

Medicine -
Prescription
Drugs

LOW-INCOME PRESCRIPTION DRUG PLANS:

AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

Prepared by:
**THE NATIONAL ECONOMIC COUNCIL /
DOMESTIC POLICY COUNCIL**

THE WHITE HOUSE

September, 2000

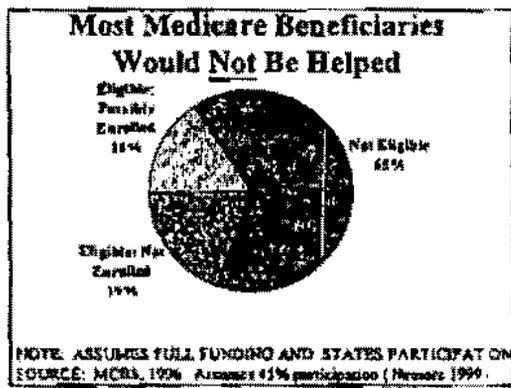
LOW-INCOME PRESCRIPTION DRUG PLANS: AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

Executive Summary

The Senate Republican Leadership and some Republicans in the House have proposed state block grant proposals to provide prescription drug coverage for low-income seniors and people with disabilities. This study examines these low-income proposals, analyzes their shortcomings, and compares them to the President's voluntary Medicare prescription drug proposal. It concludes that the low-income proposals not only would exclude all middle-income Medicare beneficiaries from any assistance but would fail to achieve their stated objective: to provide meaningful assistance to low-income beneficiaries. Specifically, they would deny eligibility to about 25 million Medicare beneficiaries – most of whom lack affordable, dependable prescription drug coverage today. Due to notoriously low enrollment in state programs, the plans would inevitably not assist more than half of eligible low-income seniors. Even the minority of Medicare beneficiaries who overcome these hurdles and actually sign up for coverage would be enrolled in programs that could cap enrollment and/or the number and types of drugs covered. Furthermore, despite the proposals' goal of providing assistance immediately, it would take years to implement programs in all 50 states and, because funding is time-limited and insufficient, some states may not participate at all. Finally, a low-income program would delay enactment of a workable and meaningful Medicare prescription drug benefit that would more quickly be implemented nationwide and more effectively cover low-income beneficiaries.

CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PLANS

- **Explicitly exclude at least 25 million – two-thirds of – Medicare beneficiaries.** Although high drug costs and lack of drug coverage are not just problems for low-income beneficiaries, the most generous Senate Republican plan restricts block grant funding to those who are not eligible for Medicaid and have income below 175 percent of poverty (about \$14,600 for singles, \$19,700 for couples). Nearly 5 million people would be excluded because they are Medicaid-eligible and another 20 million have income above the eligibility cut-off. In 16 states, 75 percent or more of Medicare beneficiaries would be excluded while in 5 states, 80 percent or more of seniors would not be eligible. Specifically, the proposal would:
 - Exclude three-fifths (60 percent) of all seniors and people with disabilities who have absolutely no coverage for prescription drugs;
 - Exclude three of five Medicare beneficiaries with the highest drug costs;
 - Exclude three-fifths of the seniors who purchase Medigap private insurance, which is expensive and provides a limited benefit;
 - Exclude most Medicare managed care enrollees with unreliable and limited drug coverage that they are at risk of losing from year to year.



- **Less than half of the low-income Medicare beneficiaries that the plan purports to help would likely get drug coverage, even if fully implemented in all states.**
 - 55 percent of low-income Medicare beneficiaries currently do not enroll in Medicaid even though they are eligible. Medicaid provides prescription drug coverage for the lowest-income seniors and helps pay for Medicare premiums for those with income below 135 percent of poverty. However, 50 percent or more eligible beneficiaries are not enrolled in Medicaid in 30 states and more than two-thirds do not participate in 7 states. In contrast, 98 percent of eligible people nationwide enroll in Medicare.
 - Less than 800,000 seniors are enrolled in state pharmacy assistance programs. These state-initiated programs have low participation rates and exclude more than 90 percent of Medicare beneficiaries in 8 of the 14 states operating such programs in 1999.
 - Enrollment barriers are common. States have not made the strides in simplifying enrollment for the elderly that they have for children. To sign up for Medicaid, eligible seniors and people with disabilities must fill out long, complex applications (in 26 states); meet extensive documentation requirements for income and assets (in 41 states); and sign up through welfare offices (34 states have no outstationed eligibility workers).
 - Many seniors reject "welfare" programs. Complex enrollment procedures contribute to the belief that state assistance is "welfare," only for "poor people" and could jeopardize the financial well-being of spouses and children. Despite efforts to overcome this, these negative perceptions remain and serve as a significant barrier to enrollment.
- **Empty promise for those who actually enroll.** The Republican plans provide no assurance of what drug coverage beneficiaries receive; what you get depends on where you live.
 - Types of drugs covered and number of prescriptions filled may be limited. States could extend their current Medicaid or state drug assistance program benefits. Five state programs limit drug coverage to specific conditions or maintenance drugs. Fourteen programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only 3 prescriptions per month.
 - No guaranteed access to needed drugs or local pharmacies. Under most low-income plans, there is no guarantee that, when a doctor prescribes a particular drug as medically necessary, the patient would get it. And, there is no assurance that seniors could continue to access local pharmacies.
 - Enrollment would inevitably be capped. With the Senate's \$1.3 billion in 2001, states would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries. Much of this Federal funding would be used to replace current state funding (about \$700 million in 1999), leaving at most only \$119 per eligible low-income senior per year compared to average annual spending that exceeds \$1,000. As such, states would inevitably have waiting lists.

- **Implementation issues would delay low-income assistance – and a long-overdue Medicare prescription drug benefit.**
 - Would not provide prescription drug coverage to low-income seniors nationwide in 2001. It is extremely unlikely that all states would implement new prescription drug programs under this plan next year. Not only does the National Governors' Association oppose taking responsibility for prescription drugs, but the time-limited and inadequate funding in most plans would give states little incentive to invest in setting up new programs. Even if states did support this approach, it would take time to implement. The last three states started enrolling children in the bipartisan, state-supported Children's Health Insurance Program just this year -- 3 years after enactment. Finally, the Federal "default plan" to provide coverage in states that do not participate could not be operational in 2001 because new systems for income-based eligibility would be needed.
 - Low-income block grants would fail to help low-income beneficiaries but would succeed in delaying implementation of a Medicare prescription drug benefit. If enacted, the next Congress would likely spend more energy on fixing this flawed low-income plan than establishing an affordable, meaningful, and accessible Medicare prescription drug benefit option. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would be available to all Medicare beneficiaries in 2002 and more effectively help low-income enrollees.

CLINTON-GORE ADMINISTRATION PLAN FOR MEDICARE DRUG BENEFIT

- **Ensures a Medicare prescription drug benefit option for all Medicare beneficiaries – including low-income seniors.** The President's plan would, beginning in 2002, offer all Medicare beneficiaries the option of reliable prescription drug coverage through traditional Medicare, managed care, or a retiree plan if available. It would help many more low-income beneficiaries than a block grant since 98 percent all people eligible for Medicare enroll.
- **Provides a meaningful benefit at an affordable premium.** Participants would pay a monthly premium of \$25 in 2002 (no premium for the lowest-income beneficiaries) for coverage that has no deductible, pays for half of costs up to \$5,000 when phased in, and limits the amount that a senior or person with disabilities pays for drugs to \$4,000. All participants would benefit from privately-negotiated price discounts for all their drug costs.
- **Guarantees coverage of prescriptions that beneficiaries need at the pharmacies that they trust.** Because Medicare beneficiaries often have multiple, complex health problems, the President's plan would cover any drug that a doctor certifies is medically necessary, even if it is "off formulary." Also, recognizing the importance of using accessible, familiar pharmacies, the President's plan ensures access to all qualified community pharmacies.
- **Adequately financed and part of a plan to improve Medicare.** Extending Medicare solvency, improving efficiency, and restoring provider payments are important elements of the President's plan to modernize Medicare. Additionally, enough budget surplus should be dedicated to finance a prescription drug benefit and take the Medicare trust fund off-budget.

LOW-INCOME PRESCRIPTION DRUG PLANS: AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

PROBLEM OF THE LACK OF PRESCRIPTION DRUG COVERAGE

Prescription drugs have become central to health care, contributing to preventing, managing, and curing diseases. They are even more important to the elderly and people with disabilities on Medicare. However, Medicare does not cover outpatient prescription drug costs. Consequently, nearly half of beneficiaries go without coverage for part or all of the year¹ – about the same percentage as those who lacked hospital insurance when Medicare was created in 1965. Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug. As a result, uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.² The situation is even worse for rural Medicare beneficiaries, who are over 60 percent more likely to fail to get needed prescription drugs due to cost.³ Medicare beneficiaries with disabilities face unique challenges, being less likely to have private coverage but needing more and different types of prescriptions than the elderly.⁴ The absence of prescription drug coverage is also a barrier for people with disabilities who want to return to work.

CONGRESSIONAL REPUBLICAN LOW-INCOME PRESCRIPTION DRUG PROPOSALS

On September 7, 2000, Senator Roth (R-DE) introduced two similar bills (S. 3016 and S. 3017) to address the lack of prescription drug coverage for Medicare beneficiaries.⁵ S. 3017, entitled the "Medicare Temporary Drug Assistance Act," would provide \$29 billion in block grants to states for four years⁶ to voluntarily provide prescription drug coverage to certain low-income Medicare beneficiaries. Senate Majority Leader Lott (R-MS) and Senate Majority Whip Nickles (R-OK) co-sponsored the less generous version of the proposal (S. 3016).

Under the more generous proposal, states would have the option of receiving time-limited Federal grants to provide prescription drug coverage to Medicare beneficiaries who are, in general, not eligible for full Medicaid (approximately above 75 percent of poverty) and have incomes below 175 percent of poverty (\$14,600 for singles, \$19,700 for couples). States could set the upper eligibility limit anywhere in this range, impose an assets test, and set caps on enrollment.

¹ Stuart B; Shea D; Briesacher B. (January 2000). *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter*. New York: The Commonwealth Fund.

² Assistant Secretary for Planning & Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President*. Washington, DC: U.S. Department of Health & Human Services.

³ White House National Economic Council / Domestic Policy Council. (June 13, 2000). *Prescription Drug Coverage For Rural Beneficiaries: A Critical Unmet Need*.

⁴ White House National Economic Council / Domestic Policy Council. (July 31, 2000). *Disability, Medicare and Prescription Drugs*.

⁵ For the purpose of this paper, we have focused on S. 3017. S. 3016 sunsets on December 31, 2003, limits eligibility to those below 150 percent of poverty (\$12,500 for singles, \$16,900 for couples) and provides \$17 billion.

⁶ S. 3017 provides \$1.3 billion in FY2001, \$4.6 billion in FY2002, \$9.7 billion in FY2003, \$13.0 billion in FY2004.

States not only would have discretion to participate and to set eligibility rules under this proposal but could design their own drug benefit package. There are only two requirements. First, the drug benefit must be equal (or be equivalent) to a "benchmark" drug plan or an alternative plan approved by the Secretary of Health and Human Services. The benchmarks include the prescription drug coverage of: (a) the state Medicaid program; (b) the Blue Cross-Blue Shield Standard Option under the Federal Employees Health Benefits Program; (c) the health plan for state employees; (d) the largest HMO in the state; and (e) the state's low-income pharmacy assistance program. Second, states could not require premiums or cost-sharing for beneficiaries below 100 percent of poverty (\$8,400 for singles, \$11,300 for couples) and premiums or cost-sharing that exceeds 5 percent of family income for beneficiaries between 100 and 175 percent of poverty. The bill includes no requirement that the Federal funding be used for plans that cover all therapeutic classes of drugs, ensure access to medically necessary prescription drugs, a managed benefit with protections against adverse drug reactions, or guarantee access to local pharmacies.

The Federal government would distribute the proposal's annual funding through state-specific capped annual allotments, allocated on the basis of a state's proportion of Medicare beneficiaries below 175 percent of poverty. States must spend their annual allotment by the end of each year or the remaining funds are returned to the Treasury. Federal matching rates under these allotments would be 100 percent for assistance to those below 135 percent of poverty (\$11,300 for singles and \$15,200 for couples). For beneficiaries between 135 percent and 175 percent of poverty, states must contribute the same percentage matching payments that they do under the State Children's Health Insurance program (SCHIP). States may cap enrollment if funding runs out because eligible beneficiaries are not entitled to the benefits they receive under these programs. States may use this new Federal funding to replace current state funding for program beneficiaries receiving coverage under a state pharmacy assistance program.

Since states are not required to offer prescription drug coverage, the Senate Republican plan includes a Federal "default plan." The Health Care Financing Administration (HCFA), which runs Medicare, would contract with a pharmacy benefit manager (PBM) to provide a drug benefit in a state that declines to participate. This coverage would be equivalent to Federal employees' Blue Cross-Blue Shield Standard Option drug coverage and would be restricted to those who are ineligible for Medicaid and have incomes below 135 percent of poverty (HCFA may set a lower eligibility level if funding is insufficient). HCFA would receive 90 percent of the funds otherwise available to the state and would pay for administrative costs from that amount. This year, states would notify HCFA by December 31st about their intent to participate; if they do not, then HCFA would have to start coverage in that state one day later, by January 1, 2001. In subsequent years, states must give HCFA one month's notice.

Congressman Bilirakis (R-FL) has introduced a companion bill, H.R. 5151, in the House of Representatives that is very similar to the Senate Republican drug proposal. It provides for \$36.9 billion in block grants to states for four years and expressly holds that states currently providing a pharmacy assistance program are under no obligation to continue their program or maintain the same effort or spending levels.

CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PROPOSALS

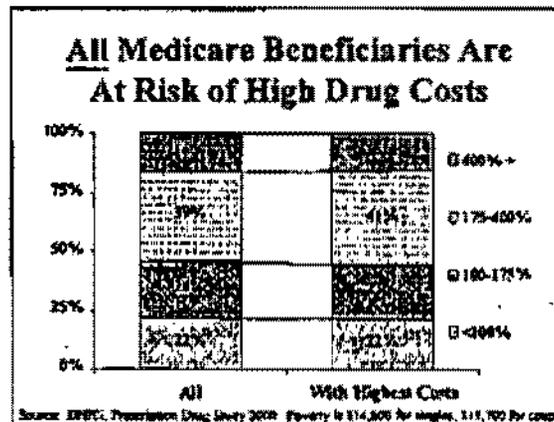
EXPLICITLY EXCLUDES AT LEAST 25 MILLION – TWO-THIRDS OF – MEDICARE BENEFICIARIES.

Most low-income block grant plans restrict funding to those who are ineligible for Medicaid and have income below 175 percent of poverty (about \$14,600 for singles, \$19,700 for couples). Nearly 5 million would be excluded because they are Medicaid-eligible and another 20 million have income above the eligibility cut-off.⁷ States do not have to expand to 175 percent of poverty, so the number of beneficiaries excluded would likely be higher. While Medicare's lack of prescription drug coverage disproportionately affects low-income beneficiaries who can least afford prescription drugs, it is not exclusively – or even disproportionately – a low-income problem. Medicare beneficiaries with no or inadequate coverage are scattered throughout the income distribution. The risk of having high prescription drug costs is also insensitive to income.

Vast majority of seniors excluded in most states. Forty states would have at least 70 percent of their seniors ineligible for assistance under the Senate Republican low-income block grant. In 16 states, the percent of excluded seniors is 75 percent or more, and in 5 states, the percent excluded is 80 percent or more.⁸ (See Table 1).

Most of those who lack prescription drug coverage today would be excluded. About three-fifths (55 percent) of all Medicare beneficiaries who now have no coverage for prescription drugs throughout the year would be ineligible assistance under a low-income plan. Unlike the lack of health insurance among the non-elderly, the lack of drug coverage is not concentrated among those with low-incomes. The difference in the rate of lack of drug coverage among middle-income elderly (income greater than 300 percent of poverty) and poor elderly is 35 versus 24 percent. In contrast, the rate of uninsured children is nearly four times higher among poor children than those in families with income above 300 percent of poverty: 26 versus 7 percent.⁹ Seniors and people with disabilities – even when they have adequate income – cannot always access and/or afford drug coverage from private health insurance. This is a particular problem for rural beneficiaries and the oldest seniors who are most likely to lack drug coverage.

Little relief for seniors and people with disabilities with high drug costs. Nearly three in five of Medicare beneficiaries with the highest prescription drug costs (57 percent) would not qualify for assistance under a low-income plan. In fact, the income distribution of the 20 percent of Medicare beneficiaries with the highest total drug spending is almost identical to that of all Medicare beneficiaries.¹⁰ This shows that middle-income beneficiaries are at equal risk of having high prescription drug costs as those with low-income.



⁷ Analysis of the 1996 Medicare Current Beneficiary Survey.

⁸ Average Current Population Survey March 1997-99 for elderly with income between 75-175 percent of poverty.

⁹ Analysis of the 1996 Medicare Current Beneficiary Survey for elderly; March 1999 CPS for uninsured children.

¹⁰ Assistant Secretary for Planning & Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Price: Report to the President*. Washington, DC: U.S. Department of Health & Human Services.

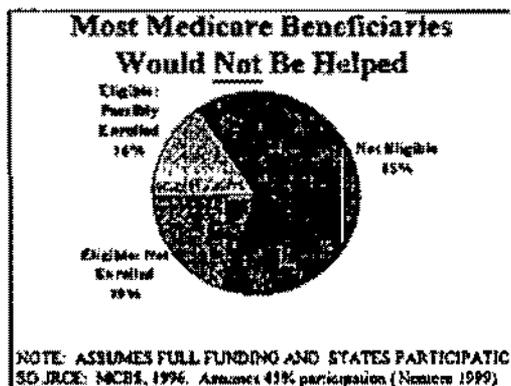
Excludes millions of Medicare beneficiaries with inadequate, expensive, and unreliable managed care or private insurance plans. Less than one-third of all Medicare beneficiaries have prescription drug coverage through a retiree health plan.¹¹ This leaves many middle-income seniors and people with disabilities who need prescription drug coverage only the choice of private Medigap insurance or, if available, a Medicare managed care plan. Premiums for private Medigap insurance with prescription drug coverage can be \$100 more per month – and much higher for those over the age of 80.¹² Yet, three-fifths of the seniors who purchase Medigap private insurance have income above 175 percent of poverty.¹³ In addition, low-income drug plans do nothing to help those who join Medicare managed care plans for prescription drug coverage since they would not directly reimburse plans for such coverage. Thus, those who remain in Medicare+Choice plans remain at risk of losing drug coverage.

LESS THAN HALF OF THE LOW-INCOME MEDICARE BENEFICIARIES THAT THE PLAN

PURPORTS TO HELP WOULD LIKELY GET DRUG COVERAGE. The second, major concern with the low-income prescription drug proposals is that they build on state programs that have failed to effectively help low-income seniors and people with disabilities.

Most (55 percent) low-income Medicare beneficiaries eligible for Medicaid do not receive assistance. The lack of prescription drug coverage is not Medicare's only benefit gap. Medicare's benefits are less generous than 80 percent of large employers' fee-for-service health plans.¹⁴ Thus, Medicaid assists the elderly and people with disabilities qualifying for Supplemental Security Income (SSI) and certain others who spend down their resources. In addition, states are required to cover Medicare premiums for those with income below 135 percent of poverty and its cost sharing for those with income below 100 percent of poverty. Despite their need for such assistance, about 55 percent of eligible low-income Medicare beneficiaries are not enrolled in Medicaid.¹⁵ While the participation rate varies by state, it is 50 percent or less in 30 states and less than one-third in 7 states.¹⁶ (See Table 1). Medicare beneficiaries who do not enroll in Medicaid tend to be older women who live alone and Hispanics.¹⁷

Combining the percent of Medicare beneficiaries who are eligible for any assistance with a 45 percent participation rate, only 16 percent of Medicare beneficiaries are likely to get any assistance under the low-income block grant plan (assuming full funding and full state participation).



¹¹ Mercer-Foster Higgins (1999). The number of large firms providing retiree coverage dropped 25% from 1994-98.

¹² U.S. General Accounting Office. (March 1, 2000). *Medigap: Premiums for Standardized Plans that Cover Prescription Drugs*. Washington, DC: US GAO/HEHS-00-70R.

¹³ Analysis of the 1996 Medicare Current Beneficiary Survey.

¹⁴ Komisar HL; Reuter JA; Feder J. (June 1997). *Medicare Chart Book*. Washington, DC: Kaiser Family Foundation.

¹⁵ Nemore PB. (December 1999). *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. Washington, DC: Kaiser Family Foundation. GAO (1999) GAO/HEHS-99-61.

¹⁶ Families USA. (July 1998). *Shortchanged: Billions Withheld for Medicare Beneficiaries*. Washington, DC: Families USA.

¹⁷ Barents Group LLC. (April 7, 1999). *A Profile of QMB-Eligible and SLM3-Eligible Medicare Beneficiaries*. Baltimore, MD: U.S. DHHS, Health Care Financing Administration.

State pharmacy assistance programs have not covered a meaningful number of seniors. Rather than extending Medicaid coverage to additional low-income elderly, a number of states have created partially to totally independent, state-funded programs to cover prescription drugs. Fourteen states had programs running in 1999, two states began programs this year, and six states are planning to but have not yet begun to enroll seniors. Benefit design, eligibility, and integration with the Medicaid prescription drug benefit vary by state. However, there is one constant: enrollment in these programs is low. Nationally, less than 800,000 seniors are enrolled in state pharmacy assistance programs. (See Table 1) In eight of the 14 state programs, 10 percent or fewer Medicare beneficiaries are enrolled.¹⁸

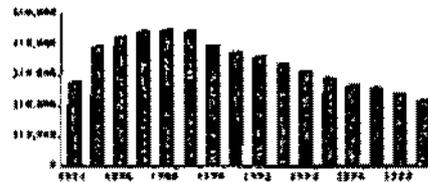
Enrollment barriers exist in many state programs for the elderly. Another reason why state programs have not reached their enrollment goal is the difficulty of the enrollment process. States have not made the same strides in simplifying Medicaid enrollment for the elderly as they have for children. To sign up for Medicaid, eligible seniors and people with disabilities must fill out long, complex applications (in 26 states); meet extensive documentation requirements for income and assets (in 41 states); and go to welfare offices (34 states have no outstationed eligibility workers). Also, at least 18 states recover Medicare cost sharing payments from the estates of deceased beneficiaries, causing fear that their estates will be tapped when they die.¹⁹ In contrast, states have employed a number of strategies to simplify enrollment for uninsured children.²⁰ And, unlike Medicare, Medicaid requires redetermination of eligibility at least once a year, and two state pharmacy assistance programs require participants to re-enroll on a monthly basis.²¹

Lack of awareness – and reluctance to participate in perceived “welfare program” – limit enrollment. Studies have found that beneficiaries are frequently unaware of state-based low-income assistance programs or their eligibility for them. It also appears that the social stigma of enrolling in Medicaid-related programs (“poor people’s programs”) and misperceptions about the effect of enrollment on immigration status and inheritance for spouses and children prevent enrollment. Despite concerted efforts by the Clinton-Gore Administration, advocates and some states, these negative perceptions persist.²²

ENROLLMENT TRENDS IN PACE

In 1999, the Pennsylvania PACE program – the largest in the nation – served 50 percent fewer Medicare beneficiaries (217,103) than in 1988 (443,518). Although the Governor expanded the program in 1996 and aimed to cover an additional 75,000 seniors, fewer people were enrolled overall in 1999, and his new PACENET program has covered less than 20,000 since 1996.

Enrollment in PACE



Source: Pennsylvania Department of Aging (2000); Pennsylvania Legislature.

¹⁸ General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets*. Washington, DC: U. S. GAO; GAO/HEHS-00-162.

¹⁹ Namore PB. (December 1999). *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*. Washington, DC: The Henry J. Kaiser Family Foundation.

²⁰ Cox L; Cohen Ross D. (April 2000). *Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

²¹ General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets*. Washington, DC: U. S. GAO; GAO/HEHS-00-162.

²² General Accounting Office. (April 1999). *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment*. Washington, DC: U.S. GAO/HEHS-99-61.

EMPTY PROMISE FOR THOSE WHO ACTUALLY ENROLL. For those seniors and people with disabilities who qualify for coverage and apply, additional barriers to meaningful drug coverage remain under the low-income proposal.

Permits limits on types of drugs covered and the number of prescriptions that can be filled. Despite the fact that virtually all of the funding for coverage in low-income plan is Federal, states have discretion to design the scope of the drug benefit. They could use block grant funds to extend their current Medicaid or state drug assistance program benefits. Five of the 14 state pharmacy assistance programs limit drug coverage to specific conditions or maintenance drugs (e.g., Maryland only covers maintenance drugs). In addition, 14 state programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only 3 prescriptions per month.

LIMITATIONS ON PRESCRIPTION DRUG COVERAGE IN STATE PROGRAMS

LIMITS ON NUMBER OF PRESCRIPTIONS*	LIMITS ON TYPES OF DRUGS**
Arkansas	Illinois
Florida	Maine
Georgia	Maryland
Michigan ***	Rhode Island
Mississippi	Vermont
Nebraska	
North Carolina	
Oklahoma	
South Carolina	
Tennessee	
Texas	
West Virginia	
Wisconsin	
Wyoming (state & Medicaid program)	

*Some Medicaid programs have number of prescriptions that may be filled per month. **Non-Medicaid programs. ***State program, limit coverage to 3 months per year.
Source: CBO, NGA 2000, National Pharmaceutical Council 1998, GAO

Permits states to limit access to medically necessary drugs. Low-income proposals generally allow states to limit the ability of a doctor to prescribe a medically necessary drug. Specifically, they would permit burdensome appeals or prior authorization requirements. Thus, a senior with cancer who is eligible and enrolls may not get coverage for needed prescription drugs.

Could restrict access to a local pharmacy. The Senate Republican bill provides no assurance that beneficiaries could continue to use their local pharmacies. Local pharmacies play an important role in quality of care for the elderly and people with disabilities who tend to use a large number of medications that interact and can cause complications. In addition, Medicare beneficiaries are not as mobile as other Americans so geographical access is important.

Enrollment would inevitably be capped. States would have the discretion to set the upper eligibility limit under this program at any level above Medicaid and below 175 percent of poverty. They could also impose assets tests. Most disturbingly, states could – and would probably – cap enrollment. States would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries with the Senate Republican's \$1.3 billion in 2001. While average annual spending on prescription drugs exceeds \$1,000, this funding would provide at most only \$119 per year per eligible senior (see Table 1). This would be even lower when taking into account people with disabilities. Much of this Federal funding would be used to replace existing state funding. In 1999, 12 states spent about \$700 million on non-Medicaid drug programs.²¹ Four of these states (Connecticut, Maryland, New Jersey, Pennsylvania) could entirely substitution their state spending with their Federal funding under this plan. Another three states (Illinois, Maine, New York) could use more than half of their Federal allotment to replace all of their state spending. This does not take into account potential substitution in Medicaid. Thus, even if a state were to effectively encourage low-income seniors to apply, those seniors would inevitably end up on waiting lists.

²¹ General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets*. Washington, DC: U. S. GAO; GAO/HEHS-00-162.

IMPLEMENTATION ISSUES WILL DELAY LOW-INCOME ASSISTANCE – AND A LONG-OVERDUE

MEDICARE PRESCRIPTION DRUG BENEFIT. While there is general agreement that Medicare beneficiaries need a prescription drug benefit as soon as possible, the Congressional block grant plans would not provide prescription drug coverage to low-income beneficiaries nationwide in 2001. The proposals would be more effective at delaying implementation of a meaningful Medicare prescription drug benefit than at helping low-income seniors immediately.

States generally oppose filling in Medicare's gaps – and specifically oppose taking responsibility for prescription drug coverage. The Clinton-Gore Administration has worked successfully with states on a number of policy initiatives, most notably the creation and implementation of the State Children's Health Insurance Program. These initiatives have succeeded due to state and bipartisan Congressional support. The same does not hold true for the Senate Republican block grant proposal for prescription drugs. States have generally opposed increasing their role in filling in gaps in Medicare. They are specifically concerned about prescription drugs given these rapidly growing costs.

Low-income proposals make it even more unlikely that states expand drug assistance programs. The low-income proposals' Federal funding is time-limited, inadequate, and capped – features which would discourage states from participating. States without pharmacy assistance programs today would have to pass enabling legislation, develop administrative systems, hire and train eligibility workers, develop claims payment systems, and conduct outreach campaigns to raise awareness. State officials would be concerned about launching such an initiative if Federal funding is temporary, since states would inevitably have to continue to provide such coverage if efforts to pass a Medicare prescription drug benefit fail. In fact, if states provide assistance, there could be less pressure to enact a Medicare drug benefit, leaving states permanently responsible. In addition, the Federal allotments under the Senate Republican plan are small, and may not be sufficient to justify the start-up costs. Finally, Federal responsibility and liability are capped. Given the rapidly rising costs of prescription drugs, states would be put in the untenable position of cutting back on either enrollment or benefits if cost growth exceeds Federal funding growth.

Even if states unanimously supported a low-income prescription drug proposal -- as they did with the State Children's Health Insurance Program (SCHIP) -- it would take significant time to implement. The legislation providing funding for SCHIP was passed on August 5, 1997. States began receiving funding on October 1, 1997. Twenty states did not begin enrollment in the first

**NATIONAL GOVERNORS' ASSOCIATION:
CONCERNS ABOUT STATE PRESCRIPTION DRUG PLAN**

- **On Medicare:** "The Governors want to ensure that elderly beneficiaries receive the best possible care, but the Medicare program is a federal program and the federal government should bear all of the costs of serving this dually-eligible population, including full federal responsibility for prescription drug costs." (HR-16-3-9)
- **On Prescription Drugs:** "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." (HR-39)
- **On Time-Limited Programs (SCHIP funding is for 10 years; Senate Republican drug plan is for 4 years)** "The design, development, and implementation of a health insurance program such as S-CHIP takes time. For states to enroll children, educate families about the benefits of a managed care delivery system, ensure that necessary services are received, and ensure that claims are submitted and subsequently paid, Governors must be confident that a stable funding stream will be available to provide health care services to beneficiaries." (HR-13-4)

year, and three of these states only began enrollment in 2000 -- nearly 3 years after enactment.²⁴ Thus, even under the best case scenario -- where all states support the approach and it is fully funded -- it is virtually impossible that low-income seniors nationwide would have access to this new prescription drug coverage in 2001.

Federal "default plan" may be impossible to implement -- and definitely could not be operational in 2001. Recognizing that some (and perhaps most) states would not want to expand prescription drug coverage, most low-income proposals would require the Health Care Financing Administration (HCFA), which runs Medicare, to establish a prescription drug benefit for low-income seniors and people with disabilities in states that opt out. Medicare has no history of or ability to selectively provide benefits based on beneficiaries' income. It would likely take Medicare longer to develop such systems than states and could, under no scenario, be operational and enrolling low-income beneficiaries on January 1, 2001, as the law requires.

Creating a new state program would divert energy and resources from implementing a Medicare prescription drug benefit. The Federal and state effort needed to make a low-income prescription drug proposal a success would likely exceed that which is needed to create a Medicare prescription drug option. If the Senate Republican proposal were enacted, the next session of Congress would more likely focus on fixing this flawed, state-based low-income program rather than creating a Medicare prescription drug benefit. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would go into effect for all Medicare beneficiaries in 2002. It would be more effective at covering low-income beneficiaries since 98 percent of seniors participate in Medicare. This low-income proposal would be more effective at diverting attention from and delaying a meaningful Medicare prescription drug option than it would be in assisting the low-income seniors that it purports to help.

CLINTON-GORE ADMINISTRATION PRESCRIPTION DRUG PROPOSAL

The Clinton-Gore Administration would establish a Medicare prescription drug benefit that is optional, affordable, meaningful, and accessible for all seniors and eligible people with disabilities beginning January 1, 2002. The benefit would have no deductible and pay for half of the costs of drug costs up to \$5,000 when fully phased in. Participants would pay no more than \$4,000 in out-of-pocket drug costs annually. Premiums for this coverage would be \$25 per month starting in 2002 while low-income beneficiaries (with incomes below 150 percent of poverty, \$12,500 for singles, \$16,900 for couples) would pay no to lower premiums and cost sharing. The Congressional Budget Office estimates that 100 percent of Medicare beneficiaries without prescription drug coverage -- including all low-income beneficiaries -- would participate. According to the HCFA Actuary, the cost of the program is \$253 billion over 10 years.

This Medicare drug benefit option would be integrated into beneficiaries' health plan choices, so that eligible seniors could choose to get their prescriptions through the traditional fee-for-service program, managed care, or a retiree health plan if available. Beneficiaries in traditional fee-for-

²⁴ U.S. Health Care Financing Administration (HCFA) (January 2000). *The State Children's Health Insurance Annual Enrollment Report, October 1, 1998 - September 30, 1999*. Washington, DC: U.S. DHHS.

service would receive their drug coverage through pharmacy benefit managers (PBMs) in the same way that most privately insured Americans do. PBMs would negotiate drug discounts on behalf of Medicare beneficiaries. Seniors who have retiree health insurance that provides drug coverage at least as good as the President's benefit could choose to keep that coverage. Medicare would contribute to part of its premium subsidy to employers in order to encourage them to maintain retiree coverage. In addition, for the first time in program history, Medicare managed care plans would receive direct payments for the provision of a prescription drug benefit. This should stabilize the Medicare managed care market and contribute towards making it more competitive. In fact, in 2001, plans will be paid to provide to their enrollees a drug benefit that is similar to the President's benefit, until the benefit is implemented one year later.

Regardless of their plan choice, all Medicare beneficiaries enrolled in the prescription drug option would have access to all prescriptions deemed medically necessary by a physician, even if not on the formulary of their PBM or managed care plan. In addition, beneficiaries would continue to be able to receive their prescriptions from their community pharmacies.

COMPARISON OF THE CLINTON-GORE AND REPUBLICAN LOW-INCOME PLAN

Middle-income widow with annual income of \$18,000. An 35-year old widow, with annual income of \$18,000 (just over 200 percent of the poverty limit), has lived independently for the 15 years since her husband died. She currently does not qualify for Medicaid prescription drug coverage and cannot afford Medigap prescription drug coverage. However, she has developed congestive heart failure which, along with her arthritis, costs her \$9,000 per year – half of her income.

- Republican Low-Income Plan would exclude this elderly widow from eligibility because her income is too high. She would receive no assistance under this plan.
- Clinton-Gore Plan would offer her a premium of \$25 per month in 2002 for a price discount of at least \$900 and coverage of \$4,100 for savings (net of premiums) of \$4,700.

Low-income person with disabilities with Parkinson's disease. A 46-year old electrician has been developed Parkinson's disease. He had to stop working at the age of 43 and became eligible for Medicare at the age of 45. He can no longer work. A new medication that helps control muscle tremors that would enable him to return to work has been developed. However, it costs \$600 per month – on top of his \$250 per month for prescriptions to alleviate his related conditions. His annual total prescription drug costs are \$10,200 and are not covered by Medicare. His income from part-time work is \$5,000 per year.

- Republican Low-Income Plan would allow the state that this person resides in to limit the types of drug covered. This state could decide not to cover this new drug that would enable this electrician to return to work full time. As such, if he decided to enroll, he could get assistance for \$3,000 of his \$10,200 in drug costs – the uncovered prescription drug costs would still exceed his annual income.

- Clinton-Gore Plan would not charge this person premiums or cost sharing and would pay for all of his prescription drug costs, enabling him to take the new drug and return to work. He would save the full \$10,200 per year.

Low-income retired couple. The Smiths, a married couple in their late seventies, have an annual income of \$15,190. Mr. Smith has diabetes and poorly controlled hypertension. They live in a state that has implemented the new low-income prescription drug program, but only 30 percent of the eligible population has enrolled in the program, because it has not been well advertised. The Smiths would apply for assistance, but they don't know about the program. They are spending more than one-third of their income on Mr. Smith's medications.

- Even though the Republican low-income plan should help this couple, it does not. Because of the difficulty of reaching out to a low-income population, confusing, complicated, and overly burdensome application process, and the strict income-based enrollment requirements, state-based programs have limited success in identifying and enrolling eligible seniors. Unfortunately, even though they should be helped by this program, the Smiths are just two of the millions of older Americans that receive no assistance from the Republican proposal.
- Clinton-Gore Plan would provide the Smiths with a comprehensive prescription drug benefit, eliminating all of the couple's out-of-pocket medication expenses. In addition, because the application process would be modeled after the one used to enroll in Medicare Part B, which covers 98 percent of all seniors, the Smiths would be able to access the assistance for which they are eligible.

Low-income single adult who receives assistance under the Republican plan. Mr. Jones, a 75-year old senior with an annual income of \$14,195, is enrolled in his state's prescription drug benefit program. Although he found the application process burdensome and humiliating, as he is embarrassed about participating in a welfare program, he enrolled because the cost of his heart medication was too much for him to handle on his own. He is concerned about his sister, who also has high prescription drug costs. She has the same income as he does, but she lives in a different state that has limited the benefit to seniors with annual incomes of less than \$8,350, and so she is ineligible for assistance. They feel this is very unfair.

- Republican Low-Income Plan creates 50 separate state programs with a patchwork of benefits and different eligibility levels. Many seniors, like Mr. Jones, suffer from the welfare stigma associated with a benefit limited to low-income seniors. And his sister – even though states have the option to cover seniors at her income level – is not guaranteed coverage.
- Clinton-Gore Plan would ensure that both Mr. Jones and his sister receive a guaranteed, comprehensive prescription drug benefit that is easy to access because the application process would be modeled after the one used to enroll in Medicare Part B, which covers 98 percent of all seniors. Because it is a Medicare benefit, there is no welfare stigma associated with enrolling in the program, and both Mr. Jones and his sister do not have to be ashamed about the assistance they receive.

**SIDE-BY-SIDE COMPARISON OF PRESIDENT'S MEDICARE PRESCRIPTION
DRUG BENEFIT VERSUS REPUBLICANS' STATE BLOCK GRANT PLAN**

	Clinton/Gore & Democrats	Republican Low-Income Block Grant
Who's Covered	All seniors and people with disabilities who lack reliable drug coverage today would gain coverage under this plan	<u>Fewer than one-third</u> of seniors and people with disabilities would be eligible and <u>less than half</u> of those would likely participate
What Do You Get	Defined Benefit: No deductible, 50 percent coinsurance up to \$5,000 in costs when phased in. Out-of-pocket spending limited to \$4,000	Unknown. States determine benefit that could include restrictions on the number and types of drugs covered
How Much Does it Cost	No premium for those with income below 135 percent of poverty; sliding scale premium for those with income between 135 and 150 percent of poverty; \$25 per month in 2002 for all other participants	Unclear: No premium below those with 100 percent of poverty; state-defined premium, not to exceed 5 percent of income for beneficiaries between poverty and the state-defined upper eligibility limit
Are Seniors and People with Disabilities Ensured Choice	Plans: <u>Yes.</u> In fee-for-service, managed care, or retiree plans if eligible Drugs: <u>Yes.</u> Doctor-prescribed drugs are guaranteed without going through insurer or HMO Pharmacies: <u>Yes.</u> All local, qualified pharmacies would be accessible	Plans: <u>No.</u> States would not have to pay managed care or retiree plans that offer seniors drug coverage. Drugs: <u>No.</u> The legislation provides no guarantees of access to needed drugs Pharmacies: <u>No.</u> States could restrict participating pharmacies
Start-Date	2002	Unknown
Part of Larger Plan to Reform Medicare	Yes	No

TABLE I. STATE DATA

	EXCLUDED	LOW PARTICIPATION		LIMITED	STATE FUNDING		
	Percent of Seniors Not Eligible	Percent of Eligible Medicare Benef. NOT in Medicaid	Seniors Enrolled in State Programs	COVERAGE Medicaid or State Program Drug Limits	Allocments (Millions)	Current Non-Medicaid \$ (Millions)	New Dollars Per Eligible Elderly
Alabama	69%	48%			\$28.6		\$159
Alaska	67%	na			\$5.5*		\$1,089*
Arizona	75%	63%			\$19.4		\$140
Arkansas	64%	53%		Number	\$18.5		\$144
California	75%	12%			\$121.0		\$146
Colorado	80%	21%			\$10.7		\$153
Connecticut	79%	43%	29,955		\$13.7	\$15.7	\$0
DC	75%	57%			\$6.5*		\$312*
Delaware	74%	61%			\$6.5*		\$252*
Florida	74%	50%		Number	\$33.6		\$134
Georgia	75%	42%		Number	\$32.3		\$178
Hawaii	81%	49%			\$6.0*		\$215*
Idaho	71%	46%			\$6.5*		\$163*
Illinois	75%	70%	40,168	Type	\$92.1	\$34.1	\$48
Indiana	71%	65%			\$28.0		\$139
Iowa	74%	15%			\$13.3		\$135
Kansas	74%	60%			\$13.8		\$143
Kentucky	70%	39%			\$23.1		\$163
Louisiana	61%	48%			\$26.3		\$134
Maine	72%	44%	25,000	Type	\$7.6	\$4.7	\$64
Maryland	78%	64%	33,156	Type	\$20.1	\$26.9	\$0
Massachusetts	74%	52%	27,482		\$28.1	\$6.3	\$112
Michigan	74%	52%	12,958	Number	\$43.6	\$5.2	\$125
Minnesota	72%	54%	1,200		\$17.4	\$1.2	\$122
Mississippi	69%	15%		Number	\$18.2		\$134
Missouri	70%	59%			\$25.4		\$145
Montana	76%	63%			\$6.5*		\$264*
Nebraska	67%	68%		Number	\$9.0		\$128
Nevada	73%	66%			\$5.6		\$123
New Hampshire	75%	76%			\$6.5*		\$185*
New Jersey	74%	44%	165,005		\$27.7	\$248.0	\$0
New Mexico	72%	57%			\$9.4		\$167
New York	72%	40%	113,000		\$92.0	\$77.8	\$22
North Carolina	70%	32%		Number	\$42.9		\$151
North Dakota	69%	57%			\$6.5*		\$218*
Ohio	74%	67%			\$53.0		\$143
Oklahoma	71%	61%		Number	\$26.1		\$137
Oregon	78%	49%			\$13.8		\$100
Pennsylvania	74%	55%	235,758		\$54.1	\$209.3	\$0
Rhode Island	64%	72%	25,776	Type	\$7.4	\$2.3	\$91
South Carolina	66%	30%		Number	\$23.9		\$165
South Dakota	72%	58%			\$8.5*		\$230*
Tennessee	70%	19%		Number	\$29.4		\$182
Texas	69%	59%		Number	\$94.1		\$147
Utah	80%	47%			\$6.5*		\$233*
Vermont	71%	40%	9,428	Type	\$6.5*		\$342*
Virginia	77%	50%			\$29.9		\$168
Washington	61%	63%			\$16.7		\$171
West Virginia	63%	63%		Number	\$14.9		\$136
Wisconsin	73%	53%		Number	\$20.1		\$124
Wyoming	72%	53%	491	Number	\$8.5*	\$0.6	\$362*
TOTAL	73%	48%	762,458	13	\$1,297.0	\$932.1	\$119

* States with statutory minimum allotments rather than allotments based on formula.

PRESCRIPTION DRUGS AND MEDICARE:

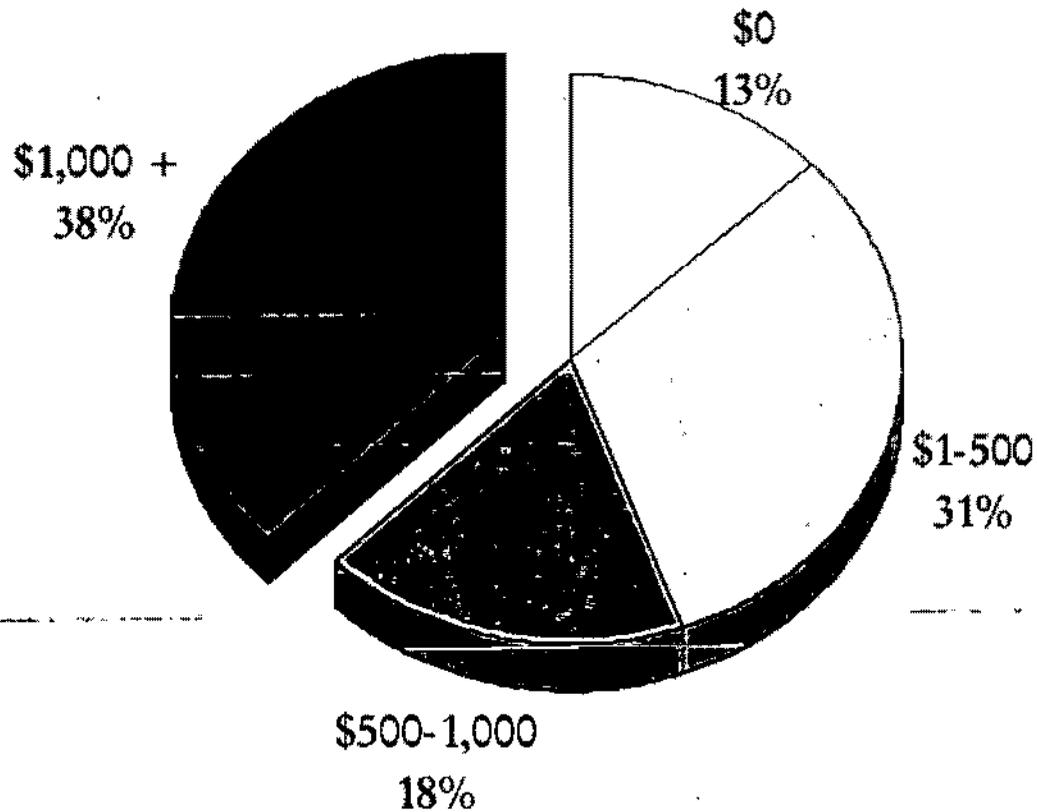
- I. Background
 - II. Principles
 - III. President's Proposal
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February 2, 2000

I. BACKGROUND

Medicare Beneficiaries Need Prescription Drugs

Beneficiaries By Total Drug Spending, 2000



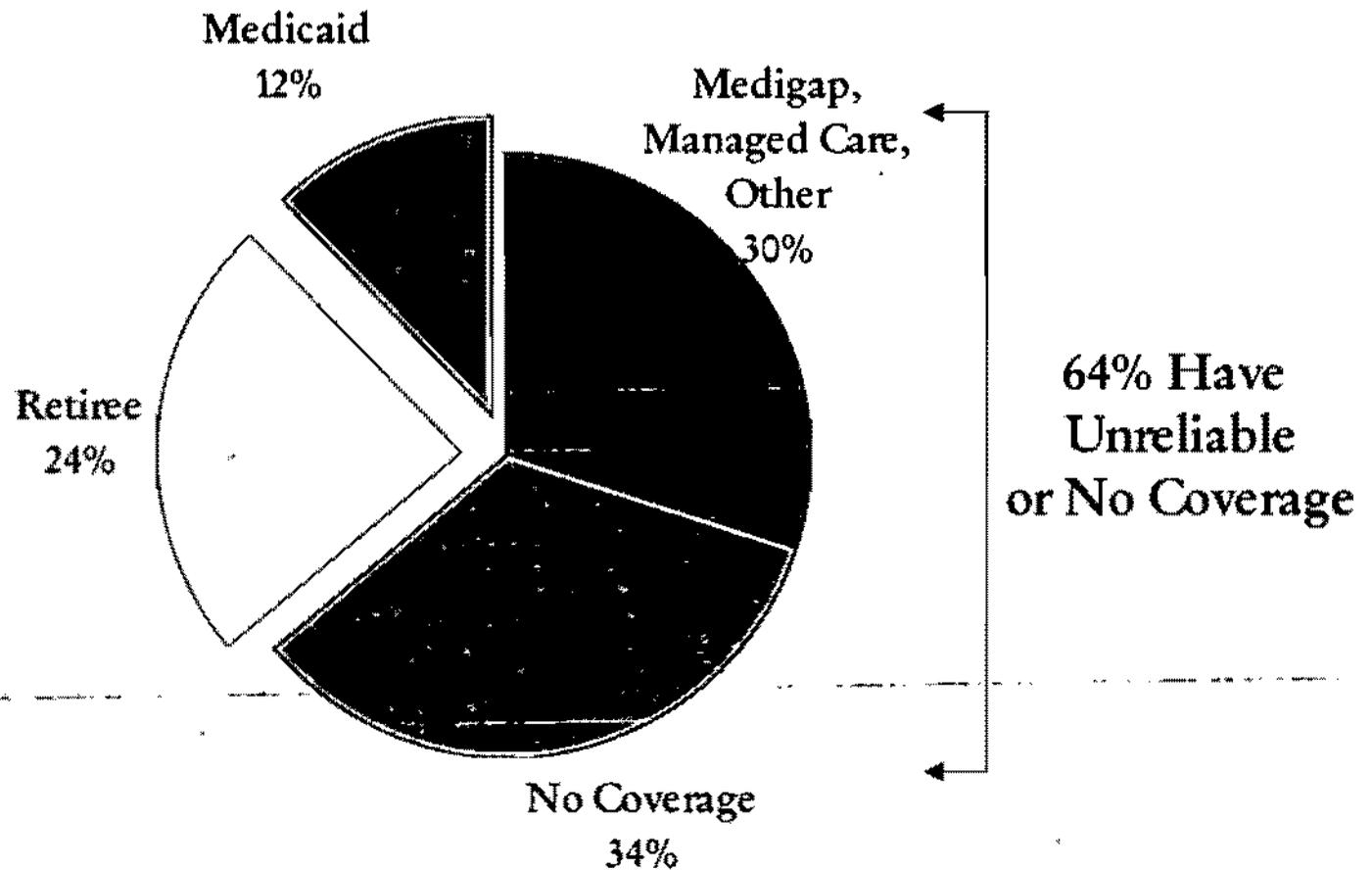
SOURCE: Actuarial Research Corporation for HHS, projected for 2000

Prescription Drug Coverage Improves Overall Health Care & Outcomes

- **Reduces institutional care.** According to recent studies:
 - Effective treatment for Alzheimer's victims, including the drug Tacrine, could keep 10 percent of patients out of nursing homes
 - Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes
- **Reduces drug-related complications.** Seniors without insurance for drugs often skip or skimp on medications.
 - Drug-related hospitalizations accounted for 6.4 percent of all admissions in the over 65 population, and an estimated that 76 percent of these admissions were avoidable

Source: Rice, DP., Fox, PJ., Max, W., et. al.: *Economic Burden of Alzheimer's Disease Care*. *Health Affairs*, 1993; 12(2): 164-7; Soumerai SB et al. *Effects of Medicaid Drug-Payment Limits on Admissions to Hospitals and Nursing Homes*. *The New England Journal of Medicine*, 1991; 325: 1072-1077. Bero LA; Lipton, H; Bird, JA: *Characterization of Geriatric Drug-Related Hospital Readmissions*. *Med Care*. 1991; 29 (10): 989-1003.

About 3 in 5 Beneficiaries Do Not Have Dependable Drug Coverage, 2000

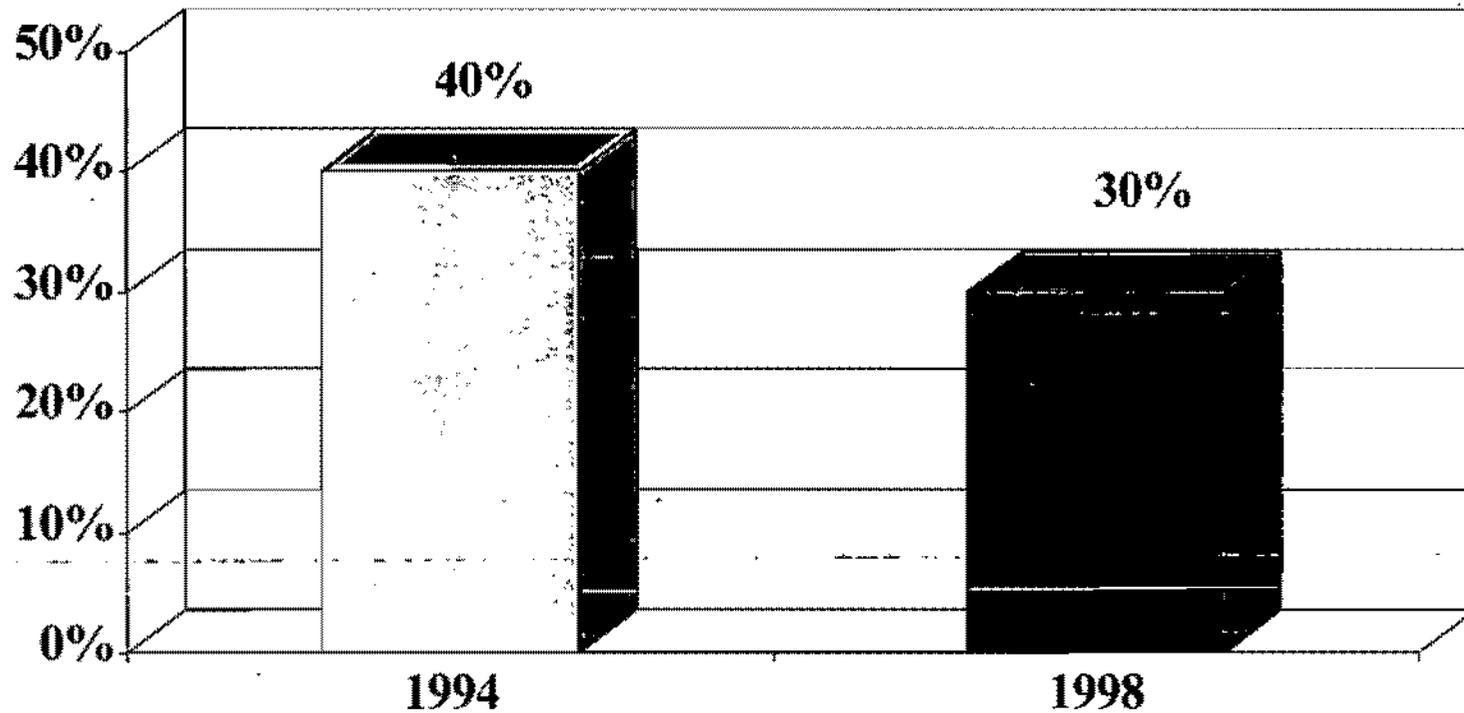


SOURCE: Actuarial Research Corporation for HHS, point-in-time, projected for 2000

Retiree Health Coverage Is Declining

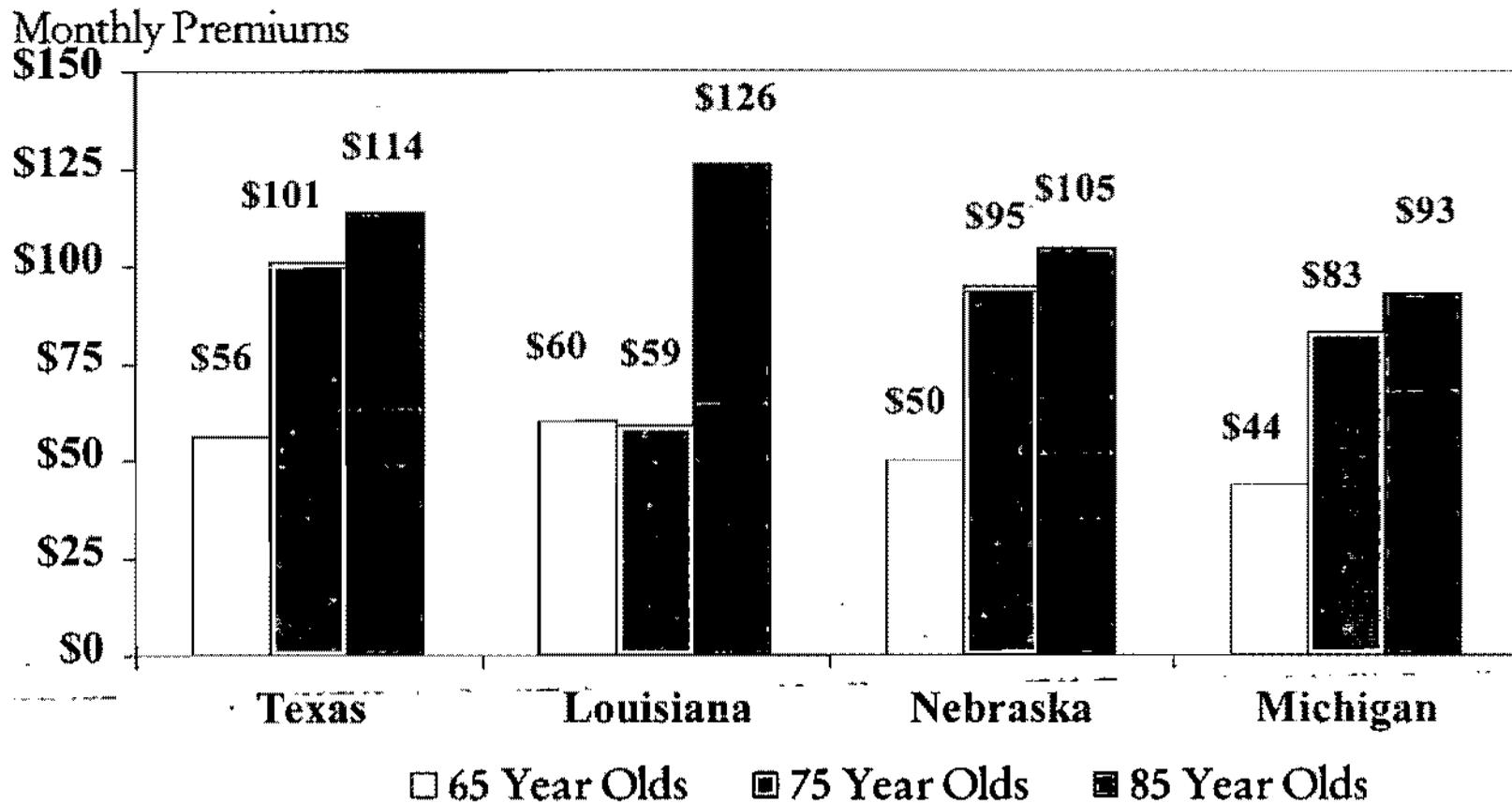
*25% Fewer Firms Are Offering Retiree Health Benefits
Over Time, Will Result in Fewer Retirees Having Employer-Based Coverage*

Firms Offering Retiree Health Coverage



SOURCE: Mercer Foster-Higgins, 1998

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

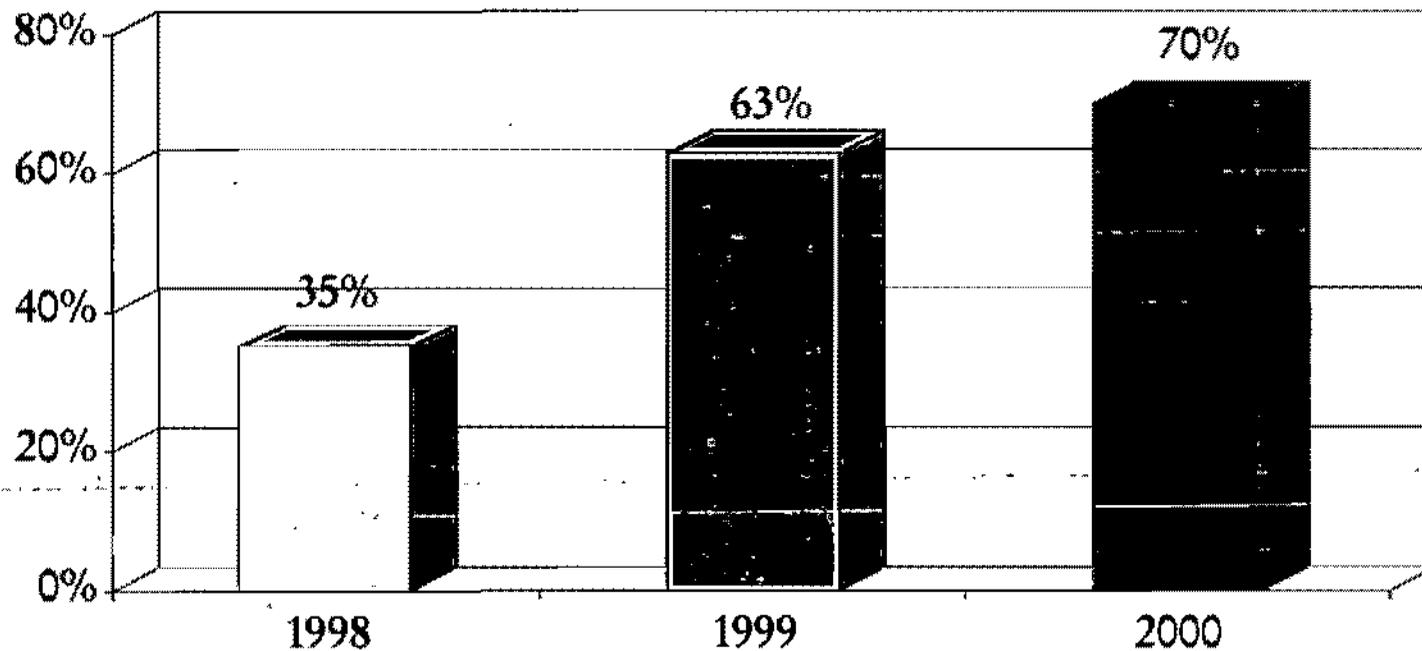


Sample Premiums for 1999. "Medigap Premiums for Drugs" are the difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. President's plan premium would be \$26 in first year.

Caps on Medicare Managed Care Drug Benefits Becoming Lower

*Nearly Three-Quarters Of Plans Will Cap Benefit Payments At or
Below \$1,000 In 2000*

Proportion of All Plans With Limits of \$1,000 or Below

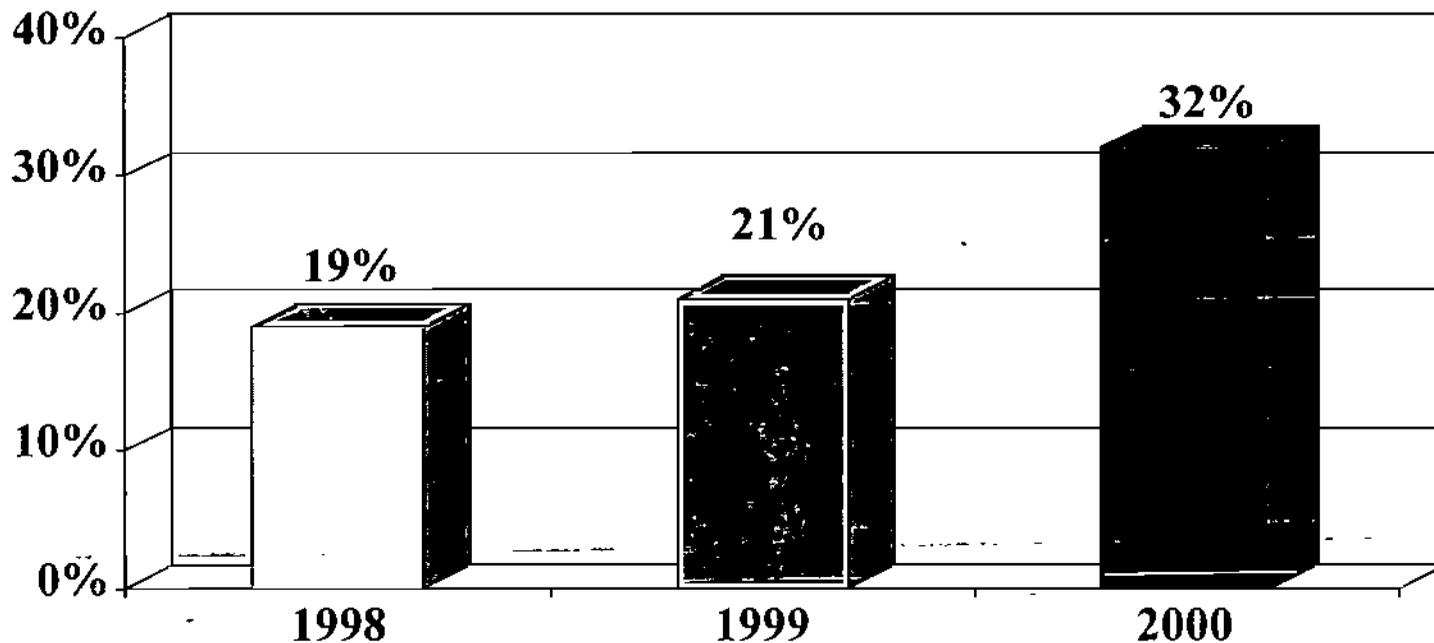


Source: HHS analysis of plan submissions for 2000; preliminary. Plans with unlimited generics and limited brand name drug spending are included with plans that cap all drug spending.

Caps on Medicare Managed Care Drug Benefit Are Getting Lower

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

Proportion of Plans With Limit of \$500 or Less

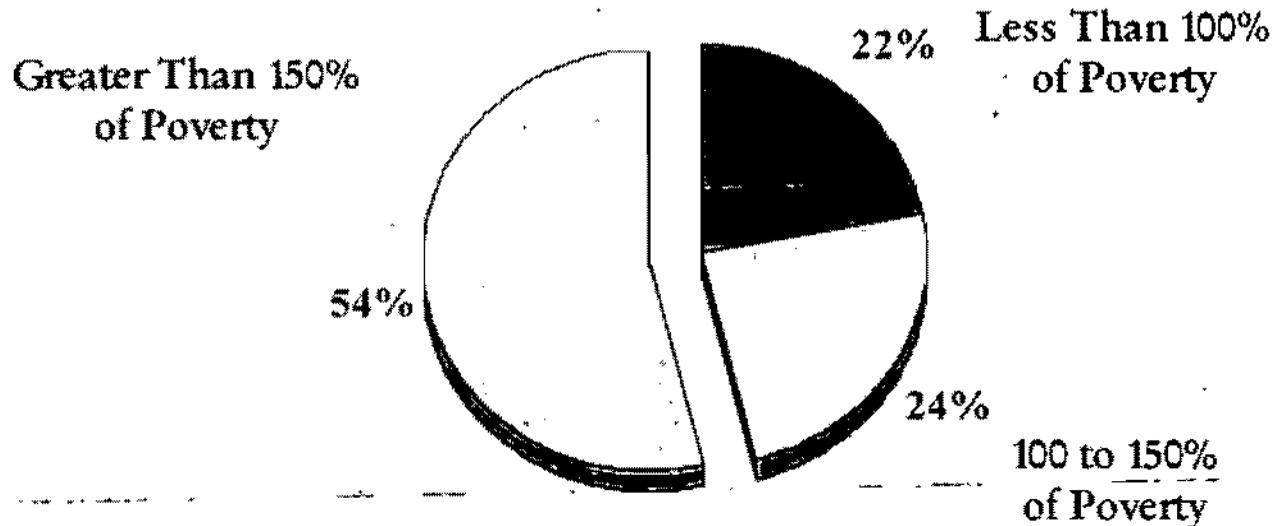


Source: HHS analysis of plan submissions for 2000; preliminary. Plans with unlimited generics and limited brand name drug spending are included with plans that cap all drug spending.

Most Uninsured Are Not Low-Income

Over Half of the 13 Million Medicare Beneficiaries Who Lack Drug Coverage Have Incomes Greater Than 150 Percent of Poverty (about \$17,000 for a couple)

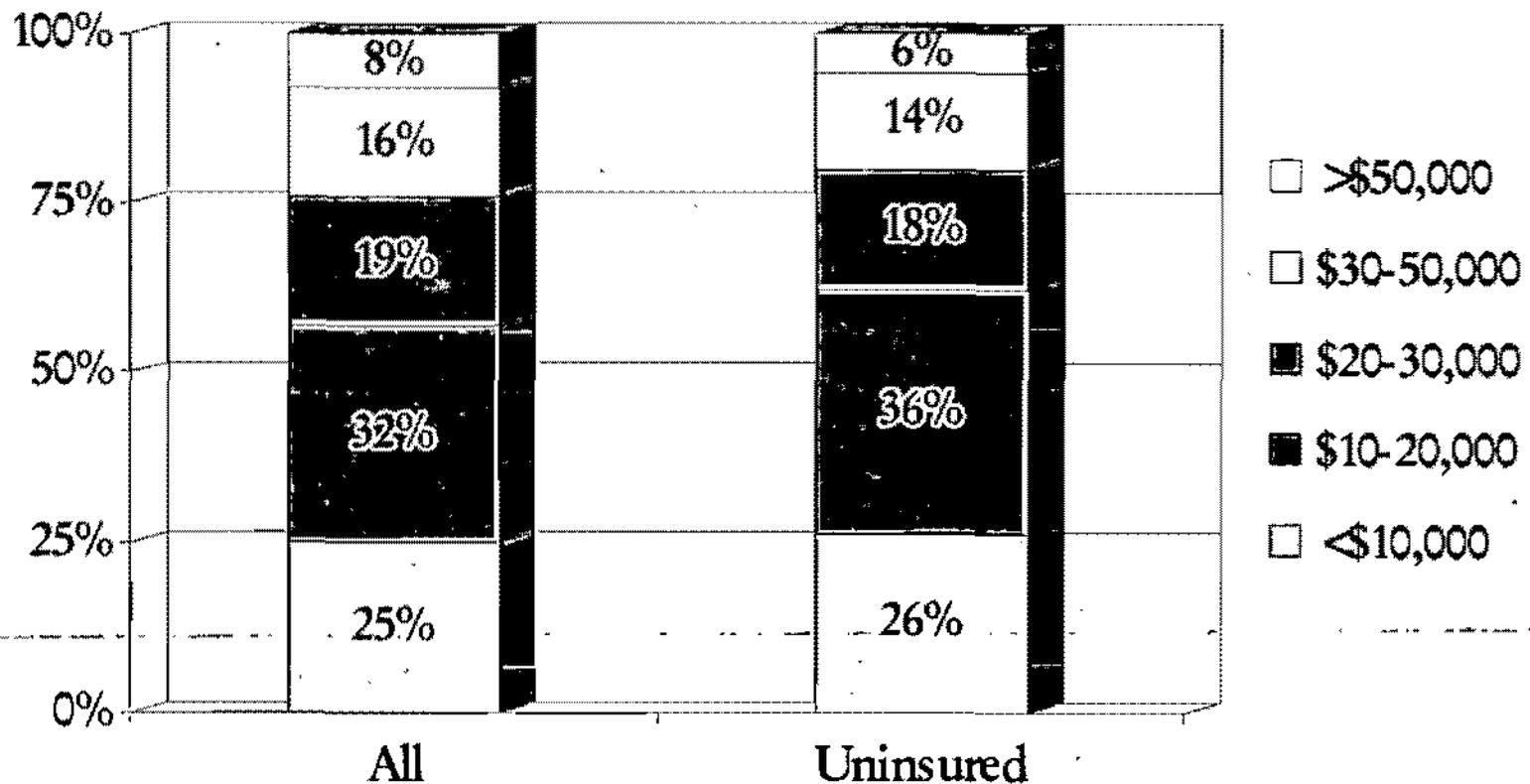
Income of Beneficiaries Without Drug Coverage , 2000
(As A Percent Of Poverty)



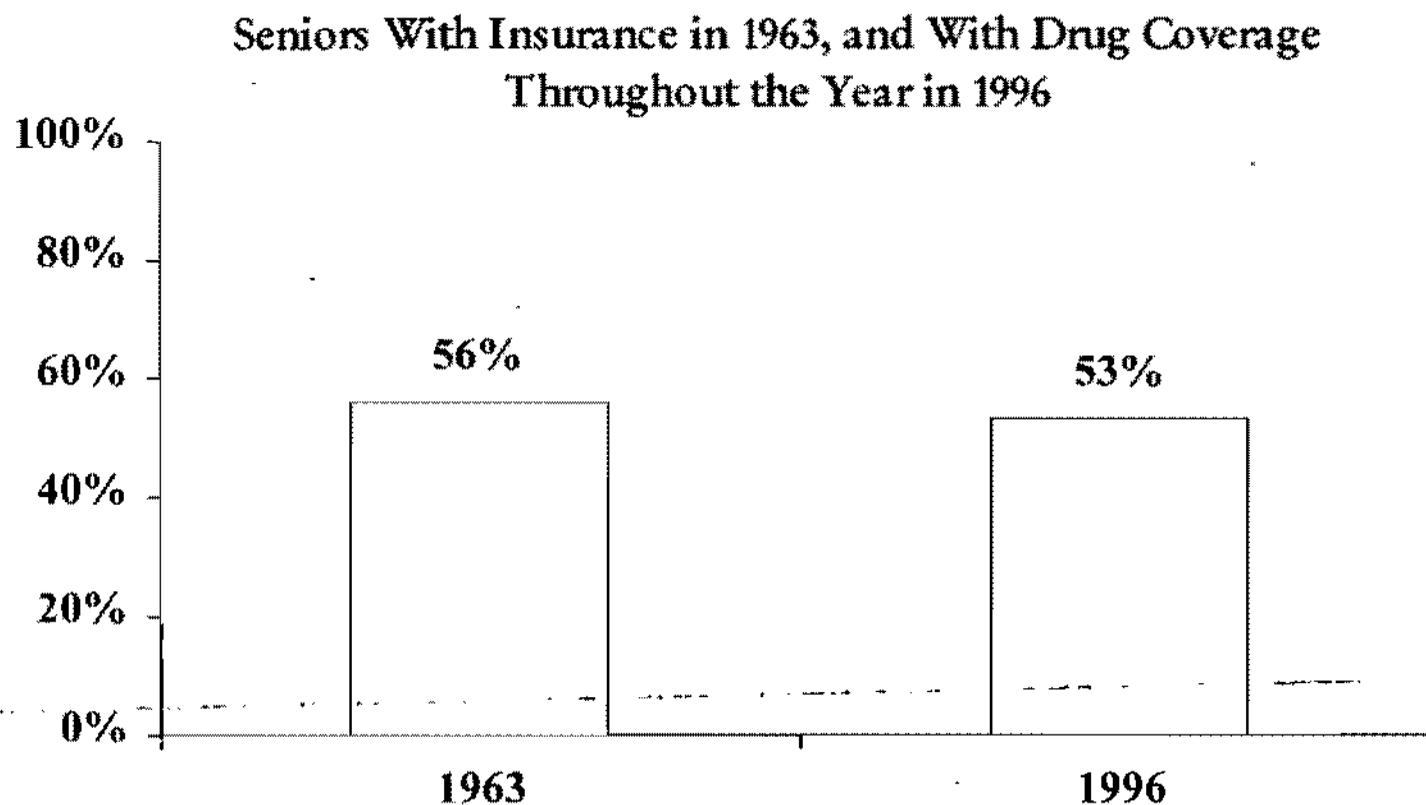
SOURCE: Actuarial Research Corporation for HHS, projected for 2000
In 2000, 150 percent of poverty for a single person is about \$12,750, for a couple is about \$17,100

Lack of Insurance Affects All Medicare Beneficiaries

Beneficiaries Lacking Coverage Are Scattered Throughout The Income Spectrum, 2000



The Lack of Drug Coverage Today Is Similar to the Lack of Hospital Coverage in 1963



SOURCES: Moon, (1996) "What Medicare Has Meant to Older Americans," Health Care Financing Review. Commonwealth Fund, based on Medicare Current Beneficiary Survey, 1996; publication forthcoming

II. PRINCIPLES

- **Accessible and Voluntary for All Beneficiaries**
- **Affordable to Beneficiaries and the Program**
- **Competitive and Efficient Administration**
- **Provides High-Quality, Needed Medications**

III. PRESIDENT'S PROPOSAL

Accessible and Voluntary

- **Option for All Beneficiaries**
 - Not limited to low-income beneficiaries
 - Provides option to those with few or no choices
- **Access Through Either Traditional Medicare or Medicare Managed Care**
 - Both options would offer enrollees high-quality, privately managed prescription drug coverage
- **Ensures Adequate Access to Pharmacists**

Affordable To Beneficiaries & Medicare

- **Affordable for Beneficiaries & Program**
 - \$26 per month in the first year (50 percent of total premium)
 - No or reduced premiums for low-income beneficiaries
 - Provides privately-negotiated discounts, gained by pooling beneficiaries' purchasing power, for all drug expenses
- **Assures Minimum Benefit**
 - All participating beneficiaries would pay no deductible
 - Plan would pay for at least 50 percent of expenses up to \$5,000 (phased in); privately-negotiated discounts available after limit
- **Limits Risk Selection and Keeps Benefit Affordable**

Competitive and Efficient Administration

- **Structured Like Private Insurance Coverage**
 - Competitively selects private benefit manager to deliver benefit to enrollees in traditional program
 - Managed care plans can offer the benefit directly or contract with a private benefit manager for the services
 - No price controls, no new bureaucracy
 - Integrated into Medicare's eligibility & enrollment system
- **Incentives for Retiree Employer Coverage**
 - Premium assistance provided to employers that choose to offer or retain retiree drug coverage

Provides High-Quality, Necessary Medications

- **Assures Access to Needed Medications**
 - Private entities that use formularies must ensure access to medications off formulary if physician deems medically necessary
- **Encourages High-Quality Coverage**
 - All benefit managers would meet minimum quality standards
 - Benefit managers must use of state-of-the-art quality improvement tools

Powerful Quake Strikes Taiwan; Taipei Estimates Death Toll at 400

TAIPEI, Taiwan (AP)—The strongest quake in Taiwan in decades jolted the island early today, wrecking a 12-story hotel in Taipei, destroying more than 100 homes islandwide and killing at least 400 people, the government said. About 2,000 people were injured.

The quake had a preliminary magnitude of 7.6 and was centered 90 miles southwest of Taipei, the U.S. Geological Survey's National Earthquake Information Center said.

It also issued warnings of possible tsunamis, or huge waves that sometimes follow earthquakes.

The tremor was about the same strength as the devastating one that struck Turkey on Aug. 17, killing more than 15,000 people.

In Taipei, the island nation's capital, the quake wrecked the 78-room Sunghshun Hotel. Fire crews turned hoses on the wreckage as smoke poured from fires raging in several rooms. Sixty people were feared trapped in the building, with 49 people already evacuated and sent to the hospital and another 11 people evacuated uninjured.

Meanwhile, 50 people were reported injured when a 12-story apartment building collapsed in the Taipei suburb of Hsinchuang. An estimated 100 others were still trapped within the building, which collapsed onto a neighboring five-story structure.

Taiwan television showed collapsed four-story residential buildings in the central city of Taichung, but gave no figures for dead or injured there.

Water poured from ruptured mains and distraught residents squatted with their heads in their hands as rescuers helped ap-

parently unhurt survivors from the building.

Severe damage was reported in the town of Puli near the quake epicenter, but details were sketchy. An explosion was reported at the town's major business, a rice wine distillery, and scores of buildings were damaged, Broadcasting Corp. of China said.

No casualty figures were immediately available there.

The Interior Ministry's disaster management center reported at least 400 dead and about 2,000 injured islandwide. Hundreds more people were reported trapped under the rubble.

In Washington, President Clinton said he and Mrs. Clinton were "saddened" by news of the quake.

"We are in touch directly with the Taiwan authorities to determine what assistance from the United States may be needed," he said.

Taiwan's financial markets shut down, and Taipei Mayor Ma Ying-jeou announced schools and offices would be closed today.

Today's quake was Taiwan's worst since a 7.4-magnitude one hit the island in 1935, killing 3,276 people.

The latest quake struck at about 1:45 a.m., while many of Taiwan's 22 million people were sleeping. It knocked out electric service throughout the northern part of the island.

State radio said the initial quake was followed by six aftershocks.

The U.S. Geological Survey's National Earthquake Information Center said the quake prompted tsunami warnings for Taiwan, Japan, the Philippines, Yap, Guam, and Palau.

Clinton Medicare Drug Plan Encourages Businesses to Drop Retirees, Group Says

By ELYSE TANOUYE

Staff Reporter of THE WALL STREET JOURNAL

A group led by the drug industry fired another shot at the White House, claiming President Clinton's proposal to add prescription-drug coverage to the government's Medicare program could encourage employers to drop from their pharmacy-benefit plans as many as nine million senior citizens.

A study commissioned by the group, Citizens for Better Medicare, concluded the Clinton plan would give employers an excuse to shift their retirees into the government program, affecting as much as 75% of senior citizens with private-employer coverage. The study's estimate is higher and more dramatic than a Congressional Budget Office estimate that 25% of senior citizens with employer plans might lose that private coverage.

The study amplifies a major point of the group's \$20 million-to-\$30 million advertising campaign, which is that the White House plan will erode options for senior citizens who have private coverage. Even though the White House plan provides a subsidy to employers to maintain their retiree coverage, the amount isn't enough in most cases to offset the savings of forcing retirees into the government plan, according to the group.

The White House has reacted angrily to the industry's attacks on its Medicare proposal and the latest claims likely will inflame those tensions.

Chris Jennings, deputy assistant to the president for health policy, disputed the report's findings. "The pharmaceutical in-

dustry's analysis is nothing more than another attempt to scare people, when in fact the current trends are much more scary than any type of drug industry-financed report suggests," he said. "The president's plan simply offers another option to address the fact that private-sector health insurance is either unaffordable, severely limited or altogether unavailable. We're disappointed that they would continue to mischaracterize the president's policy."

"This is a policy debate and it's where we differ on the issues," says Tim Ryan, head of Citizens for Better Medicare, a mix of industry and patient groups and individuals largely funded by drug makers.

The group's study, conducted by PricewaterhouseCoopers, determined that employers with typical to high retiree prescription-drug-benefit costs would save money by ending private coverage and paying the premium for Medicare benefits for their retirees. There would be even larger benefits for employers that drop their prescription-drug coverage altogether, according to the report.

Employers could save between \$3 billion and \$5 billion a year in drug spending by encouraging the senior citizens they cover to move into the Medicare program, as outlined in the White House proposal, according to the report.

About 65% of Medicare beneficiaries have prescription-drug coverage; about 28% receive their coverage through employer plans. Medicare's 40 million beneficiaries are expected to use \$49 billion of prescription drugs in the year 2000, according to the report.

Health Care -
Medicare
Prescription
Drugs

THE WALL STREET JOURNAL
TUESDAY, SEPTEMBER 21, 1999

Clinton's Russia Policy Set to Face Fire on Capitol Hill

By MICHAEL M. PHILLIPS

Staff Reporter of THE WALL STREET JOURNAL
WASHINGTON—There are allegations of a crime. The investigators are gathering evidence. The suspects are pleading their innocence. Now the Russian money-laundering scandal enters a critical trial phase—in the court of public opinion.

When Treasury Secretary Lawrence Summers sits before the House Banking Committee this morning, he will argue it is wiser to deal with a flawed, even corrupt, Russian system and install new safeguards on aid than it is to sever economic ties. He will also defend administration policies, including its support of big International Monetary Fund loans, as the best of an admittedly bad set of options.

Cutting all support for Russia, Mr. Summers will argue, "would raise the risk that the United States and the West would be labeled as scapegoats for Russia's failure to address its problems." The U.S. backed IMF lending "not because we expected that Russia would be rapidly transformed into a market economy or that corruption would be eliminated overnight, but rather on the view that to quarantine, contain or write off Russia as too corrupt would ill serve our national interest," he plans to say, according to a draft of his testimony.

During two days of hearings, committee Chairman Jim Leach (R., Iowa) will certainly delve into the impact of corruption on U.S.-Russian economic ties and into the allegation that billions of dollars leaving Russia were laundered through Bank of New York Co. Witnesses might also discuss allegations—thus far unproven—that some IMF money may have been waylaid by corrupt officials.

But charging the sober policy discussions at today's hearing—and a series of other congressional inquiries this fall—will be the political lightning storm the Russian scandal appears to be touching off. Republicans hope to milk that scandal for political advantage in the 2000 elections, and Democrats are trying to shield Vice President Al Gore's candidacy from any fallout from his ties to the Clinton Russia policy.

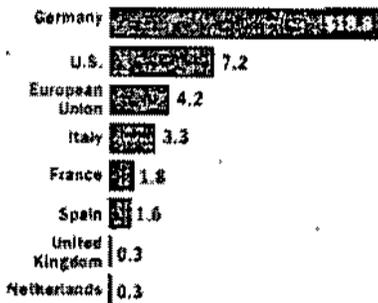
"With the elections coming up, I think the Republicans see the opportunity to beat the administration and Al Gore over the head on the Russian corruption issue," said Paul Saunders, one of today's witnesses and director of the Nixon Center, a Washington-based foreign-policy think tank. "The administration is under pressure to at least appear like it's doing something about this problem."

In the latest sign of hardening GOP attitudes, Texas Gov. George W. Bush said he wouldn't support any more IMF loans for Moscow. "I think you don't throw good money after bad," the leading GOP presidential candidate said in an interview with

Money to Russia

Rescue Squad

Leading donors of bilateral assistance to Russia, from 1989 through 1997, the latest year for which figures are available, in billions of dollars



Source: Group of Seven nations

the Washington Times. That would mean, he added, "no more IMF loans. . . . At the very minimum, we must understand what happened to IMF dollars."

And last week, GOP hopeful Steve Forbes accused the Clinton administration—and by implication Mr. Gore—of ignoring Russian corruption.

The very ambiguity of U.S. policy toward Russia leaves the administration open to charges that it either did too much to help a corrupt regime or it didn't do enough during the transition from communism. Those attacks may be based on policy disputes, as well as less-high-minded political opportunism.

"From our point of view, I don't see presidential politics playing into this," said Rep. Jim Saxton (R., N.J.), who plans to look at the IMF's role in Russia during Joint Economic Committee hearings this fall. But, he conceded, "there will be those who take the opportunity to point out to the public that there may be political ramifications from what has been done with taxpayer dollars."

The administration's response is fairly simple: It will take decades for Russia to evolve from a socialist dictatorship governed by corrupt officials into a free-market democracy governed by laws. The results have been far from perfect, but Russia has at least avoided hyperinflation, a return to communism, a collapse of the state and other worst-case outcomes. And Moscow has reduced its nuclear forces and cut its military spending.

Furthermore, Mr. Summers will point out that while there is no evidence that IMF aid has been misused, the administration is insisting that all future aid be more tightly controlled. The latest IMF loan, a \$4.5 billion deal signed this summer, is just

Interrogation Squad

Congressional committees planning hearings on Russia money issues:

- **House Banking and Financial Services Committee:** Hearings on Russian money-laundering and corruption begin today
- **Senate Foreign Relations Committee:** Hearings on U.S.-Russian relations begin Thursday
- **House International Relations Committee:** Hearings planned on U.S. policy toward Russia
- **Joint Economic Committee:** Hearings planned on International Monetary Fund, which are likely to touch on Russia scandal

sufficient to keep Moscow from defaulting on its debts to the IMF itself; the money never even leaves Washington. And the U.S. is insisting that Russia's central bank improve the way it manages its foreign-currency reserves and submit to regular external audits.

"Going forward, it will be as important as ever that we remain hardheaded and clear-eyed, and ensure that any support that is provided for Russia is used for its intended purpose and for that purpose alone," Mr. Summers will testify.

Russian officials had hoped the next installment of that loan, \$640 million, would pass the IMF board by the end of this month. But IMF staffers complain of slow response on an auditor's report on certain central-bank operations. Now, approval

may be pushed back several weeks or longer, although Russian officials hope for quicker action.

Mr. Summers also plans to preview the administration's money-laundering strategy, which he and Attorney General Janet Reno will announce in full Thursday. The administration will, among other steps, call for legislation to apply U.S. money-laundering laws to arms traffickers and corrupt foreign officials, who under current law can legally hide their money in U.S. banks. The plan also would require money transmitters, broker-dealers and casinos to file suspicious-activity reports now required of banks.

After Mr. Summers, the panel will question academic experts, as well as former U.S. and Russian intelligence agents. Tomorrow, top executives from Bank of New York and Republic New York Corp.'s Republic National Bank of New York unit will testify, along with Assistant Attorney General James Robinson and a member of Russia's parliament.

Today's hearing is unlikely to produce any startling revelations about the money-laundering probe. Congressional aides, for instance, say they have no solid evidence that last year's \$1.8 billion IMF loan installment to Russia was stolen, despite vague allegations in the Russian and Western media. But one worry is that the politicized atmosphere makes it difficult for the U.S. to stick to a coherent and sound stance toward Moscow, just as it makes it tough for presidential candidates to embrace a policy of engaging Russia.

"It's going to make it virtually impossible for any candidate, Republican or Democrat, to make any sort of constructive approach toward U.S.-Russian relations," Clifford G. Gaddy, a Brookings Institution economist, said.