. The resulting coverage is riddled with inequities, inefficiencies, and unnecessary administrative costs.

A FAILURE. About 20% of the elderly, those living below the poverty line, can obtain drug coverage by enrolling in Medicaid. About one-third receive some drug coverage through supplemental insurance policies provided through their former employers and subsidized by federal tax breaks for employer-sponsored health insurance plans.

But the private insurance market is not working well for the elderly. From 1993 to 1997, the percentage of large companies offering retiree health benefits dropped from about 40% to about 30%. About 10% of the elderly buy individual private insurance policies that provide a capped drug benefit. But premiums often exceed $1,000 per year for a policy with limited nondrug benefits and an annual cap of $1,250 on drug spending. Some elderly people obtain drug coverage by enrolling in Medicare HMO plans, but they are not available in many locations, and their drug benefits are spartan (many have a benefit cap of $200 per quarter). Today, about 35% of the elderly—and nearly half of the elderly who are living in rural areas—have no drug insurance whatsoever.

Why hasn't the private insurance market developed affordable policies to solve the drug coverage problem for the elderly? The major reason is what economists call the "adverse selection" problem in insurance. Most drug spending reflects chronic conditions. As a result, private plans that offer generous drug benefits tend to attract high-risk, high-cost enrollees. Healthy individuals with a low risk of chronic illness prefer more inexpensive plans that limit drug benefits. As a result, insurance plans that include adequate drug benefits quickly become extremely expensive.

CUTTING A DEAL. Supplemental private insurance coverage through employers avoids this selection problem because all the employees covered by a business, high risk and low risk, elderly and non-elderly, participate together, allowing the very sharing of risk that insurance is meant to provide.

Employers can also bargain for lower prices with drug producers. Without such bargaining power, the average elderly American who doesn't have drug insurance pays twice as much for drugs as larger insurers or HMOs. And without drug insurance, a growing number of Americans are forced to choose more expensive, less effective forms of inpatient care that are covered by Medicare over less expensive, more effective forms of outpatient care that are not.

Medicare was designed in 1965 with the goal of providing each elderly American, regardless of income, with health insurance as good as that available to the non-elderly. This goal is increasingly elusive as drug therapies become more central to the prevention and treatment of illness. It is time to stop debating whether or not Medicare should include drug coverage and start assuring that drug benefits are provided competitively, efficiently, and fairly to all Medicare beneficiaries.