

# Withdrawal/Redaction Sheet

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. letter	Letter with attachments: The Gore Prescription Drug Coverage Plan for Seniors (16 pages)	9/19/00	Personal Misfile

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**COLLECTION:**

Clinton Presidential Records  
 Domestic Policy Council  
 Chris Jennings (Subject File)  
 OA/Box Number: 23749 Box 17

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**FOLDER TITLE:**

Medicare Drug Benefit [1]

gf37

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### RESTRICTION CODES

**Presidential Records Act - [44 U.S.C. 2204(a)]**

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advise between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.

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RR. Document will be reviewed upon request.

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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

# Withdrawal/Redaction Marker

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001. letter	Letter with attachments: The Gore Prescription Drug Coverage Plan for Seniors (16 pages)	9/19/00	Personal Misfile

**This marker identifies the original location of the withdrawn item listed above.  
For a complete list of items withdrawn from this folder, see the  
Withdrawal/Redaction Sheet at the front of the folder.**

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**COLLECTION:**

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Domestic Policy Council  
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*Medicare Reform Prescription Drug File*

## United States Senate

COMMITTEE ON THE BUDGET  
WASHINGTON, DC 20510-6100

G. WILLIAM HOAGLAND, STAFF DIRECTOR  
BRUCE KING, STAFF DIRECTOR FOR THE MINORITY

<http://www.senate.gov/committees/budget.html>

August 21, 2000

Dr. Dan L. Crippen  
Director, Congressional Budget Office  
Ford House Office Building  
Washington, DC 20515

Dear Dr. Crippen:

On August 10<sup>th</sup>, members of your health staff met with staff of the Budget and Finance Committees to discuss the scoring conventions used to estimate the cost of four prescription drug proposals: the President's Mid-Session Review plan, the Medicare Outpatient Drug Act (S. 2758), the Medicare RX 2000 Act (H.R. 4680), and a modified version of the Medicare Prescription Drug and Modernization Act of 2000 (S. 2807). The meeting was extremely helpful and clarified a number of technical issues. The purpose of this letter is to confirm our understanding of certain key scoring elements so that we may make informed comparisons of these plans.

### Number of Uninsured Under Each Proposal

For fiscal year 2003, please provide your projections of the total number of Medicare beneficiaries (under current law), the number of beneficiaries without coverage before plan implementation and the percent of this population that would continue to be without prescription drug coverage under each of the four plans. In addition, please note the number and percentage of those who are uninsured that would receive drug coverage under each of these plans.

### Employer Coverage

We understand that for the President's Mid-Session proposal and S.2758, your staff estimates that 25 percent of employers would continue to provide the same prescription drug coverage currently provided to their retirees due to the presence of an employer incentive program. Please supply the equivalent percentage of employers who would continue to provide their same full coverage to retirees under H.R. 4680 and S. 2807. This estimate should *exclude* employers who choose to drop coverage or wrap around the new prescription drug plan.

### Private Plan Participation and Federal Fallback

It is our understanding that under H.R. 4680 and S.2807, your estimate of plan participation assumes that in addition to private plans, there will be a so-called "federal fallback plan" provided in geographic areas where private plans do not participate. In order to better understand this assumption, please clarify the following points:

- (1) Since the legislative language of H.R. 4680 and S. 2807 does not appear to outline or authorize government fallback plans, can you describe your assumptions regarding the actual design of the government "fallback" option upon which your model is constructed? Does CBO assume that Medicare will bear full risk for the fallback plan and also administer the plan?
- (2) It is our understanding that CBO would assume lower Part B participation rates and lower coverage of the uninsured under H.R. 4680 and S. 2807 if there was not a federal fallback option. Can you describe said coverage rates assuming the absence of a federal fallback plan?
- (3) Based on several discussions with your staff, we understand that the CBO has not yet taken a position on when, how, and to what extent private plans would participate in a Medicare prescription drug program. In your estimates of H.R. 4680 and S. 2807 did you make any specific projection of private plan participation in this program in the first year of enactment, by the fifth year of enactment, or in any subsequent year?

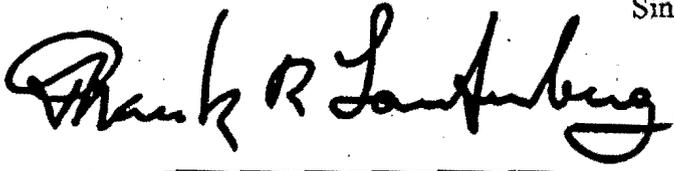
### Discount Rate and Beneficiary Protections

We understand that CBO assumes that the Administration's prescription drug plan will achieve a discount rate of 10 percent. This is 15 percent less than the discount rates assumed for both S. 2807 and H.R. 4680. Based on our discussion with your staff, it is our understanding that much of this differential is based on the fact that the President's plan incorporates provisions that provide additional protections for beneficiaries, including physician certification of coverage of medically necessary; off-formulary drugs, guaranteed access to community pharmacies, and other patient protections. Can you enumerate the kinds of the tools you believe would be available to private plans that are not available under the President's proposal, that result in a higher discount rate under private plans?

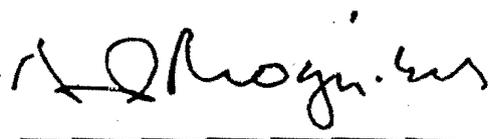
In order to prepare adequately for Finance Committee consideration of these proposals, we would appreciate your response by September 1<sup>st</sup>. Thank you again for your help in clarifying these complex issues.

Dr. Dan L. Crippen  
August 21, 2000  
Page 3

Sincerely,



Senator Frank R. Lautenberg



Senator Daniel Patrick Moynihan

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# Health Disability POLICY BRIEF

## PRESCRIPTION DRUGS FOR WORKING-AGE MEDICARE BENEFICIARIES WITH DISABILITIES

The rapidly rising expenditures for prescription drugs has precipitated a national debate about access to prescription drugs for Medicare beneficiaries.<sup>1</sup> The Medicare program does not cover outpatient prescription drugs as do most health plans including Medicare managed care plans. Stories abound about how some elderly Americans face economic hardship in paying for their prescription drugs (Blustein, 2000; Brown, 2000).

The idea of adding a prescription drug benefit (PDB) to the Medicare program has gained increased political currency especially a presidential election year. Both major political parties have proposed adding prescription drugs as a Medicare benefit but differ in how this benefit should be financed and administered.

Lost in this debate are the 5 million working-age Americans with disabilities who qualify for Medicare mainly because of their participation in the Social Security Disability Insurance (SSDI) program (HCFA, 2000). Individuals with disabilities incur far higher health care expenditures than do those without disabilities and about one-third of these expenditures are for prescription drugs. Yet, the disproportionately high needs of this population are often overlooked mainly because SSDI beneficiaries constitute only 13% of the nation's 39 million Medicare beneficiaries.

The purpose of this Health & Disability Policy Brief is to (1) outline the need for prescription drugs among working-age persons with disabilities who participate in the Medicare program, (2) describe their current annual expenditures for prescription drugs, (3) propose criteria that should be used in designing and implementing a Medicare PDB—especially criteria that are important to individuals with disabilities, and (4) briefly evaluate the two leading approaches. As of this writing, the two leading approaches include (1) adding a PDB to the current fee-for-service Medicare program and (2) making prescription drugs available through a private insurance plan.

### The Need for Prescription Drugs

Individuals who have disabilities often have one or more health-related issues in their lives. They may not be in ill health but they often must manage their health with extra vigilance not required of individuals without disabilities. For example, those with paralysis because of central nervous system trauma, may take antibiotics to ward off recurring urinary tract infections or take medications to manage spasticity. Those with mental illness, such as depression, bi-polar disorder, or schizophrenia, may need medications to keep their conditions in check and thus be able to function more effectively. Many individuals with disabilities also must cope with chronic pain and require various pre-

scriptions to manage it. Others, such as those with HIV/AIDS may require a more extensive "cocktail" of prescription drugs in order to keep their condition from progressing to a more advanced stage. These needs are borne out in the high levels of utilization outlined below.

### Utilization and Expenditure Data

We investigated the utilization of, and expenditures for, prescription drugs among working-aged adults (18-64 years old) with disabilities by analyzing data from the 1996 Medical Expenditure Panel Survey (MEPS). The MEPS is a population-based national survey of non-institutionalized civilians living in the United States. The survey is sponsored by the Agency

for Healthcare Research and Quality (AHRQ).

We conducted an analysis for three mutually exclusive samples of working-age individuals with disabilities: (1) persons receiving Medicare only, (2) persons receiving Medicaid only, and (3) persons receiving both Medicare and Medicaid.<sup>2,3</sup> Despite the enormous size of the MEPS, the actual numbers of individuals in the survey who fall into these three groups remain relatively small as outlined in Table 1. Thus, we report both the standard errors and the 95% confidence intervals for our estimates.

Working-age individuals with disabilities who qualify for the Medicare and Medicaid programs use far more prescription drugs than their counterparts without disabilities. Ignoring high-



July 20, 2000



## Health Division



Office of Management and Budget  
Executive Office of the President  
Washington, D.C. 20503

**Route to:** Director, Deputy Director

**Through:** Jeanne Lambrew  
Barry Clendenin  
Jeffrey Farkas

**Subject:** Medicare Drug Estimates -  
Differences Between CBO and the  
Administration

**From:** Yvette Shenouda

**ACTION:**

Decision \_\_\_\_\_

Signature \_\_\_\_\_

Comment \_\_\_\_\_

As requested \_\_\_\_\_

Information X \_\_\_\_\_

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Medicare/Prescription

n Drugs

On July 18, 2000, the Congressional Budget Office (CBO) released their estimates of the President's FY 2001 Mid-Session Review (MSR) Medicare prescription drug benefit. They estimate a net budget impact of \$98.4 billion over five years and \$337.7 billion over ten years. Over five and ten years, this is \$19.1 billion higher and \$85.0 billion higher than the Administration's estimate of \$79.3 billion and \$252.7 billion respectively (see summary table below). In addition to the benefit costs, CBO also includes spending subject to appropriations to cover the costs of administering the benefit. CBO estimates these costs at \$3.0 billion over five years and \$5.6 billion over ten years. There are four major reasons for the differences between the Administration and CBO:

**Price Effect.** The MSR Medicare prescription drug benefit includes a \$4,000 catastrophic limit on out-of-pocket expenditures. CBO estimates a price effect resulting from the provision of this catastrophic drug coverage to the Medicare population. CBO assumes that enrollees whose drug expenses exceed the catastrophic amount (\$4,000 per year) will no longer be price-conscious. As a result, demand will grow and prices will increase for some drugs used heavily by Medicare enrollees - particularly those with no close substitutes. CBO assumes that, after ten years, the average price of drugs consumed by the Medicare population would be 8 percent higher if our prescription drug benefit was enacted.

**Low-income Costs.** The Medicare drug benefit includes a Medicaid cost-sharing benefit for low-income Medicare beneficiaries including those who are eligible for both Medicare and Medicaid (i.e., dual eligibles). Medicaid will pay full cost-sharing and the drug benefit premium for all beneficiaries up to 135 percent of poverty. Those beneficiaries between 135-150 percent of poverty will receive premium assistance on a sliding scale

basis. The Federal government would pay 100 percent of the benefit costs for the Medicaid cost-sharing coverage for people above poverty.

CBO's assumes a total impact on Federal Medicaid of \$11.9 billion over five years and \$40.7 billion over ten years. Over five and ten years, this is \$4.7 billion and \$20.4 billion higher than the Administration's estimate of \$7.2 billion and \$20.3 billion respectively. CBO's estimates of the Federal Medicaid impact are higher due to their assumption that the drug benefit would result in an enrollment increase into the current Medicaid programs that pay Medicare cost-sharing and premiums (e.g., Qualified Medicare Beneficiary) and into full Medicaid coverage (i.e., Medicare beneficiaries that are eligible to receive prescription drugs from Medicaid).

The Administration's estimates of the MSR drug benefit assume that the benefit would result in a 2 percent enrollment increase into the current Medicaid programs that pay for Medicare cost-sharing and premiums program and no increase in enrollment into full Medicaid coverage. The Administration considered the extent to which the low-income protections included in the Medicare drug benefit would increase enrollment over existing outreach efforts and concluded that the effect would be small for two reasons. First, the average Medicare beneficiary would be likely to save money on drug costs even without enrolling in the low-income program. Second, outreach efforts to enroll dual eligibles have been going on for some time and are currently being intensified.

**Discount Rate.** The MSR drug benefit assumes administration by a pharmacy benefit manager (PBM) that is capable of achieving discounts from drug manufacturers. The Administration assumes that these discount will be approximately 12.8 percent. Previously, CBO assumed a similar discount of 12.5 percent. They revised this assumption under their MSR estimate and are now assuming a discount of 10.0 percent. CBO changed their assumptions based on a provision in the President's plan which allows Medicare beneficiaries to receive any drug, whether it is on the formulary or not, as long as the physician deems it medically necessary. Although this provision has always been in the President's plan, CBO just recently became aware of it.

**Baseline Difference.** There are additional assumptions where CBO differs from the Administration. For example, both the Administration and CBO assume that people under-report their drug use in the main data set that is used, however, CBO assumes under-reporting that is twice as high as the Administration. CBO also assumes that the new drug benefit will induce more drug utilization, but not as much as the Administration assumed. The Administration and CBO both used the same data (1999 National Health Expenditures data) to establish drug cost inflation (average growth over 10 years of 10.6 percent), however, CBO also assumed drug cost inflation higher than that reported in the 1999 NHA in the in-years. The basis for CBO assuming higher than reported drug cost inflation rates is unclear.

Finally, although CBO estimates a higher total cost for the benefit, they estimate a monthly beneficiary premium that is similar to that estimated by the Administration. CBO estimates a

monthly premium of \$23.40 in 2002, growing to \$55.20 in 2010 (compared to Administration estimates of \$25.01 in 2002, growing to \$55.02 in 2010).

**Comparison of Administration and CBO Estimates of the FY 2001 MSR Medicare Prescription Drug Benefit (dollars in billions)**

	<b>Administration</b>		<b>CBO</b>	
	<i>5-Year</i>	<i>10-Year</i>	<i>5-Year</i>	<i>10-Year</i>
<b>Net Medicare</b>	\$72.1	\$232.4	\$86.5	\$297.0
<b>Federal Medicaid</b>	\$7.2	\$20.3	\$11.9	\$40.7
<b>Net Budget</b>	\$79.3	\$252.7	\$98.4	\$337.7

# SIDE-BY-SIDE COMPARISON OF PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT VERSUS REPUBLICANS' PRIVATE INSURANCE PLAN

June 29, 2000

	Clinton/Gore & Democrats	House Republicans
<b>Who's Covered</b>	<u>All</u> seniors and people with disabilities who lack drug coverage today would gain coverage under this plan.	<u>Less than half</u> of seniors and people with disabilities who lack drug coverage today would join the plan.  <i>"Of those who purchase Part B but do not have drug coverage, CBO assumes that 46 percent purchase a qualified drug plan."</i> [Congressional Budget Office analysis of H.R. 4680, 6/28/00]
<b>Does the Plan Provide an Affordable, Workable Prescription Drug Benefit</b>	<b>Yes.</b> All Medicare beneficiaries would have the option of a reliable benefit, including those in rural and underserved areas. Seniors with retiree health coverage could keep it.  <i>The proposal "...sets the nation on exactly the correct course to guarantee that Medicare will continue to provide first-class medical care."</i> [National Council of Senior Citizens, 5/10/00]  <i>"We applaud the President's strong leadership on this issue. His proposed prescription drug benefit is voluntary, affordable, and covers all seniors through the Medicare program."</i> Martha McSteen, National Committee to Preserve Social Security and Medicare [6/29/00]  <i>"The President's plan will provide consistency and stability in premiums regardless of region, and predictability in terms of coverage."</i> [Older Women's League, 6/29/00]	<b>No.</b> Assumes private insurers will volunteer to offer coverage and collect premiums, which the insurance industry itself says won't work:  <i>"Private, stand-alone prescription drug coverage will not work. To pass legislation to provide access to such coverage would constitute an empty promise to Medicare beneficiaries."</i> [The Blue Cross / Blue Shield Association Letter to Senator Roth, 4/24/00] <i>In addition, HIAA says that coverage anticipated by the Republican proposal is "virtually impossible for insurers to offer to seniors at an affordable premium."</i> [HIAA Release, 6/13/00]  <i>"HR 4680 ... provides no assurance to a Medicare beneficiary that her prescription drug needs will be met."</i> [Consortium for Citizens with Disabilities, 6/27/00]  <i>"This legislation would not guarantee universal and affordable access to seniors (and is) at odds with the... principles of any meaningful prescription drug bill."</i> [Leadership Council of Aging Organizations 6/21/00]
<b>What Do You Get</b>	No deductible, 50 percent coinsurance up to \$5,000 in costs when phased in. Out-of-pocket spending limited to \$4,000	Benefits would vary from plan to plan. "Standard" option has a deductible of \$250, a 50 percent copayment up to \$2,100 in costs. Out-of-pocket spending limited to \$6,000
<b>How Much Does it Cost</b>	\$26 per month in 2003 for <u>all</u> participants	Premiums would vary from plan to plan. Average of \$39 in 2003 – 50 percent higher than the President's plan.
<b>What is the Value of Coverage</b>	Value of coverage in 2003: \$835	Value of coverage in 2003: \$670 <b>Seniors would pay more 50 percent more for a benefit that is 20 percent less valuable.</b>
<b>Do Seniors Have Choice</b>	<b>Plans:</b> <u>Yes.</u> In fee-for-service, managed care, or retiree plans if eligible <b>Drugs:</b> <u>Yes.</u> Doctor-prescribed drugs are guaranteed without going through insurer or managed care plan <b>Pharmacies:</b> <u>Yes.</u> All local, qualified pharmacies would be accessible	<b>Plans:</b> <u>Yes,</u> but only if private insurers participate  <b>Drugs:</b> <u>No.</u> Beneficiaries would only be able to access certain drugs through an appeals process  <b>Pharmacies:</b> <u>No.</u> Insurers could restrict participating pharmacies
<b>Start-Date</b>	2002	2003
<b>Takes Medicare Off-Budget, Improves Solvency &amp; Efficiency</b>	<b>Yes.</b>	<b>No.</b>
<b>Who Supports</b>	Virtually all major representatives of seniors and people with disabilities	Drug companies and their allies



J. Dennis Hastert  
Fourteenth District  
Illinois

<http://www.speaker.gov>

## Speaker's Press Office

United States House of Representatives  
Washington, DC 20515

FOR IMMEDIATE RELEASE:  
April 12, 2000

CONTACT: 202-225-2800  
John Feehery

### *Statement by House Speaker J. Dennis Hastert (R-IL) Regarding the Prescription Drug Plan and a Stronger Medicare*

Washington, DC – House Speaker J. Dennis Hastert (R-IL) made the following statement today:

“Today, we unveil a balanced plan to modernize Medicare by providing a voluntary prescription drug benefit to the American people.

“I want to commend Chairman Bliley, Chairman Archer, Chairman Bilirakis and Chairman Thomas, and all the members of the Commerce and Ways and Means Committees who have worked so hard for the last month on the issue of Prescription Drugs.

“This is a serious, responsible proposal, which will help American seniors get better access to prescription drug coverage. I believe that this plan will help lower the costs of prescription drugs for many senior citizens. No American should be forced to choose between putting food on the table and taking life-saving prescription drugs.

“This legislation is necessary because prescription drugs are becoming a more important part of our nation's health care needs. Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again.

“This plan gives our senior citizens flexibility to pick the plan that best fits their needs. It provides protection against high out-of-pocket and unexpected costs. This plan uses the market place, not government regulations, to control the cost of drugs. It protects innovation so we can continue to develop life-saving drugs to battle such diseases as cancer, heart disease and Alzheimer's Disease.

“I pledge to work with the President to modernize our Medicare system with a common-sense prescription drug plan.

“Now, it is my pleasure to introduce Lillie Miller from Alexandria, Virginia. I believe she will benefit under our plan.

###

# Late News

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April 12, 2000

## Republicans Try to Rally Support for Prescription Drug Plan

### Related Article

- [Issue in Depth: Health Care](#)

By ROBERT PEAR

**W**ASHINGTON, April 12 -- House Republicans began rallying support today for their plan to offer insurance coverage of prescription drug costs to all 39 million Medicare beneficiaries, even as the White House called the proposal "a major disappointment."

The AARP, a leading voice for older Americans, cautiously welcomed the proposal, but noted that Republicans had offered only an outline, without providing details of how their plan would work.

Speaker J. Dennis Hastert and a dozen other Republican representatives unveiled their proposal as winds blustered round them in an outdoor ceremony on the east side of the Capitol.

Under the proposal, the government would subsidize a variety of private insurance plans offering coverage of prescription drugs for people who are elderly or disabled. Republicans insisted that their drug insurance plan would be "affordable, voluntary and available to all," as signs at their rally said.

Mr. Hastert, who supervised development of the proposal by a group of 15 lawmakers, said, "Those Medicare beneficiaries who choose this voluntary plan will never have to pay retail prices for their prescription drugs again."

Under the Republican proposal, insurers would pool the purchasing power of large groups of Medicare beneficiaries to negotiate discounts from drug manufacturers, as labor unions and employers now do for workers and some retirees.

House Republicans said they definitely intended to impose a limit on the amount of money that a Medicare beneficiary would have to pay for prescription drugs in any year -- "a monetary ceiling beyond

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which Medicare would pay 100 percent of beneficiaries' drug costs," according to a summary of the proposal. Lawmakers refused to say what the ceiling would be; aides said the annual limit could be in the range of \$2,000 to \$3,000 a person.

Horace B. Deets, executive director of the AARP, formerly known as the American Association of Retired Persons, said the Republican proposal "has merit." It is, he said, a major improvement over earlier Republican proposals that would have provided drug coverage only to older Americans with low incomes.

Democrats plan to highlight their commitment to Medicare drug benefits in political events over the next two weeks, when the House is in recess, and they hope to use the issue to regain control of the House. With today's proposal, House Republicans will be able to offer their own plan as an alternative.

Independent observers say a compromise is possible, though by no means assured. President Clinton and Congressional Republicans generally agree on the amount to be spent, \$40 billion over five years.

The initial reaction from the White House and House Democratic leaders was negative.

President Clinton's health policy coordinator, Chris Jennings, said: "The House Republican proposal a major disappointment. The rhetoric is good, but it is not matched by the reality of the policy. There's no defined benefit. We don't know what benefits we're buying here. And we don't know what the premium would be."

The House Democratic leader, Richard A. Gephardt of Missouri, said: "Republicans are cynically making health care promises they won't fulfill. Like their efforts on managed care reform, this is a sham proposal that was designed to comfort the health insurance special interests instead of providing real relief for health care consumers."

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# NATIONAL JOURNAL'S CongressDaily

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Tuesday, April 11, 2000

## ► BUDGET

### **GOP Conferees Settle Disputes In FY2001 Spending Plan**

House and Senate Republican conferees today opened their conference on the FY2001 budget resolution with agreements already in hand on the major discrepancies between their respective versions of the \$1.8 trillion budget plan. On total discretionary spending, the House accepted the \$4 billion in extra funding the Senate provided for defense, but not the additional \$1.6 billion the Senate included for health research — bringing the FY2001 total to \$600.5 billion, of which \$311 billion would be for defense and \$289 billion for non-defense appropriations. The House-passed spending total was \$596.5 billion, while the Senate had almost \$603 billion. Despite setting a final conference discretionary spending number, **Senate Budget Chairman Domenici** — a senior member of the Senate Appropriations Committee — said he is "sure there will be a lot of activity and unseen pitfalls in implementing it this year."

On tax cuts and reconciliation, Domenici and **House Budget Chairman Kasich** agreed to provide reconciliation instructions for two tax cut bills to the House Ways and Means and Senate Finance committees; the House resolution called for four reconciliation bills, while the Senate budget provided for just one. And on top of the \$150 billion over five years both resolutions designated for tax cuts, the conference report is expected to retain the \$50 billion reserve fund the House created for further tax cuts. But instead of also keeping the reserve fund in both budgets that would direct any increase in the CBO's summer re-estimate of the on-budget surplus toward more tax cuts, the \$50 billion reserve is expected to assume the anticipated CBO increase — which sources believe will add another \$30 billion to the on-budget surplus total. And for the politically significant Medicare reserve fund, for which both chambers set aside \$40 billion over five years, the chairmen agreed to devote \$20 billion to funding a prescription drug benefit and \$20 billion to Medicare reform, most likely for an additional round of "give backs" to Medicare providers hit hard by the cuts mandated by the 1997 Balanced Budget Act. 

In their opening remarks, **House Budget ranking member John Spratt, D-S.C.**, and **Senate Budget ranking member Frank Lautenberg, D-N.J.**, both worried that the discretionary spending assumptions that underlie the GOP budget plan are "unrealistic." They also argued that to provide the amount of tax cuts they have promised, Republicans would have to make deep cuts in priority domestic spending initiatives and sacrifice some of their projected level of debt reduction. **House Majority Leader Arney** told reporters a House floor vote on the conference report will occur either Thursday or Friday. — *by Lisa Caruso and Stephen Norton*

## ► TRADE

### **Daley: Administration, Dems Discuss Parallel PNTR Bill ...**

Commerce Secretary Daley today said the details of any parallel legislation to be passed in tandem with permanent normal trade relations status for China are being discussed with congressional Democrats — and that the administration was unsure where Republicans stand on this matter. While Daley noted at a Senate Commerce panel hearing that **Sen. Kay Bailey Hutchison, R-Texas**, had implied a possible connection with support for Taiwan, he said the administration is "continuing to discuss actions." Some backers of China PNTR fear any so-called parallel legislation might lose as many votes as it would attract. Daley continued to extol the virtues of the trade agreement with China and its benefits to the United States, but shied away from making any firm commitments on its impact on the \$70 billion U.S. trade deficit with China. "The opportunity will not be there in the future if we don't act now. To address the deficit, we must open markets. Am I

Medicare Reform: Prescription Drug Report Feb

## Editorial

The New York Times  
ON THE WEB

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April 11, 2000

# Drug Prices and Medicare

## Forum

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**T**he Department of Health and Human Services issued a report yesterday that highlighted alarming disparities in prescription drug costs for Medicare beneficiaries. The Medicare recipients who lack drug coverage are charged significantly more -- and are thus forced to do without medicine more often -- than Medicare recipients who have obtained drug coverage one way or another.

Currently, about a third of Medicare beneficiaries have no drug coverage at all. The rest have drug coverage through plans provided by former employers, Medigap plans that they buy themselves, Medicaid, or through Medicare health maintenance organizations that provide drug benefits.

The new study found that Medicare recipients without drug coverage were typically charged 15 percent more for the same drug at the pharmacy than were individuals whose drug costs had been negotiated by insurers or by pharmacy benefit managers, companies that administer and negotiate drug prices for health plans. That is because those large entities are able to obtain price discounts for drugs from pharmacy chains. The report does not even take into account direct rebates from manufacturers that insurers and benefit managers can get for increasing a manufacturer's market share in a particular drug field. Such rebates can further reduce the price of prescription drugs between 2 and 35 percent.

The price disparities make a persuasive case for providing a drug benefit for all Medicare beneficiaries. A key part of President Clinton's Medicare drug benefit plan would allow those currently without drug coverage to get lower drug prices by using pharmacy benefit managers to negotiate with retailers and manufacturers. Several competing proposals in Congress also include contracting with private benefit managers to get group price discounts, though the plans differ in details.

The market is working unfairly against the elderly who have no drug coverage. Medicare reform must give them the means to use their collective purchasing power in getting better prices on prescription drugs.

# Uninsured seniors charged more for prescription drugs

## Report: Many without coverage skip medicine

By Susan Page  
USA TODAY

WASHINGTON — Older Americans who lack insurance for prescription drugs not only have to pay for the drugs, but they are also charged 15% more than what insurance companies pay.

As a result of the higher costs, people without insurance coverage are five times more likely than those with insurance to report that they didn't take a drug that they needed in the past year.

Those findings are contained in a study the White House will release today. The study examines the costs and usage of prescription drugs for seniors and disabled people in the Medicare program.

The report is sure to become fodder in the political debate over whether and how to provide drug coverage through Medicare, the federal government's health plan for the elderly.

When President Clinton ordered the study in October, he accused the pharmaceutical industry of telling "flat-out falsehoods" about his prescription proposal, particularly through a series of TV ads featuring an older woman named "Flo."

The report, written by the

Health and Human Services Department, was supposed to be completed in 90 days, but it took nearly twice that long. It portrays seniors as increasingly reliant on prescription drugs but facing costs that are rising more than twice as fast as other health-care costs.

The lack of drug coverage isn't limited to the poor; more than half of those who lack coverage have incomes that put them more than 150% above the poverty line.

The availability of coverage affects seniors' medical treatment, the study finds.

"Insurance coverage for prescription drugs makes a major difference in the amount of drugs people obtain, in how much they spend on drugs out of pocket, and in how much is spent in total on their behalf," says the report, a copy of which was obtained by USA TODAY.

"People without drug coverage face greater financial burdens and may sometimes be unable to follow the courses of treatment ordered by their physicians. There are even some indications that physicians themselves may recommend different therapies to people with and without coverage."

Among the findings:

► The gap in the price of drugs charged to those with and without insurance coverage has nearly doubled in three years, to 15% last year from 8% in 1996.

► Medicare beneficiaries who lack prescription coverage buy

one-third fewer drugs but pay nearly twice as much out-of-pocket as those with coverage.

► About one in 10 of those who lack coverage say they weren't able to afford a needed drug in the past 12 months, compared with about one in 50 among those who had coverage.

► Rural residents were 50% more likely to lack coverage than those in urban areas. Clinton will announce today that the administration will hold a conference this summer on drug costs and pricing practices. Beneficiaries, purchasers, pharmacists, pharmaceutical manufacturers and researchers are invited to attend.

Alan Holmer, president of PhRMA, a trade association for the pharmaceutical industry, issued a brief statement Sunday that criticized Clinton's approach. Industry officials say that a direct drug benefit through Medicare, as Clinton has proposed, ultimately could lead to price controls. Some Republicans have proposed subsidizing drug coverage for low-income people through private insurers.

"Expanded drug coverage is the answer, but the president's plan is the wrong solution," Holmer said. "Seniors need to be able to choose the private insurance plan that's best for them, not a big government, one-size-fits-all scheme. Momentum is growing in the Congress for a private-sector approach, and we hope the president joins in that initiative."

6A

# Uninsured Elderly Found to Pay Higher Drug Prices Than HMOs

A48

By LAURIE MCGINLEY

Staff Reporter of THE WALL STREET JOURNAL

WASHINGTON — Lacking marketplace clout, elderly people without insurance coverage for prescription drugs pay significantly higher prices for their medicines than do insurers that buy them on behalf of groups of seniors, says a report to be released today by President Clinton.

The report, by the Department of Health and Human Services, shows that the uninsured elderly pay prices at the pharmacy that are, on average, 15% higher than those paid by such third-party payers as health-maintenance organizations, pharmacy-benefits managers and employers with retiree health plans. These big purchasers are able to negotiate discounts with pharmacies because of their size, said administration officials.

The study is intended to buttress the White House's proposal for adding a voluntary drug benefit to Medicare, the federal health program for the elderly and disabled.

Mr. Clinton also will announce plans to convene a conference this summer to explore drug-pricing practices.

In discussing the report's findings, administration officials said that the price gap at the pharmacy level rose from 8% in 1996. Moreover, they maintained, it actually understates the difference in costs borne by the uninsured seniors and the big-volume buyers. That's because it doesn't reflect the rebates that insurers and other third-party payers get from drug manufacturers. These rebates are paid by drug makers to reward insurers for generating increased sales or greater market share for specific drugs.

The report estimates that these manufacturers' rebates range from 2% to 35%. The exact size isn't clear because much of the information is considered confidential, and isn't easily accessible.

Administration officials hope that the summer conference, which will include researchers, drug-makers, pharmacists and beneficiaries, will shed light on the complex web of discounts and rebates. Such information is crucial, they say, in designing the most effective delivery system for a Medicare benefit.

"We want to do it in the right way, using market principles," said Christopher Jennings, a top White House official who advises the president on health policy. "So we need to know the best practices and the worst practices in the market today."

But such a conference is sure to unnerve the drug industry, which is already struggling with an increasingly heated election-year debate in Congress over competing drug-benefit proposals and the rising costs of drugs.

Currently, House Republicans are working on a prescription-drug plan that would provide coverage to seniors with low incomes or with especially high drug costs. Taking a different tack, Sen. Slade Gorton (R., Wash.) is discussing legislation that would bar drug makers from charging higher wholesale prices in the U.S. than in Canada or Mexico.

The president would offer coverage to all 39 million beneficiaries, and when fully phased in, would cover half of drug costs up to \$5,000 a year; it also would provide additional subsidies for individuals with the highest drug costs.

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April 10, 2000

## White House Bolsters Medicare Plan

[A.P. INDEXES](#) | [TOP STORIES](#) | [NEWS](#) | [SPORTS](#) | [BUSINESS](#) | [TECHNOLOGY](#) | [ENTERTAINMENT](#)**Filed at 2:03 a.m. EDT****By The Associated Press**

WASHINGTON (AP) -- For Americans who pay full price at the pharmacy window, prescriptions cost at least 15 percent more than the discount drug prices insurance companies get, passing savings along to their enrollees, according to a new Clinton administration study.

White House officials said the study, released today, bolsters President Clinton's call for drug coverage for Medicare beneficiaries. Under Clinton's proposal, which would cost \$195 billion over 10 years, the government would contract with the same drug-purchasing firms used by many private health plans to get discounts and rebates for bulk purchases.

That would let retirees and disabled Americans in Medicare benefit from the same lower prices for drugs that people in private health plans do, the officials said.

The administration study also echoed previous findings that retirees without supplemental private drug coverage in addition to Medicare -- which doesn't cover drug costs except those administered in hospital or clinical settings -- get fewer drugs than they need. It found that although health status between the two groups is similar, senior citizens without drug coverage purchase one-third fewer drugs and pay nearly twice as much for them as those with coverage.

Using new data from Medicare and audits of pharmacy pricing, the study by the Health and Human Services Department also sought to disprove Republican assertions that lack of drug coverage is mainly a problem for poorer Americans.

It showed that one out of every four Medicare beneficiaries with higher incomes -- defined as about \$45,000 for a couple -- lack coverage for prescription drugs.

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"There is no significant decrease in the gap in drug spending as income rises, suggesting that drug coverage makes a difference across all incomes," the White House said in a statement.

The study, ordered by the White House last fall, comes as the administration and Congress are locked in a heated debate about how to help elderly and disabled Americans who get health insurance through Medicare pay for drugs.

Clinton wants a drug benefit available as an option for all 39 million Medicare beneficiaries that would start out paying up to \$1,000 in drug costs for a \$26 monthly premium, with both coverage and premiums increasing over time. He has criticized drug companies for high prices and Medicare could help the elderly get discounts.

Alan Holmer, president of the Pharmaceutical Research and Manufacturers of America said that momentum is growing in Congress for an alternative, private-sector solution and urged Clinton to work with lawmakers.

"The president's plan is the wrong solution," said Holmer in a statement.

Congressional Republicans want to target aid to low-income people who they say need the most help in paying for prescriptions. GOP lawmakers have proposed ideas such as subsidizing premiums or giving tax credits to low-income retirees who buy private insurance.

Last week the Senate passed a budget blueprint earmarking \$40 billion to help older Americans pay for drugs. But the budget does not require the new program or propose specifics.

White House officials say the HHS study probably understates the price disparity for people without drug coverage because insurers often get rebates after bulk drug purchases, further lowering their costs.

The affect of rebates, which HHS didn't examine, could mean drug costs for people paying full retail price are 17 percent to 35 percent higher than what insurers pay, the study said.

Chrö,

FYI, CBO Response to our  
Rx letter from Lautenberg/  
Moyrhuber. Working on Dev  
Colleague with Finrice using the  
letter.

— EDWIN



CONGRESSIONAL BUDGET OFFICE  
U.S. CONGRESS  
WASHINGTON, DC 20515

Honorable Daniel P.  
Ranking Minority Member  
Committee on Finance  
United States Senate  
Washington, DC 20515

Chris,

FYI, CBO Response to our  
Rx letter from Lautenberg/  
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Colleague with Finance using the  
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— EDWIN

Dear Senator:

This letter responds to your request for information on assumptions underlying CBO's estimates of several proposals to establish a Medicare prescription drug benefit. Those proposals are the President's *Mid-Session Review* plan (MSR); the Medicare Outpatient Drug Act sponsored by Senator Robb, as printed in the *Congressional Record* on June 22, 2000 (S. 2758); the Medicare Rx 2000 Act as reported by the House Committee on Ways and Means (H.R. 4680); and the Medicare Prescription Drug and Modernization Act as modified by the sponsors, Senators Breaux and Frist (S. 2807).

**Number of Uninsured.** You asked several questions about insurance status under current law and the number and percentage of Medicare beneficiaries who would participate in 2003 in the federally-subsidized prescription drug benefit offered under each proposal. CBO's estimates of those participation rates are summarized in the attached table.

CBO estimates that there will be 38.4 million enrollees in Part B of Medicare in 2003. CBO estimates that, under current law, about 60 percent of Part B enrollees (22 million people) will have prescription drug coverage and 40 percent (16 million people) will not.

CBO estimates that an additional 2.6 million people will be enrolled in Part A but not in Part B. CBO has not estimated how many of those individuals will have prescription drug coverage in 2003. However, CBO expects that a substantial number of those enrollees will have drug coverage through employer-sponsored plans or Medicaid.

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PRESERVATION



CONGRESSIONAL BUDGET OFFICE  
U.S. CONGRESS  
WASHINGTON, DC 20515

Dan L. Crippen  
Director

September 1, 2000

Honorable Daniel Patrick Moynihan  
Ranking Minority Member  
Committee on Finance  
United States Senate  
Washington, DC 20510

Dear Senator:

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A large, stylized handwritten signature in black ink, appearing to be 'D. Crippen', written over the bottom portion of the letter's text.

Honorable Daniel Patrick Moynihan  
Page Two

For each of the proposals, CBO assumes that all Medicare enrollees who, under current law, have drug coverage that is not federally subsidized (as well as Medicare beneficiaries who have coverage through Medicaid) would participate in the benefit to take advantage of the federal subsidy. Likewise, CBO assumes for each proposal that all beneficiaries who decline Part B—which has a 75 percent federal subsidy—would also decline to participate in the drug benefit.

The estimates of participation differ only for those who purchase Part B but do not have drug coverage under current law. CBO estimates that all of those enrollees would participate in the drug benefit programs under the MSR and S. 2758 proposals; about two-thirds would participate under S. 2807, and about half would participate under H.R. 4680.

**Employer Coverage.** Under the President's *Mid-Session Review* proposal and S. 2758, employer-sponsored plans that offer qualified drug coverage would receive a smaller subsidy than other participating plans, and beneficiaries covered by employer-sponsored plans would not pay a Part D premium. H.R. 4680 and S. 2807 would treat qualified employer-sponsored plans the same as other qualified plans. Therefore, CBO distinguished between participants in employer-sponsored drug plans and in other drug plans in estimates of the President's MSR proposal and S. 2758 but made no such distinction in estimates of the other proposals. CBO estimates that about 25 percent of beneficiaries with employer-sponsored prescription drug benefits would be in plans in which the employer would take the subsidy offered under the MSR proposal and S. 2758. CBO has not estimated the proportion of employer-sponsored plans that would take those subsidies.

**Discount Rate.** For each proposal, we apply a discount factor that seeks to measure how spending under the proposed plan would compare to spending for prescription drugs by an uninsured beneficiary buying retail. The discount factor takes into account the price, quantity, and mix of drugs consumed. Thus, the discount is affected by many factors, including price discounts, rebates, and the effects of utilization management and therapeutic substitution.

Honorable Daniel Patrick Moynihan  
Page Three

We estimate the discount factor by taking into account:

- the tools plans are permitted to use, or prohibited from using, to create market power and to use that market power as leverage in dealing with everyone in the distribution chain—from manufacturers through physicians and consumers—and
- the incentives plans are given to use those tools.

Because the discount factor depends on both the freedom of a plan to use tools as they evolve and the incentives it has to use those tools, we cannot assign a specific discount to any particular tool.

CBO concludes that the discount factor for the President's MSR proposal (10 percent) would be significantly lower than the discount factor for H.R. 4680 and S. 2807 (25 percent). The MSR proposal would significantly limit the tools available to plans—for example, by limiting the ability of plans to restrict formularies or limit the number of pharmacies in their network and by permitting physicians to automatically override formularies—and it gives plans little incentive to use permitted tools to hold down spending. By contrast, H.R. 4680 and S. 2807 would place few limits on the tools that plans could use, and, by subjecting them to financial risk, would give those plans substantial incentives to use those tools to hold down spending for drugs.

The discount factor is a measure of only one component of the cost of a drug benefit. It reflects certain administrative costs—such as claims processing—that would be incurred by plans under all of the proposals we have analyzed to date. However, the discount factor does not reflect certain other costs that might be borne by plans (and which would be passed onto beneficiaries and the government). We characterize those other costs as marketing expenses and a risk premium.

Marketing expenses depend on whether plans compete for enrollees. If they do, we assume a fixed amount that does not vary across proposals; otherwise, we include no marketing expenses.

Honorable Daniel Patrick Moynihan  
Page Four

Based on a Hay-Huggins survey of underwriting practices, we assume a risk premium of 7.5 percent of benefit costs if plans bear substantial risk; otherwise, we apply no risk premium.

**Private Plans' Participation and Federal Fallback Plan.** In the context of H.R. 4680 and S. 2807 (which emphasize providing the prescription drug benefit through risk-bearing entities), CBO considers the existence of a fallback plan—in which the federal government ensures that a prescription drug benefit is available to every Medicare enrollee—essential to the timely, nationwide implementation of the prescription drug benefit. CBO has not analyzed a proposal that involves risk-bearing entities and no fallback plan. Therefore, CBO has come to no conclusions regarding the number of Medicare enrollees who would have access to a prescription drug plan under such a proposal.

Neither H.R. 4680 nor S. 2807 provides a detailed description of the fallback plan. CBO's estimates assume the government would contract with private entities on a non-risk-bearing basis, similar to the system proposed by the President.

H.R. 4680 and S. 2807 put few limits on the ability of plans to use tools to control drug spending, but the non-risk-bearing entities in the federal fallback program might have little incentive to achieve a large discount. On the other hand, they would also not have the marketing expenses or risk premiums that risk-bearing entities would incur. On balance, CBO assumes that the cost of the benefits under H.R. 4680 or S. 2807 would not depend significantly on the extent to which the benefits would be administered by the plans in the federal fallback program or by risk-bearing entities. Therefore, CBO has not attempted to estimate the share of participants who would be in a federal fallback program or in risk-bearing entities.

Honorable Daniel Patrick Moynihan  
Page Five

I hope this information is helpful to you. The CBO staff contact is Tom Bradley, who can be reached at 226-9010.

Sincerely,



Dan L. Crippen  
Director

Attachment

Identical letter sent to Senator Frank R. Lautenberg

cc: Honorable Pete V. Domenici  
Chairman  
Committee on the Budget

Honorable William V. Roth  
Chairman  
Committee on Finance

**Assumptions About Medicare Enrollment and Participation in CBO's Estimates of Several Proposals to Establish a Medicare Prescription Drug Benefit, in Fiscal Year 2003**

	President's Mid-Session Review	S. 2758	H.R. 4680	S. 2807
<b>Medicare Enrollment (Millions of enrollees)</b>				
Part B	38.4	38.4	38.4	38.4
Part A, but not Part B	<u>2.6</u>	<u>2.6</u>	<u>2.6</u>	<u>2.6</u>
Total	41.1	41.1	41.1	41.1
<b>Participation in Prescription Drug Benefit (millions)</b>				
Participants in federally overseen benefit	35.9	35.9	30.6	32.6
Participants in federally subsidized employer-sponsored plans	<u>2.5</u>	<u>2.5</u>	<u>n.a.</u>	<u>n.a.</u>
Subtotal, participants	38.4	38.4	30.6	32.6
Nonparticipants enrolled in Part B	0	0	7.8	5.9
Nonparticipants not enrolled in Part B	<u>2.6</u>	<u>2.6</u>	<u>2.6</u>	<u>2.6</u>
Subtotal, nonparticipants	2.6	2.6	10.4	8.5
<b>Participation in Prescription Drug Benefit (as a Percentage of Medicare enrollment)</b>				
Participants in federally overseen benefit	87	87	75	79
Participants in federally subsidized employer-sponsored plans	<u>6</u>	<u>6</u>	<u>n.a.</u>	<u>n.a.</u>
Subtotal, participants	94	94	75	79
Nonparticipants enrolled in Part B	0	0	19	14
Nonparticipants not enrolled in Part B	<u>6</u>	<u>6</u>	<u>6</u>	<u>6</u>
Subtotal, nonparticipants	6	6	25	21

SOURCE: Congressional Budget Office.

NOTE: n.a. = not applicable

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Medicare Rx Drug Pricing

- Back/Finance Committee markup → Budget rule
- Cooper strategy - Brown / Brown / Murray / Peckle / Mitt strategy
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EXECUTIVE OFFICE OF THE PRESIDENT  
OFFICE OF MANAGEMENT AND BUDGET  
WASHINGTON, D.C. 20503

THE DIRECTOR

September 10, 2000

MEMORANDUM FOR THE CHIEF OF STAFF

FROM: Jacob J. Lew

SUBJECT: Preliminary Analysis of the Senate Republican Prescription Drug Proposal

This memo provides you with a preliminary analysis of the "Medicare Temporary Drug Assistance Act." This Senate Republican Leadership proposal, introduced by Senator Roth last week, would provide capped funding to states for four years to provide drug coverage to Medicare beneficiaries with income below 175 percent of poverty (about \$14,600 for a single) who are not eligible for Medicaid. Its sponsors claim that it would immediately provide prescription drug coverage to those who most need it.

Contrary to assertions made by its proponents, our preliminary analysis suggests that the Senate Republican proposal would exclude from eligibility for drug coverage nearly two-thirds (25 million) of all Medicare beneficiaries — most of whom lack an affordable prescription drug option today. Moreover, the Senate Republican prescription drug proposal would fail to reach many of the low-income seniors and people with disabilities that it purports to help. This is largely because: (a) state-based programs for Medicare beneficiaries have historically had low participation rates; (b) enrollment of eligible seniors would inevitably be capped since a significant proportion of Federal funding would displace existing state spending; and (c) it would likely take longer to implement 50 different state prescription drug programs than it would to set up a Medicare optional drug benefit. Greater details on these concerns are described below. Later this week, the National Economic Council/Domestic Policy Council will supplement this analysis with a more comprehensive review of the proposal, a comparison to the President's plan, and a state-based analysis.

**BACKGROUND**

On September 7, 2000, Senator Roth introduced two similar bills to address the lack of prescription drug coverage for Medicare beneficiaries. S. 3016, "Medicare Temporary Drug Assistance Act," provides capped state grants for four years to provide prescription drug coverage to certain low-income Medicare beneficiaries. In general, eligibility under S. 3016 would be limited to Medicare beneficiaries who are ineligible for Medicaid, have resources below a state-defined limit, and have income below 150 percent of poverty. States would, within broad guidelines, determine deductibles, copays, limits on prescriptions, and access to drugs and pharmacies. If a state decided not to participate, the Federal government would provide a benefit in the state. S. 3017 has the same structure, but provides for more funding and expanded eligibility (175 percent of poverty). For purposes of this analysis, we have focused on the bill with the higher eligibility limit (S. 3017).

## ISSUES

We identified three major concerns in our preliminary analysis of this bill. The first is its failure to help all Medicare beneficiaries – not just those with low-income – who need affordable, dependable prescription drug coverage. Nearly two-thirds (25 million) of Medicare beneficiaries have income above 175 percent or qualify for Medicaid and thus would not be eligible for basic prescription drug coverage under this plan (MCBS 1996). Nearly half (48 percent) of all Medicare beneficiaries without any drug coverage today have income above the Senate Republican plan's income limitation and would receive no help under the plan (MCBS 1996). For example, an 85-year old with \$15,000 in income, \$4,000 in drug costs, and no insurance would be excluded. In addition, there is no link between having low income and high drug costs; nearly 3 out of 5 Medicare beneficiaries with the highest prescription drug costs have income above \$14,600 for a single, \$19,700 for a couple (DHHS Drug Study, 2000).

Second, only a fraction of the low-income seniors that the Republican plan aims to help would likely receive it. Unlike in Medicare where virtually all eligible people (98 percent) participate, less than half (45 percent) of Medicare beneficiaries eligible for state-based programs enroll (Kaiser Family Foundation, 1999). Similarly, enrollment in the 15 non-Medicaid state pharmacy assistance programs has been low: nationwide, they cover only 700,000 to 1.2 million seniors (AARP 1999; NGA 2000). This is due largely to seniors' lack of knowledge about or interest in so-called "welfare" programs and barriers to enrollment (e.g., long waits in welfare offices, extensive income and assets documentation requirements) (Kaiser Family Foundation, 1999). While many states have removed such barriers for children eligible for health programs, there has been less interest in doing so for the elderly since states argue that the Federal government – not states – should be responsible for filling gaps in Medicare coverage. In fact, the National Governors' Association has explicitly rejected plans like that of the Senate Republicans: "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." (NGA resolution HR-39, Winter 2000) Given the low level of Federal funding, it is also clear that enrollment in these new state plans would be capped. The bill provides \$1.3 billion in 2001 – but allows Federal dollars to replace current non-Medicaid state spending for prescription drugs which, nationwide, is about \$1.1 billion (NGA, 2000). Clearly, a large proportion of first-year funding would go to replace existing state spending rather than new coverage.

Third, our experience in implementing the Children's Health Insurance Program suggests it would take far longer to establish 50 separate state programs for low-income seniors than it would take to establish a Medicare option for all beneficiaries. States must pass enabling legislation, determine the program design, hire new staff to handle enrollment, and educate beneficiaries of the new option. In contrast, a Medicare benefit can use its existing systems, not require new or complicated applications, and integrate the benefit into current plan choices. Moreover, diverting resources and energy towards a new, separate state-based program for prescription drug coverage will seriously delay the addition of a reliable, efficient, meaningful prescription drug benefit in Medicare.

In conclusion, our preliminary assessment is that the Senate Republican plan excludes many who need an affordable prescription drug benefit, fails to effectively reach the low-income beneficiaries it targets, and represents a step away from – not towards – the Medicare prescription drug benefit that all acknowledge is needed.

*The number of seniors who are not covered by Medicare is 15.2 million*

FOR IMMEDIATE RELEASE Press Release #106-455

September 18, 2000

ROTH CALLS ON CLINTON, GORE TO WORK ACROSS PARTY LINES ON IMMEDIATE RX COVERAGE FOR NEEDIEST SENIORS

WASHINGTON -- The following is the statement of Senate Finance Committee Chairman William V. Roth, Jr. (R-DE) in response to another White House press briefing held today on Roth's prescription drug plan:

"I am profoundly frustrated by the partisanship that has been shown on prescription drug coverage by the staff of this Administration. I have put forward a temporary solution that could, upon enactment, take care of the prescription drug needs of our nation's neediest seniors. This legislation would cover those seniors until Congress and the White House reach agreement on a more comprehensive Medicare prescription drug plan -- which, judging from the tone coming out of the White House staff, isn't going to be this year.

"My legislation does not cover every senior -- but it gives immediate coverage to millions more than have coverage today. Under every other plan, including the Gore plan, they would have to wait as long as 8 years for coverage.

"I am disappointed that the White House staff has let politics get in the way of immediate relief for our nation's neediest seniors. I hope that this partisanship does not extend to the President and Vice President.

"I call on both President Clinton and Vice President Gore to repudiate their staff's petty politics and help me extend immediate prescription drug coverage to America's neediest seniors."

The following is a point by point rebuttal to the White House criticism of Roth's drug plan:

OMB point #1: The Roth plan would exclude from eligibility for drug coverage nearly two-thirds (25 million) of all Medicare beneficiaries -- most of whom lack an affordable prescription drug option today.

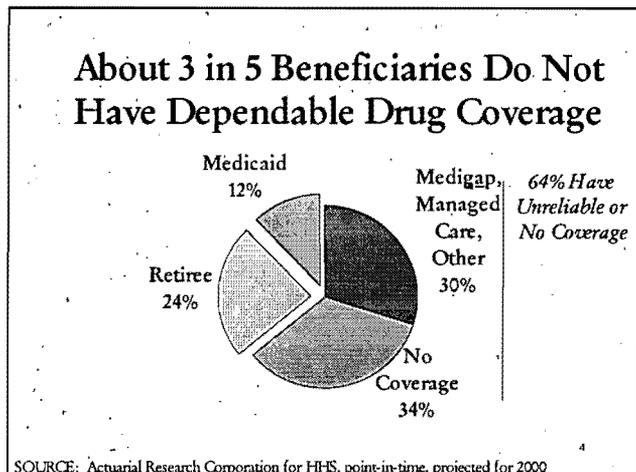
Rebuttal: First, two-thirds of Medicare beneficiaries have prescription drug coverage under the current system. The Roth plan would extend coverage to more than half of the remaining third, ensuring that more than 80% of Medicare beneficiaries have prescription drug coverage through this new program or through existing coverage.

The Roth drug plan is not meant to be a comprehensive solution to the challenges facing Medicare. It is simply a temporary solution that could immediately take care of lower income seniors until Congress and the President can reach an agreement on a comprehensive solution.

*the plan would provide coverage for 25 million seniors who are not covered by Medicare today. The number of seniors who are not covered by Medicare today is 15.2 million.*

*Senator Roth's measure ignores the fact that ~~more~~ more the cost of drugs have no or less affordable, durable & measurable criteria. <sup>High coverage</sup> seniors who pay higher prices for seniors who have severely limited out-of-pocket expense. Medicare is the only coverage that offers seniors a ~~substantial~~ <sup>substantial</sup> protection against catastrophic drug costs.*

**Response:** We – and most Americans – disagree that that the problem of the lack of prescription drugs is confined to one-third of Medicare beneficiaries. The facts show that three out of five Medicare beneficiaries lack affordable, reliable prescription drug insurance. Nearly one-third of beneficiaries pay high premiums for capped private Medigap coverage or enroll in managed care plans that may or may not be there next year. And, while 34 of beneficiaries lack prescription drug coverage for the entire year, nearly half of Medicare beneficiaries spend at least a month of the year without drug coverage. To assert that two-thirds of Medicare beneficiaries do not need prescription drug coverage undermines a commitment to a comprehensive solution.



Second, it is impossible for this proposal to cover half of uninsured Medicare beneficiaries since half are not even eligible for assistance under these block grants. Nearly one-fourth of the beneficiaries without drug coverage with income below 175 percent of poverty are eligible for Medicaid and NOT eligible for this program. Even if they were eligible, history shows that there is no state-based program that has gotten implemented in all states within a year and no state-based program has 100 percent participation.

Finally, we disagree that this will help low-income beneficiaries get needed drugs and

OMB point #2: The Roth drug proposal would fail to reach many of the low income seniors and people with disabilities that it purports to help. This is largely because (a) state based programs for Medicare beneficiaries have historically had low participation rates; (b) enrollment of eligible seniors would inevitably be capped since a significant proportion of Federal funding would displace existing state spending.

Rebuttal: The Roth plan would reach low income beneficiaries with incomes of up to 175% of poverty. a) Both bills are designed to provide states with immediate assistance in conducting outreach and enrollment initiatives to help eligible beneficiaries participate in the new program. Because prescription drug coverage is so much in demand by beneficiaries, we would expect high levels of participation unless the Administration persists in trying to attach a welfare stigma to prescription drug assistance. Drug coverage is not welfare - it is common sense. Republicans have worked with the White House and the states to destigmatize Medicaid and SCHIP – the Administration cannot have it both ways. b) The bill is fully funded to meet CBO's projections on cost. States will receive

financial assistance to expand and build upon their existing state drug assistance programs. There is no maintenance of effort requirement on these programs, because the bill acknowledges that the federal government, rather than the states, should be primarily responsible for providing prescription drug coverage to Medicare beneficiaries. Over the full life of the program, new federal spending dramatically exceeds current state spending on existing programs, ensuring that overall capacity will be greatly enhanced.

OMB point #3: It would likely take longer to implement 50 different state prescription drug programs than it would to set up a Medicare optional drug benefit.

Rebuttal: The comprehensive reform proposal supported by the Administration would not implement a drug benefit until 2002 or 2003 and then would phase it in over several years. In contrast, this proposal would make funding available beginning October 1, 2000. All 50 states are actively administering drug benefits today through a variety of programs such as S-CHIP, Medicaid and state - specific pharmacy assistance programs. Building on existing state drug assistance programs will allow new funds to be quickly utilized to make benefits available to those who need them the most. These provide the infrastructure needed to move rapidly and which does not exist today in the Medicare program. It is hoped that the Health Care Financing Administration will work cooperatively with the states in an effort to get assistance to those who need it most - those on fixed incomes who are forced to choose between food and medicine.

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**LOW-INCOME  
PRESCRIPTION DRUG PLANS:**

*AN UNWORKABLE PRESCRIPTION FOR  
AMERICA'S SENIORS*

**THE NATIONAL ECONOMIC COUNCIL /  
DOMESTIC POLICY COUNCIL**

**THE WHITE HOUSE**

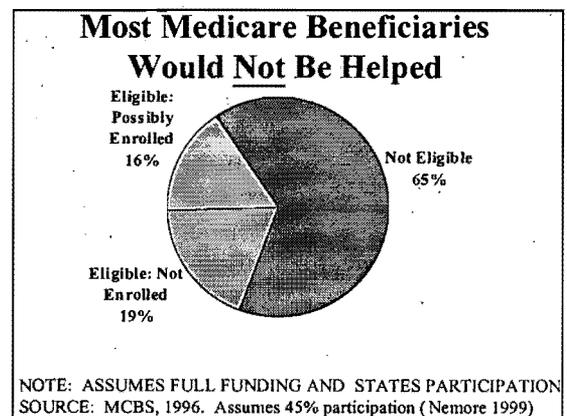
*September, 2000*

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

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

**CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PLANS**

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



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

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

#### **CLINTON-GORE ADMINISTRATION PLAN FOR MEDICARE DRUG BENEFIT**

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

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

### **PROBLEM OF THE LACK OF PRESCRIPTION DRUG COVERAGE**

Prescription drugs have become central to health care, contributing to preventing, managing, and curing diseases. They are even more important to the elderly and people with disabilities on Medicare. However, Medicare does not cover outpatient prescription drug costs. Consequently, nearly half of beneficiaries go without coverage for part or all of the year<sup>1</sup> – about the same percentage as those who lacked hospital insurance when Medicare was created in 1965. Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug. As a result, uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.<sup>2</sup> The situation is even worse for rural Medicare beneficiaries, who are over 60 percent more likely to fail to get needed prescription drugs due to cost.<sup>3</sup> Medicare beneficiaries with disabilities face unique challenges, being less likely to have private coverage but needing more and different types of prescriptions than the elderly.<sup>4</sup> The absence of prescription drug coverage is also a barrier for people with disabilities who want to return to work.

### **CONGRESSIONAL REPUBLICAN LOW-INCOME PRESCRIPTION DRUG PROPOSALS**

On September 7, 2000, Senator Roth (R-DE) introduced two similar bills (S. 3016 and S. 3017) to address the lack of prescription drug coverage for Medicare beneficiaries.<sup>5</sup> S. 3017, entitled the “Medicare Temporary Drug Assistance Act,” would provide \$29 billion in block grants to states for four years<sup>6</sup> to voluntarily provide prescription drug coverage to certain low-income Medicare beneficiaries. Senate Majority Leader Lott (R-MS) and Senate Majority Whip Nickles (R-OK) co-sponsored the less generous version of the proposal (S. 3016).

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

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

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

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

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

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

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

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

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

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

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

## CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PROPOSALS

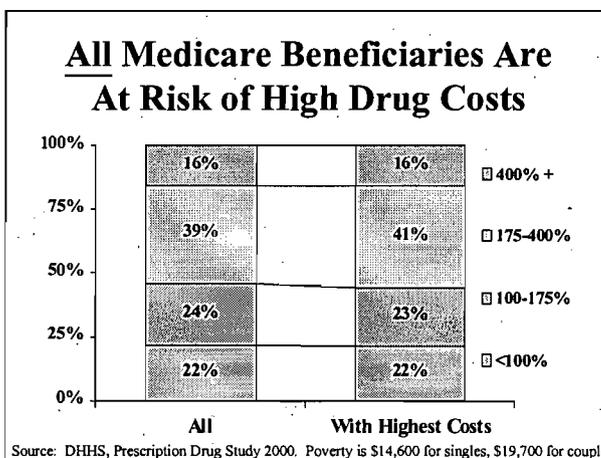
### **EXPLICITLY EXCLUDES AT LEAST 25 MILLION – TWO-THIRDS OF – MEDICARE BENEFICIARIES.**

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

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

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

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



<sup>7</sup> Analysis of the 1996 Medicare Current Beneficiary Survey.

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

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

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

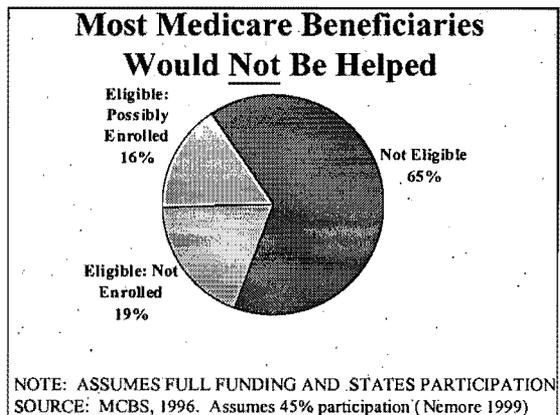
**Excludes millions of Medicare beneficiaries with inadequate, expensive, and unreliable managed care or private insurance plans.** Less than one-third of all Medicare beneficiaries have prescription drug coverage through a retiree health plan.<sup>11</sup> This leaves many middle-income seniors and people with disabilities who need prescription drug coverage only the choice of private Medigap insurance or, if available, a Medicare managed care plan. Premiums for private Medigap insurance with prescription drug coverage can be \$100 more per month – and much higher for those over the age of 80.<sup>12</sup> Yet, three-fifths of the seniors who purchase Medigap private insurance have income above 175 percent of poverty.<sup>13</sup> In addition, low-income drug plans do nothing to help those who join Medicare managed care plans for prescription drug coverage since they would not directly reimburse plans for such coverage. Thus, those who remain in Medicare+Choice plans remain at risk of losing drug coverage.

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

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

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

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



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

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

<sup>13</sup> Analysis of the 1996 Medicare Current Beneficiary Survey.

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

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

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

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

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

**Enrollment barriers exist in many state programs**

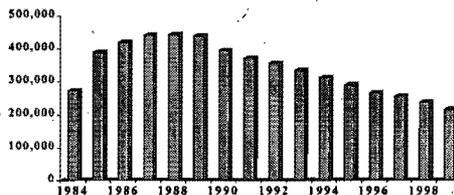
**for the elderly.** Another reason why state programs have not reached their enrollment goal is the difficulty of the enrollment process. States have not made the same strides in simplifying Medicaid enrollment for the elderly as they have for children. To sign up for Medicaid, eligible seniors and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

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

**ENROLLMENT TRENDS IN PACE**

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

**Enrollment in PACE**



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

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

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

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

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

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

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

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

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

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

**Enrollment would inevitably be capped.** States would have the discretion to set the upper eligibility limit under this program at any level above Medicaid and below 175 percent of poverty. They could also impose assets tests. Most disturbingly, states could – and would probably – cap enrollment. States would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries with the Senate Republican’s \$1.3 billion in 2001. While average annual spending on prescription drugs exceeds \$1,000, this funding would provide at most only \$119 per year per eligible senior (see Table 1). This would be even lower when taking into account people with disabilities. Much of this Federal funding would be used to replace existing state funding. In 1999, 12 states spent about \$700 million on non-Medicaid drug programs.<sup>23</sup> Four of these states (Connecticut, Maryland, New Jersey, Pennsylvania) could entirely substitution their state spending with their Federal funding under this plan. Another three states (Illinois, Maine, New York) could use more than half of their Federal allotment to replace all of their state spending. This does not take into account potential substitution in Medicaid. Thus, even if a state were to effectively encourage low-income seniors to apply, those seniors would inevitably end up on waiting lists.

**LIMITATIONS ON PRESCRIPTION DRUG COVERAGE IN STATE PROGRAMS**

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

\*Some Medicaid programs limit number of prescriptions that may be filled per month. \*\*Non-Medicaid programs. \*\*\*State program; limits coverage to 3 months per year.  
Sources: CCH; NGA 2000; National Pharmaceutical Council 1998; GAO

<sup>23</sup> General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets*. Washington, DC: U. S. GAO; GAO/HEHS-00-162.

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

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

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

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

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

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

- **On Medicare:** "The Governors want to ensure that elderly beneficiaries receive the best possible care, but the Medicare program is a federal program and the federal government should bear all of the costs of serving this dually-eligible population, including full federal responsibility for prescription drug costs." (HR-16-3-9)
- **On Prescription Drugs:** "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." (HR-39)
- **On Time-Limited Programs (SCHIP funding is for 10 years; Senate Republican drug plan is for 4 years)** "The design, development, and implementation of a health insurance program such as S-CHIP takes time. For states to enroll children, educate families about the benefits of a managed care delivery system, ensure that necessary services are received, and ensure that claims are submitted and subsequently paid, Governors must be confident that a stable funding stream will be available to provide health care services to beneficiaries." (HR-15-4)

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

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

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

## **CLINTON-GORE ADMINISTRATION PRESCRIPTION DRUG PROPOSAL**

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

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

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

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

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

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

**Middle-income widow with annual income of \$18,000.** An 85-year old widow, with annual income of \$18,000 (just over 200 percent of the poverty limit), has lived independently for the 15 years since her husband died. She currently does not qualify for Medicaid prescription drug coverage and cannot afford Medigap prescription drug coverage. However, she has developed congestive heart failure which, along with her arthritis, costs her \$9,000 per year – half of her income.

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

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

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

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

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

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

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

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

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

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

TABLE 1. STATE DATA

	EXCLUDED	LOW PARTICIPATION		LIMITED	STATE FUNDING		
	Percent of Seniors Not Eligible	Percent of Eligible Medicare Benes. NOT in Medicaid	Seniors Enrolled in State Programs	COVERAGE Medicaid or State Program Drug Limits	Allotments (Millions)	Current Non-Medicaid \$ (Millions)	New Dollars Per Eligible Elderly
Alabama	69%	48%			\$28.6		\$159
Alaska	81%	na			\$6.5*		\$1,089*
Arizona	75%	63%			\$19.4		\$140
Arkansas	64%	53%		Number	\$18.5		\$144
California	75%	12%			\$121.0		\$146
Colorado	80%	21%			\$10.7		\$153
Connecticut	79%	43%	29,969		\$13.7	\$15.7	\$0
DC	72%	67%			\$6.5*		\$312*
Delaware	74%	61%			\$6.5*		\$255*
Florida	74%	50%		Number	\$90.8		\$134
Georgia	75%	42%		Number	\$32.3		\$176
Hawaii	81%	49%			\$6.5*		\$215*
Idaho	71%	46%			\$6.5*		\$163*
Illinois	75%	70%	49,186	Type	\$50.1	\$34.1	\$48
Indiana	71%	65%			\$26.0		\$130
Iowa	74%	15%			\$13.3		\$135
Kansas	74%	60%			\$13.8		\$143
Kentucky	70%	39%			\$23.1		\$163
Louisiana	61%	48%			\$26.3		\$134
Maine	72%	44%	25,000	Type	\$7.6	\$4.7	\$64
Maryland	78%	64%	33,185	Type	\$20.1	\$26.9	\$0
Massachusetts	74%	52%	27,492		\$28.1	\$6.3	\$112
Michigan	74%	52%	12,968	Number	\$43.6	\$5.2	\$125
Minnesota	72%	54%	1,200		\$17.4	\$1.2	\$122
Mississippi	59%	15%		Number	\$19.2		\$154
Missouri	76%	59%			\$25.4		\$145
Montana	76%	63%			\$6.5*		\$264*
Nebraska	67%	69%		Number	\$9.0		\$126
Nevada	73%	66%			\$6.6		\$120
New Hampshire	75%	76%			\$6.5*		\$196*
New Jersey	74%	44%	195,005		\$32.7	\$248.0	\$0
New Mexico	72%	57%			\$9.4		\$167
New York	72%	40%	113,000		\$92.0	\$77.8	\$22
North Carolina	70%	32%		Number	\$42.9		\$161
North Dakota	65%	80%			\$6.5*		\$218*
Ohio	74%	67%			\$53.0		\$143
Oklahoma	71%	61%		Number	\$20.1		\$157
Oregon	78%	49%			\$13.8		\$160
Pennsylvania	74%	65%	235,758		\$64.1	\$209.3	\$0
Rhode Island	64%	72%	29,776	Type	\$7.4	\$2.3	\$91
South Carolina	65%	36%		Number	\$23.9		\$165
South Dakota	72%	59%			\$6.5*		\$230*
Tennessee	70%	19%		Number	\$29.4		\$162
Texas	69%	59%		Number	\$84.1		\$147
Utah	83%	47%			\$6.5*		\$203*
Vermont	71%	40%	9,428	Type	\$6.5*		\$342*
Virginia	77%	59%			\$29.9		\$168
Washington	81%	59%			\$16.7		\$171
West Virginia	63%	63%		Number	\$14.9		\$136
Wisconsin	73%	53%		Number	\$20.1		\$124
Wyoming	72%	53%	491	Number	\$6.5*	\$0.6	\$389*
<b>TOTAL</b>	<b>73%</b>	<b>48%</b>	<b>762,458</b>	<b>19</b>	<b>\$1,297.0</b>	<b>\$632.1</b>	<b>\$119</b>

## NOTES ON STATE DATA.

Column 1. Three-year average number of elderly with income below 75 and above 175 percent of poverty. Does not include people with disabilities. Medicare beneficiaries with disabilities have lower income which lowers the percent of all Medicare beneficiaries excluded.

Column 2. Percent of eligible beneficiaries not participating in Medicaid. Families USA. 1998. About 98 percent of people eligible for Medicare participate.

Column 3. Number of participants in state programs in 1999. U.S. GAO, 2000.

Column 4. Limits on prescription drug coverage. "Number" indicates that a participant's number of covered prescription is limited; "type" indicates that prescriptions only for certain conditions / types of drugs are covered. Note that Michigan limits the number of months per year that a senior qualifies for prescription drug coverage. Source: CCH; NGA 2000; National Pharmaceutical Council 1998.

Column 5. Estimates of state allotments calculated using the five-year average number of Medicare enrollees with income below 175 percent of poverty. Includes territory set-aside and floors. States with asterisks get the minimum allotment of \$6.5 million.

Column 6. Estimate of non-Medicaid State spending net of rebate. Note that not all states get the entire amount of the rebate; state spending is likely somewhat higher. U.S. GAO 2000.

Column 7. State allotments divided by number of seniors with income between 75 and 175 percent of poverty. Before calculating amount per eligible elderly, current net state prescription drug spending is subtracted. States that currently have state spending that exceeds their allotments are assumed to use the entire amount of the allotments to replace state spending. Note that states that get the minimum allotment of \$6.5 million have much higher dollars per eligible elderly person than they would have received without this minimum allotment.



CONGRESSIONAL BUDGET OFFICE  
U.S. CONGRESS  
WASHINGTON, DC 20515

Dan L. Crippen  
Director

August 31, 2000

Honorable Pete V. Domenici  
Chairman  
Committee on the Budget  
United States Senate  
Washington, DC 20510

Dear Mr. Chairman:

At your request, the Congressional Budget Office has prepared the attached cost estimate of the Medicare Outpatient Drug Act of 2000, which was offered as an amendment to H.R. 4577, the Labor-HHS appropriations bill.

CBO estimates that the proposal, if enacted, would have no budgetary impact in 2001. However, it would increase direct spending by \$61 billion over the 2001-2005 period and \$246 billion over the 2001-2010 period. The proposal would also reduce revenues by about \$1 billion through 2010. Assuming that the necessary amounts are appropriated, CBO estimates that additional discretionary spending would total \$5 billion through 2010.

You also asked for an assessment of the impact of the proposal on Medicare's financial status in the long term. Clearly, any additional federal spending for prescription drugs for the elderly would add to fiscal pressures in the coming decades, particularly as the baby boomers become eligible for Medicare.

Under current law, CBO projects that Medicare premiums and payroll taxes will fall short of Medicare outlays by 1.1 percent of GDP in 2010. This proposal would add to that gap by 0.25 percent of GDP in 2010. If the costs of prescription drugs continue to grow faster than GDP in subsequent years, the incremental cost of this proposal, as a percent of GDP, would grow in subsequent years.

Honorable Pete V. Domenici  
Page 2

I hope this information is helpful to you. The CBO staff contact is Tom Bradley, who can be reached at 226-9010.

Sincerely,

  
Dan L. Crippen  
Director

Attachment

cc: Honorable Frank R. Lautenberg  
Ranking Member

Honorable Charles S. Robb



## CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

August 31, 2000

### **Amendment 3598 to H.R. 4577 The Medicare Outpatient Drug Act of 2000**

*As printed in the Congressional Record of June 22, 2000*

#### **SUMMARY**

The Medicare Outpatient Drug Act of 2000 would establish a voluntary outpatient prescription drug benefit, beginning in 2003, under a new Part D of Medicare.

The Congressional Budget Office (CBO) estimates that this proposal, if enacted, would have no budgetary impact in 2000 or 2001. However, it would increase direct spending by \$61 billion over the 2002-2005 period and \$246 billion over the 2002-2010 period. The proposal would also reduce revenues by about \$1 billion through 2010. Assuming that the necessary amounts are appropriated, CBO estimates that discretionary spending would total \$5 billion through 2010. Because the proposal would affect direct spending and revenues, pay-as-you-go procedures would apply.

The bill contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). State spending for Medicaid would increase by about \$1 billion over the 2001-2005 period, but state, local, and tribal governments could also realize savings in their employee retirement programs because of incentive payments provided by the proposal.

#### **ESTIMATED COST TO THE FEDERAL GOVERNMENT**

The estimated budgetary impact of the Medicare Outpatient Drug Act is shown in Table 1. The proposal would affect mandatory spending in budget functions 550 (health) and 570 (Medicare) and would add to discretionary spending by all agencies. It also would reduce federal revenues.

**TABLE 1. ESTIMATE OF THE BUDGETARY EFFECT OF THE MEDICARE OUTPATIENT DRUG ACT OF 2000 (Outlays, by fiscal year, in billions of dollars)**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	Total, 2001- 2005	Total, 2001- 2010
<b>Direct Spending</b>												
<b>Medicare</b>												
Benefits	0	0	25.5	37.7	42.6	47.7	53.2	59.6	66.7	74.7	105.9	407.7
Part D premium receipts	0	0	-13.0	-19.2	-21.6	-24.2	-27.0	-30.2	-33.7	-37.8	-53.8	-206.6
Subsidy to health plans for retirees	0	0	0.6	0.9	1.0	1.1	1.3	1.4	1.6	1.8	2.5	9.7
Subtotal	0	0	13.2	19.5	22.0	24.6	27.5	30.8	34.5	38.7	54.6	210.8
<b>Medicaid (federal share)<sup>a</sup></b>												
Part D benefits and premiums	0	0	2.5	4.6	6.3	7.4	8.3	9.3	10.4	11.7	13.4	60.5
Change to current-law drug spending	0	0	-2.8	-4.1	-4.7	-5.3	-6.0	-6.8	-7.6	-8.6	-11.6	-46.0
Part A/B benefits and premiums	0	0	0.4	1.1	1.9	2.3	2.4	2.6	2.8	3.1	3.5	16.8
Administrative costs	0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.6	1.4
Effect of higher drug prices on Medicaid	0	0	*	0.1	0.1	0.2	0.2	0.4	0.5	0.7	0.2	2.2
Subtotal	0	0.1	0.4	1.8	3.8	4.6	5.1	5.7	6.3	7.0	6.1	34.9
<b>Effect of higher drug prices on FEHB program (for annuitants)</b>	0	0	*	*	*	*	*	*	*	0.1	*	0.2
<b>Total</b>	0	0.1	13.6	21.2	25.8	29.3	32.7	36.5	40.8	45.8	60.7	245.8
<b>Revenues</b>												
<b>Income and Medicare Payroll Taxes (on-budget)</b>	0	0	*	*	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.1	-0.9
<b>Social Security Payroll Taxes (off-budget)</b>	0	0	*	*	*	*	-0.1	-0.1	-0.1	-0.1	*	-0.4
<b>Total</b>	0	0	*	*	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-0.1	-1.3
<b>Spending Subject to Appropriations</b>												
<b>Administration of drug benefit</b>	0	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	0.6	1.6	4.2
<b>Effect of higher drug prices on FEHB program (for active workers) and other federal purchasers</b>	0	0	*	*	*	*	0.1	0.1	0.1	0.1	0.1	0.5
<b>Total</b>	0	0.3	0.4	0.4	0.5	0.5	0.6	0.6	0.6	0.7	1.6	4.7

NOTES: \* = costs or savings less than \$50 million; FEHB program = Federal Employees Health Benefits Program.

## BASIS OF ESTIMATE

The proposal would create a voluntary outpatient prescription drug benefit, beginning in 2003, under a new Part D of Medicare. That benefit would be operated by states or private entities that are awarded a contract to serve a geographic area by the Secretary of Health and Human Services. The Secretary would award at least two contracts in each area (if at least two entities submit qualified bids) and would arrange to provide the drug benefit in areas not covered by a contract.

In 2003 and 2004, a \$250 annual deductible would apply, although the contracting entity could waive that deductible for generic drugs. The beneficiary would then be responsible for paying 50 percent coinsurance on the next \$6,500 of total drug spending and 25 percent coinsurance on subsequent spending until the beneficiary reaches a \$4,000 limit on out-of-pocket spending (see Table 2). That limit would be reached when total drug spending reaches \$8,750, and the plan would cover all subsequent spending in that year. Beginning in 2005, the deductible and cost-sharing amounts would be updated annually by the percentage increase in average per-capita expenditures for covered outpatient drugs for Medicare beneficiaries.<sup>1</sup> The insured component of the benefit would be financed equally by premium payments withheld from enrollees' Social Security checks and by general tax revenues.

**TABLE 2. SCHEDULE OF BENEFICIARY'S OUT-OF-POCKET SPENDING FOR PRESCRIPTION DRUGS IN 2003 AND 2004**

Total Annual Spending	Percentage Paid by Beneficiary	Annual Out-of-Pocket Spending by the Beneficiary <sup>a</sup>	
		Spending in the Interval	Cumulative Spending
\$0 to \$250	100 percent	\$ 250	\$ 250
\$250.01 to \$6,750	50 percent	3,250	3,500
\$2,350.01 to \$8,750	25 percent	500	4,000
Above \$8,750	0 percent	0	4,000

a. Assumes beneficiary spends the full amount in the interval.

1. The amendment printed in the Congressional Record on June 22, 2000, contains a drafting error that would result in the deductible and cost-sharing amounts being updated by the percentage increase in total expenditures for covered outpatient drugs for Medicare beneficiaries, rather than by the percentage increase in average per-capita expenditures. The estimate assumes updates would be based on average per-capita expenditures.

The premiums and cost-sharing payments of certain low-income Medicare beneficiaries would be subsidized through the Medicaid program. Subsidies would be available to beneficiaries who are fully eligible for both Medicare and Medicaid or have income below 150 percent of the poverty level. (People with income between 135 percent and 150 percent of the poverty level would only receive assistance with their premiums, on a sliding-scale basis.) The federal government would pay for subsidies for people who are fully eligible for both programs and for other beneficiaries with income below 120 percent of the poverty level at the normal Medicaid matching rate (57 percent, on average), with states paying the rest. Subsidy costs for other beneficiaries would be paid entirely by the federal government.

The proposal also includes an incentive that is intended to preserve employer-sponsored drug coverage for retirees. Medicare would pay employers 67 percent of the premium-subsidy costs it would have incurred if their retirees had enrolled in Part D instead. In addition, enrollees in Medicare's managed care plans would receive their prescription drug coverage through those plans, which for the first time would be paid directly for providing such coverage (for enrollees who opt for the Part D benefit).

CBO's cost estimate assumes that everyone who participates in Part B of Medicare would also participate in Part D, with one exception: a quarter of those beneficiaries who have drug coverage through health plans for retirees would retain that coverage. In addition, CBO assumes that people who are eligible for benefits under Part B but do not enroll would also not enroll in Part D. Under those assumptions, nearly 36 million people would sign up for Part D in 2003, 2.5 million would receive prescription drug coverage from employer-sponsored plans, and 2.5 million Medicare enrollees would have no federally-subsidized prescription drug coverage.

### **Medicare and Medicaid Spending for the Prescription Drug Benefit**

CBO estimates that the proposed prescription drug benefit would increase direct spending by \$61 billion over the 2001-2005 period and \$246 billion over the 2001-2010 period.

**Medicare Spending.** The bulk of estimated spending for the prescription drug benefit over 10 years (\$211 billion) would come from Medicare. Payments for drug benefits would total an estimated \$408 billion through 2010, but they would be partially offset by \$207 billion in premiums paid by beneficiaries. (CBO estimates that the premium for Part D would start at about \$40 a month in 2003 and rise to about \$80 in 2010.) In addition, subsidies for employer-sponsored drug coverage would total \$10 billion over the 2001-2010 period.

**Medicaid Spending.** The prescription drug proposal would also increase net federal spending for Medicaid—by \$6 billion through 2005 and \$35 billion through 2010, CBO

estimates. The premium and cost-sharing subsidies that Medicaid would pay for low-income Medicare beneficiaries would cost the federal government \$60 billion over 10 years, but that increase would be partly offset by savings in Medicaid, because Medicare would replace Medicaid as the primary payer for drug spending for people who were fully eligible for both programs. CBO estimates that the federal share of those Medicaid savings would total \$46 billion through 2010. In addition, Medicaid spending would rise by \$17 billion over 10 years because the new drug benefit would induce more low-income Medicare beneficiaries to enroll in Medicaid. Finally, Medicaid's administrative spending would rise by \$1 billion through 2010 because of the costs of administering subsidies and handling claims for new Medicaid enrollees.

**Administrative Costs.** In addition to direct spending for Medicare and Medicaid, the proposed drug benefit would necessitate additional administrative costs to hire additional staff, promulgate regulations, contract with pharmacy benefit managers, buy computer systems, notify beneficiaries, and prepare the Social Security Administration to deal with millions of beneficiaries and the additional premium offsets against their Social Security benefits. Those administrative costs would total about \$4 billion through 2010 if sufficient funds to establish and operate the benefit were appropriated.

#### **Effect of the Prescription Drug Benefit on Federal Purchasers of Drugs**

Medicare enrollees who spent enough on prescription drugs to trigger the catastrophic coverage would no longer have to be conscious of the price of drugs. As a result, demand would grow and prices would increase for some drugs used heavily by Medicare enrollees—particularly drugs with no close substitutes. CBO estimates that, after 10 years, the average price of drugs consumed by Medicare beneficiaries would be 15 percent higher if the proposal were enacted.

Those higher prices would also affect spending for prescription drugs by other federal programs, such as Medicaid, the Federal Employees Health Benefits (FEHB) program, and programs of the Department of Defense (DoD), the Department of Veterans Affairs (VA), the Public Health Service (PHS), and the Coast Guard. CBO estimates that higher drug prices would add \$2 billion over the 2001-2010 period to direct spending for Medicaid and for annuitants covered by the FEHB program. We estimate that the higher discretionary spending needed by federal agencies (for current workers covered by FEHB) as well as by DoD, VA, PHS, and the Coast Guard would total \$0.5 billion over the 2001-2010 period.

#### **Effect on Revenues**

Higher drug prices would also lead to a loss of federal revenues from income and payroll taxes by raising the cost of employer-sponsored health insurance and correspondingly

reducing the amount of taxable compensation. CBO estimates that the decrease in revenues from income taxes and Medicare payroll taxes, which are on-budget, would amount to about \$1 billion through 2010. The estimated decrease in Social Security payroll taxes, which are off-budget, would total \$0.4 billion over through 2010.

## PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	0	100	13,600	21,200	25,800	29,300	32,700	36,500	40,800	45,800
Changes in receipts	0	0	0	-10	-30	-60	-90	-120	-160	-200	-250

## ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The proposal contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act, although CBO estimates that state spending for Medicaid, on balance, would increase by about \$1 billion over the 2001-2005 period.

State Medicaid programs initially would realize significant savings because the costs of some prescription drug benefits would be shifted to Medicare. In turn, Medicaid would pay premium and cost-sharing expenses for benefits provided under the new Part D program. The net effect of these two impacts would be a savings of about \$2.4 billion over the 2001-2005 period. More than offsetting those savings, however, would be additional administrative expenses, higher drug costs, and, in particular, higher enrollment rates for low-income beneficiaries, resulting in about \$3.4 billion in additional Medicaid costs to states over that period. On balance, the proposal would result in additional Medicaid spending approaching \$1 billion from 2001 to 2005.

The proposal also would offer incentives to employers in order to encourage them to continue offering prescription drug benefits within their health insurance programs for

retirees. Depending on the degree to which their retirement programs met requirements of the proposal, state, local, and tribal governments could qualify for those incentives, thereby realizing savings in those programs.

### **ESTIMATED IMPACT ON THE PRIVATE SECTOR**

The proposal contains no private-sector mandates as defined in the Unfunded Mandates Reform Act.

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**PRESIDENT CLINTON URGES CONGRESS TO EXTEND PRESCRIPTION DRUG  
COVERAGE TO MILITARY RETIREES AND THEN TO ALL MEDICARE  
BENEFICIARIES**  
May 16, 2000

Today, the President will announce his support for extending prescription drug coverage to military retirees and will urge Congress to show the same bipartisan support for extending prescription drugs to all Medicare beneficiaries. Tomorrow, the House is scheduled to vote on the Department of Defense Authorization bill that includes a provision, passed by an overwhelmingly bipartisan 56 to 1 committee vote, to extend the prescription drug coverage now available to military retirees under the age of 65 to all military retirees over the age of 65. Like other seniors, the nation's 1.4 million Medicare-eligible military retirees are disproportionately uninsured and face prohibitively high prices for prescription drugs. While some military retirees live close enough to military treatment facilities to access prescription drugs, these facilities are out of reach for about three out of four retirees. The President will point out that passage of this prescription drug legislation will not only provide long overdue assistance to the American men and women who have served in the military, but it will assist in the Defense Department's recruitment and retention efforts that the Secretary and Chairman of the Joint Chiefs has stated is critical. He will also emphasize that it is essential to ensure that all seniors and eligible Americans with disabilities have access to an affordable, voluntary, accessible Medicare prescription drug benefit.

**UNCOVERED SENIORS PAY MORE FOR LESS.** Uninsured seniors purchase one-third fewer drugs but pay nearly twice as much out-of-pocket. Many of the 1.4 million Medicare-eligible military retirees lack access to affordable prescription drugs. While they have become essential to modern health care, prescription drugs are not covered by Medicare.

**PRESIDENT CLINTON URGES CONGRESS TO EXTEND PRESCRIPTION DRUG COVERAGE TO MILITARY RETIREES OVER AGE 65.** The House Armed Services Committee's Authorization bill, developed by Congressmen Spence, Skelton, Buyer and Abercrombie, would provide affordable prescription drugs to military retirees. A similar provision was passed in the Senate Armed Services Committee, under the leadership of Senators Warner, Levin, Allard and Cleland. The House bill would allow retirees to access:

- Mail-order prescription drugs. Medicare-eligible military retirees would be able to purchase drugs through the National Mail Order Pharmacy, which ensures affordable pharmaceuticals through the distribution and pricing agreements DoD negotiates with pharmaceutical companies. Retirees over age 65 will pay an \$8 copay for a 90-day prescription, like other DoD retirees.
- Prescription drugs at pharmacies using both the TRICARE network and out-of-network pharmacies. The provision would also allow all Medicare-eligible retirees to pay 20 percent coinsurance for prescription drugs at pharmacies in the TRICARE network and 25 percent coinsurance with a \$150 deductible for prescriptions at pharmacies out-of-network.

**BUILDS ON ADMINISTRATION'S COMMITMENT TO REWARDING MILITARY SERVICE AND IMPROVING RECRUITMENT AND RETENTION.** Supporting the House provision will help the nation live up to its commitment to provide needed health care for our military retirees. As Secretary Cohen stated in his letter of support, "They spent their careers defending our country, and deserve our support in retirement." The provision of prescription drug coverage also complements our past efforts to attract and retain needed personnel with pay and pension improvements.

**TODAY'S ACTION IS CONSISTENT WITH THE PRESIDENT'S EFFORTS TO EXTEND PRESCRIPTION DRUGS TO ALL MEDICARE BENEFICIARIES.** Extending prescription drug coverage to military retirees is entirely consistent with the need for a voluntary Medicare prescription drug benefit that is accessible and affordable to all beneficiaries. The President's plan is:

- Voluntary. Medicare beneficiaries who now have dependable, affordable coverage would have the option of keeping that coverage.
- Accessible to all beneficiaries. Beneficiaries who join the program would pay the same premium and get the same benefit, no matter where they live, through a private, competitively selected benefit manager or, where available, through managed care plans.
- Designed to give beneficiaries meaningful protection and bargaining power. A reserve fund in the President's budget helps Medicare beneficiaries with catastrophic prescription drug costs. The plan also gives beneficiaries bargaining power they now lack; according to CBO, discounts would average 12.5 percent.
- Affordable to all beneficiaries and the program. According to CBO, premiums would be \$24 per month in 2003 and \$48 per month in 2009, when fully phased-in. Low-income beneficiaries – below 150 percent of poverty (\$17,000 for a couple) – would receive extra help with the cost of premiums; those below 135 percent would have no cost sharing.
- Consistent with broader reform. The new, voluntary prescription drug benefit is part of a larger plan to strengthen and modernize Medicare. This plan would make Medicare more competitive and efficient, reduce fraud and out-year cost increases, promote fair payments, and improve preventive benefits in Medicare. The plan would also dedicate \$299 billion from the non-Social Security surplus to Medicare to help extend its solvency to at least 2030.

Office of Management and Budget  
National Security Division

Operations Branch

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Date: \_\_\_\_\_

TO: Jeanne / Bob

FAX NUMBER: 55631 / 50345

FROM: Suzanne White (swhite@omb.eop.gov)

PHONE: (202) 395-3853

Examples of cleared statements given by  
DoD on health - as requested by  
Chris Jennings.

Also a press article w/ good comprehensive  
summary of Shelton's arguments.

Shelton  
Testimony 2/00

The claims process is another major source of frustration for our Active Duty members and their families. We must have a system that ensures the government, not the beneficiary, receives the bills. Additionally, the protracted time it takes contractors to pay provider bills creates a disincentive for providers to remain in the network. My staff is working closely with Dr. Sue Bailey, ASD (Health Affairs), to fix or remove these major irritants.

In the near-term, the Joint Chiefs would like to see improvements in the overall health care benefit. For years our recruiters have promised health care for life for career members and their families. As we all know, that is not what they receive. To honor this promise, the President's budget includes the expansion of TRICARE Prime Remote for active duty family members and the elimination of co-pays for all active duty family members enrolled in the TRICARE Prime network.

The Chiefs and I recognize the compelling need to provide more comprehensive coverage for our retirees and their family members. Where specific TRICARE coverage is not available, we must offer them other benefits. Our intent is to reduce out-of-pocket expenses.

Let me stress that the Joint Chiefs' commitment to quality healthcare for all military members, including retirees, remains firm. Keeping our promise of ensuring quality healthcare for military retirees is not only the right thing to do, it also is a pragmatic decision because it sends a strong signal to all those considering a career in uniform.

*Rudy de  
Leon  
Statement  
of 00*

2. **Improve telephone access** –deploying uniform standards for both military treatment facilities and civilian networks.
3. **Improve and standardize appointing processes** – accelerating deployment of the standardized system, and integrating demand management and appointing.
4. **Improve primary care management** – implementing a standard definition of Primary Care Manager by Name/Team for TRICARE Prime enrollees.
5. **Improve case management** –identifying patients who require case management and those whom need case management services but do not meet the current definition.
6. **Implement DEERS 3.0 on schedule** –facilitating continuity of care and improving portability.
7. **Improving TRICARE Claims Processing through such reforms as:**
  - **Claims Processing Cycle Time:** The TRICARE Program has adopted claims processing timeliness standards compatible with industry standards, requiring contractors to process 95% of retained claims within 30 days / 100% of retained claims within 60 days. Implementation of this process began on 1 September 1999.
  - **Ease Provider Authorization:** With this change, when a contract is awarded, the new contractor is required to re-certify only TRICARE network providers and will depend on existing state licensing and credentialing records for all non-network providers. All contractors completed implementation of this process in 1999.
  - **Better Explanation of Why Claims Returned to Providers:** If a problem claim is submitted, the contractor returns the claim to the submitting party with an explanation as to why the claim is being returned. All contractors completed implementation of this process in summer 1999.
  - **Third-Party Liability:** Contractors will be permitted to process claims to completion and not defer it until all third-party liability issues are resolved. Implementation expected in spring 2000.
  - **Comprehensive Evaluation of Claims Processing System:** The Department has contracted with an expert-consulting firm to assess the claims processing system. Initiatives identified through this review include proposals to increase electronic claim submission; increase auto-adjudication; improve customer service, provider and beneficiary education, improve program-wide data quality; improve enrollment and eligibility process; and enhance fraud and abuse mitigation capabilities.

### **The Military Health Care Benefit**

Secretary Cohen and General Shelton have identified healthcare, along with housing, as a key quality of life issue for our service members and their families that must be addressed this year. The President's budget adds funding for two important expansions of the TRICARE benefit that will lower out-of-pocket medical costs for service members and their families. First, the budget proposal includes \$30 million to expand TRICARE Prime Remote to cover family members. In October of last year, the Department launched TRICARE Prime Remote to reduce out-of-pocket co-payments for service members living and working in areas far from Military Treatment Facilities. The

President's budget proposal would now extend this benefit to health care obtained by these service members' families. The budget request also includes \$50 million to eliminate co-pays for all active duty family members enrolled in TRICARE Prime when they receive care from civilian health care providers. This proposal will stop service members from having to pay out of their own pocket for health care simply because there is no appointment available for them in a military hospital or clinic.

Among our beneficiaries are those who have extraordinary or very costly medical needs. Our healthcare providers and military treatment facilities have developed dynamic case management programs to help these families identify all available resources in both the civilian and military communities. Our individual case management program, which we implemented in March 1999, now gives us an opportunity under many circumstances to provide for services, such as custodial care, that we previously were unable to provide for our CHAMPUS-eligible beneficiaries. While we do not have a definitive projection of what this individual case management program will cost, President's budget includes \$20 million for implementation of this new benefit.

Secretary Cohen and the Chairman have expressed their strong commitment to expand health care access to our military retirees. The President's budget includes funding for the demonstrations we currently have underway, or will soon begin, to test alternative means of expanding health care benefits to our Medicare-eligible retirees, their spouses, and survivors. The Department is conducting several demonstration programs to test the best means to expand health care to Medicare-eligible retirees. Over 130,000 retirees are eligible to participate in these demonstrations. These demonstrations are:

**1) TRICARE Senior Prime: 28,000 enrollees**

Now being tested in a three-year demonstration period at eight military treatment facilities. Under this program, Medicare-eligible retirees enroll with an MTF which serves as their Medicare+Choice plan, and Medicare reimburses DoD at a capitated rate for care provided to these enrollees beyond the level of effort already provided by DoD.

**2) Federal Employee Health Plan: 70,000 eligibles**

Under this demonstration, Medicare-eligible retirees at eight demonstration sites can enroll in the FEHBP. The DoD and beneficiaries will pay the same premium cost shares of other participants in the FEHBP and receive the same benefits as all other federal employees and annuitants under this program.

**3) Expanded Pharmacy Benefit: 6,000 eligible enrollees**

Effective spring 2000, DoD will offer an expanded pharmacy benefit for Medicare-eligible retirees at two sites. Retirees will be offered a pharmacy benefit equivalent to the TRICARE Extra pharmacy benefit with an enrollment fee plus applicable co-payments.

**4) TRICARE Senior Supplement: 11,000 eligible enrollees**

In spring 2000, DoD will test offering a TRICARE Senior Supplement to military retirees at 2 sites. Under this program, TRICARE will cover Medicare cost sharing as well as services not now covered by Medicare.

Shelton's  
first big  
speeches  
on  
issue

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Subject: Shelton Ready to Tackle TRICARE Issues

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By Staff Sgt. Kathleen T. Rhem, USA  
American Forces Press Service

WASHINGTON -- DoD has made huge strides in quality-of-life issues, but healthcare for service members and their families still needs serious work, the nation's top military officer said Jan. 31.

"To have implemented TRICARE worldwide in five years with its 8.3 million beneficiaries is quite an accomplishment," Army Gen. Henry Shelton, chairman of the Joint Chiefs of Staff, said in opening remarks at the three-day 2000 TRICARE Conference here. "A tremendous amount has been achieved, but I'm sure you'll all agree with me that we still have a long way to go."

Shelton told his audience of some 400 civilian and military healthcare providers and administrators that healthcare is one of DoD's "big four" quality-of-life issues -- the building blocks of a quality volunteer force. The other three are pay and compensation, retirement benefits, and housing.

He cited the 4.8 percent pay raise, pay table reform and repeal of the Redux retirement plan in the fiscal 2000 budget as examples of the defense leadership's commitment to recruit and retain a quality force. Also, Defense Secretary William Cohen in January announced a major initiative to eliminate out-of-pocket housing costs within five years.

"This year we've got to address healthcare," Shelton said. "The bottom line is that our service members and their families must be able to count on their healthcare system. Our fighting men and women on the frontlines of freedom need to know that their families are being taken care of."

He told the group that thanks to e-mail, today's deployed troops know almost immediately if there is a problem with healthcare at home. "While they are doing their job taking care of the nation's defense, they expect us to provide an effective, user-friendly healthcare system," he said.

Overall, TRICARE beneficiaries may say they're satisfied with the healthcare they receive, but many complain about the process of getting that care, Shelton said. "Every time I talk to them, one of their most frequent complaints is ... with the process it takes to finally get the care they need," he said.

"To the health system's credit, once our men and women and families receive care, few of them complain about the quality of care or the attitude of the healthcare providers," he told the conference attendees. "This is a bright spot in the system, and when it works it is the result of the hard work that you all do."

Shelton said many frustrations can be traced to poor customer relations and bad business practices. TRICARE's regional structure works against consistency in such "common-sense areas" as appointments, claims and enrollment, he noted.

"As many of you know, TRICARE requires that members re-enroll every time they change regions, something that occurs frequently as our service members and their families must pick up and move every two to three years," he said. "This adds to their stress and frustration, and oftentimes, their workload."

Another concern is that there are differences in benefits between those stationed stateside and those stationed overseas. "These challenges require our urgent attention," Shelton said. He noted that Dr. Sue Bailey, assistant secretary of defense for health affairs, addressed the Joint Chiefs in January and laid out a plan and a schedule to fix these issues. But that's still not enough, he said.

"We ask our service members to be ready to serve any time, anywhere. They expect no less from their healthcare system," he said. "If a service member can't count on TRICARE when it's needed, then when the time comes to re-enlist, the answer might just be 'no.' In short, TRICARE can't be just an insurance agency; it must be much more."

Shelton said he has testified before the Senate Armed Services Committee that improving medical care is a top DoD priority in the fiscal 2001 defense budget. He said improvements should focus on several areas:

- o Fully funding and placing more emphasis on the Defense Health Program. Shelton said the program has been

underfunded for several years. "We are encouraging unit leadership, from the senior flag officers to the platoon leaders, to understand, get involved and become advocates for the military health system," he said. "This is clearly a program that deserves command attention and support."

o Ensuring every installation has a TRICARE hot line, "(This is) not to bypass the chain of command, but to bring medical care issues to the attention of the appropriate people at the appropriate levels," Shelton said.

o Increasing retirees' benefits. Important first steps would be to increase pharmacy benefits and to fully fund and expand TRICARE Senior Prime. "Our retirees deserve the healthcare that they have earned and DoD committed to," he said. 

o Establishing a healthcare network to meet the needs of all beneficiaries. Start this with automatic enrollment of all active duty members and their families, Shelton said. He said beneficiaries should have quick, easy access to case managers, and fair and timely claim payments. All enrollees need to know who their primary case manager is and how to contact them. "I applaud your recent initiative to make sure that the patient knows his doctor by name," he said. "This is just plain good medicine."

o Changing "navigation" to make the system as customer-focused and easy to use as possible. "Many service members' attitudes toward TRICARE stem from their experiences on the telephone," Shelton said. "Our service members and their families should not be forced to wait on the phone and listen to recordings for 20 minutes just to secure an appointment." He said another irritant, the claims process, should be "invisible to the active duty members and simplified for all others."

The chairman told the group his staff will work actively with DoD's new Defense Medical Oversight Committee, which aims to address current irritants and future benefits of the military healthcare system.

He urged managers to test their own systems. "For those who are military healthcare members, try not wearing your uniform one day -- you've got my permission -- and walk into the TRICARE offices you're responsible for to see how you're treated," he said. "If you find things not to your liking, fix them."

"Remember, if it's hard for you, imagine what it's like for the young, inexperienced mother of two whose husband is deployed to Bosnia or Kosovo or any of the other garden spots our troops are deployed to," Shelton said.

He told the group they should act as advocates for their

beneficiaries, not adversaries. "You work on behalf of our warriors and their families. They need your support, and I know that you are committed to helping them," he said. "It is my goal that a future chairman a few years from now can come before you and say with conviction, 'Our healthcare system is a success and better than any other in the world, bar none.'"

Related Site of Interest: <a href =http://www.tricare.osd.mil/>TRICARE</a> web site

##END##

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