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**May 16, 2000**

**STATEMENT BY THE PRESIDENT ON PRESCRIPTION DRUG BENEFIT FOR MILITARY RETIREES**

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

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STATEMENT BY THE PRESIDENT  
ON PRESCRIPTION DRUG BENEFIT FOR MILITARY RETIREES

The Rose Garden

2:09 P.M. EDT

THE PRESIDENT: Good afternoon, ladies and gentlemen. Before we start, I would just like to say a few words of appreciation and respect about Helen Thomas, who has decided today to leave UPI after 57 years.

Presidents come and go, but Helen's been here for 40 years now, covering eight Presidents, and doubtless showing the ropes to countless young reporters -- and, I might add, more than a few press secretaries. I hope this change will bring new rewards and new fulfillment to her. Whatever she decides to do, I know I'll feel a little better about my country if I know she'll still be spending some time around here at the White House. After all, without her saying, "Thank you, Mr. President," at least some of us might never have ended our news conferences.

When I gave my State of the Union address this year, I said that in good conscience we could not let another year pass without finding a way to offer voluntary prescription drug coverage to every older American. I think we're beginning to make progress toward that goal, and today I want to support one step in the right direction: a congressional proposal, scheduled for a vote this week in the House, to extend prescription drug coverage to all retired military personnel over 65.

Keeping faith with men and women in America who have served in our armed forces is a sacred obligation for all of us. That's why we have raised military pay over eight percent over the last two years; why we're working to provide our troops with better housing, and taking steps to improve access to medical care for all military personnel, families and retirees. We asked them to risk their lives for freedom, and in return we pledged our support.

Part of that promise is a medical network that helps to provide prescription drugs at reasonable costs. Some senior retirees are able now to take advantage of that network. But they're out of reach for as many as

three of four of them.

This proposal would make sure that we meet our promise to more than 1 million older military retirees across the nation, providing every single one of them with a prescription drug benefit, sharing with them the price discounts that the military negotiates with drug companies. At a time of unprecedented prosperity, there is no reason for military retirees to go without these prescription drugs that they need to live longer and healthier lives. We need to show them that they count, and they can count on us.

This initiative is another step for finding a way to offer every older American voluntary prescription drug coverage, and affordable prescription drugs. That ought to be our next goal, because today more than three in five American seniors lack such coverage. Too many spend huge percentages of their income on prescription drugs. Too many have to choose every month between filling those prescriptions and filling grocery carts. Too many are simply not getting the medicine they need.

If we were creating Medicare today, as I have said over and over and over again, we certainly would include a prescription drug benefit to give older Americans and people with disabilities access to the most cost-effective health care. Prescription drugs help to keep seniors mobile and healthy. They help to prevent expensive hospital stays and surgical procedures. They promote the dignity that every retired person is entitled to -- the quality of life all of us want for our own parents. We should act this year to make sure all seniors have access to such coverage.

In my budget, I proposed a comprehensive plan to provide a Medicare benefit that is optional, affordable and available to all, based on price competition, not price controls; a plan to boost seniors' bargaining power to get the best prices possible, just as this military plan would; a plan that is part of an overall effort to strengthen and modernize Medicare so that we won't have to ask our children to shoulder the burden of the baby boomers' retirement.

I'm glad there is growing bipartisan support for providing this coverage to all beneficiaries. Both sides say they want to get it done. Unfortunately, I still believe that the proposals put forward by the congressional majority will not achieve the goal. They'd provide no assistance to middle-income seniors, nearly half of all those who now lack coverage. They'd subsidize private insurance plans that the industry itself says it will not offer. This will not get the job done.

But the bipartisan spirit of this proposal for military retirees shows us the way forward for all retirees. In reaching out to extend coverage to older military retirees, Congress has recognized that high prescription drug costs are a burden for every senior, and that we owe every military retiree a dignified and healthy retirement.

Both parties now have agreed that prescription drug coverage should be available, and affordable, to older Americans. We can, surely, come to an agreement on the details of how to do this. We all want our seniors, all of them, to live longer, healthier lives. And I'm very glad that here, as so often before, our armed forces are leading the way.

Thank you very much.

Q Mr. President, on --

Q Mr. President, you --

THE PRESIDENT: I'll take them both. Go ahead.

Q Mr. President, you seem to be having a prescription drug event

each week, now. Is it safe for us to assume that this is the one piece of what would be historical legislation -- historic legislation -- that you would like to sign on behalf of your legacy?

THE PRESIDENT: No. It's safe for you to assume that I think there's a fair chance we could pass this, and I think it's the right thing to do for America. The Congress will have a chance to cast any number of profoundly important votes, including the vote on China and the trade relations. And I hope they'll do the right thing on each and every one.

But you know, my philosophy has always been the same in election years as in off-years. I think that we owe it to the American people to govern, to do as much together as we can in good conscience, secure in the knowledge that no matter how much we get done there will still be significant areas of disagreement between the two parties -- beginning with our presidential candidates and extending to the Senate and the House candidates -- on which we can have a marvelous election and a rousing debate.

So, do I want to get this done? Absolutely, I do. But I want to do it because we have the money to do it now, and we know how to do it, and because the people need it.

Go ahead.

Q Sir, on the economy, are you concerned that if the Fed Chairman's efforts to slow this economy down have the desired effect, it might negatively impact the Vice President's campaign going into the November election, and really give the Republican challenger some ammunition to go after Mr. Gore with?

THE PRESIDENT: No, because what we've done is to minimize inflation, by paying down the debt and keeping our markets open. And I think that if anything, the Chairman of the Fed has made it clear that if you had a huge tax cut, it would cause even higher interest rate increases. So I think -- you know, the Fed will do its job, and we will do ours. And I'm going to let them make whatever decision that Chairman Greenspan and the others think is warranted.

But I think it should remind us all of the wisdom of continuing to pay down the debt, because the more we pay down the debt, the more we'll keep interest rates as low as they can, the more we'll keep inflation down. It's also a good argument for passing the normal trade relations with China and continuing to expand our trade.

Q Mr. President --

Q Mr. President -- excuse me -- poll after poll continues to show that Governor Bush is ahead of Vice President Gore. Do you think his campaign strategy, the Vice President's, is working?

THE PRESIDENT: I don't want to comment on the campaign. It's a long time before it's over, and I think that in these elections the fundamentals tend to take over, and the American people tend to take the measure of both the candidates, especially in the course of the debates. And you know, I trust them to make the decision. I don't have anything to comment about that.

Q Sir, are you a registered voter in New York, sir?

Q Mr. President, on --

THE PRESIDENT: Go ahead, I'm sorry.

Q Mr. President, on the Chinese vote, how are you doing? And could

you elaborate on your statements of the other day that China could still get WTO membership, and the U.S. would be hurt, if the Congress doesn't pass it?

THE PRESIDENT: Sure. China could get into the WTO, and will get into the WTO, but the United States would not be able to claim the benefits of the agreement we negotiated. So all those big cuts in agricultural tariffs, all that right to sell automobiles in China without putting plants up there or transferring technology, all the access to what will clearly be the biggest telecommunications market in the world -- all those benefits we negotiated will go to the Europeans, the Japanese, and others who will be in a position to take advantage of them.

So that, it seems to me, is clear. You can't -- if they go in, they have to be accepted on membership terms that apply to everyone else -- and that's fair, because we expect them to follow the rules that apply to everyone else. And therefore, any nation that withholds those membership terms doesn't get the benefit of the agreement that was negotiated. And it would be quite significant.

Q How hard are you finding this China trade fight? And when you meet one on one with Democrats, are they saying they're just facing terrific pressure from the labor unions? Are you losing some of those one-on-ones? And what's your prediction for the outcome?

THE PRESIDENT: I'm losing some and getting some. My view is that in the end it will pass, not only because the economic benefits are clear and overwhelming, but in a larger sense because the national security interests are so clear.

Let me just say again, I think it's quite interesting that, for all the differences the Taiwanese and the Chinese have had, and the tensions between them, everyone, beginning with the President-elect of Taiwan, wants us to approve China going into the WTO. Why is that? They think it's good for them economically, but in a larger sense, they think it will reduce tensions along the Taiwan Straits, and maximize the chance that the Chinese and the people of Taiwan will have a chance to work out their differences in a peaceful way, which is consistent with over 20 years of American policy. I think it's interesting that Martin Lee came all the way over here from Hong Kong -- a man who cannot even legally go to China, who has never met the Premier of China -- to say to us we had to support this, because China had to be brought into a system that extols the rule of law. And that was the beginning of liberty.

I think it's interesting that Chinese dissidents in China -- people who have been subject to abuses we would never tolerate in our country, whose phones have been tapped, who can't sponsor public events -- still implore us to support this, because they know it is the beginning of the rule of law and change in China, and ironic that the people in China who do not want us to vote for this are those that hope they will have a standoff with us and continuing control at home -- the more reactionary elements in the military and in the state-owned industries.

So I think the national security arguments are so overwhelming, that notwithstanding the pressures, and especially given the economic realities of this agreement, in the end that Congress will do the right thing. I believe they will.

Q Mr. President, Charlie Rangel came out today and said he's going to go ahead and support normalizing trade relations with China. Can you tell us how you feel about that, and how it may affect other Democrats?

THE PRESIDENT: Well, I think it's an enormously important decision by Mr. Rangel. If we're successful in the elections in November in the House, then he would become the Chairman of the Ways and Means Committee. I think his decision will affect other members on the Committee. And I think if

we're fortunate enough to get a majority of Democrats on the Committee to vote for this, because of Charles Rangel's leadership and because some of the others are already come out, that surely will have an effect on our caucus, because they are in the best position to understand the economic issues involved here. And I think it's an immensely important thing.

And I think if this passes, combined with the bill for Africa and Caribbean Basin trade, which was passed with overwhelming majorities last week, this Congress will build quite a legacy for itself in this area, and one that would be well-deserved for members of both parties that vote for it.

Q Mr. President, can you tell us how you came to the decision to go up to New York tonight, and any thoughts you have on seeing the First Lady nominated?

THE PRESIDENT: I just decided I ought to be there. I mean, it's a big deal for her, a big night for her, and I want to be there with her. I just want to be there to support her. And I also -- a secondary but important consideration for me is it's Senator Moynihan's -- kind of his farewell address to the people in New York who have elevated him to the Senate and given him the chance to serve our country in a remarkable way. I'd like to hear what he has to say as well.

But mostly, I just wanted to be with Hillary tonight. It's a big night for her, and I just started working on my schedule today to see if I could go.

Q Are you yet registered to vote in New York, Mr. President?

THE PRESIDENT: Excuse me?

Q Are you yet registered to vote in New York?

THE PRESIDENT: No. But I intend to register so I can vote for her in November.

You know, this was a -- Mark, this was kind of a difficult issue. I just voted in the last school election in Little Rock a few days ago. And for me, it's hard, you know, on a personal basis. But this is a commitment that we made together. And it's something that she wanted to do, and a lot of people in New York wanted her to do, and I want to support her in every way I can. And I certainly intend to vote for her. And since I'm a tax-paying resident of New York now, I'm entitled to vote, and I intend to take advantage of it.

Q Mr. President, on guns, I know you didn't want to talk about the campaign in general terms, but there are a lot of polls that shows Bush is doing as well or even better than Mr. Gore on the issue of guns. How can that be? What's your take on that?

THE PRESIDENT: The people don't know what their respective positions are. You know, one of the things I said here on Sunday morning, before the Million Mom March, is that I think we'd lose -- particularly in how people vote on this issue -- if it gets muddled in rhetoric; and we win, if people know what the specifics are. And this just -- and that's often true about issues in America.

If you say that you want more gun control or not, or you want the government to control guns more, we'd probably win that, but it would be close. If you say, do you believe we should close the gun show loophole, and ban large-capacity ammunition clips from being imported, and require child trigger locks; or should we have people who buy handguns get a photo ID license showing they passed the Brady background check and a safety course -- then I think we'd win.

And I think that it's really interesting -- it's very instructive to compare this with automobiles. The NRA always talks about the right to keep and bear arms. Well, the Supreme Court says there's a constitutional right to travel, enshrined in and guaranteed by the Constitution. And when we have speed limits, seat belt laws, child safety restraint laws, and drivers have to get licenses, nobody talks about car control in ominous terms. You don't hear all the -- there's a big threat of car control out there.

Now, if I come get your car, park it in my backyard, that's car control. Otherwise, it's highway safety. And I have not proposed to confiscate the gun or take away the gun or the right to hunt or sport shoot or even to have a gun in self-defense for any law-abiding American. I have not made any proposals. Neither to the best of my knowledge has anyone else in Congress. So what we're talking about is gun safety legislation to keep guns away from criminals and other people who shouldn't have them, and out of the hands of kids.

So my view is that as this debate unfolds, and we have a chance to debate the specifics -- and I hope we'll do it in a civilized fashion. I really enjoyed -- I did one of the morning programs last week. And there were people on both sides of the issues there. And we actually had a chance to talk specifics. And some of them made a couple suggestions that I agreed with. And I think that surprised them.

I think we need to get down to the specifics here, and get away from the labeling, and I think it will turn out just fine. The American people will make the right decision on this if we give them a chance to.

Q Sir, Senator Moynihan, who you mentioned, Senator Bob Kerrey, many of the Democrats from the DLC wing of the party like yourself have suggested changes to Social Security not unlike those outlined by Governor Bush. Yet the Vice President says the Governor would "destroy" the program. Would Democrats like those recommend changes that would destroy Social Security?

THE PRESIDENT: Well, I'm not sure they are the same. And you know, I saw a headline in the paper today that said that the governor's campaign had released more details on Social Security and Medicare, and I need the chance to study them before I do.

I do think -- I will say again, to get something done on this in the longer term, you need a bipartisan solution. And it's going to have to come out of the Congress. And I had hoped we could get it done this year.

But let me just caution you. You have to see all this stuff together. I'll say -- you know, one thing people all over America ask me is, what did you do different on the economy that changed America? And I always say, only half-jokingly, we brought arithmetic back to Washington.

So what you need to do on this is, for purposes of analysis, is take the projected revenues over the next decade, when they get -- you know, and they'll be written up some when the so-called mid-session review comes out, because we've had more growth this year than was anticipated -- subtract the size of both candidates' proposed tax cuts, take the Social Security program and see what the so-called transition costs are, and then the other differences in spending in defense and education vouchers, and what's inflation going to be, see what you've got left and whether you can pay for it, and then what do you think the chances are that we won't have this much robust revenue growth over the last ten years, and don't you have to have some sort of guard against that, and then evaluate where it is.

We need to -- I think it's going to be a good thing that we'll have a Social Security debate. But keep in mind, the people who want these

private accounts, they argue two things. One is, we ought to have a higher rate of return on Social Security, because it's going to go broke in 2034. Two is, we ought to give more Americans a chance to share in the wealth of the country with private savings.

Now, what I argued back is that if you take the interest savings that we get from paying down the debt because of the Social Security tax -- just that that comes from the Social Security tax; so arguably that's a savings that you're entitled to as a payer of the Social Security tax -- if you put that into the Trust Fund, you get it up to 2054, for probably no more cost than the transition costs would be -- that is, if you let the people start taking money out of the Trust Fund, obviously, and you guarantee the rights of the retirees that are here, you've got to put something back in from somewhere.

Then what I suggested, that did not find favor with the Congress, was that we have some means of letting the Trust Fund as a whole benefit from the markets, up to about 15 percent of the Trust Fund. That would increase the rate of return. And then remember, the year before last I proposed a very ambitious program -- and I proposed a more modified, income-limited program this year -- that would have the government support private savings and wealth creation outside the Social Security system by individual citizens. I still think that's the safer way to go, and we could easily get the Social Security Trust Fund out beyond the life of the baby boom generation just by doing that.

> Gore  
opposed

So we've got a chance now to have a big debate. I haven't seen the Medicare proposals, but I think that we've got to be particularly careful with that. We've added 24 or 25 years to the life of the Medicare Trust Fund since I've been here, and we need to put some more time on that, and do the drug issue. And there are some -- I've proposed some structural reforms, but we need to be careful with that.

But just -- let me just say, there are four or five different variations that I've seen, of people who have proposed various kinds of private accounts. So I think it's important -- again, you've got to get behind the labels to the facts and see how everybody's proposal works. And that would be my advice on that. I think the way we're -- the safer way is to take it the way we've done, and it would achieve the other two objectives -- that is, you could get a higher rate of return on the Social Security Trust Fund, and you could open savings and wealth-creation opportunities for individual Americans, without actually privatizing the fund itself, and running some of the risks that are inherent in that.

But that's a debate the American people will get a chance to resolve, if they get together and discuss it, and if they flesh out their ideas. I think it's an important debate to have.

Q Mr. President, what was your reaction to the first McCain tobacco regulation bill, that gives the FDA direct authority to regulate tobacco products?

THE PRESIDENT: Well, you know, I think they should have that authority.

Q In your discussions with House Speaker Hastert last week on patients' bill of rights, what assurances were you given that he's willing to support some form of coverage for everyone?

THE PRESIDENT: He said that that was his position. And I must say, so far he's been as good as his word on everything he said.

Now, we do have some differences there. You know, he admitted that we still don't have the liability issues worked out, and we've got some other issues to resolve. But I think he wants legislation to pass, in this area

and in the New Markets area, which is terribly important. Again, that's something that could change the face of America. It could give us a chance to bring free enterprise to poor areas in a way that we've never tried to do before as a nation, and to go beyond, even, what we've done with the empowerment zones, which has been quite successful.

So we were just talking and that's what he said. And I've found that when he says something, he normally means it -- or he always means it, when he's talked to me.

Q Sir, on prescription drugs, isn't this similar to a measure that you told the Secretary of Defense and the Chairman of the Joint Chiefs that you couldn't afford to put into an already bulging FY 2001 defense budget? And how is it that that measure can be afforded now by members of Congress?

THE PRESIDENT: Well, for one thing, when they -- no. What happened is, after I had already presented the budget they asked me about it. And I pointed out that under our program all the military retirees would be covered by a system very similar to this legislation. But I'm certainly not opposed to the military retirees being covered.

I think that the real question is how can the Congress, in good conscience, provide this coverage in the same way -- actually, the mechanism works just like what I want to do to cover all seniors. How can they do this and say they're not going to do it for people in the same situation in the rest of the country, the other senior population, when we can do it and do it with the same sort of mechanism that they provide here?

So I'm fine for them to do this, and if they do it in this way, and then they pass the other, then the cost of the other program will be diminished if -- for the military retirees who stay in this program. In other words, they're not going to be in both programs buying the same drugs twice.

So what I said was, I didn't -- I had already presented the budget and that all military retirees would be covered in my program, along with all other seniors. But now that Congress is doing this, I think that this ought to be evidence that they understand, A, that people over 65 need this coverage and, B, that this is a good kind of mechanism to guarantee that they get the medicine at affordable prices.

Thank you.

Q Mr. President, are you worried about Colombia aid? Mr. President? The aid to Colombia?

THE PRESIDENT: Well, it's funny, I talked to General McCaffrey about it this morning, actually. At this time I'm not worried about it, but I think it's important, given the continuing difficulties and challenges the government in Colombia is facing, that it pass as soon as possible. We need to send a signal to those people down there who are fighting for democracy, fighting for freedom, fighting for the rule of law, fighting against the narco-traffickers, fighting against terrorism, that we're on their side.

And we also need to signal to them that there is an alternative economic way that the people can make a living who've been caught up in the drug trade kind of at the grass-roots farmer level. And this bill does that, so that I think in the end, Congress will pass this bill. But I hope it can be put on some bill I'll get as quick as possible so we can send the right signal in a very timely fashion. I just don't want it dragged out another three or four months. I think it would be a really bad mistake in terms of our national security interests, not just in Colombia, but throughout the Andean region. People are looking at us to see if we're really going to make a serious commitment.

It also will help Colombia to get the other support it needs from the international institutions, from other countries, to make a stand there, and in the process, hopefully, to see victory there for a democratic government and the rule of law, a reduction in drug production and exports, and a stabilization of the democracies that surround Colombia in the Andean region.

Thank you very much.

END

2:35 P.M. EDT

[Back to summary page](#)



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**From:** Rick Foster  
Office of the Actuary

Per conversation, these are not final.

GRAHAM01

Model run 03/22/2000

03/22/2000 13:26

250 DEDUCT, 50 PCT COINS TO 1000 OOP, 25 PCT COINS TO 3000 OOP — (Start date 1/1/2003.) — PBM administration — \$3,000 OOP protection starting in 2003 with 50% coinsurance— Low Income Premium Subsidy Option — 0% new SLMB's — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

CPIU Update index  
 50% Premium Rate (total)  
 1.02 Effect of Income Related Premium

Fiscal Year	Medicare Cash Outlays			Monthly Premium Rate	Medicare Premiums	Net Medicare Impact	Federal Medicaid	Low Income Subsidy	Net Budget Impact
	Total Cost	FFS Cost	M+C Cost						
(\$ millions)									
2001	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2002	\$0	\$0	\$0	\$0.00	\$0	\$0	\$0	\$0	\$0
2003	\$25,848	\$21,501	\$4,347	\$49.35	\$17,340	\$8,508	\$1,026	\$200	\$9,734
2004	\$47,566	\$39,309	\$8,257	\$54.44	\$25,208	\$22,358	\$1,209	\$290	\$23,857
2005	\$53,043	\$43,459	\$9,584	\$60.15	\$28,197	\$24,846	\$1,282	\$325	\$26,452
2006	\$59,304	\$48,219	\$11,086	\$66.21	\$31,492	\$27,812	\$1,353	\$363	\$29,529
2007	\$66,244	\$53,508	\$12,736	\$72.57	\$35,097	\$31,147	\$1,428	\$406	\$32,981
2008	\$73,909	\$59,355	\$14,554	\$79.26	\$39,112	\$34,797	\$1,491	\$453	\$36,741
2009	\$82,490	\$65,856	\$16,633	\$86.58	\$43,580	\$38,909	\$1,554	\$506	\$40,969
2010	\$92,191	\$73,106	\$19,085	\$94.60	\$48,500	\$43,691	\$1,622	\$565	\$45,878
2001-2004	\$73,414	\$60,810	\$12,604		\$42,548	\$30,865	\$2,235	\$491	\$33,591
2005-2009	\$334,991	\$270,398	\$64,593		\$177,479	\$157,512	\$7,108	\$2,053	\$166,672
2001-2009	\$408,404	\$331,207	\$77,197		\$220,027	\$188,377	\$9,342	\$2,543	\$200,263
2001-2005	\$126,457	\$104,269	\$22,188		\$70,745	\$55,711	\$3,516	\$816	\$60,043
2006-2010	\$374,139	\$300,044	\$74,094		\$197,782	\$176,357	\$7,448	\$2,292	\$186,098
2001-2010	\$500,596	\$404,314	\$96,282		\$268,527	\$232,069	\$10,965	\$3,108	\$246,141

250 DEDUCT, 50 PCT COINS TO 1000 OOP, 25 PCT COINS TO 3000 OOP — (Start date 1/1/2003.) — PBM administration  
 — \$3,000 OOP protection starting in 2003 with 50% coinsurance — Low Income Premium Subsidy Option — 0% new SLMB's  
 — 0% new QI's — 5% new QMB's — 100% Induction — MSP — Institutionalized expenses included

### Benefit structure

Year	Breakpoints (set 1)			Breakpoints (set 2)			Breakpoints (set 3)			Breakpoints (set 4)		
	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP	Rx Expense	Coinsurance Rate	OOP
2003	\$250	100.00%	\$250	\$1,750	50.00%	\$1,000	\$9,750	25.00%	\$3,000	\$∞	0.00%	\$3,000
2004	\$256	100.00%	\$256	\$1,794	50.00%	\$1,025	\$9,994	25.00%	\$3,075	\$∞	0.00%	\$3,075
2005	\$263	100.00%	\$263	\$1,839	50.00%	\$1,051	\$10,244	25.00%	\$3,152	\$∞	0.00%	\$3,152
2006	\$269	100.00%	\$269	\$1,885	50.00%	\$1,077	\$10,500	25.00%	\$3,231	\$∞	0.00%	\$3,231
2007	\$276	100.00%	\$276	\$1,932	50.00%	\$1,104	\$10,762	25.00%	\$3,311	\$∞	0.00%	\$3,311
2008	\$283	100.00%	\$283	\$1,980	50.00%	\$1,131	\$11,031	25.00%	\$3,394	\$∞	0.00%	\$3,394
2009	\$290	100.00%	\$290	\$2,029	50.00%	\$1,160	\$11,307	25.00%	\$3,479	\$∞	0.00%	\$3,479
2010	\$297	100.00%	\$297	\$2,080	50.00%	\$1,189	\$11,590	25.00%	\$3,566	\$∞	0.00%	\$3,566

Medicare Prescription Drug Benefit - Catastrophic Options

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 01-05	FY 01-10
<b>President's Budget</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,563		
Stoploss	N/A									
Premium	26	27	35	36	43	44	51	54		
Net Budget (1)	6.8	14.5	16.8	19.0	21.7	24.2	27.2	30.2	38.1	160.3
<b>Reserve Fund Stream</b>										
	0.0	0.0	0.0	4.0	5.0	6.8	8.4	10.8	0.0	35.0
<b>Option 1 - Plan Benefit and \$4,000 Stoploss Starting in 2006, Indexed to CPI</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,563		
Stoploss (2)				4,000	4,100	4,202	4,308	4,415		
Premium	26	27	35	53	61	66	74	80		
Net Budget	6.8	14.5	16.8	22.0	27.3	31.1	35.0	39.4	38.1	192.8
Difference (3)	0.0	0.0	0.0	3.0	5.6	6.9	7.9	9.2	0.0	32.5
<b>Option 2 - Plan Benefit and \$4,000 Stoploss Starting in 2006, Both Indexed to Rx Index (4)</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,710		
Stoploss				4,000	4,348	4,713	5,109	5,538		
Premium	26	27	35	53	59	63	70	75		
Net Budget	6.8	14.5	16.8	22.0	27.0	30.3	33.8	37.6	38.1	188.8
Difference	0.0	0.0	0.0	3.0	5.3	6.2	6.6	7.4	0.0	28.5
<b>Option 3 - Plan Benefit and \$4,000 Stoploss Starting in 2006, Both Indexed to Drug CPI</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,628		
Stoploss				4,000	4,204	4,418	4,644	4,881		
Premium	26	27	35	53	60	64	72	78		
Net Budget	6.8	14.5	16.8	22.0	27.2	30.7	34.4	38.6	38.1	191.0
Difference	0.0	0.0	0.0	3.0	5.5	6.6	7.3	8.3	0.0	30.7
<b>Option 4 - Plan Benefit and \$3,600 Stoploss Starting in 2006, Both Indexed to Drug CPI</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,628		
Stoploss				3,600	3,784	3,977	4,179	4,393		
Premium	26	27	35	55	62	67	74	80		
Net Budget	6.8	14.5	16.8	22.4	28.0	31.7	35.5	39.7	38.1	195.4
Difference	0.0	0.0	0.0	3.4	6.3	7.5	8.3	9.5	0.0	35.0

**Medicare Prescription Drug Benefit - Catastrophic Options**

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 01-05	FY 01-10
<b>Option 5 - Plan Benefit and \$3,500 Stoploss Starting in 2006, Both Indexed to Rx Index</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,710		
Stoploss				3,500	3,805	4,124	4,471	4,846		
Premium	26	27	35	56	62	66	73	78		
Net Budget	6.8	14.5	16.8	22.6	28.1	31.5	35.0	38.9	38.1	194.1
Difference	0.0	0.0	0.0	3.6	6.3	7.4	7.8	8.7	0.0	33.8
<b>Option 6 - Plan Benefit and \$4,000 Stoploss Starting in 2003, Both Indexed to CPI</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,563		
Stoploss	4,000	4,100	4,202	4,308	4,415	4,526	4,639	4,755		
Premium	36	39	48	52	60	64	72	79		
Net Budget	8.2	18.2	21.0	23.9	27.3	30.7	34.6	39.0	47.4	203.1
Difference	1.4	3.7	4.2	5.0	5.6	6.6	7.5	8.8	9.3	42.7
<b>Option 7 - Plan Benefit and \$4,000 Stoploss Starting in 2003, Both Indexed to Rx Index</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,710		
Stoploss	4,000	4,376	4,792	5,228	5,683	6,160	6,677	7,238		
Premium	36	38	46	48	55	58	65	70		
Net Budget	8.2	18.0	20.4	22.9	25.8	28.6	31.9	35.7	46.7	191.6
Difference	1.4	3.5	3.6	3.9	4.1	4.5	4.8	5.5	8.5	31.3
<b>Option 8 - Plan Benefit and \$4,000 Stoploss Starting in 2003, Both Indexed to Drug CPI</b>										
Cap	1,000	1,000	1,500	1,500	2,000	2,000	2,500	2,628		
Stoploss	4,000	4,204	4,418	4,644	4,881	5,129	5,391	5,666		
Premium	36	39	47	50	58	62	69	75		
Net Budget	8.2	18.1	20.8	23.5	26.7	29.8	33.4	37.5	47.1	198.0
Difference	1.4	3.6	4.0	4.5	5.0	5.6	6.3	7.2	9.0	37.7

(1) Net Budget and Difference are dollars in billions

(2) Stoploss is based on out-of-pocket spending. Total spending is higher

(3) "Difference" is the differential between the net budget impact of the option and the net budget impact of the current benefit

(4) Rx Index is the per capita drug growth (price and utilization)



March 15, 2000

## Democrats Devise an Alternative to Clinton's Drug Plan

### Related Article

- [Clinton Denounces G.O.P. on Medicare \(March 14, 2000\)](#)
- [Issue in Depth: Health Care](#)



### Forum

- [Join a Discussion on Health Care Reform](#)

By **ROBERT PEAR**

**W**ASHINGTON, March 14 -- Moderate Democrats on the Senate Finance Committee are drafting their own proposal to offer prescription drug coverage to Medicare beneficiaries, as an alternative to President Clinton's plan, and they say their ideas could be a basis for a bipartisan compromise.

The proposal, like one advanced by Mr. Clinton last June, would offer drug coverage to all Medicare beneficiaries. But it differs from the Clinton plan in important ways.

The senators, led by Bob Graham of Florida, said that the coverage under their proposal would look more like true insurance. They would require people to pay a deductible, perhaps \$250 a year, before getting drug benefits from Medicare.

Mr. Clinton's plan has no deductible. He boasts that his proposal would help pay drug costs from the first dollar of the first prescription.

White House officials welcomed Mr. Graham's effort.

"Conceptually, it's consistent with what the president has proposed," said Chris Jennings, the health policy coordinator at the White House.

Republicans on the Finance Committee said that they had not been briefed on details of Mr. Graham's proposal, but that they had worked well with Democrats on several issues in recent few years, and expected to do so on drug benefits this year.

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Representative Mark Foley, Republican of Florida, said he was "very interested" in Senator Graham's approach and expected to introduce a similar bill in the House.

Under the Democratic senators' proposal, the federal contribution would increase gradually, so the government would pay a growing share as a person's drug costs rose.

Thus, for example, the beneficiary might have to pay all of the first \$250 in drug costs, then half of the next \$750. The beneficiary's share would decline and would be limited; the government would pay all of a beneficiary's drug expenses beyond a certain amount, say \$3,000 a year.

Under Mr. Clinton's plan, the government would pay half the drug costs incurred by any Medicare beneficiary who signed up for coverage. The maximum federal payment would start at \$1,000 a year in 2003 and rise to \$2,500 in 2009. In a late addition to his budget this year, Mr. Clinton sought more money to assist people with very high drug costs, but he has not given any details concerning how he wants to use the money.

The moderate Democratic senators are also considering a proposal charging higher premiums for drug coverage to beneficiaries with incomes above certain levels -- say \$75,000 a year for an individual and \$100,000 for a couple. Under this arrangement, drug benefits would be available to all, as Mr. Clinton wants, but the government would provide larger subsidies to beneficiaries with low or moderate incomes.

By a vote of 70 to 30, the Senate in 1997 endorsed the idea that affluent elderly people should pay higher premiums for basic Medicare coverage. But lobbyists for the elderly opposed the idea, and it never became law.

Mr. Graham said "the Finance Committee, with a large number of knowledgeable and pragmatic moderates," was the best forum in which to forge a compromise on the issue.

He said that in town hall meetings with elderly constituents in Orlando, St. Petersburg and Sarasota, Fla., only a third said they would sign up for Mr. Clinton's plan.

Mr. Graham said the support was low because "they viewed the Clinton plan as prepayment for known obligations, rather than as insurance against an uncertain future risk."

"I think it's more desirable for Medicare to follow the insurance model," the senator said.

Under Mr. Clinton's proposal, Medicare beneficiaries would pay premiums of about \$25 a month, or \$300 a year, for drug coverage.

Thus, Mr. Graham said, "to make it worthwhile," beneficiaries would need to have more than \$600 a year in drug expenses, and fewer than one-third of beneficiaries do.

Mr. Graham's plan also calls for premiums; on average, he said, they would be no higher than the president's.

The Democrats with whom Mr. Graham is working include Senators Kent Conrad of North Dakota, Richard H. Bryan of Nevada and Charles S. Robb of Virginia.

"We see this as a refinement of the president's proposal," Mr. Conrad said. "It's appropriate to have a deductible so the first expenses fall on the beneficiary. For the government to provide first-dollar coverage would be very expensive."

Senator Bryan said: "The public demand is reaching a critical mass. Republicans and Democrats alike want to be able to say at the end of this Congress that we enacted a Medicare drug benefit."

The House Budget Committee is scheduled to meet on Wednesday to approve a blueprint for federal spending. House Republicans said they would set aside \$40 billion over the next five years to help low-income elderly pay for prescription drugs. That sum is similar to the amount Mr. Clinton would spend in the first five years of his plan.

Senator William V. Roth Jr., the Delaware Republican who is chairman of the Finance Committee and is running for re-election, said he also intended to send Medicare drug legislation to the Senate floor.

Mr. Graham recalled the fiasco after Congress expanded Medicare in 1988 to cover catastrophic illnesses and prescription drugs. The extra coverage was partly financed by a surtax on the elderly, many of whom concluded that the extra benefits were not worth the added cost. Congress repealed the law a year later.

Mr. Graham said he worried that Mr. Clinton's plan might meet with "a repetition of that experience, as the elderly put pencil to paper and decide not to participate."

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THE WALL STREET JOURNAL  
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FROM THE ARCHIVES



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March 15, 2000

## Drug Makers Boosted Campaign Contributions

By LAURIE MCGINLEY and PHIL KUNTZ

Staff Reporters of THE WALL STREET JOURNAL

WASHINGTON -- Manufacturers of drugs and other health products sharply stepped up campaign contributions between 1995 to 1999, as prescription-drug prices and other health issues grabbed the political spotlight, a new analysis shows.

The report, to be released at a press conference Wednesday by Rep. Bernard Sanders (I., Vt.) a harsh critic of the drug industry, was based on figures compiled by the Center for Responsive Politics, a nonpartisan group that monitors campaign contributions.

The figures, based on a preliminary review of data from the Federal Election Commission, show that individuals and companies affiliated with the health-products industry contributed more than \$6 million last year, up at least a third from 1995.

The biggest chunk by far came from the drug-manufacturing sector, which is facing a proliferation of proposals in Congress to provide prescription drugs through **Medicare**, the federal health program for the elderly. The industry fears such coverage could ultimately lead to price controls. The sector's donations rose to more than \$4.5 million in 1999, about 50% more than in 1995.

The totals listed in the new study for 1999 are significantly understated because complete computerized data for last year aren't yet available. So the increases over 1995 donations are actually much bigger. For example, the Sanders study includes only \$3 million in corporate "soft-money" donations from the health-products makers,

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while a recent Common Cause study of the campaign-contribution reports themselves disclosed a total of \$4.3 million in such donations. These are unregulated contributions made to the political parties for so-called party-building activities.

Besides soft money, the report also tracks contributions from individuals and political-action committees. Corporations and unions are barred from giving money to candidates directly, but they are allowed to set up PACs funded by their employees or members. Individuals may contribute \$1,000 a candidate per election.

Rep. Sanders accused the pharmaceutical industry of using the stepped-up contributions to head off significant reform in the prescription-drug area. "This is a classic case of the revolving door," he said in a statement. "The industry takes in billions in profits from high prices and gives out millions in campaign contributions to make sure Congress protects those profits."

But Jackie Cottrell, a spokeswoman for Pharmaceutical Research and Manufacturers of America, defended the industry's practices. "The pharmaceutical industry plays by the rules," she said. "To the extent that the rules allow contributions, we participate in the process."

Rep. Sanders has repeatedly criticized the industry for what he says are excessive prices, and has authored a bill that would allow American pharmacists and distributors to buy FDA-approved prescription drugs at lower prices in other countries -- a measure the drug industry staunchly opposes.

Write to Laurie McGinley at [laurie.mcginley@wsj.com](mailto:laurie.mcginley@wsj.com) and Phil Kuntz at [phil.kuntz@wsj.com](mailto:phil.kuntz@wsj.com)



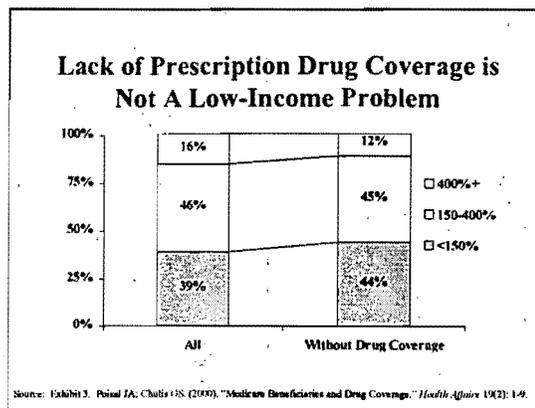
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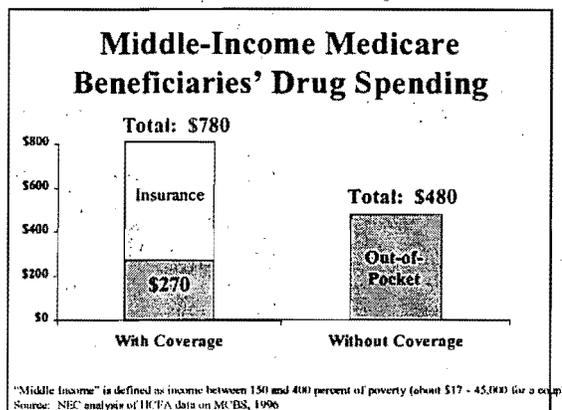
## FACTS ON MIDDLE-INCOME MEDICARE BENEFICIARIES WHO LACK PRESCRIPTION DRUG COVERAGE

March 13, 2000

- **Most Medicare beneficiaries without prescription drugs are middle income.** Over half of all Medicare beneficiaries who lack prescription drug coverage have income greater than 150 percent of poverty (about \$17,000 for a couple) and would not qualify for most low-income drug benefit plans.



- **Middle-income seniors without drug coverage take fewer medications.** For middle income beneficiaries (with income between 150 and 400 percent of poverty), those without prescription drug coverage take 20 percent fewer medications on average (16 versus 20) and have total costs that are about one-third lower (\$480 versus \$780).



- **However, because they lack insurance, these middle-income seniors pay 75 percent more out-of-pocket than insured seniors.** (\$480 versus \$270 per year).

- **Who are Medicare beneficiaries who lack prescription drug coverage but would not qualify for a low-income block grant drug benefit?**
  - **Almost one in four is age 80 or older.** Older seniors tend to have worse health and lower income, making the prescription drug costs a greater burden.
  - **Over half (52 percent) are women.** Older women tend to have more chronic conditions and a greater need for medications.
  - **Over one-third live in rural areas.** This is much higher than the one-quarter of all Medicare beneficiaries who live in rural areas. Many rural seniors do not even have the option of buying prescription drug coverage since few private Medigap insurers – and typically no Medicare managed care plans – operate in their areas.

Source: National Economic Council, data unpublished from the Medicare Current Beneficiary Survey, 1996.

TOM DASCHLE  
SOUTH DAKOTA

United States Senate  
Office of the Democratic Leader  
Washington, DC 20510-7020

March 9, 2000

The President  
The White House  
Washington, DC 20500

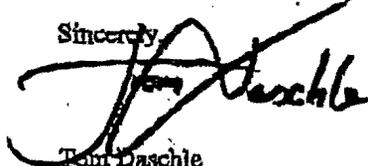
Dear Mr. President:

Prescription drug coverage for Medicare beneficiaries is among the most important issues before the Congress, and Senate Democrats are committed to working with you to pass a meaningful, voluntary prescription drug benefit for all seniors this year.

Democrats in the Senate have developed the following set of principles to guide congressional action. Specifically, we believe that an effective Medicare drug benefit should be: 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; and consistent with broader Medicare reforms. We have elaborated on these principles in the attached document.

There is no reason older Americans should pay the highest prices at the drug store, and unlike virtually all other insured Americans, not have access to affordable drug coverage. The time for action is now. Senate Democrats are eager to work with you toward passage of a Medicare drug benefit that reflects these principles and provides seniors and other Medicare beneficiaries long-overdue access to affordable prescription drugs.

Sincerely,



Tom Daschle  
United States Senate

## **STRENGTHENING MEDICARE: PRINCIPLES FOR AN EFFECTIVE PRESCRIPTION DRUG BENEFIT**

Senate Democrats are committed to passing this year a voluntary prescription drug benefit that is affordable and accessible for all Medicare beneficiaries. We agree on six basic principles to guide congressional action. An effective Medicare benefit should be:

- **Voluntary:** Medicare beneficiaries who now have dependable, affordable prescription drug coverage should have the option of keeping that coverage. Any proposal should provide incentives to preserve the best available private options.
- **Accessible to all beneficiaries:** A hallmark of Medicare is that all beneficiaries, even those in rural or underserved communities, have access to dependable health care. The same should hold true of a prescription drug benefit: all seniors, including those in traditional Medicare, should have access to a reliable, accessible Medicare drug benefit.
- **Designed to provide meaningful protection and bargaining power for seniors:** A Medicare drug benefit should assist seniors with the high cost of prescription drugs and protect them against excessive out-of-pocket costs. It should give beneficiaries the bargaining power in the marketplace they lack today. It also should include a minimum defined benefit that assures access to all medically necessary drugs and uses cutting-edge quality improvement tools.
- **Affordable to all beneficiaries and the program:** Medicare should contribute enough toward the prescription drug premium to make it affordable and attractive for all beneficiaries and to ensure the viability of the benefit. Low-income beneficiaries should receive extra help with prescription drug premiums and cost sharing.
- **Administered using private sector entities and competitive purchasing techniques:** The management of the prescription drug benefit should mirror the practices employed by private insurers in delivering prescription drugs. Discounts should be achieved through competition, not through regulation or price controls. Private organizations should negotiate prices with drug manufacturers and handle the day-to-day administrative responsibilities of the benefit.
- **Consistent with broader Medicare reform:** The addition of a Medicare drug benefit should be consistent with an overall plan to strengthen and modernize Medicare. Medicare will face the same demographic strain as Social Security when the baby boom generation retires. Improving its benefits is only one step in preparing Medicare for this new century's challenges.

EVENT: PRESCRIPTION DRUGS DEPARTURE STATEMENT  
DATE: THURSDAY, MARCH 9, 2000  
TIME: 11:10 AM-11:45 AM  
LOCATION: BEHIND THE OVAL OFFICE  
PARTICIPANTS: THE PRESIDENT  
SEN. DASCHLE

Members should arrive no later than 11:00 AM at the NW gate, park on the NW drive, and enter the WEST lobby.

**Accepting (12)**

Biden, Jr., Joseph R. (D-DE)  
Breau, John B. (D-LA)  
Bryan, Richard H. (D-NV)  
Daschle, Thomas A. (D-SD)  
Dorgan, Byron L. (D-ND)  
Durbin, Richard J. (D-IL)  
Feingold, Russell D. (D-WI)  
Kennedy, Edward M. (D-MA)  
Levin, Carl (D-MI)  
Rockefeller, IV, John D. (D-WV)  
Sarbanes, Paul S. (D-MD)  
Wyden, Ron (D-OR)

**Pending (9)**

Lieberman, Joseph I. (D-CT)  
Mikulski, Barbara A. (D-MD)  
Akaka, Daniel K. (D-HI)  
Byrd, Robert C. (D-WV)  
Feinstein, Dianne (D-CA)  
Graham, Bob (D-FL)  
Johnson, Tim (D-SD)  
Reid, Harry (D-NV)  
Schumer, Charles E. (D-NY)

March 8, 2000

## MEDICARE PRINCIPLES DEPARTURE STATEMENT

**DATE:** March 9, 2000  
**LOCATION:** Behind the Oval Office  
**BRIEFING TIME:** 11:10am – 11:25am  
**EVENT TIME:** 11:30am – 11:45am  
**FROM:** Bruce Reed  
Chuck Brain  
Chris Jennings

### I. PURPOSE

To accept and endorse a set of “Prescription Drug Principles” from the Senate Democratic Caucus, which will be used to evaluate any Medicare prescription drug proposals developed in the Congress.

### II. BACKGROUND

**MILLIONS OF MEDICARE BENEFICIARIES NEED PRESCRIPTION DRUG COVERAGE.** Approximately three out of five Medicare beneficiaries lack decent, dependable prescription drug coverage.

- **Millions of beneficiaries have no prescription drug coverage and millions more are at risk of losing coverage.** Thirteen million Medicare beneficiaries have no prescription drug coverage. Millions more are at risk of losing coverage or have inadequate, expensive benefits. Nearly half of rural beneficiaries, and a disproportionate number of seniors over 85, do not have prescription drug coverage.
- **Current drug coverage is unstable and declining.** Only about one in four beneficiaries has retiree health insurance – and the proportion of firms offering such coverage has dropped 25 percent in the last four years. Even fewer beneficiaries have Medigap insurance for prescription drugs. This coverage is often expensive, and many insurers “age rate” (increase premiums as people get older), making it more expensive when seniors can least afford it.
- **Most seniors are middle-income and would not benefit from a low-income prescription drug benefit.** About 15.6 million, or 49 percent, of all elderly

Americans have incomes between \$15,000 and \$50,000. And over half of beneficiaries without drug coverage have incomes above 150 percent of poverty (\$12,750 for a single earner, \$15,000 for a couple). Thus, a benefit targeted to the low-income will simply not help most seniors.

- **Only about half of all seniors have high enough income to benefit from a tax scheme.** Not only is it impossible to target needy Medicare beneficiaries through a tax deduction, but studies have repeatedly concluded that the tax code is an extremely expensive and inefficient way to expand insurance coverage for anyone, let alone seniors.

**SENATE DEMOCRATS AGREE ON PRINCIPLES FOR A NEW MEDICARE PRESCRIPTION DRUG BENEFIT.** Senator Daschle and the Senate Democratic Caucus released a set of "Prescription Drug Principles" that will guide the current Congressional debate over the provision of a new Medicare prescription drug benefit to millions of seniors. These principles state that any new benefit should be:

- **Voluntary.** Medicare beneficiaries who now have dependable, affordable coverage should have the option of keeping that coverage.
- **Accessible to all beneficiaries.** All seniors and individuals with disabilities, including those in traditional Medicare, should have access to a reliable benefit.
- **Designed to give beneficiaries meaningful protection and bargaining power.** A Medicare drug benefit should help seniors and the disabled with the high cost of prescription drugs and protect against excessive out-of-pocket costs. It should give beneficiaries bargaining power they lack today and include a defined benefit assuring access to medically necessary drugs.
- **Affordable to all beneficiaries and the program.** Medicare should contribute enough towards the prescription drug premium to make it affordable for all beneficiaries. While subsidies should be provided to all to assure the benefit is affordable, low-income beneficiaries should receive extra help with the cost of premiums and cost sharing.
- **Administered using private sector entities and competitive purchasing techniques.** Discounts should be achieved through competition, not regulation or price controls, and should mirror practices employed by private insurers in delivering prescription drugs. Private organizations should negotiate prices with drug manufacturers and handle the day-to-day administrative responsibilities of the benefit.
- **Consistent with broader reform.** The addition of a Medicare drug benefit should be considered as part of an overall plan to strengthen and modernize Medicare. Medicare will face the same demographic strain as Social Security when the baby

boom generation retires. Improving benefits is only one step in preparing Medicare for this new century's challenges.

**YOU URGE CONGRESS TO ACT NOW.** You will urge Congress to act this year to strengthen and improve Medicare. Your FY 2001 budget includes a comprehensive plan that makes Medicare more competitive and efficient and dedicates part of the surplus to improve Medicare solvency and to add a long-overdue prescription drug benefit. This plan:

- **Establishes a new voluntary Medicare drug benefit that is affordable – to all beneficiaries and to the program.** The benefit, at \$160 billion over 10 years, would be:
  - Accessible and voluntary. Optional for all beneficiaries. Provides financial incentives for employers to develop and retain their retiree health coverage.
  - Affordable for beneficiaries and the program. Premiums of \$26 per month in the first year with lower or no premiums for low-income beneficiaries. Provides privately-negotiated discounts, gained by pooling beneficiaries' purchasing power, for all drug expenses. Has no deductible and pays for half of each beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending when fully phased in.
  - Competitively and efficiently administered. Competitively selects private benefit manager to deliver benefit to enrollees in traditional program. No price controls, no new bureaucracy. Integrated into current eligibility and enrollment systems.
  - High-quality and provide necessary medications. Private entities that use formularies must ensure access to medications off formulary if physician deems medically necessary. Requires use of state-of-the-art quality improvement tools.
- **Creates a Medicare reserve fund to add protections for catastrophic drug costs.** To build on your prescription drug benefit, the budget also includes a reserve fund of \$35 billion, available to offer protections for beneficiaries with extremely high drug spending. This reserve will permit the Administration to work in collaboration with Congress to design such an enhanced prescription drug benefit. If no consensus emerges, the reserve would be used for debt reduction.

### III. PARTICIPANTS

Briefing Participants:  
Secretary Donna Shalala

Bruce Reed  
Chuck Brain  
Chris Jennings  
Karen Robb  
Jeff Shesol

Statement Participants:

**YOU**

Secretary Donna Shalala

*Senators Confirmed to Attend:*

Sen. Joseph Biden, Jr. (D-DE)  
Sen. Richard Bryan (D-NV)  
Sen. Thomas Daschle (D-SD)  
Sen. Byron Dorgan (D-ND)  
Sen. Richard Durbin (D-IL)  
Sen. Russell Feingold (D-WI)  
Sen. Edward Kennedy (D-MA)  
Sen. Carl Levin (D-MI)  
Sen. John Rockefeller, IV (D-WV)  
Sen. Paul Sarbanes (D-MD)  
Sen. Ron Wyden (D-OR)

*Senators Pending:*

Sen. Joseph Lieberman (D-CT)  
Sen. Barbara Mikulski (D-MD)  
Sen. Daniel Akaka (D-HI)  
Sen. John Breaux (D-LA)  
Sen. Robert Byrd (D-WV)  
Sen. Dianne Feinstein (D-CA)  
Sen. Bob Graham (D-FL)  
Sen. Tim Johnson (D-SD)  
Sen. Harry Reid (D-NV)  
Sen. Charles Schumer (D-NY)

Program Participants:

**YOU**

Senator Tom Daschle

**IV. PRESS PLAN**

Open Press.

**V. SEQUENCE OF EVENTS**

- **YOU** greet Members of Congress in the Oval Office.

- **YOU** proceed with the Members of Congress to the podium positioned behind the Oval Office.
- Senator Tom Daschle makes remarks and introduces **YOU**.
- **YOU** make remarks and depart.

## **VI. REMARKS**

To be provided by speechwriting.

## Income-Related Medicare Drug Premiums

### Overview

- **Should subsidies be related to income?**

Income-relating drug subsidies would enable the government to focus its scarce resources on drug subsidies for seniors who can least afford to pay full price. Taking this approach might also increase the likelihood that Part B premiums would be tied to income in the future.

But for the revenue gain to be significant, a substantial number of seniors would have to face a reduced net subsidy. The HCFA actuaries have concluded that the Administration's proposed 50 percent subsidy is needed to ensure near-universal take-up, and that lower subsidies could lead to substantial adverse selection. If adverse selection is severe enough, some of the direct revenue gain could be offset by higher program costs per participant. Moreover, the approach would make the tax code more complex.

- **If we income-relate subsidies, how is that best achieved?**

There are two related advantages to using the tax system. First, the tax system already collects information on income, eliminating the need for a new administrative structure. Second, the tax system would naturally make this year's subsidy dependent on this year's income, which is probably preferable to basing this year's subsidy on last year's income as might occur in a non-tax system.<sup>1</sup>

Within the tax system, there are two ways to income-relate subsidies:

- Include subsidies in taxable income, or
- Subject subsidies to a separate recapture tax that increases with income.

### Background

The Administration has proposed a subsidized prescription drug benefit for all Medicare participants. The subsidy would be 50 percent for individuals who pay their own premiums for drug coverage through the new fee-for-service drug plan or a comparable managed care drug plan.<sup>2</sup> The subsidy would be 33 percent for employers who pay for comparable drug coverage

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<sup>1</sup> Under this alternative, individuals who experience a decline in income would receive a subsidy that might be deemed too small. This could be a particular problem for senior citizens.

<sup>2</sup> Because the drug benefit is phased in over 7 years and then indexed to prices, this subsidy would start at roughly \$300 in 2003, grow to about \$600 in 2009, and rise further thereafter.

for their retirees, either by providing it themselves or by paying premiums to Medicare. Individuals below 150 percent of poverty would receive additional subsidies, which would be income-related through a separate mechanism from those discussed below.

For comparison, the Breaux-Frist plan would offer a 25 percent subsidy for individuals and include it in taxable income. The plan provides additional subsidies for individuals below 150 percent of poverty, but it has no subsidies for employers.

## Discussion

This memo describes the mechanics of the two tax approaches and then considers a number of issues that arise in the context of income-related premiums:

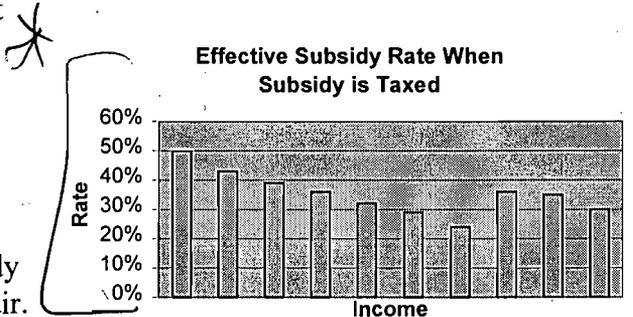
- taxing employer subsidies,
- fairness,
- take-up rates and adverse risk selection,
- government costs and beneficiary premiums, and
- administrability.

*[Handwritten signature]*

## **Including Subsidies in Taxable Income**

- An argument in favor of inclusion is that the subsidy is a form of income to the recipient. Insofar as the progressive income tax reflects society's view of people's ability to pay tax, including subsidies in taxable income may be seen as a natural way to determine an individual's ability to pay for prescription drug coverage.

- However, the resulting net subsidies would not decrease smoothly with income because effective marginal tax rates for seniors do not rise steadily with income. Over the income range in which Social Security benefits are subject to tax, subsidy rates would fall sharply and then rise. Taxing a 50 percent subsidy would produce the schedule of effective subsidy rates shown in the chart, which may seem unfair.



- Moreover, taxable income may not be a good measure of ability to pay for the elderly. A working couple with \$50,000 in earnings but no pensions or saving may have fewer financial resources than a retired couple with \$30,000 in unearned income. Also, the retired couple may receive another \$20,000 in Social Security benefits that would not be taxed and thus would not be counted in taxable income.

- About 60 percent of all seniors face a Federal marginal income tax rate of 0, and they would still enjoy the full 50 percent subsidy.<sup>3</sup> Roughly 20 percent of seniors would face a net subsidy rate below 40 percent, and about 40 percent would face a net subsidy rate below 43 percent. A few seniors would have effective subsidy rates below 25 percent.<sup>4</sup>
- This approach would not affect marginal tax rates for most seniors. Only those seniors whose income before the subsidy falls just below the threshold for a higher tax bracket would find their marginal tax rates increased from 0% to 15%, 15% to 28%, and so on.
- Including the subsidies in income would make some seniors now claimed as dependents on another taxpayer's return ineligible for that status. (About 1.5 million elderly people are claimed as dependents. Their gross income cannot exceed \$2,800.) The additional tax paid by the taxpayer formerly claiming the dependent would frequently exceed the amount of the subsidy. Creating an exception to avoid this problem would further complicate the tax code.

### **Separate Recapture Tax**

- A recapture tax would be phased in at a specified rate for incomes above a specified threshold.
- This approach would allow the most accurate targeting by income (subject to the above-mentioned caveat that income reported on tax returns may not accurately represent ability to pay for some seniors).
- However, creating a separate schedule for the recapture tax would be more complicated than simply including the subsidy in income.
- Relating subsidies through a recapture tax would raise marginal tax rates for beneficiaries in the phase-in income range (although not for those above it or below it). The average increment to marginal tax rates could be small because the drug subsidy is fairly small. For example, if the \$1,200 joint (\$600 single) subsidy phased out over a \$60,000 (\$30,000) income range, the average increase in marginal tax rates would be 2 percent ( $\$1,200/\$60,000$ ). However, a wide phase in range would mean that the revenue collected would be small compared with the number of persons affected.

### **Taxing Employer Subsidies**

- It is not clear how employer drug subsidies should be treated under this scheme.

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<sup>3</sup> In states that followed the Federal government in including these subsidies in taxable income, state tax rates would reduce the effective subsidy a little more.

<sup>4</sup> These numbers are based on counts of all seniors; as we discuss below, these proposals could involve taxing employer subsidies or not, and in the latter case, the more relevant calculations would be based on marginal tax rates for individuals not covered by an employer plan.

- If individual subsidies are taxed and employer subsidies are not, some people without employer coverage might complain that they were being disadvantaged.
- At the same time, if retired employees currently receiving employer-provided drug benefits were required to include the new employer subsidy in taxable income, they would be taxed without receiving any new benefits. Because they are retired, their employers could not pass on their new subsidies in the form of higher wage compensation, and are unlikely to pass them on in the form of higher pension payments.
- The mechanics of taxing employer subsidies at the individual level would add an extra complication as well.
- One way to restore the plan's existing relationship between employer and employee subsidies would be to further reduce the employer subsidy relative to the individual subsidy, but to exclude individuals receiving drug benefits from employers from taxation.

### **Fairness**

- One argument for income-related premiums is that the government should focus its scarce resources for drug subsidies on seniors who can least afford to pay full price.
- A counter-argument is that Part B premiums do not vary with income, and treating Part D premiums differently could appear inconsistent. Some people or groups (such as labor unions) may also be concerned that taxing this health benefit would set a precedent for taxing other health benefits. And some people might even view this new "tax" as somehow analogous to the very unpopular catastrophic health insurance law of 1988.

### **Take-Up Rates and Adverse Risk Selection**

- Individuals would have a one-time election to join the prescription drug program during the first year of the program, during the first year of Medicare eligibility, or when employer-provided benefits cease due to retirement, death of a spouse, or employer dropping of coverage for all retirees. The one-time election would reduce adverse selection compared with a program that allowed choice every year. Individuals who are currently healthy may opt for the program to ensure that they can participate in later years when their health may decline.
- Because the actuaries have argued that a 50 percent subsidy is needed to ensure near-universal take-up, they may conclude that reducing effective subsidies in our plan would induce adverse selection. (Because the Breaux-Frist subsidy is only half as large as the Administration's, that plan would have a serious adverse selection problem even in the absence of their proposal to tax subsidies.)
- Healthy high-income seniors would be less likely to purchase drug coverage if subsidies are income-related, but how *much* less likely is unclear. (Under proposals such as Breaux-Frist that do not specify the drug benefit, the availability of certain options – such

as catastrophic-only – could also influence people’s decisions.) More generally, it is unclear whether ensuring the enrollment of high-income seniors might require a larger or smaller effective subsidy than is required for lower-income seniors:

- Because these beneficiaries have higher income, they may feel less need than lower-income beneficiaries to buy insurance against moderate drug expenses.
- On the other hand, high-income beneficiaries have higher Medicare spending than low-income beneficiaries, and they are likely to live longer. They may be able to take a longer view than low-income beneficiaries and pay premiums beginning at age 65 rather than face unpredictable future expenses. They may also want to ensure that they can afford the new wave of expensive drugs developed over time. All of these factors imply that high-income beneficiaries may expect to receive greater benefits from drug coverage than low-income beneficiaries, which would encourage their purchase of insurance.

### **Government Costs and Beneficiary Premiums**

- Reducing the effective drug subsidy for higher-income beneficiaries would have several effects on government spending:
  - The government would save money on everyone in that group who would still buy coverage (the difference between the official 50 percent subsidy and the effective subsidy). The average subsidy rate would fall to about 44 percent if subsidies were included in taxable income, suggesting that the government would save \$15 to \$20 billion over ten years before accounting for the following effects.<sup>5</sup>
  - The government would save the subsidy dollars that would be paid on behalf of those who drop coverage.
  - But the loss of healthier-than-average beneficiaries because of adverse selection would raise average spending by those in the risk pool, and the government would lose money by paying higher subsidies to those people.
- Only the third of these effects would matter for beneficiary premiums, which would therefore be higher. However, part or all of the savings could be used to increase the pre-tax subsidy rate in an attempt to hold beneficiaries at lower tax rates harmless.
- If drug subsidies were taxed separately, then the share of seniors who faced a notably lower effective subsidy could be designed to be fairly small. This suggests that all of the effects described in the previous bullets could be small – the direct government savings, the change in average spending by the insured population, and the change in premiums, but the added complexity to the tax system would remain.

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<sup>5</sup> This saving includes increases in Social Security revenue owing to an increase in the number of individuals exceeding the thresholds for taxation of Social Security benefits.

## **Administrability**

- Proponents of taxing drug subsidies argue that the relevant information could be reported on 1099 forms that are already sent to all Social Security recipients. And since drug premiums would generally be deducted from Social Security benefit checks, the additional work involved in reporting the subsidy on the 1099 might be small. However, the precise mechanics would need to be developed by SSA and the IRS.
- Beneficiaries would need to include subsidy information in computing their tax liabilities. Some current non-filers would have to file tax returns because the subsidies would increase their taxable income above the filing threshold.
- Both proposals would complicate the tax system. In addition, creating a separate recapture tax could set an unfortunate precedent for other complicated new taxes.



United States General Accounting Office  
Washington, DC 20548

Health, Education, and  
Human Services Division

B-284796

March 1, 2000

The Honorable John D. Dingell  
Ranking Minority Member  
Committee on Commerce  
House of Representatives

Subject: Medigap: Premiums for Standardized Plans that Cover Prescription Drugs

Dear Mr. Dingell:

This letter is in response to your request for information on premiums for Medicare supplemental insurance (Medigap) policies that provide outpatient prescription drug coverage. Many Medicare beneficiaries purchase Medigap plans because they supplement Medicare by covering, for example, hospital deductibles and physician coinsurance amounts. Three of the 10 standard plans cover outpatient prescription drugs.<sup>1</sup> In 1996, 9 percent of Medicare beneficiaries obtained some prescription drug coverage through individually purchased Medigap plans.

We obtained Medigap premiums for four standard plans from insurance commissions in 38 states.<sup>2</sup> (See enclosure I for a description of the benefits under each plan.) The tables in enclosure II show average premiums by state and various ages for standard plans F, H, I, and J, which are generally comparable except for their prescription drug coverage. Plans H and I provide drug coverage with a \$250 deductible, 60 percent coinsurance, and an annual limit of \$1,250. Plan J has the same drug benefit deductible and coinsurance and an annual limit of \$3,000. Premiums for plan F, the most frequently purchased plan, are presented as a comparison because it does not cover prescription drugs.

The average premiums presented in enclosure II reflect insurance company reporting practices as well as different state regulations. The insurance companies report their premiums to state insurance commissions. Some companies list different premiums that are specific to a certain type of policy. For example, a company may have different premiums for policies that use different age-rating methodologies. Premiums may also differ by characteristics of the policyholder, such gender or smoking status. Other companies may

<sup>1</sup> All policies sold after July 1992 are required to conform to one of 10 standard benefit packages.

<sup>2</sup> We requested premium information from all states. Three states, Massachusetts, Minnesota, and Wisconsin, are exempt from the standard plans because they standardized their Medigap policies prior to the establishment of plans A through J. Arizona, California, Hawaii, Idaho, Indiana, Kentucky, Maryland, and Tennessee did not publish premium information. We were unable to obtain information from New Jersey.

port a single sample premium for each age. States may also have regulations that affect the premiums listed. For example, some states do not allow premiums to vary based on age.

The average premiums should not be interpreted as the average prices that Medicare beneficiaries are paying for Medigap policies in a given state. Although companies may offer policies at the published premiums, the number of Medicare beneficiaries who are actually paying the premiums listed was not available from the states, so we were not able to calculate the average premiums weighted by the number of policyholders.

We did not independently verify the Medigap premium data provided by the state insurance commissions. With this exception, we performed our work in accordance with generally accepted government auditing standards.

Please call me at (202) 512-7114 if you or your staff have any questions about the information in this letter.

Sincerely yours,



Laura A. Dummit  
Associate Director, Health Financing  
and Public Health Issues

Enclosures-2

**Table I.1: Standard Medigap Benefits for Plans F, H, I, AND J**

<b>Core benefits</b>	<b>Plan F</b>	<b>Plan H</b>	<b>Plan I</b>	<b>Plan J</b>
Part A hospitalization (days 61-90)	X	X	X	X
Lifetime reserve (days 91-150)	X	X	X	X
365 Lifetime hospital days—100%	X	X	X	X
Parts A and B blood	X	X	X	X
Part B coinsurance—20%	X	X	X	X
<b>Additional benefits</b>				
Skilled nursing facility coinsurance (days 21-100)	X	X	X	X
Part A deductible	X	X	X	X
Part B deductible	X			X
Part B excess charges	100%		100%	100%
Foreign travel emergency	X	X	X	X
At-home recovery			X	X
Prescription drugs		X	X	X
Preventive medical care				X

**Table II.1: 1999 Annual Premiums for Standard Medigap Plans F, H, I, and J for Age 65 in Selected States (In Dollars Rounded to the Nearest Dollar)**

State	F	H	I	J
AK	1,173	1,529	1,572	2,163
AL <sup>a</sup>	1,220	1,487	1,622	2,433
AR	1,412	1,901	2,318	2,771
CO <sup>b</sup>	1,170	1,622	1,863	2,165
CT	1,426	2,487	2,763	2,924
DE	1,167	1,434	1,767	2,380
FL <sup>c</sup>	1,586	2,002	2,391	2,849
GA <sup>d</sup>	1,365	2,577	2,987	2,893
IA	1,034	1,364	1,481	2,269
IL	1,166	1,572	1,746	2,384
KS	1,126	1,510	1,712	2,501
LA <sup>e</sup>	1,429		2,135	3,694
ME <sup>f</sup>	1,359	2,368	2,659	2,237
MI	1,300	1,997	2,147	2,469
MO <sup>g</sup>	1,144	1,626	1,797	2,007
MS <sup>h</sup>	1,225	1,681	1,767	2,753
MT <sup>i</sup>	1,082	1,334	1,513	2,221
NC	1,096	1,496	1,670	2,313
ND <sup>j</sup>		1,459	1,647	2,185
NE <sup>km</sup>	1,068	1,336	1,512	2,448
NH	1,170	1,255	1,504	1,901
NM	1,199	1,691	2,102	2,274
NV <sup>l</sup>	1,331	1,715	1,938	2,279

<sup>a</sup> Alabama reports the lowest monthly premium offered by the company.

<sup>b</sup> Colorado rates may vary by location, age, sex, and smoking status.

<sup>c</sup> Florida rates are as of November 1998. Premiums are based on a policy for a 65-year-old man at the time of issue, living in Tampa.

<sup>d</sup> Georgia premiums are for males living in the metropolitan Atlanta area and are based on the policyholder's age at the time of purchase.

<sup>e</sup> Only companies responding to a Louisiana Department of Insurance survey are included.

<sup>f</sup> No plan H premiums are listed for Louisiana.

<sup>g</sup> Maine premiums cannot vary based on age or sex, but can vary by smoking status.

<sup>h</sup> Missouri materials show statewide average annual rates for women. As of 2000, insurers can no longer sell policies with premiums that change with the policyholder's age.

<sup>i</sup> Mississippi reports premiums for 10 companies writing Medigap policies with the largest market share as of 12/31/1997.

<sup>j</sup> Montana published premiums are based on responses to a state survey. Some companies provided ranges of premiums; in those cases, the end points of the ranges were used to calculate the averages.

<sup>k</sup> North Dakota published premiums for 65-year-old male non-smokers.

<sup>l</sup> North Dakota did not provide plan F premiums.

<sup>m</sup> Some companies provided ranges of premiums; in those cases the end points were used to calculate the averages.

<sup>n</sup> Premiums listed are for individuals living in Las Vegas.

State	F	H	I	J
NY <sup>a</sup>	1,667	1,905	2,312	3,216
OH	1,165	1,573	1,755	2,566
OK <sup>b</sup>	1,121	1,350	1,551	2,352
OR <sup>c</sup>	1,100	1,428	1,576	2,293
PA	1,303	1,706	1,685	2,110
RI	1,168	1,288	1,555	1,712
SC	1,129	1,701	1,868	2,437
SD <sup>d</sup>	1,049	1,355	1,604	2,219
TX <sup>e</sup>	1,169	1,489	1,803	2,246
UT <sup>f</sup>	1,022	1,358	1,339	1,781
VA <sup>g</sup>	1,006	1,174	1,289	1,940
VT		1,857		2,694
WA <sup>h</sup>	1,337	1,911	2,293	2,398
WV <sup>i</sup>	1,252	1,392	1,941	2,237
WY	1,187	1,481	1,787	2,020

<sup>a</sup> Premiums are the same for all policyholders based on the area of residence.

<sup>b</sup> Premiums are as of March 1998; premiums are based on responses to a state survey.

<sup>c</sup> Some rates may be from 1998 or earlier.

<sup>d</sup> Only companies responding to a South Dakota Department of Social Services survey are included.

<sup>e</sup> Premiums are as of December 1998. Some companies provide ranges of premiums; in those cases the end points were used to calculate the averages.

<sup>f</sup> Premiums are from 1998.

<sup>g</sup> Virginia notes that not all insurers are listed in their materials.

<sup>h</sup> No plan F listed.

<sup>i</sup> No plan I listed.

<sup>j</sup> Washington does not allow premiums to vary based on characteristics of the policyholder.

**Table II.2: 1999 Annual Premiums for Standard Medigap Plans F, H, I, and J for age 70 in Selected States (In Dollars Rounded to the Nearest Dollar)**

State	F	H	I	J
AK	1,369	1,867	1,863	2,691
AL <sup>a</sup>	1,429	1,794	1,976	2,889
AR	1,412	1,901	2,318	2,771
CO <sup>b</sup>	1,969	1,853	2,101	2,448
CT	"	"	"	"
DE	1,882	1,848	2,023	2,759
FL	"	"	"	"
GA <sup>c</sup>	1,631	2,809	3,260	3,102
IA	1,223	1,612	1,758	2,640
IL	1,969	1,775	2,057	2,739
KS	1,307	1,716	1,998	2,802
LA <sup>d</sup>	1,650	"	2,547	3,975
ME <sup>e</sup>	1,359	2,368	2,659	2,237
MI	"	"	"	"
MO <sup>f</sup>	1,325	1,896	2,109	2,900
MS <sup>g</sup>	1,425	1,977	2,093	3,155
MT <sup>h</sup>	1,280	1,645	1,865	2,740
NC	1,276	1,532	1,836	2,418
ND	"	"	"	"
NE <sup>i</sup>	1,251	1,535	1,783	2,769
NH	1,357	1,544	1,805	2,281
NM	1,399	2,024	2,507	2,652
NV <sup>j</sup>	1,562	2,150	2,392	2,787

<sup>a</sup> Alabama lists the lowest monthly premium offered by the company.

<sup>b</sup> Colorado rates may vary by location, age, sex, and smoking status.

<sup>c</sup> Connecticut materials do not provide rates for a 70-year-old.

<sup>d</sup> Florida materials do not provide rates for a 70-year-old.

<sup>e</sup> Georgia premiums are for males living in the metropolitan Atlanta area and are based on the policyholder's age at the time of purchase.

<sup>f</sup> Only companies responding to a Louisiana Department of Insurance survey are included.

<sup>g</sup> No Plan H premiums are listed for Louisiana.

<sup>h</sup> Maine premiums cannot vary based on age or sex, but can vary by smoking status.

<sup>i</sup> Michigan materials do not provide rates for a 70-year-old.

<sup>j</sup> Missouri materials show statewide average annual rates for women. As of 2000, insurers can no longer sell policies with premiums that change with the policyholder's age.

<sup>k</sup> Mississippi reports premiums for 10 companies writing Medigap policies with the largest market share as of 12/31/1997.

<sup>l</sup> Montana published premiums are based on responses to a state survey. Some companies provided ranges of premiums; in those cases, the end points of the ranges were used to calculate the averages.

<sup>m</sup> North Dakota materials do not provide rates for a 70-year-old for any plans.

<sup>n</sup> Some companies provided ranges of premiums; in those cases the end points were used to calculate the averages.

<sup>o</sup> Premiums listed are for individuals living in Las Vegas.

## ENCLOSURE II

## ENCLOSURE II

State	F	H	I	J
NY*	1,667	1,905	2,312	3,216
OH	1,354	1,808	2,068	2,993
OK*	1,291	1,618	1,863	2,718
OR*	1,296	1,716	1,902	2,717
PA	1,514	1,916	1,685	2,410
RI	1,358	1,504	1,824	2,020
SC	1,322	2,112	2,278	3,018
SD*	1,230	1,614	1,921	2,638
TX	1,850	1,680	2,103	2,553
UT*	1,112 <sup>a</sup>	1,438 <sup>a</sup>	1,443 <sup>a</sup>	1,807 <sup>a</sup>
VA*	1,152	1,374	1,491	2,190
VT	"	1,914	"	2,694
WA*	1,337	1,911	2,293	2,398
WV	" <sup>b</sup>	" <sup>b</sup>	" <sup>b</sup>	" <sup>b</sup>
WY	" <sup>b</sup>	" <sup>b</sup>	" <sup>b</sup>	" <sup>b</sup>

- \* Premiums are the same for all policyholders based on the area of residence.
- \* Premiums are as of March 1998; premiums are based on responses to a state survey.
- \* Some rates may be from 1998 or earlier.
- \* Only companies responding to a South Dakota Department of Social Services Survey are included.
- \* Premiums are as of December 1998. Some companies provide ranges of premiums; in those cases the end points were used to calculate the averages.
- \* Premiums are from 1998.
- \* Premiums are actually listed in state materials as premiums for a 69-year-old.
- \* Virginia notes that not all insurers are listed in their materials.
- \* No plan F listed.
- \* No plan I listed.
- \* Washington does not allow premiums to vary based on characteristics of the policyholder.
- \* West Virginia materials do not provide rates for a 70-year-old.
- \* Wyoming materials do not provide rates for a 70-year-old.

**Table II.3: 1999 Annual Premiums for Standard Medigap Plans F, H, I, and J for age 75 in Selected States (In Dollars Rounded to the Nearest Dollar)**

State	F	H	I	J
AK	1,594	2,366	2,271	3,504
AL				
AR	1,412	1,901	2,918	2,771
CO <sup>b</sup>	1,582	2,049	2,334	2,732
CT				
DE	1,627	2,634	2,480	3,451
FL				
GA <sup>c</sup>	1,698	3,028	3,535	3,181
IA	1,416	1,961	2,119	3,133
IL	1,582	2,112	2,418	3,270
KS	1,555	2,095	2,398	3,676
LA <sup>d</sup>	1,872		3,015	3,975
ME <sup>e</sup>	1,959	2,968	2,659	2,237
MI				
MO <sup>f</sup>	1,520	2,207	2,451	2,735
MS <sup>g</sup>	1,657	2,379	2,546	3,757
MT <sup>h</sup>	1,434	1,792	2,079	3,007
NC	1,444	1,600	2,030	2,490
ND				
NE				
NH	1,549	1,886	2,144	2,677
NM	1,588	2,379	2,916	3,058
NV				

<sup>a</sup> Alabama materials do not provide rates for a 75-year-old.

<sup>b</sup> Colorado rates may vary by location, age, sex, and smoking status.

<sup>c</sup> Connecticut materials do not provide rates for a 75-year-old.

<sup>d</sup> Florida materials do not provide rates for a 75-year-old.

<sup>e</sup> Georgia premiums are for males living in the metropolitan Atlanta area and are based on the policyholder's age at the time of purchase.

<sup>f</sup> Only companies responding to an Louisiana Department of Insurance survey are included.

<sup>g</sup> No plan H premiums are listed for Louisiana.

<sup>h</sup> Maine premiums cannot vary based on age or sex, but can vary by smoking status.

<sup>i</sup> Michigan materials only provide rates for a 65-year-old.

<sup>j</sup> Missouri materials show statewide average annual rates for women. As of 2000, insurers can no longer sell policies with premiums that change with the policyholder's age.

<sup>k</sup> Mississippi reports premiums for 10 companies writing Medigap policies with the largest market share as of 12/31/1997.

<sup>l</sup> Montana published premiums are based on responses to a state survey. Some companies provided ranges of premiums; in those cases, the end points of the ranges were used to calculate the averages.

<sup>m</sup> North Dakota materials do not provide rates for a 75-year-old.

<sup>n</sup> Nebraska materials do not provide rates for a 75-year-old.

<sup>o</sup> Nevada materials do not provide rates for a 75-year-old.

State	F	H	I	J
NY <sup>a</sup>	1,667	1,905	2,312	3,216
OH	1,567	2,151	2,489	3,589
OK <sup>b</sup>	1,471	1,891	2,191	3,100
OR <sup>c</sup>	1,486	2,141	2,288	3,332
PA	1,665	2,093	1,685	2,672
RI	1,526	1,684	2,064	2,272
SC	1,514	2,463	2,501	3,470
SD <sup>d</sup>	1,414	1,970	2,335	3,012
TX <sup>e</sup>	1,537	1,915	2,415	2,824
UT	"	"	"	"
VA <sup>f</sup>	1,804	1,520	1,664	2,384
VT	"	2,070	"	2,694
WA <sup>g</sup>	1,337	1,911	2,293	2,998
WV	"	"	"	"
WY	1,590	2,041	2,540	2,788

<sup>a</sup> Premiums are the same for all policyholders based on the area of residence.

<sup>b</sup> Premiums are as of March 1998; premiums are based on responses to a state survey.

<sup>c</sup> Some rates may be from 1998 or earlier.

<sup>d</sup> Only companies responding to a South Dakota Department of Social Services Survey are included.

<sup>e</sup> Premiums are as of December 1998. Some companies provide ranges of premiums; in those cases the end points were used to calculate the averages.

<sup>f</sup> Utah materials do not provide rates for a 75-year-old.

<sup>g</sup> Virginia notes that not all insurers are listed in their materials.

<sup>h</sup> No plan F listed.

<sup>i</sup> No plan I listed.

<sup>j</sup> Washington does not allow premiums to vary based on characteristics of the policyholder.

<sup>k</sup> West Virginia materials do not provide rates for a 75-year-old.

**Table II.4: 1999 Annual Premiums for Standard Medigap Plans F, H, I, and J for Age 80 in Selected States (In Dollars Rounded to the Nearest Dollar)**

State	F	H	I	J
AK	1,756	2,594	2,433	3,717
AL <sup>a</sup>	1,805	2,298	2,531	3,727
AR	1,412	1,901	2,318	2,771
CO <sup>b</sup>	1,697	2,234	2,535	2,944
CT				
DE	1,804	2,778	2,756	3,669
FL				
GA <sup>c</sup>	1,874	3,325	3,844	3,421
LA	1,587	2,072	2,323	3,429
IL	1,767	2,170	2,640	3,514
KS	1,768	2,161	2,629	4,180
LA <sup>d</sup>	2,097		3,457	4,281
ME <sup>e</sup>	1,359	2,368	2,659	2,237
MI				
MO <sup>f</sup>	1,692	2,444	2,744	3,127
MS <sup>g</sup>	1,827	2,379	2,687	3,619
MT <sup>h</sup>	1,597	1,865	2,203	3,171
NC	1,612	1,640	2,261	2,592
ND				
NE <sup>i</sup>	1,599	1,899	2,289	3,379
NH	1,710	1,976	2,429	2,842
NM	1,763	2,740	3,315	3,348
NV				

<sup>a</sup> Alabama lists the lowest monthly premium offered by the company.

<sup>b</sup> Colorado rates may vary by location, age, sex, and smoking status.

<sup>c</sup> Connecticut materials do not provide rates for a 80-year-old.

<sup>d</sup> Florida materials do not provide rates for a 80-year-old.

<sup>e</sup> Georgia premiums are for males living in the metropolitan Atlanta area and are based on the policyholder's age at the time of purchase.

<sup>f</sup> Only companies responding to an Louisiana Department of Insurance survey are included.

<sup>g</sup> No plan H premiums are listed for Louisiana.

<sup>h</sup> Maine premiums cannot vary based on age or sex, but can vary by smoking status.

<sup>i</sup> Michigan materials do not provide results for a 80-year-old.

<sup>j</sup> Missouri materials show statewide average annual rates for women. As of 2000, insurers can no longer sell policies with premiums that change with the policyholder's age.

<sup>k</sup> Mississippi reports premiums for 10 companies writing Medigap policies with the largest market share as of 12/31/1997.

<sup>l</sup> Montana published premiums are based on responses to a state survey. Some companies provide ranges of premiums; in those cases, the end points of the ranges are used to calculate the averages.

<sup>m</sup> North Dakota materials do not provide rates for a 80-year-old.

<sup>n</sup> Some companies provide ranges of premiums; in those cases the end points were used to calculate the averages.

<sup>o</sup> Nevada materials do not provide rates for a 80-year-old.

State	F	H	I	J
NY <sup>a</sup>	1,667	1,905	2,312	3,216
OH	1,743	2,817	2,759	3,807
OK <sup>c</sup>	1,643	2,036	2,394	3,352
OR <sup>b</sup>	1,623	2,280	2,453	3,543
PA	1,758	2,298	1,685	2,799
RI	1,707	1,780	2,276	2,404
SC	1,683	2,716	2,904	3,838
SD <sup>d</sup>	1,583	2,076	2,556	3,332
TX	"	"	"	"
UT	"	"	"	"
VA <sup>e</sup>	1,414	1,633	1,761	2,547
VT	"	"	"	"
WA <sup>f</sup>	1,337	1,911	2,293	2,398
WV	"	"	"	"
WY	"	"	"	"

<sup>a</sup> Premiums are the same for all policyholders based on the area of residence.

<sup>b</sup> Premiums are as of March 1993; premiums are based on responses to a state survey.

<sup>c</sup> Some rates may be from 1988 or earlier.

<sup>d</sup> Only companies responding to a South Dakota Department of Social Services Survey are included.

<sup>e</sup> Texas materials do not provide rates for a 80-year-old.

<sup>f</sup> Utah materials do not provide rates for a 80-year-old.

<sup>g</sup> Virginia notes that not all insurers are listed in their materials.

<sup>h</sup> Vermont materials do not provide rates for a 80-year-old.

<sup>i</sup> Washington does not allow premiums to vary based on characteristics of the policyholder.

<sup>j</sup> West Virginia materials do not provide rates for a 80-year-old.

<sup>k</sup> Wyoming materials do not provide rates for a 80-year-old.

(201041)

Amendment Proposed by Senators Snowe, Wyden, and Gordon Smith

Strike Section 202 and insert the following:

**Sec. 202 RESERVE FUND FOR PRESCRIPTION DRUGS**

(a) ALLOCATION. - In the Senate, spending aggregates and other appropriate budgetary levels and limits may be adjusted and allocations may be revised for legislation reported by the Committee on Finance to provide a prescription drug benefit for fiscal years 2001, 2002, and 2003, provided that this legislation will not reduce the on-budget surplus by more than \$20 billion total during these three fiscal years, and provided that the enactment of this legislation will not cause an on-budget deficit in any of these three fiscal years.

(b) EXCEPTION. - The adjustments provided in section (a) shall be made for a bill or joint resolution, or an amendment that is offered (in the Senate), that provides coverage for prescription drugs, if the Senate Committee on Finance has not reported such legislation on or before ~~July 15, 2000.~~  
September 1

(c) ADJUSTMENT. - If legislation is reported by the Senate Committee on Finance that extends the solvency of the Medicare Hospital Insurance Trust Fund without the use of transfers of new subsidies from the general fund, without decreasing beneficiaries' access to health care, and excluding the cost of extending and modifying the prescription drug benefit created pursuant to section (a) or (b), then the Chairman of the Committee on the Budget may change committee allocations and spending aggregates by no more than \$20 billion total for fiscal years 2004 and 2005 to fund the prescription drug benefit if such legislation will not cause an on-budget deficit in either of these two fiscal years.

(d) BUDGETARY ENFORCEMENT. - ~~The revision of allocations and aggregates made under this section shall be considered for the purposes of the Congressional Budget Act of 1974 as allocations and aggregates contained in this resolution.~~

# **PRESCRIPTION DRUGS AND MEDICARE:**

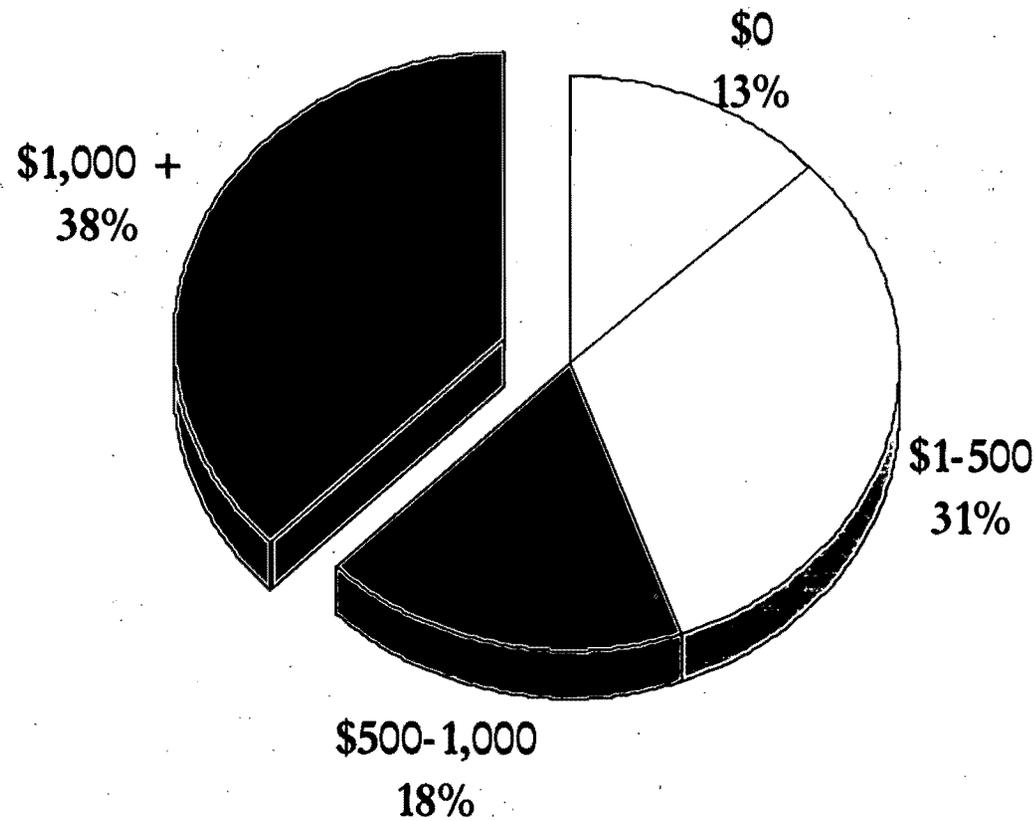
- I. Background**
- II. Principles**
- III. President's Proposal**

*February 2, 2000*

# I. BACKGROUND

## Medicare Beneficiaries Need Prescription Drugs

Beneficiaries By Total Drug Spending, 2000



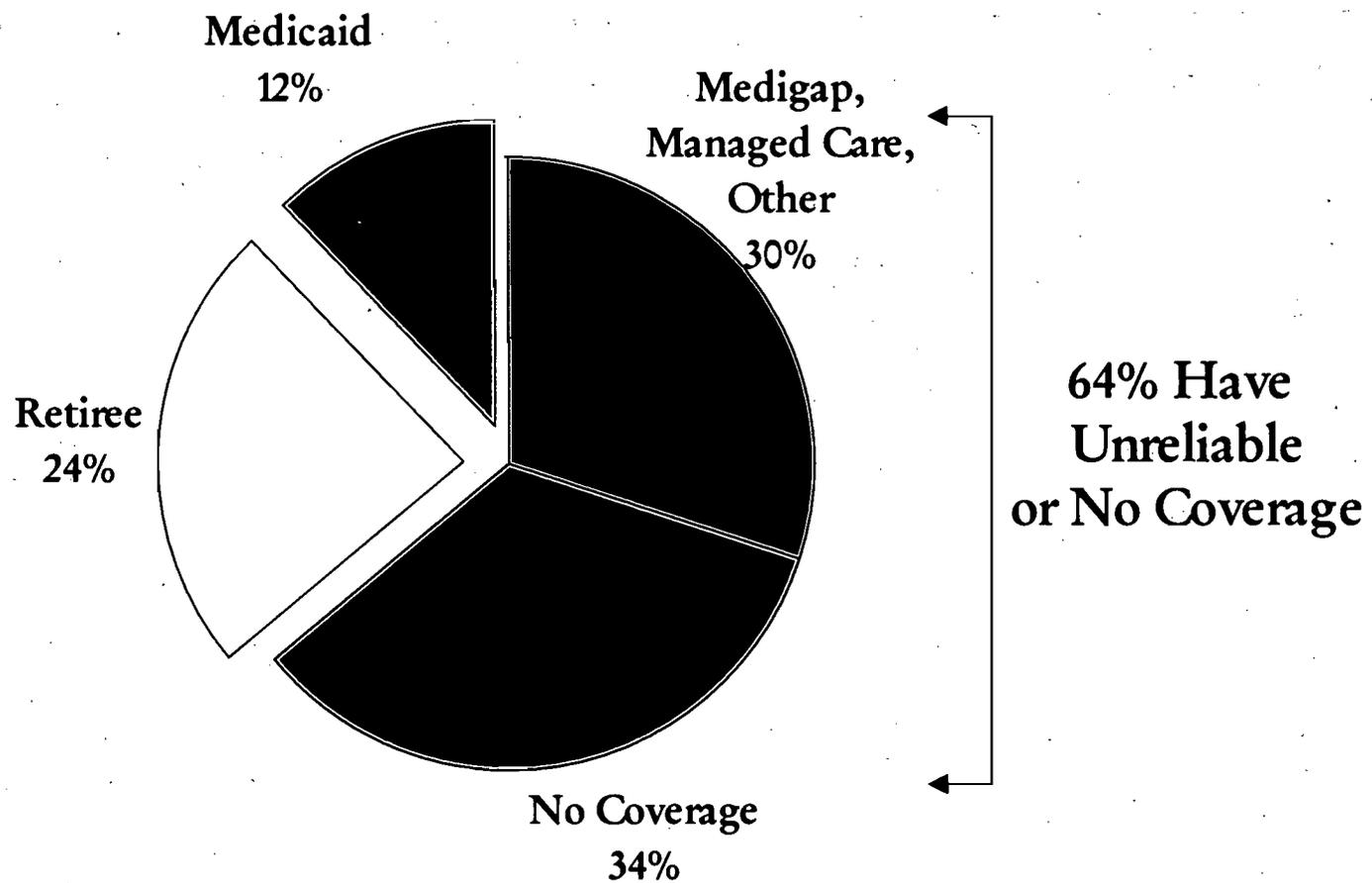
SOURCE: Actuarial Research Corporation for HHS, projected for 2000

# Prescription Drug Coverage Improves Overall Health Care & Outcomes

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

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

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

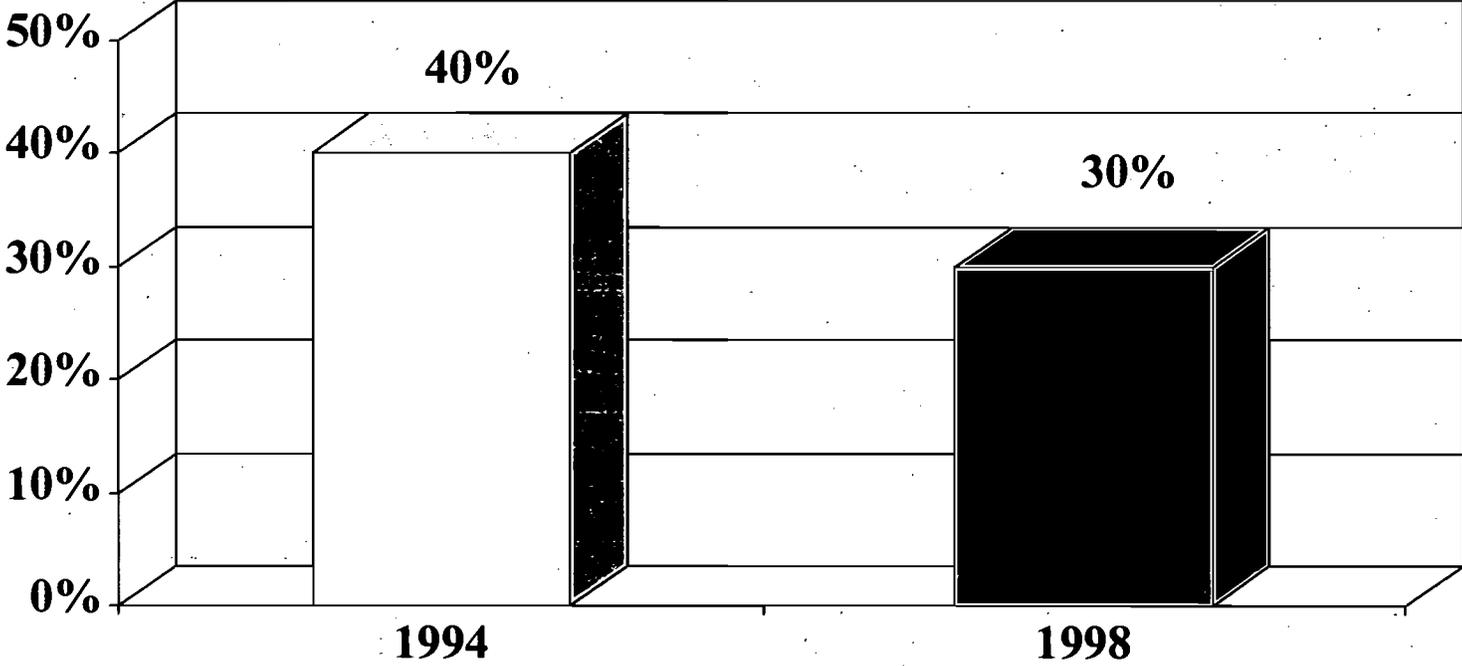


SOURCE: Actuarial Research Corporation for HHS, point-in-time, projected for 2000

# Retiree Health Coverage Is Declining

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

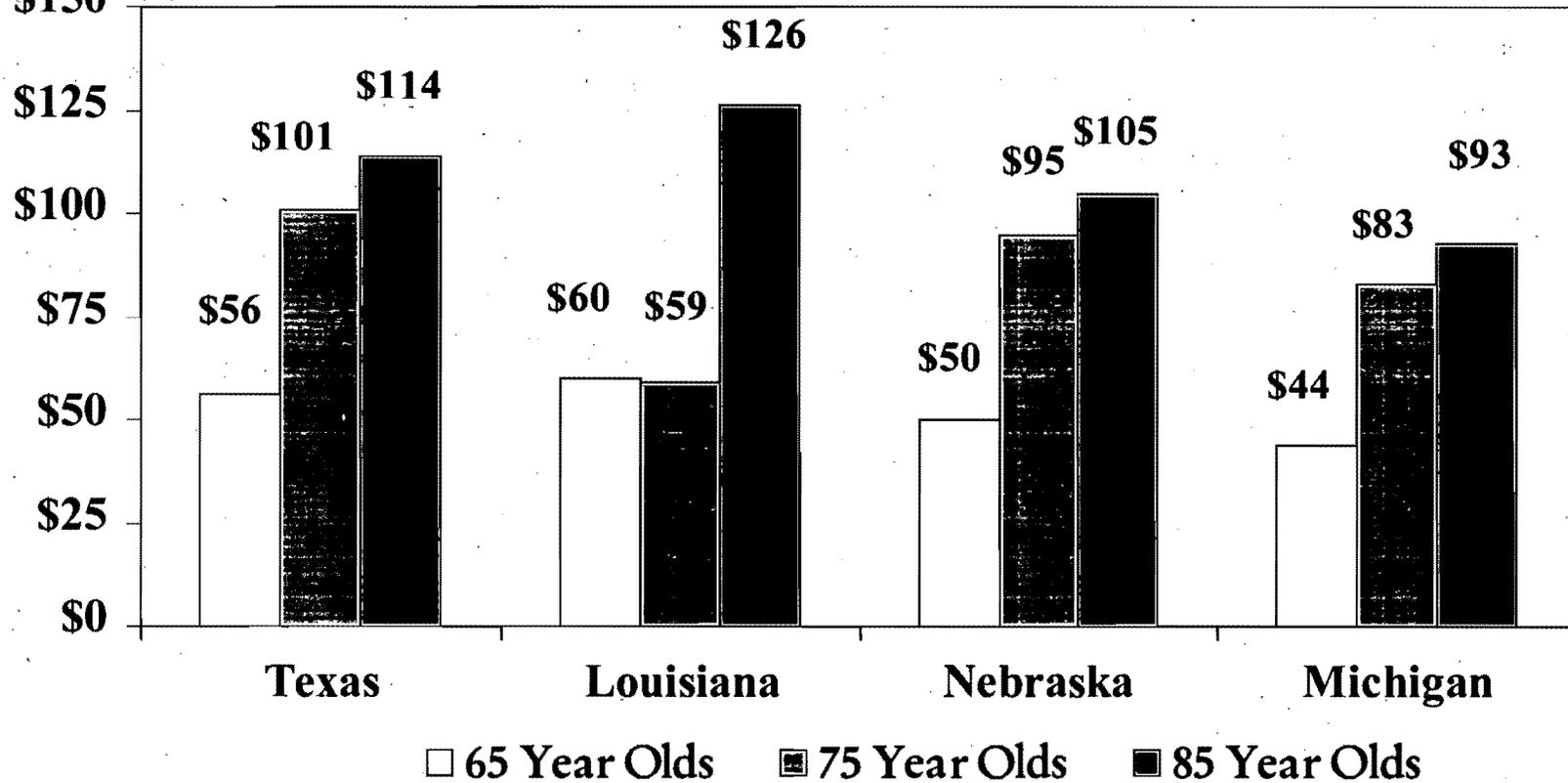
Firms Offering Retiree Health Coverage



SOURCE: Mercer Foster-Higgins, 1998

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

Monthly Premiums  
\$150

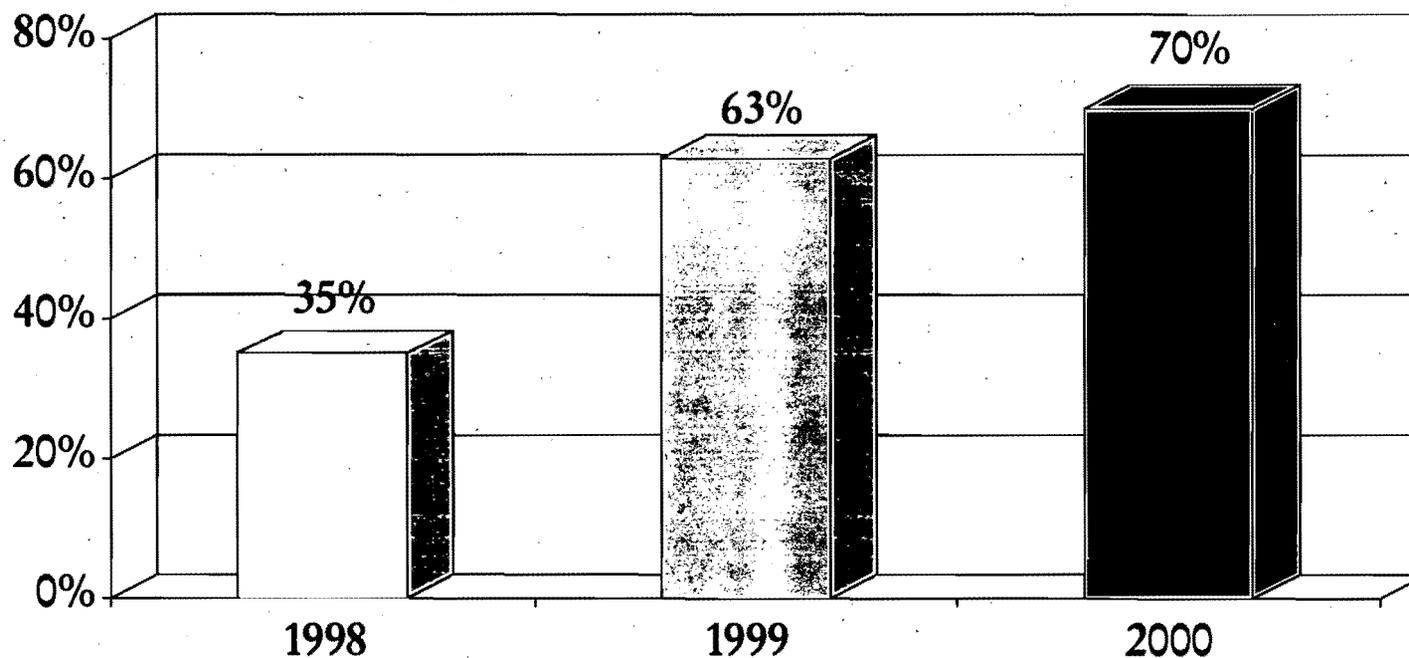


Sample Premiums for 1999. "Medigap Premiums for Drugs" are the difference between Plans I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. President's plan premium would be \$26 in first year.

# Caps on Medicare Managed Care Drug Benefits Becoming Lower

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

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

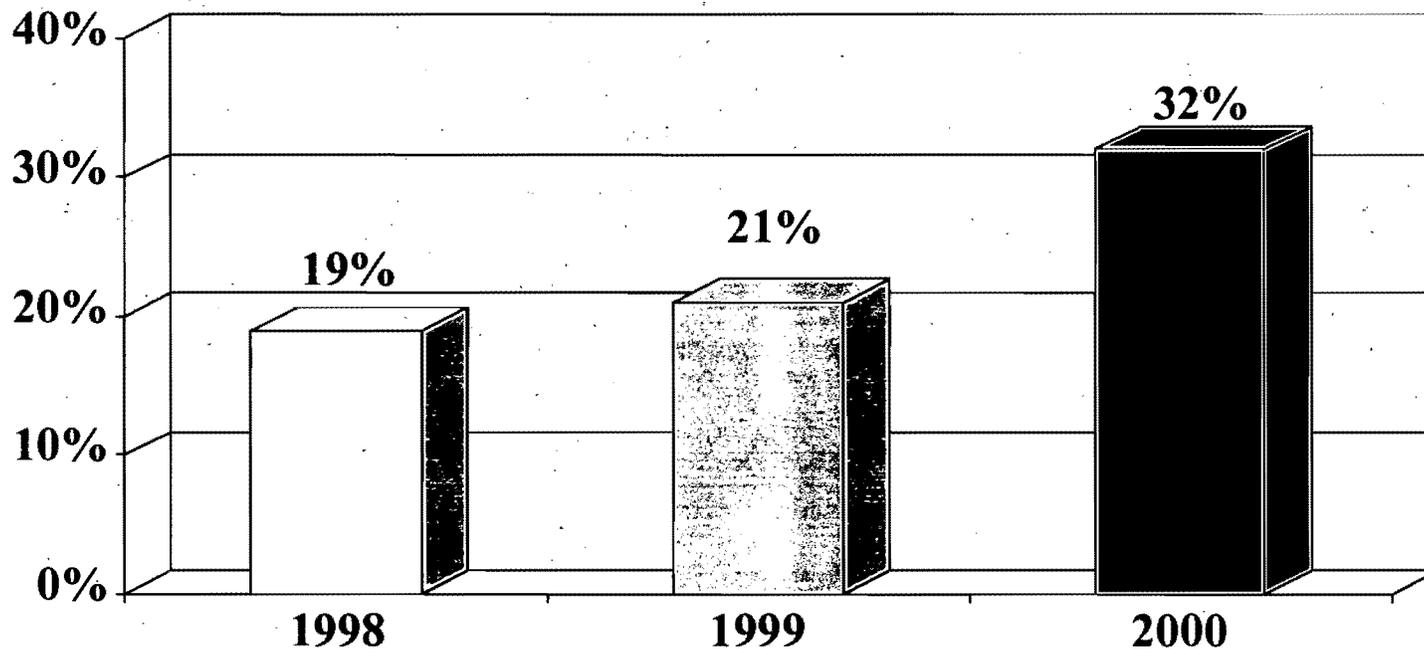


Source: HHS analysis of plan submissions for 2000; preliminary. Plans with unlimited generics and limited brand name drug spending are included with plans that cap all drug spending.

# Caps on Medicare Managed Care Drug Benefit Are Getting Lower

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

Proportion of Plans With Limit of \$500 or Less

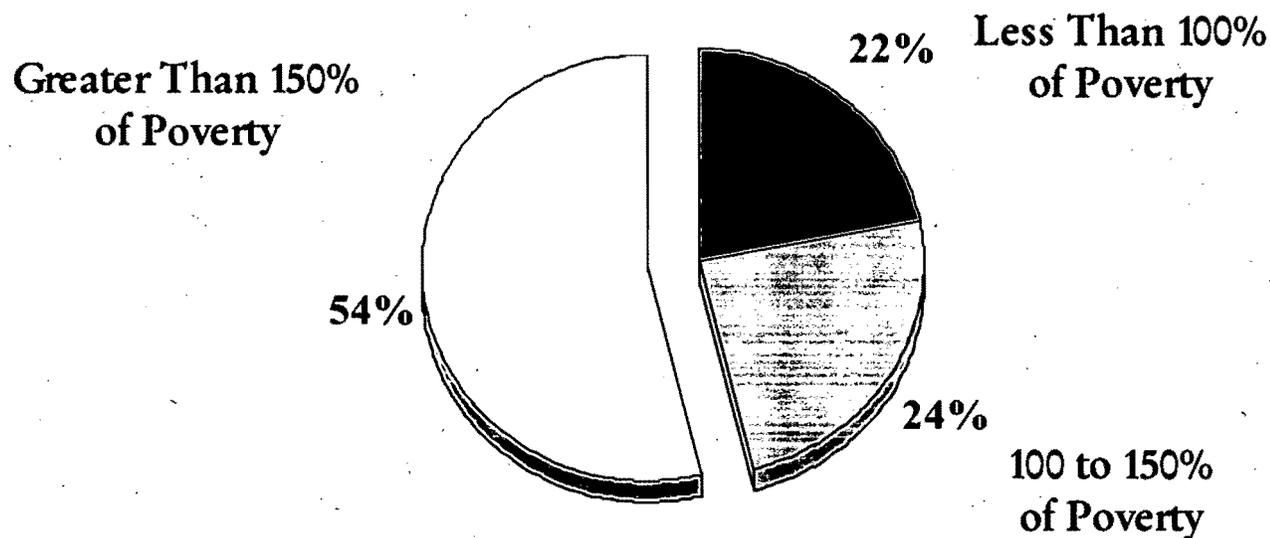


Source: HHS analysis of plan submissions for 2000; preliminary. Plans with unlimited generics and limited brand name drug spending are included with plans that cap all drug spending.

# Most Uninsured Are Not Low-Income

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

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

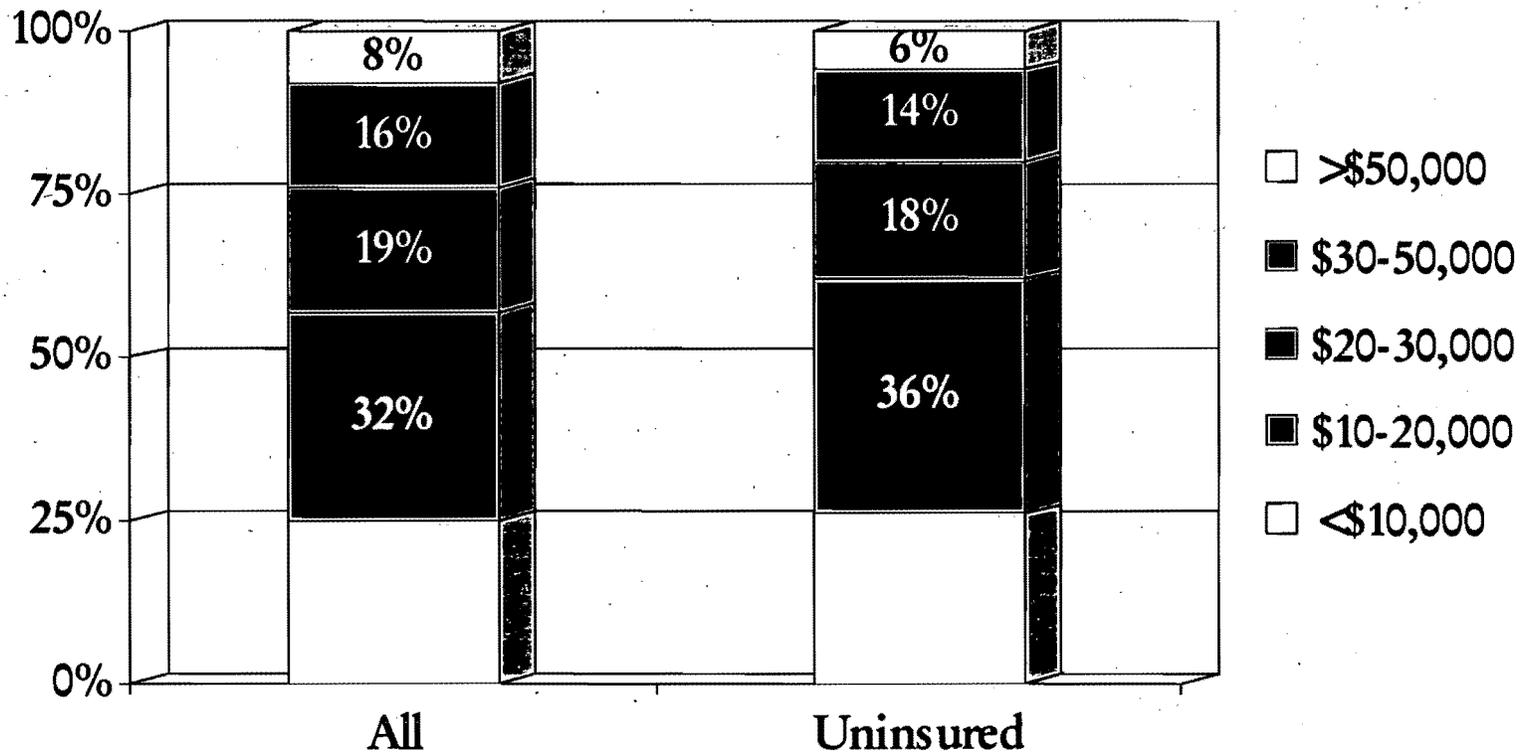


SOURCE: Actuarial Research Corporation for HHS, projected for 2000

In 2000, 150 percent of poverty for a single person is about \$12,750, for a couple is about \$17,100

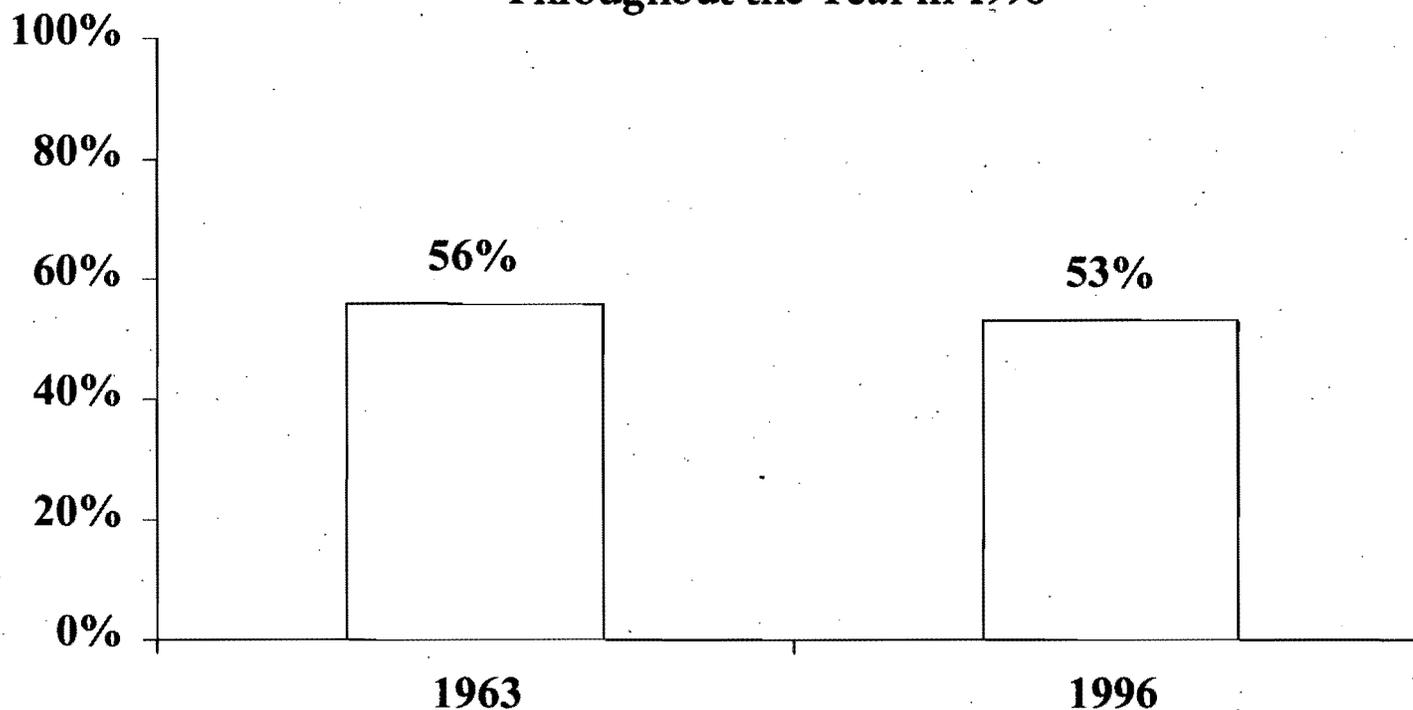
# Lack of Insurance Affects All Medicare Beneficiaries

*Beneficiaries Lacking Coverage Are Scattered Throughout The Income Spectrum, 2000*



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

Seniors With Insurance in 1963, and With Drug Coverage Throughout the Year in 1996



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

## **II. PRINCIPLES**

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

# **III. PRESIDENT'S PROPOSAL**

## **Accessible and Voluntary**

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

# Affordable To Beneficiaries & Medicare

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

# Competitive and Efficient Administration

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

# **Provides High-Quality, Necessary Medications**

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

Draft 02/05/00 12:00pm  
Jeff Shesol

**PRESIDENT WILLIAM J. CLINTON  
REMARKS ON THE FY 2001 BUDGET  
THE WHITE HOUSE  
February 7, 2000**

**Acknowledgments:** My economic team. Sec. Summers; John Podesta; Gene Sperling; Jack Lew; Sylvia Mathews; Martin Baily; Bruce Reed; the staff members of OMB who are here today and have worked so hard to put together this budget.

Today I am submitting my budget for fiscal year 2001. It is the eighth budget I have had the privilege to present as President. It is a balanced budget – and a balanced approach to our national priorities. By maintaining our fiscal discipline, by paying down the debt and extending the life of Social Security and Medicare, this budget enables us to invest in our future and, most important of all, our families.

Eight years ago, opportunities like these seemed, to many Americans, a distant hope. Irresponsible policies had piled deficit upon deficit, quadrupling the debt in just 12 years, sending interest rates high and keeping growth low. I said then that we needed a new course for a new economy.

Today, at the dawn of this new century, we have charted that course – of fiscal discipline, expanded trade, and investment in our people. And, as I said in my State of the Union Address, we have built that new economy. In the last seven years, it has generated nearly 21 million new jobs; an unemployment rate of 4.0 percent last month, the lowest in 30 years; the fastest economic growth in more than 30 years; the lowest poverty rates in 20 years; the highest homeownership ever. And this month, America will achieve the longest economic expansion in our entire history.

This is the right kind of growth: driven by private-sector investment, not public-sector spending. As a share of the economy, federal spending is the lowest since 1966. Federal deficits, the only way to sustain that level of spending, are last century's news. By balancing the budget for the first time in a generation, we have turned record deficits into record surpluses – the first back-to-back surpluses in 42 years. And this year, according to our latest projections, we'll make it three in a row, and hit a new high of \$167 billion.

If we stay on the path of fiscal discipline that got us here, we can reach even greater heights of prosperity. And we can achieve something that was once inconceivable: we can make America debt-free for the first time since Andrew Jackson was President, in 1835.

Take a look at this chart. You can see the mountain of debt that built up during the 12 years before I took office, and you can see what we've done to reverse the trend. By the end of this year, we'll have paid down the debt by nearly \$300 billion. But you can also see that the

debt is still far too high. Now, let me show you what our budget does to the debt. [*walk over to chart and draw line to the bottom.*] Our budget eliminates the debt entirely by 2013.

Now, the chart may make me look a little like an economics professor, but there's nothing academic about these issues. Fiscal discipline matters to all of us. When interest rates fall, more Americans can buy homes, retire student loans, start new businesses. And when deficits disappear, more capital is freed up to create wealth, jobs, and opportunity at every level of our economy.

Our budget ensures that the benefits of debt reduction go to strengthen two of the most important guarantees we make to every American: Social Security and Medicare. It makes a critical down payment on Social Security reform by crediting the interest savings from debt reduction to the Social Security Trust Fund – keeping it strong, solvent, and sound for the next 50 years.

Today we also take significant steps to strengthen and modernize Medicare. Our budget dedicates [more than half] of the non-Social Security surplus to guarantee the soundness of Medicare, and to add a long overdue, voluntary prescription drug benefit. When I became President, Medicare was projected to go bankrupt by 1999. Today, it's secure until 2015, thanks to the tough choices we've already made. With the further reforms in this budget, and the investment of this share of the surplus, we can extend the life of Medicare until at least 2025.

My budget also provides funds to give every older American, at long last, a choice of affordable coverage for prescription drugs. Lifesaving drugs are an indispensable part of modern medicine. No one creating a Medicare program today would even think of excluding coverage for prescription drugs. Yet more than three in five Medicare beneficiaries now lack dependable drug coverage which can lengthen and enrich their lives. My budget would extend them this lifeline. It also creates a reserve fund of \$35 billion to build on this new benefit, and protect those who carry the heavy burden of catastrophic drug costs.

Our budget will help meet America's other pressing priorities. It makes historic investments in education – from HeadStart to afterschool, from school construction to more and better teachers. It expands health care coverage for more than 5 million uninsured children and families. It makes unprecedented investments to speed discoveries in science and technology. It funds more police and tougher gun enforcement to make America the safest big country on earth; and makes the critical commitments to keep our military the best-trained and best-equipped in the world. Finally, it does more to invest in America's new markets – from the inner cities to poor rural areas and Native American reservations.

We also offer tax cuts to America's working families: to help pay for college or save for retirement; to help care for aging or ailing loved ones; to reduce the marriage penalty; and to reward work and family with an expanded Earned Income Tax Credit. We can do these things – but only if we maintain the fiscal discipline that got us here. We can do them only in the context of a realistic, responsible, balanced budget. This is that balanced budget.

The first steps we take into the 21<sup>st</sup> Century must be the right steps. The decisions we make today will help our children meet the tests of tomorrow. And that is all any of us could ever wish for or work toward. Thank you.

**LIST FOR YOU****1. Revised Statement on Budget**

I got a call that these edits **NEED** to be in TONIGHT. You should page Jeff Shesol.

**2. Gene Therapy**

Melissa called to say that she had a conversation with Bruce and he was okay with **NOT** announcing any new actions that NIH / FDA are taking on this issue on Tuesday. He did tell her, however, that we would still have to reference it in the remarks. She was okay with that as long as she can review the language, which he agreed to send over. Bruce apparently also talked to the Secretary.

**3. Budget Rollout**

OMB is making edits to the budget paper, so I don't want to send you the versions I have. I will send you the versions once they are edited – sometime tomorrow okay?

Also, Jeanne and I have the Secretary's testimony on the budget. We will edit together and give you our version this weekend.

**4. Breast Cancer**

Dan wanted me to tell you that he was trapped by Eshoc's staff person and did not tell the world about our proposal. Also, you should know that Jeanne's conference call went great – they did everything but give her a medal. In addition, our real person was interviewed by NBC. I am suspecting that I will need your edits on the q&a for the press office.

**5. Maine, Massachusetts, and Tim Westmoreland**

Tim called to let you know that Maine is almost ready to go – probably early next week. He wants you to take care of communicating this issue to Sarah B – Mary Beth Donahue told him that he should not do this directly because it is too political.

**6. Alternative Medicine Commission**

Please do not forget that you need to call Harkin's office to review the slate.

**7. Charts for your presentation on Sunday**

Jeanne is taking care of you. She is also going to blow that cartoon up into a chart for you – so you can throw out the 40 copies I made.

Call Chip Kahn  
David Podatz

Steve Riedel - me

# CONFERENCE ITINERARY

## IMPROVED ACCESS TO HEALTHCARE FOR AMERICA'S FAMILIES

### SATURDAY, FEBRUARY 5, 2000:

**4:00 PM - 10:00 PM**

CHECK IN & REGISTRATION  
(*Garden Room at the Homestead Resort*)

\*If you arrive after 10:00 p.m. you will have to pick up your conference registration materials Sunday morning

**8:00 PM -**

DINNER

### SUNDAY, FEBRUARY 6, 2000:

**7:00 AM - 8:00 AM**

BREAKFAST

**12:00 PM**

CHECK OUT\*

**12:30 PM - 1:30 PM**

LUNCH

**1:45 PM - 3:00 PM**

Improved Access to Healthcare for America's  
Families  
(*Lexington*)

\*Please remember to checkout before the deadline. A holding room will be available for your luggage.

## MEMORANDUM

TO: Panel Participants

FROM: Rep. Martin Frost  
Rep. Robert Menendez

RE: Improving Access to Health Care for America's Families

DATE: February 5, 2000

---

The following is a timeline and summary of topics to be covered during the Access Panel:

- 1:45 Panel Begins
- 1:45-1:52 Congressman Pallone sets up panel, introduces topic and provides background/status of issue in the House
- 1:53-2:00 Congressman Dingell discusses politics of the issue in the House, issues surrounding GOP approach in Patients' Bill of Rights, and how Democrats win this issue
- 2:01-2:11 Judy Waxman briefly poses the problem of the uninsured (focusing on middle income, as well as the poor), provides anecdotal information for Members to use in framing the issue, raises some of the problems with the GOP access bill, and discusses Families USA effort to expand access
- 2:12-2:22 Chris Jennings discusses President's proposal for expanding access, including anecdotal information for Members
- 2:23-3:00 Members Q & A

**2000 Democratic Caucus Issues Conference  
February 5-7, 2000**

**The Homestead Resort Restaurants  
Meal Options**

**Breakfast**

Homestead Dining Room 7:00 am – 10:00 am

**Lunch**

Homestead Dining Room 12:00 noon – 2:00 pm

*(Closed Monday only)*

Sam Snead's Tavern 11:30 am – 3:00 pm

*\*Friday – Sunday Only\**

Café Albert on Cottage Row 11:00 am – 4:00 pm

**Dinner**

Homestead Dining Room 6:30 pm – 9:00 pm

*Coat & tie are required at dinner.*

Sam Snead's Tavern 5:30 pm – 9:30 pm

Player's Pub 7:00 pm – 12:00 am

*The Player's Pub offers lighter food like pizza & nachos.*

*Dinner reservations are required and can be made by calling  
1-800-838-1766 (option 4 on the automated menu).*

For all meals, be prepared to present the room card that you received at check-in. This will cover your dinner on the day you arrive and your breakfast and lunch on the day you depart. Alcoholic beverages are not covered and will be charged to your room.

*Medicaid Reform: Prescription Drug*

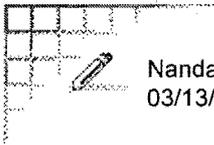


**Anna Richter**  
03/13/2000 03:52:06 PM

Record Type: Record

To: Devorah R. Adler/OPD/EOP@EOP  
cc:  
Subject: remarks on prescription drugs

----- Forwarded by Anna Richter/OPD/EOP on 03/13/2000 03:52 PM -----



**Nanda Chitre**  
03/13/2000 03:49:42 PM

Record Type: Record

To: See the distribution list at the bottom of this message  
cc:  
Subject: remarks on prescription drugs

THE WHITE HOUSE

Office of the Press Secretary  
(Cleveland, Ohio)

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For Immediate Release March 13, 2000

REMARKS BY THE PRESIDENT  
TO THE CLEVELAND COMMUNITY  
ON PRESCRIPTION DRUG BENEFIT

City Public Library  
Cleveland, Ohio

2:55 P.M. EST

THE PRESIDENT: Thank you very much. Thank you. First, I think Wanda did a pretty good job, don't you? Let's give her another hand. (Applause.) I am delighted to be here in Cleveland. I want to thank all the people who are up here with me -- Alice Katchianes, thank you for being here. And, Mr. Venable, thank you for your welcome. If I could sing like that I'd be in a different line of work. (Laughter.)

I thought that was great.

I want to thank Congressman Sherrod Brown and Congressman Dennis Kucinich; Congresswoman Stephanie Tubbs Jones; my great friend, Lou Stokes; all the other officials who are here today. State Representative Jack Ford; County Commissioner Jimmy Dimora; State Senate candidate Donna MacNamee, a woman I met at the dedication of the FDR Memorial, at President Roosevelt's wheelchair. I'm glad to see her here.

I want to say a special word of appreciation to Congressman Dick Gephardt for his leadership and his passionate commitment to this and so many other good causes. Without him and these other members of our caucus, we wouldn't have a prayer of passing this proposal today. And I thank him.

And I want to say, obviously, how pleased I am to be here with Donna Shalala, who is, as Dick Gephardt suggested, not only the longest serving, but by a good long stretch, the ablest and best Secretary of Health and Human Services this country has ever, ever had. (Applause.) And I love to see her mother, and I'm glad she made room for me at tax time. (Laughter.) I told her, I said, you know, when I get out of this job, I hope I need the services of a tax lawyer. (Laughter.) Right now, it's all pretty straightforward. But that was, without a doubt, the shortest speech I ever heard a lawyer give, what she said to me. (Laughter.) You probably doubled your business just by being here today.

I do love coming to Cleveland, and you heard Donna say that we have a lot of people in this administration from Cleveland, including my Deputy Chief of Staff, Steve Ricchetti, who is here today. But Clevelanders, they may go anywhere, but they never get it, Cleveland, out of their soul.

If you go into Steve's office, there is a great photograph from the opening day of baseball at Jacobs Field in 1994. Now, I remember that because I threw out the first pitch. But Steve's got the picture on the wall because when I threw the pitch, everyone was absolutely stunned that it didn't hit the dirt -- (laughter) -- and Sandy Alomar caught it. So he really got -- I'm incidental to the picture. He's got Sandy Alomar catching a ball which he was convinced would go into the dirt. I thought I did pretty well for a guy who played in the band, myself. (Laughter.)

Let me say, this is a great time for this city and a great time for our nation. As I said in the State of the Union address, I hope this time will be used by our people to take on the big challenges facing America. One of those big challenges is what to do about the aging of America, which is a high-class problem. That is, we're living longer, we're living better -- and the older I get, the more I see that as an opportunity, not a problem. But it does impose certain challenges on us.

There is also a challenge to modernize our health care systems and to do other things to increase the health care of the American people. And that's what we're here to talk about today.

But because this is my only formal opportunity to be before -- thanks to you -- before the press and, therefore, the American people, I would like to just refer to another issue that relates to the health and safety of the American people, just briefly.

I have been fortunate enough to have the support of the members of Congress on this stage in our efforts to drive the crime rate down, to make our streets safer in Cleveland, and every other major city in America is a safer place than it was seven years ago. We have a 25-year low in crime, a 33-year low in the gun death rate. And I am grateful for the support I have received to put more police on the street, to have more summer school and after-school programs for young people, and to do more to keep guns out of the hands of criminals -- banning the cop-killer bullets, the assault weapons ban, the Brady Bill -- which has kept half a million felons, fugitives and stalkers from getting handguns.

Now, all of you know we had some tragic deaths last week. We had that six-year-old girl killed in

Michigan by a six-year-old boy, who was a schoolmate of hers. We had terrible shootings in Memphis. And just in the last year we had the horrible incident at Columbine High School, almost a year ago; and in the year before that, lots and lots of school shootings.

Now, after Columbine, I suggested that what we ought to do is to, number one, make sure there were child safety locks on these guns; number two -- which would have made a big difference in the case of children getting the guns. Number two, make sure we ban the importation of large ammunition clips which make a mockery of the assault weapons ban because they can't be made or sold here in America, but they can be imported. Number three, close the loophole in the background check law, the Brady law, which says people can buy handguns at gun shows or urban flea markets and not have to do a background check. It's a serious problem. And fourth, I think when adults intentionally or recklessly let little kids get a hold of guns, they should have some sort of responsibility for that.

And so I asked the Congress to do that. Eight months ago, Vice President Gore broke a tie in the Senate and passed a pretty strong bill, and then a bill passed in the House that was weaker. And I asked them to get together and pass a final bill. And they never even met until last week when we got them together, after this last round of horrible shootings.

And I ask all Americans to join me, because I think these things are reasonable. This won't affect anybody's right to hunt or sport-shoot or anything, but it will save kids' lives.

The response we got from the National Rifle Association was to run a bunch of television ads attacking me. And yesterday morning I went on television again to talk about these measures. I'm not trying to pick a fight with anybody; I'm trying to fight for the lives of our kids. But I want you to see what we're up against whenever we try to change here.

The head of the NRA said yesterday -- I want to quote -he said that my support of these measures was all political, and he said this: "I have come to believe that Clinton needs a certain level of violence in this country. He's willing to accept a certain level of killing to further his political agenda -- and his Vice President, too."

Well, he could say that on television, I guess. I'd like to see him look into the eyes of little Kayla Rolland's mother and say that. Or the parents at Columbine, or Springfield, Oregon, or Jonesboro, Arkansas. Or the families of those people who were shot in Memphis.

I say that, again, to emphasize change is hard, but sooner or later, if you know you've got a problem, you either deal with it or you live with the consequences. And the older you get, the more you understand that.

We do not have -- I'm grateful that our country is a safer place than it was seven years ago. I don't think it's safe enough. I don't think you think it's safe enough. I don't think you think it's safe enough for seniors; I don't think you think it's safe enough for little kids. And if we can do more things to keep guns away from criminals and children, that don't have anything to do with the legitimate right of people to go hunting or engage in sports shooting, we ought to do it. And we ought not to engage in this kind of political smear tactics. (Applause.)

Now, I feel the same way about this issue. And I want to try to explain to you what is going on now with this issue, because most people in America -- you heard Dick Gephardt talk about it -- most people in America think, well, why are we even arguing about this? Well, all health care issues are fraught with debate today. I know you're having a big debate here about hospital closures in Cleveland, and I don't know enough about the facts to get involved with it, but I'll tell you this. One of the problems we have is, there's too much uncompensated care in America.

And we're trying to -- we're trying hard, the people you see on this stage, we're trying hard to

make sure every child that's eligible is enrolled in the Children Health Insurance Program that was created in 1997. We want Congress to let their parents be insured under the same program. We want people over 55 but under 65 who aren't old enough for Medicare, but have lost their insurance on the job, to be able to buy into Medicare, and we want to give them a little tax credit to do it. If we do things like this, then, whatever happens, in Cleveland or anyplace else, will have to be determined based on the merits of the case, but at least the people who need health care will be able to know that the people who give it to them -- whether it's hospitals or doctors or nurses or whoever -- will be able to get reimbursed for it. And that's a very important thing. I hope you'll support us in that.

And then we come to the issue at hand. Now, what's this about, this prescription -- you all know what it's about. If we were starting -- suppose I came here today as President and I were in my first year as President and I proposed Medicare, just like President Johnson did in 1965, in the first full year after he was elected -- and I told you in 1965 what he said, it would be fine. But in 2000, if I said, okay, I'm going to set up this health care program for senior citizens, and you can see a doctor and we'll pay for your hospital care, but even though we could save billions of dollars a year keeping people out of hospitals and out of emergency rooms by covering the medicine, we're not going to cover medicine.

If we were starting today, given all the advances in prescription drugs in the last 35 years, you would think I was nuts, wouldn't you? The only reason that prescription drugs aren't covered by Medicare is that it was started 35 years ago, when medicine was in a totally different place. That's the first thing.

The second thing I want to say is that it has really cost us a lot not to cover these seniors. And you see American seniors, for example, who live in New York or Vermont, going to take a bus trip to Canada because they can buy drugs made in America for 30 percent less -- because very often the seniors, the people that are least able to pay for these drugs, are paying the highest prices for them.

Now, that's why our budget has this plan. And I want to tell you exactly what we propose, and what we're all up here on this stage supporting today. We want to provide with Medicare a prescription drug benefit that is optional, that is voluntary, that is accessible for all -- anybody who wants to buy into it can -- a plan that is based on price competition, not price controls -- that is, we don't want to control the price, but we want to use the fact that if we're buying a lot of medicine, seniors ought to be able to get it as cheap as anybody else. (Applause.) And we also want it to be part of an overall plan to continue to modernize Medicare and make it more competitive.

Because, I can tell you, I'm the oldest of the baby boomers, and people in my generation, we're plagued by the notion that our retirement could cause such a burden on our children, it would undermine their ability to raise our grandchildren. We don't want that.

Now, medically speaking, this is not just the right thing to do, it is the smart thing to do. As I said, we already pay for doctor and hospital benefits. But an awful lot of seniors go without prescription drugs -- and preventive screenings, I might add -- that ought to be a part of their health care. We've worked hard to put preventive screenings back into Medicare, for breast cancer, for osteoporosis, for prostate cancer. These are very, very important. But not having any prescription drug coverage is like paying a mechanic \$4,000 to fix your engine because you wouldn't spend \$25 to change the oil and get the filter replaced.

In recent months I have been really encouraged because a number of Republicans have expressed an interest in joining us to do this. And we can't pass it unless some of them join us, because we don't have enough votes on our own. But so far, the proposals they're making, I think, are not adequate, and I'll explain why.

There are two different proposals basically coming out of the Republicans. Some of them propose giving a block grant to the states to help only the poorest seniors, those below the poverty line. That would leave the middle-income seniors, including those that are lower-middle-income, just above the

poverty line, to fend for themselves. And here in Ohio, 53 percent of all the seniors are middle-income seniors. None of them would be covered by this plan.

In 1965, when Medicare was created, some in Congress used these very same arguments. They said, we should only pay for hospital and medical care for the poorest seniors. They were wrong then, and they're wrong now. More than half the seniors today without any prescription drugs at all are middle-class seniors. I want to say that again. More than half the seniors without any prescription drug at all are middle-class seniors. On average, middle-class seniors without coverage buy 20 percent less drugs than those who have coverage, not because they're healthier, but because they can't afford it.

And even though they buy 20 percent less medication -- listen to this -- because they have no insurance, their out-of-pocket burden is 75 percent higher. Without insurance, 75 percent higher.

So I say, let's do this right. This is voluntary; we're not making anybody do it. But we ought to offer it to everybody who needs it. It doesn't take much, if you're a 75-year-old widow to be above the so-called federal poverty line. You can have a tiny little pension tacked on your Social Security and you can be there. But if you've got -- as you've just heard -- \$2,300 worth of drug bills a year -- and a lot of people have much higher -- it's a terrible problem.

Now, some other members of Congress are proposing a tax deduction to help subsidize the cost of private Medigap insurance. If any of you own Medigap, you know what's the matter with that proposal. This proposal would benefit the wealthiest seniors without providing any help to the low- and middle-income seniors. And the Medigap marketplace is already flawed. Today -- listen to this -- in Washington, the General Accounting Office is releasing a report that shows that Medigap drug coverage starts out expensive and then goes through the roof as seniors get older. On average, it costs about \$164 a month for a 65-year-old to buy a Medigap plan with drug coverage, and premiums rise sharply from there.

For example, in Ohio, an 80-year-old person would pay 50 percent more than a 65-year-old person for the same coverage under Medigap. This is not a good deal, folks. We don't want to put more money into this program. It is not a good deal. Even those who offer Medigap plans say the approach wouldn't work, because it would force Medigap insurers to charge excessively high premiums for the drugs or to refuse to participate at all.

Now, there's another problem that we have in the Congress, which is that the congressional majority just last week voted on budget resolutions that together allocate nearly half a trillion dollars to tax cuts. And if we cut taxes that much, we won't be able to afford this. And we may not be able to save Social Security and Medicare and pay down the debt, and have money left over to invest in the education of our children.

I'm for a tax cut, but we've got to be able to afford it. And we, first of all, have got to keep this economy going. We need to pay down the debt. We can get out of debt for the first time since 1835, within a little more than 10 years, if we just keep on this road. A lot of you never thought you'd ever see that.

We can lengthen Social Security out beyond the life of the baby boom generation. We can put 25 years on the Medicare program, which is longer than it's had in blows and blows, a long time. And we can add this prescription drug coverage. But we can't do it if the tax cut's too big, and we shouldn't do it in the wrong way and say you can only get it if you're really poor, or you can only get it if you buy into Medigap.

Now, let me tell you why this is such a big deal. The average 65-year-old in America today has a life expectancy of 82 to 83 years. The average 65-year-old woman has a life expectancy higher than that. The fastest-growing group of American seniors are those over 85. So to knowingly lock ourselves into a program that would get 50 percent more expensive as you got older and older, and needed more and

more medicine and had less and less money does not make much sense.

We have given them a good program. It is the right thing to do. And so I would like to ask all of you to help all of these members of Congress on the stage, and to tell the people in Washington, look, this is not a partisan issue. You know, a lot of people say, we don't want to do this; this is an election year. Look, they can name this prescription drug program after Herbert Hoover, Calvin Coolidge and Warren Harding. It's fine with me. I don't -- put some Republican's name on it. I don't care. Just do it, because it's the right thing to do for the seniors of this country. (Applause.)

\* So I would just implore you, help us pass this. Write to your United States senators. Tell them it's not a partisan issue. Tell them what life is like. Tell them it's not right for seniors in Ohio to pay 30 to 50 percent more for medicine than seniors in Canada pay for the same medicine that's made in America in the first place. Tell them it's not right for you to need something you can't have, so you get sick, but then when you show up at the emergency room, it gets paid for.

We can afford this. Everybody in America has worked hard for it. We've got this budget in good shape. We can make a commitment to our future. If you think is necessary now, imagine what it's going to be like when the number of seniors doubles in 30 years.

That's the last point I want to leave you with. Look how many seniors there are in Cleveland today. In 30 years, the number of people over 65 will double, and Donna Shalala and I hope to be among them. (Laughter.) And you think about it. And then the average age in America will be well over 80.

Now, if we have to take care of all these people by waiting until they get sick and they go to the hospital, instead of worried about hospitals closing, 30 years from now you'll worry about the city going bankrupt because everybody will be in the hospital. We've got to be healthier, we've got to keep people healthy. We need to keep them playing tennis, like Lawyer Shalala there; but we also need to be able to give people medication to keep them out of the hospital, and to manage people in a way that will maximize their health. This will be a huge issue.

So I implore you, this country -- this is the first time we've been in shape to do this in 35 years. We can do this now. And we can do it now and take care of the future. We can help the seniors of today and take a great burden off of tomorrow. But we need your help to do it.

Again, I implore you, talk to your members of Congress, talk to your senators. Tell them it's not a partisan issue, it's an American issue, it's a human issue and it's a smart thing to do.

Thank you and God bless you. (Applause.)

END

3:17 P.M.

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Message Sent To:

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## Republican Arguments Against Modernizing Medicare In 1999 Echo Their Arguments Against Creating Medicare In 1965

Thirty-four years ago, on July 30, 1965, President Lyndon Johnson signed Medicare into law. Arguments that Republicans opposed to the creation of Medicare used were very similar to those used by Republicans today opposed to strengthening and modernizing Medicare.

1965 Arguments Against Medicare Hospital and Physician Coverage	1999 Arguments Against Medicare Prescription Drug Coverage
<p><b>Sen. Milward Simpson (R-WY)</b> “Presently, over 60 percent of our older citizens purchase hospital and medical insurance without Government assistance. This private effort would cease if Government benefits were given to all our older citizens.” [Sen. Congressional Record (#15874), 7/8/65]</p> <p><b>Sen. John Williams (R-DE)</b> “Such a program of complete coverage without regard to need is socialized medicine and it has failed in practically every country which has thus far tried it. In every instance it has resulted in a deterioration of doctors’ services.” [Senate Congressional Record (#16147), 7/9/65]</p> <p><b>Rep. John Anderson (R-IL):</b> “It will needlessly force duplication of coverage for those over 65 who are already adequately covered at no cost to themselves under adequate programs of group health insurance, provided by their employers, their unions or by other organization. These people have no need for a government program.” [House Congressional Record (#7376), 4/8/65]</p> <p><b>Rep. Tim Carter (R-KY)</b> “We are now embarking on a new adventure in medical practice, one in which the rich will enjoy the same free medical care we have always given the poor. I would ask if the expenditure of these vast sums of money is necessary to help the rich instead of the poor who really need the help.” [House Congressional Record (#7410), 4/8/65]</p>	<p><b>Senate Majority Leader Trent Lott (R-MS)</b> “Why would you want to make it available to people, many of whom already have it now? In fact, 68 percent of people on Medicare have prescription drugs in one way or another.” [Federal News Service, 6/29/99]</p> <p><b>House Majority Leader Dick Armey (R-TX)</b> “It’s been the tradition in the president’s party to do one size fits all. If you have 31 percent of people with a problem, you ought to put together a 31 percent solution, not a 100 percent solution.” [Associated Press, 6/29/99]</p> <p><b>Sen. Phil Gramm (R-TX)</b> “It isn’t a matter of whether there ought to be a prescription drug benefit offered by Medicare, but whether we’re going to help those who need it most or launch a “universal” program we don’t need and can’t afford.... New drug benefits should go to those who need them – roughly a third of retirees – not to the two-thirds who are already covered,” [Op-Ed by Sen. Phil Gramm, USA Today, 6/30/99]</p> <p><b>Sen. Rick Santorum (R-PA)</b> “What we need to do is focus our resources toward lower income people and really narrow the benefits, particularly to those who have higher prescription drug bills.” [Morning Call (Allentown), 6/30/99]</p>

**PRESIDENT CLINTON AND MEMBERS OF CONGRESS HIGHLIGHT NEW ANALYSIS SUPPORTING ADMINISTRATION'S PRESCRIPTION DRUG PLAN**

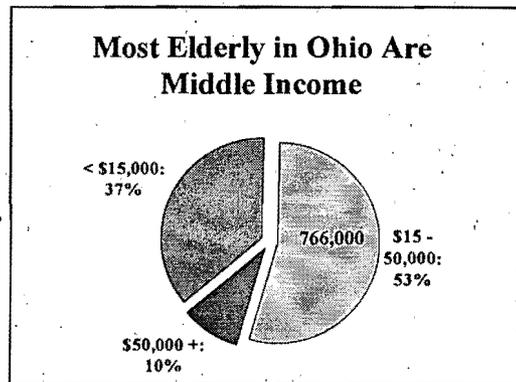
March 13, 2000

Today, President Clinton will participate in an event in Cleveland to highlight new data documenting the financial burdens middle-income Medicare beneficiaries face in purchasing prescription drugs and accessing affordable insurance coverage for these lifesaving medications. The analysis being released today shows that: (1) middle-income beneficiaries without prescription drug coverage purchase 20 percent fewer drugs but pay about 75 percent more out-of-pocket than those with drug coverage; and (2) premiums for private Medigap insurance with drug coverage – mostly purchased by middle-class seniors – are extremely expensive and get more costly as beneficiaries age. These findings, combined with additional recent research, reveal the shortcomings of some narrowly-targeted proposals by some in the majority party that fail to cover middle-income seniors. The President today will renew his call for his own comprehensive reform plan that includes a voluntary drug benefit accessible to all Medicare beneficiaries.

**LOW-INCOME BLOCK GRANT WOULD EXCLUDE MILLIONS OF SENIORS**

Some Republicans propose to expand prescription drugs through a block grant to states to cover low-income seniors. While low-income Americans would certainly benefit from a prescription drug benefit, the data show that targeting only the low-income would leave millions of seniors without affordable, dependable coverage.

- **Middle-income seniors without drug coverage purchase fewer prescription drugs but pay more out-of-pocket.** Analysis by the National Economic Council shows that middle-income beneficiaries without coverage average 20 percent fewer prescriptions but spend about 75 percent more out-of-pocket on drugs than insured middle-class beneficiaries.
- **Over half of Medicare beneficiaries who lack prescription drug coverage have income above 150 percent of poverty.** This is the income limit (about \$17,000 for a couple) for most low-income block grants.
- **In Ohio, most seniors would not qualify for a low-income block grant.** There are 776,000 middle-income seniors in Ohio who earn too much income to receive assistance in a low-income plan but too little to be able to afford expensive private premiums.
- **Governors oppose shifting responsibility of drug coverage for seniors to states.** Although some states have extended Medicaid coverage to additional low-income seniors, the National Governors' Association, at its meeting last month, called on Congress "not to shift the cost or responsibility of any new prescription drug benefit for seniors to states."



**RELIANCE ON FLAWED PRIVATE MEDIGAP AND TAX APPROACHES LEAVE MAJOR GAPS IN COVERAGE.** Others in Congress propose solving the prescription drug problem by expanding private Medigap insurance and through tax breaks rather than creating a voluntary Medicare prescription drug benefit. But such policies would disproportionately assist high-income seniors and would still leave millions of middle-income seniors without a dependable, affordable option. And because they do not promote group purchasing, these approaches cannot leverage price reductions for seniors.

- **New General Accounting Office (GAO) data being released today show private Medigap premiums are expensive – especially for older seniors.** On average, it costs about \$164 per month for a 65-year old to buy a Medigap plan that pays for prescription drugs and lower cost sharing (seniors cannot buy insurance for prescription drugs alone). Monthly premiums range from \$107 to \$249.
  - **In most states, Medigap for an 80-year old costs 33 percent more than the same coverage for a 65-year old.** In all but 12 states, Medigap insurers can charge premiums based on age. As a result of “age-attained rating,” younger seniors, who are healthier and wealthier, sign up for coverage but get priced out of Medigap as they age – and just as they need coverage most. The average premium for Medigap with prescription drug coverage is \$217 per month for an 80-year old – 33 percent more than the same coverage for a 65-year old.
  - **In Ohio, an 80-year old can expect to pay over 50 percent more -- \$84 per month – than a 65-year old for Medigap that includes prescription drugs.** For seniors on fixed incomes, this can be prohibitively expensive.
  - **Extra amount for a plan with prescription drugs is high.** A 65-year old beneficiary pays nearly \$60 more a month for a Medigap plan with prescription drugs than for one without drugs. In some states, the extra cost for the plan with drugs is higher than the value of the coverage itself (\$1,250 per year).
- **These high and variable premiums help explain why only about 10 percent of beneficiaries get prescription drugs through Medigap – and why almost half of these all Medigap enrollees do not keep it for the entire year.** A recent study found that Medigap is the most unreliable source of prescription drug coverage.
- **A new prescription Medigap plan covering only prescription drugs would be prohibitively expensive or inaccessible altogether.** Medigap insurers have testified that the likelihood of attracting sicker beneficiaries in this type of option would force them to charge excessively high premiums or not participate at all.
- **Providing tax breaks for prescription drug costs misses many seniors.** About 40 percent of seniors do not have any tax liability and thus would not be helped by a tax-based approach to helping cover prescription drug costs.
- **Tax and Medigap approaches not only provide for poor coverage but do not achieve discounts for medications purchased.** Because these approaches do not promote group purchasing, they cannot leverage price reductions for seniors.

## **PRESIDENT'S APPROACH ASSURES AFFORDABILITY AND ACCESS**

President Clinton's FY 2001 budget includes a comprehensive plan that makes Medicare more competitive and efficient and dedicates part of the surplus to improve Medicare solvency and to add a long-overdue prescription drug benefit. Last week, the Congressional Budget Office (CBO) released an analysis of the President's plan that estimated its cost at about \$150 billion over 10 years. This analysis confirms that the President's plan meets the principles, agreed to by all Senate Democrats, that a prescription drug benefit should be:

- **Voluntary.** Medicare beneficiaries who now have dependable, affordable coverage would have the option of keeping that coverage. According to CBO, 75 percent of seniors with retiree coverage would keep it under the President's plan.
- **Accessible to all beneficiaries.** All seniors and people with disabilities would have access to a reliable benefit. 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.
- **Accessible to all beneficiaries.** All seniors and people with disabilities would have access to a reliable benefit. 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 enhances the base benefit and helps seniors and people with disabilities 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.

## GAO INFORMATION ON MEDIGAP PREMIUM, 1999

Selected States	Monthly Premium for Medigap Plan I			
	Age 65	Age 80*	Age Difference	
			\$	%
Alabama	\$135	\$211	+\$76	+56%
Alaska	\$131	\$203	+\$72	+55%
Arkansas	\$193	Same	-	-
Colorado	\$155	\$211	+\$56	+36%
Connecticut	\$230	na	na	na
Delaware	\$147	\$230	+\$82	+56%
Florida	\$199	na	na	na
Georgia	\$249	\$320	+\$71	+29%
Illinois	\$146	\$220	+\$75	+51%
Iowa	\$123	\$194	+\$70	+57%
Kansas	\$143	\$219	+\$76	+54%
Louisiana	\$178	\$289	+\$111	+62%
Maine	\$222	Same	-	-
Michigan	\$179	na	na	na
Mississippi	\$147	\$224	+\$77	+52%
Missouri	\$150	\$229	+\$79	+53%
Montana	\$126	\$184	+\$58	+46%
Nebraska	\$126	\$191	+\$65	+51%
Nevada	\$162	\$199	+\$38	+23%
New Hampshire	\$125	\$202	+\$77	+62%
New Mexico	\$175	\$276	+\$101	+58%
New York	\$193	Same	-	-
North Carolina	\$139	\$188	+\$49	+35%
Ohio	\$146	\$230	+\$84	+57%
Oklahoma	\$129	\$200	+\$70	+54%
Oregon	\$131	\$204	+\$73	+56%
Pennsylvania	\$140	Same	-	-
Rhode Island	\$130	\$190	+\$60	+46%
South Carolina	\$155	\$242	+\$87	+56%
South Dakota	\$134	\$213	+\$79	+59%
Texas	\$150	\$201	+\$51	+34%
Utah	\$112	\$120	+\$9	+8%
Virginia	\$107	\$147	+\$39	+37%
Washington	\$191	Same	-	-
West Virginia	\$162	na	na	na
Wyoming	\$149	\$212	+\$63	+42%
<b>Average of States</b>	<b>\$164</b>	<b>\$217</b>	<b>+\$53</b>	<b>+33%</b>

NOTES: Please see GAO/HEHS-00-70R, Letter to Congressman Dingell for methodology and notes

Plan I includes reduced cost sharing, drug coverage of: \$250 deductible, 50% copay \$1,250 payment cap

\* For TX & WY, premium is for a 75 year old; for NV & UT, it is for a 70 year old

Average is weighted by Medicare beneficiaries by state. 80-yr old premium excludes community-rated states

Same indicates states with either community rating or no attained-age rating. 12 states prohibit age rating