F401

STRENGTHENING MEDICARE FOR THE 21st CENTURY: SUMMARY

COST:	Savings:	$70 billion over 10 years
	Costs:	$160 billion for drugs, $9 billion for other (prevention, buy-in)
	NET:	**About $100 billion over 10 years**
	Solvency:	**About $300 billion** (all transfers since we are using conventional scoring)

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT.

- **Gives traditional Medicare new private purchasing and quality improvement** (e.g., competitive pricing, authority to contract with disease management firms for services; coordinated care models for dual eligibles)

- **Creates the Competitive Defined Benefit** program that injects true price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices by moving away from competition based on benefits. Saves money over time for both beneficiaries and the program;

- **Reduces Medicare spending growth and fraud**, ensuring that program growth does not significantly increase after 2002 and continues the Administration's fight against waste, fraud and abuse.

MODERNIZING MEDICARE'S BENEFITS.

- **Voluntary prescription drug benefit** that is affordable and available to all beneficiaries.

    - Affordable, decent benefit: $26 / mo in first year (to about $50 in '09); no premiums for low-income; No deductible, pays for half of expenses up to $5,000 (phased in); provides discounts after limit

    - Accessible: Option for all – irrespective of location, health status, income, type of plan (managed care)

    - Efficiently Administered: Uses competition to get best discounts for beneficiaries; encourages employers to continue providing retiree coverage; no price controls

- **Eliminates preventive services costs sharing:** Eliminates deductibles and copays for Medicare colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, mammographies, etc.

- **Rationalizes cost-sharing requirements** by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation;

- **Reforms Medigap** policies by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and

- **Includes the President's Medicare Buy-In** proposal which provides an affordable coverage option for vulnerable Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY.

- **Dedicates over $300 billion to Medicare solvency over 10 years.** In addition to slowing Medicare growth through improved efficiency and competition, the plan would dedicate funds from the on-budget surplus to the Medicare HI trust fund. These resources will be used to pay down the debt, helping to prepare the government – and the Nation – to meet the challenge of the retiring baby boomers and rising health costs.

MEDICARE: BACKGROUND FACTS

PRESCRIPTION DRUGS

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

  - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage. The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years.

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

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

  - At least 13 million beneficiaries have absolutely no prescription drug coverage.

  - 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.

- **Total prescription drug spending for women on Medicare averages $1,200 – nearly 20 percent more than that of men.** Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about $12,750 for a single, $17,000 for a couple), despite older women's lower average income.

- **Rural beneficiaries are at particular risk.** Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries.

FINANCIAL HEALTH OF MEDICARE

- **Improvements in Medicare Trust Fund.** When President Clinton took office, the Medicare Trust Fund was projected to be bankrupt in 1999. Today, its solvency is projected to last to about 2015 (note: with the BBA givebacks this fall, it is 2104 but this is not public). And, under his plan to strengthen and modernize Medicare, solvency would be extended to at least 2025 – the longest period of solvency in Medicare's history.

- **Last year, for the first time in Medicare's history, spending declined.** This resulted from a combination of a strong economy and low inflation, vigilant efforts on reducing Medicare fraud, and legislative and administration actions to effectively manage this program. Recent success in reducing fraud include:

  - Collecting about $500 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings.

  - Excluded nearly 4,000 providers or organizations that have been convicted of certain health care offenses, lost their licenses, or engaged in other professional misconduct from participating in Medicare, Medicaid or other federally sponsored health care programs

  - Reduced improper Medicare payments by about $10.6 billion -- a 45 percent drop in over the last two years.

FUTURE CHALLENGES

- **More beneficiaries**: Enrollment in Medicare will climb when the baby boom generation retires -- from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.

- **Fewer workers**: The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (from 3.6 workers per beneficiary in 2010 to 2.3 in 2030).

- **Cost growth will rise**: Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** To significantly extend Medicare solvency, Medicare spending growth per beneficiary would have to be constrained to less than inflation.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2025. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

I. MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare Trust Fund from 1999 to 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms.

- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums.

- **Constrains out-year program Medicare spending growth.** To ensure that program growth does not significantly increase after most current Medicare savings policies expire, the proposal includes out-year policies that protect against a return to excessive growth rates.

II. MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the President's Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:

  - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to $5,000 in spending ($2,500 in Medicare payments) when fully phased-in by 2009.

  - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the $5,000 limit is reached.

  - Cost about $26 per month beginning in 2003 (when the coverage is capped at $2,000 in spending) and $51 per month when fully phased-in by 2009. (This is one-half to one-third of the typical cost of private Medigap premiums.)

  - Ensure that beneficiaries with incomes below 135 percent of poverty ($11,000/$15,000 single/ couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.

  - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

  Most Medicare beneficiaries will probably choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, we estimate that about 31 million beneficiaries would benefit from this coverage each year. Cost: $160 billion over the next 10 years, beginning in 2003.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would:

  - Eliminate existing copayments and the deductible for preventive service, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, mammographies.

  - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.

  - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would rationalize the current cost sharing requirements for Medicare by:

  - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.

  - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately $300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.

III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY.

The President's Medicare plan would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2025.** Dedicating $300 billion of the surplus over 10 years to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2025, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

PRESIDENT CLINTON'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

June 29, 1999

Today, President Clinton will unveil his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st Century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the life of the Medicare Trust Fund until 2027. The President will call on the Congress to work with him to reach a bipartisan consensus on important reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare trust fund from 1999 through 2015. Building on this success, the plan he unveils today:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: $25 billion over 10 years.

- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans in Medicare. Plans would be paid for covering Medicare's defined benefits, including a new subsidized drug benefit, and would compete by offering lower cost and higher quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by providing beneficiaries with 75 cents of every dollar of savings that result from choosing lower cost plans. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: $8 billion over 10 years, starting in 2003.

- **Constrains out-year program growth, but more moderately than the BBA 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to unsustainable growth rates, but are more modest than those included in the BBA of 1997. This proposal would reduce average annual Medicare spending growth from 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: $39 billion over 10 years (including interactions and premium offsets).

- **Takes administrative and legislative action to smooth out the Balanced Budget Act (BBA) of 1997 provider payment reductions.** The proposal includes a provider set-aside designed to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions that are designed to moderate the impact of the BBA 1997 on some health care providers' ability to deliver quality services to beneficiaries. Cost: $7.5 billion over 10 years.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drug and preventive services that have become essential elements of high-quality medicine. It also addresses excess utilization and waste associated with first-dollar coverage of clinical lab services and reforms the current Medigap market. Finally, it integrates the President's Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. His plan:

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:

    - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to $5,000 in spending ($2,500 in Medicare payments) when fully phased-in by 2008.

    - Ensure beneficiaries a discount similar to that offered by many employer sponsored plans (estimated to be, on average, over 10 percent) for each prescription purchased – even after the $5,000 limit is reached.

    - Cost about $24 per month beginning in 2002 (when the benefit starts at a $2,000 cap) and $44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)

    - Ensure that beneficiaries with incomes below 135 percent of poverty ($11,000/$17,000 single/couples) would not pay premiums or cost sharing. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well.

    - Provide financial incentives for employers to retain their retiree health coverage if they provide a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

  Most Medicare beneficiaries will choose this new prescription drug option because of its attractiveness and affordabilty. Because older and disabled Americans rely so heavily on medications, about 31 million beneficiaries would benefit from this coverage each year. Cost: $118 billion over 10 years, beginning in 2002.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost $3 billion over 10 years and would:

  - Eliminate existing copayments and the deductible for every preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.

  - Initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.

  - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save $11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:

  - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, reduce fraud, and has been advocated by the Medicare Payment Advisory Commission.

  - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 43 percent in 1967 to about 3 percent in 1999, according to CBO.

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program and steps to make it easier for beneficiaries to compare the cost and quality of private Medigap options; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expand the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer any American between the ages of 62-65 the choice to buy into the Medicare program for approximately $300 per month if they agree to pay a small risk adjusted payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The $1.4 billion cost is offset in the President's FY 2000 budget.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. The Medicare plan the President is proposing would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be enough to handle the doubling of the elderly population from almost 40 million today to 80 million over the next three decades. Every respected expert recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. The President believes that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children. That is why he has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2027.** Dedicating 15 percent of the surplus ($794 billion over 15 years) to Medicare not only ensures the financial health of the Trust Fund through at least 2027, but it also eliminates the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about $118 billion over 10 years. It would be fully financed by:

  - Savings from competition and efficiency. About 60 percent of the $118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.

  - Dedicating a small fraction of the surplus. About 40 percent, or $45.5 billion, of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:

    - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and

    - Less than the reduction in the Medicare baseline spending between January and June, 1999.

    Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently underscored their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

- **Goals for Reform:**
  - ° Make Medicare More Competitive and Efficient
  - ° Modernize Medicare's Benefits
  - ° Strengthen Medicare's Financing for the 21st Century

- **Reduces Medicare spending by $72 billion over 10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.

- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009.
  - ° Over 60 percent of the costs are offset by the proposal's savings.
  - ° The remaining $45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the $374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.

PRESIDENT'S PROPOSAL
(Dollars in Billions, Trustees' Baseline)

	00-04	00-09
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	***-5***	***-64.5***
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	***+27***	***+110***
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	***-22***	***-45.5***
Surplus Allocation	***-50***	***-374***

* Includes $5.7 billion in interactions/premium offset
** Does not count toward package

- **Extends the life of the Medicare trust fund for a quarter of a century, to at least 2027.** The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the life of the Medicare Trust Fund for a quarter century, through at least 2027. This is the best prognosis for Medicare since the program was created.

*

NOT FOR DIST

Q: Republicans are reportedly forming a Task Force to devise a plan to provide prescription drug coverage for seniors. What is your response?

A: Like the Patients' Bill of Rights, there should be no party difference or income distinction over the need for an affordable, voluntary, prescription drug benefit option for older Americans and individuals with disabilities. We hope that the Republican leadership's decision to form a Task Force won't result in the same type of delay and partisanship that marked the leadership's formation of the Patients' Bill of Rights Task Force last year. We don't have much time this year, and we need to develop a bipartisan consensus on how to address this issue. We hope Republicans will reach out to the Democratic leadership and ask them, as well as Administration representatives to develop a common ground position on how best to develop a long overdue, optional, Medicare prescription drug benefit.

NOT FOR DISTRIBUTION

November 8, 1999

PRESCRIPTION DRUG EVENT

Date:	**Tuesday, November 9, 1999**
Time:	**11:00 a.m. -12:00 p.m.**
Location:	**Rayburn House Office Building Room 2168**
From:	**Chris Jennings Ann O'Leary**

I. PURPOSE

To join House Democratic Leader Richard Gephardt, House Democratic Whip David Bonior, and Representatives Henry Waxman (D-CA), Pete Stark (D-CA) and Ronnie Shows (D-MS) in calling for Congressional action to address the problem of prescription drug costs for seniors.

The House will also be using the event to release a study of drug companies pricing practices and their impact on senior citizens without prescription drug coverage. The event will also allow the Democrats to announce their intent to collect signatures for a discharge petition.

II. BACKGROUND

As you know, in this year's State of the Union the President outlined his plan to modernize and strengthen the Medicare program. In June, he announced the specifics of the plan that included a proposal to establish a new voluntary Medicare "Part D" prescription drug benefit. Since the State of the Union address, there has been an enormous increase in interest in developing policies to address this issue. This is driven not only because it is impossible to defensibly reform Medicare without modernizing it to include at least some prescription drug coverage, but because this issue has become one of the highest priority domestic policy issues for the electorate.

It is clear, however, that the Congress will recess for the year without acting on any issue related to either prescription drug cost or coverage. The Democrats have a number of legislative proposals on the table and plan to spend the recess getting ready for the battle ahead in the next year. [Note: Interestingly, one of the reasons why the BBA provider give-back provisions have become so complicated to navigate through the Congress is that the Republican leadership fears that Democrats will offer prescription drug amendments to whatever provider give-back legislative vehicle is pending.]

President's Proposal

As a reminder, the President's drug benefit, in the context of broader reform, has a zero deductible and pays for half of all drug costs up to a $5,000 cap when fully implemented. It uses private sector purchasers to negotiate discounts for Medicare beneficiaries that are also accessible after the cap has been reached.

NOT FOR DIST

Legislative Proposals on the Hill

The Hill is tackling the prescription drug problem within three distinct areas: (1) expanding prescription drug coverage (2) reducing prices of prescription drugs (3) international drug parity.

Expanding Prescription Drug Coverage

Congressmen Stark and Dingell and Senators Kennedy and Rockefeller have introduced a more expensive and comprehensive but complicated prescription drug benefit. While promising front end and catastrophic coverage, it leaves seniors with drug costs of $1,500 to $3,200 exposed and vulnerable. With a 75 percent premium subsidy, our actuaries estimate that it costs nearly $300 billion over 10 years (compared to our $116 billion).

Reducing Prices of Prescription Drugs

Congressmen Allen, Waxman, Turner, and Berry have introduced legislation (the "Allen bill") that would require pharmacists serving seniors to provide them with access to the same discounts they provide to Federal and corporate purchasers. This policy is viewed by the drug industry as straight-up price controls, and this criticism has been validated by a number of businesses, insurers, and elite policy validators. Congressman Allen, a "New Democrat" from Maine, counters that this policy is not price controls, since the drug industry can choose the level of discounts it provides to large purchasers and thus the discount provided to Medicare beneficiaries through their local pharmacists. The bill, which has a broad based collection of Democratic sponsors (over 130 sponsors including Blue Dogs, New Dogs, and traditional liberals), is not going anywhere and has very few advocates in the Senate, but is attractive to many because there are no new Federal costs since it provides no new insurance coverage; rather, it simply requires access to discounts that are currently unavailable.

Congresswoman Thurman recently offered a version of the Allen bill during the Ways and Means markup of the BBA provider give-back legislation. It was rejected along party lines with subcommittee Chair Thomas arguing that this was the wrong vehicle to use for broad Medicare reform. (Parenthetically, Mr. Thomas does not appear to have problems with including GMNE reforms, which have nothing to do with the BBA and are harmful to New York teaching hospitals, in the package to submitted to the floor last week.)

International Drug Parity

Fairly recently, Congressman Sanders and Berry and Senators Dorgan and Wellstone introduced legislation permitting the re-importation of prescription drugs from Canada to pharmacies in the United States in order to access the discounts that Canadian pharmacists receive. The FDA has raised strong safety concerns about this legislation, but it can be cited as an example of the frustration members of Congress and the public at large are having with the price differentials between drugs sold in Canada and the United States, even though these medications were initially manufactured in this country.

NOT FOR DIST

Other Legislative Proposals

Numerous other prescription drug initiatives have either been unveiled or suggested by members of Congress. Senators Wyden and Snowe have introduced legislation to provide subsidies for HMOs and Medigap plans to offer prescription drug coverage. (We have criticized this legislation because it is a block grant approach that undermines Medicare's guarantee of coverage and does not provide for a workable fee-for-service benefit, thus making access to affordable prescription drugs impossible for millions of beneficiaries living in rural communities.)

At 10:00 a.m. just prior to your event, Senators Breaux and Frist will offer a prescription drug benefit in the context of broader Medicare reforms; at the time of the release of their plan, they had suggested a Medicaid benefit for beneficiaries up to 150 percent of the poverty level. (We have criticized this benefit as inadequate because over half of the seniors without prescription drug coverage have incomes over 150 percent of the poverty level.)

The Republican tax package included a tax deduction to offset the cost of prescription drug insurance for seniors. This proposal was widely criticized because the seniors who most need the drug benefit do not file taxes and would not be eligible for the tax deduction, and because the proposal does nothing to make affordable insurance more accessible.

Recommendation

We would advise that you use all of these bills as illustrations of the importance of moving ahead on the prescription drug cost and coverage issue. Rather than endorsing any approach – other than the President's – we would recommend that you highlight these initiatives in that context. They can be used to underscore the numerous problems Americans face in accessing affordable prescription drugs, as well as to highlight the unwillingness of this Congress to act. The Republican leadership continues to quietly support the status quo and not move any of the bills designed to address this challenge forward.

III. PARTICIPANTS

Speaking Program

Minority Leader Richard Gephardt
Representative Henry Waxman (D-CA)
First Lady
Ed Dillon, pharmacist
Representative Bonior (D-MI), House Democratic
Rep. Ronnie Shows (D-MS)
Rep. Pete Stark (D-CA)

NOT FOR DIST

Bios

Edward F. Dillon is a registered pharmacist who has been practicing in a community retail pharmacy in Maryland for over 25 years. His pharmacy practice emphasizes patient contact and counseling and working with other professionals to optimize patient care.

Audience

The audience will include 38 senior citizens. They come from 3 different senior groups - Older Women's League, National Committee to Preserve Social Security and Medicare, and the National Council of Senior Citizens.

Press and Hill staff will also be in the audience.

IV. SEQUENCE OF EVENTS

Speaking Program

- Gephardt will open by welcoming you and give the broad overview of the need for
- Representative Henry Waxman (D-CA) will release the investigative study that was conducted in over 100 congressional districts examining the price differentials between the manufactures, preferred customers, seniors, and international comparisons. The studies find that senior citizens who pay for their own drugs pay, on average, 134% more.
- You will then outline the problem, applaud the Democrats for putting forward solutions, call for the Majority to act, and introduce the pharmacist.
- Ed Dillon, pharmacist, will talk about problems seniors face every day in accessing affordable prescription drugs
- Representative Bonior (D-MI), House Democratic Whip, will announce the intent to file a discharge petition for the Allen Bill and the Stark bill.
- Rep. Ronnie Shows (D-MS) will talk about the importance of the Allen bill and the need for lower prices.
- Rep. Pete Stark (D-CA) will talk about the Stark bill and the need for comprehensive coverage.
- Gephardt will close the event and will excuse you before they take press questions.

V. PRESS PLAN

- Open press
- No Q&As

VI. REMARKS

- Talking Points Attached