

# Withdrawal/Redaction Sheet

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. survey	Survey- Prescription Drug Benefit (16 pages)	4/28/00	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 Drugs Benefit [3]

gf38

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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]

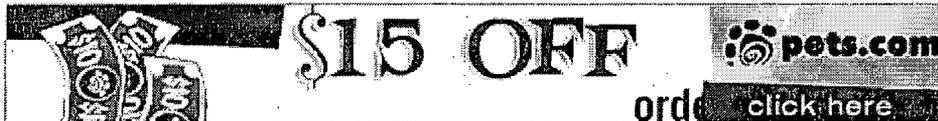
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May 11, 2000

## Drug Benefits For Medicare Are Proposed By Democrats

By ROBERT PEAR

**W**ASHINGTON, May 10 -- Congressional Democrats rallied today around a bill that would offer prescription drug benefits as part of the Medicare program, in contrast to the approach favored by Republicans, who want to subsidize private insurance to help pay such costs.

Several dozen House and Senate Democrats joined in a display of unity at the White House, where they said they had agreed on a proposal to offer coverage of prescription drugs to all Medicare beneficiaries -- 39 million elderly or disabled people.

The proposal is similar to one offered by President Clinton, but it is somewhat more generous to beneficiaries and somewhat more expensive for the government.

Mr. Clinton and lawmakers appeared in the White House Rose Garden with Betty Dizik, a 73-year-old widow who said she sometimes skipped prescribed medications for diabetes and a heart condition because she could not afford them.

"I am not asking for a handout or for charity," Ms. Dizik said. "I am willing to work and do my part. I am just asking for a little help."

The Democrats' proposal is embodied in a bill introduced today by the Senate minority leader, Tom Daschle of South Dakota, with 32 of the 45 Democratic senators as co-sponsors. The House Democratic leader, Representative Richard A. Gephardt of Missouri,



Paul Hoscitros/ The New York Times

President Clinton hugged Betty Dizik, a Medicare recipient, yesterday after she spoke at the White House about the high cost of prescription drugs. Speaking in support of Mr. Clinton's plan to offer drug benefits through Medicare, Ms. Dizik said she would vote for the president again if she could.

said he would soon introduce a bill nearly identical to the Senate measure.

In a Congress controlled by Republicans, the Democrats have no chance of seeing their bills enacted. But they hope that by taking a unified position, they can put pressure on the Republicans to enter negotiations leading to the enactment of Medicare drug benefits this year.

Vice President Al Gore and many Congressional Democrats have denounced the Republicans as slow to act on the issue.

But the president sounded more cooperative today. "We all know we can't achieve our efforts without bipartisan support in the Congress," Mr. Clinton said. "That's why, just as we are trying to do with the patient's bill of rights, we want to reach across the aisle to encourage Republican support, as well. This can and should be a truly bipartisan effort."

The Congressional Democrats, like Mr. Clinton, say Medicare should cover half of a person's drug expenses up to certain limits -- half of the first \$2,000 in drug expenses starting in 2002. The ceiling would rise gradually. By 2009, Medicare would cover half of the first \$5,000 in drug expenses.

Some drugs cost much more than \$5,000 a year. The Congressional Democrats would provide assistance for people with very high expenses; Medicare would pay their drug costs after they spent \$3,000 or \$4,000 of their own money.

Mr. Daschle said his bill "dedicates \$50 billion" to insurance covering such catastrophic expenses from 2003 to 2010. By contrast, the president requested \$35 billion for the years from 2006 to 2010.

Republicans are developing their own proposals. The chairman of the Senate Finance Committee, William V. Roth Jr., Republican of Delaware, is drafting legislation but has not given any hint of the details. House Republicans are fleshing out their proposal, under which the government would subsidize private insurance to help pay drug costs for Medicare beneficiaries.

Congress and the administration are both scrutinizing drug prices. Federal officials said they were investigating several drug companies to see if they had overcharged Medicaid, Medicare or other government programs by overstating their wholesale prices.

The American unit of Bayer A.G., the German drug company, said it had begun talks with the Justice Department in the hope of reaching a settlement over drug prices that would avoid costly litigation.

In another sign of concern about drug costs, Senator James M. Jeffords, Republican of Vermont, introduced a bill that would make it easier for Americans to import medications from Canada, where drug prices are often much lower.

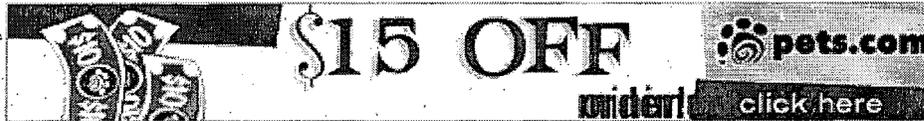
Under Mr. Jeffords's bill, Americans could import a limited amount of prescription drugs, perhaps a three-month supply, for personal use. In addition, pharmacists and wholesalers could import certain prescription drugs and pass the discounts on to American consumers.

The drug industry opposes the bill, saying it could expose Americans to adulterated or counterfeit drugs. But the bill instructs the Department of Health and Human Services to regulate imports to ensure that drugs are safe and effective.

Mr. Clinton and Congressional Republicans generally say that Medicare drug benefits should be enacted as part of a more comprehensive effort to revamp Medicare.

Chris Jennings, the president's health policy coordinator, today commended the sponsors of an ambitious bipartisan proposal to redesign Medicare, Senators John B. Breaux, Democrat of Louisiana, and Bill Frist, Republican of Tennessee. Mr. Jennings said the senators' efforts were "quite encouraging."

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ABC NEWS

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**SHOW:** WORLD NEWS TONIGHT (6:30 PM ET)

**May 10, 2000, Wednesday**

**TYPE:** Newscast

**LENGTH:** 465 words

**HEADLINE:** PRICE OF **PRESCRIPTION DRUGS** HOTTEST ISSUE IN POLITICS

**ANCHORS:** PETER JENNINGS

**REPORTERS:** JOHN COCHRAN

**BODY:**

PETER JENNINGS, anchor:

When the election gets closer this year, the issue is getting the most attention may be different than they are right now. But right now judging by the political parties, the hottest issue is the price of **prescription drugs**, especially for the very valuable group of voters eligible for **Medicare** and those not too far off. That's where we begin tonight. Today, the Democrats have raised the stakes. And ABC's John Cochran is in the Clinton White House. John:

JOHN COCHRAN reporting:

(OC) Peter, you are absolutely right. With their new proposal, the Democrats have raised the stakes, not only that, to put more pressure on Republicans to act on prescription coverage.

(VO) The president decided to do back a proposal from House and Senate Democrats that is more generous than the one he proposed earlier this year.

President BILL CLINTON: This is not about winning a political fight. It's about giving people a chance to fight for a good, long life.

COCHRAN: (VO) The new plan would give **Medicare** recipients the option of paying about \$ 25 a month. In return, the government would pay for half of their prescription costs, up to \$ 2,000 a year the first year and even more later. It would also pay a large part of catastrophic expenses for people suddenly hit by huge drug bills.

Senator TOM DASCHLE (Minority Leader): So, if your bill is \$ 800 a month, **Medicare** would pay at least \$ 400 of that bill.

COCHRAN: (VO) Politicians are focusing on **prescription drugs** because the conventional wisdom is the issue that matters to elderly voters and they go to the polls in large numbers. But a new ABC News poll has a surprise: middle-aged Americans, 45 to 60, also care about prescription coverage. Sixty-four percent saying prescription coverage by **Medicare** is very important in their vote this fall and they are much more likely to vote than the elderly. Those in middle age often have parents with big drug bills and they know they will soon be joining the ranks of the elderly themselves. To deal with those concerns, Republicans have come up with more modest proposals that would help the elderly pay for private insurance policies that would cover drugs. But Republicans are worried about losing control of the House this fall and seem eager for a compromise with Democrats.

Representative DENNIS HASTERT (Speaker of the House): We're going to move forward. We're looking forward to working with the White House, if they ask us to do that. And I am sure that they will.

COCHRAN: A deal on **prescription drugs** is by no means certain, Peter. But in an election year short on issues, our new poll show more and more voters care about this one.

JENNINGS: Right now. Thanks very much. John Cochran at the White House.

**LANGUAGE:** English

**LOAD-DATE:** May 11, 2000

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**FOCUS<sup>TM</sup>**

**Search: General News; medicare and prescription drugs**

To narrow this search, please enter a word or phrase:

*Example:* House of Representatives

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Chris  
Fy,  
Barbara

**LEADERSHIP COUNCIL**  
*of*  
**AGING ORGANIZATIONS**

**STATEMENT BY LEADERSHIP COUNCIL OF AGING ORGANIZATIONS**

**RESPONSE TO THE  
SENATE DEMOCRATIC LEADERSHIP PRESCRIPTION DRUG PLAN**

**PRESS CONTACT: BRIAN LINDBERG  
202-789-3606**

**FOR IMMEDIATE RELEASE  
MAY 10, 2000**

Today, the U.S. Senate Democratic Leadership will introduce its Medicare prescription drug benefit legislation, which it hopes Congress will consider this year. The Democrats' legislation is consistent with the Leadership Council of Aging Organizations' (LCAO) statement of principles on a Medicare prescription drug benefit. The legislation meets the principles of creating a voluntary, comprehensive prescription drug benefit that is available to all Medicare beneficiaries regardless of income or health status.

In a letter to Minority Leader Tom Daschle, James Firman, President and CEO of the National Council on the Aging, stated "We are particularly pleased that the proposal provides direct assistance to all beneficiaries to help pay for coverage, not just those who are poor. As you know, approximately 6.5 million seniors with income above 150 percent of poverty do not have any prescription drug coverage."

Martha A. McSteen, President of the National Committee to Preserve Social Security and Medicare, said, "Americans seem to be behind the approach taken in the Democratic legislation." She cited her organization's new poll conducted by Peter Hart Research, which revealed that "Seventy percent of all Americans support the direction taken in this new legislation, and a majority consider it a top priority for Congress this year. The public wants the real McCoy - not a means-tested plan or a plan based on private insurance, but, instead, coverage through Medicare for all seniors for at least part of the costs of pharmaceutical medications."

The LCAO is very concerned that any new prescription drug benefit protect all beneficiaries from burdensome out-of-pocket expenses and unaffordable cost sharing. The Democrats' bill is sensitive to low- and middle-income individuals by first, ensuring the availability of a benefit and not relying on the private insurance market to offer such a policy, and second, by eliminating the cost sharing and premiums for the lowest income beneficiaries.

- more -

03/10/2000 11:40 FAX 003

According to Brian Lindberg, Chair of the LCAO Health and Long-Term Care Committee, "We are particularly pleased to see a realistic and long-term funding commitment for the prescription drug benefit. The commitment of significant resources to the basic benefit and to catastrophic coverage over ten years is a pledge that all older and disabled individuals in fee-for-service Medicare and Medicare+Choice will have affordable access to prescription drugs. Further, this is not a means-tested benefit – it preserves Medicare's universal approach."

Finally, the LCAO looks forward to working with President Clinton and Congress to provide a prescription drug benefit that is affordable, useful, and cost-saving to all Medicare beneficiaries.

In February, 33 member organizations of the LCAO sent a letter to each member of the House and Senate outlining the critical issues that must be addressed in any Medicare prescription drug benefit that will gain their support. The LCAO clearly stated that the principles set forth in that communication were essential elements that must be incorporated into the bills that were being drafted. The following are some of the LCAO principles:

#### **Benefits**

- Medicare should guarantee access to a voluntary prescription drug benefit as apart of its defined benefit package.
- Medicare's contribution toward the cost of the prescription drug benefit must keep pace with the increase in prescription drug costs and not be tied to budgetary caps.

#### **Coverage**

- The Medicare prescription drug benefit should be available to all Medicare eligible older Americans and persons with disabilities, regardless of income or health status.
- The Medicare prescription drug benefit must be voluntary and provide safeguards against erosion of current prescription drug coverage provided by others.

#### **Affordability**

- The financing of a new Medicare prescription drug benefit should protect all beneficiaries from burdensome out-of-pocket expenses and unaffordable cost sharing, particularly low-income beneficiaries.
- The government subsidy must be sufficient to guard against risk selection and to provide an attractive benefit design.



"Taylor, Bridgett" <Bridgett.Taylor@mail.house.gov>  
05/12/2000 09:29:46 AM

Record Type: Record

To: Jeanne Lambrew/OMB/EOP

cc:

Subject: FW: Prescription drugs in defense bill

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Here's the stuff I mentioned last night. WOW!!! Thanks again for last night. It was wonderful!!! When you get a chance I would like to talk about this CHIP thing more.

BT

> -----

> From: Stein, Todd

> Sent: Thursday, May 11, 2000 5:59 PM

> To: Droskoski, Amy; King, Andrea; Montgomery, Anne; Beausang, Beth;

> Taylor, Bridgett; Pesanti-Payson, Debbie; Dehoney, Eleanor; Sheiner, Jon;

> Folk, Karen; Lightfoot, Karen; Nelson, Karen; Kapsa, Michael; Giuli,

> Steve; Heuer, Tate; Vaughan, Bill

> Subject: Prescription drugs in defense bill

>

> \*\*\* Message opportunity on prescription drugs when House considers Defense

> Authorization bill next week \*\*\*

>

> Yesterday, in the Defense Authorization bill mark-up, the Armed Services

> Committee (HASC) approved a provision, with the support of Committee

> Republicans, to extend a federal government-run prescription drug benefit

> to a segment of the Medicare-eligible population (military retirees), in

> which a federal agency negotiates prices on behalf of beneficiaries (more

> details below).

>

> In order to include this provision, HASC requested and received from Ways

> and Means a letter waiving jurisdiction, in order to avoid sequential

> referral. Therefore, Ways and Means has assented to expanding a

> government-run prescription drug benefit for one segment of the Medicare

> population, at the same time that its GOP leadership criticizes Democrats

> and the President for proposing a government-run benefit for the rest of

> the Medicare population.

>

> During debate, Rep. Allen asked Personnel Subcommittee Chairman Steve

> Buyer whether the Tricare Senior Pharmacy Program was run by a government

> agency, the Defense Department. Buyer said yes. Rep. Allen asked whether

> pharmaceutical prices for beneficiaries were negotiated by a government

> agency, the Defense Supply Center in Philadelphia (DSCP). Buyer said yes.

> Rep. Allen asked whether he considered this a "price control." After

> hemming and hawing, Buyer essentially admitted that yes, it was a form of

> price control.

>

> The provision, called Tricare Senior Pharmacy Program, extends

> prescription drug benefits to all 1.4 million Medicare-eligible military

> retirees and family members (600,000 of which already are eligible because

> they live close enough to a military facility). It gives them access to

> the Tricare mail order and retail programs. According to CRS (RS20295),

> some drugs are obtained at the FSS price, while the DSCP uses the VA 24%

> discount as the starting price, and often gets discounts of 24% to 70% for

> its beneficiaries.

>

> This program was a key piece of the Democratic military health care

> legislation put forth by Reps. Abercrombie, Taylor and Skelton, so care

> must be taken not to jeopardize support or enactment of the provision. It

> was included in the Personnel Subcommittee mark by Rep. Buyer and included

> in the full Defense Authorization bill without dissent among Committee

> Republicans or Democrats.

>

To: CHAIRS

*Premium stuff - I also found some stuff on M&A*

above is illustrative. Through the action of the premium formula, an increase in the private enrollment proportion relative to present law would tend to further increase fee-for-service premiums, by lowering the weighted average premium. Under the Medicare Commission's two alternative proposals, enrollment was estimated to increase by about 6 to 8 percentage points but the impact of the current bill could be significantly different.

As indicated above, a substantial part of the illustrative increase in fee-for-service premiums is due to the 12-percent factor in the premium formula, rather than the actual level of SMI premiums as a percentage of total Medicare costs (currently estimated to be 9.8 percent in 2003). The Medicare Commission's intent was for beneficiaries in average-cost plans to pay the same proportion of total Medicare costs as would happen under present law (once the home health costs transferred to SMI have been fully reflected in the SMI premium). This proportion had been estimated at roughly 12 percent at the time of the Commission's deliberations. Under current projections, the present law percentage is estimated to increase gradually from about 10.1 percent in 2004 (when the home health cost is fully reflected) to an estimated 10.8 percent in 2010.

Mr. Stark also asked about the cost of high-option coverage compared to the standard option. In the absence of antiselection by beneficiaries, we estimate the following costs and premiums under the proposal for fee-for-service beneficiaries in 2003 (for beneficiaries with incomes above the section 2229 threshold):

Coverage	Monthly cost	Monthly premium	Annual cost	Annual premium
Standard option.....	\$564.00	\$81.45	\$6,768	\$977
+ catastrophic coverage.....	45.83	45.83	550	550
+ drug coverage.....	76.67	57.50	920	690
Subtotal, additional coverages .....	122.50	103.33	1,470	1,240
High option .....	\$686.50	\$184.78	\$8,238	\$2,217

In practice, however, it is very likely that beneficiaries choosing high-option plans would tend to have greater health care costs than those choosing standard-option plans. This result could increase the cost of the supplementary coverage substantially, causing high-option plans to face a terminal "antiselection spiral" with steadily increasing premiums and declining enrollment. Limiting enrollment in high-option plans to a one-time opportunity at initial eligibility would substantially reduce or eliminate this problem and we understand that Senators Breaux and Frist have specified this modification to their original bill.

We cannot comment at this time about the financial status of the Medicare program or its general revenue financing requirements under the bill, since we have not yet been able to estimate the program savings. Please let us know if you have any questions about the preliminary estimates shown in this memorandum.

*Richard S. Foster*  
Richard S. Foster, F.S.A.  
Chief Actuary

# DEMOCRATIC MEDICARE PRESCRIPTION DRUG ACT OF 2000

## Major Features of the House Proposal

**Universal, Voluntary.** Establishes a voluntary Prescription (Rx) Drug Benefit Program for seniors and disabled in Medicare (called Part D), beginning in 2002.

**Eligibility and Enrollment.** Enrollment is voluntary when a senior or disabled person first becomes eligible for Medicare, or if and when they lose coverage from an employer, Medicare+Choice plan, or Medicaid.

**Coverage.** Enrollees (1) receive Medicare payment for covered drugs from any participating pharmacy and (2) are charged negotiated, discounted prices on all their covered drug purchases regardless of whether the annual benefit limit has been reached. The program covers FDA-approved drugs, including immunosuppressive drugs. Beneficiaries are guaranteed coverage for any covered drug their doctor prescribes.

**Benefits.** Medicare, through a Rx Drug Insurance Account, will pay for at least 50% of the negotiated price for the drug, up to 50% of annual limits equal to \$2000 in 2002-2004, \$3000 for 2005-6, \$4000 for 2007-8, and \$5000 for 2009, and for succeeding years, the previous year's limit adjusted for inflation. If the benefit providers achieve greater than anticipated discounts, the savings can be used to decrease the beneficiaries' 50% copay. Each year, the Secretary determines the premium amount necessary to pay no more than half the benefit cost.

The Secretary by 2002 implements (through private sector benefit providers) a catastrophic benefit limiting a beneficiary's maximum out-of-pocket costs to approximately \$3000 per year adjusted for inflation.

**Private Sector Administration.** The Secretary shall contract with a private benefit provider in various designated geographic areas. Benefit providers are any entity the Secretary determines can fulfill the contract. The Secretary is prohibited from establishing a formulary or setting prices.

**Ending Price Discrimination.** In order to ensure that drug prices are equitable and affordable to beneficiaries, the private benefit providers are charged with using Medicare's volume purchasing power to negotiate and achieve the same drug price discounts that favored large purchasers obtain. Benefit providers shall use proven market-based strategies to negotiate prices for Rx drugs that eliminate unfair price discrimination against seniors.

**Other Duties of Private Benefit Providers.** Benefit providers shall ensure convenient access to physician prescribed drugs through distribution systems and work with local pharmacies to establish drug utilization review, quality improvement and error reduction programs. Benefit providers are also responsible for patient confidentiality standards and ensuring beneficiary grievance and independent appeals procedures.

Participating pharmacies must meet licensing, access, quality, and confidentiality requirements and not balance bill beneficiaries.

**General Accounting Office Oversight.** The GAO will monitor the success of benefit providers in achieving through price discounts the prices paid by favored large purchasers, assuring access by all beneficiaries to drugs prescribed by doctors, improving quality and reducing errors, ensuring patient record confidentiality, and meeting other contract requirements.

**Employer Incentive Program.** Employers providing drug coverage equal to or better than the Medicare coverage receive an incentive payment to maintain such coverage.

**Low-Income Protections.** Beneficiaries up to 135% of poverty would receive full assistance with premiums and cost sharing. Between 135 and 150% of poverty, beneficiaries would receive assistance with premiums on a sliding scale.

**Guaranteed Rural Access.** The Secretary is instructed to ensure residents in rural areas have full access to all benefits.

**Studies and Medicare Payment Advisory Commission.** MedPAC is expanded from 17 to 19 Commissioners to allow the appointment of 2 experts in the pharmaceutical delivery area. Studies will be conducted on ways to encourage pharmaceutical R&D, identify public R&D subsidies to the industry, assess industry sales practices, and explain differences in US and developed country drug prices.

**Medicare Coverage of Self-Adminstrable Drugs.** In 2001, Medicare reforms will encourage cost-saving substitution of self-adminstrable drugs.

## **PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP UNITE BEHIND A MEDICARE PRESCRIPTION DRUG PLAN**

**May 9, 2000**

Today, President Clinton will join Senate Democratic Leader Daschle, House Democratic Leader Gephardt, and many other Democratic members of Congress to unveil their voluntary Medicare prescription drug benefit plans. These detailed proposals are consistent with the President's Medicare reform initiative and his principles for a prescription drug benefit option that is affordable and available to all beneficiaries. The President will praise the Democratic leaders and the members of their caucuses and will point out that a strong unified Democratic position will help lay the foundation for eventual bipartisan consensus, as was the case with the Norwood-Dingell Patients' Bill of Rights compromise. He will also highlight a new report today that underscores the importance of a Medicare prescription drug benefit for older women. The report, to be released today by the Older Women's League, states that women on Medicare spend 13 percent more out-of-pocket than men for prescription drugs, but have incomes that are on average 40 percent lower.

### **UNIFIED DEMOCRATIC SUPPORT FOR A NEW, PRESCRIPTION DRUG BENEFIT OPTION THAT IS AFFORDABLE AND AVAILABLE TO ALL BENEFICIARIES.**

Today, Senate Democratic Leader Tom Daschle and House Democratic Leader Dick Gephardt, together with numerous Democratic members of the House and Senate, will announce the details of their plans to provide for a voluntary Medicare prescription drug benefit. The plans would be:

- **Voluntary and Accessible To All Beneficiaries.** Both plans ensure that all beneficiaries can access prescription drug coverage, whether they are in traditional Medicare, managed care, or a retiree health plan. Employers will receive financial incentives to provide retiree coverage and maintain existing coverage.
- **Designed To Give Beneficiaries Meaningful Protection.** Both plans will cover up to half of a beneficiary's drug costs up to \$5,000 when phased in and provide protection against catastrophic drug costs. In addition, the plan will create financial incentives to ensure that beneficiaries in rural and hard to serve areas can access prescription medications.
- **Affordable To All Beneficiaries And The Program.** Under the plan, Medicare will contribute at least 50 percent of the prescription drug premium to make it affordable for all beneficiaries. The plans will also include special protections for low-income beneficiaries; those with incomes below 135 percent of the poverty level will receive full coverage of cost sharing and premiums, and those with incomes between 135 and 150 percent of poverty will receive premium assistance on a sliding scale.
- **Administered Using Private Sector Entities And Competitive Purchasing Techniques.** Private sector entities will negotiate prices with drug manufacturers and administer the benefit, a mechanism used by most private insurers. Drugs will be purchased at privately negotiated rates, giving beneficiaries the bargaining power they lack today. As a result, beneficiaries will not only receive prescription drug coverage for the first time, they will receive better prices for their drugs.

**NEW STATISTICS UNDERSCORE THE IMPORTANCE OF A MEDICARE PRESCRIPTION DRUG BENEFIT FOR OLDER WOMEN.** Today, the President will highlight a new report being released by the Older Women's League entitled "Prescription for Change" that underscores the importance of a Medicare prescription drug benefit for women. Key findings from the report include:

- **On Average, Women Spend More Out-Of-Pocket For Prescription Drugs Than Men.** Women on Medicare spend 13 percent more out-of-pocket than men for prescription drugs, but have incomes that average 40 percent lower.
- **More Than One in Three Women on Medicare Lack Prescription Drug Coverage Throughout the Year.** Fully half of women on Medicare without any drug coverage have incomes above 150 percent of poverty. In addition, women with coverage are less likely to have employer-sponsored coverage.
- **More Likely to Have Catastrophic Drug Costs.** Nearly three in five beneficiaries with out-of-pocket drug expenditures of more than \$1,000 are women.

**A UNIFIED DEMOCRATIC FRONT PROVIDES THE FOUNDATION FOR BIPARTISAN CONSENSUS.** President Clinton today will point out that a strong, unified Democratic position enhances the likelihood of passing a Medicare drug benefit, just as it helped to assure the eventual House passage of a strong, enforceable, and bipartisan Patients Bill of Rights. He will hail the announcement of Democratic consensus on the details of a drug benefit and urge Congress to move forward on this vital issue.

**Frost & Stark to 137 Democrat Cosponsors of Allen  
Price Control Drug Bill:**

*- We changed our minds, you should too -*

**IN QUICK REVERSAL, LATEST  
DEMOCRAT DRUG PLAN DRAFT  
APPARENTLY DROPS  
PRICE CONTROLS**

*In Attached Memo to Democratic colleagues, Frost and Stark  
Reverse Position on Price Controls in Bill They Cosponsored  
(HR 664), Urge 137 Democrat Cosponsors to Reverse Themselves*

A new memo circulating today (May 9<sup>th</sup>) by Reps. Martin Frost (D-TX) and Pete Stark (D-CA), Chair and Convening Co-Chair of the Democrat Medicare task force, includes the following reference to price controls:

**“The Secretary is prohibited from establishing a formulary or setting prices.”**

Last week, a draft Democrat prescription drug plan included the following legislative language:

**“If the GAO determines, and the Secretary agrees that benefit providers are failing to meet the goals of this section, then the Secretary will issue regulations within 3 months, and shall implement such regulations 3 months later to ensure that manufacturers make prescriptions available for Medicare beneficiaries at prices that are substantially equivalent to the favored prices paid by other large purchasers in order to ensure that they are equitable and affordable to seniors.”**

The Memorandum from Reps. Frost and Stark follows.

## MEMORANDUM

To: Democratic Colleagues  
From: Martin Frost, Chair, Pete Stark, Convening Co-Chair, Medicare Task Force  
Date: 9 May 2000  
Re: Democratic Caucus Proposal on Medicare Prescription Drug Benefit

Attached is a 2 page summary of a proposed Democratic Medicare Prescription Drug bill.

It is Rep. Gephardt's hope to announce at a Wednesday press conference with Senator Daschle and the President, that House Democrats are in support of adding a prescription drug benefit to Medicare and that there is general agreement on the type of bill described in this attachment.

The bill is largely the President's proposal from last June, but with the catastrophic benefit designed to start earlier, and the GAO to monitor the effectiveness of the benefit providers in ending price discrimination against seniors.

Each of us would undoubtedly like to see changes in the details of this proposal, but we hope that you will support the general effort and the general concept. If you have strong objections to this proposal, please let me or the Health Subcommittee Minority staffs of Ways and Means and Commerce know at #54318 or let the Minority Leader's office know as soon as possible.

Attachment follows:

### DEMOCRATIC MEDICARE PRESCRIPTION DRUG ACT OF 2000 -- Major Features of the House Proposal

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**Benefits.** Medicare, through a Rx Drug Insurance Account, will pay for at least 50% of the negotiated price for the drug, up to 50% of annual limits equal to \$2000 in 2002-2004, \$3000 for 2005-6, \$4000 for 2007-8, and \$5000 for 2009, and for succeeding years, the previous year's limit adjusted for inflation. If the benefit

providers achieve greater than anticipated discounts, the savings can be used to decrease the beneficiaries' 50% copay. Each year, the Secretary determines the premium amount necessary to pay no more than half the benefit cost.

The Secretary by 2002 implements (through private sector benefit providers), a catastrophic benefit limiting a beneficiary's maximum out-of-pocket costs to approximately \$3000 per year adjusted for inflation.

**Private Sector Administration.** The Secretary shall contract with a private benefit provider in various designated geographic areas. Benefit providers are any entity the Secretary determines can fulfill the contract. The Secretary is prohibited from establishing a formulary or setting prices. Participating pharmacies must meet licensing, access, quality, and confidentiality requirements and not balance bill beneficiaries.

**Duties of Private Benefit Providers.** In order to ensure that drug prices are equitable and affordable to beneficiaries, the private benefit providers are charged with using Medicare's volume purchasing power to negotiate and achieve the same drug price discounts that other large purchasers obtain. Benefit providers shall negotiate formularies and prices for Rx drugs, ensure convenient access to physician prescribed drugs through distribution systems and work with local pharmacies to establish drug utilization review, quality improvement and error reduction programs. Benefit providers are also responsible for patient confidentiality standards and ensuring beneficiary grievance and independent appeals procedures.

**General Accounting Office Oversight:** The GAO will monitor the success of benefit providers in achieving through volume-based price discounts the favored prices paid by other large purchasers, assuring access by all beneficiaries to drugs prescribed by doctors, improving quality and reducing errors, ensuring patient record confidentiality, and meeting other contract requirements.

**Employer Incentive Program.** Employers providing drug coverage equal to or better than the Medicare coverage receive an incentive payment to maintain such coverage.

**Low-Income Protections.** Beneficiaries up to 135% of poverty would receive full assistance with premiums and cost sharing. Between 135 and 150% of poverty, beneficiaries would receive assistance with premiums on a sliding scale.

**Guaranteed Rural Access.** The Secretary is instructed to ensure residents in rural areas have full access to all benefits.

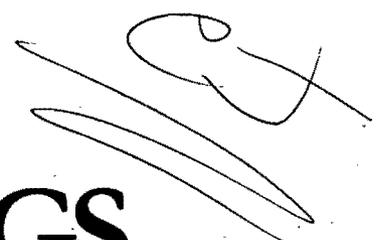
**Studies and Medicare Payment Advisory Commission.** MedPAC is expanded from 17 to 19 Commissioners to allow the appointment of 2 experts in the pharmaceutical delivery area. Studies will be conducted on ways to encourage pharmaceutical R&D, identify public R&D subsidies to the industry, assess industry sales practices, and explain differences in US and developed country drug prices.

**Medicare Coverage of Self-Administrable Drugs.** In 2001, Medicare reforms will encourage cost-saving substitution of self-administrable drugs.

**HOW PRESCRIPTION DRUGS ARE DELIVERED IN PRIVATE PLANS AND THE SENATE DEMOCRATS' MEDICARE PLAN**

May 3, 2000

	<b>PRIVATE PLANS TODAY</b>	<b>SENATE DEMOCRATS' PRESCRIPTION DRUG PLAN</b>
<b>How are prescription drugs managed and delivered?</b>	Pharmaceutical benefit managers (PBMs) manage over 70 percent of drugs purchased by privately insured Americans. Other insurers reimburse for retail purchases.	<b>Same.</b> Competitively selected PBMs would be used for Medicare's traditional plan, just as they are now used for virtually every managed care and retiree health plan now serving Medicare beneficiaries.
<b>How do PBMs compete?</b>	Use of formularies, negotiated discounts, innovative quality tools, performance goals.	<b>Same.</b> However, ensures that all medically necessary drugs are covered.
<b>Are price controls used to set prices?</b>	No. PBMs pool their purchasing power to negotiate price discounts.	<b>No.</b> Medicare would use the same private-sector practices, and statutory language explicitly prohibits use of price controls.
<b>How are benefit managers paid? Do they bear risk?</b>	Through competitive contracts, not through fully capitated, risk-based payments. PBMs are not licensed to bear full risk and most have stated they do not want to bear risk.	<b>Same,</b> although allows for – but does not require – PBMs to bear partial risk. Rejected requiring risk-based payments because it could reduce access to drug benefit and raise premium costs.
<b>Do insurers contract with multiple PBMs and require enrollees to choose their drug benefit manager?</b>	No. Like other "carved out" benefits, insurers competitively select one PBM that offers the highest quality for the best price. Enrollees choose their health plan and PBM as a package.	<b>Same.</b> Beneficiaries choose traditional Medicare, Medicare managed care, or, when available, a retiree health plan – each of which would offer its own PBM.
<b>Doesn't this use of only one PBM limit beneficiaries' choices?</b>	No. Choice occurs at the health plan level, not the benefit level. Nearly two-thirds of employees have at least two health plan options.	<b>No.</b> Medicare beneficiaries would have more plan choices than today. Explicit payments for drugs to managed care and retiree health plans ensures more stable market.
<b>Will the use of PBMs lead to market consolidation?</b>	No. Over 200 million Americans, including some seniors, already are covered by PBMs under contract with insurers. Many insurers have as many as millions enrollees per plan.	<b>No.</b> About 20 to 30 million Medicare beneficiaries will newly gain coverage through PBMs. At least 16 million are in retiree or managed care plans that typically use PBMs. Given at least 15 regions, each contract would serve no more than 2 to 4 million people – less than many private plans do today.



# **PRESCRIPTION DRUGS AND MEDICARE:**

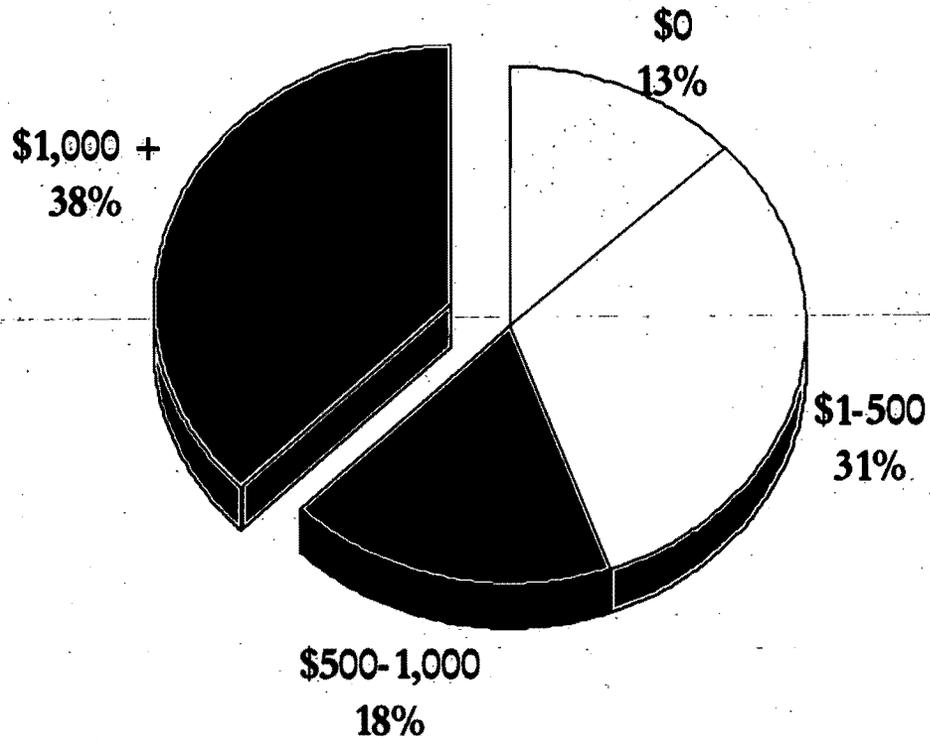
- I. Insurance Gaps for Medicare Beneficiaries**
- II. Implications of Lack of Drug Coverage**
- III. Senate Democrats' Principles**
- IV. Key Design Questions**

*May 3, 2000*

# I. INSURANCE GAPS FOR MEDICARE BENEFICIARIES

*Over One-Third of Medicare Beneficiaries Spend More than  
\$1,000 Annually On Prescription Drugs*

**Beneficiaries By Total Drug Spending, 2000**



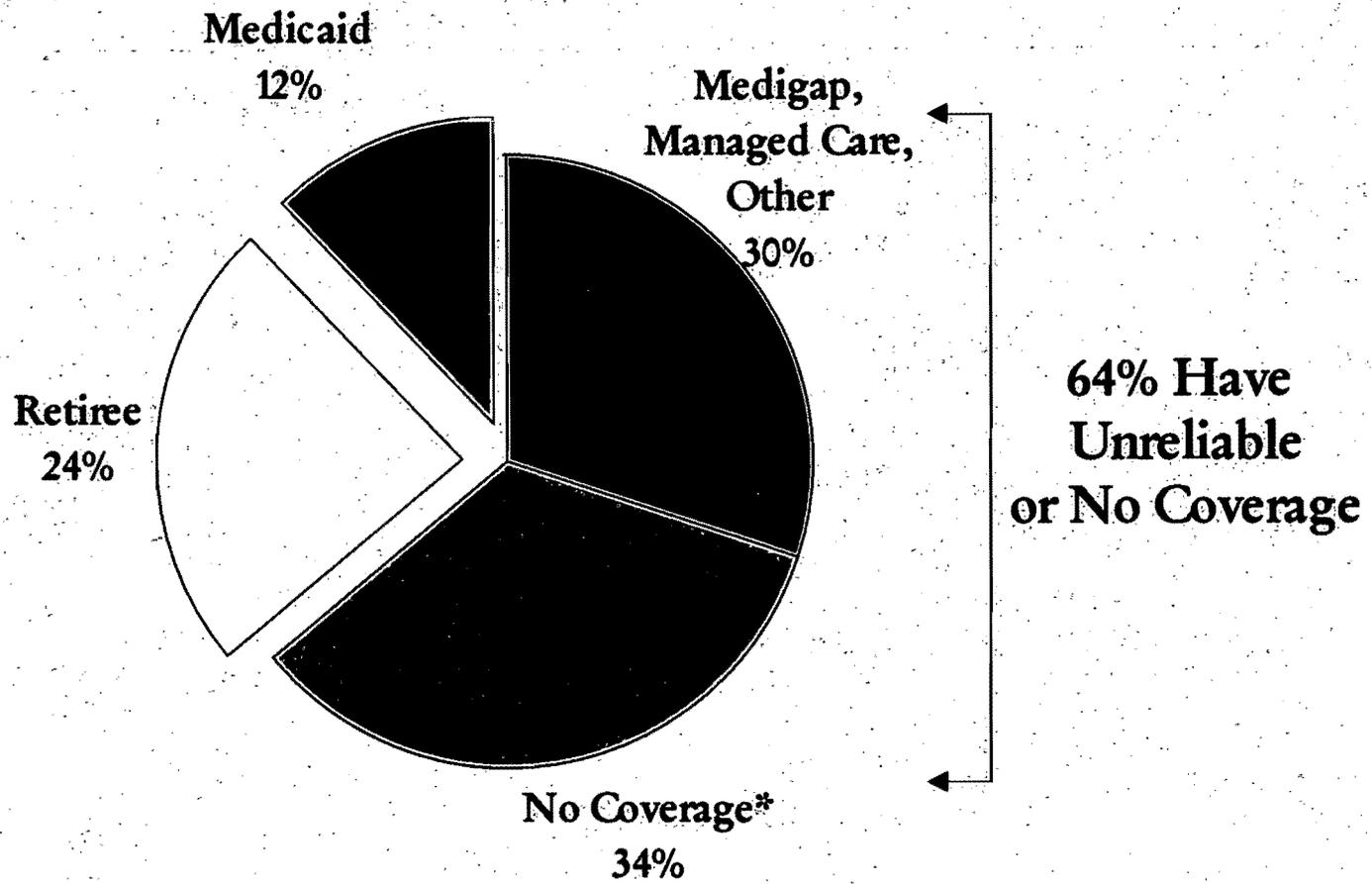
Page 8

47%

Percent 50%

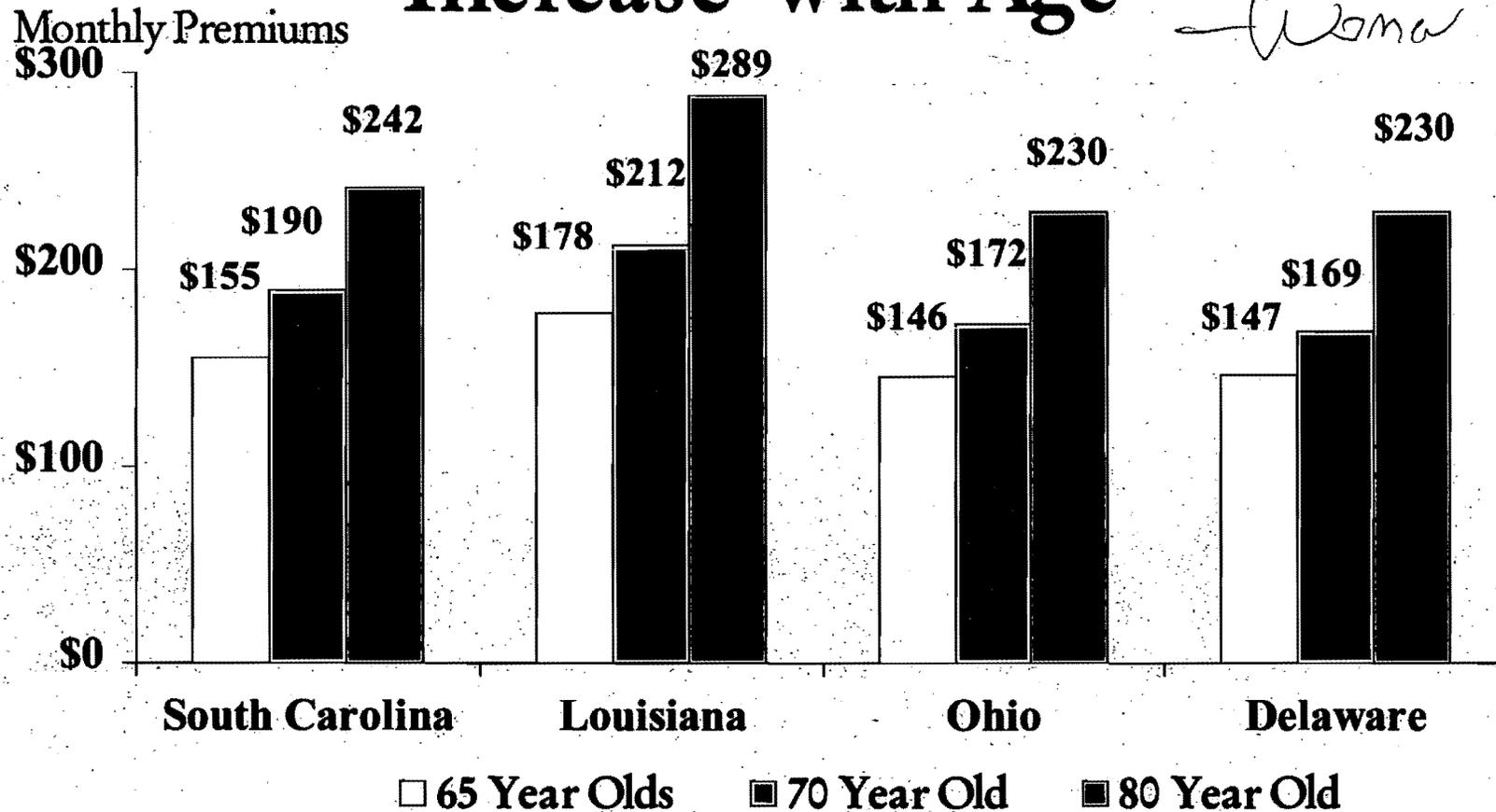
~~Drug  
Coverage~~

# Over 3 in 5 Beneficiaries Do Not Have Dependable Drug Coverage



\*NOTE: "No coverage" is defined as lacking coverage throughout the year; 47 percent of beneficiaries lacked coverage for part of the year  
SOURCE: Actuarial Research Corporation for HHS, point-in-time

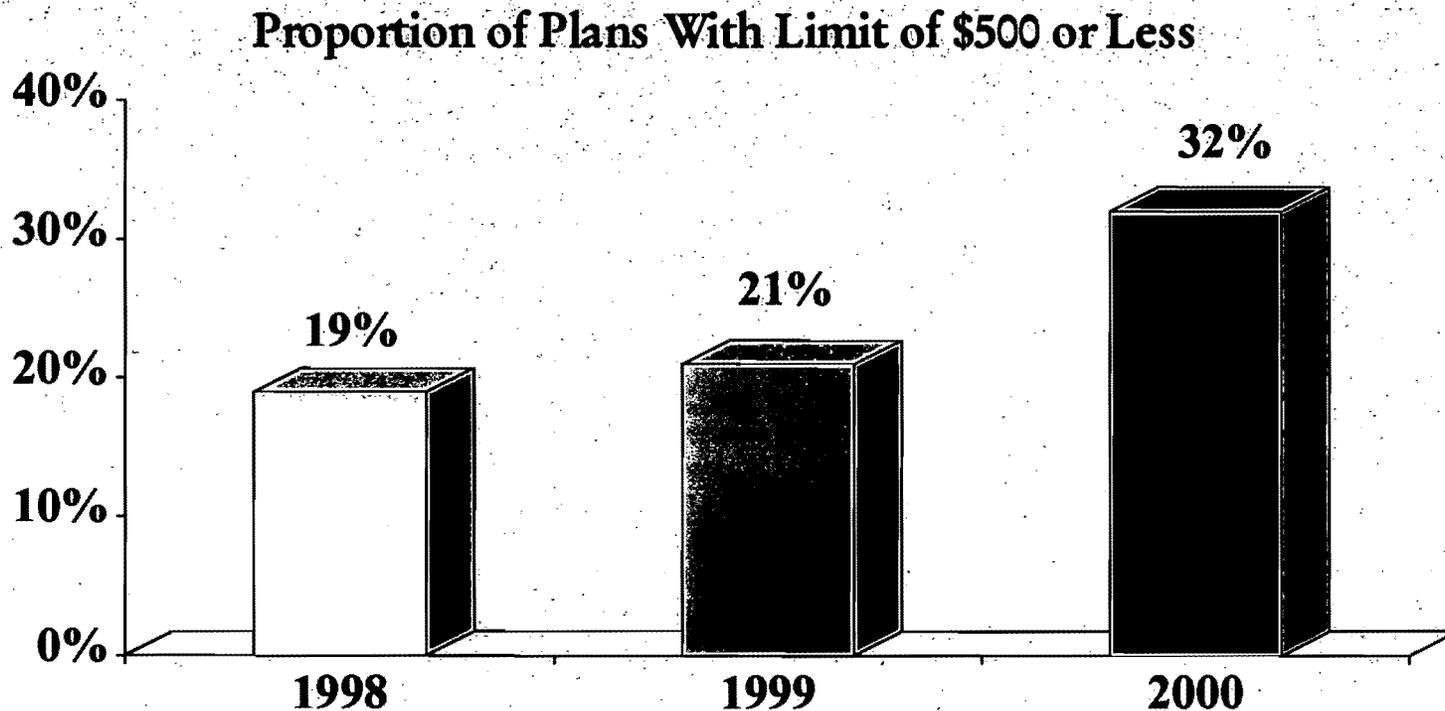
# Medigap Premiums For Plans Including Drugs Are High And Increase With Age



Sample Premiums for 1999. General Accounting Office (March 2000). For Plans I which covers basic Medicare cost sharing plus prescription drugs with a \$250 deductible, 50% coinsurance, and \$1,250 benefit limit.

# Caps on Medicare Managed Care Drug Benefit Are Getting Lower

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



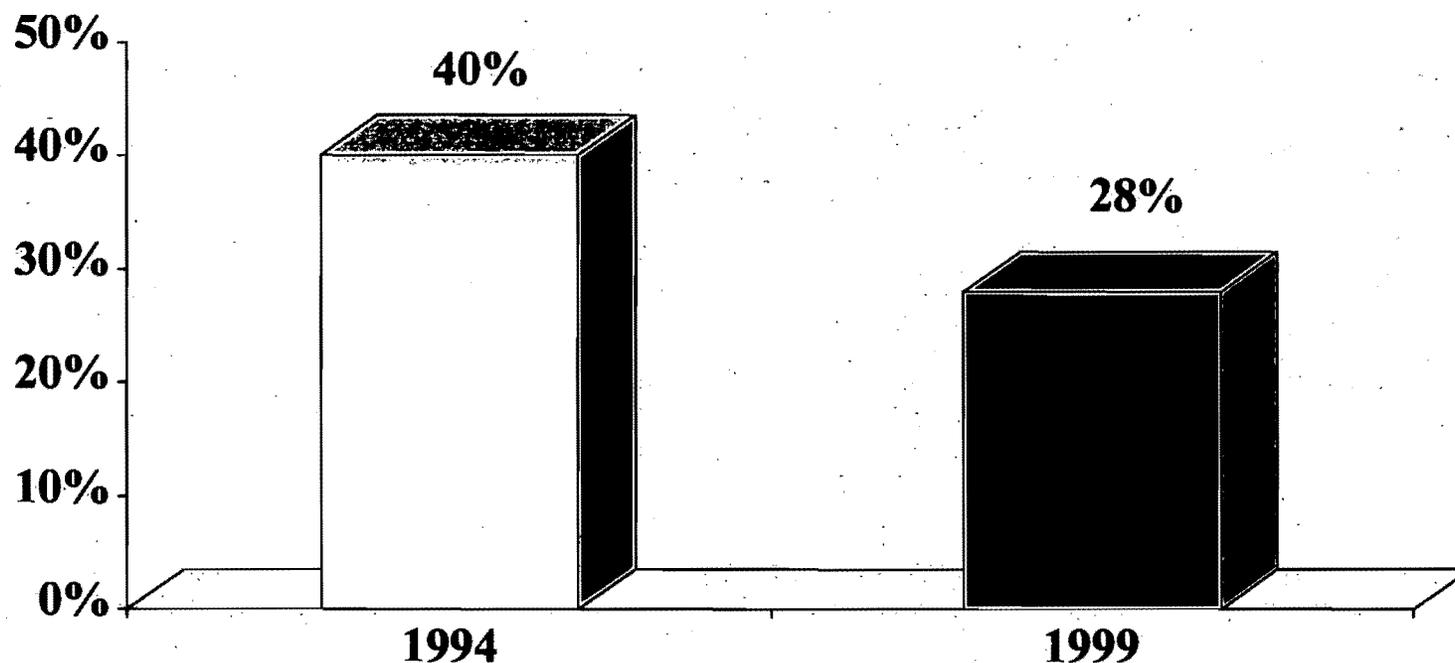
\* Nearly three-quarters of plans will cap benefit payments at or below \$1,000 in 2000 (not shown)

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

# Retiree Health Coverage Is Declining

*30% Fewer Firms Are Offering Retiree Health Benefits  
Over Time, Will Result in Fewer Retirees Having Employer-Based Coverage*

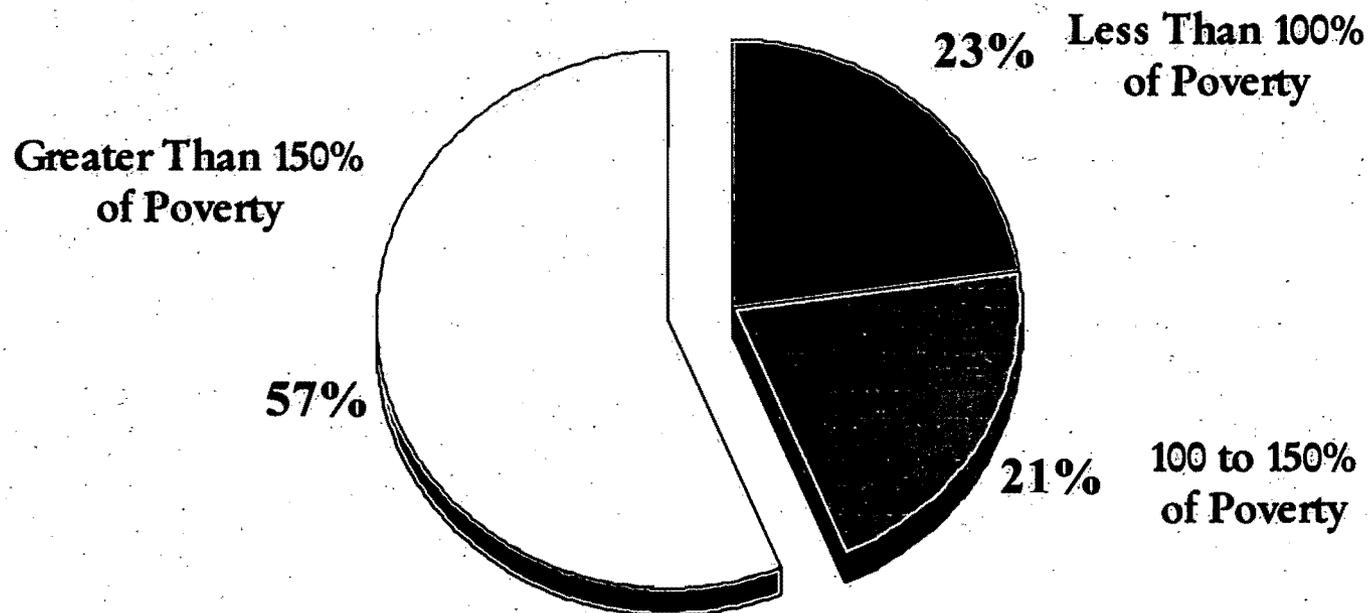
**Firms Offering Retiree Health Coverage**



# Most Uninsured Are Not Low-Income

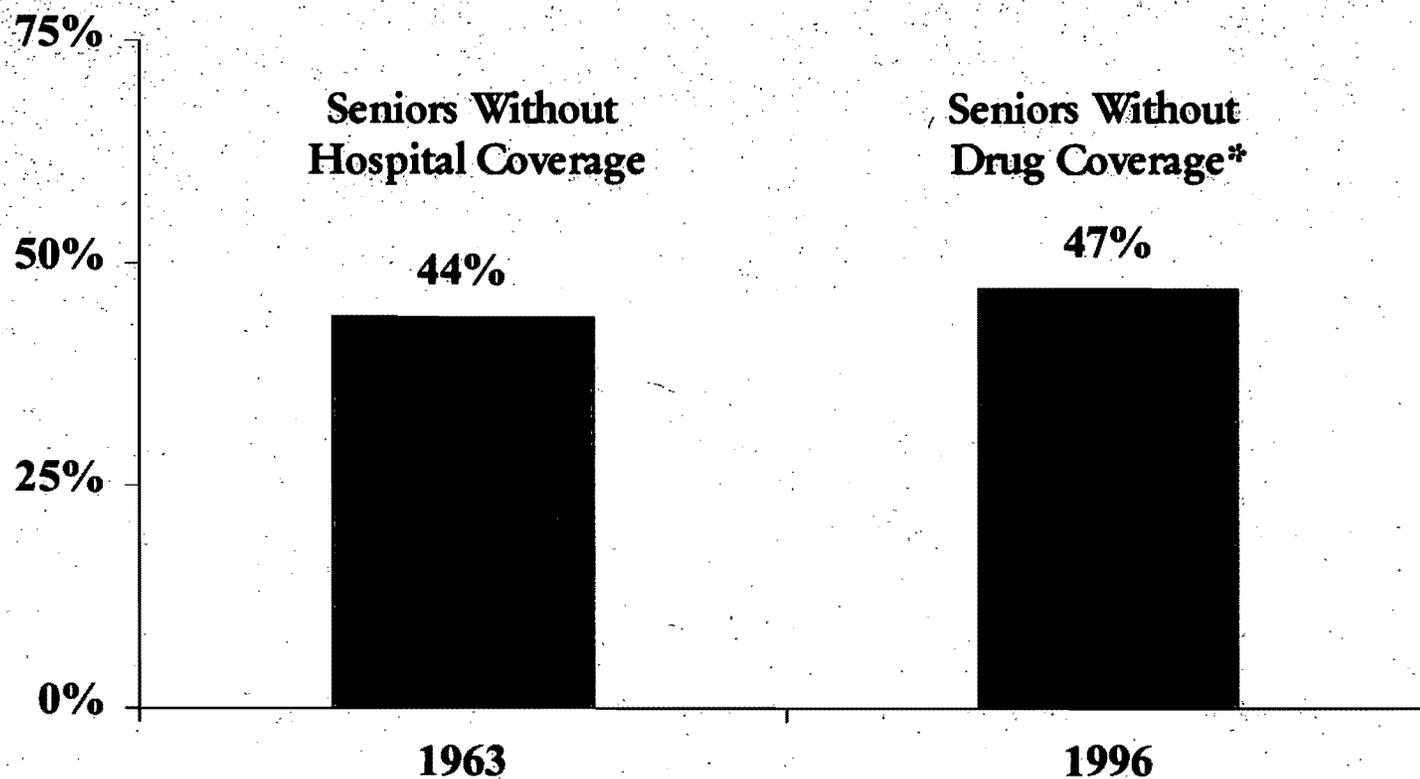
*Over Half of the 12 Million Medicare Beneficiaries Who Lack Drug Coverage Have Incomes Greater Than 150 Percent of Poverty (nearly \$17,000 for a couple)*

**Income of Beneficiaries Without Drug Coverage , 1996  
(As A Percent Of Poverty)**



SOURCE: Data from DHHS (April 2000). Prescription Drug Coverage, Spending, Utilization, and Prices. Washington, DC: U.S. DHHS<sup>7</sup>  
In 2000, 150 percent of poverty for a single person is about \$12,525, for a couple is about \$16,875

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



\*These are Medicare beneficiaries who lacked drug coverage for part or all of 1996.

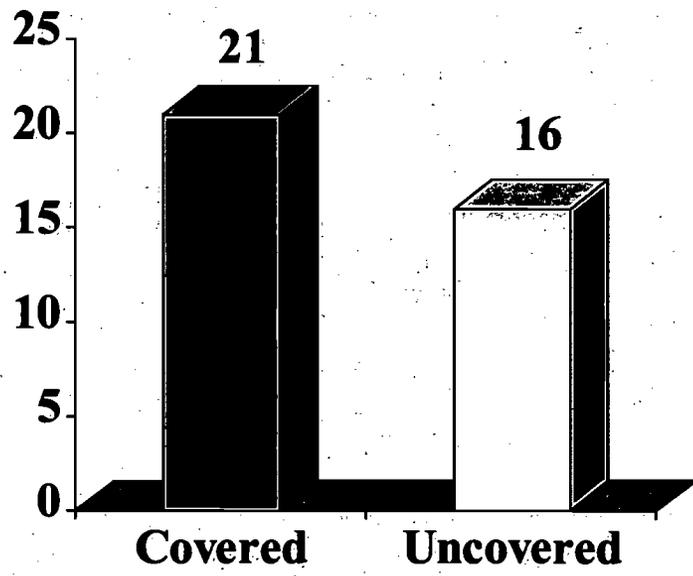
SOURCES: Moon, (1996) "What Medicare Has Meant to Older Americans," Health Care Financing Review.

Data from DHHS (April 2000). Prescription Drug Coverage, Spending, Utilization, and Prices. Washington, DC: U.S. DHHS

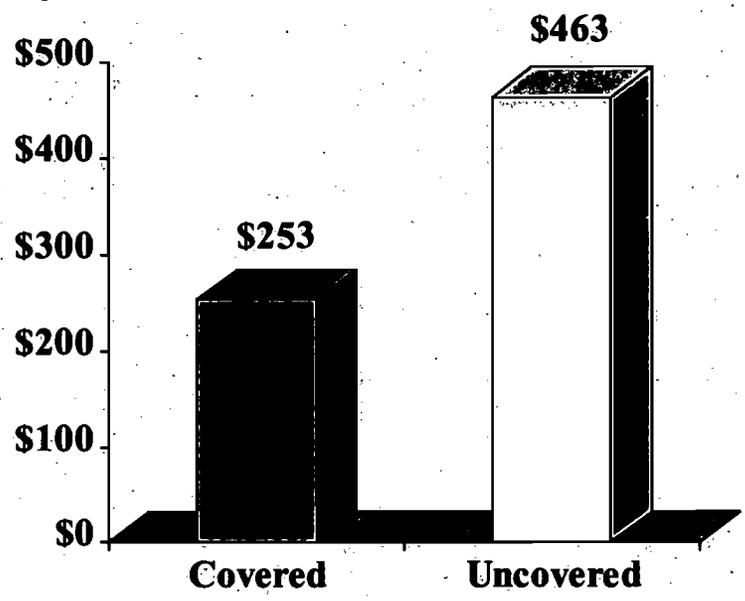
# II. IMPLICATIONS OF LACK OF DRUG COVERAGE

*Those Lacking Drug Coverage Pay More for Less*

Uncovered Fill Nearly 30%  
Fewer Prescriptions...



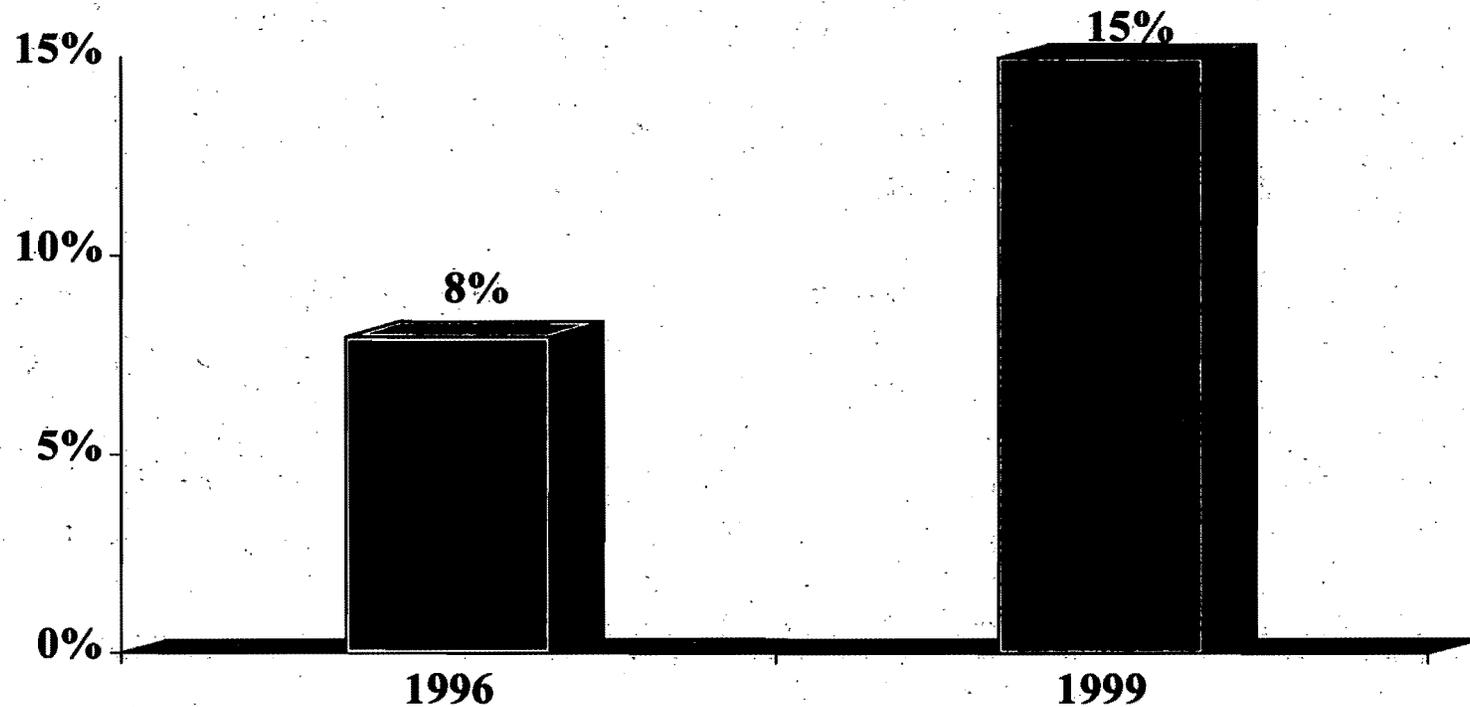
But Pay 83% More Out-Of-Pocket For Drugs



SOURCE: Data from DHHS (April 2000). Prescription Drug Coverage, Spending, Utilization, and Prices. Washington, DC: U.S. DHHS

# Retail Price Gap for Seniors With and Without Insurance Has Doubled

Ratio of Typical Retail Difference in Prices at the Retail Pharmacy for People With and Without Insurance-Negotiated Discounts\*



\*NOTE: This does not include manufacturers' rebates which, according to industry sources, range from 2 to 37 percent.

SOURCE: Data from DHHS (April 2000). Prescription Drug Coverage, Spending, Utilization, and Prices. Washington, DC: U.S. DHHS

# **III. SENATE DEMOCRATS' PRINCIPLES**

- **Voluntary**
- **Accessible to All Beneficiaries**
- **Designed to Provide Meaningful Protection and Bargaining Power for Seniors**
- **Affordable to All Beneficiaries and the Program**
- **Administered Using Private-Sector Entities and Competitive Purchasing Techniques**
- **Consistent with Broader Medicare Reforms**

# IV. KEY DESIGN QUESTIONS

## — Who Delivers the Benefit

- How are drugs purchased?
- How is premium set to assure affordability
- **Medicare:** Directly pays for prescriptions
  - What is the benefit,
- **Medicare:** Competitively Contracts Out with Private Benefit Managers, Managed Care, and/or Retiree Plans
- **Private Insurers / Medigap Plans:** Requires full or significant risk payments
- **State Block Grant or Medicaid Expansion**

# How Are Prescription Drugs Purchased

- **Use Price Schedule** (Like VA, Federal Supply Schedule)
- **Use “Best Price” Manufacturers’ Rebates** (Like Medicaid)
- **Negotiate Discounts** (Like Private Sector through PBMs)
- **Pay Retail with No Discounts** (Like Most Medigap Plans)

# How Is the Premium Set to Assure Affordability to Beneficiaries & Program

- **Provide Direct Premium Assistance** (e.g., 75, 50 or 25 percent of total premium). Variations include:
  - Lower Premiums for Low-Income Beneficiaries
  - Higher Premiums for High-Income Beneficiaries
  - Exempt Catastrophic Benefit From Premium
- **Provide No Direct Premium Assistance and Give Subsidies to Insurance.** Variations include:
  - Direct Subsidies for Low-Income Beneficiaries only

# What Is the Benefit Design

- **Retiree Health-Like Benefit** (first dollar, low copays, no cap, stop-loss protection)
- **Managed Care-Like Benefit** (first dollar, low copays, low benefit cap, no stop-loss protection)
- **Medigap-Like Coverage** (deductible, high coinsurance, low benefit cap, no stop-loss protection)
- **Combination** (low or no deductible, higher copays, high benefit cap, stop-loss protection)
- **Actuarial Value** (not specified, private insurers set benefit)

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September 13, 2000

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LIBERTIES

# Grilled Over RATS

By MAUREEN DOWD

**W**ASHINGTON -- It's the year of the rat.

On CBS's "Survivor," rats were a leitmotif. The contestants ate grilled rat while competing to see who was the biggest rat.

In our political reality drama, rats have also scurried center stage. The presidential race, which seems doomed to stay on a tatty, ratty low road, has fallen into another kerfuffle over a sneaky epithet.

Gore campaign aides went nuts when they figured out that a Republican ad lacing into the vice president on prescription drugs had one frame that flashed the word "RATS" in big white letters, as a Cubist fragment of the word "bureaucrats."

W. dismissed the charge, saying "conspiracy theories abound. . . ." Just as his father used to parrot the tactical talk of his handlers, W. spouted insider jargon. "This ad is coming out of rotation" anyway, he said.

He denied over and over that there was any subliminal intent. Well, actually, he denied over and over that there was any "subliminable" intent.

The reporters pounced on that superfluous syllable, taking off after the Republican for not being able to pronounce the crime he was accused of. Soon we had an abominable subliminable flapdoodle.

The hullabaloo, I think, is preposterous. One RATS, and Bush is a SNAKE?

Experts tell me that animation and graphics are done by computer, frame by frame. So if the word "RATS" appeared on the screen, even for a thirtieth of a second, it could only happen if somebody told a computer he wanted the word "RATS" to appear in a frame.

Poppycock. When it comes to **Republicans**, reporters **are** just too finicky.

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Whiny and babyish Gore aides are **blowing it** out of proportion.

All those **bigfeet** at **Time** and other publications who keep saying that W. is too jejune to run for president have **goofed!**

The **notion** that W. is so addled by Al Gore that he has resorted to being **cryptographic** in going after **his** critics is utterly **without** merit. It was surely **unintentional**.

A **gopher** couldn't dig a bigger hole than Al Gore does when he makes these **ad hominem attacks** with his supercilious sound **bites** about how he's "never seen anything like" the RATS. Autumn should be **big picture time**.

**Why is** everyone piling on poor Governor Bush, never **thanking** him for bringing a new tone to politics, always treating him as a **frat** boy?

To suggest **that** **maniacal** desperation drove those fine Bush professionals in Austin to **hastily** approve a brainwashing ad is a **canard out of control** — begone, pundits!

**This was** just more evidence that the Gore camp is packed with **renowned slippery** strategists who will get their **comeuppance** in November.

Before Gore **officials** continue this misguided **course** of railing against the **Republicans**, they should remember that most TV viewers are not **replaying** the ad in slow motion, frame by frame, in some Paul-McCartney-is-dead moment. So why go **ballistic** at **that** one little **wayward** word fragment?

**The** truth is, it's **Bush** league that the Gore **team turns** to **demeaning** its rival **when it falls back** on snitching and peddling gaffes to reporters.

**Remember** that Al Gore may be leading now, but he is still struggling to claim any votes in the **South**, from the mountains of North **Carolina** to the beaches of Dade County.

What about the real issues Americans care about, like your drug **prices** and **your** pressing questions about school **staffing**? The Gore cabal should stop **berating** the Bushies because, **boy**, do they look silly.

Wouldn't it be better to **talk about** the merits of the Bush plan to secure **lower-cost** drugs for our aging **parents**?

Should a man like George W. **Bush** suffer such **indignity** at the **hands** of **dishonorable** Democrats and biased, liberal journalists? **Hardly**. **Hands off**, you vultures.

It's simply a Gore **calumny**. The Democrats should learn to stop tattling and play by the **rules**.

W., **don't** pay any heed to the media sharks circling, to the frenzy of bluefish. As your dad always liked to say before he cast his line,

"Those bluefish are dead meat." I believe there was no subliminal or subliminable message in your ad.

**Remember, it's only the middle of September. It's not too late to recover your lead. Chin up, Mr. Bush, your critics are just stupid!**

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**HOW PRESCRIPTION DRUGS ARE DELIVERED IN  
PRIVATE PLANS AND THE PRESIDENT'S MEDICARE PLAN**

May 3, 2000

	<b>PRIVATE PLANS TODAY</b>	<b>SENATE DEMOCRATS' PRESCRIPTION DRUG PLAN</b>
<b>How are prescription drugs managed and delivered in private health insurance plans?</b>	Pharmaceutical benefit managers (PBMs) manage over 70 percent of drugs for privately insured Americans. Other insurers reimburse for retail purchases.	<b>Same.</b> Competitively selected PBMs would be used for Medicare's traditional plan, just as they are now used for virtually every managed care and retiree health plan now serving Medicare beneficiaries.
<b>How do PBMs compete?</b>	Use of formularies, negotiated discounts, innovative quality tools, performance goals.	<b>Same.</b> However, ensures that all medically necessary drugs are covered.
<b>Are price controls use to set prices?</b>	No. PBMs pool their purchasing power to negotiate price discounts.	<b>Same.</b> Medicare would use the same private-sector practices, and statutory language explicitly prohibits use of price controls.
<b>How are benefit managers paid? Do they bear risk?</b>	Through competitive contracts, not through fully capitated, risk-based payments. PBMs are not licensed to bear risk and most have stated they do not want to bear risk.	<b>Same,</b> although allows for – but does not require – PBMs to bear partial risk. Rejected requiring risk-based payments because it could reduce access to drug benefit and raise premium costs.
<b>Do insurers contract with multiple PBMs and require enrollees to choose their drug benefit manager?</b>	No. Like other "carved out" benefits, insurers typically competitively select one PBM that offers the highest quality for the best price. Enrollees have choice of plans, not choice of PBMs.	<b>Same.</b> Beneficiaries choose traditional Medicare, Medicare managed care, or, when available, a retiree health plan, but do not select PBMs within a health plan.
<b>Doesn't this use of only one PBM limit beneficiaries' choices?</b>	No. Choice occurs at the health plan level, not the benefit level. Nearly two-thirds of employees have at least two health plan options.	<b>No.</b> Medicare beneficiaries would be given more plan choices. Explicit managed care payments for drugs assures more stable market and more plan choices in addition to traditional plans.
<b>Will the use of PBMs lead to market consolidation?</b>	No. Over 200 million Americans, including some seniors, already are covered by PBMs under contract with insurers. Many insurers have as many as millions enrollees per plan.	<b>No.</b> About 20 to 30 million Medicare beneficiaries will newly gain coverage through PBMs. At least 16 million are in retiree or managed care plans that typically use PBMs. Given at least 15 regions, PBMs would typically serve no more than 2 to 4 million people – less than many private plans do today.

~~AAWP~~ Banking

~~Stand~~

AAWP - AAWP

Glenn Aron

# DESIGN QUESTIONS

## 1 WHO DELIVERS

MEDICARE DIRECT  
MEDICARE CONTRACT  
MEDIGAP  
STATE

Gordon  
Reform

The AP  
etc

CBS says will  
make-up

REPUBLICANS: RELY ON VOLUNTARY  
MEDI GAP INDIVIDUALS

DASCHLE: MEDICARE THROUGH  
COMPETITIVE CONTRACTS  
WITH PBM  
• Managed Care  
• Retirement plan

## 2 HOW DRUGS PURCHASED

FEE SCHEDULE (residuals)  
PRIVATE NEGOTIATION  
Retail

REPUBLICANS: MEDIGAP usually  
Does NOT NEGOTIATE

DASCHLE: PRIVATE NEGOTIATION

How

## 3 PREMIUMS: STRUCTURED TO ASSURE AFFORDABILITY

How much • AMOUNT 25/5/75

To whom • DIRECT/INDIRECT

REPUBLICANS:

DIRECT LOW-INCOME  
INDIRECT INSURERS,  
NO MIDDLE CLASS

DASCHLE: DIRECT SUBSIDY  
50%  
LOW-INCOME  
(INC-Related)

WHAT IS OF

## 4 DESIGN BENEFIT

- RETIREES
- Managed Care
- MEDIGAP
- ACTUARIAL VALUE

REPUBLICANS: ACTUARIAL  
VALUE

DASCHLE:  
0 DEDUCTIBLE  
50% COINSURANCE  
5000 CAP  
- STOPLOSS

EMBARGOED UNTIL  
FURTHER NOTICE

## MEMORANDUM

**TO:** NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

**FROM:** HART RESEARCH ASSOCIATES

**DATE:** MAY 2000

**SUBJECT:** RESEARCH ON MEDICARE PRESCRIPTION DRUG COVERAGE

On behalf of the National Committee to Preserve Social Security and Medicare, Hart Research has recently completed a survey on the issue of prescription drug coverage for Medicare beneficiaries. A national sample of 825 registered voters were interviewed, including an oversample of 203 Medicare beneficiaries. This executive summary reviews the key findings of the opinion research.

**Overview.** The survey data points to three central conclusions about public attitudes on the issue of prescription drug coverage. First, the voting public ranks prescription drug coverage for Medicare beneficiaries as a top priority, and congressional candidates who support creating a Medicare drug benefit stand to gain substantial political support. For Medicare beneficiaries, prescription drug coverage is a central and overriding policy concern. Second, voters have an important message for Congress regarding what they consider to be the right approach for providing prescription drug coverage: do it through *Medicare*, not private insurance; provide a *universal* benefit, not a means-tested one; and get it done *soon*. Third, voters strongly embrace the Clinton Administration's prescription drug plan, and most Medicare beneficiaries indicate they are likely to subscribe if the plan is adopted.

**Medicare prescription drug coverage has broad support, and is positioned to be a powerful voting issue in the 2000 electoral cycle.**

By a substantial 64% to 27% margin, voters today favor adding a voluntary prescription drug benefit to Medicare coverage. This consensus is quite broad-based, with voters under 35 expressing just as much support (66% favor) as seniors (66%), and Republicans registering nearly as much support (65%) as Democrats (68%).

Driving this support is widespread recognition of the burden that escalating drug costs represent. Fully 80% of voters recognize that prescription drug costs for senior citizens are on the rise, including 55% who say these costs have risen "a great deal" (the corresponding figures for Medicare beneficiaries are 80% and 61%). In addition, beneficiaries identify the high cost of prescription drugs as their top health care concern today. The voting public also rejects the proposition that high drug costs are the price we pay for medical research and innovation, believing instead that "drug companies are charging far more for prescriptions than is necessary in order to increase their profits" (70% to 25%).

The survey data indicate that the prescription drug issue could play a powerful role in this year's elections. It ranks at the very top of voters' agenda for congressional action, by an overwhelming margin among Medicare beneficiaries (see table). In addition, congressional candidates who support establishing a prescription drug benefit stand to realize a substantial electoral gain. Registered voters say by a more than five-to-one margin that they are more likely (43%) rather than less likely (8%) to vote for a pro-benefit candidate.

**VOTERS' TOP PRIORITIES FOR CONGRESS**

	<u>All Voters</u>	<u>Medicare Beneficiaries</u>
<b>Adding prescription drug benefits to Medicare</b>	<b>32</b>	<b>47</b>
Cutting taxes	29	26
Passing tougher gun-control restrictions	25	25
Passing laws to protect consumers' privacy	21	15
Passing an HMO patients' bill of rights	20	16
Increasing the minimum wage	14	15

**The public has three rules for providing prescription drug coverage: do it through Medicare, do it on a universal basis, and do it soon.**

The survey results indicate that voters have some strong views about the right – and wrong – way to remedy the prescription drug coverage problem. Americans have a three part message for Congress as it considers different approaches.

*A real solution is only possible through Medicare.* Fully 72% of voters say that “Medicare needs to become involved” because current forms of coverage are eroding, while just 22% of voters oppose a Medicare-based program because “a big government program would undermine” the private and employer-provided coverage many people have today. A solution that rests on private or employer-based insurance, Americans say, is no solution at all.

*Prescription drug coverage should be available on a universal basis, not a means-tested one.* The voting public believes that a Medicare prescription drug benefit should be universally available, even when apprised of concerns that a universal plan could be “too costly.” The majority says that benefits “should be available to all seniors, regardless of income” (55%), rather than limited to seniors with incomes below \$16,000 who “cannot afford private insurance” (41%). The survey also clearly shows that the need for this benefit is not limited to low income beneficiaries. Among Medicare beneficiaries with incomes over \$20,000, fully 49% *strongly* favor a universal approach and 67% report they would definitely or probably enroll if the Clinton Administration plan were adopted. Finally, while the public wants all seniors to have access to a voluntary benefit, it also supports subsidies to reduce or eliminate premiums for the poorest seniors (61% identify this as a very important principle).

*Congress should get to work and establish a prescription drug benefit soon.* About one-third of voters believe that a prescription drug benefit should be enacted only as part of a more comprehensive reform of Medicare, so the system doesn’t “take on expensive new commitments until its long-term funding is secure” (35%). However, the large majority (61%) of voters disagree, agreeing instead that “because of the seriousness of the problem, a Medicare prescription medicine benefit should be enacted soon and should not have to wait for other Medicare reforms.” The public’s sense of urgency, and demand for action, could not be more clear.

**Americans strongly support the Medicare prescription drug benefit plan put forward by the Clinton Administration, and most Medicare beneficiaries say they would probably enroll if the plan were offered.**

Seven in ten voters (70%) say they favor the Clinton Administration's proposed Medicare prescription drug benefit, while only 16% oppose the plan. Support is equally strong among Medicare beneficiaries (68%) and non-beneficiaries (70%), with beneficiaries registering especially intense support (37% strongly favor). Support among Democrats is nearly universal (86% to 5%), but is also strong among independents (64% to 13%) and Republicans (54% to 31%).

The survey goes on to describe individual elements of the Administration's plan, and voter's response is quite favorable. Among the appealing provisions are:

- Low-income seniors would pay a reduced cost, or no premium, depending on income (80% appealing)
- Participation would be voluntary (75%)
- The new benefit would help pay some catastrophic drug costs for recipients with the highest drug expenses (69%)
- All beneficiaries would be able to purchase their prescriptions at lower prices negotiated by private-sector benefit managers (59%)

After voters learn more about the Administration plan, support grows to an overwhelming 82%. Increased support is especially dramatic among independents (up 14 points to 78%), and Republicans (up 16 points to 70%). Moreover, almost two in three Medicare beneficiaries (65%) report that they would definitely or probably enroll if this benefit were offered. Interest is especially strong among beneficiaries who are under age 70 (70%), currently lack drug coverage (75%), or face monthly drug costs over \$100 per month (78%). Interestingly, there is even substantial interest in subscribing among beneficiaries who currently have drug coverage (55%) and those with incomes over \$20,000 (66%). Demand for the type of benefit provided in the Administration plan is clearly both strong and broad.

## **PRESIDENT CLINTON URGES THE CONGRESS TO ACT NOW ON THE NATION'S HEALTH CARE PRIORITIES**

**April 29, 2000**

Today, in his weekly radio address, President Clinton will urge the Congress to take long overdue action and pass a strong, enforceable Patients' Bill of Rights and a voluntary Medicare prescription drug benefit. He will point out, that despite an overwhelming bipartisan vote in support of the Norwood-Dingell Patients' Bill of Rights, the legislation has been languishing in the Congress for over six months. He will also reiterate his challenge to the Congress to move beyond rhetoric and pass, in the context of broader reform, a long overdue and voluntary prescription drug benefit for all Medicare beneficiaries. The President will urge the Congress to come back from their recess and get back to work on improving health care for Americans of all generations.

Today, President Clinton will urge the Congress to:

### **PASS A STRONG, ENFORCEABLE, PATIENTS' BILL OF RIGHTS WITHOUT FURTHER DELAY.**

**Patients need protections now.** Unnecessary delay in passing legislation to curb insurance company abuse results in harm to thousands of patients daily and millions of patients annually. Recently released data indicates that each day without a strong Patients Bill of Rights results in: 14,000 physicians seeing patients harmed because a plan failed to provide coverage for a prescription drug; 10,000 physicians seeing patients harmed because a plan refused a diagnostic test or procedure; and 7,000 physicians seeing patients harmed because their insurance plan refused a referral to a specialist. In the last three State of the Union Addresses, the President has called on the Congress to pass strong patient protections for over two years. Despite the passage of the Norwood-Dingell bill, a strong, enforceable, bipartisan Patients' Bill of Rights that the President has repeatedly indicated he would sign, the Congress has delayed action on this critical legislation for over six months.

**The Norwood-Dingell legislation is the only real Patients' Bill of Rights.** This legislation, endorsed by over 200 health care provider and consumer advocacy groups, is the only proposal currently being considered that meets the Administration's fundamental criteria: that patient protections be real and that court enforced remedies be accessible and meaningful. The legislation includes critical protections such as:

- Guaranteed access to needed health care specialists; access to emergency room services when and where the need arises
- Continuity of care protections
- Access to a fair, unbiased and timely internal and independent external appeals process
- Guaranteed protections for all Americans in all health plans
- An enforcement mechanism that ensures recourse for patients who have been harmed as a result of a health plan's actions

## **ENSURE THAT A NEW MEDICARE PRESCRIPTION DRUG BENEFIT OPTION IS AFFORDABLE AND ACCESSIBLE FOR ALL BENEFICIARIES.**

**Millions of Medicare beneficiaries have no prescription drug coverage.** President Clinton put out a detailed proposal to modernize and reform the Medicare program over 9 months ago, and since then, seniors and Americans with disabilities have been waiting for the Congress to act. The President will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option that 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 2025.

**Republican policy does not meet their stated goals.** Although the House Republican leadership recently recognized the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. The current House Republican proposal:

- Reneges on funding commitments for a meaningful prescription drug benefit. Earlier this year, the Republicans indicated they would commit \$40 billion for a prescription drug benefit, but their budget resolution dedicated as little as \$20 billion to improve the Medicare program to include a prescription drug benefit. Moreover, their failure to release 10-year numbers on their prescription drug proposal raises serious concerns that their tax policy consumes virtually all revenue necessary to adequately fund a drug benefit into the future.

- Does not assure availability of prescription drug coverage. Because the Republican plan relies on private insurers to offer a drug-only benefit voluntarily, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. In testimony before the Congress, the insurance industry itself has expressed skepticism about the effectiveness of the Republican approach.
- Not affordable for most seniors, even if it is available. Furthermore, because it provides direct premium assistance only to beneficiaries with annual incomes of under \$12,600, the Republican benefit will almost certainly fail to be an affordable option even if it's available. If enacted, the Republican proposal would mark the first time in the program's history that Medicare would not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program.

**REPUBLICAN CONGRESS HAS DELAYED ACTION ON NATIONAL PRIORITIES FOR TOO LONG.** So far this year, the House of Representatives has been in session 39 days this year, and the Senate has been in session 33. There are just 73 working days left until the target adjournment date of October 6. The House and Senate struggled to pass the FY2001 budget resolution and the Congress has failed to:

- Reduce gun violence with common sense gun legislation, buckling under the pressure of the powerful gun lobby and allowing sensible gun safety legislation to languish for over 9 months.
- Give American families a needed increase in the minimum wage, spending over a year delaying action on this legislation and attaching costly and unnecessary poison pill tax cuts to this common-sense measure.
- Fund urgent needs in the President's supplemental request, causing delays that could have devastating effects at home and abroad – curtailing military training activities essential to peace and stability in Kosovo; eroding international support for Colombia's effort to fight drug traffickers; leaving more than 2,300 families without funds to relocate after their homes were destroyed by Hurricane Floyd; providing debt relief to the poorest nations; and leaving low-income elderly nationwide vulnerable to summer's high temperatures.

# Withdrawal/Redaction Marker

## Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. survey	Survey- Prescription Drug Benefit (16 pages)	4/28/00	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  
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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 Drugs Benefit [3]

gf38

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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.

**Freedom of Information Act - [5 U.S.C. 552(b)]**

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- 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]



U.S. Department of Justice  
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

April 28, 2000

The Honorable John D. Rockefeller IV  
United States Senate  
Washington, DC 20510

Dear Senator Rockefeller:

This correspondence is in response to your letter to the Department of Justice dated February 18, 2000. We have reviewed S. 1895, the "Medicare Preservation and Improvement Act of 1999," as you requested, and offer our preliminary views regarding the separation of powers issues raised by the bill. As set forth below, we believe that the provision concerning the removal of officers of the new Medicare Board raises serious separation of powers concerns under the Supreme Court's decisions and would create a significant risk that a court might declare the provision unconstitutional. Moreover, even if a court were to uphold this provision against a constitutional challenge, we are convinced that it would constitute an unwarranted and unwise erosion of the President's authority to oversee the functioning of the Executive Branch. As currently drafted, S. 1895 poses a serious threat to the core constitutional values of political accountability and coordinated Executive Branch policy-making. We also believe that the provision requiring the Director of the Division of Health Care Financing Administration ("HCFA")-Sponsored Plans to submit legislative recommendations to Congress and precluding Executive Branch oversight of such recommendations likely violates the Recommendations Clause.

S. 1895 would establish as an "independent agency" a Medicare Board ("Board") that would administer a new competitive premium Medicare system and would assume from the Secretary of the Department of Health and Human Services general oversight authority over Medicare plans. Specifically, the Board "will coordinate determinations of beneficiary eligibility and enrollment" with the Commissioner of Social Security; "enter into, and enforce, contracts with entities for the offering of Medicare plans;" and "disseminate to Medicare beneficiaries information with respect to benefits [and] limitations on [ ] payment under Medicare plans." § 2242(a). The President may remove members of the Board "only for neglect of duty or malfeasance in office." See § 2244(a)(3). The bill would also reorganize HCFA, which is within the Department of Health and Human Services, into two new divisions: the Division of HCFA-Sponsored Plans and the Division of Health Programs.

To the extent the bill would limit presidential oversight of the Board's statutory duties and responsibilities, by restricting the President's removal authority, it raises a significant constitutional question. As the Supreme Court has explained, legislation that places restrictions on the power of the President to remove Executive Branch officers passes constitutional muster if it does not "impede the President's ability to perform his constitutional duty." Morrison v. Olson, 487 U.S. 654, 691 (1988); see also Nixon v. Administrator of General Services, 433 U.S. 425, 443 (1977) ("Nixon II") (legislation that affects the power of the President is unconstitutional if it "prevents the Executive Branch from accomplishing its constitutionally assigned functions"). In evaluating whether a restriction on the President's removal authority impedes the ability of the President to carry out his constitutional duties, we must look to the functions that the Board performs. See Morrison, 487 U.S. at 691.

Although the bill does not provide a detailed description of the Board's powers, two characteristics of its functions stand out. First, the Board may exercise broad policy-making authority over the Medicare Program, a wide-reaching program that is undeniably of great significance to the American public. The Board is authorized to make fundamental policy decisions such as what benefits or services, beyond a statutorily prescribed minimum, will be offered to beneficiaries; which private entities will provide services or benefits; the amount of money the federal government will pay to those entities; and the amount that Medicare beneficiaries must pay for various levels of benefit coverage. In light of the President's constitutional role as Chief Executive and his responsibilities to ensure proper execution of the laws, we believe a strong argument can be advanced that the President must be able to supervise Executive Branch officers who are charged with making such policy determinations. Indeed, the Supreme Court has concluded that Congress may delegate policy-making responsibilities to agencies because, "[w]hile agencies are not directly accountable to the people, the Chief Executive is, and it is entirely appropriate for this political branch of the Government to make . . . policy choices . . . which Congress itself either inadvertently did not resolve, or intentionally left to be resolved by the agency charged with the administration of the statute in light of everyday realities." Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 865-66 (1983). Consistent with that view, the Court upheld the removal restriction for the independent counsel in Morrison, in part, because this inferior officer lacked any policy-making authority. See 487 U.S. at 691.<sup>1</sup>

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<sup>1</sup> To be sure, in Humphrey's Executor v. United States, 295 U.S. 602 (1935), the Court stated that the Federal Trade Commission (FTC), in "carry[ing] into effect legislative policies embodied in [a] statute in accordance with the legislative standard therein prescribed . . . acts in part quasi-legislatively and in part quasi-judicially." Id. at 628. The Court's more recent pronouncements, however, cast considerable doubt on its earlier characterization of FTC functions as "quasi-legislative." In Morrison itself, the Court noted the "difficulty of defining such categories of 'executive' or 'quasi-legislative' officials," and stated that "it is hard to dispute that the powers of the FTC at the time of Humphrey's Executor would at the present time be considered 'executive,' at least to some degree." Morrison, 487 U.S. at 689-90 n.28. Accordingly, we do not believe that the Court would view delegated policy-making of the sort

Second, it does not appear that the Board will possess any significant "quasi-judicial" functions that might otherwise constitutionally warrant a restriction on the President's removal authority. Although the determination whether the Constitution allows Congress to impose a "for cause" restriction on the President's power to remove an officer does not turn entirely on whether the officer performs quasi-judicial functions, Morrison, 487 U.S. at 689, to the extent that such functions would be absent here, one of the key arguments advanced to defend removal restrictions would be unavailable. See Humphrey's Executor, 295 U.S. at 628-30 (relying on FTC's "quasi-judicial" functions as evidence that restrictions on President's authority to remove members of the Commission did not interfere with President's ability to discharge his constitutionally-assigned functions); see also Morrison, 487 U.S. at 691 n.30 (noting that freedom from executive or political control may be desirable in circumstances in which an official is performing "quasi-judicial" functions).

Finally, the findings accompanying the legislation fail to identify the type of "overriding need" for independence necessary to justify limitations on presidential oversight of the Board. In its more modern jurisprudence, the Court has adopted a balancing approach to evaluate "disruptions of the proper balance between coordinate branches." Nixon II, 433 U.S. at 443 (citing United States v. Nixon, 418 U.S. 683, 711-12 ("Nixon I") (1974)). Where Congress seeks to limit the President's ability to supervise an executive entity that exercises broad policy-making authority and that lacks significant adjudicative functions, such a disruption in the normal powers of the Executive Branch must be "justified by an overriding need to promote objectives within the constitutional authority of Congress." Nixon II, 433 U.S. at 443 (citing Nixon I, 418 U.S. at 711-12). In Morrison, for example, the Court explained that Congress "was concerned when it created the office of independent counsel with the conflicts of interest that could arise in situations when the Executive Branch is called upon to investigate its own high-ranking advisers." Morrison, 487 U.S. at 677. The removal restriction on the independent counsel, the Court noted, "was essential, in the view of Congress, to establish the necessary independence of the office." Id. at 693. Here, by contrast, the legislation cites only a need "to reduce Government micromanagement of the Medicare Program." Sec. 2(a)(7). We do not believe this justification is a sufficiently substantial or overriding reason for insulating the Board from executive oversight.

In light of the Board's broad policy-making authority and apparent lack of significant adjudicatory authority -- and because Congress has failed to identify a substantial need for the independent status of the Medicare Board -- we believe that, to the extent Congress intends to insulate the Board from presidential direction,<sup>2</sup> the proposed legislation raises serious

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contemplated by this legislation as a "quasi-legislative" function for separation of powers purposes.

<sup>2</sup> The extent to which a statutory removal restriction, like that in the proposed legislation, precludes the President from determining the policy direction of the tenure-protected office is unsettled. As a result of practice in our system of government as it has developed over time, it is

constitutional concerns. Nonetheless, even if the courts were to sustain the legislation in the face of a constitutional challenge, we would strongly oppose the bill's restrictions. As the bill seeks to remove from the President's oversight functions of an agency that are already under his supervision, it appears to constitute a serious, and unnecessary, erosion of the President's authority to oversee activities within the Executive Branch, and to compromise the core constitutional commitments to political accountability and coordinated policy-making.

Section 2284, which concerns communications with, *inter alia*, Congress by the Director of the Division of HCFA-Sponsored Plans, also raises serious constitutional concerns. This provision provides, in relevant part, "No officer or agency of the United States may require the Director to submit [a business plan that includes a legislative proposal to implement the plan] to any officer or agency of the United States for approval, comments, or review, prior to the submission of the plan to Congress and such individual." In addition, this provision affirmatively requires the Director to submit annually a business plan that includes legislative recommendations to both Houses of Congress. See § 2284(a). We believe this provision is invalid under the Recommendations Clause, which provides that the President "shall from time to time . . . recommend to [Congress] . . . such Measures as he shall judge necessary and expedient." U.S. Const. Art. II, § 3. The Recommendations Clause protects the President's constitutional prerogative to formulate and present his own recommendations and proposals, and to control the policy agenda of the Executive Branch. By requiring the President's subordinates to provide the Congress with legislative recommendations, the legislation infringes on the President's authority to decline to offer any legislative recommendation if, in the President's

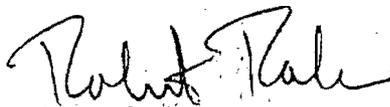
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commonly assumed that policy differences do not give the President "cause" to remove an officer. There is some support for that assumption in Humphrey's Executor, where the Court, in upholding a "for cause" removal restriction on the President's ability to remove members of the FTC, stated that the FTC's "duties are performed without executive leave and, in contemplation of the statute, must be free from executive control." 295 U.S. at 628; see also Wiener v. United States, 357 U.S. 349 (1958) (emphasizing that removal limitations prevent officials from being "subject in the discharge of their duties to the control of the Executive"). Similarly, in Mistretta v. United States, 488 U.S. 361 (1989), in discussing the "for cause" removal limitation for members of the United States Sentencing Commission, the Court stated that the restriction "is specifically crafted to prevent the President from exercising 'coercive influence' over independent agencies." *Id.* at 411 (citing Morrison, 487 U.S. at 688). In contrast, the Supreme Court suggested in Bowsher v. Synar, 478 U.S. 714, 729-30 (1986), that a provision permitting removal for "inefficiency," "neglect of duty," and "malfeasance" conferred a "very broad" removal power, "could sustain removal . . . for any number of" reasons, and would ensure that an officer subject to removal under such standards "will be subservient" to any person or entity that could exercise such power. It is thus possible that, in order to avoid the difficult constitutional question of whether Congress may preclude the President from removing a principal officer of an independent agency for policy differences – an issue that neither Humphrey's Executor and Morrison squarely addressed – courts would construe the removal provision in the Medicare legislation not to so limit the President's authority.

judgment, no such recommendation is necessary or expedient. The invalidity of such a congressionally-compelled legislative recommendation is heightened to the extent that the provision attempts to prohibit the President,<sup>3</sup> or his subordinates, from reviewing, analyzing, or approving the legislative recommendation before it is sent to Congress.<sup>4</sup>

Thank you for requesting our views. The Office of Management and Budget has advised that there is no objection to the submission of this letter from the standpoint of the Administration's program.

Sincerely,



Robert Raben  
Assistant Attorney General

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<sup>3</sup> There is substantial doubt that the statutory classification "officer or agency of the United States" in sections 2284 and 2245(b), see infra note 4, includes the President himself. As the Supreme Court explained in Gregory v. Ashcroft, 501 U.S. 452 (1991), when Congress intends to alter the constitutional balance of powers, it must be "unmistakably clear in the language of the statute." Id. at 458 (quoting Atascadero State Hospital v. Scanlon, 473 U.S. 234, 242 (1985)) (interpreting statute narrowly to avoid altering usual constitutional balance of federal and state powers). Consistent with this reasoning, the Court in Franklin v. Massachusetts, 505 U.S. 788 (1992) stated that, "[o]ut of respect for the separation of powers and the unique constitutional position of the President," it would require an "express statement by Congress" before interpreting the Administrative Procedure Act to authorize review for abuse of discretion of the President's performance of his statutory duties. Id. at 800-01. Even if the terms "officer" or "agency" are construed so as not to include the President himself, however, we do not believe Congress can preclude the President from relying on subordinate officers in the discharge of his constitutional duty to supervise legislative recommendations.

<sup>4</sup> For similar reasons, because we believe the Board must be subject to presidential control, we also believe that section 2245(b), which precludes Executive Branch oversight of certain types of Board communications with Congress, raises serious constitutional concerns. Section 2245(b) provides, in relevant part, "The Board may directly submit to Congress reports, legislative recommendations, testimony, or comments on legislation. No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to submission to Congress of such report, recommendations, testimony, or comments." To the extent that this provision applies to legislative recommendations and other policy proposals, we believe it raises serious constitutional concerns under the Recommendations Clause. See U.S. Const. Art. II, § 3.

Joshua S. Gottheimer  
04/28/2000 01:12:52 PM

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Subject: Revised Radio Address.Comments ASAP to Gottheimer 62554.

Draft 04/28/00 1pm

Josh Gottheimer

**PRESIDENT WILLIAM J. CLINTON**  
**RADIO ADDRESS ON PATIENTS BILL OF RIGHTS AND PRESCRIPTION DRUGS**  
**THE WHITE HOUSE**  
**April 28, 2000**

Good morning. Next week, when the full Congress returns from its Easter recess, they will have less than 75 working days left to make this a year of real progress for the American people. There is no more important critical piece of unfinished business than our need to ensure that every American -- young and old -- has adequate, affordable health care. Today, I want to again urge the Congress to step up to this challenge by making the passage of a strong patients bill of rights and the provision of a voluntary Medicare prescription drug benefit top priorities when they get back to Washington. This critical health care legislation is long overdue.

The more than 190 million Americans who use managed care or other insurance plans have waited too long for a strong, enforceable patients' bill of rights. They deserve the right to see a specialist; the right to emergency room care whenever and wherever they need it; and the right to hold health care plans accountable for harmful decisions.

Last year, in an overwhelmingly bipartisan vote, the House passed a strong patients' bill of rights that provides the right protections all Americans need and deserve. And it's a bill that I would sign. But more than six months later, the bill is still languishing in Congress. Despite their pledge to complete a real bill, the Republican majority has not only delayed action, it's actually considering legislation that would leave tens of millions of Americans without federal protections. A right that cannot be enforced isn't a right at all -- it's just a request. We need a strong bill that protects all Americans, in all plans -- not one that provides more cover for the special interests, than real coverage for patients.

Congress also has an obligation to strengthen Medicare and modernize it with a voluntary affordable prescription drug benefit. No one creating a Medicare program today would even think of excluding coverage for prescription drugs. Yet more than three in five

older Americans still lack affordable and dependable prescription drug coverage. Our seniors deserve better.

Just this week we saw further evidence of the unacceptable burden the growing cost of prescription drugs is placing on seniors Americans. According to a report by the non-profit group, Families USA, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years running. That's a burden that falls hardest on seniors who lack drug coverage -- because they simply don't receive the price discounts that most insurers negotiate.

Seniors and people with disabilities living on fixed incomes simply cannot continue to cope with these kinds of price increases. That is why we must take action to help them -- not next year or the year after that, but this year. My budget includes a comprehensive plan to modernize Medicare, and provide for a long overdue prescription drug benefit for all beneficiaries.

I'm pleased that there is growing bipartisan support for tackling this challenge. Earlier this month, Republican leaders in the House put forth the skeletal outline of a plan that offers, as a stated goal, access to affordable coverage for older Americans. Unfortunately, their plan falls short of meeting that goal. Instead, it would subsidize insurance companies to offer prescription-drug-only policies for middle-income seniors -- policies the insurance industry itself has already said it will not offer. And because the plan would provide direct support only to low-income seniors and disabled Americans, it would do nothing for those with modest, middle-class incomes between \$15,000 and \$50,000. Nearly half of all Medicare beneficiaries who lack prescription drug coverage fall into that category.

Conventional wisdom says that nothing substantive can get done in an election year. But if you're a member of a managed care plan or an older American who depends on life-saving drugs to keep you out of the hospital, you don't care about partisan politics. You just care about getting well and staying well.

So I say to Congress, when you get back to Washington next week, let's get back to work on a strong and enforceable patients bill of rights. Let's get back to work on a voluntary Medicare prescription drug benefit. The healthcare of Americans is too important to be sidetracked by partisan politics. The need is urgent, and the time to act is now.

Thanks for listening.

Message Sent To: \_\_\_\_\_



U.S. Department of Justice  
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

April 28, 2000

The Honorable John D. Rockefeller IV  
United States Senate  
Washington, DC 20510

Dear Senator Rockefeller:

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S. 1895 would establish as an "independent agency" a Medicare Board ("Board") that would administer a new competitive premium Medicare system and would assume from the Secretary of the Department of Health and Human Services general oversight authority over Medicare plans. Specifically, the Board "will coordinate determinations of beneficiary eligibility and enrollment" with the Commissioner of Social Security; "enter into, and enforce, contracts with entities for the offering of Medicare plans;" and "disseminate to Medicare beneficiaries information with respect to benefits [and] limitations on [ ] payment under Medicare plans." § 2242(a). The President may remove members of the Board "only for neglect of duty or malfeasance in office." See § 2244(a)(3). The bill would also reorganize HCFA, which is within the Department of Health and Human Services, into two new divisions: the Division of HCFA-Sponsored Plans and the Division of Health Programs.

To the extent the bill would limit presidential oversight of the Board's statutory duties and responsibilities, by restricting the President's removal authority, it raises a significant constitutional question. As the Supreme Court has explained, legislation that places restrictions on the power of the President to remove Executive Branch officers passes constitutional muster if it does not "impede the President's ability to perform his constitutional duty." Morrison v. Olson, 487 U.S. 654, 691 (1988); see also Nixon v. Administrator of General Services, 433 U.S. 425, 443 (1977) ("Nixon II") (legislation that affects the power of the President is unconstitutional if it "prevents the Executive Branch from accomplishing its constitutionally assigned functions"). In evaluating whether a restriction on the President's removal authority impedes the ability of the President to carry out his constitutional duties, we must look to the functions that the Board performs. See Morrison, 487 U.S. at 691.

Although the bill does not provide a detailed description of the Board's powers, two characteristics of its functions stand out. First, the Board may exercise broad policy-making authority over the Medicare Program, a wide-reaching program that is undeniably of great significance to the American public. The Board is authorized to make fundamental policy decisions such as what benefits or services, beyond a statutorily prescribed minimum, will be offered to beneficiaries; which private entities will provide services or benefits; the amount of money the federal government will pay to those entities; and the amount that Medicare beneficiaries must pay for various levels of benefit coverage. In light of the President's constitutional role as Chief Executive and his responsibilities to ensure proper execution of the laws, we believe a strong argument can be advanced that the President must be able to supervise Executive Branch officers who are charged with making such policy determinations. Indeed, the Supreme Court has concluded that Congress may delegate policy-making responsibilities to agencies because, "[w]hile agencies are not directly accountable to the people, the Chief Executive is, and it is entirely appropriate for this political branch of the Government to make . . . policy choices . . . which Congress itself either inadvertently did not resolve, or intentionally left to be resolved by the agency charged with the administration of the statute in light of everyday realities." Chevron U.S.A. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 865-66 (1983). Consistent with that view, the Court upheld the removal restriction for the independent counsel in Morrison, in part, because this inferior officer lacked any policy-making authority. See 487 U.S. at 691.<sup>1</sup>

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<sup>1</sup> To be sure, in Humphrey's Executor v. United States, 295 U.S. 602 (1935), the Court stated that the Federal Trade Commission (FTC), in "carry[ing] into effect legislative policies embodied in [a] statute in accordance with the legislative standard therein prescribed . . . acts in part quasi-legislatively and in part quasi-judicially." Id. at 628. The Court's more recent pronouncements, however, cast considerable doubt on its earlier characterization of FTC functions as "quasi-legislative." In Morrison itself, the Court noted the "difficulty of defining such categories of 'executive' or 'quasi-legislative' officials," and stated that "it is hard to dispute that the powers of the FTC at the time of Humphrey's Executor would at the present time be considered 'executive,' at least to some degree." Morrison, 487 U.S. at 689-90 n.28. Accordingly, we do not believe that the Court would view delegated policy-making of the sort

Second, it does not appear that the Board will possess any significant “quasi-judicial” functions that might otherwise constitutionally warrant a restriction on the President’s removal authority. Although the determination whether the Constitution allows Congress to impose a “for cause” restriction on the President’s power to remove an officer does not turn entirely on whether the officer performs quasi-judicial functions, Morrison, 487 U.S. at 689, to the extent that such functions would be absent here, one of the key arguments advanced to defend removal restrictions would be unavailable. See Humphrey’s Executor, 295 U.S. at 628-30 (relying on FTC’s “quasi-judicial” functions as evidence that restrictions on President’s authority to remove members of the Commission did not interfere with President’s ability to discharge his constitutionally-assigned functions); see also Morrison, 487 U.S. at 691 n.30 (noting that freedom from executive or political control may be desirable in circumstances in which an official is performing “quasi-judicial” functions).

Finally, the findings accompanying the legislation fail to identify the type of “overriding need” for independence necessary to justify limitations on presidential oversight of the Board. In its more modern jurisprudence, the Court has adopted a balancing approach to evaluate “disruptions of the proper balance between coordinate branches.” Nixon II, 433 U.S. at 443 (citing United States v. Nixon, 418 U.S. 683, 711-12 (“Nixon I”) (1974)). Where Congress seeks to limit the President’s ability to supervise an executive entity that exercises broad policy-making authority and that lacks significant adjudicative functions, such a disruption in the normal powers of the Executive Branch must be “justified by an overriding need to promote objectives within the constitutional authority of Congress.” Nixon II, 433 U.S. at 443 (citing Nixon I, 418 U.S. at 711-12). In Morrison, for example, the Court explained that Congress “was concerned when it created the office of independent counsel with the conflicts of interest that could arise in situations when the Executive Branch is called upon to investigate its own high-ranking advisers.” Morrison, 487 U.S. at 677. The removal restriction on the independent counsel, the Court noted, “was essential, in the view of Congress, to establish the necessary independence of the office.” Id. at 693. Here, by contrast, the legislation cites only a need “to reduce Government micromanagement of the Medicare Program.” Sec. 2(a)(7). We do not believe this justification is a sufficiently substantial or overriding reason for insulating the Board from executive oversight.

In light of the Board’s broad policy-making authority and apparent lack of significant adjudicatory authority – and because Congress has failed to identify a substantial need for the independent status of the Medicare Board – we believe that, to the extent Congress intends to insulate the Board from presidential direction,<sup>2</sup> the proposed legislation raises serious

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contemplated by this legislation as a “quasi-legislative” function for separation of powers purposes.

<sup>2</sup> The extent to which a statutory removal restriction, like that in the proposed legislation, precludes the President from determining the policy direction of the tenure-protected office is unsettled. As a result of practice in our system of government as it has developed over time, it is

constitutional concerns. Nonetheless, even if the courts were to sustain the legislation in the face of a constitutional challenge, we would strongly oppose the bill's restrictions. As the bill seeks to remove from the President's oversight functions of an agency that are already under his supervision, it appears to constitute a serious, and unnecessary, erosion of the President's authority to oversee activities within the Executive Branch, and to compromise the core constitutional commitments to political accountability and coordinated policy-making.

Section 2284, which concerns communications with, *inter alia*, Congress by the Director of the Division of HCFA-Sponsored Plans, also raises serious constitutional concerns. This provision provides, in relevant part, "No officer or agency of the United States may require the Director to submit [a business plan that includes a legislative proposal to implement the plan] to any officer or agency of the United States for approval, comments, or review, prior to the submission of the plan to Congress and such individual." In addition, this provision affirmatively requires the Director to submit annually a business plan that includes legislative recommendations to both Houses of Congress. *See* § 2284(a). We believe this provision is invalid under the Recommendations Clause, which provides that the President "shall from time to time . . . recommend to [Congress] . . . such Measures as he shall judge necessary and expedient." U.S. Const. Art. II, § 3. The Recommendations Clause protects the President's constitutional prerogative to formulate and present his own recommendations and proposals, and to control the policy agenda of the Executive Branch. By requiring the President's subordinates to provide the Congress with legislative recommendations, the legislation infringes on the President's authority to decline to offer any legislative recommendation if, in the President's

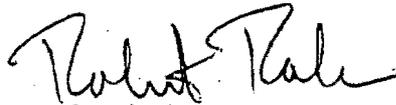
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commonly assumed that policy differences do not give the President "cause" to remove an officer. There is some support for that assumption in Humphrey's Executor, where the Court, in upholding a "for cause" removal restriction on the President's ability to remove members of the FTC, stated that the FTC's "duties are performed without executive leave and, in contemplation of the statute, must be free from executive control." 295 U.S. at 628; *see also* Wiener v. United States, 357 U.S. 349 (1958) (emphasizing that removal limitations prevent officials from being "subject in the discharge of their duties to the control of the Executive"). Similarly, in Mistretta v. United States, 488 U.S. 361 (1989), in discussing the "for cause" removal limitation for members of the United States Sentencing Commission, the Court stated that the restriction "is specifically crafted to prevent the President from exercising 'coercive influence' over independent agencies." *Id.* at 411 (citing Morrison, 487 U.S. at 688). In contrast, the Supreme Court suggested in Bowsher v. Synar, 478 U.S. 714, 729-30 (1986), that a provision permitting removal for "inefficiency," "neglect of duty," and "malfeasance" conferred a "very broad" removal power, "could sustain removal . . . for any number of" reasons, and would ensure that an officer subject to removal under such standards "will be subservient" to any person or entity that could exercise such power. It is thus possible that, in order to avoid the difficult constitutional question of whether Congress may preclude the President from removing a principal officer of an independent agency for policy differences – an issue that neither Humphrey's Executor and Morrison squarely addressed – courts would construe the removal provision in the Medicare legislation not to so limit the President's authority.

judgment, no such recommendation is necessary or expedient. The invalidity of such a congressionally-compelled legislative recommendation is heightened to the extent that the provision attempts to prohibit the President,<sup>3</sup> or his subordinates, from reviewing, analyzing, or approving the legislative recommendation before it is sent to Congress.<sup>4</sup>

Thank you for requesting our views. The Office of Management and Budget has advised that there is no objection to the submission of this letter from the standpoint of the Administration's program.

Sincerely,



Robert Raben  
Assistant Attorney General

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<sup>3</sup> There is substantial doubt that the statutory classification "officer or agency of the United States" in sections 2284 and 2245(b), see *infra* note 4, includes the President himself. As the Supreme Court explained in *Gregory v. Ashcroft*, 501 U.S. 452 (1991), when Congress intends to alter the constitutional balance of powers, it must be "unmistakably clear in the language of the statute." *Id.* at 458 (quoting *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985)) (interpreting statute narrowly to avoid altering usual constitutional balance of federal and state powers). Consistent with this reasoning, the Court in *Franklin v. Massachusetts*, 505 U.S. 788 (1992) stated that, "[o]ut of respect for the separation of powers and the unique constitutional position of the President," it would require an "express statement by Congress" before interpreting the Administrative Procedure Act to authorize review for abuse of discretion of the President's performance of his statutory duties. *Id.* at 800-01. Even if the terms "officer" or "agency" are construed so as not to include the President himself, however, we do not believe Congress can preclude the President from relying on subordinate officers in the discharge of his constitutional duty to supervise legislative recommendations.

<sup>4</sup> For similar reasons, because we believe the Board must be subject to presidential control, we also believe that section 2245(b), which precludes Executive Branch oversight of certain types of Board communications with Congress, raises serious constitutional concerns. Section 2245(b) provides, in relevant part, "The Board may directly submit to Congress reports, legislative recommendations, testimony, or comments on legislation. No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to submission to Congress of such report, recommendations, testimony, or comments." To the extent that this provision applies to legislative recommendations and other policy proposals, we believe it raises serious constitutional concerns under the Recommendations Clause. See U.S. Const. Art. II, § 3.

# NEWS

## FROM THE COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE  
April 26, 2000

CONTACT: Trent Duffy or Greg Crist  
(202) 225-8933

### Thomas Reaction to President Clinton's News Conference on a Prescription Drug Benefit for Medicare and Study on Drug Costs

WASHINGTON – Ways and Means Health Subcommittee Chairman Bill Thomas (R-CA) today responded to President Clinton's news conference on prescription drug coverage for Medicare beneficiaries and a new study by Families USA that suggests drug prices are rising faster than the rate of inflation.

"This is precisely why our prescription drug plan includes protection for all seniors from runaway out of pocket drug expenses, which is called stop-loss coverage. The President's plan fails to cover seniors' drug costs once they exceed \$2,000, which leaves seniors way too vulnerable to escalating drug prices."

"Furthermore, I must clarify that our plan helps all seniors by creating a private-public partnership to help cover the costs of the sickest patients. This in turn, will lower the premiums that all seniors pay for drug benefits, which means more affordable coverage for all seniors -- regardless of income. Our plan is universally offered as an option under Medicare, which is similar to the President's approach. Despite the President's partisan rhetoric, I look forward to working in a bipartisan fashion on building a prescription drug plan for a stronger Medicare that can be signed into law this year. I hope the President's intention is the same."

On April 12<sup>th</sup>, House Speaker Dennis Hastert (R-IL) and several Members of the Ways and Means and Commerce Committees introduced a comprehensive plan to strengthen Medicare while modernizing the program with a prescription drug benefit for seniors. The market-based plan will offer voluntary prescription drug coverage to every senior while protecting them from exploding prices that threaten their financial security. Contact Tim Scharf in the Ways and Means Press Office at (202) 225-8933 if you would like a summary of the plan. Statements from the AARP and the American Association of Health Plans about the GOP plan follow this release. The brief outline of the plan is as follows:

- ◆ Lowers Drug Prices and Expands Access to Prescription Drugs for All Beneficiaries Without Threatening the Patient-Doctor Relationship.
- ◆ Protects Against Higher Drug Prices and Runaway Out-of-Pocket Costs.
- ◆ Expands Seniors' Right to Choose the Coverage that Best Suits Their Needs Through a Voluntary and Universally-Offered Benefit.
- ◆ Rejects Big Government Approach With A Public-Private Partnership That Lowers Premiums.
- ◆ Invests \$40 Billion to Modernize and Strengthen Medicare.
- ◆ Preserves and Protects Medicare to Keep Program Solvent for Future Generations.
- ◆ Ensures that Today's Scientific Research and Medical Innovation will Continue to Find Tomorrow's Cures

*-AARP and AAHP statements on GOP Prescription Drug Plan Follow-*

**Statement by AARP Executive Director Horace B. Deets on House Republican Medicare Prescription Drug Proposal, April 12, 2000**

“House Republican leaders today outlined a new proposal to help Medicare beneficiaries purchase prescription drug coverage. Many details of this plan are yet to be spelled out, but we are pleased that this proposal moves beyond the prescription drug benefit developed by the Medicare Commission - a proposal that would have provided prescription drug coverage only to low-income older Americans - to providing prescription drug coverage to all older and disabled Americans in Medicare.

As we understand it, the proposal would provide a full subsidy for low-income beneficiaries without jeopardizing Medicare's social insurance foundation. In addition, it has the potential for reducing the premiums that all older Americans would pay for their Medicare prescription drug coverage by providing a government subsidy for those people in Medicare who have extraordinarily high drug costs.

AARP supports a prescription drug benefit in Medicare that would be available to and affordable for all beneficiaries. Many questions must be answered about this proposal before we can judge whether it meets these criteria. Among these questions: Would the level of federal subsidy, which is the same as in the President's proposal, prove adequate to attract the broad risk pool that is needed to make the coverage affordable for the vast majority of beneficiaries? Would this public-private partnership, with its many implementation details, prove workable?

At this early stage, we believe this proposal has merit and should be explored carefully. AARP is prepared to work with the proponents of this idea, as well as with other Members of Congress and the President on a bipartisan basis, to help shape a Medicare prescription drug benefit that will meet the needs of older Americans today and in the future.”

**Statement of AAHP, in a Letter to Senator William Roth, April 11, 2000**

“We believe the most effective way to provide this coverage is through private risk-bearing insurance entities to ensure minimal disruption to current prescription drug coverage. As Congress moves to act to authorize new drug coverage options for Medicare beneficiaries, we believe they should be able to purchase coverage from competing private sector plans that choose to offer such coverage, including existing Medicare+Choice plans, employer-sponsored plans, Medigap plans, and other innovative private insurance entities that would provide this drug benefit.”

**PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP HIGHLIGHT  
NEW STUDY DOCUMENTING PRESCRIPTION DRUG PRICE INCREASES  
THAT DOUBLE INFLATION RATES**

**Families USA Report Validates the Need for a Medicare Prescription Drug Benefit  
April 26, 2000**

President Clinton today, along with Senator Tom Daschle and House Democratic Leader Dick Gephardt, will join Families USA in releasing a new report on prescription drugs. The report shows that, on average, the price for the 50 drugs most commonly used by seniors increased at nearly twice the rate of inflation during 1999. The President will point out that this finding, combined with the recent HHS report showing that the price differential for older and disabled Americans with and without coverage has nearly doubled, underscores the need for a voluntary Medicare prescription drug benefit. While praising the House Republican leadership for endorsing the principle of the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. He will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option.

**NEW ANALYSIS INDICATES THAT PRESCRIPTION DRUG PRICES WILL CONTINUE TO RISE.** While senior citizens generally live on fixed incomes that are adjusted to keep up with the rate of inflation, a new report by Families USA entitled *Still Rising* demonstrates that prescription drug costs have risen at double that rate over the past six years – and are expected to continue to rise. Key findings of the Families USA report include:

- **In 1999, the prices of the prescription drugs most commonly used by seniors increased at almost double the rate of inflation.** The report found that prices of the 50 prescription drugs most frequently used by the elderly rose by nearly two times the rate of inflation during calendar year 1999. On average, the prices of these drugs reportedly increased by 3.9 percent from January 1999 to January 2000 (versus 2.2 percent for general inflation).
- **Moreover, these increases are part of a trend: Over the past six years, the prices of the prescription drugs most commonly used by seniors also increased by twice the rate of inflation.** The report finds that the price of the 50 prescription drugs most commonly used by older Americans increased by 30.5 percent since 1994 – twice the rate of inflation. More than half of the most commonly used drugs that were on the market for the entire six year period had price increases that were double the rate of inflation. In addition, the Families USA report concludes that more than 20 percent of these prescription drugs increased in price by three times the rate of inflation over that time period.
- **Seniors with common chronic illnesses are often forced to spend well over 10 percent of their income on prescription drugs.** The new Families USA study demonstrates that a widow with diabetes, hypertension, and high cholesterol, living on an annual income of \$12,525 (150 percent of the poverty level) will spend 18.3 percent of her annual income on prescription medications. The same woman with an annual income of \$16,700 (200 percent of the poverty level) will spend 13.7 percent of her income on these medications. This finding, which is consistent with the conclusions of studies conducted by HHS, clearly demonstrates that failure to provide a voluntary, affordable, and accessible Medicare prescription drug benefit will impose a continuing and growing burden on middle-class older Americans and people with disabilities.

**PRESIDENT CLINTON CHALLENGES THE REPUBLICAN LEADERSHIP TO MODIFY THEIR POLICY TO MATCH THEIR STATED GOALS.**

While praising the House Republican leadership for recognizing the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. Their current approach is underfunded, unlikely to be available to all beneficiaries, and would almost inevitably be unaffordable to millions of seniors and people with disabilities, even if it is available in some places. In addition, because of its lack of details, it raises more questions than it answers, including how much the premiums are, what the benefit would be, and how much it will cost. The President will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option. The House Republican proposal:

- **Reneges on funding commitments for a meaningful prescription drug benefit.** Earlier this year, the Republicans indicated they would commit \$40 billion for a prescription drug benefit, but their budget resolution dedicated as little as \$20 billion to improve the Medicare program to include a prescription drug benefit. Moreover, the lack of their willingness to release 10-year numbers on their prescription drug proposal raises serious concerns that their tax policy consumes virtually all revenue necessary to adequately fund a drug benefit into the future.
- **Does not assure availability of prescription drug coverage.** Because the Republican plan relies on private insurers to offer a drug-only benefit voluntarily, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. In testimony before the Congress, the insurance industry itself has expressed skepticism about the effectiveness of the Republican approach.
- **Not affordable for most seniors, even if it is available.** Furthermore, because it provides direct premium assistance only to beneficiaries with annual incomes of under \$12,600, the Republican benefit will almost certainly fail to be an affordable option even if it's available. If enacted, the Republican proposal would mark the first time in the program's history that Medicare would not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program. Finally, because of the proposals reliance on the Medigap insurance market, which frequently does not negotiate lower prices on behalf of its enrollees, it casts doubt on whether beneficiaries would have access to market-leveraged discounts.

**HOUSE REPUBLICANS'  
PRESCRIPTION DRUG PLAN**

*April 20, 2000*

# SUMMARY OF HOUSE REPUBLICAN PRESCRIPTION DRUG PLAN

- Dedicates at least \$20 billion for 2001-05 for prescription drugs
- Provides undefined, prescription drug-only benefit through private insurers
- Low-income Medicare beneficiaries (below 150 percent of poverty) would receive direct premium assistance
- Private plans would have to offer some level of stop-loss (catastrophic) coverage, and the government would share the risk of that coverage with private insurers
- An “Entity” would administer the prescription drug benefit

# QUESTIONS ABOUT PLAN

## 1. How can all seniors be assured that there will even be one private insurance prescription drug benefit?

### We DON'T Know:

- What provision of the proposal assures that all / most / any beneficiaries will have access to the new drug benefit
- Whether private insurers will be required to offer coverage in all areas
- Whether and, if so, how the individual insurance market would be reformed to assure that all beneficiaries have the same options at the same price regardless of age, geography or health

### We DO Know:

- Lack of insurer interest in covering seniors in 1965 led to the creation of Medicare.
- Industry representatives as well as specific, large insurers have previously testified that they would not participate in a drug-only, private Medigap plan.
- Today, few private plans offer -- and fewer seniors participate (only 10 percent) -- in private Medigap drug plans despite the fact that current Medigap insurer liability is limited.
- Most private insurers neither guarantee that all beneficiaries can participate nor offer Medigap coverage at the same premium for beneficiaries regardless of age or sickness. Without protections, access would be limited by high premiums or outright denials of coverage.

## 2. What are the premiums for the prescription drug benefit? Will they be affordable to middle-income seniors and people with disabilities?

### We DON'T Know:

- What premiums beneficiaries would pay under the plan
- What is the value of the benefit and the extent of government contribution
- How much variation in premiums there would be across the country

### We DO Know:

- Premiums would vary significantly nationwide as they do in the current Medigap market.
- There is no explicit premium assistance for any single Medicare beneficiary with income above \$12,600. About half of beneficiaries without prescription drug coverage have income above the Republicans' plan cut-off.
- Most experts agree that a 50 percent premium subsidy is needed to make a Medicare drug benefit affordable for all beneficiaries. For those above the premium assistance cut-off, the Republican plan provides no direct subsidies and only indirectly subsidizes an unknown amount of the stop-loss provision.

### 3. What is the actual drug benefit being purchased by beneficiaries and tax payers?

#### We DON'T Know:

- What are the deductibles, copays, and benefit limits for the plan options
- What is the stop-loss level and whether that varies by plan and area
- What is the minimum value of insurance that private insurers would offer under this plan

#### We DO Know:

- Managed care plans in the Medicare+Choice system have used their flexibility to design drug benefits that attract healthier beneficiaries (e.g., low copays but quarterly caps on plan payments). Few chronically ill beneficiaries have found plans that have designed their prescription drug benefits to suit their needs.
- Widely varying, insurer-defined benefits led to confusion and fraud in the Medigap market, resulting in a bipartisan law that standardized benefits in the early 1990s.
- Most economists and health policy experts agree that informed choices of health plans cannot occur unless benefits are standardized in a manner in which consumers can make “apples-to-apples” comparisons.

## 4. How is the premium assistance for low-income Medicare beneficiaries structured, who administers it, and how does it ensure all low-income beneficiaries have access to it?

### We DON'T Know:

- If the benefit is a Medicare means-tested benefit or a Medicaid benefit. If it is a Medicaid benefit, would states be responsible for all or part of the cost and would they be responsible for administering it
- Whether the cost sharing as well as premiums would be subsidized
- How prescription drugs would be delivered for low-income beneficiaries – through the Medicaid rebate program or through private plans. If through private plans, it is not known whether low-income seniors would get a choice of plans or be forced into the lowest cost private plan option

### We DO Know:

- Medicare has never means-tested its benefits. Doing so for prescription drugs would effectively limit access to an essential health benefit.
- Expanding through Medicaid means expanding the Medicaid rebate program. Participation in Medicaid is typically lower than Medicare, lessening the effectiveness of covering low-income beneficiaries.
- The National Governors' Association's position is that states want neither the responsibility for or costs of a prescription drug benefit.

## 5. How much are Republicans dedicating to a prescription drug benefit over 5 and 10 years and is it sufficient for a meaningful benefit?

### We DON'T Know:

- How much over the next 5 years will be dedicated for prescription drugs since the Republican budget resolution does not explicitly commit the full \$40 billion to the benefit
- If there is a funding commitment after 5 years and whether it can be afforded if the Republicans' tax cut uses virtually all of the available resources

### We DO Know:

- The budget resolution allocation for a drug benefit in the first 5 years assumes unrealistically large cuts in non-defense discretionary spending.
- The Republican tax cut over 10 years appears to be as large as the \$792 billion tax cut that the President vetoed last year. This tax cut, and its associated interest, will require \$932 billion -- more than CBO's projected \$893 billion surplus. This would leaving no room for any investment for a drug benefit or other domestic priorities.
- This Republican budget resolution also would commit any additional resources to tax cuts or debt reduction, not for a drug benefit or other priorities.