Women's Domestic Issues

PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

FOR THE 21st CENTURY

National Economic Council / Domestic Policy Council

The White House

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

TAB 1.

OVERVIEW: BUDGET PRIORITIES

BUDGET PRIORITIES:

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

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

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

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

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

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

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

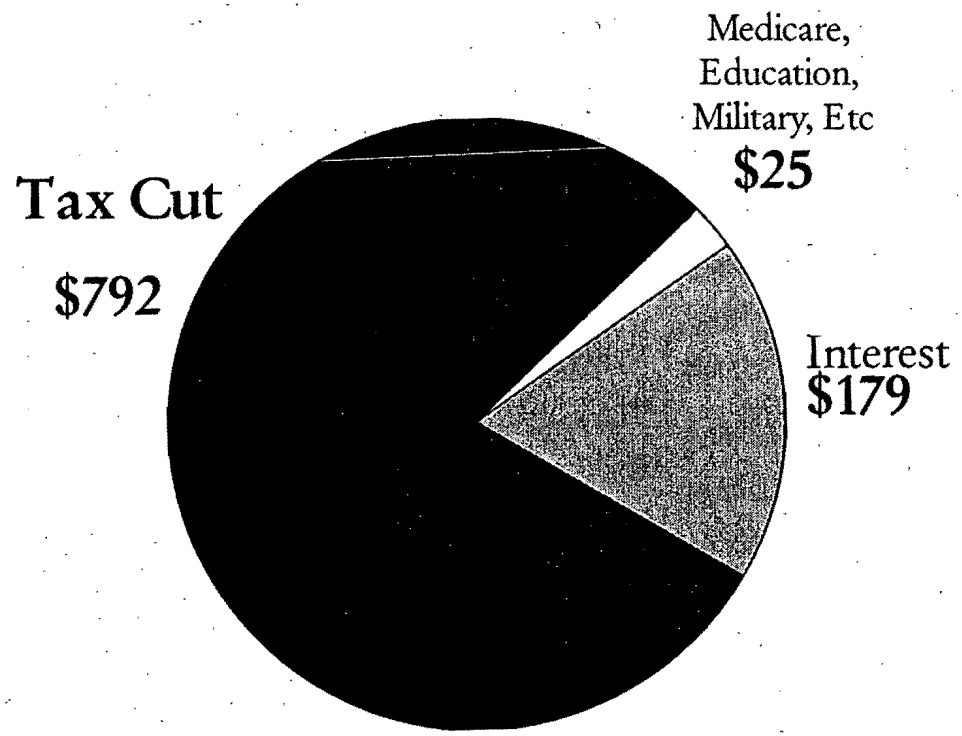
- Republican plans would lead to deep, across the boardcuts in domestic priorities. In order to pay for their risky tax cut and fund our military at the same level as the President, Republicans would have to cut *more than $700 billion* from domestic spending. In 2009, that would mean roughly a 50% cut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

TAB 2.

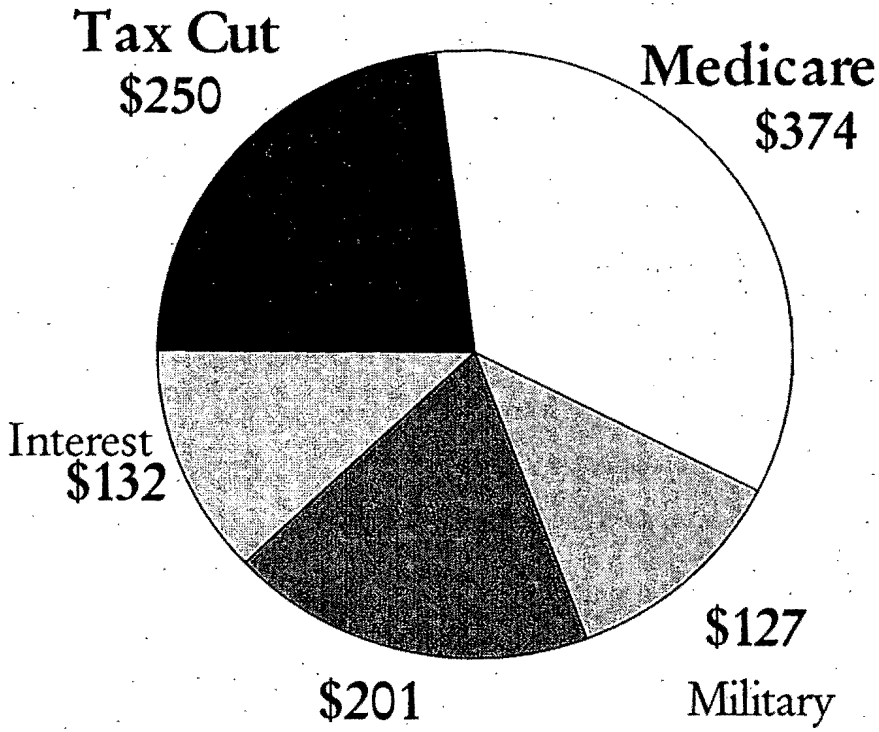
COMPARISON OF PRESIDENT'S AND REPUBLICANS' PRIORITIES

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

Republican Plan



President's Plan



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

Impact of Republican Tax Plan

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

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

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

Education and Training

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

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

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

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

Environment and Health

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

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

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

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

Crime, Housing, and Other Priorities

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

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

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

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

Source: Office of Management and Budget

TAB 3.

PRESIDENT'S MEDICARE PLAN

STRENGTHENING MEDICARE FOR THE 21st CENTURY

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

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

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

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

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

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

- It is impossible to reduce provider payments enough to extend the life of the Medicare trust fund for any significant length of time. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person.
- Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster, helping to eliminate public debt by 2015. This would make America debt-free for the first time in the 160 years

June 30, 1999

The New York Times

Founded in 1851

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

Improving Medicare

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

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

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

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

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

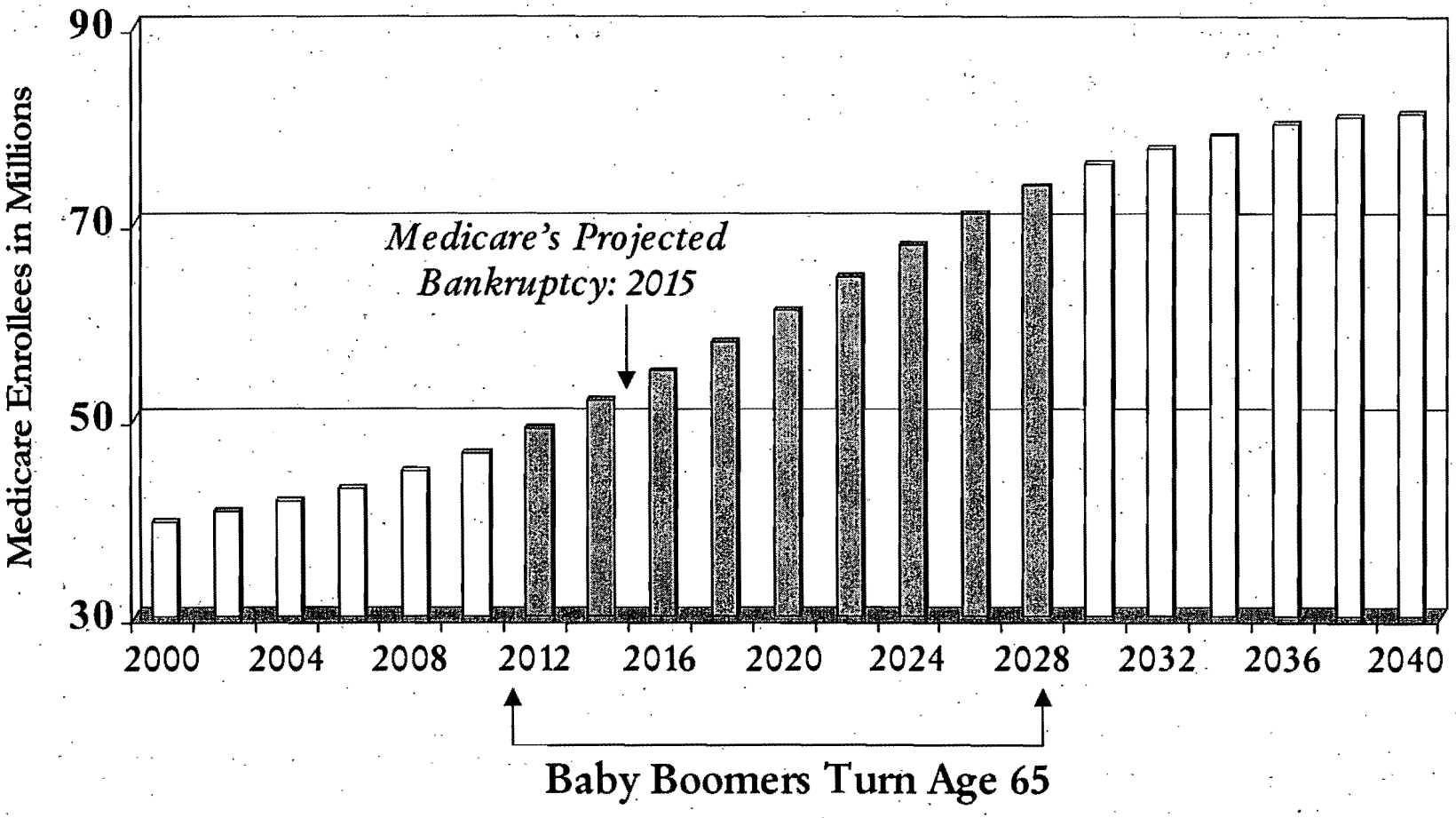
Reforming Medicare requires modernizing the benefits and improving cost controls. The Clinton proposal, made feasible by the surplus, offers some sensible ways to achieve those goals while keeping Medicare a broad-based social insurance program.

PRESIDENT'S PLAN TO MODERNIZE & STRENGTHEN MEDICARE

Plan To Modernize and Strengthen Medicare

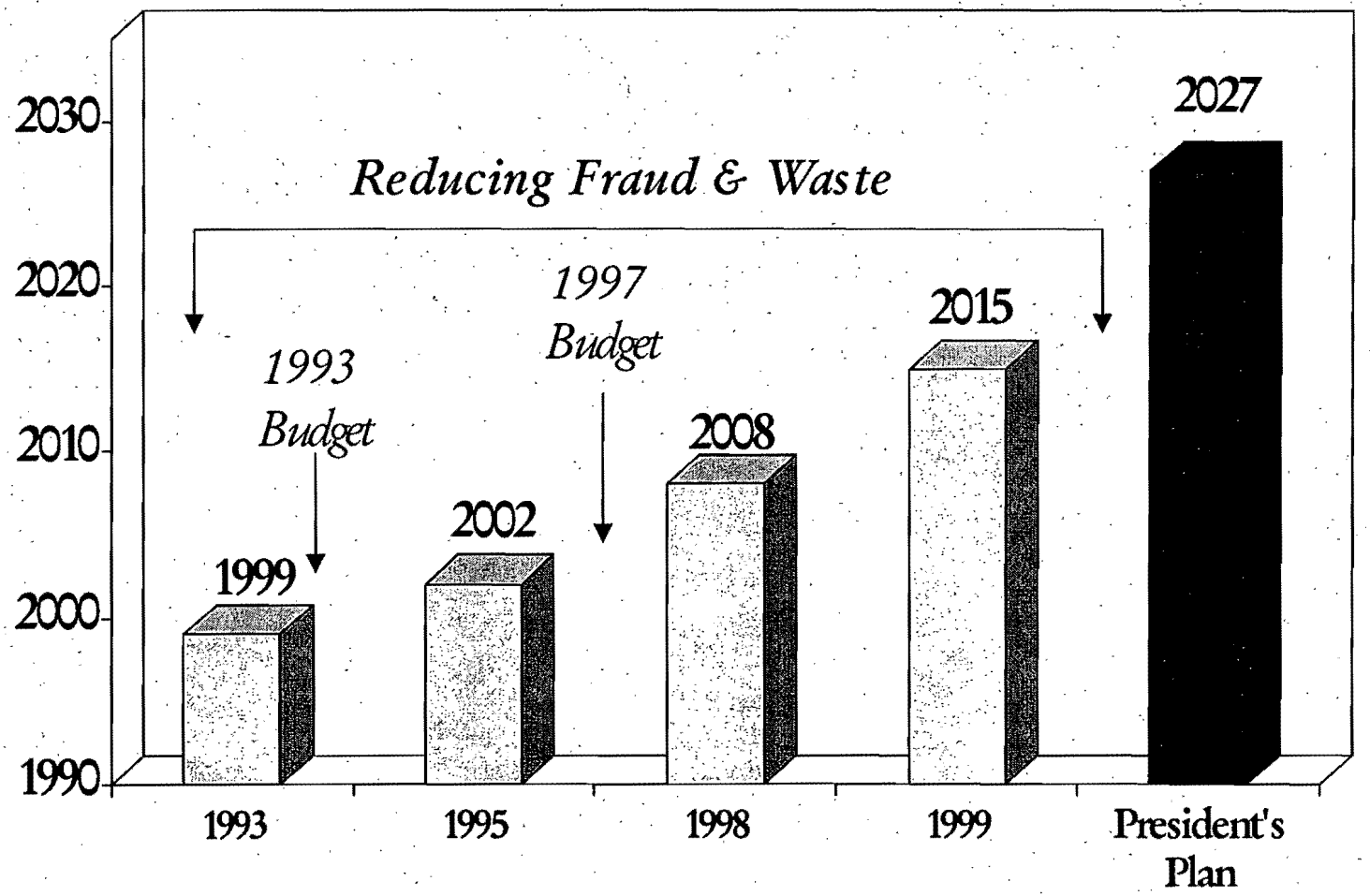
- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Financing for the 21st Century By Dedicating Part of the Surplus to Medicare

Medicare Enrollment Will Double As The Baby Boom Generation Retires



Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



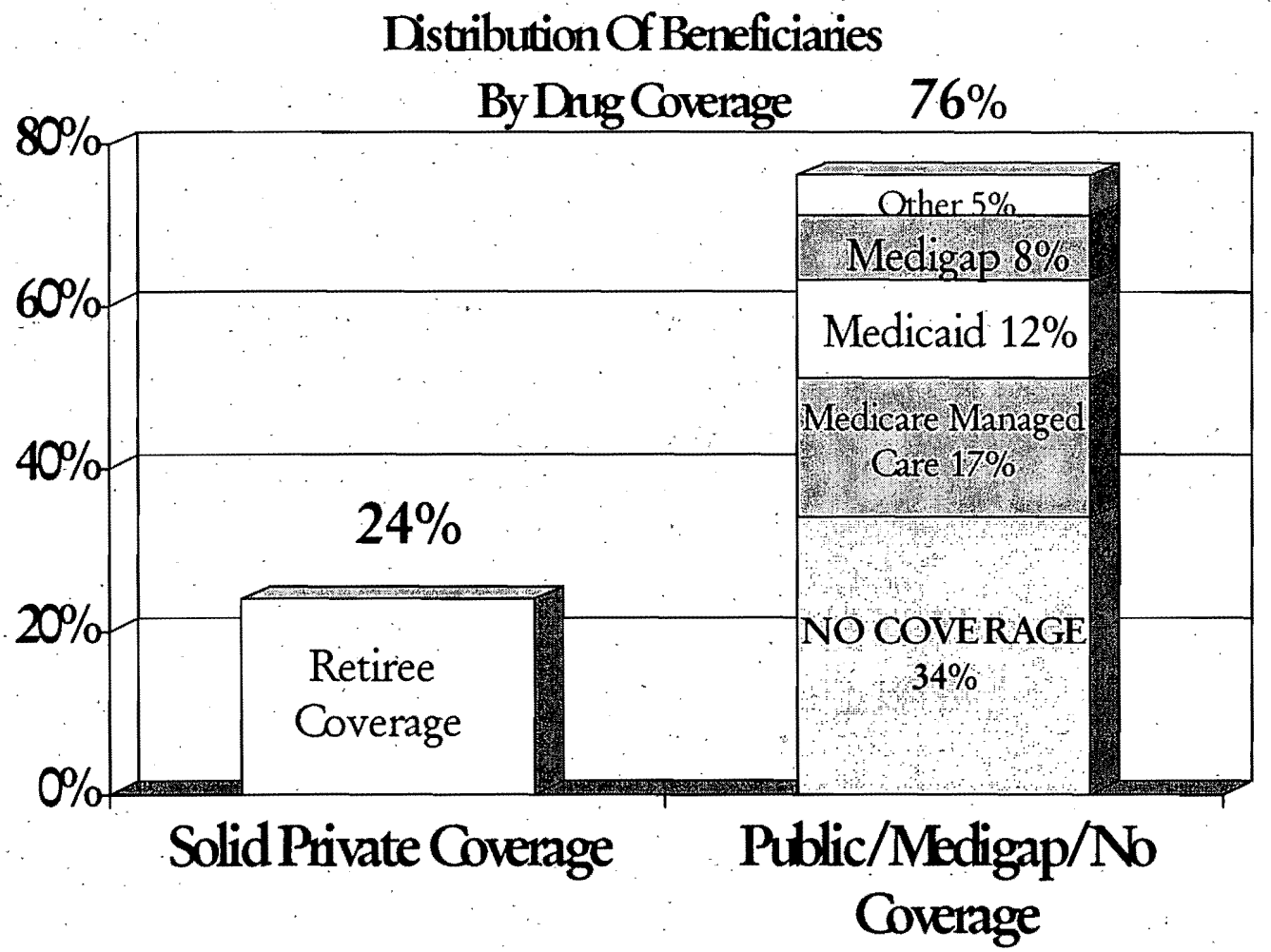
President's Proposal For Medicare Prescription Drug Coverage

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

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

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

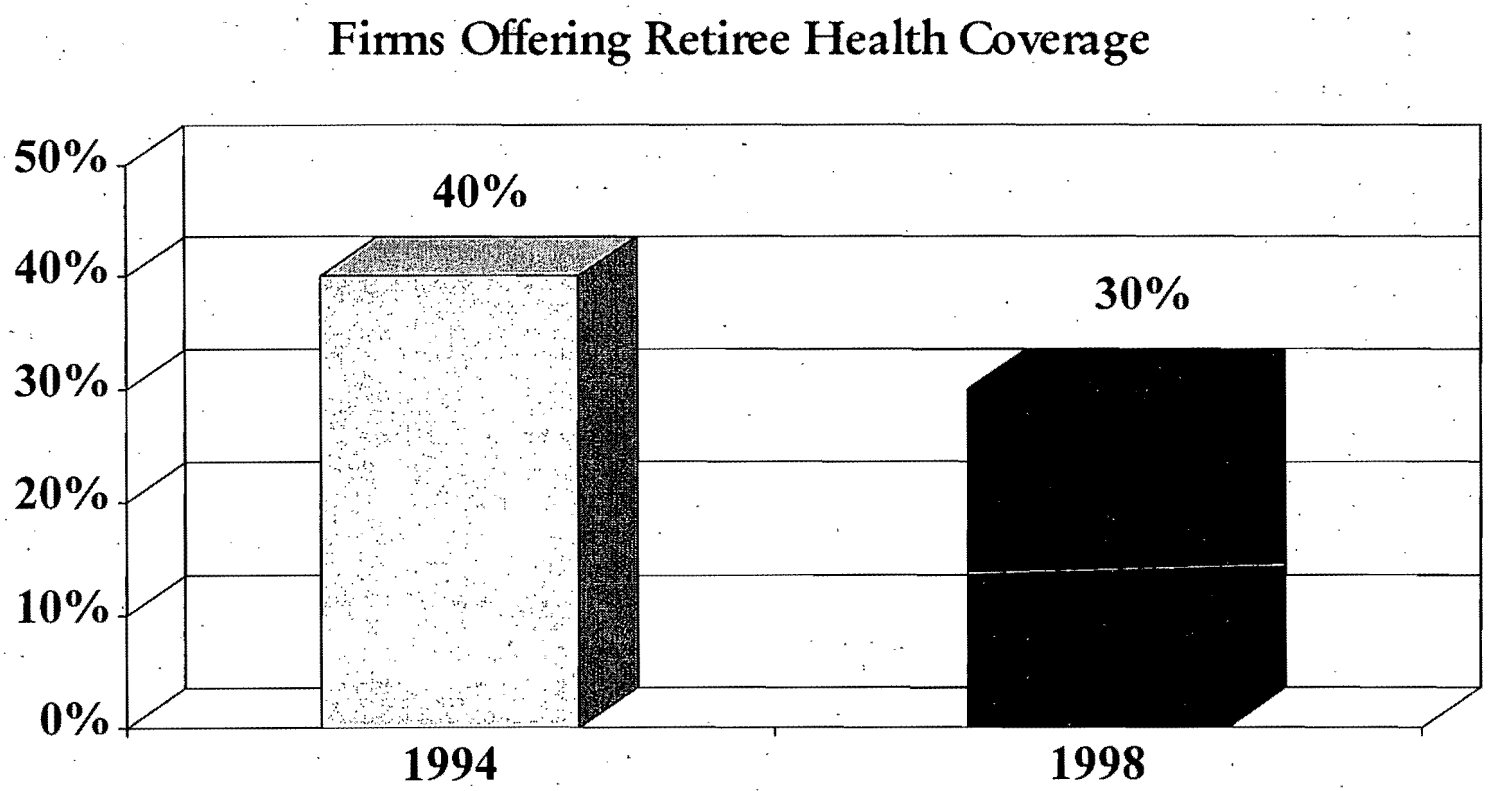
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



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

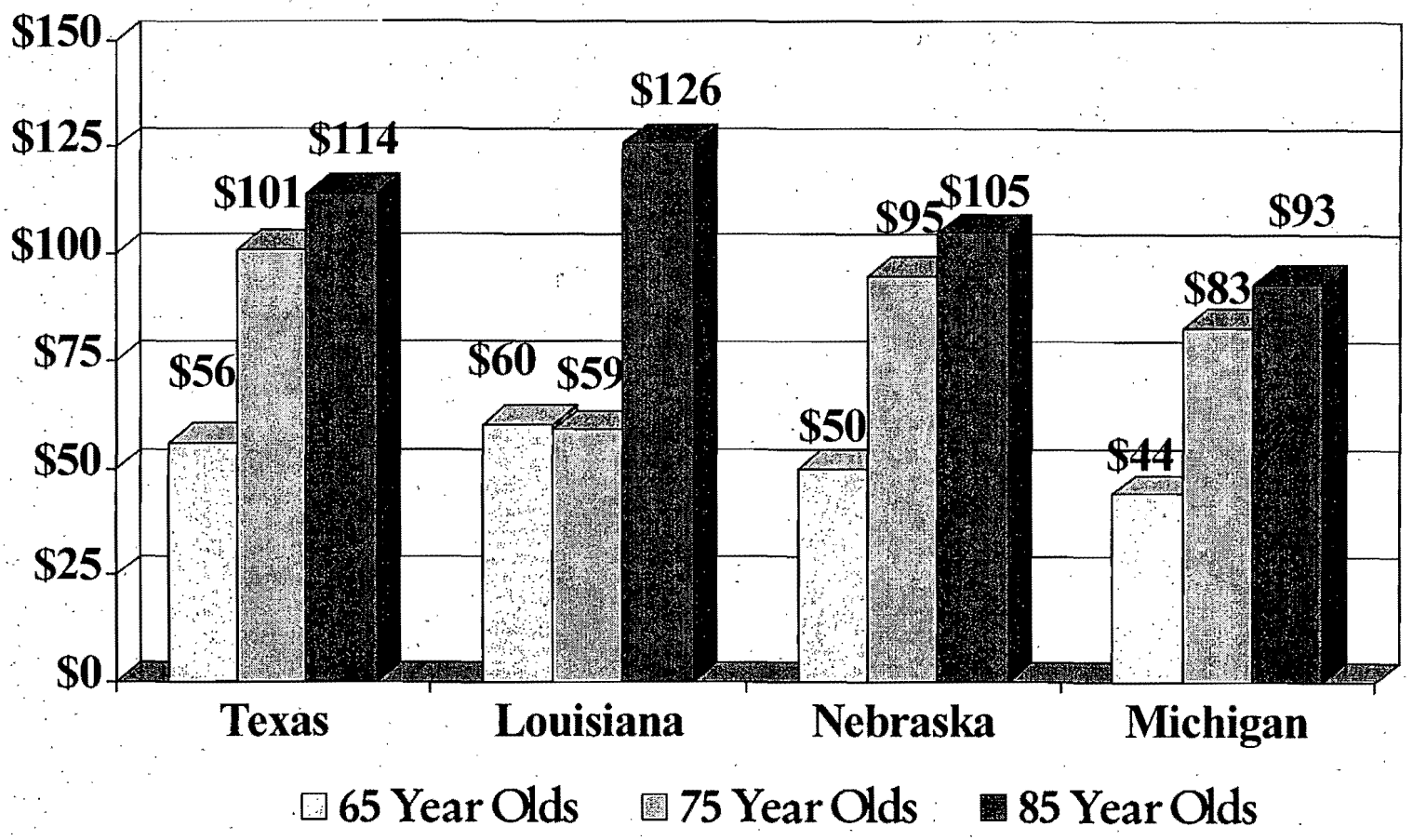
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

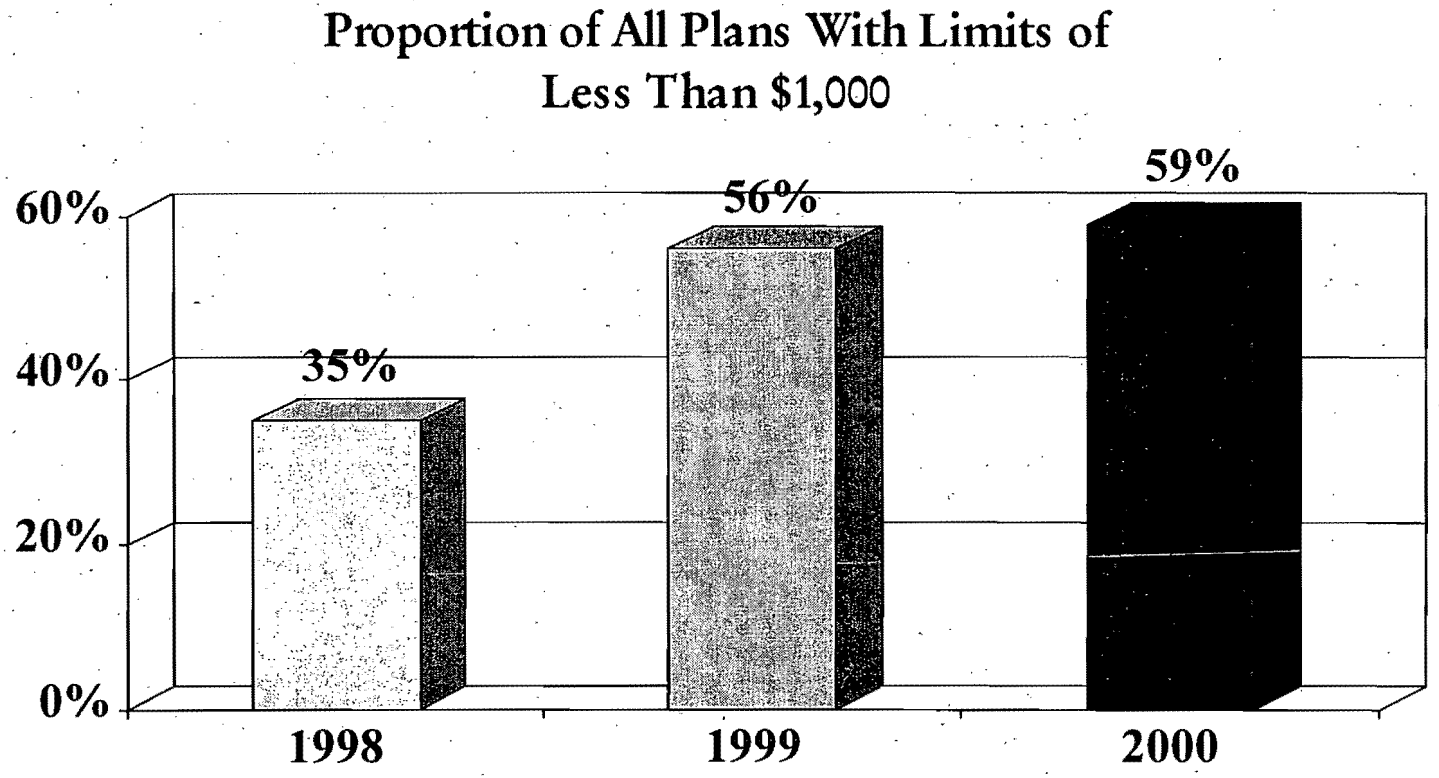
Premiums for Medigap, Which Only Covers 8% of Beneficiaries, Are High And Increase With Age



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

Value of Medicare Managed Care Drug Benefits Is Declining

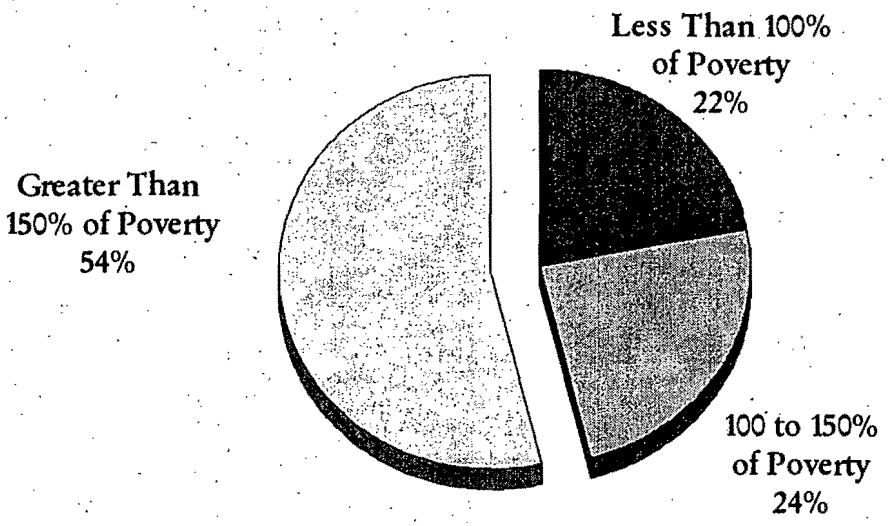
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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

Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

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



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

Disproportionately Affects:

- **Rural beneficiaries,** since nearly half have no coverage
- **Older women,** for whom total prescription drug spending averages $1,200 -- 20% more than men's

SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, 150% of poverty for a single person is about $12,750, for a couple is about $17,000

Making Medicare Managed Care More Competitive

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

Smoothing Out Balanced Budget Act Policies In The Short Run

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

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

- **$7.5 Billion Quality Assurance Fund**

TAB 4.

PRESCRIPTION DRUG BENEFIT

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

National Economic Council
Domestic Policy Council

July 22, 1999

DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

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OVERVIEW

DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug

This report describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. This report shows that the accessing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance – it is an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

- **Prescription drug coverage is good medicine.**

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

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

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

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

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

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

- **Private trends: Decline in coverage and affordability.**

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

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

- **Public drug coverage trends: managed care benefits reduced.**

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

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

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

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

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

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV and Parkinson's). Some of the major advances in public health – the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

- **Greatest need for prescription drugs.** The elderly and people with disabilities are particularly reliant on prescription drugs. Not only do they experience greater health problems, but these problems tend to include conditions that respond to drug therapy. As a result, about 85 percent of beneficiaries fill at least one prescription a year. Some examples of common conditions include:

  - Osteoporosis: Over 1 in 5 older women have osteoporosis and about 15 percent have suffered a fracture as a result.[1] It is a leading risk factor for hip fractures, which affects 225,000 people over the age of 50. Estrogen replacement can reduce the risk of osteoporosis as well as that of cardiovascular disease. One commonly used drug costs $20 per month, $240 per year.

  - Hypertension: About 60 percent of people over age 65 have hypertension.[2] African Americans are more likely to have hypertension. For a person over age 55, hypertension increases the risk of a heart attack or other heart problem over 10 years by 10 percent.[3] Hypertension roughly doubles the risk of cardiovascular disease and is the leading factor for stroke. According to one study, treatment results in a one-third reduction in the probability of stroke and a one-quarter reduction in the probability of a heart attack.[4] ACE inhibitors which typically cost $40 per month, $480 per year are commonly prescribed to control hypertension, and are frequently used in combination with diuretics and /or beta-blockers.

  - Myocardial Infarction (Heart Attack): Heart disease is the leading cause of death for persons 65 and over. About 1.5 million Americans each year have heart attacks, which are fatal in about 30 percent of patients. Since people who survive heart attacks are much more likely to have subsequent attacks, disease management including drugs can significantly improve health and longevity. For example, a study of the use of a lipid lowering drug by people who had an acuate myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.[5] A common lipid reduction drug costs about $85 per month, $1,020 per year. A beta-blocker costs about $30 per month, $360 per year, and can reduce long-term mortality by 25 percent.[6]

  - Adult-Onset Diabetes: About 1 in 10 elderly have Type I or II diabetes.[7] Diabetes can lead to blindness, kidney disease and nerve damage. Glucose (blood sugar)

control can prevent or delay these conditions. Commonly used medications include cost around $60 per month, $720 per year.

- Depression: An estimated 1 in 10 to 1 in 20 community-based elderly experience depression.[8] Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.[9] New therapies can cost from $130 to $290 per month or $1,560 to $3,480 per year.

- **Many beneficiaries need drugs but do not use them as prescribed because they do not have well managed, affordable drug insurance.** Most research has found that drug coverage influences use of needed drugs:

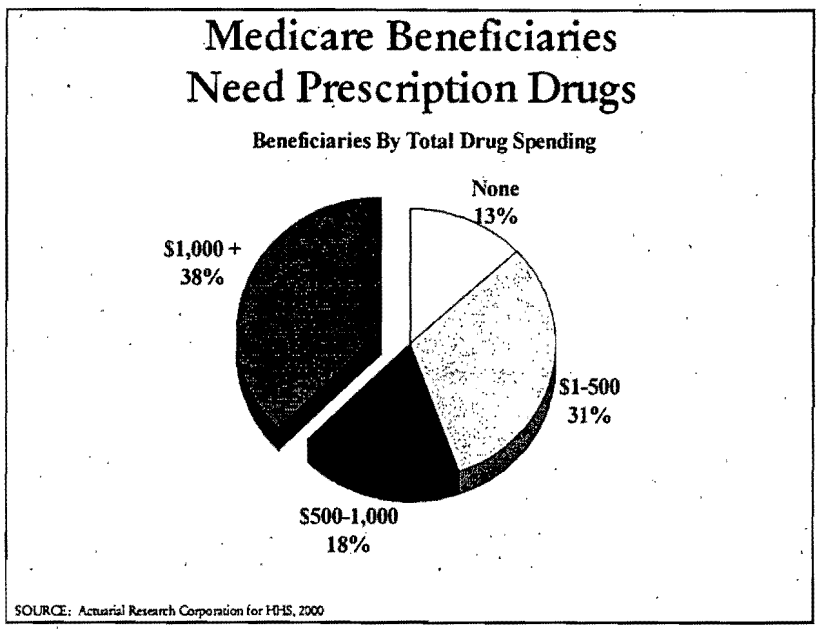
  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.[10] Many elderly must choose between prescriptions and other basic household needs.[11]

  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.[12]

  - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs. One study which classified the geriatric admissions to a community hospital found that drug-related hospitalization accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.[13]

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

- **Because of their greater need, the elderly and people with disabilities have greater health care costs.** The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug spending.



- **Over one-third (38%) of Medicare beneficiaries will spend more than $1,000 on prescription drugs.** Less than 5 percent will spend more than $5,000.

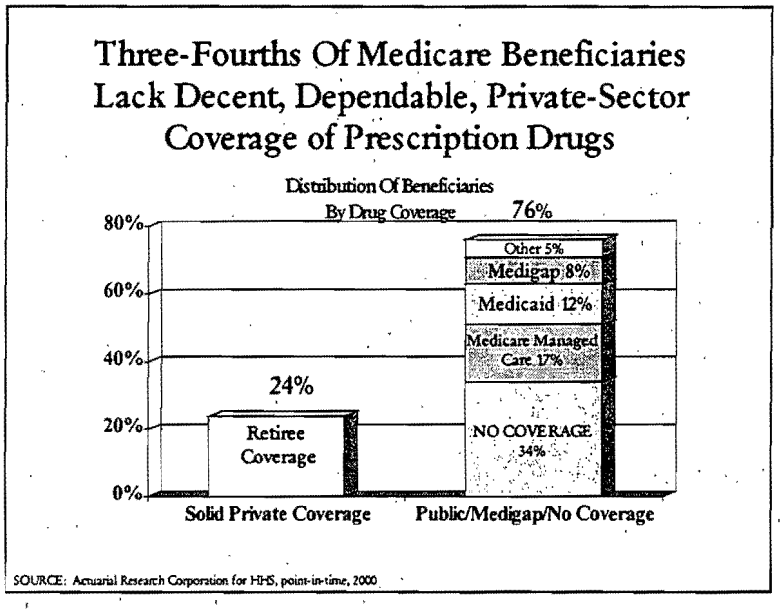
- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than $500.

- **Spending is higher for women.** Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.

- **Out-of-pocket spending is also high.** In 2000, Medicare beneficiaries are estimated to spend about $525 on prescription drugs out-of-pocket. This spending is linked to insurance coverage – it is much higher for those with no coverage ($800) and people with Medigap ($650) than those with retiree coverage ($400).

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

- **Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs.** As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.



- **Only one-fourth of Medicare beneficiaries have retiree drug coverage.** Employers provide health insurance for most Americans under the age of 65, but pay for supplemental coverage for only a fraction of their elderly retirees. When available, this coverage tends to have reasonable cost sharing and affordable premiums.

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs.** These beneficiaries include those with:

  - Medigap. About 8 percent of beneficiaries purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries.

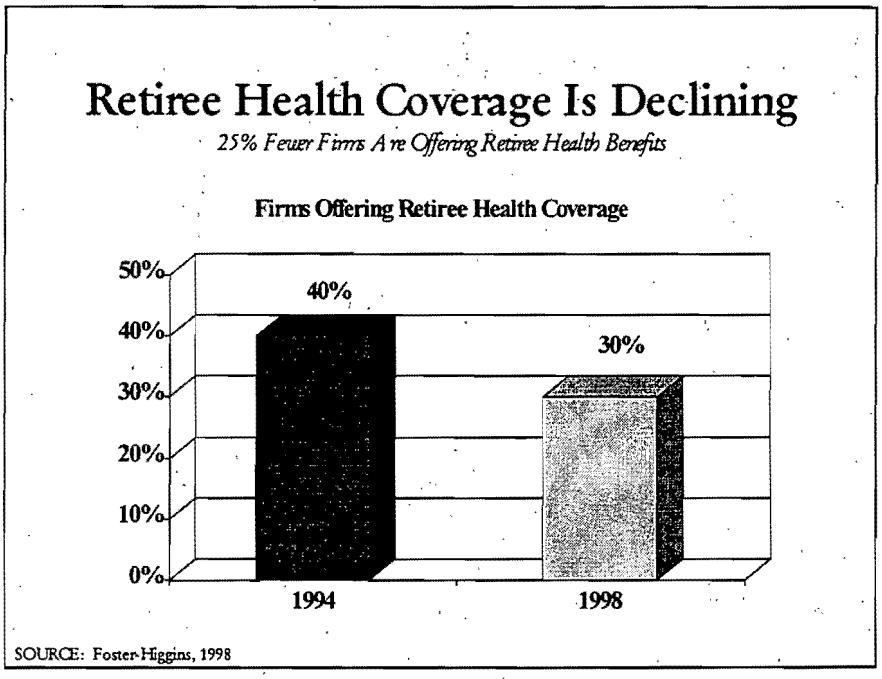
  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

  - Medicaid and other public programs. Medicaid covers about 12 percent of beneficiaries and programs like the Veterans' Administration cover another 5 percent of beneficiaries. Eligibility for these programs is very restrictive.

  - No coverage at all. 34 percent of Medicare beneficiaries has no drug coverage.

RETIREE HEALTH COVERAGE

- **About one in four Medicare beneficiaries has prescription drug coverage through their retiree health plan.** These employer-based plans offer decent, affordable coverage.



- **Firms offering retiree health coverage have declined by 25 percent in the last four years.**[14] Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage.

  - The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

- **Most serious effect will occur when the baby boom generation retires.** Although there are employers who are dropping health coverage for current retirees, most are restricting coverage for future retirees. This means that the access problems that are emerging now could be more severe in the future.

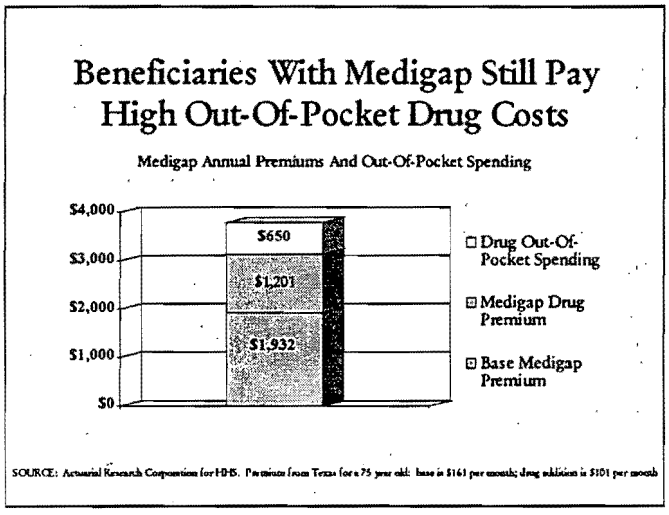
- **Firms are increasingly moving their retirees to Medicare managed care.** To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in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

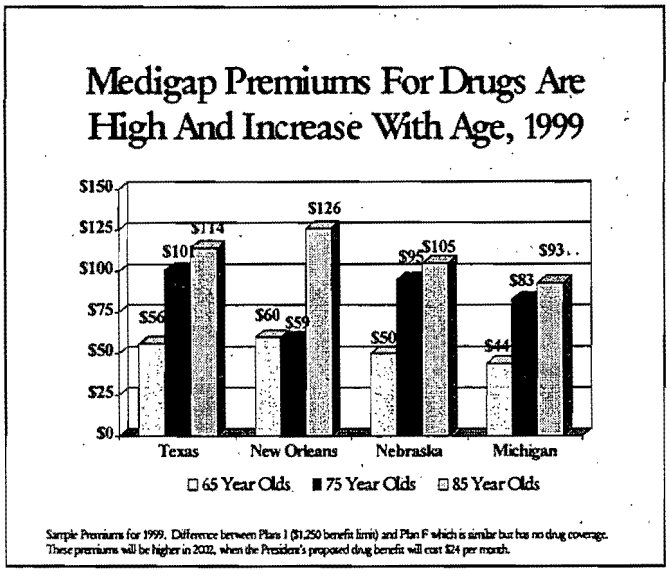
MEDIGAP PRESCRIPTION DRUG COVERAGE

- **Because of its high cost relative to its benefit, less than one in ten Medicare beneficiaries purchases a Medigap plan with prescription drugs.** Three of the ten standardized Medicare supplemental plans, (plans H, I, and J) include prescription drug coverage. All three plan types have a $250 deductible for the drug benefit and require 50 percent coinsurance. The H and I plans have a cap on drug benefits of $1,250 while the J plan caps the benefit at $3,000. The typical premium for a plan with the lower cap costs about $90 per month or $1,080 per year.

- **Medigap is expensive, inefficient, and often uses higher prices to discriminate against the oldest beneficiaries.**

  - Expensive. Medigap policies that cover prescription drugs are expensive relative to comparable policies that do not cover drugs. Additionally, premiums vary tremendously from place to place, and from beneficiary to beneficiary. Finally, a beneficiary cannot only pay for prescription drugs – they must also buy the other benefits in the package.





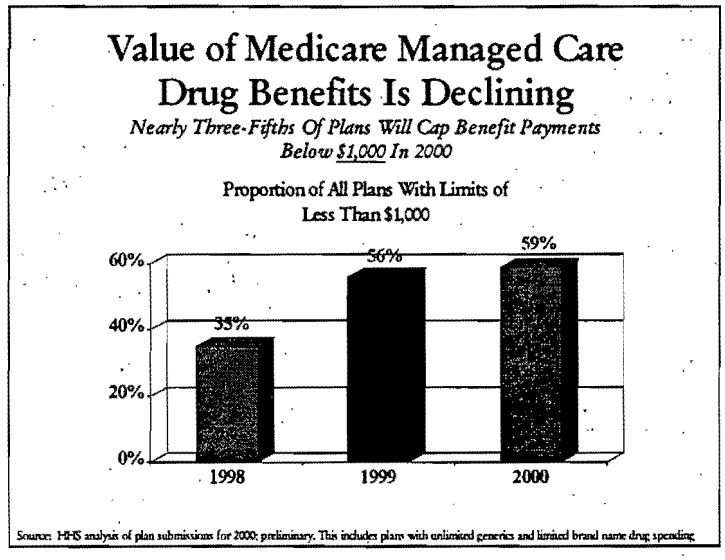
Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

Costs increase with age as well as health inflation. This "attained age" pricing practice causes excessive premiums for those who need it most – the very old. It also disproportionately affects women since they comprise nearly three-fourths of people over age 85.

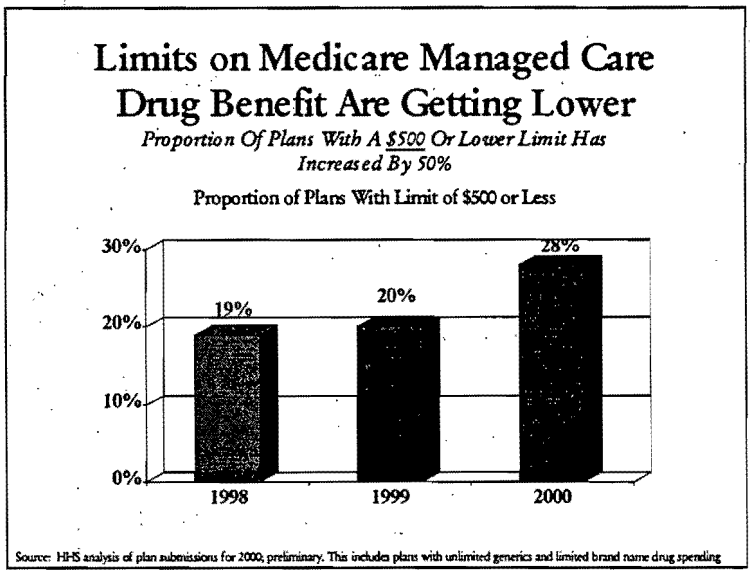
MEDICARE MANAGED CARE

- **The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent.** Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.

- **Drug coverage under Medicare+Choice is unstable.** Managed care plans are not required to offer a drug benefit, but can do so with any excess Medicare payments or by charging a premium. This results in wide variation across areas, since payments vary by area, and over time.



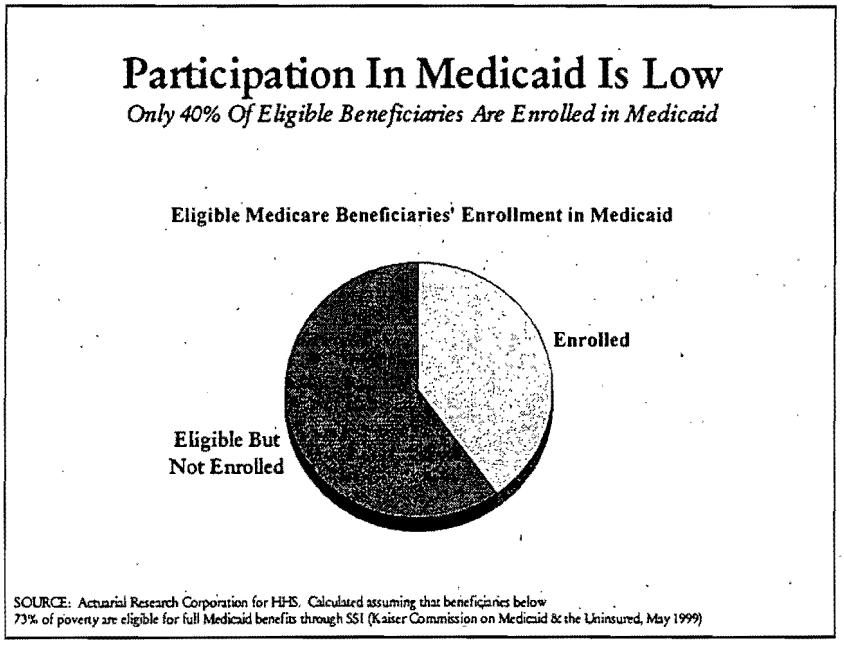
- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.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



- **Plans dropping out of Medicare limit access to drugs.** Nearly 80,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.

MEDICAID

- **About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit.** Most of these "dual eligibles" qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- $6,200 for a single, $8,300 for a couple in 2000). States have other options for covering the elderly and disabled, including "medically needy" or "spend-down" programs that extend eligibility to sick and/or institutionalized people.



- **Participation by Medicaid eligible populations remains low.** Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.

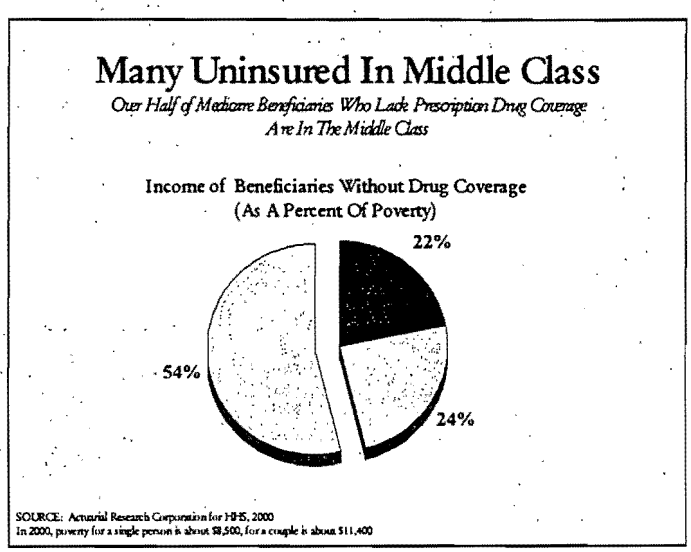
  - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.

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

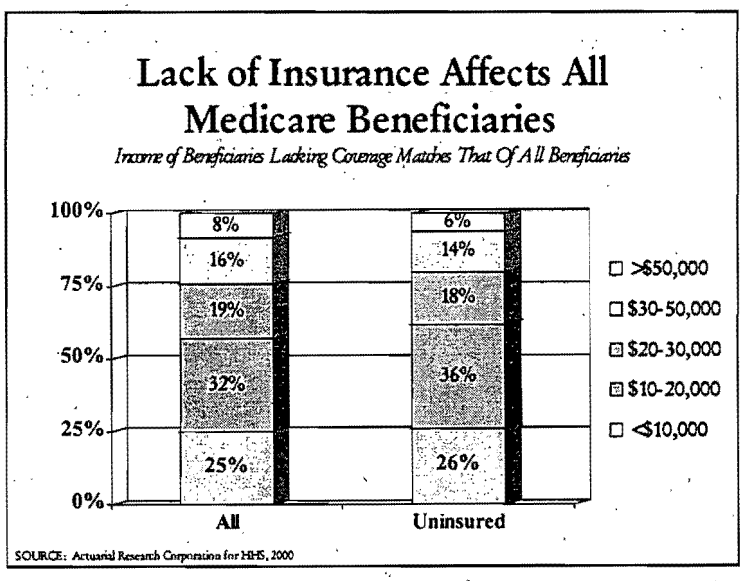
BENEFICIARIES LACKING DRUG COVERAGE

- **At least 13 million or 34 percent of Medicare beneficiaries have no insurance coverage for prescription drugs.** These beneficiaries pay retail prices for prescription drugs, which can often be significantly more expensive than what large firms or public programs pay for the same drugs.

- **More than half of Medicare beneficiaries without drug coverage are middle class.** Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This indicates that targeting a drug benefit only to the low-income cannot address even half of the problem.



- **The income distribution of beneficiaries lacking drug coverage closely parallels that of all beneficiaries.** This lack of difference suggests that everyone is at risk of losing their health insurance.



PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost the Federal government about $118 billion from 2000 to 2009. It would be fully offset, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare.

- **Meaningful coverage.** Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:

  - No deductible – coverage begins with the first prescription filled and

  - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

  The benefit would be limited to $5,000 in costs ($2,500 in Medicare payments) in 2008. It would phase it a $2,000 for 2002-2003; $3,000 for 2004-2005; $4,000 for 2006-2007; and $5,000 in 2008 (indexed to inflation in subsequent years).

- **Affordable premiums.** Beneficiaries who opt for Part D would a pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008 when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and, after an initial open enrollment for all beneficiaries in 2001, would occur when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would generally be deducted from Social Security checks.

  - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty ($17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty ($15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.

- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

APPENDIX: METHODOLOGY & ENDNOTES

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

Endnotes.

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[11] Families USA, 1994.

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

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

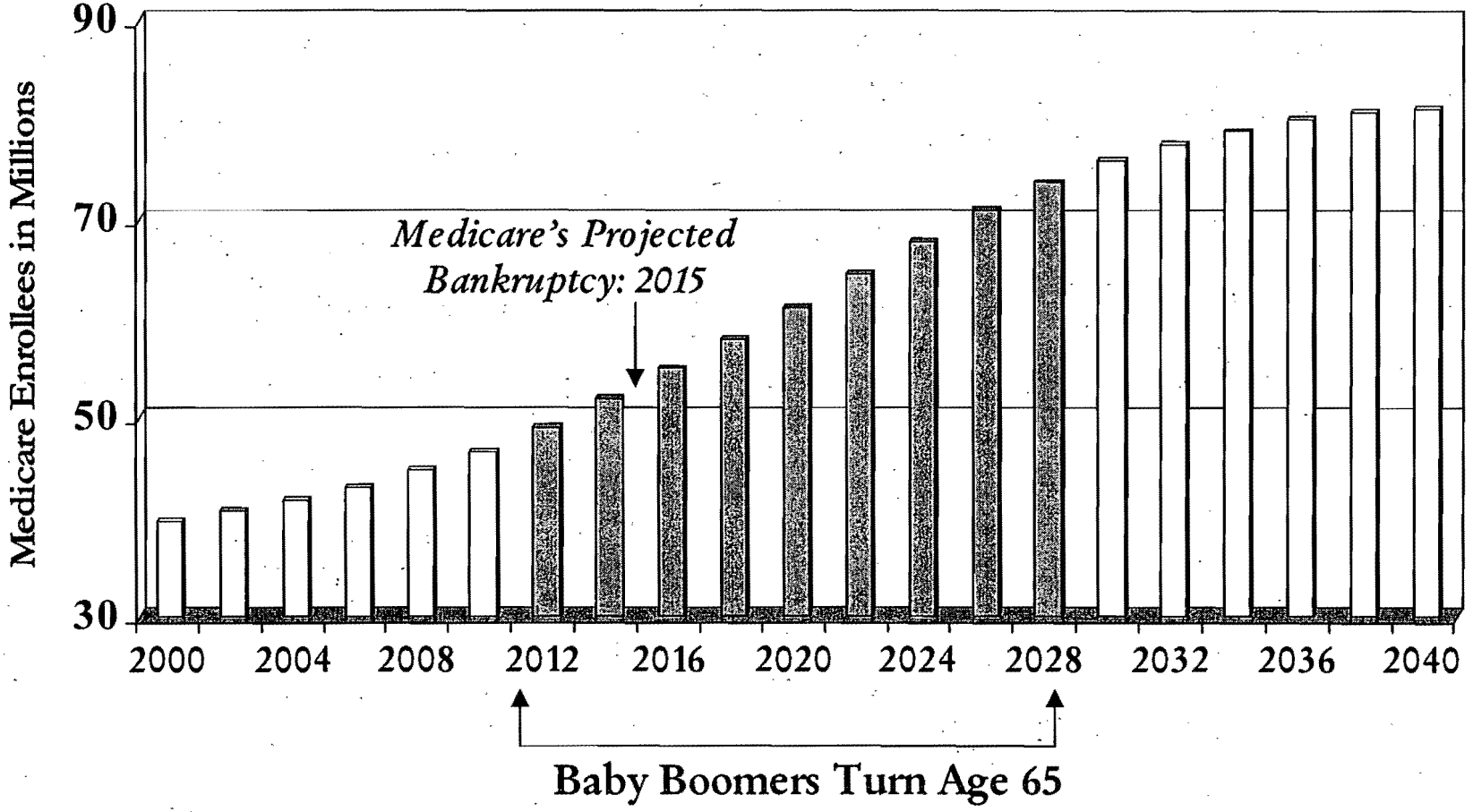
[14] Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.

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

TAB 5.

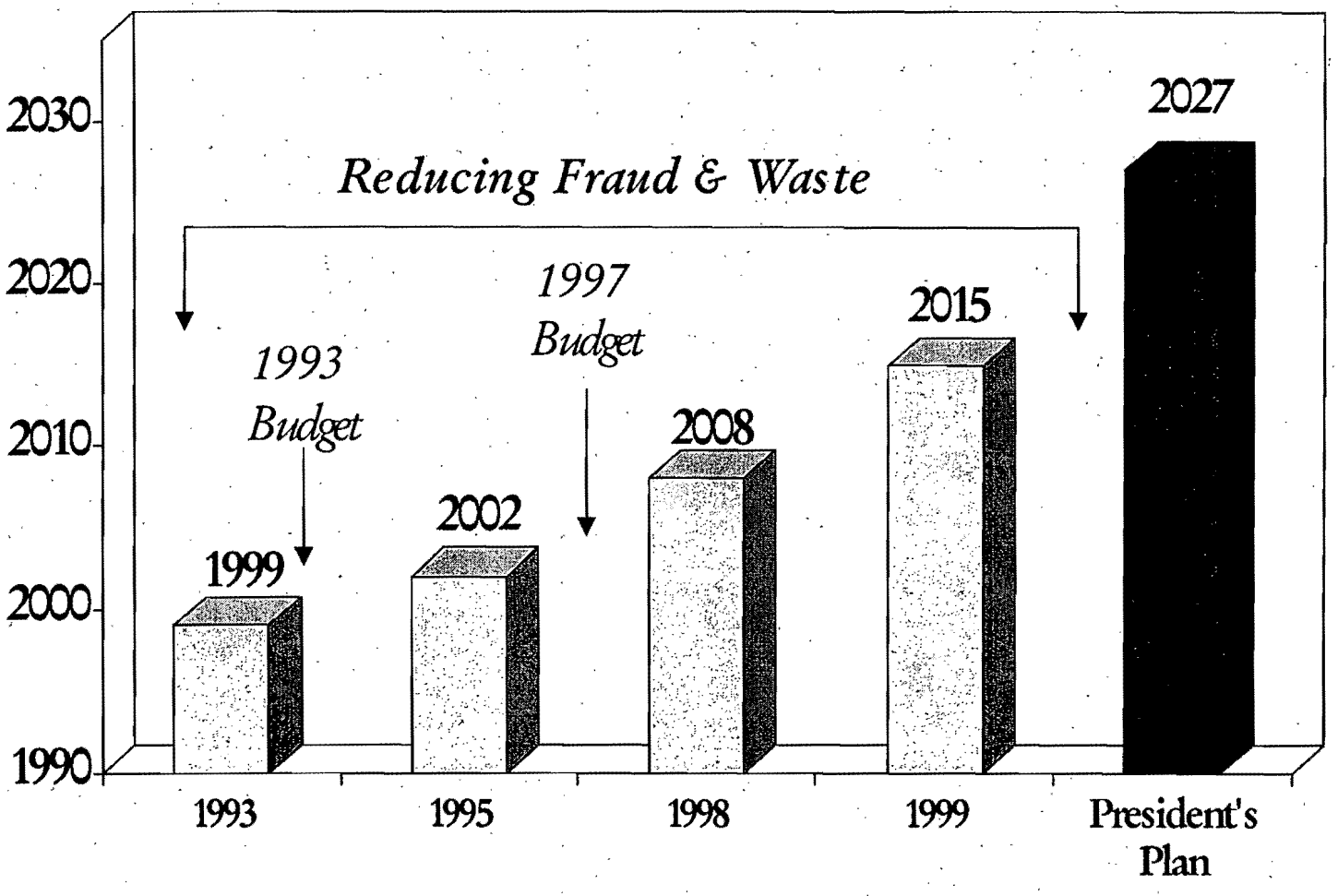
CHARTS

Medicare Enrollment Will Double As The Baby Boom Generation Retires

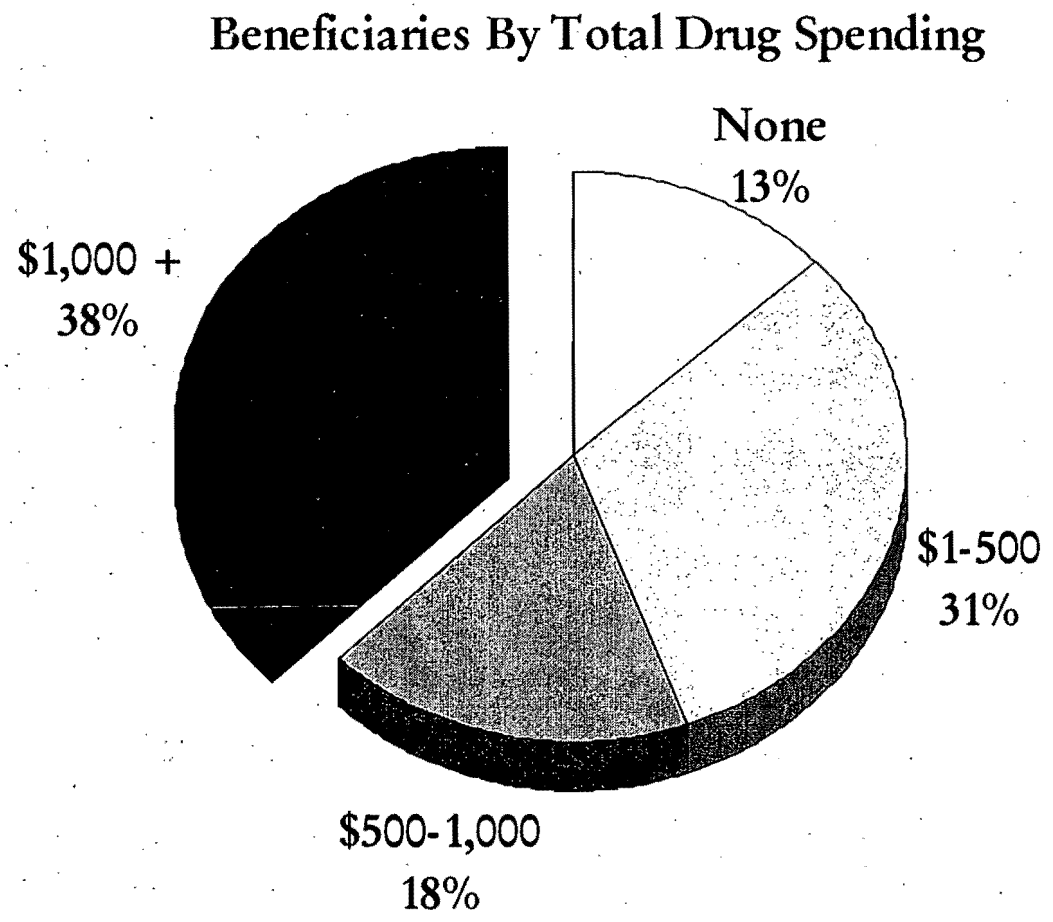


Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027

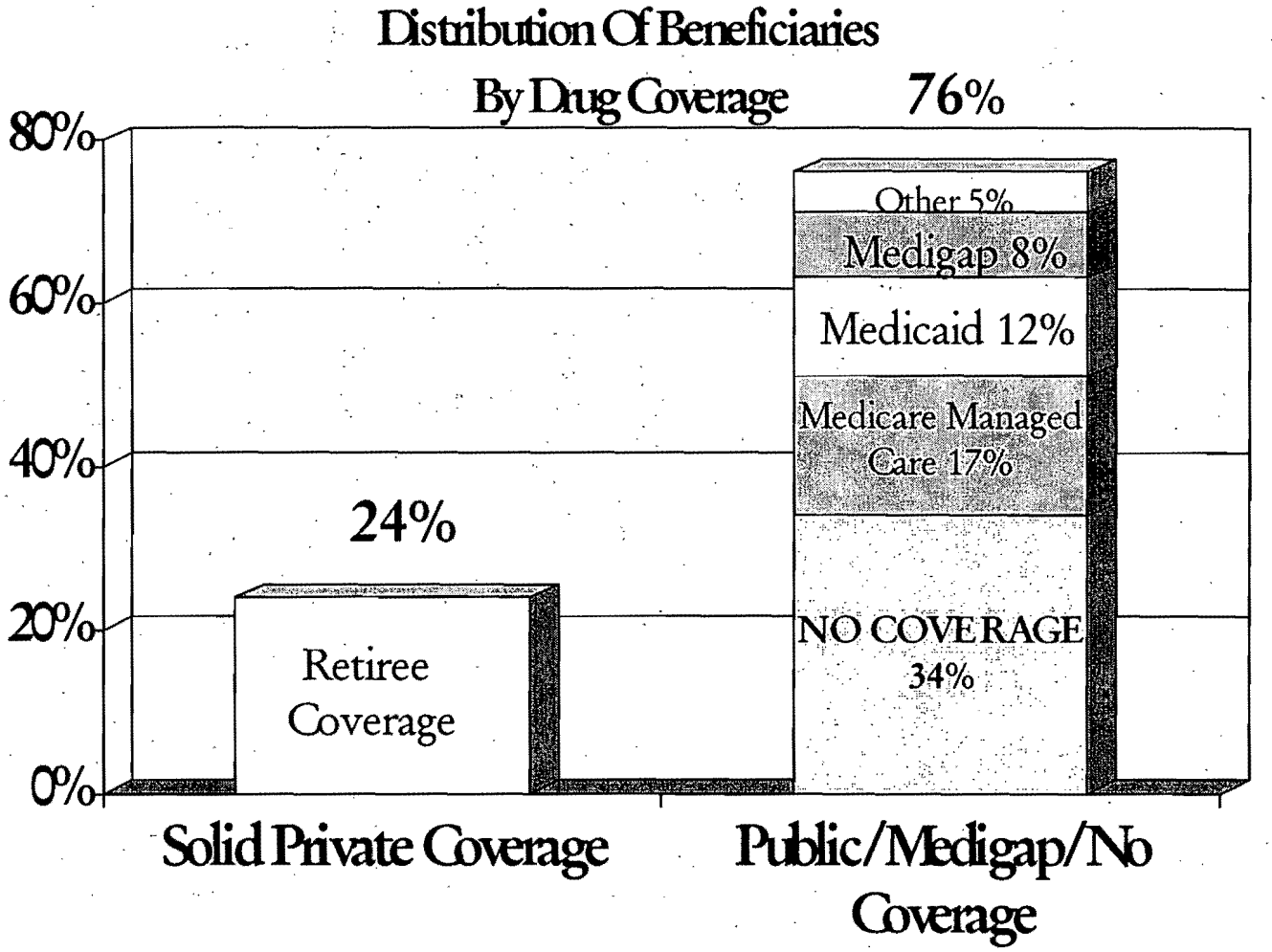


Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

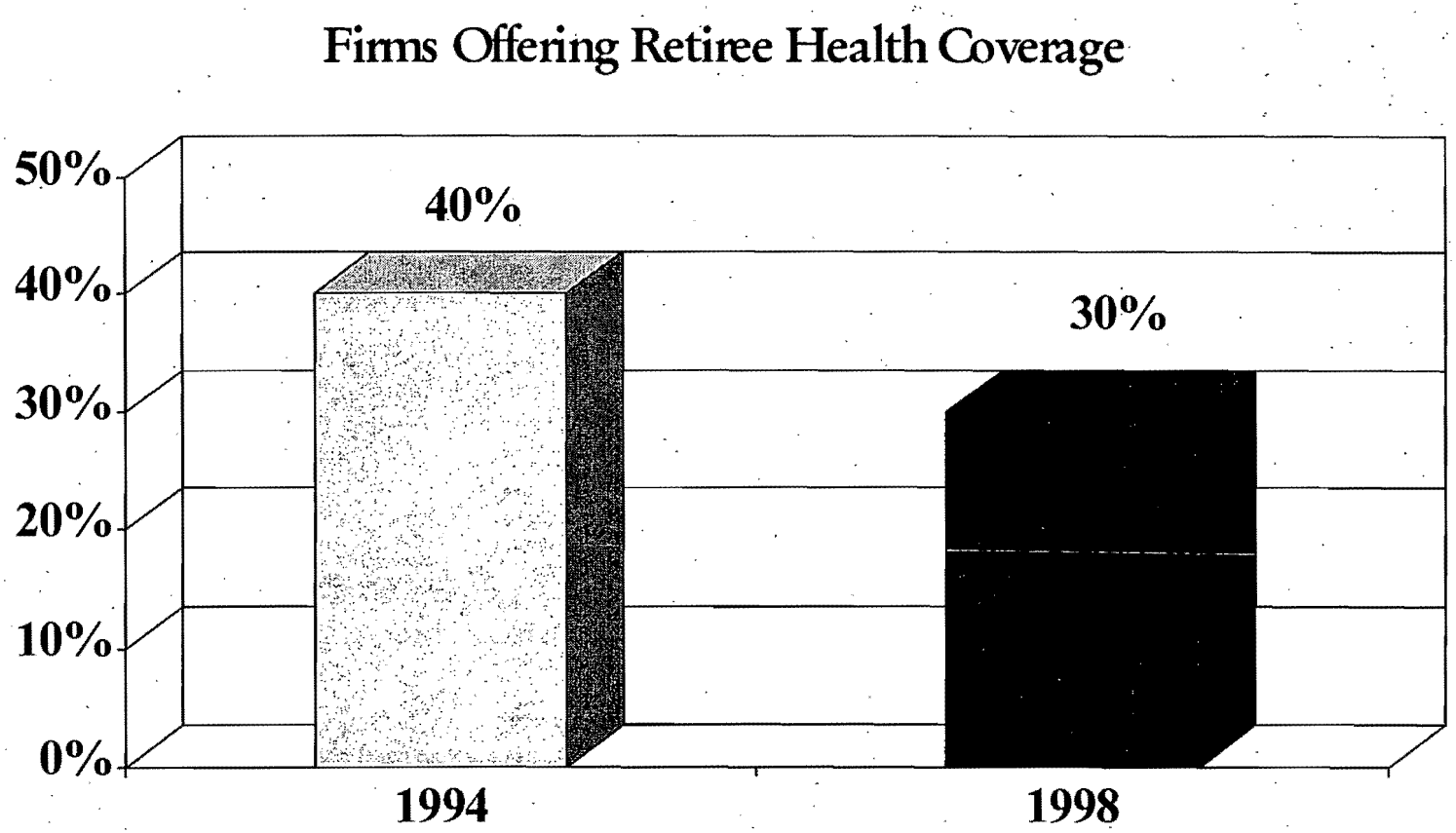
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



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

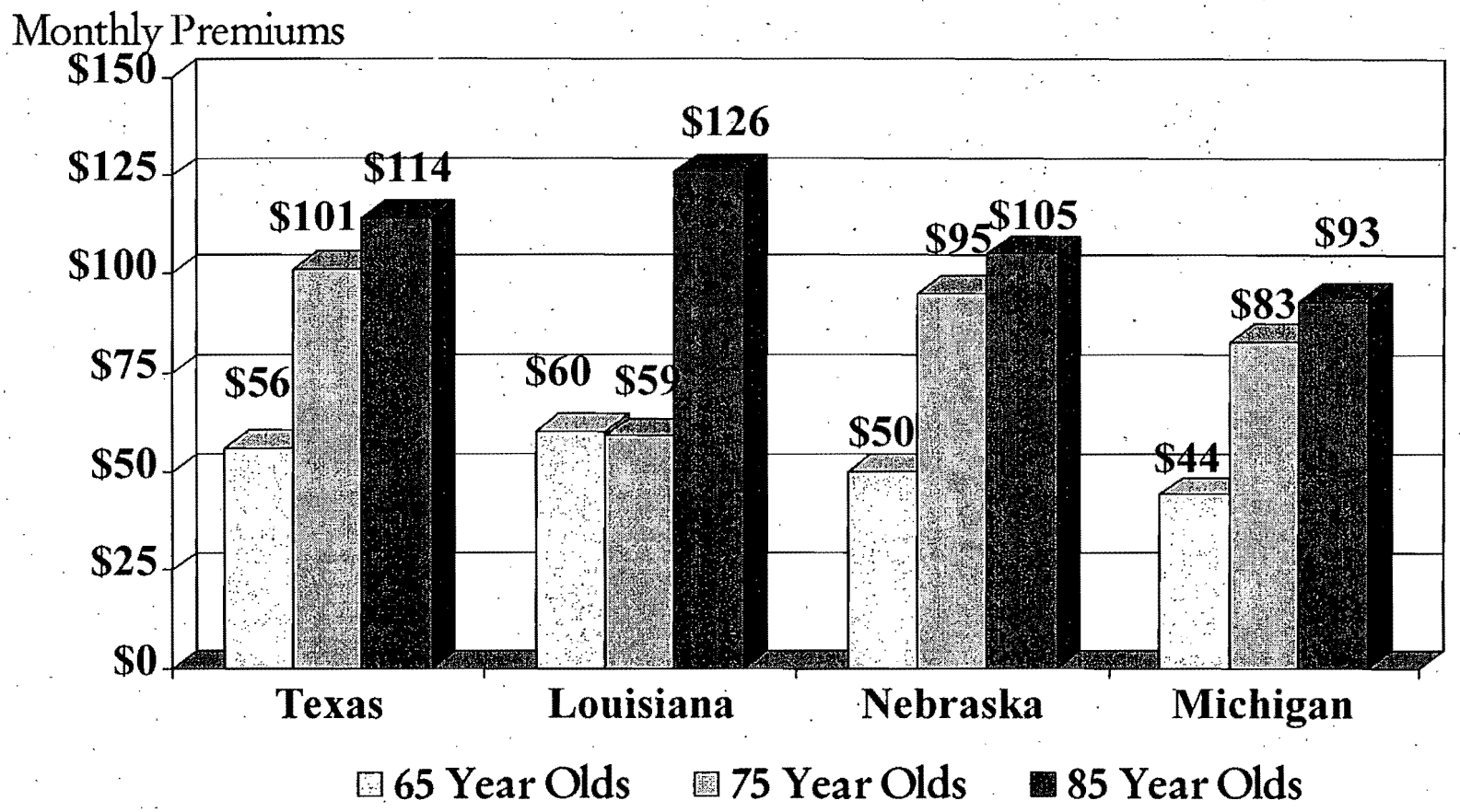
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

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

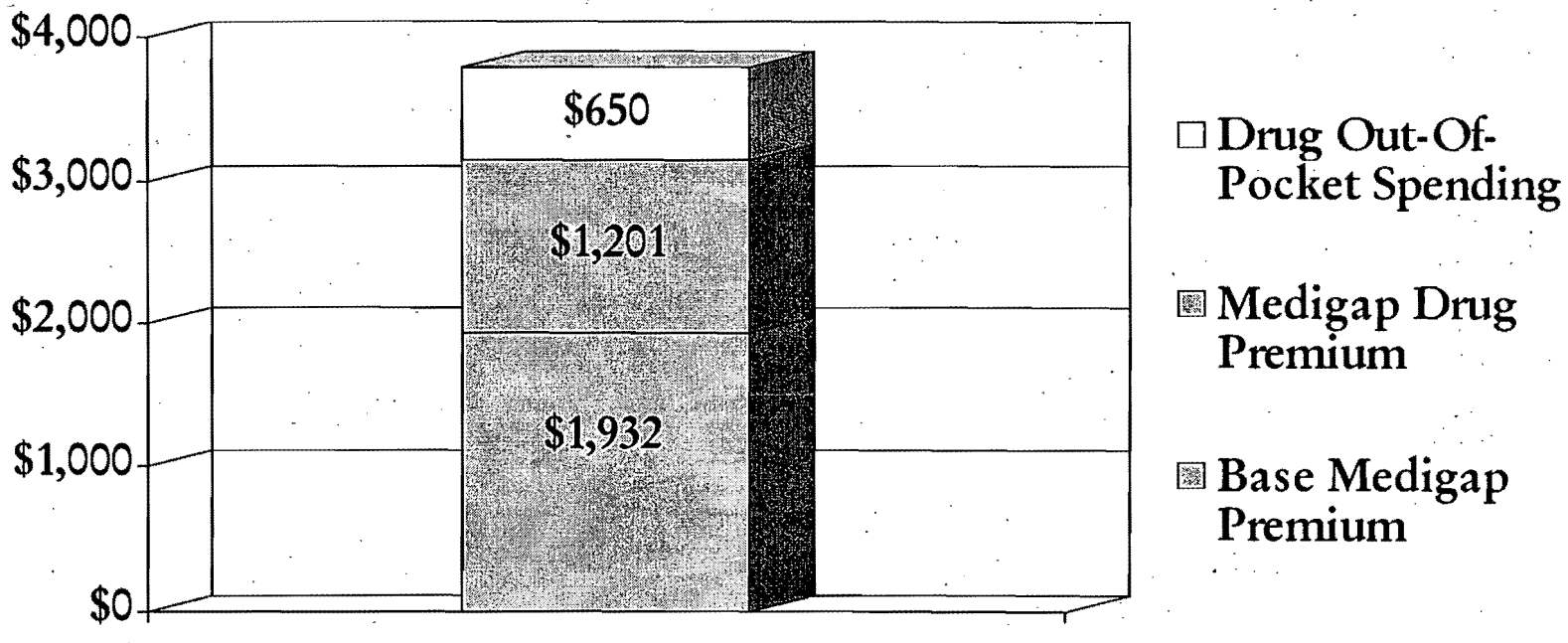


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

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

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

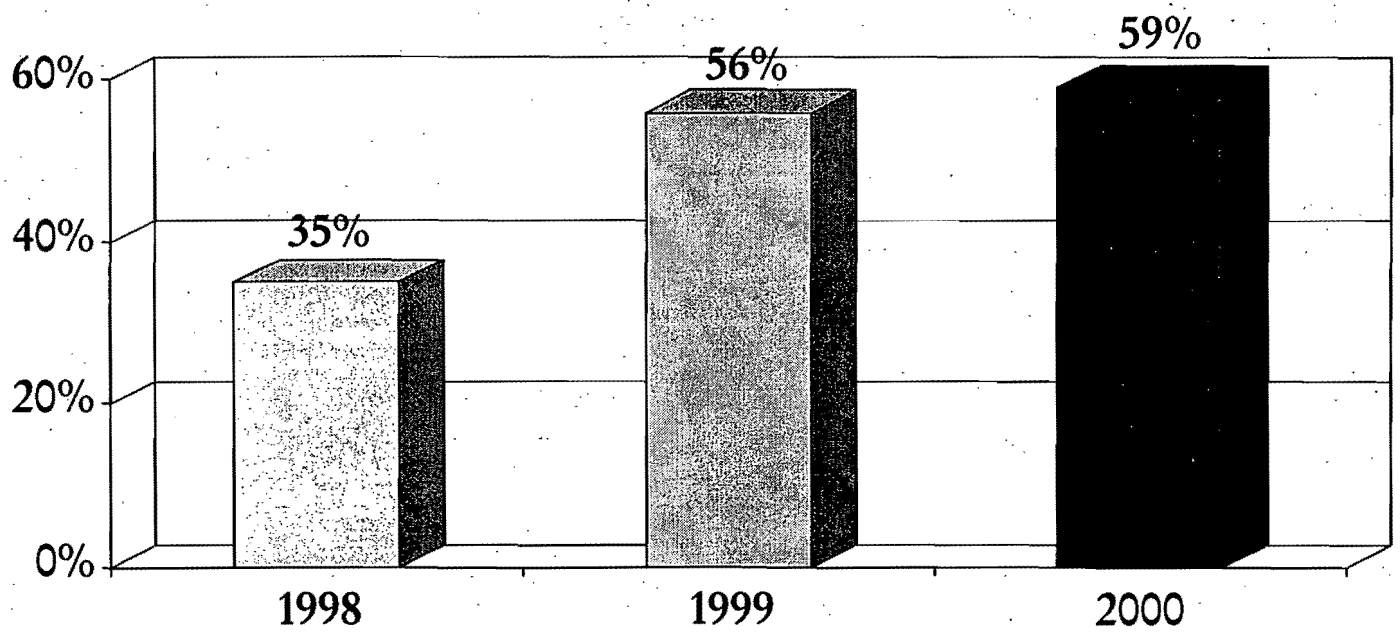
Medigap Annual Premiums And Out-Of-Pocket Spending



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

Value of Medicare Managed Care Drug Benefits Is Declining

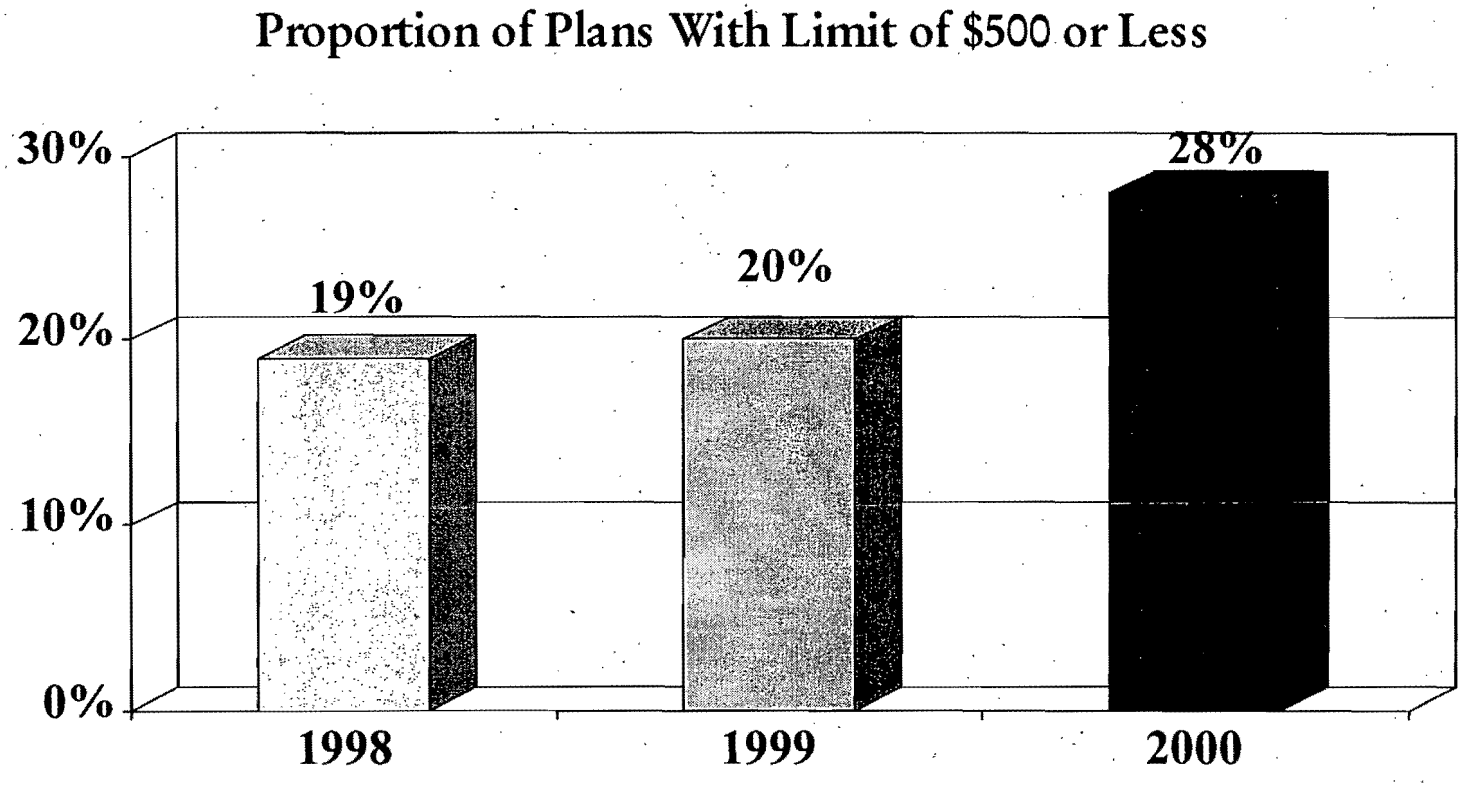
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

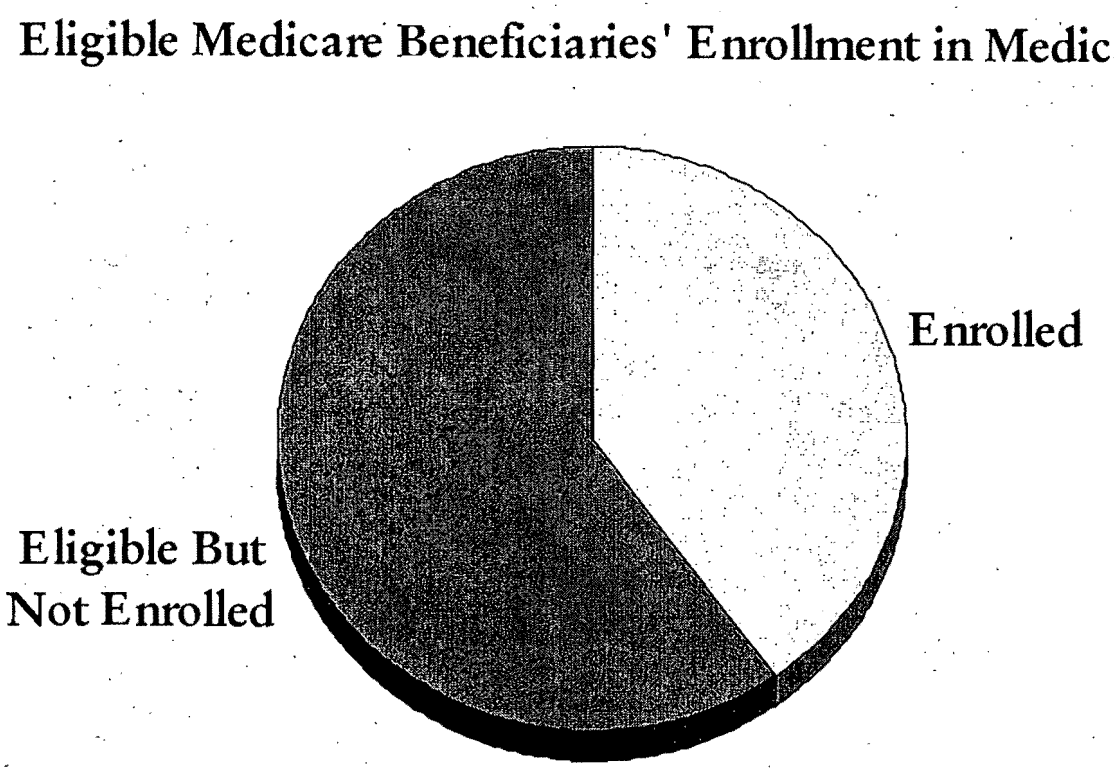
Proportion Of Plans With A $500 Or Lower Limit Has Increased By 50%



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

Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid



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

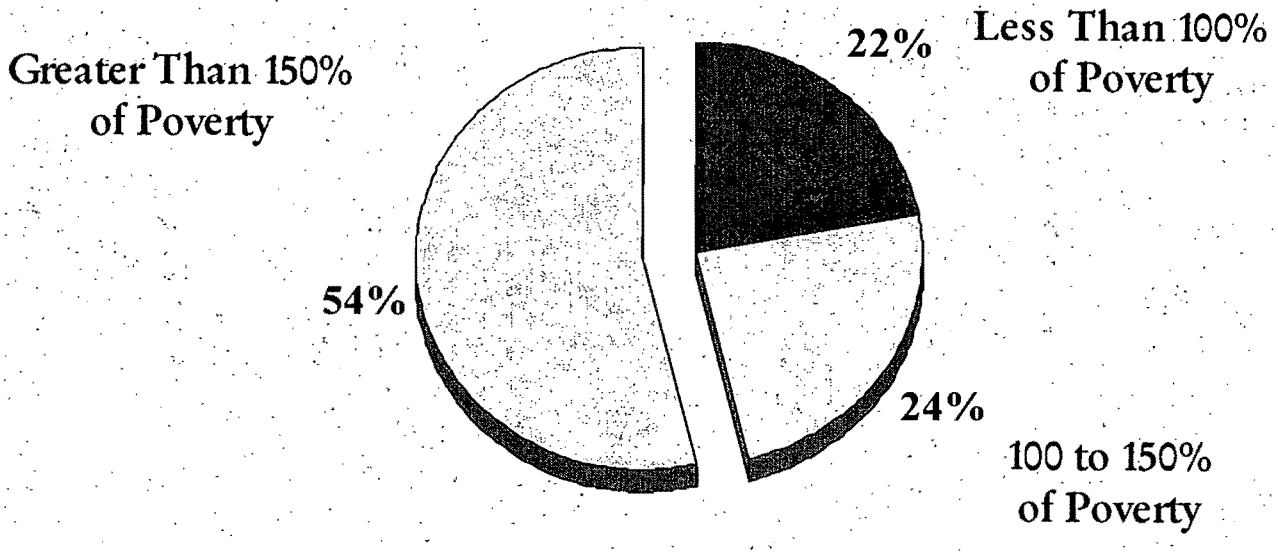
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

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

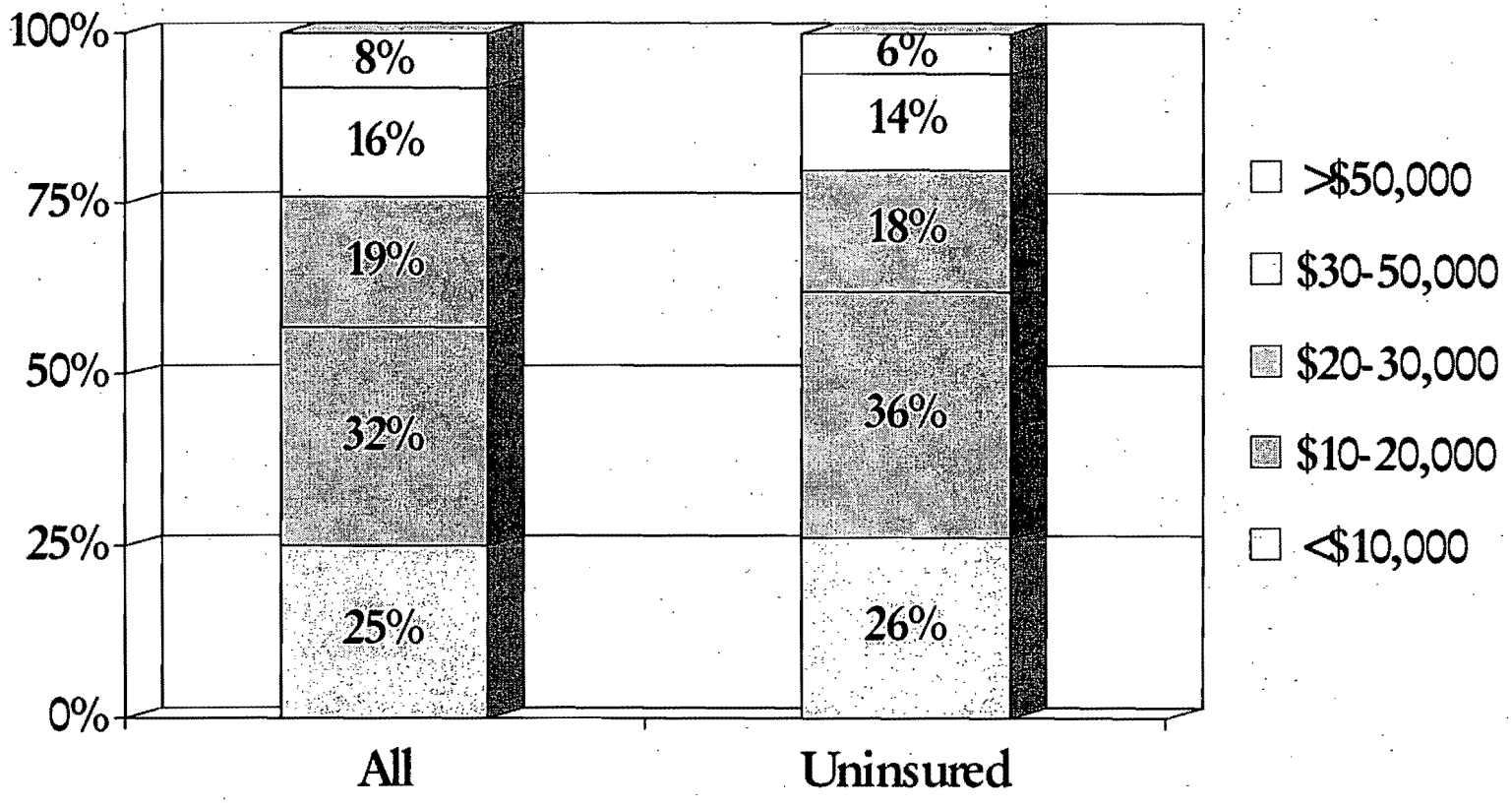
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



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

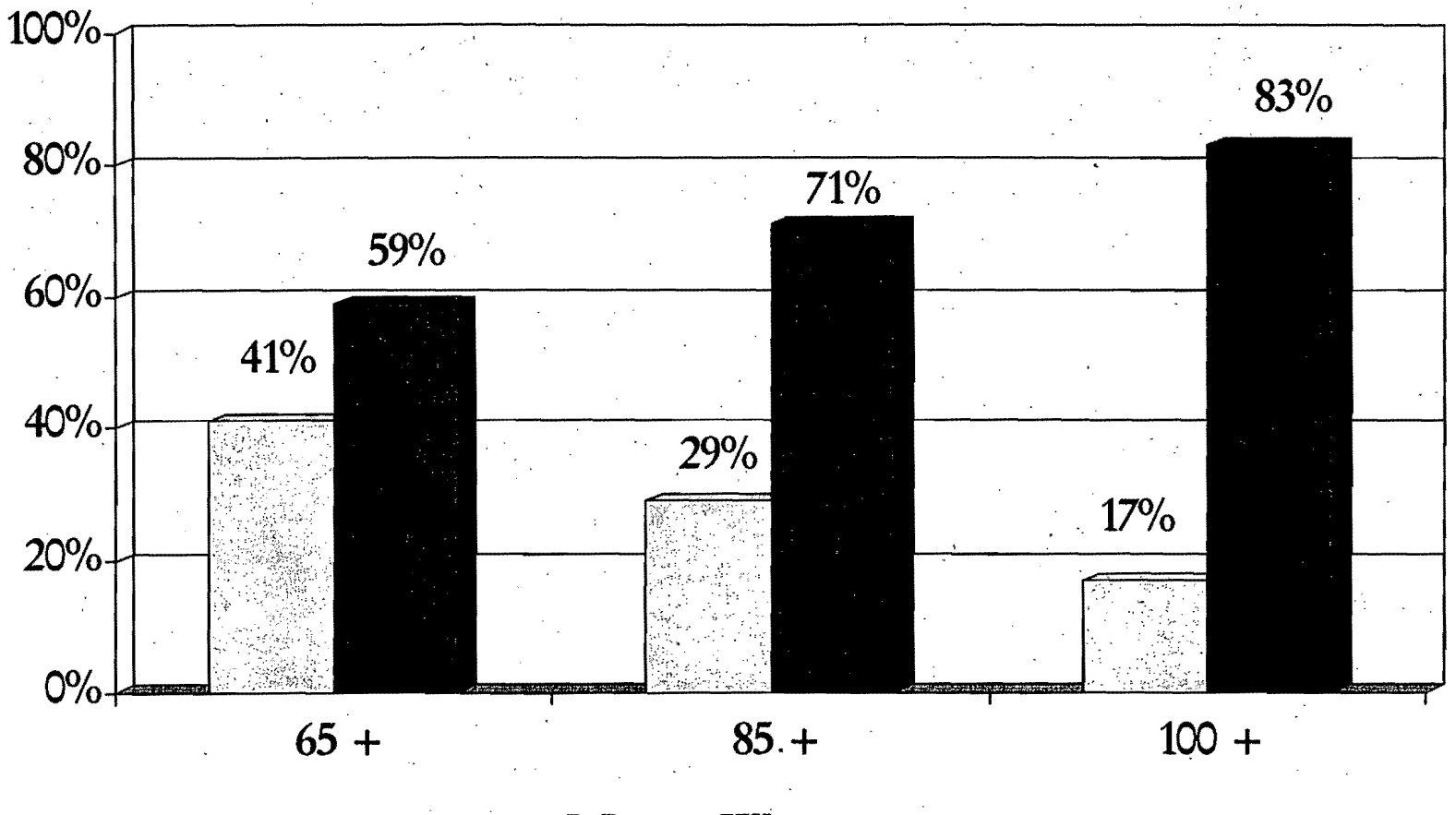
Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



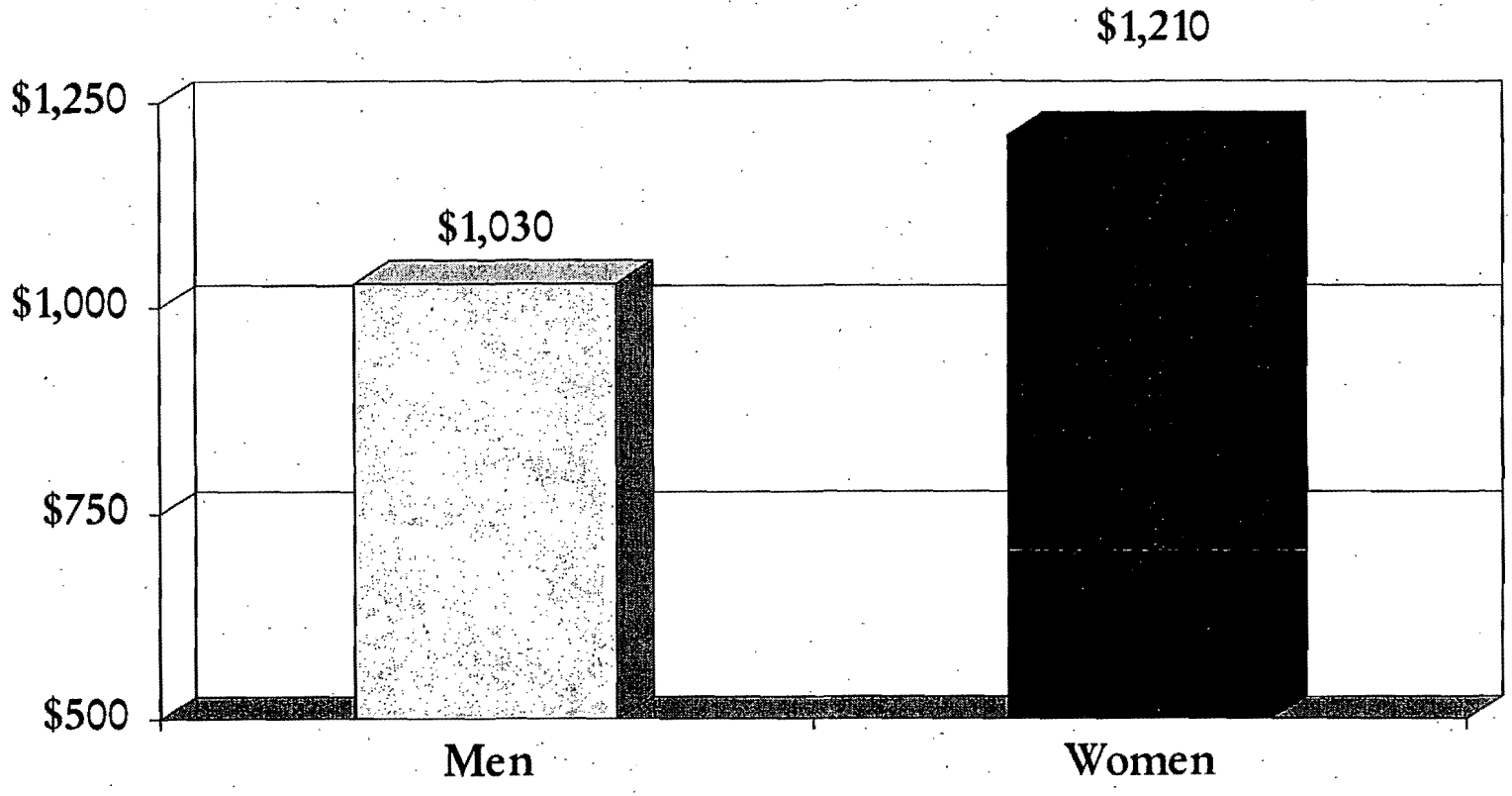
SOURCE: Actuarial Research Corporation for HHS, 2000

Most Medicare Beneficiaries Are Women



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

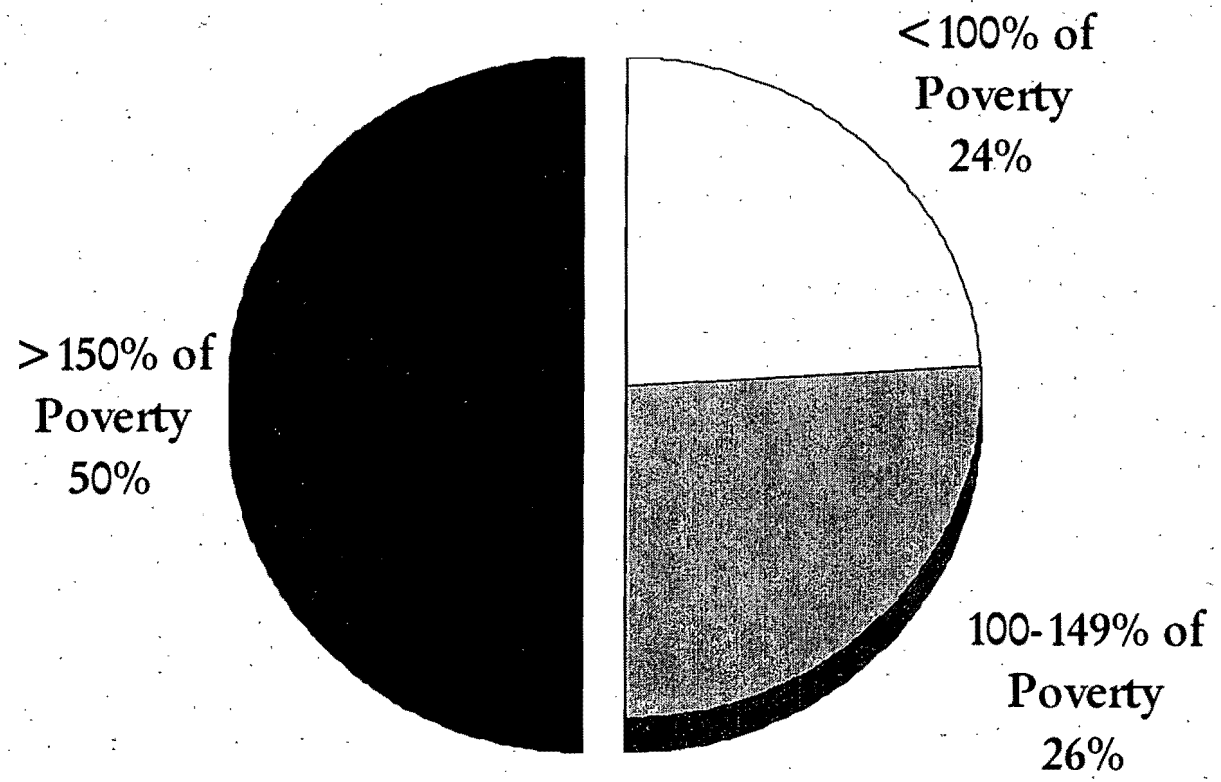
Total Prescription Drug Spending For Women On Medicare Is $1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

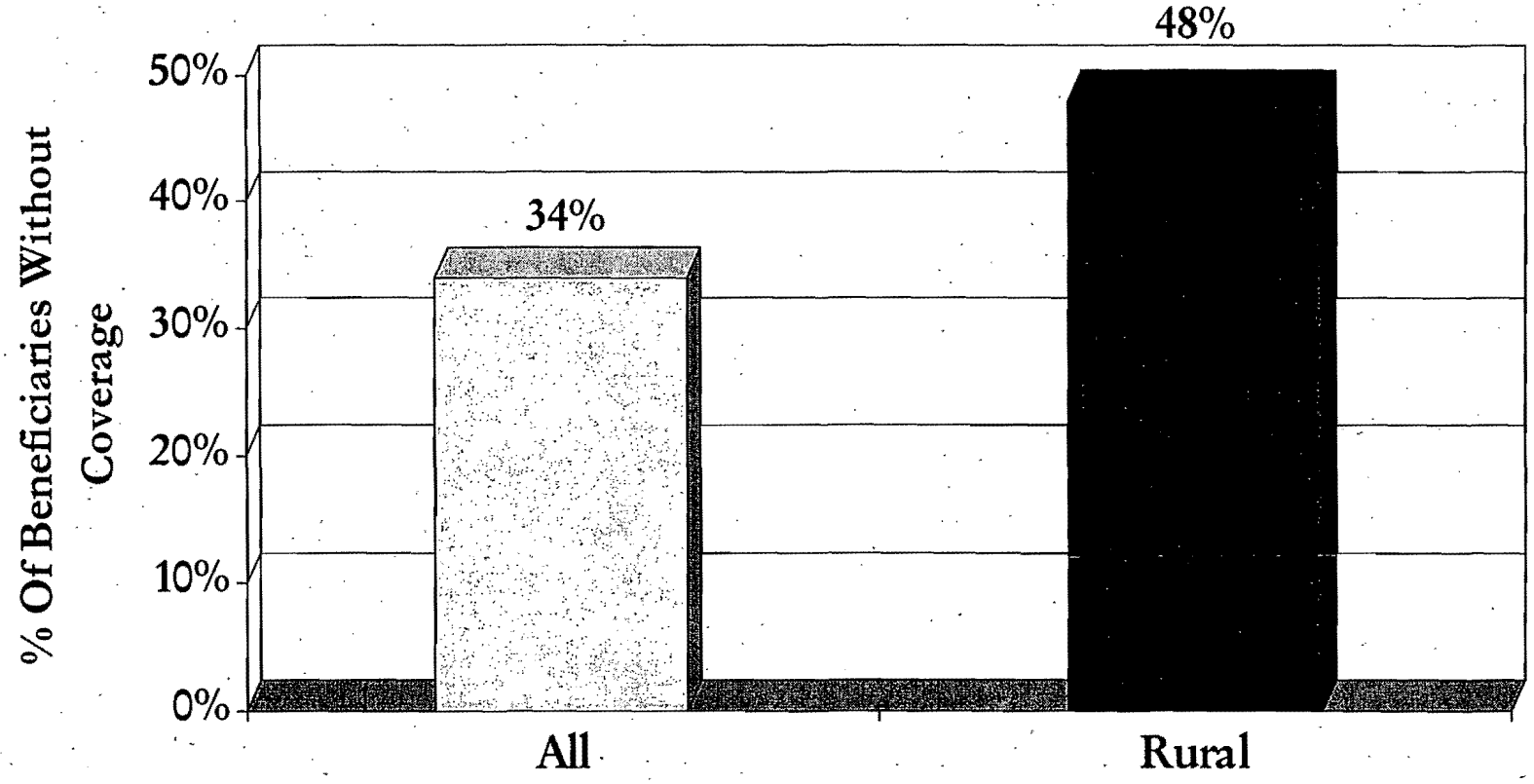
Source: Actuarial Research Corporation. As cited in OWL Report

Half Of Women on Medicare Without Drug Coverage Are Middle Income



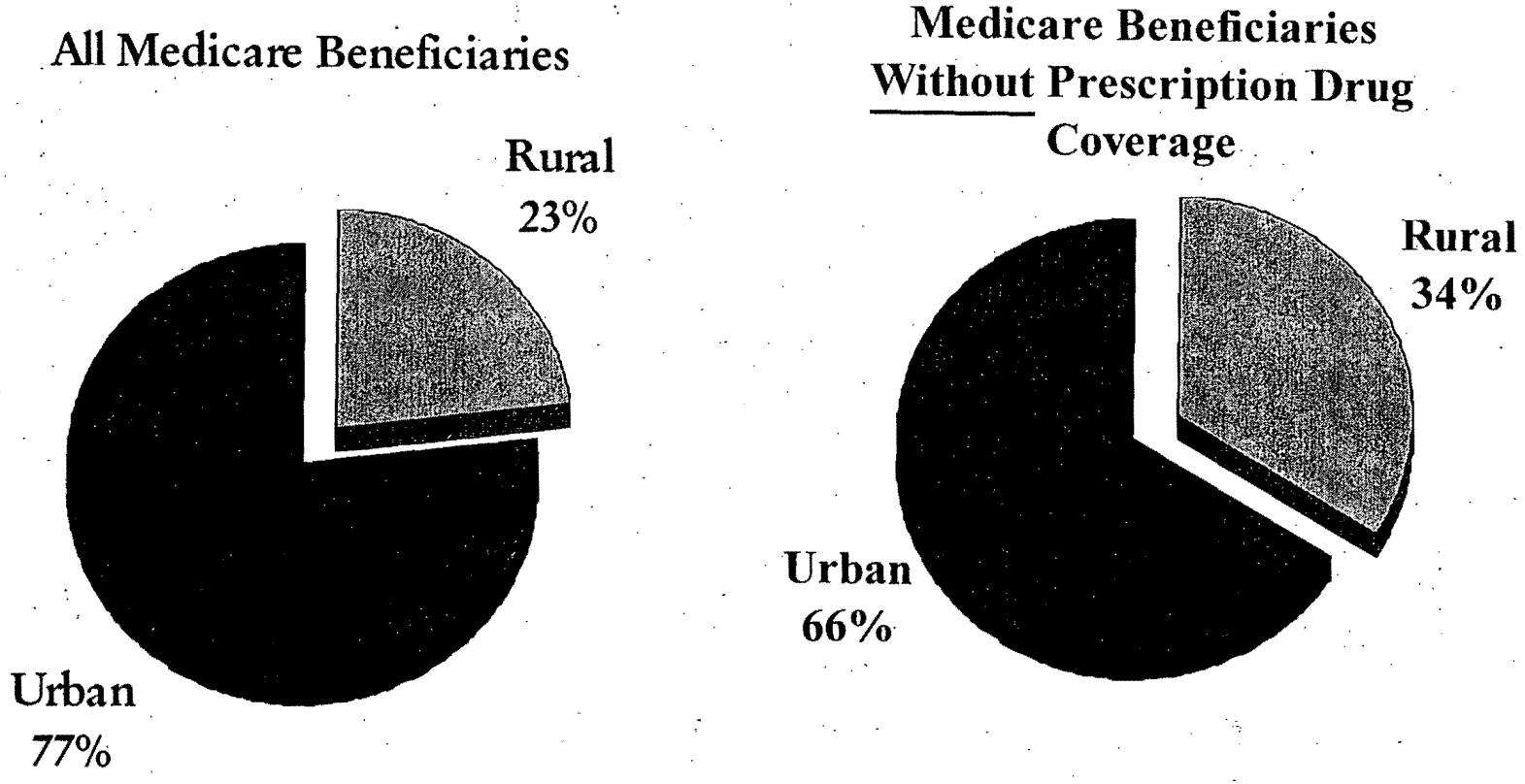
Source: Actuarial Research Corporation. As cited in OWL Report
150% of poverty is about $12,750 for a single, $17,000 for a couple in 2000

More Rural Medicare Beneficiaries Lack Prescription Drug Coverage



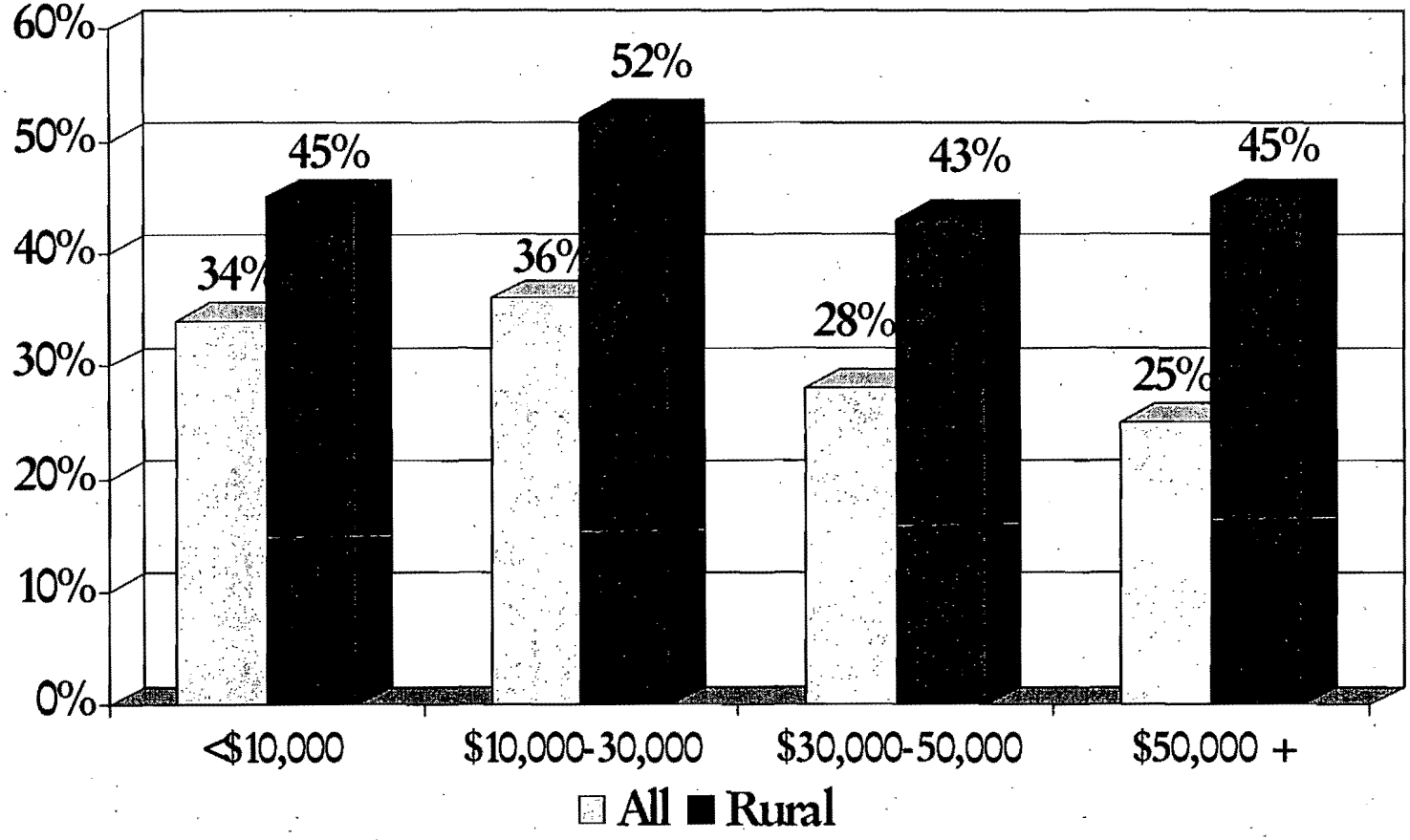
SOURCE: Actuarial Research Corporation for HHS, 2000

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



SOURCE: Actuarial Research Corporation for HHS, 2000

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



SOURCE: Actuarial Research Corporation for HHS, 2000

TAB 6.

BREAUX-THOMAS MEDICARE REFORM PLAN

ISSUES WITH BREAUX-THOMAS MEDICARE REFORM PLAN

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

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

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

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

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

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

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

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

TAB 7.

TOP-TIER QUESTIONS AND ANSWERS ABOUT MEDICARE REFORM

TOP-TIER MEDICARE QUESTIONS AND ANSWERS

PRESCRIPTION DRUG BENEFIT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q6: Will this new prescription drug benefit cover Viagra?

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

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

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

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

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

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

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

IMPORTANCE OF DEDICATING PART OF THE SURPLUS TO MEDICARE

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

A: Both structural reforms and new financing are needed to significantly extend the life of Medicare. We need to make Medicare a more competitive and efficient program – but all experts agree that it is impossible to rely only on provider payment reductions to extend the life of the Medicare trust fund for any significant length of time, given the doubling of Medicare enrollment that will occur as the baby boom generation retires. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person. Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. Providers are already concerned that the BBA cuts were excessive, making it highly unlikely that significant additional savings could be achieved.

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

UNCERTAINTY OF PROJECTED SURPLUS, SAVINGS, AND DRUG COSTS

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

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

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

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

PROVIDER REIMBURSEMENT

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

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

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

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

STRUCTURAL REFORM

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

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

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

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

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

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

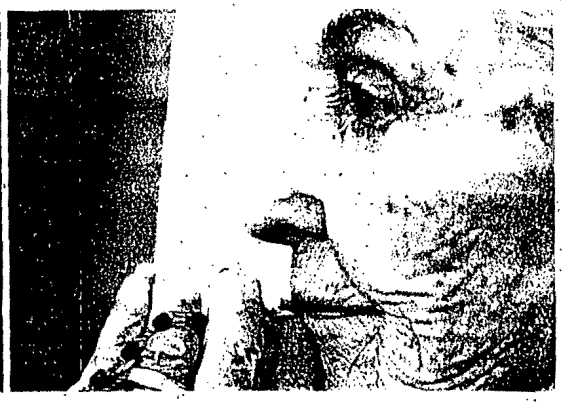
Q18: What is the problem with Senator Breaux and Congressman Thomas' proposal?

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

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

MEDICARE AND WOMEN

Nearly 7 in 10 Medicare beneficiaries with incomes below the poverty level are women.



As a partner program to Social Security, Medicare provides a health and financial safety net for virtually all older Americans and for many with disabilities who are under 65. Though Medicare covers both women and men, more than half of the nearly 40 million beneficiaries are women.

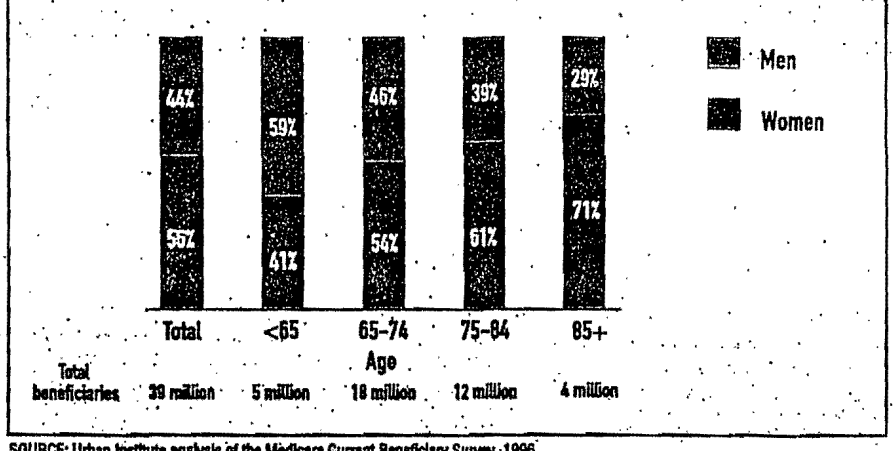
Women's life expectancy at birth, on average, is 79—seven years longer than men's. They, therefore, rely on Medicare for more years than men, and are disproportionately represented among beneficiaries 85 and older (Figure 1). Compared with men, older women are three times likelier to be widowed and far more apt to live alone. Among women 85 and older, four out of five are widowed; more than 43 percent live alone.

Health and Long-Term Care Needs

Given their longer life span, women are likelier than men to live with multiple chronic conditions and certain health problems (Figure 2). A greater share report having often disabling conditions, such as arthritis, hypertension, urinary incontinence, and osteoporosis.

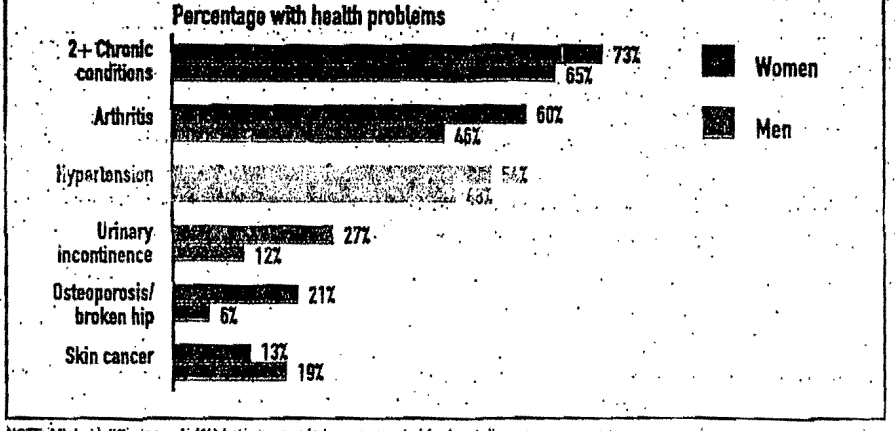
Also compared with men, women are more likely to have functional impairments and long-term care needs. Of the 6 million beneficiaries with functional limitations—measured as needing assistance with one or more activities of daily living (ADL) such as eating or bathing—two-thirds (65 percent) are women. One-third (34 percent) of women 65 to 74 report functional limitations, as do 82 percent of women 85 and older.

Figure 1 More than half of all Medicare beneficiaries are women



SOURCE: Urban Institute analysis of the Medicare Current Beneficiary Survey, 1996.

Figure 2 Women on Medicare are likelier than men to have many health problems



NOTE: Minimal differences (<4%) between genders were reported for heart disease, diabetes, pulmonary disease, strokes, and mental disorders.
SOURCE: Medicare Current Beneficiary Survey, 1996.

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THE HENRY J. KAISER FAMILY

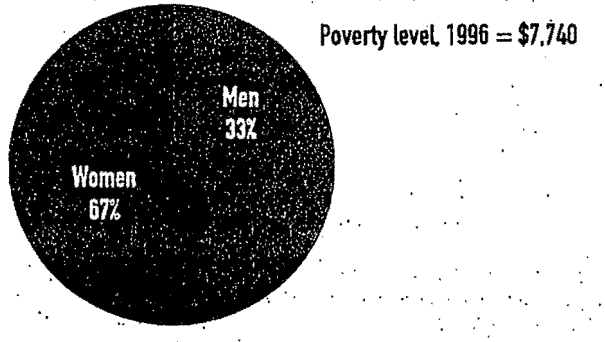
Given their disproportionately low incomes and their greater long-term care needs, women on Medicare are more likely than men to rely on Medicaid.

Women are therefore more likely than men to use long-term care services: two-thirds of all Medicare beneficiaries who receive home health services and three-quarters of all nursing home residents are female. Policies affecting users of these services thus have a disproportionate impact on women.

Poverty

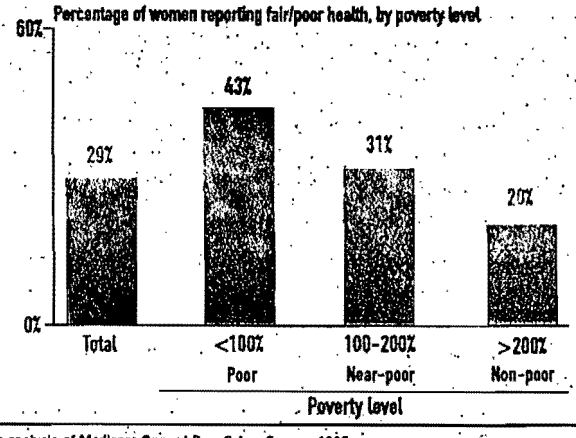
Women are especially hard-hit by changes in policies and programs that affect poor Medicare beneficiaries. Not only do they have higher poverty rates than their male counterparts—nearly 7 in 10 with incomes below poverty are women—but disparities increase with age (Figure 3). Of all female beneficiaries, 17 percent have incomes below the federal poverty level ($7,740 for an individual in 1996), compared with 11 percent of men. Half have incomes below twice the poverty level ($15,480 for an individual), compared with 39 percent of men. Nearly two-thirds (62 percent) of all women 85 and older have incomes below twice the poverty rate, compared with 53 percent of all men in this age group.

Figure 3 **Seven of 10 Medicare beneficiaries with incomes below poverty are women**



SOURCE: Urban Institute analysis of the Current Population Survey of noninstitutionalized population, 1997.

Figure 4 **Poor women on Medicare have higher rates of health problems than those with higher incomes**



SOURCE: Urban Institute analysis of Medicare Current Beneficiary Survey, 1995.

Compounding the financial difficulties of living in poverty, women with low incomes are, on average, in worse health than those who are better-off financially. Of all poor female Medicare beneficiaries, 43 percent report being in fair or poor health, compared with 20 percent of those with incomes above 200 percent of poverty (Figure 4).

Insurance Coverage

While Medicare provides coverage for basic acute care services, it has high cost-sharing requirements and does not cover outpatient prescription drugs. Consequently, most beneficiaries have public or private supplemental insurance to fill in the gaps in Medicare's benefit package. Like their male counterparts, 60 percent of all female beneficiaries have private supplemental insurance. In 1995, 33 percent had employer-sponsored retiree health benefits (versus 36 percent of men) and 27 percent had individually purchased Medigap policies (versus 23 percent of men). A growing share of

beneficiaries (9 percent for both men and women in 1995) are enrolling in Medicare HMOs for supplemental benefits.

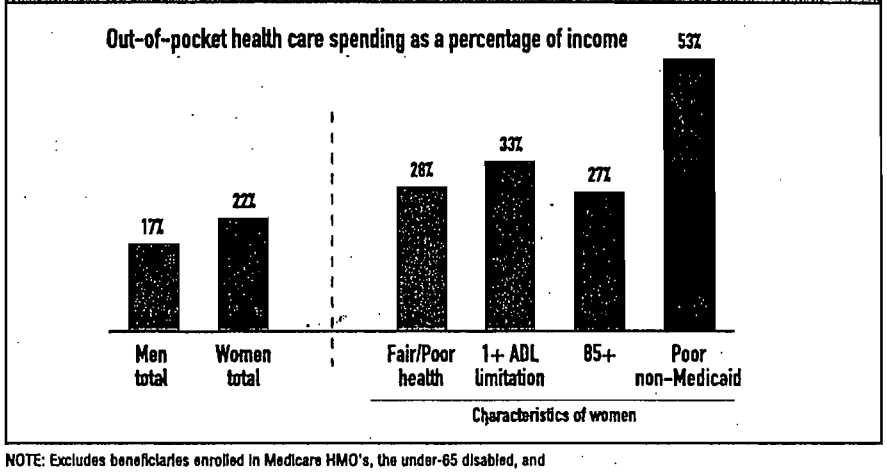
Given their disproportionately low incomes and their greater long-term care needs, female Medicare beneficiaries are more likely than males to rely on Medicaid, the federal/state health program that provides health and long-term care coverage for the poor. Nearly 17 percent of women rely on Medicaid to fill in Medicare's gaps, compared with 11 percent of men. Despite Medicaid's protections for the very poor, nearly 10 million female Medicare beneficiaries with incomes below twice the poverty level are not on Medicaid. This group is especially vulnerable to financial burdens in the event of a serious, high-cost illness.

Out-of-Pocket Spending

Because Medicare provides basic rather than comprehensive coverage, many beneficiaries face high-out-of-pocket health care expenses. Women, on average, devote a greater share of their income to health care than men. In 1998, women spent 22 percent of their incomes for health care, compared with 17 percent for men (Figure 5). These figures mask the fact that the most vulnerable spent a significantly larger share of their incomes for health care: women 85 and older spent 27 percent of their incomes, on average, for health. Those with ADL impairments spent a third of their incomes on medical care. But the financial burden was highest for poor women without Medicaid, whose health care spending consumed over half of their income.

That traditional Medicare does not cover outpatient prescription drugs exposes many beneficiaries to high out-of-pocket costs. Most women on Medicare—17 million—use prescription drugs regularly. More than a quarter (29 percent) of women spend over $50 a month for their medications, according to the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries.

Figure 5 **Women on Medicare have significant out-of-pocket health care costs**



NOTE: Excludes beneficiaries enrolled in Medicare HMO's, the under-65 disabled, and those in long-term care facilities. ADL = activity of daily living, such as eating or bathing.
SOURCE: AARP Public Policy Institute analysis using the Medicare Benefits Simulation Model, 1998.

Issues for Women

Women are major stakeholders in the debate over Medicare's future. Given their higher rates of poverty, multiple chronic conditions, and long-term care needs, adequate health insurance is especially important as women grow older. Policies that improve financial protections for the poor and near-poor would provide relief for all low-income beneficiaries, the majority of whom are women. Likewise, policies that expand access to outpatient prescription drugs and long-term care would help fill coverage gaps that drive up out-of-pocket spending for women. Conversely, policies that erode coverage or that shift costs to beneficiaries could adversely affect women, especially those with low incomes. Understanding the full implications of proposed reforms for aging women will be an essential component of efforts to preserve and protect Medicare for future generations.

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