



DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C. 20220

**INFORMATION**

July 9, 1999

## MEMORANDUM FOR SECRETARY SUMMERS

FROM: Mark McClellan *MM*  
Deputy Assistant Secretary (Economic Policy)

SUBJECT: **Reaction to Medicare Plan, and Next Steps**

As you requested, this memo reports on the initial reaction to the Administration plan and its implications for Medicare strategy. On this page, I review the likely legislative developments and decisions you need to make about your involvement in this process going forward. The remainder of the memo describes reaction, focusing on the issues that will need to be resolved in order to reach a Medicare deal.

### Legislative Process on Medicare

- Breaux and Thomas are unlikely to release a bill based on their "bipartisan" proposal anytime soon. They are happy to wait to see how criticism of the President's plan plays out.
- It is likely that Senate Finance will mark up a Medicare reform bill, but not before September at the earliest. Sen. Roth has said that he wants a Medicare reform bill, and Sen. Lott appears willing to let such a "bipartisan" bill get through Committee.
- Rep. Thomas and the House Republicans may do their own bill, but they are more likely to follow the Senate Finance lead.
- Senate Finance will continue their series of hearings on Medicare reform. As you know, Secretary Shalala and Director Lew are tentatively scheduled to appear during the week of July 19. They will be followed by GAO Director Walker, who is likely to testify again that the President's proposed surplus transfer will reduce pressure for further reform to limit Medicare's costs. The hearings are likely to focus on: (1) the high cost and questionable need for a universal Medicare drug benefit; and (2) the lack of any limits on rising general-revenue spending on Medicare in the President's proposal. More on these issues below.

## **Your Involvement**

- You need to decide next week whether you want to participate as an Administration witness in the first Senate Finance hearing on the Administration plan. You have not been invited to participate. You also need to decide whether and how actively to "reach out" to Senate Finance members on Medicare.

*Cons:* Moynihan's staff director (David Podoff) advises against participating in the first hearing. It is likely to feature some harsh criticisms from Sens. Breaux, Kerrey, and the Republicans of the Administration's drug benefit and the absence of proposals to constrain general revenue spending on Medicare. Sen. Moynihan would like you to avoid an unpleasant situation on your first visit as Secretary.

*Pros:* Could help establish your leadership on Medicare, and make a constructive start to the process of reaching a Medicare deal. You are likely to have more credibility with Senate Finance members than any other Administration representative.

- As opportunities arise inside and outside the Administration, it would be helpful for you to encourage technical/staff discussions to begin resolving outstanding issues, to push our competition proposal (which is carrying some weight with moderates), and to explore ways to resolve the remaining difficult issues described below.

## **Reaction to President's Plan from Democrats and Advocacy Groups on the Left**

In general, reaction has been very positive. For example, Kennedy, Gephardt, Stark, and others have strongly endorsed the plan. The principal criticisms from Democrats have been: (1) more should be done to address the current problems of low provider payments caused by the Balanced Budget Act; and (2) the BBA "extenders" would be too painful for some providers, such as teaching hospitals. *Our responses:* (1) we want to work with Congress to address problems with the BBA, and have set aside a "pot" to do so; and (2) our BBA "extenders" are a carefully considered and significantly more modest package, and one that protects vulnerable providers - for comparison, CBO's 10-year scoring of BBA savings was over \$350B; our "extenders" will save only an additional \$39B over 10 (on top of the existing BBA reductions).

## **Reaction from Blue Dogs, Breaux-Thomas, Republicans, and Advocacy Groups on the Right**

The remainder of the memo describes the five major areas where further work and compromise will be necessary in order to reach a Medicare deal. For additional background, I have attached the Progressive Policy Institute's "analysis" of the President's plan; as you know, this group is close to Sen. Breaux. They have three major concerns. Rep. Thomas and some Republicans have two additional major criticisms.

## Likely Breaux/Senate Finance Criticisms

*1. The drug benefit is too expensive and poorly targeted.* The specific criticisms (and our likely responses) include:

- Almost two-thirds of beneficiaries have coverage now, so a universal benefit is not needed. We should provide a comprehensive benefit for low-income beneficiaries only, not a relatively bad and costly benefit for all beneficiaries.

### *Responses:*

- Much of the existing coverage is already paid for by the government -- including Medicaid (15% of the 65%) or Medicare managed care plans (10%).
- Much of the existing coverage is low-quality and deteriorating. Most managed care drug benefits are capped at a low level (\$1000/year), and a declining number of plans are offering them. And Medigap coverage -- the only private option available now for all beneficiaries -- provides a very costly, capped drug benefit that few beneficiaries purchase.
- Thus, even though the President's plan is not comprehensive, it is significantly better than the coverage many have now -- and provides more secure insurance for those who are appropriately worried about losing their existing coverage.
- The President's plan also provides comprehensive drug coverage for low-income beneficiaries (with some support up to 150% of poverty).
- But a benefit for those with low incomes does not help the many better-off beneficiaries who do not have insurance. About 40% of beneficiaries without drug coverage have incomes over 200% of poverty. Nearly 30% of those with incomes over 300% of poverty do not have coverage. Very few beneficiaries are wealthy enough not to worry at all about drug costs: less than 5% have incomes over \$100,000.
- Drug insurance for the elderly today is much like hospital and doctor insurance was for the elderly in the 1960s, when Medicare was created. Much of the coverage available today has low spending limits, and is very costly. A fundamental principle of Medicare is that the most equitable and efficient way to provide basic health insurance benefits is to guarantee a basic benefit for all those who are entitled.

- The President's proposal would "crowd out" private dollars going to good drug benefits, and replace them with government dollars going to worse drug benefits.

*Responses:*

- There are two types of private coverage: individual "Medigap" insurance (8% of beneficiaries) and employer-provided coverage (30%).
- Individual Medigap coverage is usually a very costly, limited benefit: a typical plan costs close to \$100/month, and provides only \$1250/year in benefits (due to adverse selection). Beneficiaries who want Medigap could continue to buy it to supplement the basic Medicare benefit.
- Employer-provided coverage has historically been good, but it too is deteriorating. The share of medium and large employers offering coverage has declined by over 20% in the past 5 years, and most experts, employers, and unions expect this decline to accelerate.
- The President's plan makes it easier for both managed care plans and employers to continue offering coverage, by providing new partial subsidies for it rather than "crowding it out." Far from weakening private drug coverage, the President's plan gives it much-needed support.

*Compromise?* It will be difficult. Democrats are only likely to support a benefit that is universal and adequate (i.e., not much less generous than what we proposed). The proposals for coverage of low-income beneficiaries supported by Republicans and Breaux cost only around \$60B over 10, about half as much as our plan. For now, our best strategy is to make a strong case for the universal benefit. It is possible that a compromise could include an additional payfor, such as an income-related premium (which Breaux has supported), that would bring the net cost down to a "compromise" range of \$90B. This solution would also address the critique that we are "subsidizing Ross Perot's drug benefits."

***2. The President's proposal does nothing to improve the long-run fiscal status of Medicare, in fact it worsens it and also creates a false sense of security that further reforms will not be needed to keep the program's costs under control.*** As you know, 75% of Medicare Part B (and 50% of our proposed Part D) are financed by general revenue. Because Part B is the fastest-growing part of Medicare, the share of Medicare spending from general revenues is projected to increase from 37% today to over 45% by 2015. Our proposal increases general revenue financing. Thus, by claiming to extend Part A solvency to 2027 or further based on revenue transfers that have not yet materialized, we distract attention from the steadily-rising overall cost of the program.

Breaux/Thomas have advocated a Unified Medicare Trust Fund in which general revenue transfers to Medicare would be limited by formula. In particular, they have proposed that general revenue transfers be limited to 40% of overall program costs - a level that will be reached within 5 years under current law, because Part B spending is growing much more rapidly than Part A. Then, when this Trust Fund is approaching exhaustion (which would happen sooner than the Part A Trust Fund), a "Congressional and national debate" about further Medicare reforms would be triggered. They are very vague about what this would be. But their view is that such a Trust Fund would impose stronger and more accurate pressure to encourage reform to limit Medicare costs. HHS and Core Democrats are opposed to any explicit limit on current-law general revenue transfers.

*Responses:*

- The President has proposed real Medicare reforms, and is open to a bipartisan dialogue about further reforms. But even if all of these reforms are enacted - including those proposed by Breaux-Thomas that many in Congress do not support - the simple fact is that Medicare will need additional financing to remain viable for the Baby Boom.
- The Breaux-Thomas proposal would extend Medicare solvency by only a few years, and much of this extension is due to accounting gimmicks (e.g., moving payments to teaching hospitals out of the Part A Trust Fund) or unacceptable benefit cuts (e.g., raising the eligibility age). In contrast, the President's proposal includes real reforms and surplus transfers that extend solvency by 12 years. This is a more fiscally responsible approach to meeting our obligations in a reformed, modernized Medicare program.
- A "national dialogue" under the gun of insolvency is not likely to lead to credible or responsible program reforms. The time to reform Medicare is now, when a financial crisis is not immediate.

*Compromise?* This is an area where a creative solution may be possible. Breaux/Thomas' main goal is to keep on the pressure for reforming Medicare to limit costs in the future, even though they do not have any particularly effective proposals for doing that today. Thus, they may be open to:

- Something like a "debt ceiling" for Medicare, in which a Congressional vote would be required to increase general revenue financing, or to block an increase in general revenue financing, above a certain percentage of program costs (e.g., 40%, 42%, 44%, etc.). This would provide a relatively soft limit, as it is likely to get even harder in the future to vote against meeting Medicare obligations.

- Alternatively, legislation could require that, whenever we move within 5-10 years of insolvency of the Unified Trust Fund, a bipartisan commission be appointed to make reform recommendations that would be voted up or down by Congress; if voted down, the general revenue transfers would be increased to restore longer-term solvency.

**3. An independent Medicare Board is essential, to allow Medicare benefits to be modernized and managed more efficiently than HCFA can do it, and to eliminate the conflict of interest that HCFA now has between running the traditional program and managing its private-plan competitors.** Breaux/Thomas have proposed an independent Medicare Board to administer competition and benefits for Medicare. While they have been vague on details, their goal is to give the Board two kinds of authorities: (1) ability to change Medicare benefits, and possibly Medicare payment rules, which now require Congressional legislation; and (2) ability to manage competition between traditional Medicare and private plans, which now is done by HCFA. HCFA's role would be limited to managing the traditional program. Underlying their proposal is a strong distaste for the "regulation-intensive" way that they think HCFA and HHS run Medicare. HHS and HCFA strongly oppose any changes that would reduce their authority.

*Responses:*

- HCFA does not now have the authority or structure in place to manage Medicare as effectively as it could. The President's plan, like the President's budget proposal, includes many management reforms that would enable HCFA to do so.
- A "Medicare Board" would create a duplicative bureaucracy, and would interfere with the ability of HCFA, HHS, and the executive branch to manage the Medicare program effectively.

*Compromise?* HCFA and HHS will never support an independent Medicare Board, and the Administration is not in a position to propose a compromise in this area. The following features would make an outside proposal easier to live with in a final deal:

- President appoints Board management.
- Board housed as independent office within HHS, analogous to IRS or Criminal Division at DOJ.
- Board has "accounting firm"-like functions, not policymaking, limited to areas where clear conflict of interest exists for HCFA as manager of traditional Medicare (e.g., providing measures of plan quality to beneficiaries; auditing competing plans; managing the annual plan choice process).

## **Additional Republican Concerns/Criticisms**

**4. *The President's competitive reform proposal isn't real competition; it exempts the traditional program.*** As you know, the expert and press reaction to our competitive proposal has been largely positive. Also, groups close to Breaux such as the Progressive Policy Institute have given it at least lukewarm support - they applaud the President for supporting competition, but they think that their proposal which achieves more savings is better for the long run. However, some Republicans including Thomas as well as the managed-care industry are continuing to claim publicly that this is not real competition since traditional Medicare is protected. They may also be concerned that providing a drug benefit to all beneficiaries will reduce interest in managed care plans, which can now use drug coverage as an enticement out of traditional Medicare.

### *Responses:*

- Our proposal is real price competition: if private plans can deliver Medicare's benefits at lower cost or higher quality than the traditional program, then our proposal provides just as much encouragement as Breaux-Thomas for beneficiaries to join private plans.
- The key difference is that we maintain an affordable "safety net" of the traditional program. As we implement a fundamental change in competition in Medicare, we need to be sure that beneficiaries will not be made worse off.
- It is true that we retain a 4% "discount" in payments to managed-care plans, like that in current law to share in the benefits of the greater efficiency of private plans. As we have said, we would reduce or eliminate this discount as savings from competition permit.
- Our proposal gives managed care plans a new, explicit subsidy for better drug coverage than most plans provide today. Thus, even with the drug benefit and additional benefits that they may choose to purchase, beneficiaries' total premiums will be lower in managed care.

*Compromise?* Our preliminary discussions with Senate Finance, Breaux staff, and PPI suggest that they are willing to adopt our approach to competition, perhaps with some qualification that the Breaux-Thomas approach would be revisited after experience with the new system shows that more efficient private plans can provide adequate care for Medicare beneficiaries. However, we still need to work hard to sell our competitive proposal to moderates, conservatives, and the managed-care industry.

**5. *The Balanced Budget Act has imposed excessive payment cuts on Medicare providers already, threatening beneficiaries' quality of care. It is irresponsible and unrealistic to propose funding a drug benefit by extending such excessive policies for 7 more years (2003-2009).*** Even though the Breaux-Thomas Commission report and Senate Finance Dems have

previously supported even more stringent versions of BBA "extenders" than we proposed, Rep. Thomas and many Republicans are now saying they are opposed to any BBA extension. This will help them get support from provider groups.

*Responses:*

- For many years, it has been standard practice to increase payments to providers by a rate somewhat lower than the rate of health care price inflation. This reflects the fact that the price indices generally do not reflect efficiency gains in delivering medical care over time, and so tend to overstate increases in the actual cost of providing care. For example, over the past 15 years, the updates for hospital payments have averaged 1.7 percentage points less than measured hospital cost inflation.
- The Administration's proposal is far more modest than the Balanced Budget Act and previous limitations on provider payment growth. Many providers - for example, nursing homes and outpatient departments - are completely exempt. And virtually all of the "extenders" are significantly less stringent than in the BBA. Whereas the BBA was scored as leading to over \$350B in savings over 10 years, our "extenders" were scored as leading to less than \$40B over 10 years.

*Compromise?* Even though the new Republican position puts us in a more difficult position of defending some politically unpopular provider "cuts," we should have support from Senate Finance and hopefully Breaux in doing so. We need these additional savings to fund the drug benefit.

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The Secretary of the Treasury

July 12, 1999

NOTE TO MARK McCLELLAN

FROM: Larry Summers

Good memo.

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Page 2; Your involvement; My guess is round of calls not testimony.

EXECUTIVE SECRETARIAT CORRESPONDENCE MEMO COVER SHEET

Friday, July 09, 1999

PROFILE #: 1999-SE-007478

DATE CREATED: 07/09/1999

ADDRESSEE: Lawrence H. Summers  
Secretary

AUTHOR: McClellan  
DAS, Economic Policy

SUBJECT: Reaction to Medicare Plan, and Next Steps

ABSTRACT: Reaction to Medicare Plan, and Next Steps

RM 3419

TO REVIEWERS

TO EXECUTIVE SECRETARY

IN:

IN:

TO THE SECRETARY

DATE SIGNED:

DISTRIBUTION: AS, ECONOMIC POLICY

DI to LS (READING) 7/9/99

cc: SS

TS  
Mart: Thomas

DI electronic cc: to lhs grp.



DEPARTMENT OF THE TREASURY  
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July 29, 1999

**MEMORANDUM FOR SECRETARY SUMMERS  
DEPUTY SECRETARY EIZENSTAT**

**FROM:** Mark McClellan *MM*  
**SUBJECT:** Current Status of Medicare Debate

This memo summarizes recent developments in the Medicare debate and provides a guide to the Administration's recent public documents on Medicare reform, which have focused on the need for a universal drug benefit in Medicare. The recent event highlighting the obstacles facing the President's Medicare reform plan was testimony before Senate Finance last Thursday, 7/22. At the testimony, Secretary Shalala defended the Administration plan against sharp criticism on many topics, especially on the cost and wisdom of a universal drug benefit and on traditional Medicare somehow being "exempt" from competition under the reform proposal. She was followed by Comptroller Walker and Director Crippen, both of whom were critical of the Administration's cost estimates and the fiscal implications of the proposal. This memo reviews the major criticisms raised, the Administration's responses so far, and possible further developments. Tab A includes a critical summary of the Finance Committee hearing by Phil Ellis, which includes a Senator-by-Senator review of questions raised about the President's proposal.

**Criticisms of the President's Drug Benefit Proposal**

*Costly.* Director Crippen's presentation at last week's hearing illustrates the cost-related criticisms of the President's proposal. CBO estimates that the President's drug benefit would cost \$168B over 10 years, not \$118B as estimated by the HCFA Actuaries. There were three main reasons for the differences:

- Higher rate of increase in drug spending: This accounts for the bulk of the differences in the estimates. The Actuaries have recently revised upward their expected growth rate for drug costs in the in-years, based on high growth rates in pharmaceutical costs in the recent past. However, the Actuaries assume that this rate moderates after several years; CBO assumes that it remains rapid for a longer time.
- Inclusion of drug costs for nursing home residents. The Actuaries assumed that nursing home residents would receive all of their drugs through their institution, and generally would stop participating in the Part D benefit. CBO assumes that these individuals will have significant Part D expenditures, though it is difficult to see how since institutionalized individuals cannot take pharmacy-purchased drugs.

- Higher Medicaid costs, due to increased take-up of Medicaid by those eligible for some support for Medicare premiums and cost-sharing. The idea is that a free drug benefit would be an added incentive to get full or limited Medicaid support for the large share of elderly below 150% of poverty who are eligible for it.

**Administration Response.** Essentially, we are standing by the estimates of the independent HCFA Actuaries, who have historically been very conservative in their cost estimates. For example, actual Medicare costs under the Balanced Budget Act have been significantly lower than the Actuaries' projections.

- It seems unlikely that institutionalized Medicare beneficiaries would have any significant outpatient drug costs; their drugs are paid for through existing payments to the nursing homes. CBO's different assumptions about more rapid growth in drug costs and a greater increase in Medicaid takeup are not unreasonable.
- Criticisms of costs resulting from increased Medicaid takeup is really a non-issue; since both Republicans and Democrats support full coverage for those up to 150% of poverty. Thus, CBO will also presumably score the Breaux-Thomas proposal as equally more costly for low-income beneficiaries.
- There is a question of whether the drug benefit creates a significant unfunded mandate on states, who must pay some of the Medicaid costs. The Actuaries concluded that the states would come out about even: savings from Medicare paying for drugs for those currently on Medicaid would offset new costs for those who take up Medicaid support for the Medicare benefit. In contrast CBO concluded that states would face about \$12B in additional costs over 10 years, and pointed out that even under the Actuaries' estimates, some states (e.g., New York and California) were winners while others (e.g., Texas and Florida) were losers. The issue of addressing state concerns about an "unfunded mandate" seems like one that can be resolved through the political process.

**Tab B** is the Q&As on the controversy over the cost of the drug benefit and other elements of the President's reform plan.

**Poorly Targeted, Poorly Designed Benefit.** As you know, the proposal has also been heavily criticized for "crowding out" existing coverage, as over 60% of beneficiaries currently have some drug coverage, and for providing little protection for beneficiaries who need it the most. Republicans and Sen. Breaux are advocating a comprehensive benefit for beneficiaries below 150% of poverty – essentially replicating the President's proposal for comprehensive coverage of low-income seniors.

**Administration Responses.** The Administration's primary message now and for the August recess is that a universal drug benefit for Medicare is essential. There are 2 main arguments for this:

- Relatively few seniors have good coverage. Only around 25% (and declining) have good private drug coverage from a former employer. Another 10%-15% have good public coverage through Medicaid and other state drug programs for low-income beneficiaries. The rest of the coverage is not very good. Around 10% of beneficiaries purchase drug coverage through individual "Medigap" plans. But these plans have capped benefits (the most common plan has a cap of \$1,250 in government payments), and premiums are very high (on average, over \$1,000 per year for the \$1,250 benefit). Perhaps 15% of beneficiaries have coverage through a Medicare managed care plan (largely paid for through the current government payments to managed care plans). But an increasing share of managed care plans that offer drug coverage are capping their benefits at a low level (under \$1,000).
- It is not possible to "target" a drug benefit well. For example, the drug benefit for those below 150% of poverty endorsed by Senator Breaux and the Republicans would cover less than half of the beneficiaries who do not have coverage now. Even at the highest income levels, over 300% of poverty, almost 30% of beneficiaries are uninsured.

The President's plan includes a Treasury proposal to support employers who continue offering coverage, by providing a subsidy for them equal to two-thirds of the cost of the Medicare benefit. This plus the existing tax subsidy for employer coverage is viewed by CBO, the HCFA Actuaries, and many industry groups as providing an adequate incentive for most employers to continue coverage, rather than "wrapping around" the Medicare benefit. The partial subsidy also helps reduce the cost of the drug benefit.

On policy grounds, it is hard to argue for the Administration's capped benefit over a catastrophic benefit. However, from a practical standpoint, few beneficiaries would be willing to buy a catastrophic benefit that is no more expensive than the President's proposal.

Tab C is a recent Administration study and accompanying summary talking points on the inadequacy of existing prescription drug coverage for the elderly, and the great need for a drug benefit for all Medicare beneficiaries.

### **Criticisms of the President's Competition Proposal**

*Erroneous Criticism.* Senator Breaux, some other conservative Democrats, and many Republicans are erroneously criticizing the Treasury-developed Competitive Defined Benefit proposal as a "second cousin" to real competition in Medicare, because the traditional program is "exempted" or protected from competition because its premium cannot increase.

Competitive reform - in which private plans and traditional Medicare would compete on price and quality to attract beneficiaries - is the centerpiece of the Breaux-Thomas proposal. Under the Breaux-Thomas "premium support" proposal, the government contributes an amount toward the cost of a plan that is based on the average cost of all plans. Beneficiaries who choose a plan that is more expensive than average pay the full additional cost; those choosing a plan that is less expensive get most of the savings. Because most people expect the government fee-for-

service plan to be more costly than average, this means that beneficiary premiums for the government plan will be higher than under current law. This feature of the Breaux plan led to virulent opposition from core Democrats.

The President's proposal features similar price competition, in that beneficiaries who choose plans that are less expensive than the government plan get most of the savings. Unlike the Breaux plan, the President's plan does not increase the beneficiary premium for traditional Medicare. Instead, beneficiaries pay a lower premium for less expensive private plans. The President's base proposal does retain a 4% "discount" in payments to private plans that is in current law. Thus, it is a legitimate criticism to say that we do not go "all the way" to "full" competition, at least initially. The reason is that an increase in payments to plans could increase Medicare costs, if few more beneficiaries choose to enroll in private plans compared to current law. We do propose to reduce or eliminate the 4% discount as savings from competition permit, i.e., as more beneficiaries enroll in less costly private plans.

**Tab D** is a set of talking points we prepared for the White House that defends our competition proposal as real competition, and that presents supporting arguments from outside validators on this issue.

**Treasury Leadership Needed.** Secretary Shalala made our arguments in support of our competitive proposal at the Senate Finance hearing. But defending our competitive plan is not her comparative advantage, and she does not have a high level of credibility on the Hill on private sector competition. After the criticism in the hearing and after Gene Sperling was recently misquoted as saying that the Administration opposes competition in Medicare, the White House agrees with us that explaining our competitive reform plan must be a high priority in selling the Medicare proposal. They hope to work with Treasury in the days ahead to set up appropriate forums for presenting our competitive proposal. This is an area where the Secretary and Deputy Secretary could play a leading role.

### **Criticisms of the Fiscal Responsibility of the President's Proposal**

**"Sham" Improvement in Fiscal Status.** Republicans, GAO, and Senator Breaux have also been criticizing the President's proposal for creating a misleading sense of financial security about Medicare. Breaux describes the surplus transfers as "nothing real, nothing but putting IOU's in the Trust Fund that are going to mean higher taxes later." GAO Comptroller Walker has repeatedly argued that the surplus transfers into the Hospital Insurance Trust Fund inappropriately reduces pressure for real reform. Republicans are particularly annoyed that we are claiming to secure Medicare while in fact increasing its general revenue liabilities, as a result of a drug benefit that is not fully paid for.

**Administration Response, Treasury Leadership.** We have proposed "real" reforms that reduce costs and extend solvency, and we are open to further discussion of reasonable reform proposals that could extend solvency further. For example, Secretary Shalala reiterated the President's willingness to support an income-related premium, and Senators Breaux, Chafee, and others agreed. (An income-related premium has been adopted by the Finance Committee in past

sessions.) But we have also emphasized that, even with all of the reforms that have been proposed, Medicare needs additional financing in order to remain solvent for the Baby Boom. For example, the Medicare Commission proposals would have extended solvency by only four years, and this included unacceptable proposals (e.g., increase in retirement age without an affordable "buy-in" option) and cost-shifting proposals (e.g., moving DSH payments to hospitals out of the Part A Trust Fund). Thus, we should work together to implement real Medicare reforms, but then we need to recognize that additional funding will surely be needed to meet our Medicare obligations.

Treasury leadership is needed in advocating the idea of implementing real reform plus taking the additional steps needed to secure the program by buying down debt. Treasury involvement in this issue now may also be helpful down the road, when we may need to negotiate with the Republicans and moderate Democrats about moving to a unified Medicare Trust Fund, as they have advocated.

### **Balanced Budget Act "Fixes" for Providers**

Provider groups continue to lobby for "fixes" to the reductions in payment updates in the Balanced Budget Act, which will bite even harder in the coming fiscal year. Though this issue did not come up much in Secretary Shalala's hearing, Senate Finance has reportedly been working on a \$20 billion set of fixes, in contrast to our proposed \$7.5 billion "pot". House Ways and Means Republicans are also working on a "fix" bill. This will remain a core issue in the weeks ahead, and our \$7.5 billion is now being viewed as the low end of the policy debate.

## Tab A: Senate Finance Hearing on the President's Plan, July 22

### Summary

Secretary Shalala faced tough questioning from the Senate Finance Committee about the Administration's Medicare proposal, particularly on the grounds that the drug benefit should be targeted to lower-income seniors instead of being universal, and that the plan exempts traditional Medicare from competition. While she was generally effective in putting forward the Administration's arguments, the panel appeared to remain quite skeptical. The most forceful opposition naturally came from committee Republicans, but Democrats who did not take issue with the plan's main elements generally chose to focus on their lower-level concerns rather than helping to rebut the larger charges. CBO Director Crippen and Comptroller General Walker followed with their own critiques – including CBO's estimate that the drug benefit would cost \$50 billion more over 10 years than the Administration had projected – but did not offer much in the way of alternatives. Senator Roth indicated that the Committee would take up Medicare reform legislation in September. No mention was made of Secretary Summers.

### Shalala Testimony and Q&A

Secretary Shalala briefly summarized her prepared statement, which was drawn primarily from previously released documents describing the plan. She focused particular attention on the case for a universal drug benefit, arguing that existing drug coverage is limited and eroding and that access to it (via a managed care plan) often depends on where a beneficiary lives. She also noted that the majority of those lacking coverage are above 150% of poverty and thus would not be helped by proposals to target the benefit at lower-income seniors. Senator Rockefeller made the only substantive opening remarks – and his statement that the President's plan took the best of the what the Medicare Commission did while taking out its "risky" elements was about the most positive statement made all afternoon. Highlights of the Q&A are as follows:

- **Chairman Roth** said he couldn't see how the proposal constituted "genuine competition" since managed care plans would receive capitated payments but fee-for-service (FFS) costs were not constrained. He also asked about the Progressive Policy Institute's critiques of the plan: that there should be a Medicare board to oversee competition, that the drug benefit should be targeted at lower-income seniors, and that there should be some constraints on general revenue financing. Shalala responded that managed care plans would compete with FFS because they could offer lower premiums; that the oversight bureaucracy shouldn't be split or given over to a private sector board (perhaps leaving open the possibility of a separate entity within HHS); and that Congress provides a check on how much general revenues are used in the program.
- **Senator Moynihan** asked about support for teaching hospitals and was concerned that the proposal didn't go far enough to protect this "most important element" of the health care system. Shalala's response noted both the \$7.5 billion set aside to address problems caused by the BBA cuts and the proposal to "carve out" disproportionate share payments from managed care reimbursements and provide them directly to hospitals.

- **Senator Grassley** focused his comments on the subsidy payments for employer drug coverage, questioning whether this was the best use of tax dollars and whether the proposed universal benefit would cause employers to drop this coverage. Shalala's response emphasized that the Administration did not want to introduce a highly centralized program, but rather would help stop the erosion of coverage from existing sources – employers and managed care plans. She also stressed that the decision to provide universal coverage was primarily one of good health policy and not a financing decision (though she later noted that the proposed benefit was kept “modest” in order to control its out-year costs).
- **Senator Graham's** comments focused on the competitive pricing demonstrations that HCFA had been authorized to undertake, including one in Florida, and indicated support for the expansions of this approach proposed in the Administration's plan. He also noted that the demonstration of managed care competition in Kansas City and Phoenix had been quietly axed in the Committee's tax bill. Shalala responded that price competition both within fee-for-service and between FFS and managed care was the only way to control costs effectively, but did not take the opportunity to point out that the new competition proposal improved on the KC/Phoenix demonstration by having managed care plans compete with fee-for-service, not just with each other.
- **Senator Nickles** criticized the drug benefit and surplus transfer proposals. In particular he argued that many would not find the drug benefit attractive, and that it was absurd to subsidize employers to keep them doing what they are doing. Shalala argued that you had to look at the insurance it provided over a lifetime – that you might not get many benefits when young but would know affordable coverage would be when you got older – and that the 50 percent subsidy was just enough to get virtually everyone to enroll. As for the surplus transfers, she argued that the alternative Part A cut would have to be 20%, and asked who had a plan that would yield savings of that magnitude.
- **Senator Rockefeller** argued that the drug benefit plan he and others had proposed was preferable because it provided catastrophic protection, and asked what the basis of the 7.5 billion in BBA give-backs was and whether it was enough. Shalala reiterated the case for the drug proposal, stressing that it started from the Medicare Commission proposal (to go to 150% of poverty) and then went further. She also noted the administrative actions being taken to moderate BBA effects, over and above the \$7.5 billion.
- **Senator Gramm** had perhaps the most pointed remarks, calling this a “phony proposal” that was “about as disingenuous as you can get.” In particular he charged that making the drug benefit universal was a political move, not one based on the merits, and that giving HCFA more negotiating authority would just lead to monopoly abuses and price controls. He also charged that the Administration had “no idea what competition is” and argued for going back to the Breaux proposal. Shalala's response noted that the Medicare Commission had proposed the same authorities for HCFA, and again made the case that this constituted competition between managed care and fee-for-service. She thought that

if she could discuss it further with the Senator she might “soften him up,” but Gramm replied “I don’t think so.”

- **Senator Jeffords** was concerned that the drug benefit did not start until 2002 and noted his proposal to start earlier for low-income seniors. He also asked about the billing system for home health services.
- **Senator Chaffee** said he supported adding a drug benefit and even using part of the surplus for it – as long as other serious reforms were adopted. In particular he focused on means-testing; he also said the argument that a drug benefit would save the rest of the program money in the long run did not hold up. Shalala raised concerns about means-testing particular benefits, but noted that the President was open to income-relating Part B premiums. She also made clear she was not arguing that the drug benefit would have offsetting savings because she didn’t want to oversell the proposal.
- **Senator Breaux** said he also supported adding a drug benefit but complained that the Administration’s proposal was not means-tested, did not provide catastrophic coverage, and had no drug deductible. Noting the CBO estimates on how many beneficiaries would exceed the proposed benefit caps, he argued that a better proposal could be constructed at the same cost. He also criticized the competition plan as putting a fence around fee-for-service, and argued that the meagerness of the competitive element was shown by the fact that lab co-pays generated more total savings. Shalala’s rapid-fire response stressed the “positive economic incentive” to switch to a managed care plan, vice the higher fee-for-service premiums under the Breaux plan (which generated much of the savings).
- **Senator Bryan** thought the drug proposal would go over well in rural Nevada, noted that Congress often “worships at the alter of competition” but then does an “el foldo” when HCFA actually tries to bring it to their district, and wondered what effect the drug proposal might have on previously negotiated collective bargaining agreements.
- **Senator Baucus** asked if implementation of the BBA blended payment system (which raises payments to managed care plans) could be accelerated, and asked whether solvency to 2027 was “enough” of an improvement and if other steps proposed in Breaux-Thomas were too much. Shalala did not respond directly, but suggested the Administration would work with Congress provided they could agree on certain fundamentals, e.g., that savings were not enough to extend solvency and thus new revenues were required.
- **Senator Mack** noted the large discrepancy in CBO and Administration cost estimates, and was concerned about explosive cost growth in the out-years. He suggested starting off with a low-income benefit before jumping to the full bore proposal. Shalala responded that she was confident in the Administration’s cost estimates, and said that they wouldn’t have put forward this proposal if they thought its costs would spin out of control.
- **Senator Robb** thought the proposal was a good first step but did not constitute full

systemic reform. Asked if there were any additional steps she would propose to meet Medicare's long-term challenges, Shalala mentioned only the need to adequately fund HCFA administrative costs.

- **Senator Kerrey** was present for the start of the hearing but left before asking questions.

### **GAO and CBO Testimony on the President's Plan**

Comptroller General Walker concluded that this proposal would not help ensure the long-run sustainability of Medicare, and argued that the most pressing issue facing Medicare was the large unfunded liability in the program. Director Crippen noted the main reasons that the CBO estimate of drug costs differed so sharply from the Administration's: differences in the rate of increase in drug spending; the inclusion of drug costs for those in nursing homes; and the increased take-up of Medicaid support for Medicare premiums and cost-sharing that would occur if a free drug benefit were added for those below 135% of poverty. While his prepared remarks contained positive comments about the competition plan, he concluded that basing the system on fee-for-service costs would "blunt the incentives for efficiency." Because this part of the proposal is "extremely complex," with many details "unclear," CBO had not done its own cost estimate -- though he described the modest savings projected by the Administration as reasonable.

In Q&A Walker noted that pressures would build down the road to expand the drug benefit and/or lower its premium (as happened in Part B), yet he suggested hard dollar limits on drug expenditures as a potential remedy. He also argued that the Administration's competition plan would not force fee-for-service to compete, and suggested the Commission's approach as an alternative. Senator Gramm raised concerns both about induced demand for drugs and adverse selection into the program, suggesting many would not find it worthwhile to enroll. He also thought a universal benefit would lead inevitably to price controls. In turn, he argued that this would put pressure on research and development expenditures, reducing drug innovation.

## Tab B: Q&As on the Cost of the President's Medicare Reform Plan

**Q: CBO testified that the Administration had grossly underestimated the cost of the new prescription drug benefit in the President's Medicare reform proposal by as much as \$50 billion. What is your response?**

**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. We stand by our estimates. 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. Because of our history of conservative budget estimates, we are comfortable with our estimates and stand behind them.

**Q: CBO suggests that their estimates of the cost of the prescription drug benefit are based on new information supplied by HCFA. What are the specific reasons why you think their estimates are inaccurate?**

**A:** First of all, we don't believe that the motivations and professionalism of CBO's career staff should be called into question. Having said this, we do not agree with a number of the assumptions included in the current CBO estimate presented to the Finance Committee.

Specifically, CBO only assumes about \$4 billion (compared to \$25 billion) in savings for the Administration's proposal to provide new market based purchasing tools for Medicare to use within the fee-for-service program. CBO Director Crippen indicated the Administration proposal had great potential to achieve significant savings. However, CBO scored our proposal to achieve less than 20 percent of our projected savings because it made an assumption that the Congress would never give the Medicare program this authority. We believe that is not a policy driven conclusion.

In addition, their drug cost assumptions are higher than any projections that the Health Care Financing Administration (HCFA) has produced. While CBO has suggested that their numbers are based on HCFA's projections, the early year cost forecasts exceed any estimate the Administration has produced.

**Q: The President keeps saying that CBO is less accurate than the Administration's forecasting. Can you give an example of when the Congressional Budget Office was less accurate in a Medicare estimate than the Medicare actuary and more conservative than actual experience?**

**A:** In 1997, when Congress and the Administration were working on the most significant changes to the Medicare program since its enactment in 1965, the Medicare actuary projected that the Medicare savings package would achieve more savings than CBO did.

As it turned out, the baseline spending for the Medicare program was billions of dollars less than the projections of either CBO or the Administration. As such, the Medicare actuary's projection was more accurate than the CBO estimate but significantly more conservative than actual experience.

**Q: Why do you believe your prescription drug estimates and your overall Medicare savings projections are accurate?**

**A:** The independent career actuary worked extremely hard to ensure that his drug cost estimates were as accurate and as realistic as possible. In fact, in many cases, we would argue that he was extremely conservative. For example, the actuary's office assumed that utilization would actually double as a result of the new drug benefit, an assumption which exceeds most analysts' expectations and projections. In addition, our estimates did not include savings associated with the reduced hospitalizations which would be the result of the provision and correct utilization of prescription drugs.

**PRESIDENT CLINTON:  
HIGHLIGHTING THE NEED FOR A MEDICARE PRESCRIPTION DRUG BENEFIT  
July 22, 1999**

*"According to this report, 75% of older Americans lack decent, dependable, private-sector coverage of prescription drugs. That's three out of every four seniors. To those who think prescription drug coverage isn't a problem for most Medicare beneficiaries, I say, think again."*

President Bill Clinton  
July 22, 1999

Today, in Lansing, Michigan, President Clinton met with community members to discuss the future of the Medicare program. At the meeting, the President released a new report detailing the inadequate and unstable nature of prescription drug coverage currently available to Medicare beneficiaries. The President underscored the importance of seizing this historic opportunity to strengthen and modernize Medicare for the next quarter century.

**New Report Shows the Need for a Medicare Prescription Drug Benefit.** The President released a new report today entitled, "Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage." Key findings of the report include:

- ✓ Three out of four Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs.
  - \* Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage.
  - \* Over three-fourths of beneficiaries have no coverage, inadequate Medigap coverage, or public coverage for prescription drugs. At least one-third of Medicare beneficiaries have no drug coverage at all.
- ✓ Private trends indicate a decline in coverage and affordability.
  - \* The number of firms offering retiree health coverage has declined by 25 percent in the last four years.
  - \* Medigap premiums for drugs are high and increase with age.
- ✓ Public trends show that managed care benefits are being reduced, and Medicaid participation is low.
  - \* The value of Medicare managed care drug benefits is declining, due to a trend by plans to severely limit benefits through low caps.
  - \* Participation by those eligible for Medicaid remains low, raising serious questions about the advisability of using the Medicaid program to provide coverage for a population at higher income levels.
- ✓ Millions of beneficiaries have no drug coverage.
  - \* At least 13 million Medicare beneficiaries have no prescription drug coverage.
  - \* More than half of Medicare beneficiaries without drug coverage are middle class. This means that if a plan is adopted that limits prescription drug coverage to below 150 percent of poverty, as some in Congress are proposing, the vast majority of the Medicare population will be left unprotected.
- ✓ Prescription drug coverage makes sense.
  - \* Prescription drugs are an integral part of modern medicine, serving as complements to medical procedures, substitutes for surgery, and tools for managing chronic diseases.
  - \* Medicare beneficiaries are particularly reliant on prescription drugs. Not only do the elderly and people

with disabilities have more health problems, but these problems tend to be the type that respond to drug therapy.

- \* Studies have shown that being uninsured leads to inadequate use of necessary medications, which can result in increased costs and unnecessary institutionalization.

**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

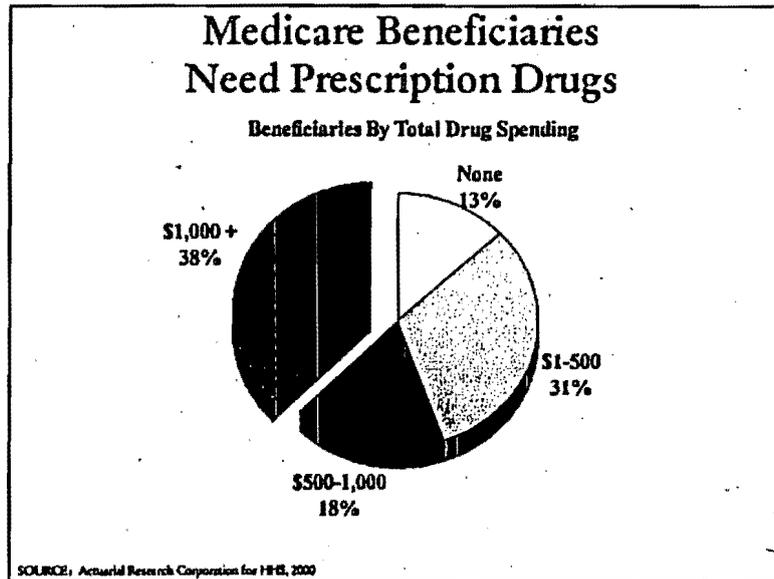
- Part of modern medicine. Prescription drugs serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> 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 acute myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.<sup>5</sup> 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.<sup>6</sup>
  - Adult-Onset Diabetes: About 1 in 10 elderly have Type I or II diabetes.<sup>7</sup> 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.<sup>8</sup> Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.<sup>9</sup> 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, bronchodilators) when their Medicaid drug coverage was limited.<sup>10</sup> Many elderly must choose between prescriptions and other basic household needs.<sup>11</sup>
  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.<sup>12</sup>
  - 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.<sup>13</sup>

## PREScription DRUG SPENDING BY MEDICARE BENEFICIARIES

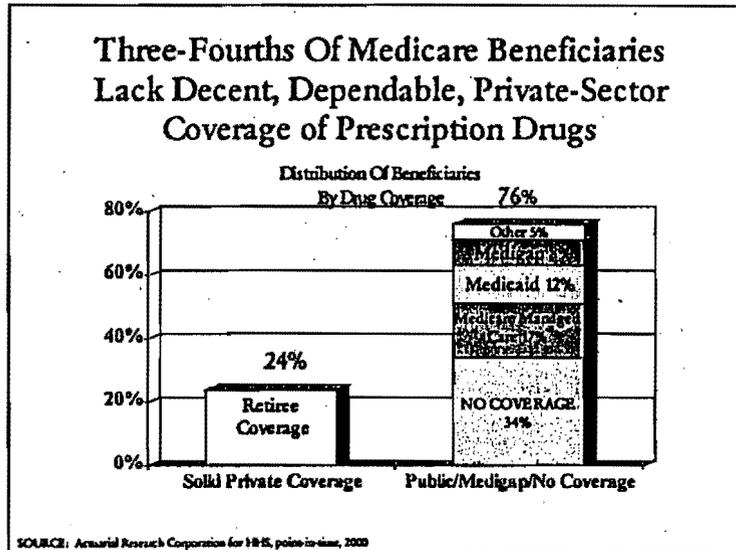
- Because of their greater need, the elderly and people with disabilities have greater health care costs. The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug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

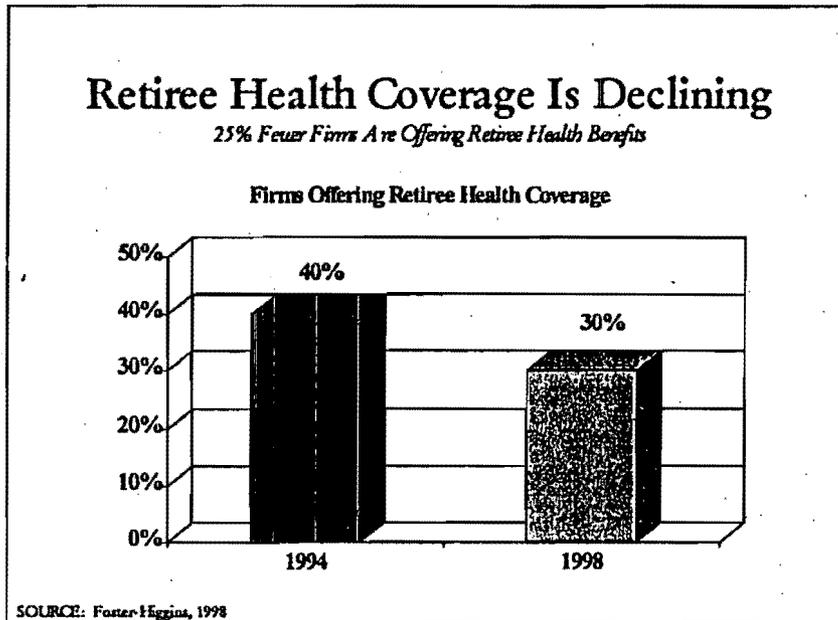
- Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs. As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.



- 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.



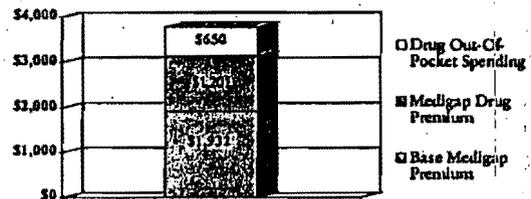
- Firms offering retiree health coverage have declined by 25 percent in the last four years.<sup>14</sup> Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage.
  - The decline was more pronounced among the largest employers (greater 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.<sup>15</sup>

## 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.

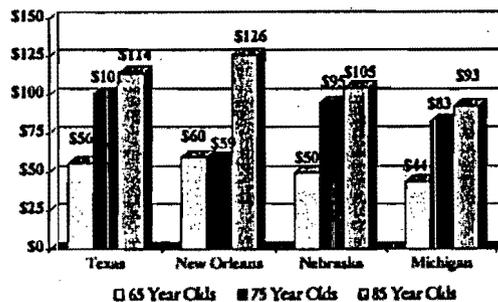
### Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

Medigap Annual Premiums And Out-Of-Pocket Spending



SOURCE: Annual Research Corporation for I.D.B. Premium from Texas for a 75 year old. Base is \$141 per month; drug addition is \$191 per month.

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



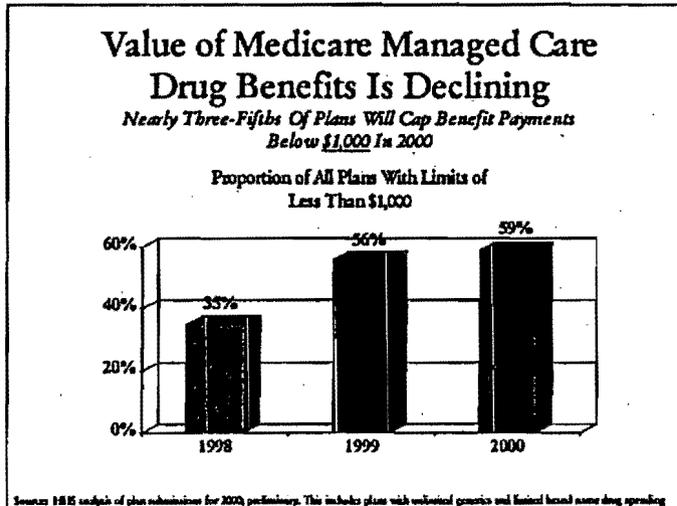
Sample Premiums for 1999. Difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2001, when the President's proposed drug benefit will cost \$19 per month.

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.

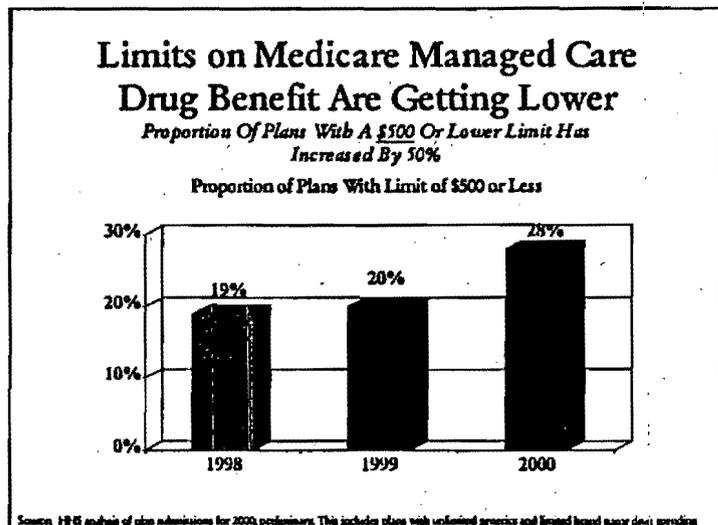
Costs increase with age as well as health inflation. This "attained age" pricing practice causes excessive premiums for those who need it most – the very old. It also disproportionately affects women since they comprise nearly three-fourths of people over age 85.

## 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.

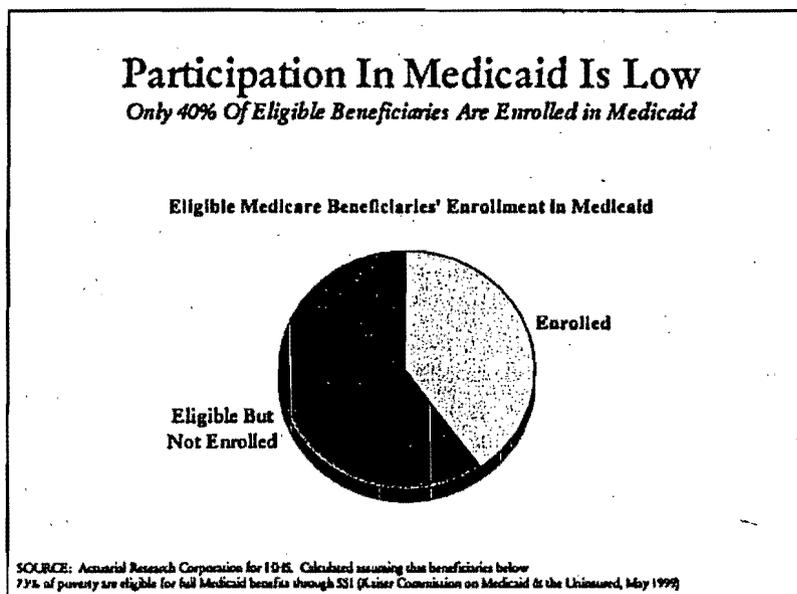


- The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below \$1,000 in the year 2000. The proportion of plans with \$500 or lower benefit caps will increase by over 50 percent between 1998 and 2000. This 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 50,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.



## MEDICAID

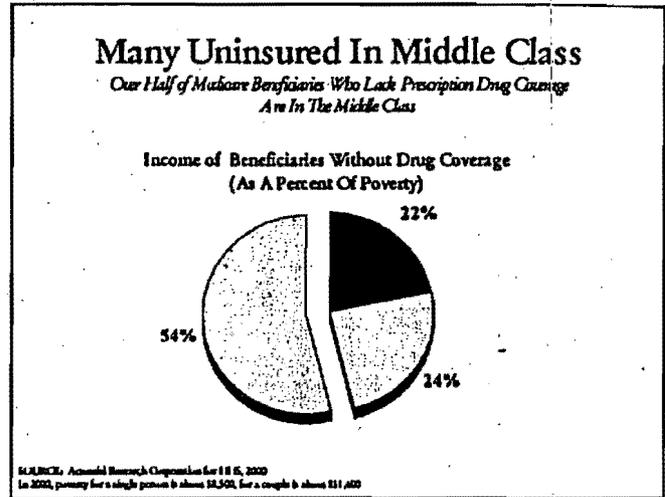
- About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit. Most of these “dual eligibles” qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- \$6,200 for a single, \$8,300 for 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.



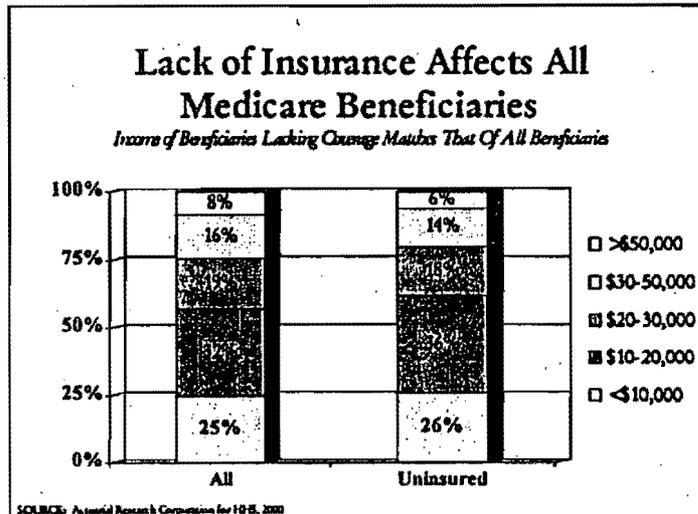
- Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about \$6,000 for a single, \$8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.
  - Lack of information,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

- <sup>1</sup> Hazzard, WR; Blass JP (Editor); Ettinger WH; Halter JB; Ouslander JG. (1998). *Principles of Geriatric Medicine and Gerontology*. New York: McGraw Hill.
- <sup>2</sup> Centers for Disease Control and Prevention, National Center for Health Statistics. (1993). (National High Blood Pressure Education Working Group): Report on primary prevention of hypertension. *Archives of Internal Medicine*. 153: 186.
- <sup>3</sup> Wilson PWF. (1991). Established risk factors and coronary artery disease: The Framingham Study. *American Journal of Hypertension*. 7: 75.
- <sup>4</sup> SHEP Cooperative Research Group. (1991). Prevention of stroke by hypertensive treatment in older patients with isolated systolic hypertension. *JAMA*, 265: 3255-3264.
- <sup>5</sup> Randomized trial of cholesterol lowering in 4444 patients with coronary heart disease: The Scandinavian Simvastatin Survival Study (4S). *Lancet* 1994; 344: 1388-1389.
- <sup>6</sup> The beta-blocker heart attack trial: Beta-Blocker Heart Attack Study Group. *JAMA*. 1981; 246: 2073-2074.
- <sup>7</sup> National Health Interview Survey.
- <sup>8</sup> Tierney LM; McPhee SJ; Papadakis MA (editors). (1998). *Current Medical Diagnosis and Treatment 1998*. Appleton and Lange.
- <sup>9</sup> Tierney LM, et al.; *ibid*.
- <sup>10</sup> Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1987). Payment restrictions for prescription drugs under Medicaid: Effects on therapy, cost and equity. *The New England Journal of Medicine*, 317: 550-556.
- <sup>11</sup> Families USA, 1994.
- <sup>12</sup> Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy L. (1991). Effects of Medicaid drug-payment limits on admissions to hospitals and nursing homes. *The New England Journal of Medicine*, 325: 1072-1077.
- <sup>13</sup> Bero LA; Lipton HL; Bird, JA. (1991). Characterization of Geriatric Drug-Related Hospital Readmissions. *Medical Care*, 29 (10): 989-1003.
- <sup>14</sup> Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.
- <sup>15</sup> 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 D: The President's Plan: Real Competition Without Making Beneficiaries Worse Off

- The Administration's Medicare reform proposal puts the traditional fee-for-service Medicare program and managed care plans into direct, head-to-head competition. It does so by linking the amount that beneficiaries pay for a similarly-priced managed care plan to premium for traditional Medicare.
- Beneficiaries can get lower premiums by choosing a managed care plan that bids less than the cost of care in traditional. This means that plans which are more efficient than the traditional program will be able to attract seniors by lowering their premium payments, perhaps even to \$0 -- from \$45 or more per month currently.
- If the fee-for-service program is not as efficient as private plans, the plans will be able to bid below the cost of fee-for-service and pass most of the savings on to beneficiaries (the government keeps 25% of the savings). This is price competition for the entire program: beneficiaries have a strong new financial incentive to choose private plans that are more efficient. But beneficiaries on fixed incomes are not coerced by increases in Medicare premiums into joining managed-care plans that may not be well-suited to their needs.
- Initially, the President's proposal includes a small (4%) discount that is built into the Balanced Budget Act payments to managed care plans. Simply eliminating this discount would raise government spending and eliminate most of the savings from the plan. The discount in payments to private plans will be reduced and even eliminated as savings from competition occur. If private plans are able to compete effectively by providing attractive benefits at a significantly lower cost, then part of the savings resulting from beneficiaries switching to the more efficient plans would be used to reduce the small private-plan discount.
- Because more competition will increase efficiency and lower costs, it can be implemented in a way that saves money for the Medicare program and for beneficiaries. It is not necessary to increase premiums in the fee-for-service plan in order to create real competition.
- The main difference between the Administration's proposal and some other proposals for competitive reform is that it creates price competition by *lowering* the beneficiary premium for more efficient managed care plans, not by *raising* the premium for beneficiaries in traditional Medicare, many of whom have no good private-plan alternatives.
- This approach reflects the President's objective that savings come only from competition, not from premium increases masquerading as "competitive reform."

## Support for the President's Competitive Defined Benefit Plan

- As *The New York Times* said, those who have criticized the President's plan for not creating direct competition between traditional Medicare and private plans should "take another look... The tournament that Mr. Clinton would set up between the Government's fee-for-service plan and private managed-care plans largely duplicates Mr. Breaux's... Beneficiaries who choose inexpensive plans would pocket 75 percent of the savings; the Treasury would receive the rest... The big difference between the plans is that Mr. Clinton would tie financial rewards and penalties to the cost of the government plan rather than to the cost of the average plan in a region... [This difference] would not muffle competition. Managed-care plans would have plenty of opportunity and incentive to lure enrollees from the high-cost government plan by offering better benefits and steep discounts. (*New York Times*, July 1, 1999, page A14.)
- Economists also agree that the President's plan represents fundamental competitive reform of the Medicare program. For example, Robert Reischauer said of the President's proposal: "The emphasis is on the drug benefit, but the new structure of competition is at least as fundamental." According to the *New York Times*, Mr. Reischauer said that, like Mr. Breaux's proposal, the President's proposal would restructure competition in Medicare at its root. (*New York Times*, July 1, 1999, page A14.)
- Recent testimony by CBO Director Crippen also notes that the President's proposal "would give beneficiaries strong incentives to choose lower-cost plans." He also noted that "if [fee-for-service] costs rose faster than the costs of managed care plans, those plans might be able to offer beneficiaries significant premium discounts relative to the fee-for-service sector." And he pointed out that this is a fundamental reform of the current payment system: "Under current law... even though beneficiaries gain if they enroll in managed care plans that are more efficient than the fee-for-service sector, Medicare does not" because plans can only compete by adding extra, nonstandardized benefits. "Moreover, beneficiaries who might prefer less generous benefits for a lower price do not have that option. The President's plan would remove that bias and allow both beneficiaries and the Medicare program to benefit from less costly choices."
- Editorial support for the President's plan also reflects the fact that the President's plan creates competition effectively. The *New York Times* said that the President's proposal takes a "prudent" approach to changing Medicare's structure: "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... If a plan could provide the same coverage for less money [than traditional Medicare], enrollees would benefit directly from those savings, most likely through discounts off the current \$45.50 monthly Medicare premium." (*New York Times*, June 30, 1999, page A22.) The *Washington Post* called the President's proposal for reforming managed care payments "rather elegant." (*Washington Post*, June 30, 1999, page A30.)

1999-SE-008607



DEPARTMENT OF THE TREASURY

Washington

August 5, 1999

TO: SECRETARY SUMMERS

For your information.

Mark McClellan

Attachment

**PLAN TO STRENGTHEN AND  
MODERNIZE MEDICARE**

**FOR THE 21<sup>st</sup> CENTURY**

*National Economic Council / Domestic Policy Council*

*The White House*

## PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

- Tab 1.      **Overview: Budget Priorities**
- Tab 2.      **Comparison of the President's and Republicans' Priorities**  
Charts on Budget Priorities  
Programmatic Impacts of Republican Tax Cut
- Tab 3.      **President's Medicare Plan**  
Summary of the President's Plan  
*New York Times* Editorial on President's Plan  
Charts on Medicare Plan
- Tab 4.      **Prescription Drug Benefit**  
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- Tab 5.      **Charts**  
Demographic Challenges Facing Medicare and Its Trust Fund  
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Rural Beneficiaries and Prescription Drugs
- Tab 6.      **Breaux-Thomas Medicare Reform Plan**  
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- Tab 7.      **Top-Tier Questions and Answers About Medicare Reform**  
Prescription Drug Benefit  
Importance of Dedicating Part of the Surplus to Medicare  
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Structural Reform

**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 cuts for 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 21<sup>st</sup> which said: "[C]ommitting to a large tax cut would create significant risks to the budget and the economy." And on July 22<sup>nd</sup>, 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 board cuts 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.

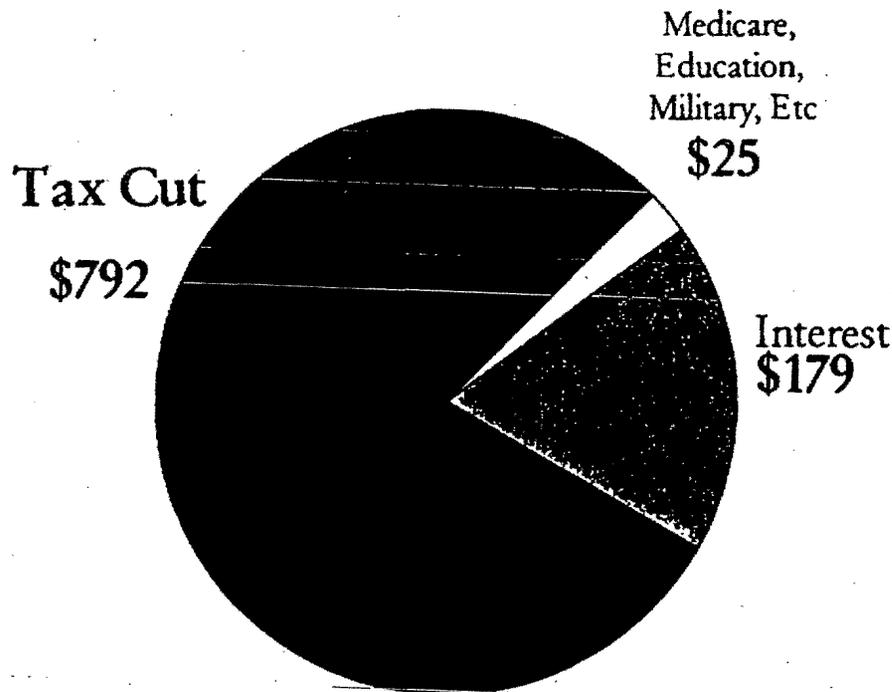
**TAB 2.**

**COMPARISON OF PRESIDENT'S AND  
REPUBLICANS' PRIORITIES**

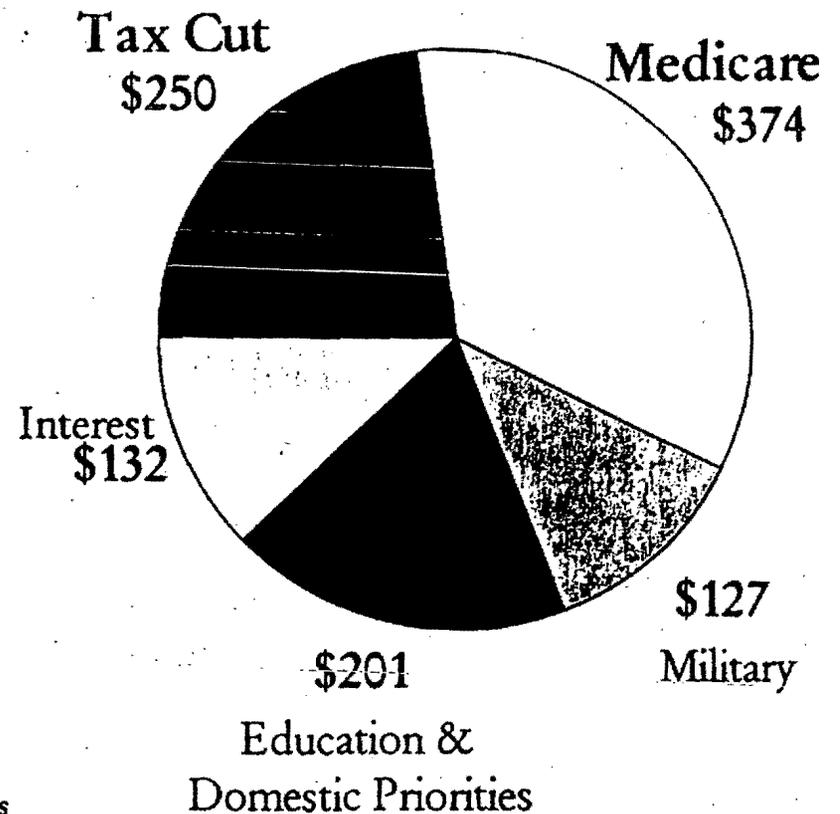
# Plans For The On-Budget Surplus

(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 1,622,000 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 6 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 year

June 30, 1999

# The New York Times

Founded in 1851

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## 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.

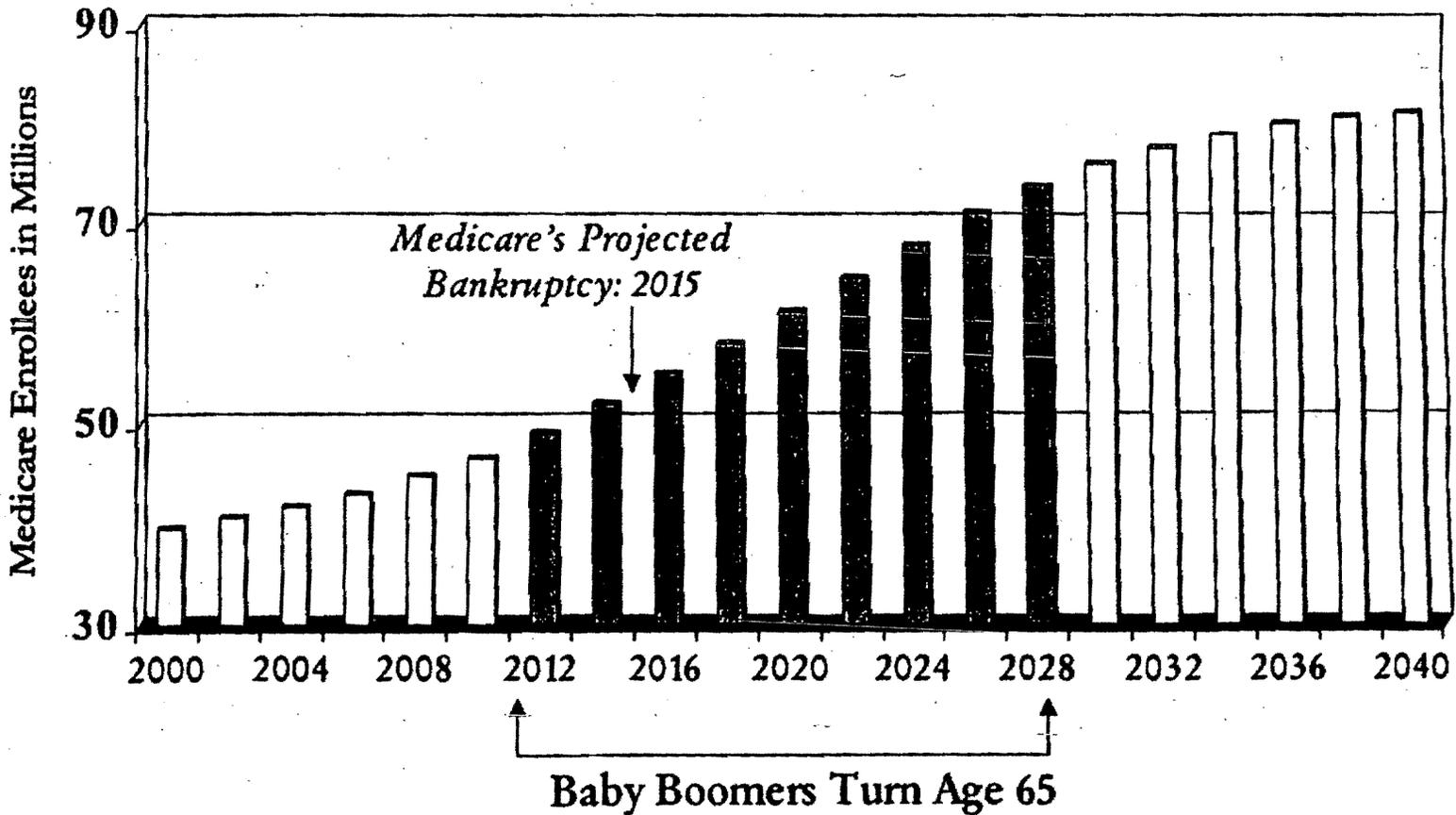
Reforming Medicare requires modernizing the benefits and improving cost controls. The Clinton proposal, made feasible by the surplus, offers some sensible ways to achieve those goals while keeping Medicare a broad-based social insurance program.

**PRESIDENT'S PLAN TO  
MODERNIZE & STRENGTHEN  
MEDICARE**

# Plan To Modernize and Strengthen Medicare

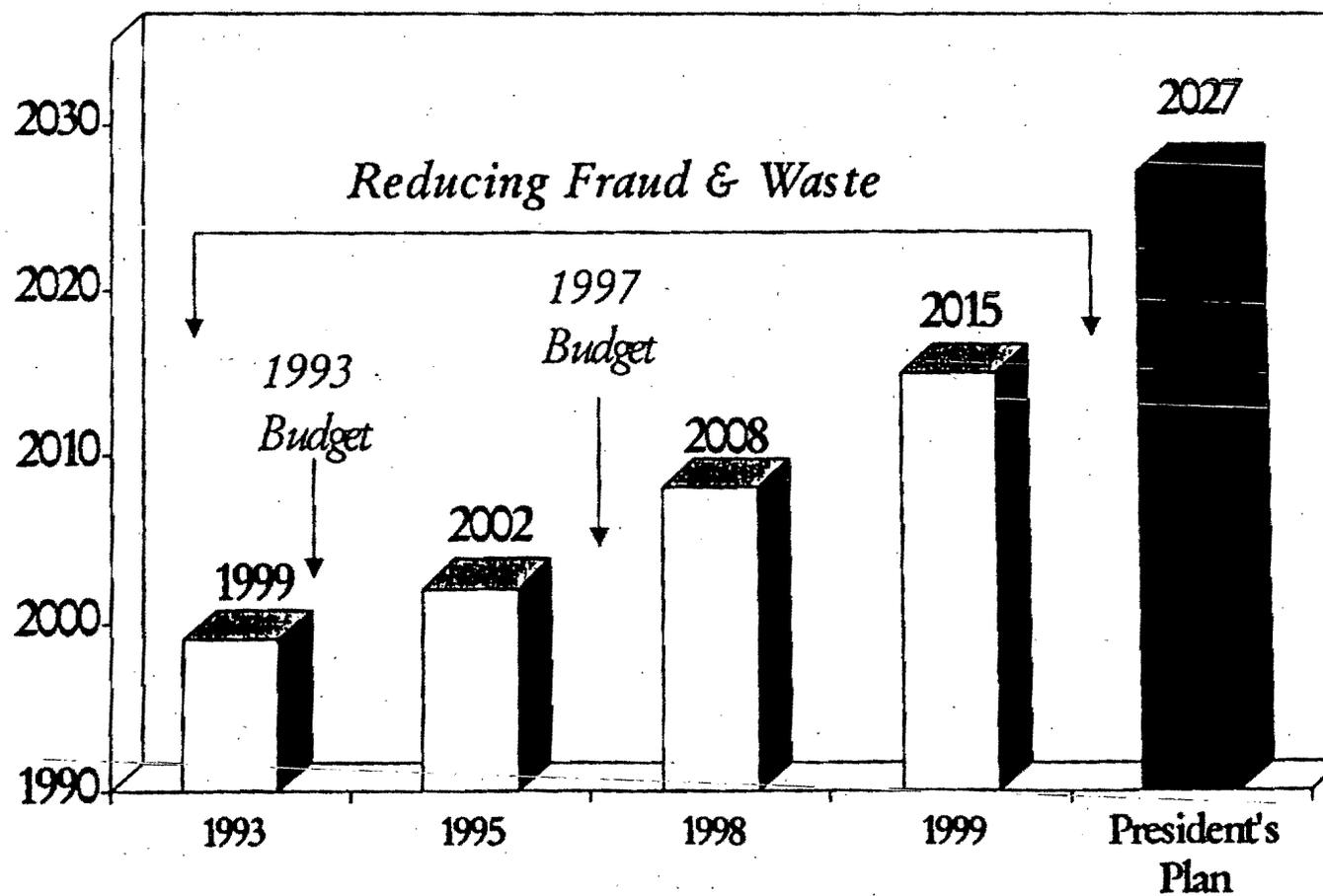
- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Financing for the 21st Century By Dedicating Part of the Surplus to Medicare

# Medicare Enrollment Will Double As The Baby Boom Generation Retires



# Modernizing and Strengthening MEDICARE

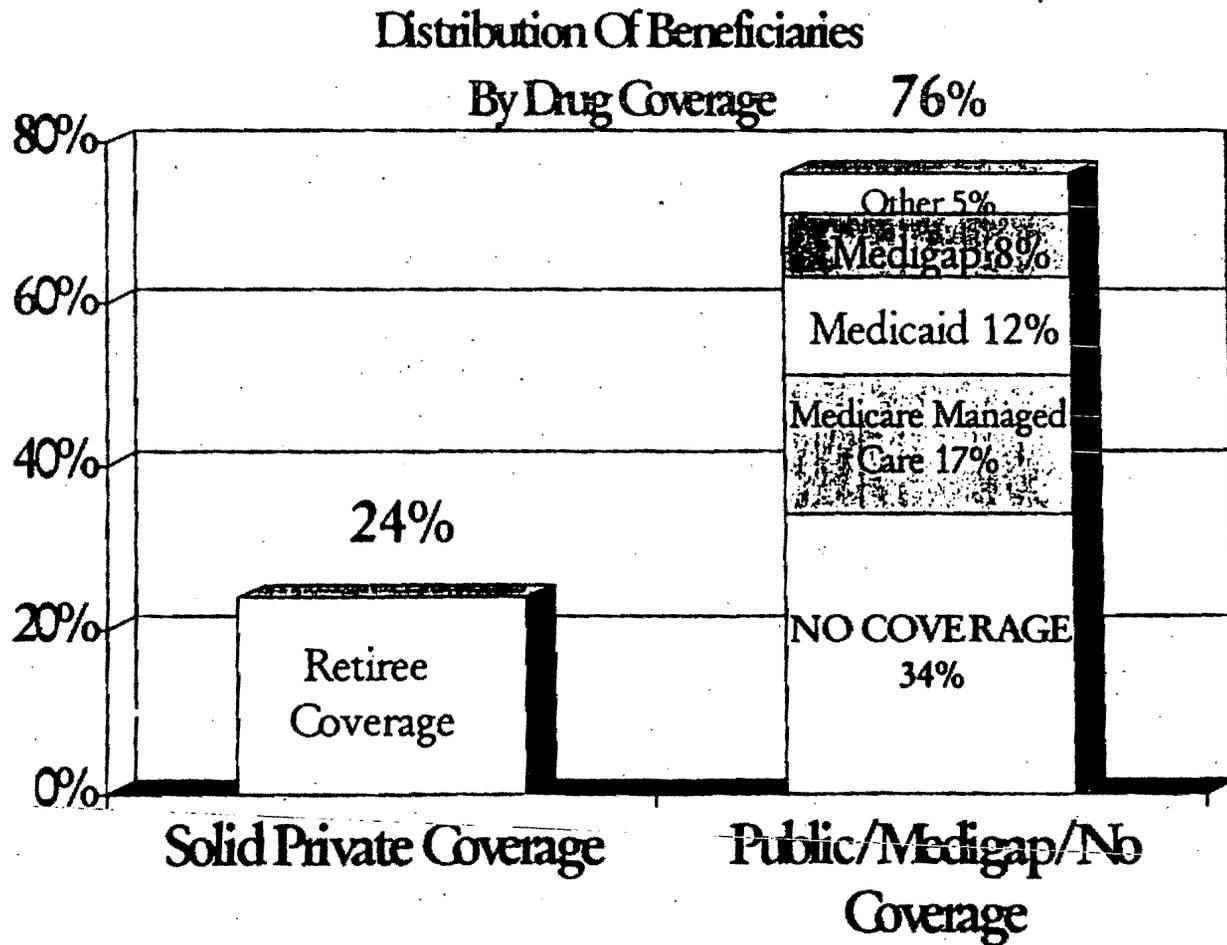
*Extending The Solvency Of Medicare To 2027*



# 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

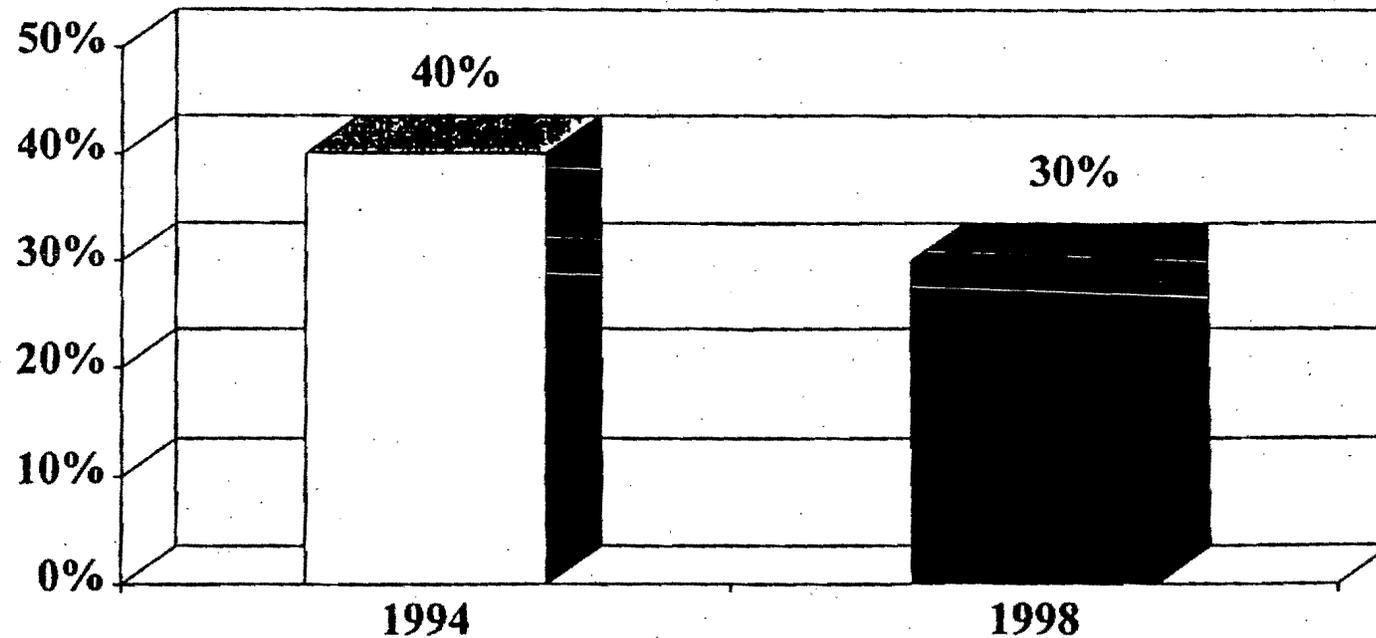
# Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



# Retiree Health Coverage Is Declining

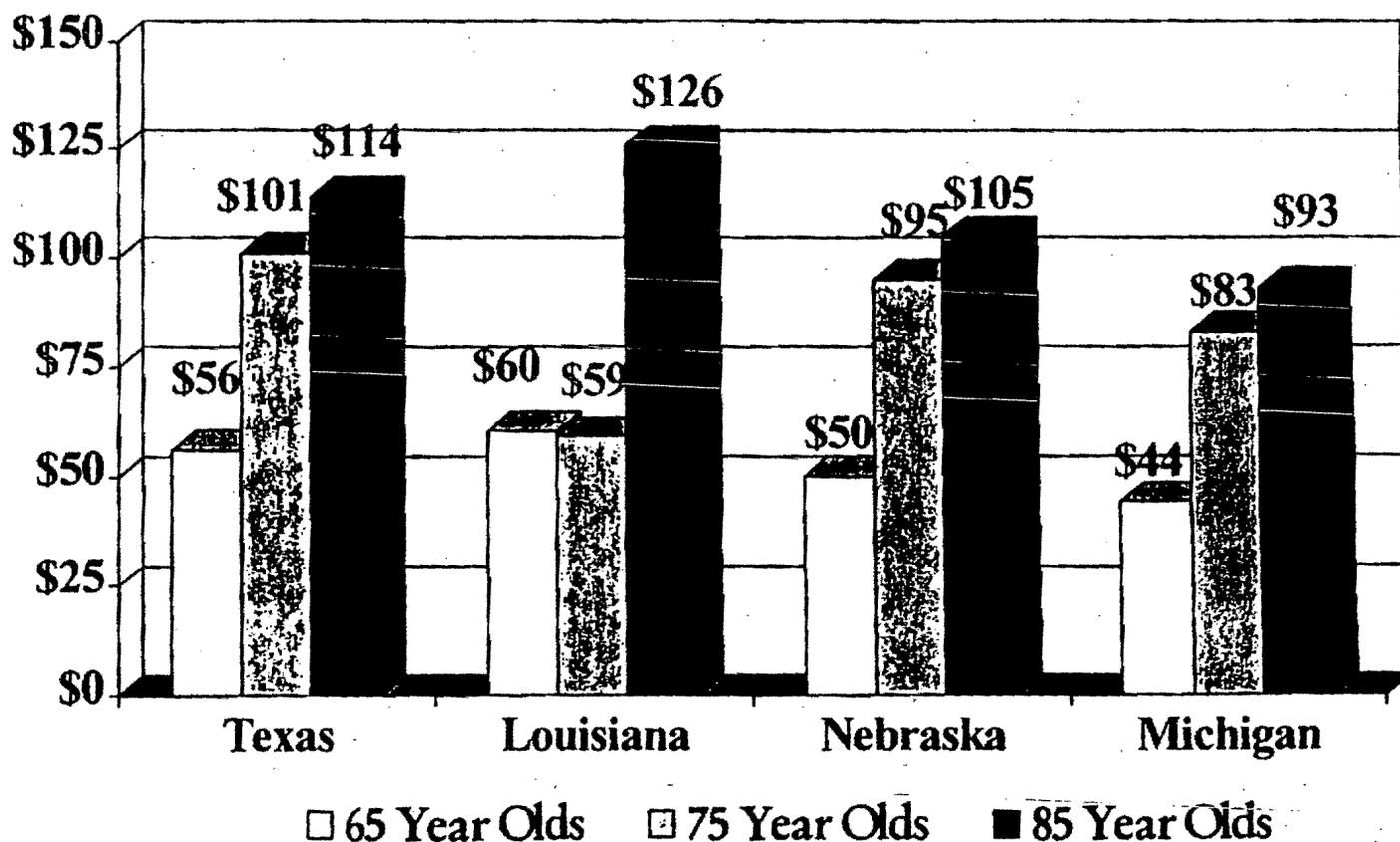
*25% Fewer Firms Are Offering Retiree Health Benefits*

Firms Offering Retiree Health Coverage



SOURCE: Foster-Higgins, 1998

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

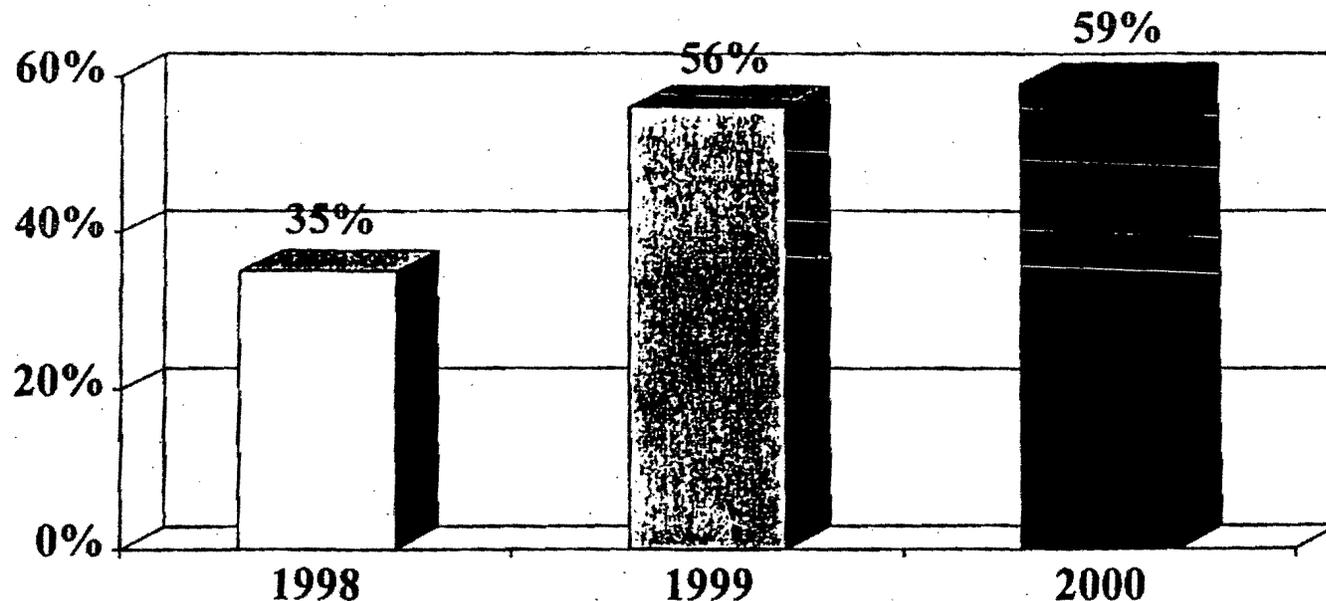


Sample Premiums for 1999. Difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost \$24 per month.

# Value of Medicare Managed Care Drug Benefits Is Declining

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

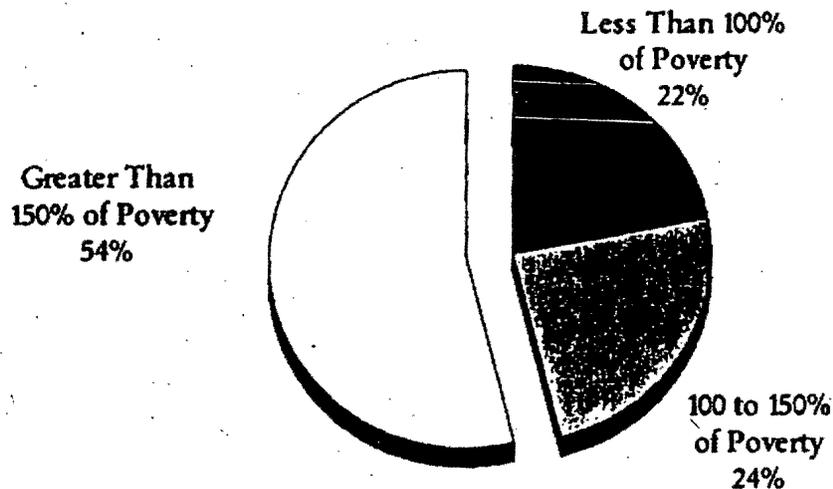
Proportion of All Plans With Limits of  
Less Than \$1,000



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

- No price competition
- Plans compete by offering hard-to-compare benefits
- Over 1 in 4 beneficiaries do not have access to managed care -- or the extra benefits they offer

## Competitive Defined Benefit

- Plans paid based on price and quality
- Plans compete by lowering premium & cost sharing for clearly defined benefits
- 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

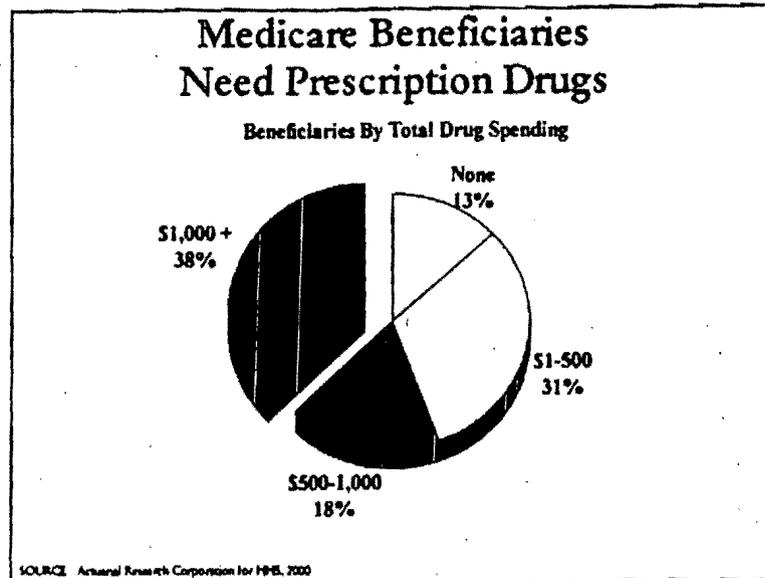
- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures (e.g., anti-coagulants with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4</sup> 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 acute myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.<sup>5</sup> 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.<sup>6</sup>
  - **Adult-Onset Diabetes:** About 1 in 10 elderly have Type I or II diabetes.<sup>7</sup> 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.<sup>8</sup> Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.<sup>9</sup> 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, bronchodilators) when their Medicaid drug coverage was limited.<sup>10</sup> Many elderly must choose between prescriptions and other basic household needs.<sup>11</sup>
  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.<sup>12</sup>
  - 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.<sup>13</sup>

## PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

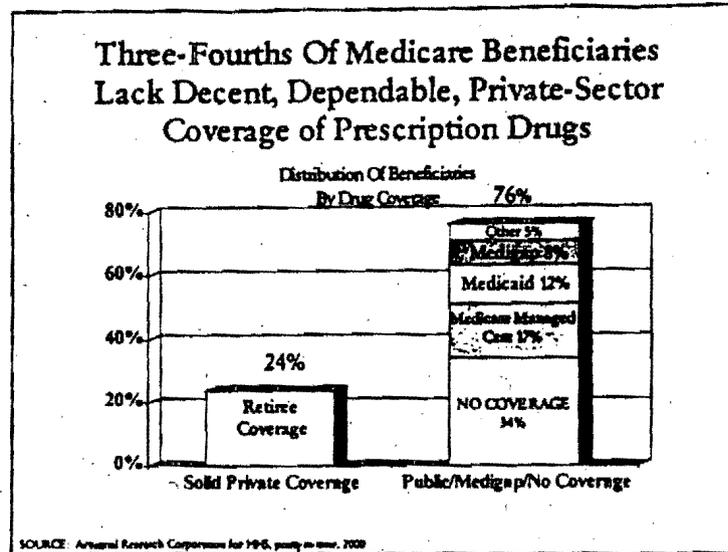
- Because of their greater need, the elderly and people with disabilities have greater health care costs. The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug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

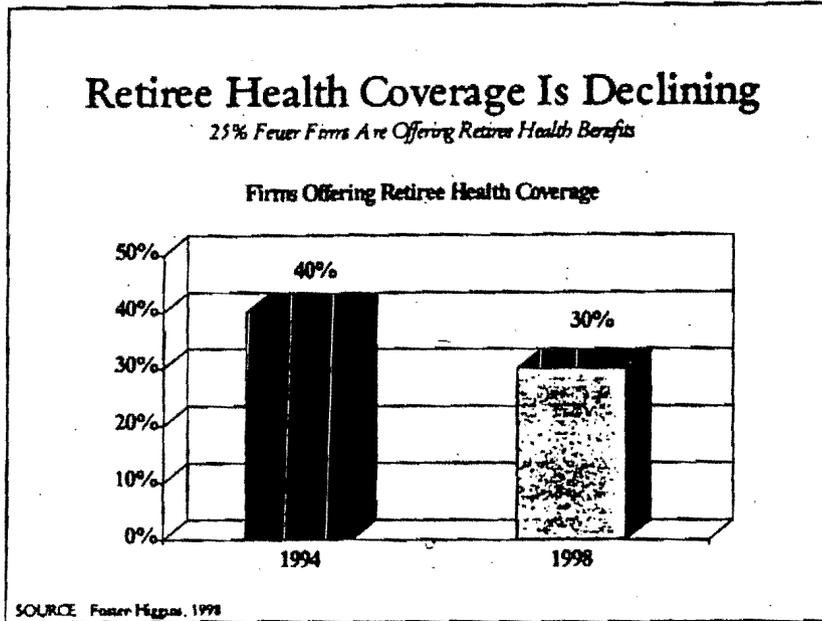
- Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs. As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.



- 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.<sup>14</sup> 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.<sup>15</sup>

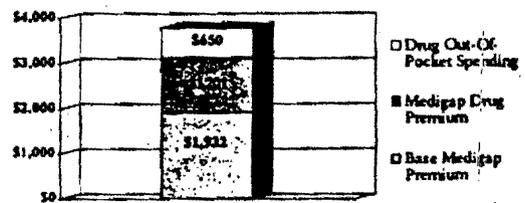
## MEDIGAP PRESCRIPTION DRUG COVERAGE

- 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.

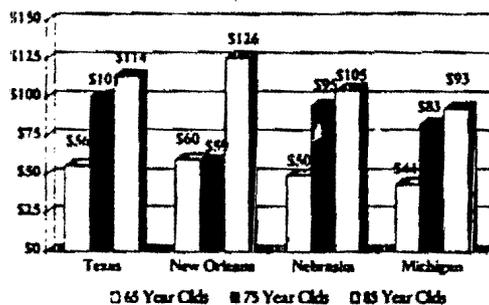
### Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

Medigap Annual Premiums And Out-Of-Pocket Spending



SOURCE: Annual Research Corporation for 1998. Premiums from Texas for a 75 year old. Base is \$141 per month, drug out-of-pocket is \$161 per month.

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



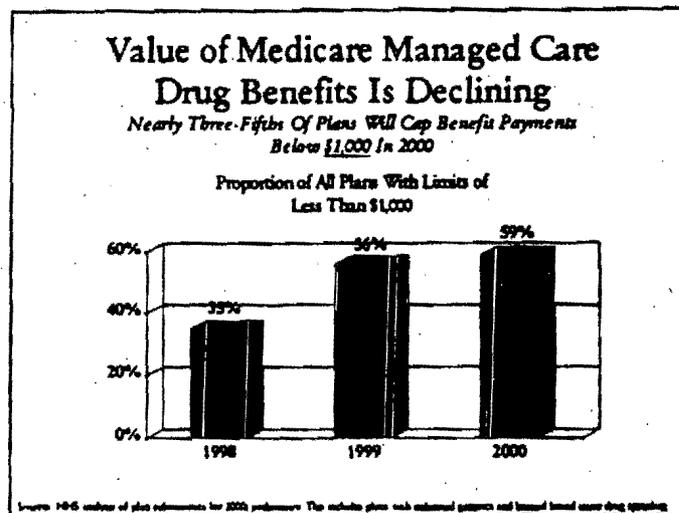
Source: Premiums for 1999. Difference between Plan I (\$1,200 benefit limit) and Plan F (which is similar but has no drug coverage). Their premiums will be higher in 2001, when the President's proposed drug benefit will cost \$24 per month.

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.

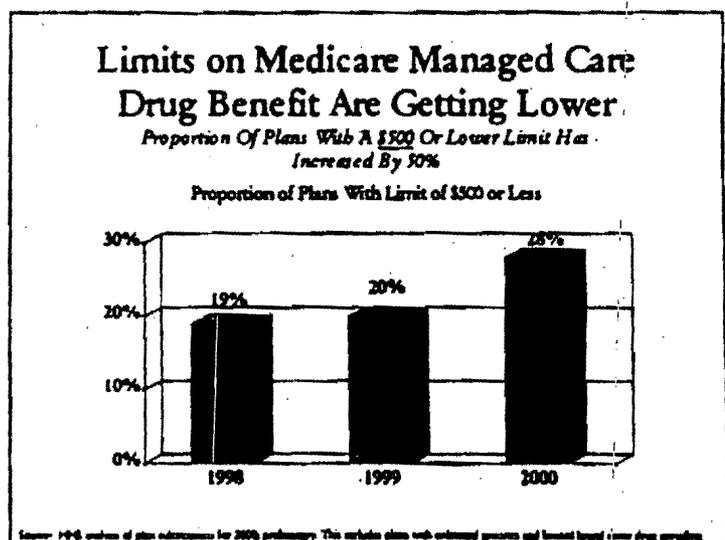
## MEDICARE MANAGED CARE

- 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.



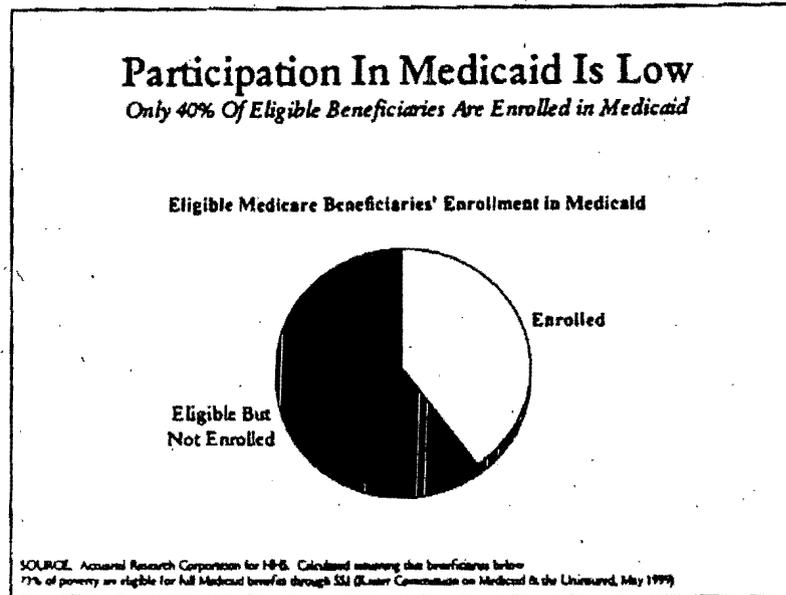
- The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below \$1,000 in the year 2000. The proportion of plans with \$500 or lower benefit caps will increase by over 50 percent between 1998 and 2000. This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

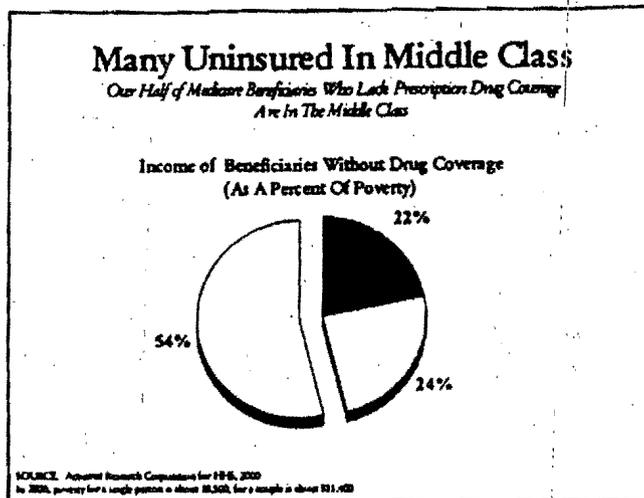
- About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit. Most of these “dual eligibles” qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- \$6,200 for a single, \$8,300 for 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.



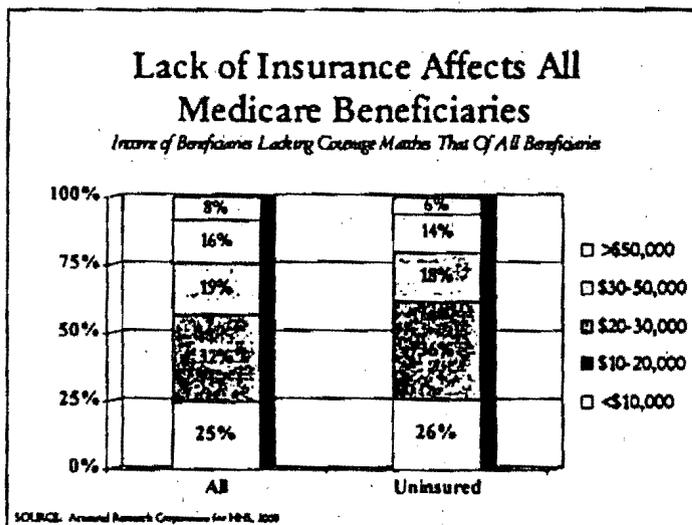
- Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about \$6,000 for a single, \$8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.
  - Lack of information,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

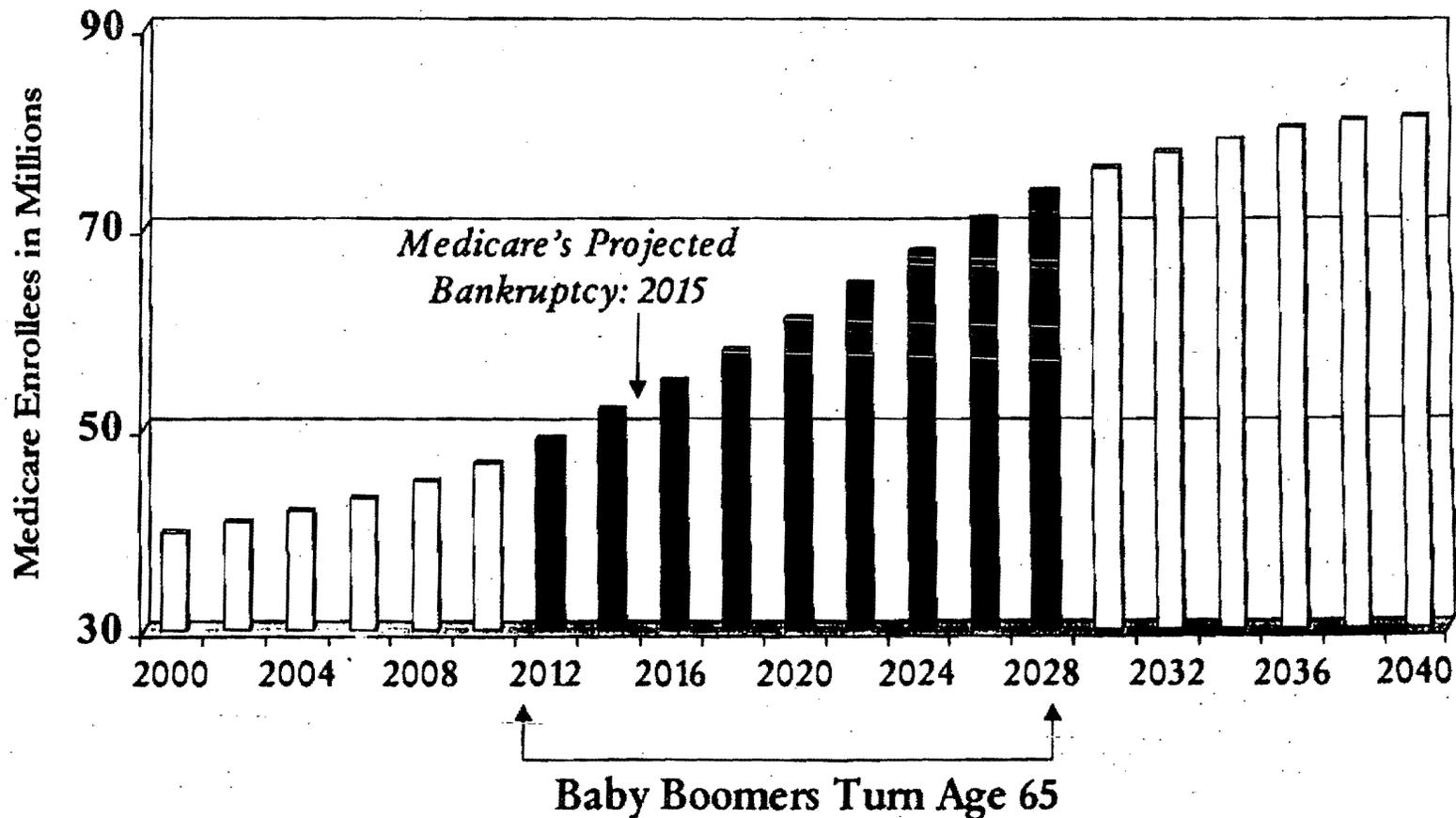
### Endnotes.

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- <sup>1</sup> Hazzard WR; Blass JP (Editor); Ettinger WH; Halter JB; Ouslander JG. (1998). *Principles of Geriatric Medicine and Gerontology*. New York: McGraw Hill.
  - <sup>2</sup> Centers for Disease Control and Prevention, National Center for Health Statistics. (1993). (National High Blood Pressure Education Working Group): Report on primary prevention of hypertension. *Archives of Internal Medicine*. 153: 186.
  - <sup>3</sup> Wilson PWF. (1991). Established risk factors and coronary artery disease: The Framingham Study. *American Journal of Hypertension*. 7: 75.
  - <sup>4</sup> SHEP Cooperative Research Group. (1991). Prevention of stroke by hypertensive treatment in older patients with isolated systolic hypertension. *JAMA*, 265: 3255-3264.
  - <sup>5</sup> Randomized trial of cholesterol lowering in 4444 patients with coronary heart disease: The Scandinavian Simvastatin Survival Study (4S). *Lancet* 1994; 344: 1388-1389.
  - <sup>6</sup> The beta-blocker heart attack trial: Beta-Blocker Heart Attack Study Group. *JAMA*. 1981; 246: 2073-2074.
  - <sup>7</sup> National Health Interview Survey.
  - <sup>8</sup> Tierney LM; McPhee SJ; Papadakis MA (editors). (1998). *Current Medical Diagnosis and Treatment 1998*. Appleton and Lange.
  - <sup>9</sup> Tierney LM, et al.; *ibid*.
  - <sup>10</sup> Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1987). Payment restrictions for prescription drugs under Medicaid: Effects on therapy, cost and equity. *The New England Journal of Medicine*, 317: 550-556.
  - <sup>11</sup> Families USA, 1994.
  - <sup>12</sup> 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 England Journal of Medicine*, 325: 1072-1077.
  - <sup>13</sup> Bero LA; Lipton HL; Bird, JA. (1991). Characterization of Geriatric Drug-Related Hospital Readmissions. *Medical Care*, 29 (10): 989-1003.
  - <sup>14</sup> Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.
  - <sup>15</sup> 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.**

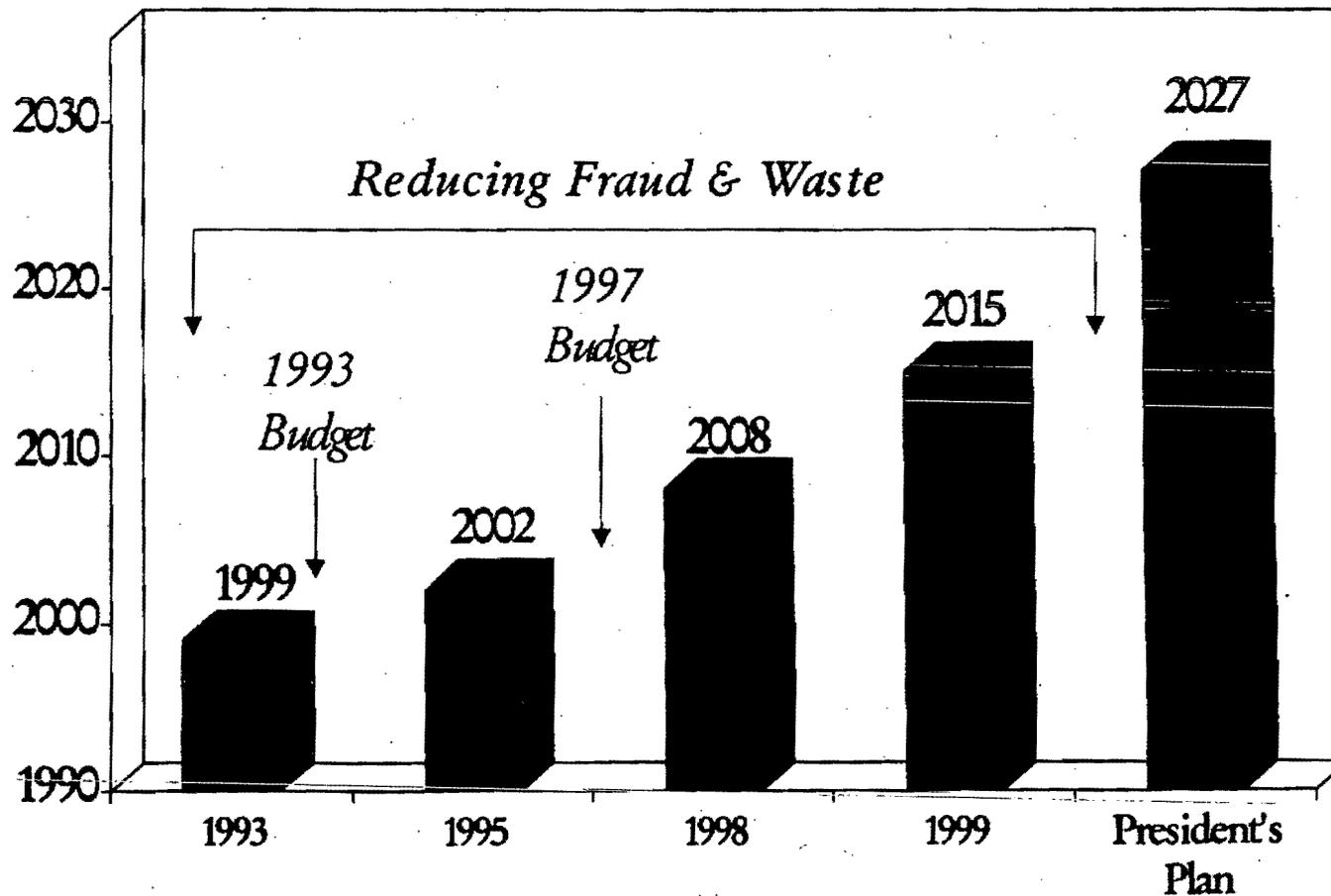
**CHARTS**

# Medicare Enrollment Will Double As The Baby Boom Generation Retires



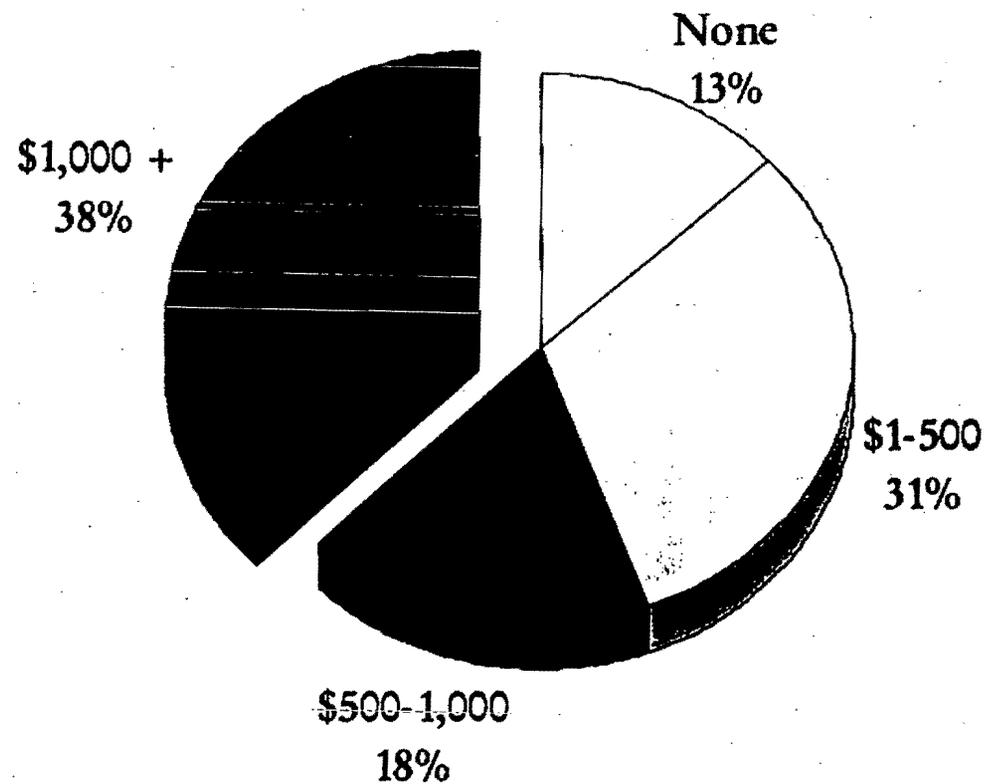
# Modernizing and Strengthening MEDICARE

*Extending The Solvency Of Medicare To 2027*



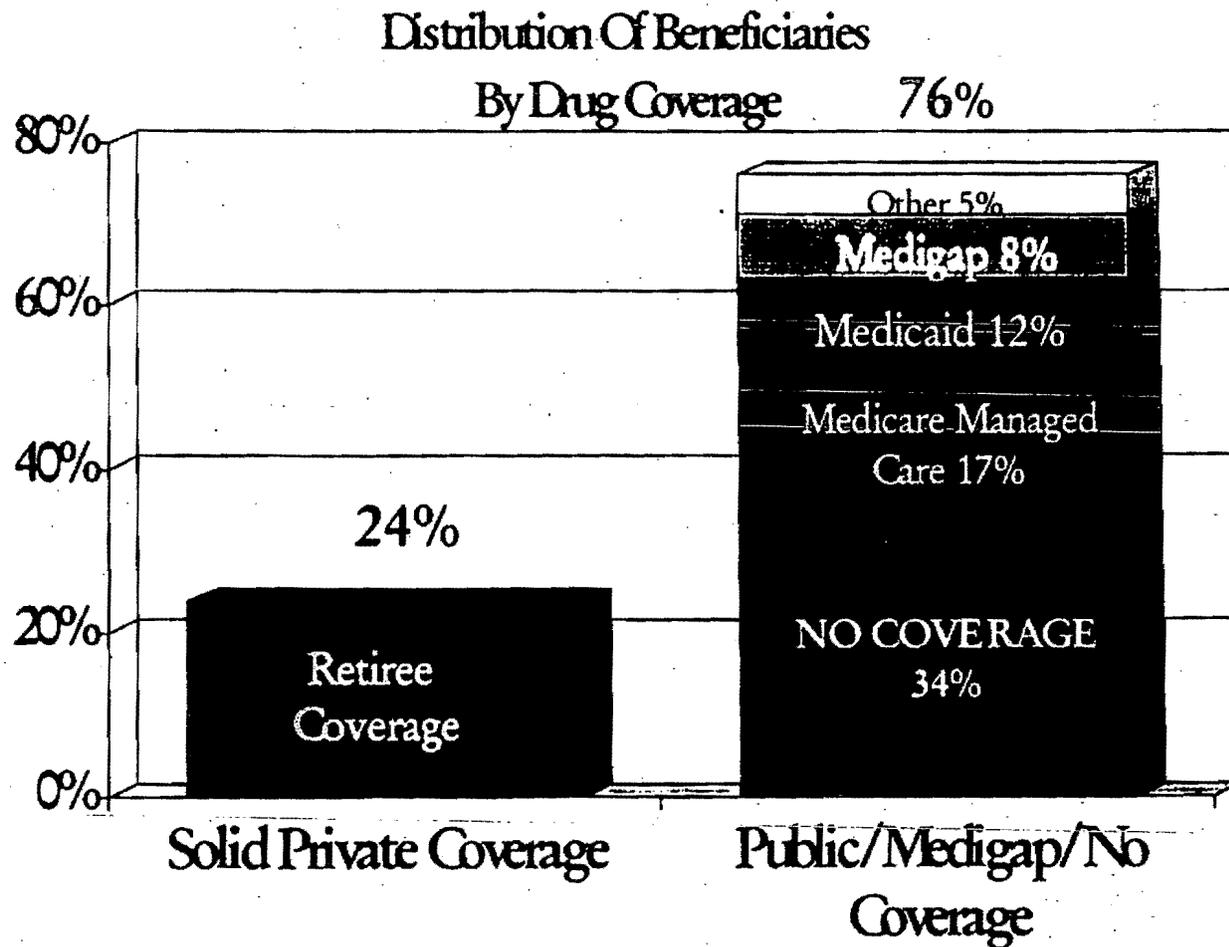
# Medicare Beneficiaries Need Prescription Drugs

Beneficiaries By Total Drug Spending



SOURCE: Actuarial Research Corporation for HHS, 2000

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

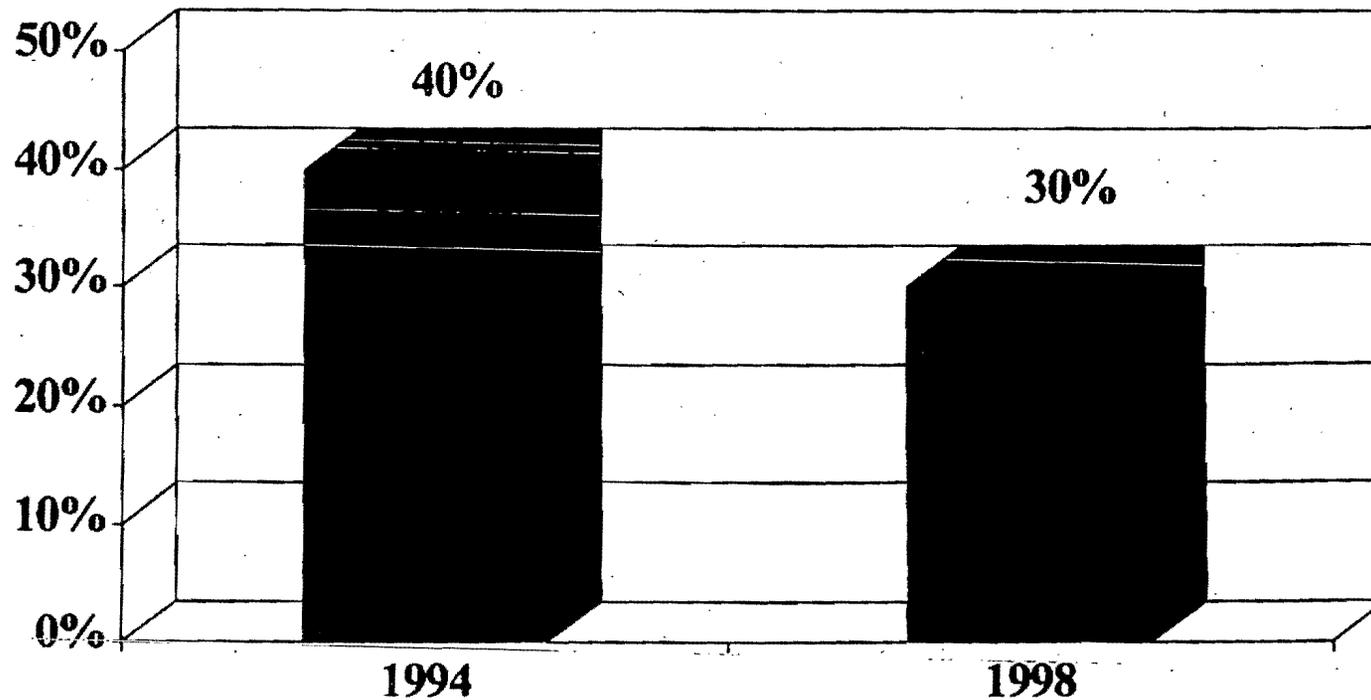


SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

# Retiree Health Coverage Is Declining

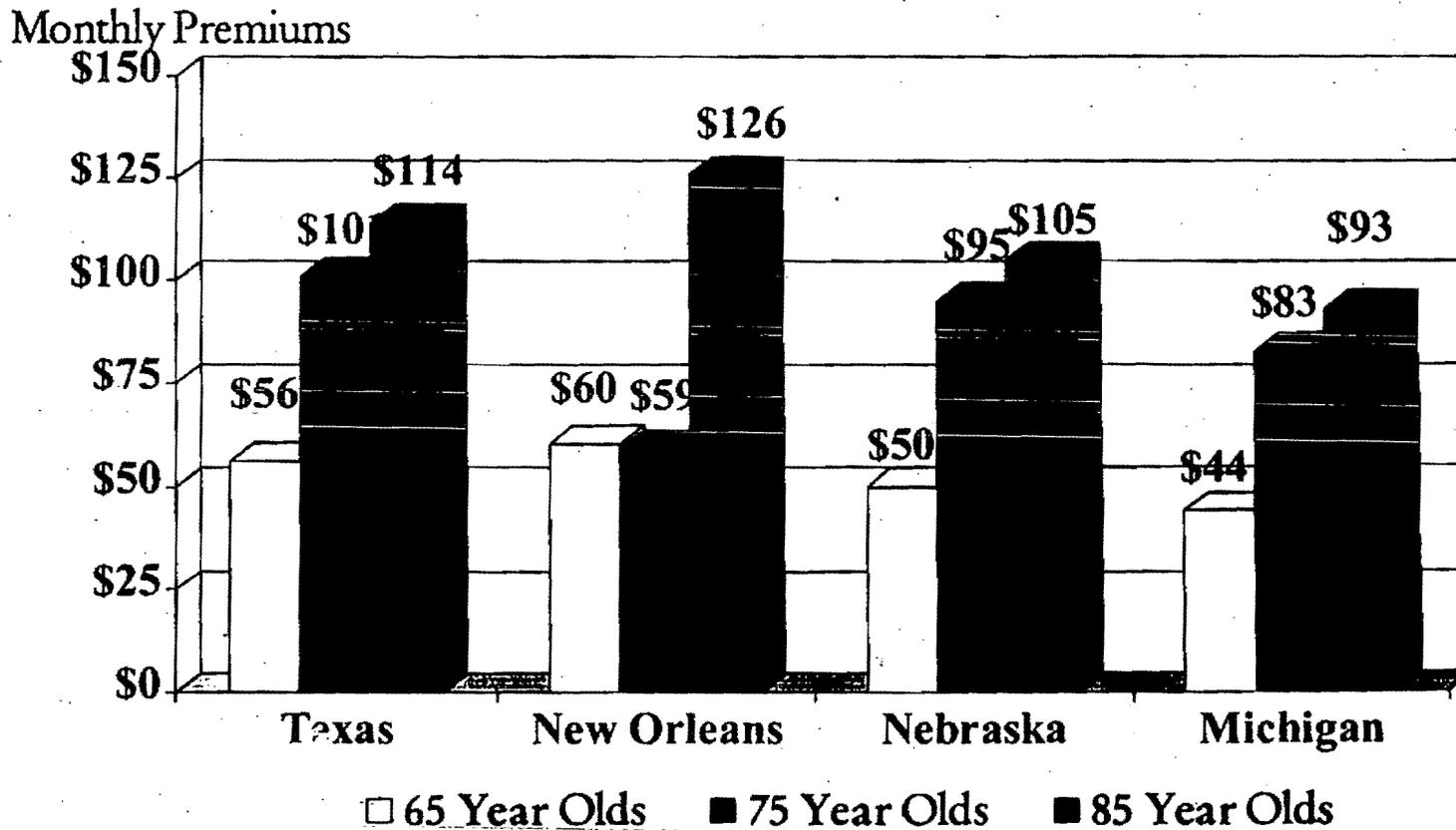
*25% Fewer Firms Are Offering Retiree Health Benefits*

**Firms Offering Retiree Health Coverage**



SOURCE: Foster-Higgins, 1998

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

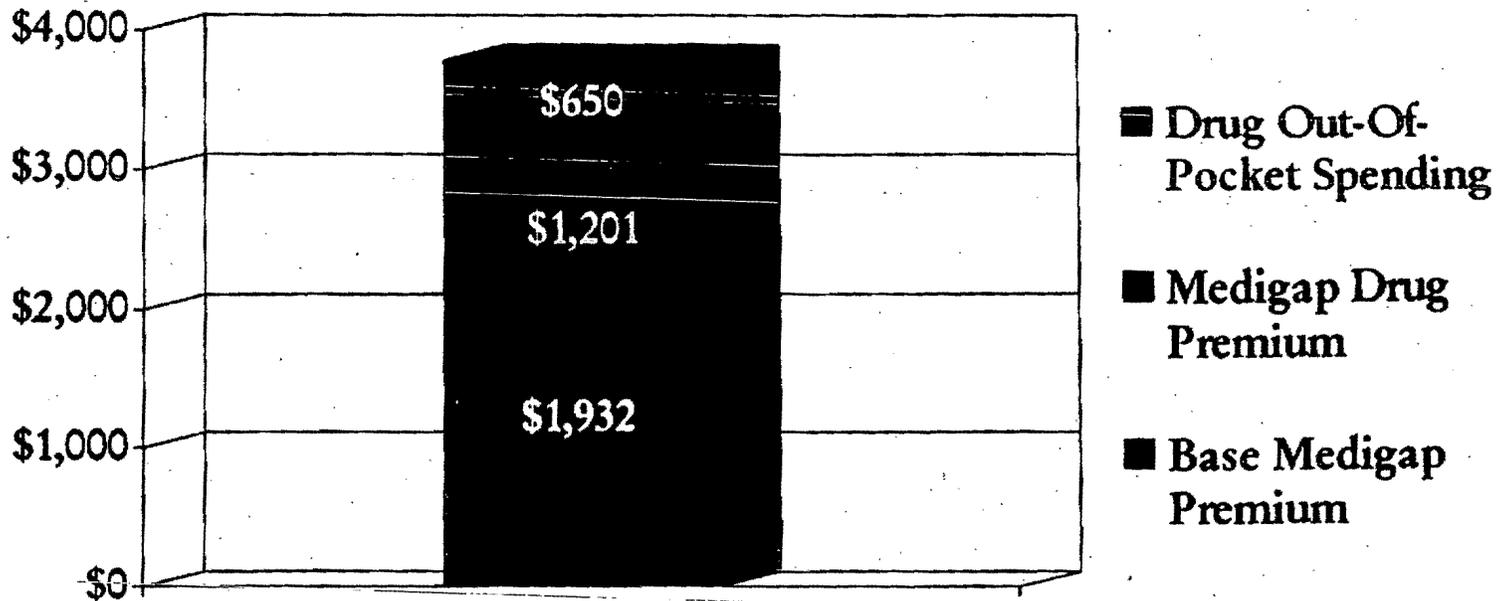


Sample Premiums for 1999. Difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost \$24 per month.

# 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

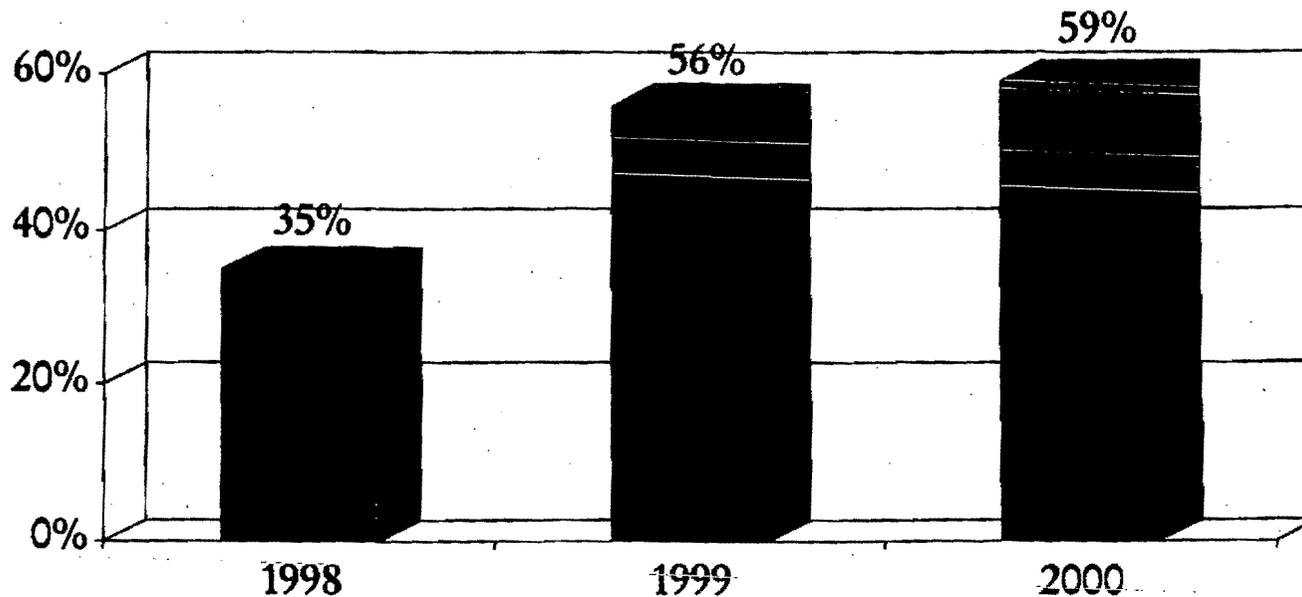


SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is \$161 per month; drug addition is \$101 per month

# Value of Medicare Managed Care Drug Benefits Is Declining

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

**Proportion of All Plans With Limits of  
Less Than \$1,000**

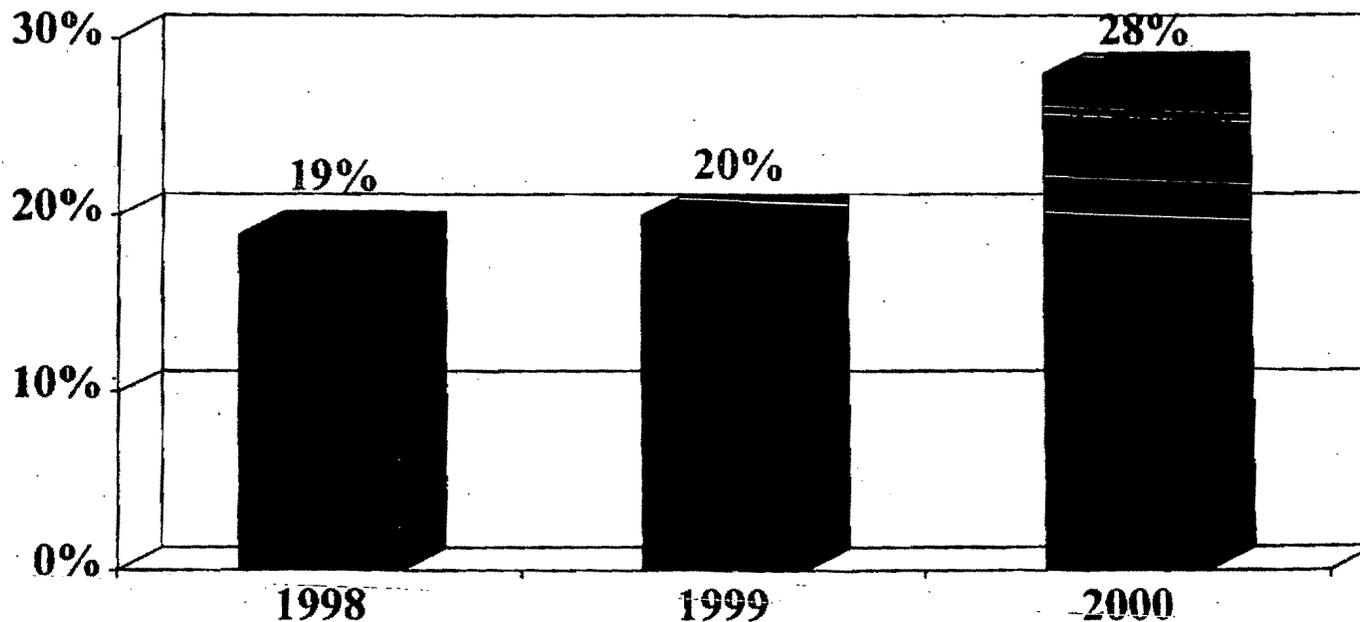


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

# Limits on Medicare Managed Care Drug Benefit Are Getting Lower

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

Proportion of Plans With Limit of \$500 or Less

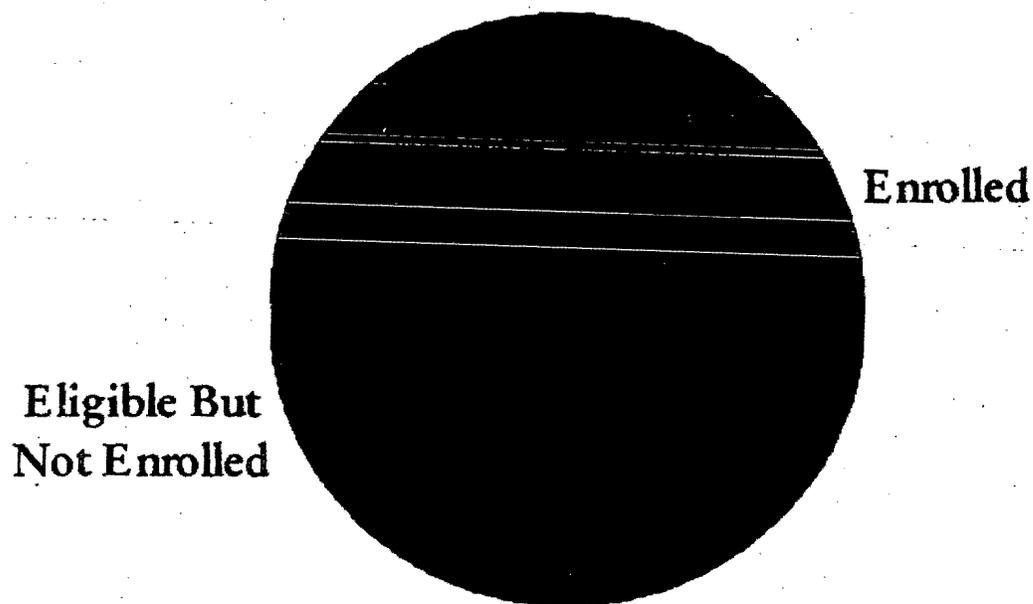


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending.

# Participation In Medicaid Is Low

*Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid*

## Eligible Medicare Beneficiaries' Enrollment in Medicaid



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

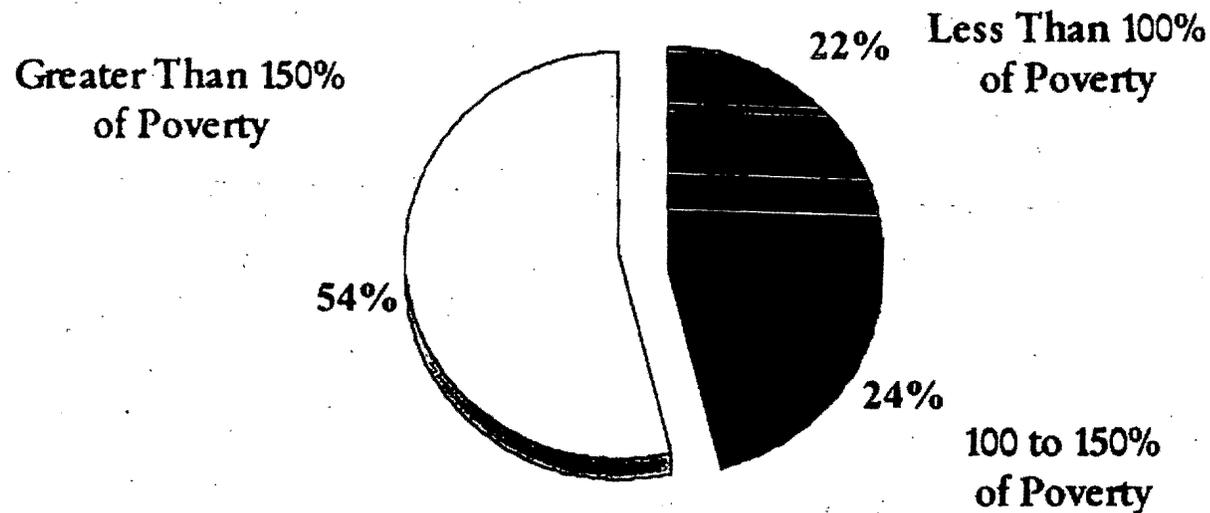
**MILLIONS OF  
BENEFICIARIES HAVE NO  
DRUG COVERAGE**

*At Least 13 Million Medicare  
Beneficiaries Lack Prescription  
Drug Coverage*

# Many Uninsured In Middle Class

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

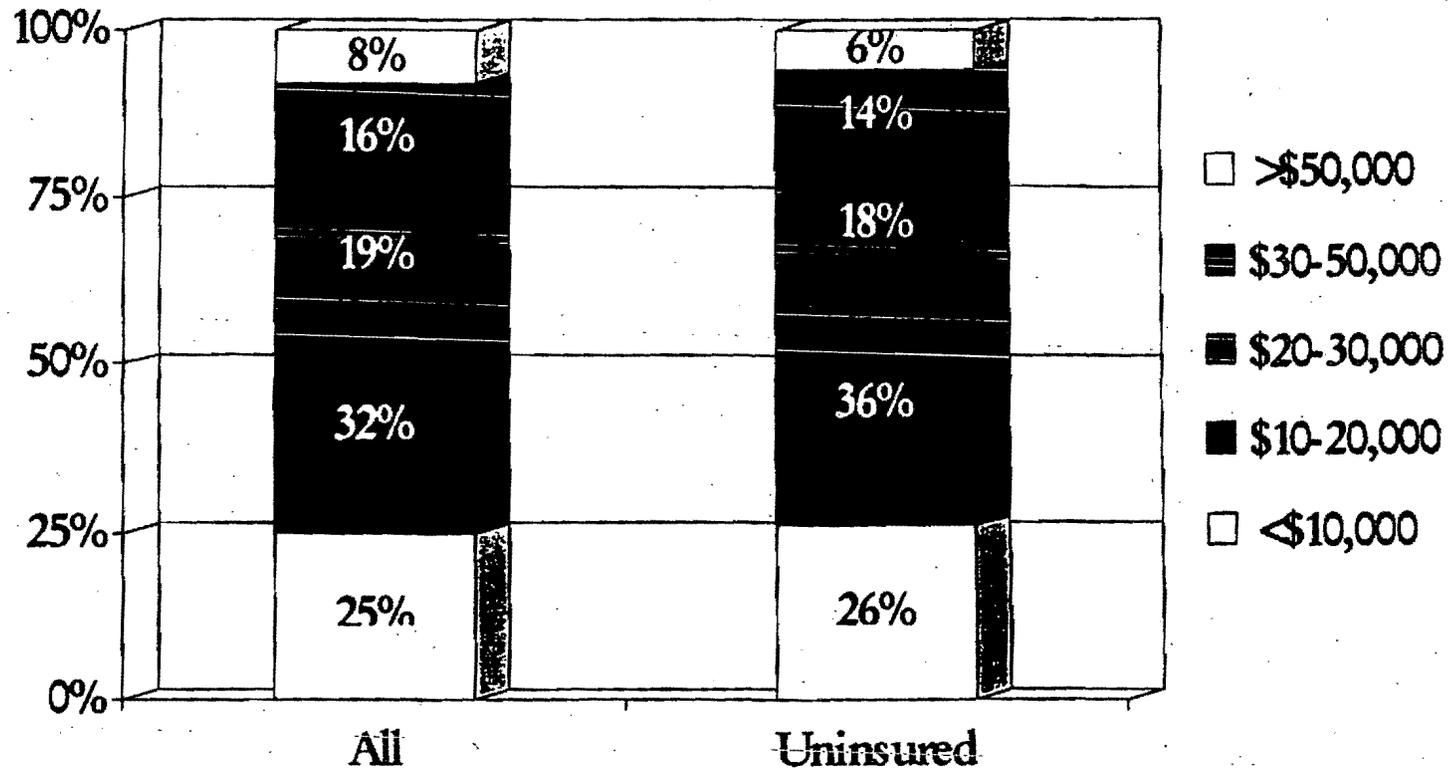
## Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



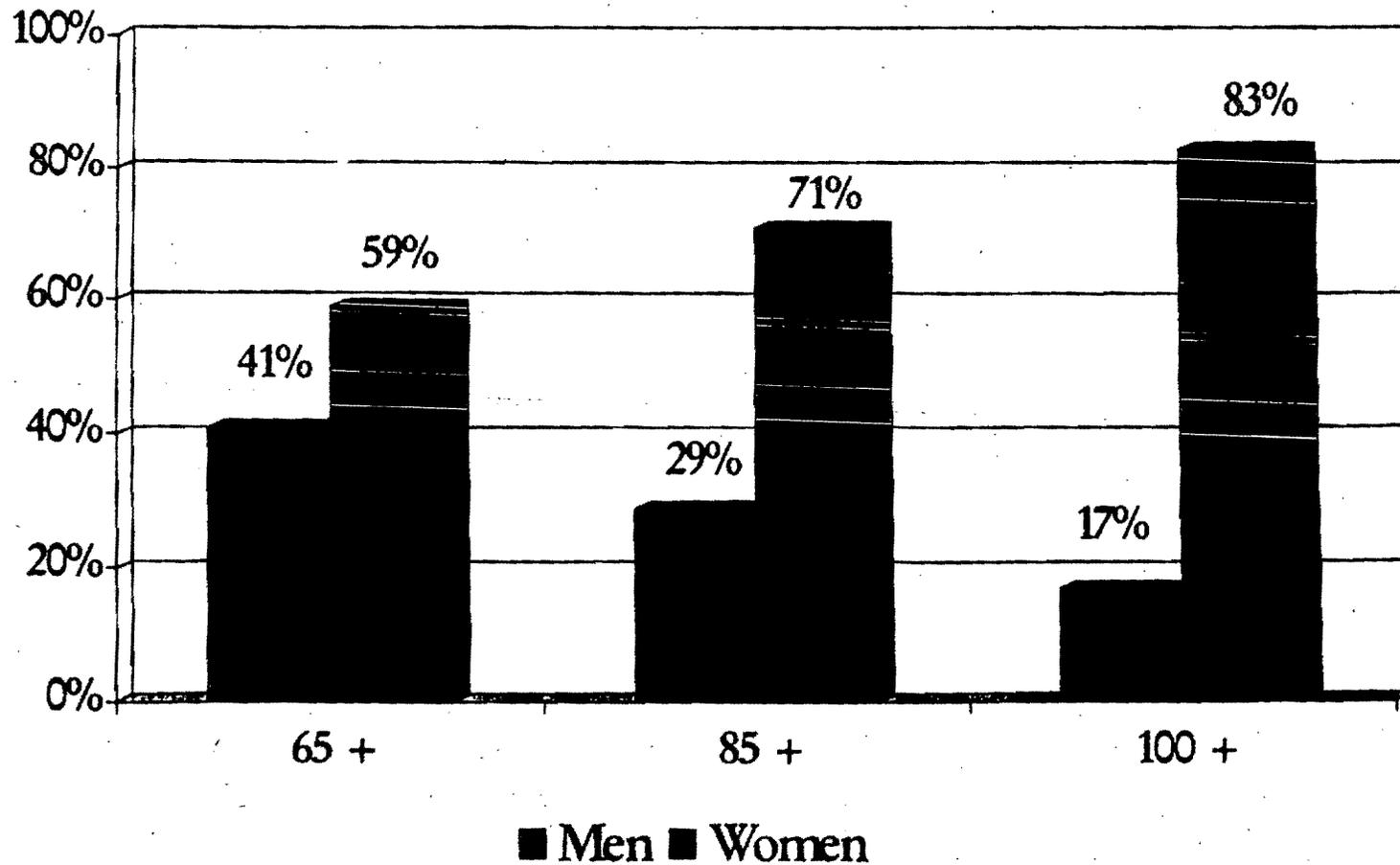
SOURCE: Actuarial Research Corporation for HHS, 2000  
In 2000, poverty for a single person is about \$8,500, for a couple is about \$11,400

# Lack of Insurance Affects All Medicare Beneficiaries

*Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries*

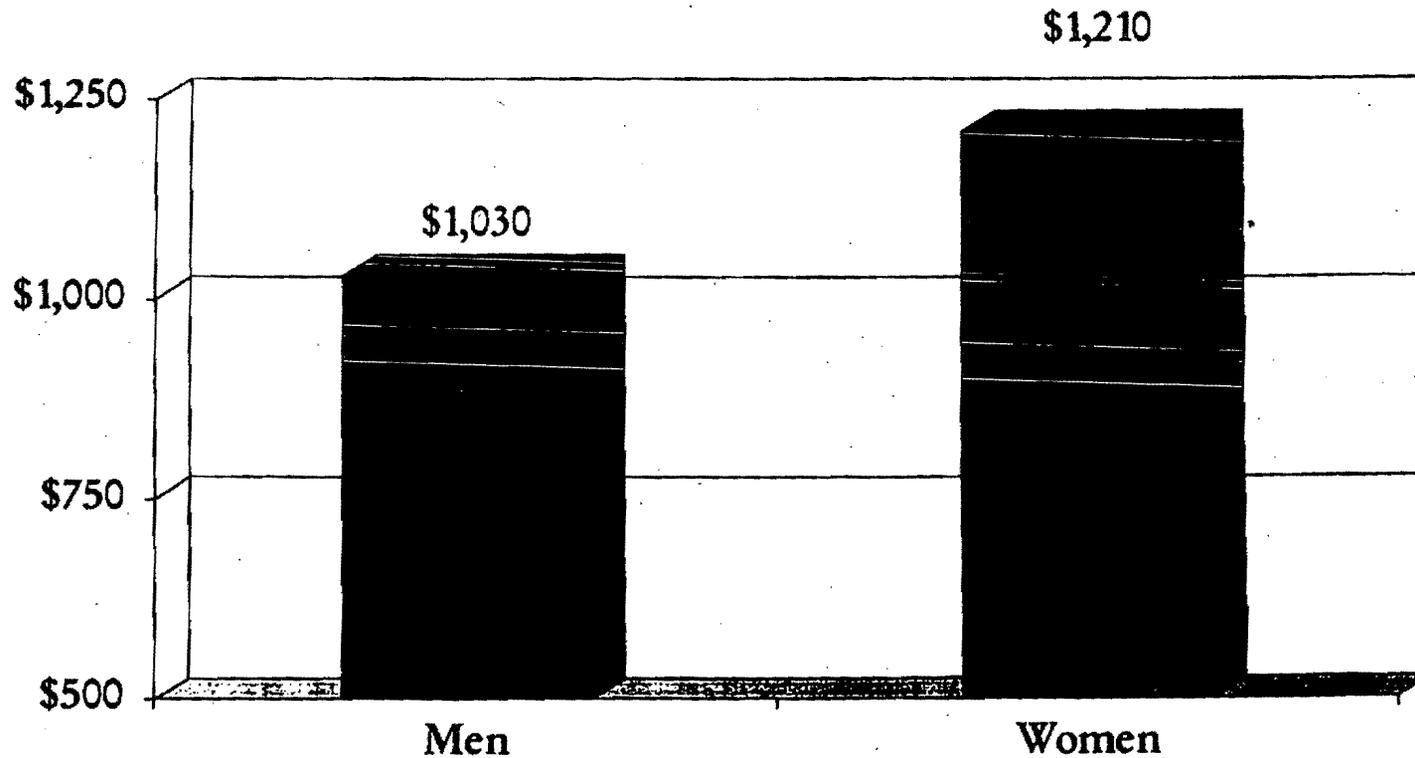


# Most Medicare Beneficiaries Are Women



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

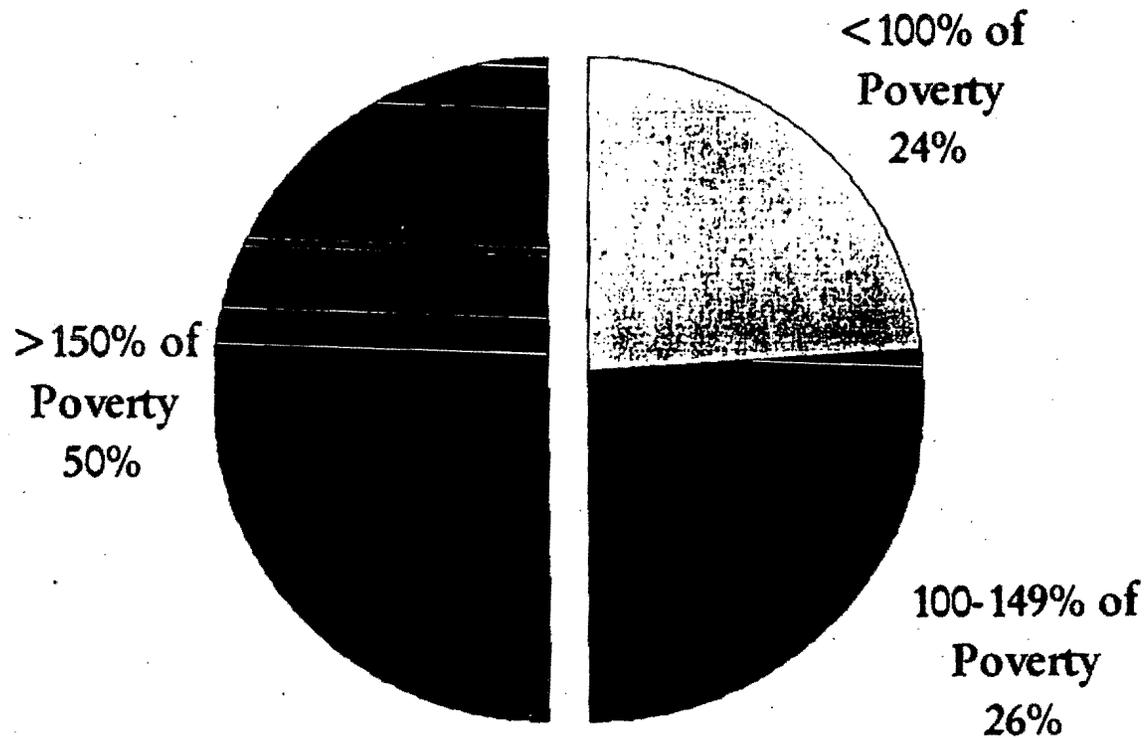
# Total Prescription Drug Spending For Women On Medicare Is \$1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

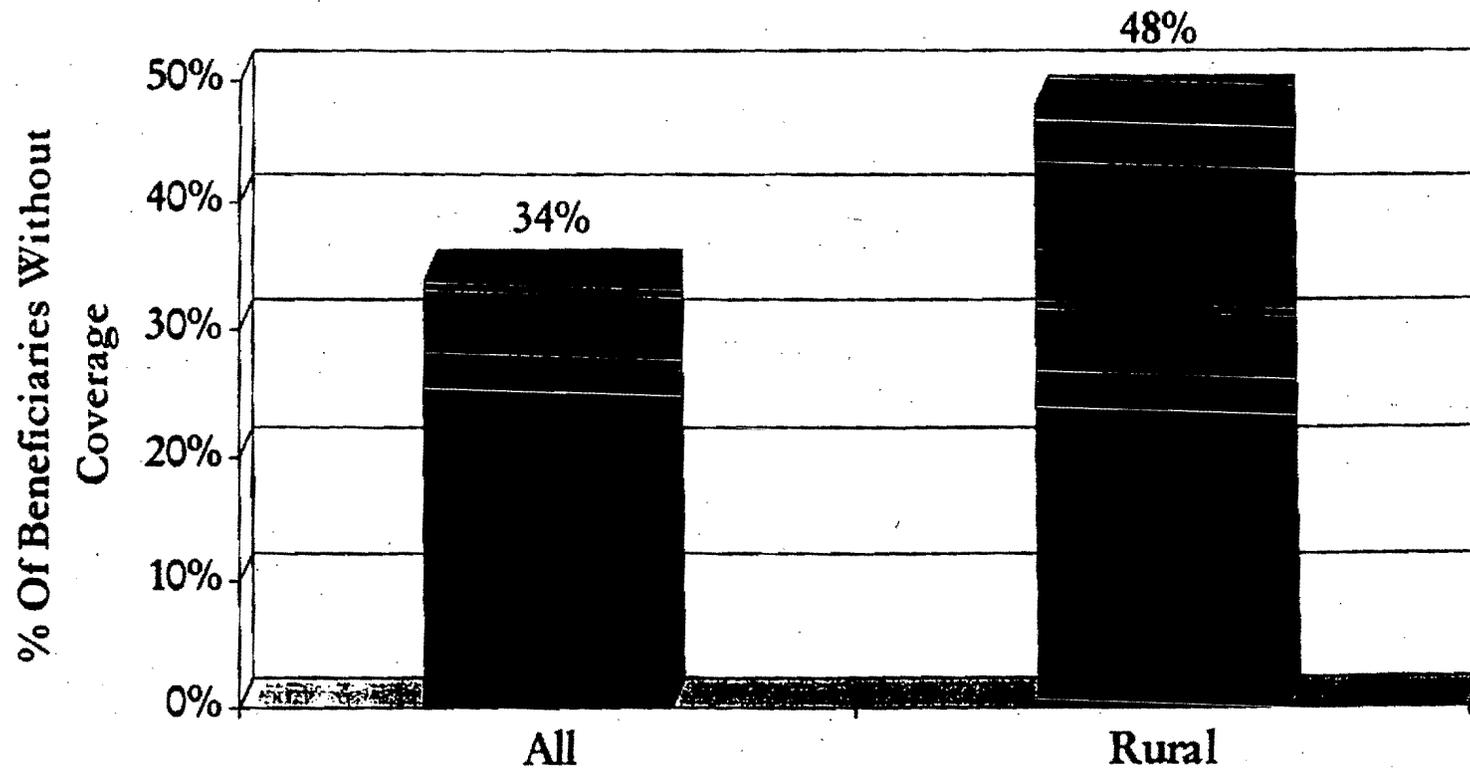
Source: Actuarial Research Corporation. As cited in OWL Report

# 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

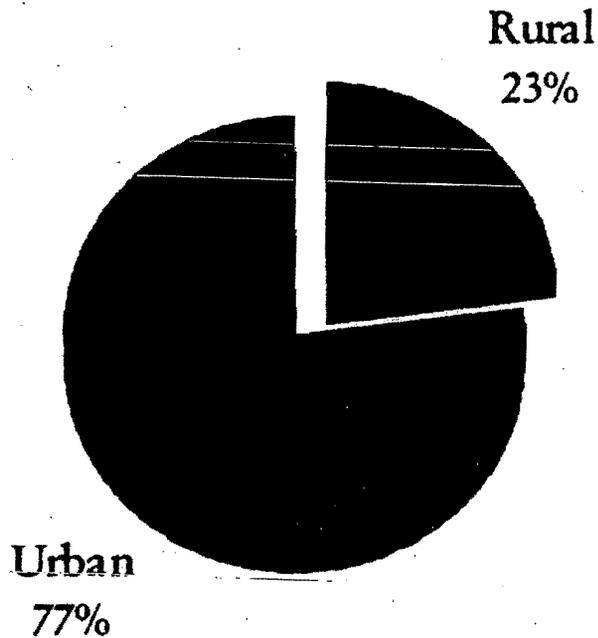
# More Rural Medicare Beneficiaries Lack Prescription Drug Coverage



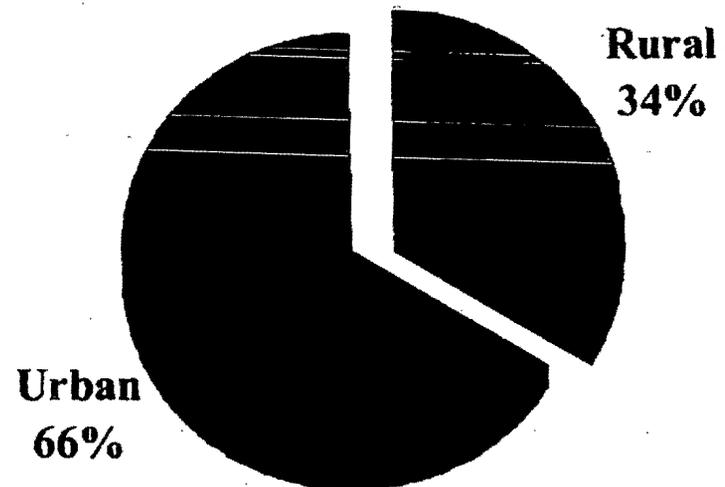
SOURCE: Actuarial Research Corporation for HHS, 2000

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

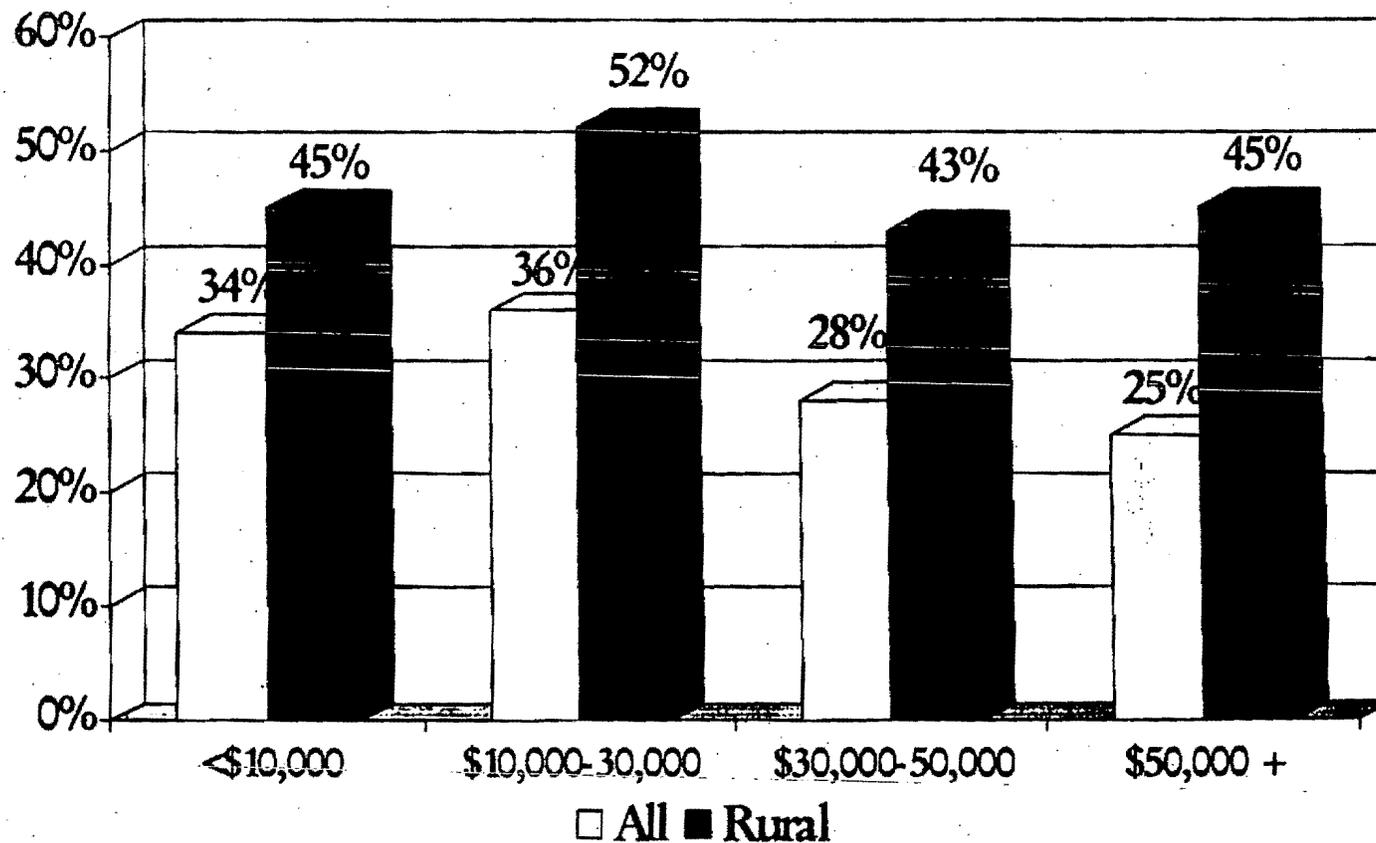
All Medicare Beneficiaries



Medicare Beneficiaries  
Without Prescription Drug  
Coverage



# 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?..... 1
- Q2: How do you respond to opponents' arguments that the proposal represents another step toward socialized medicine and a government takeover?..... 2
- Q3: Why not just target the benefit to the low-income beneficiaries who really need it? ..... 2
- Q4: Why should the Medicare program subsidize a drug benefit for people like Ross Perot?.....3
- Q5: How will beneficiaries who already have very good retiree health coverage be affected by this proposal? ..... 3
- Q6: Will this new prescription drug benefit cover Viagra? ..... 4
- Q7: How do you reconcile a brand new entitlement with the need to constrain the growth of the Medicare program?..... 4
- Q8: Does the prescription drug benefit impose an unfunded mandate on states? ..... 4
- Q9: Will a prescription drug benefit eventually lead to some form of price control?..... 4

### 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?..... 5

### UNCERTAINTY OF PROJECTED SURPLUS, SAVINGS, AND DRUG COSTS

- Q11: What happens if the surplus doesn't materialize?..... 5
- 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? ..... 5

### PROVIDER REIMBURSEMENT

- Q13: How can you propose additional provider savings without restoring some of the excessive savings of the BBA? ..... 6
- 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? ..... 6

### STRUCTURAL REFORM

- Q15: What do you say to those who say that this is about politics not substance?..... 6
- Q16: Does this proposal qualify as real, structural reform of Medicare? ..... 7
- Q17: Does your plan suggest that Medicare can be fixed without beneficiaries have to bear any burden?... 7
- Q18: What is the problem with Senator Breaux and Congressman Thomas' proposal? ..... 7

## 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 21<sup>st</sup> 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.