

Withdrawal/Redaction Sheet

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Democratic Leadership Meeting and Statement on Medicare and Prescription Drug Coverage (6 pages)	5/24/00	P5

COLLECTION:

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

FOLDER TITLE:

Medicare Drug Benefit [3]

gf39

RESTRICTION CODES

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

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
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Freedom of Information Act - [5 U.S.C. 552(b)]

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PRESIDENT CLINTON AND SENATE DEMOCRATS UNIFIED IN VISION FOR NEW MEDICARE PRESCRIPTION DRUG BENEFIT

March 9, 2000

President Clinton today will receive and endorse a set of "Prescription Drug Principles" from Senate Democratic Leader Tom Daschle which will be used by the Senate Democratic Caucus to evaluate any Medicare prescription drug benefit proposal developed in Congress. These principles affirm that drug benefits targeted only to low-income Americans through block grants, or primarily to high-income beneficiaries through tax incentives, would be unworkable and unacceptable. The "Prescription Drug Principles" state that any drug benefit should be: voluntary; accessible to all beneficiaries; designed to provide meaningful protection and bargaining power for seniors; affordable for all beneficiaries and for the program; administered using competitive purchasing techniques; and consistent with broader Medicare reform. Senator Daschle will inform the President that the Administration's proposal meets all these principles and that he will work to ensure that any plan emerging from Congress will be guided by them.

**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 either 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.** Today, 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.

PRESIDENT URGES CONGRESS TO ACT NOW. The President will urge Congress to act this year to strengthen and improve Medicare. His 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 the President's 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.

Final 03/08/00 7:30pm
Jeff Shesol

**PRESIDENT WILLIAM J. CLINTON
DEPARTURE STATEMENT
ON MEDICARE PRESCRIPTION DRUG BENEFIT
THE WHITE HOUSE
March 9, 2000**

Senator Daschle, thank you. To the other Senators who join us here today, thank you as well for your hard work on this important issue.

Today, Senate Democrats have come together to agree on principles for a voluntary Medicare prescription drug benefit – something so many seniors need and too few of them have. There have been a lot of proposals on the table, a good number of good ideas. But today, together, we are moving forward on the path to progress. By uniting around these common principles, you're setting standards that any prescription drug plan should meet. That's a significant step. It moves us further toward the day when every older American has the choice of affordable prescription drug coverage.

More than three in five seniors and people with disabilities still lack dependable drug coverage that could lengthen and enrich their lives. Our budget would, at long last, extend them that lifeline. It also creates a reserve fund of \$35 billion to build on this new benefit, to protect those who carry the heavy burden of catastrophic drug costs.

Most important, our prescription drug plan embodies the essential principles that Senator Daschle described. I believe that any plan passed by the Congress must be optional, affordable and accessible to all beneficiaries; it must use price competition, not price controls; it must boost seniors' bargaining power to get the best prices possible; and it should be part of an overall plan to strengthen and modernize Medicare.

We owe it to our people to pass this prescription drug plan. We owe it to our seniors – all of them, not just some of them – to create this new choice and to do it this year. We shouldn't be satisfied with half-measures. Keep in mind that a tax deduction would help only the wealthiest seniors; and a block grant, which some in the majority have proposed, would help only the very poorest. Neither plan would do anything for seniors with modest, middle-class incomes between \$15,000 and \$50,000. That's nearly half of all seniors; and most of them lack dependable drug coverage as well. It would be wrong, I think, to deny them that choice.

There is no better time to get this done. Our economy is strong; our people are infused with a sense of purpose. Our balanced budget gives us a once-in-a-lifetime opportunity – not only to pay down the debt, but to lengthen the life of Social Security and Medicare, and to modernize Medicare with a long-overdue, voluntary prescription drug benefit. Today, we take a significant step toward that goal; and if we keep working together, I believe we will reach it. Thank you.

Revised Final 5/25/00 9:20am
Edmonds

PRESIDENT WILLIAM J. CLINTON
REMARKS ON PRESCRIPTION DRUGS
THE WHITE HOUSE
MAY 25, 2000

Good morning. I have just had a very productive meeting with Democratic leaders from both the House and Senate. Before I discuss the substance of our meeting, I would like to announce new evidence that shows that our strategy of fiscal discipline, investment in our people and expanded trade is working. Revised GDP figures released today confirm that our economy grew at 5.4 percent in the first quarter.

Our commitment to fiscal discipline has contributed to strong growth and investment for 7 consecutive years. We are now in the midst of the longest economic expansion in history. We should stay on the path that got us here – not endanger it with a risky tax plan that would undermine our prosperity.

We should use this moment of unprecedented prosperity to strengthen Social Security, lengthen the life and modernize Medicare, and invest in key priorities like education and paying down the debt by 2013.

In the meeting that we just concluded, we discussed one of those key priorities – providing prescription drug coverage for America’s seniors. We pledged to redouble our efforts to pass legislation this year that will provide affordable prescription drug coverage for the tens of millions of seniors and people with disabilities who depend on Medicare. I want to thank Senator Daschle, Congressman Gephardt and all the leaders here who are standing with us on this important issue.

This is more than a show of unity – it is a demonstration of resolve. There is simply no reason why this Congress cannot take the necessary steps to ensure that every older American has access to the life-saving and life-enhancing prescription drugs they need.

A few weeks ago, Senator Daschle and Congressman Gephardt stood with me here to announce that the Democrats in Congress were united behind a single plan for prescription drug coverage. Today, they are joined by the leading architects and backers of that plan to call on the entire Congress to unite on behalf of the American people.

There really is no argument about the need for a prescription drug benefit. If we were creating Medicare today, we would certainly include a benefit to give older Americans and people with disabilities access to the most cost-effective health care available.

Prescription drugs not only help keep seniors healthy, they help prevent expensive hospital stays and surgical procedures – and most importantly, they promote the dignity and quality of life that we all want for our parents and for ourselves.

But, today, more than three in five American seniors lack dependable prescription drug coverage.

And the cost of prescription drugs is taking too big a bite out of the fixed incomes of too many seniors. Too many of them are forced to choose between filling their prescriptions and filling their grocery carts; and too many are simply not getting the medicines they need.

America's seniors deserve better. No older American should have to forgo or cut-back on life-saving medication because he or she can't afford it. And no one should be forced to take a bus trip to Canada, where medicines made in the United States are often sold for much less.

That's why my budget continues our efforts to pay off the debt by 2013, make Medicare more competitive, while also providing voluntary prescription drug coverage to all Americans.

I am pleased that there is growing bipartisan support for creating a new prescription drug benefit. In fact, earlier this month, Republican leaders in the House put forth the outlines of a plan with the stated goal of providing access to affordable coverage for all seniors.

Unfortunately, to date their vague policy falls far short of its grand promise. But when it comes to the health of our seniors, we can't fall short.

Suggesting a private insurance drug benefit that the insurers themselves say they won't offer is nothing more than an empty promise. And limiting direct financial assistance for prescription drugs to seniors with incomes below \$12,500 will leave out over half of those seniors without drug coverage – the majority of whom are middle income Americans. Any plan that is not available and accessible to all and not affordable to all is not a real plan at all.

Next week, as members of Congress head out for another recess, they should remember that the health care needs of our seniors never take a day off.

Protecting them is our full-time obligation. So, I say to the Congressional majority, this isn't a partisan issue outside of Washington. Work with us to provide a real prescription drug benefit that is worthy of our seniors and worthy of the great nation we are. We also must work together on other pressing priorities – investing in education, raising the minimum wage, passing common sense gun legislation, opening new markets in our hardest-pressed communities, expanding health insurance, and passing a strong, enforceable patients' bill of rights.

Today, the House and Senate conferees are meeting yet again on the patients bill of rights. The American people have waited too long for this legislation.

The time for the conferees to conclude their work has come. Send me a strong bill and I'll sign it.

Now, I'd like to ask leaders Gephardt and Daschle to say a few words...

PRESCRIPTION DRUGS AND MEDICARE:

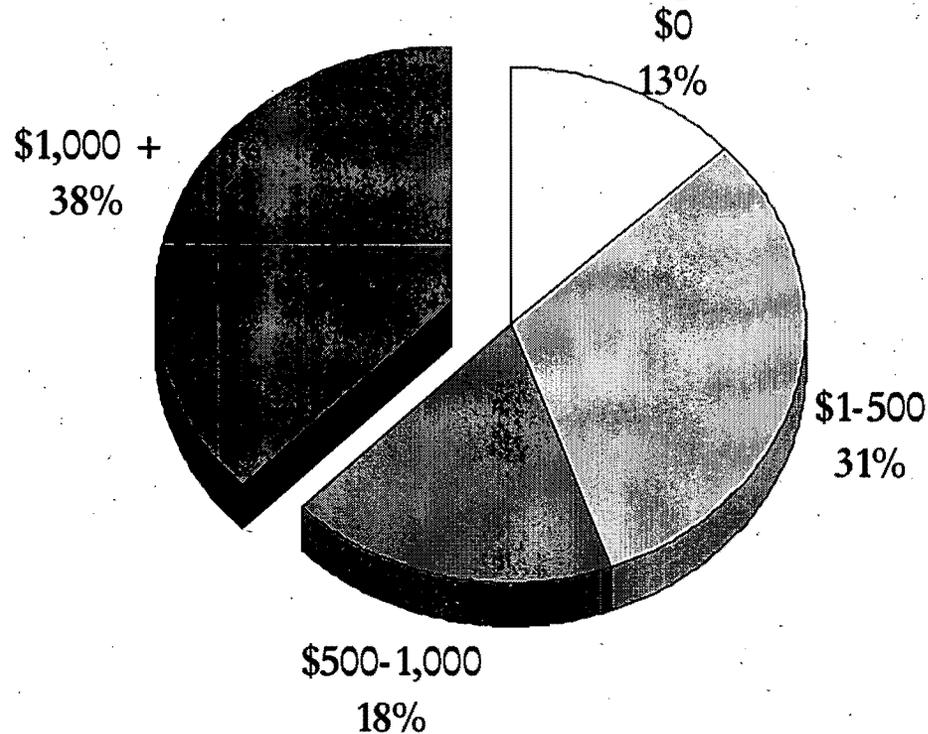
- I. Insurance Gaps for Medicare Beneficiaries**
- II. Implications of Lack of Drug Coverage**
- III. President's Principles**
- IV. Design Issues**
- V. Major Concerns**

May 24, 2000

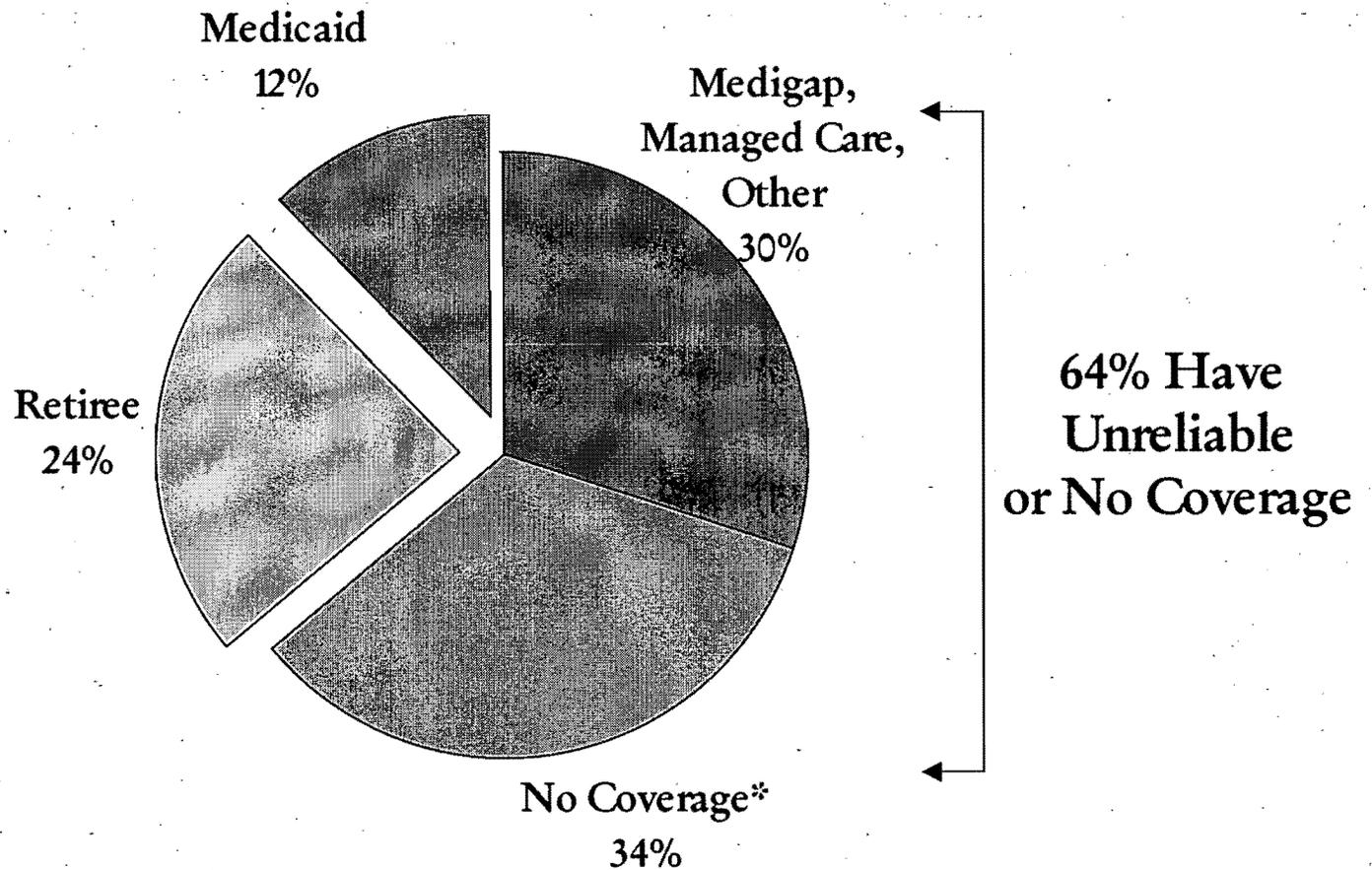
I. INSURANCE GAPS FOR MEDICARE BENEFICIARIES

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

Beneficiaries By Total Drug Spending, 2000

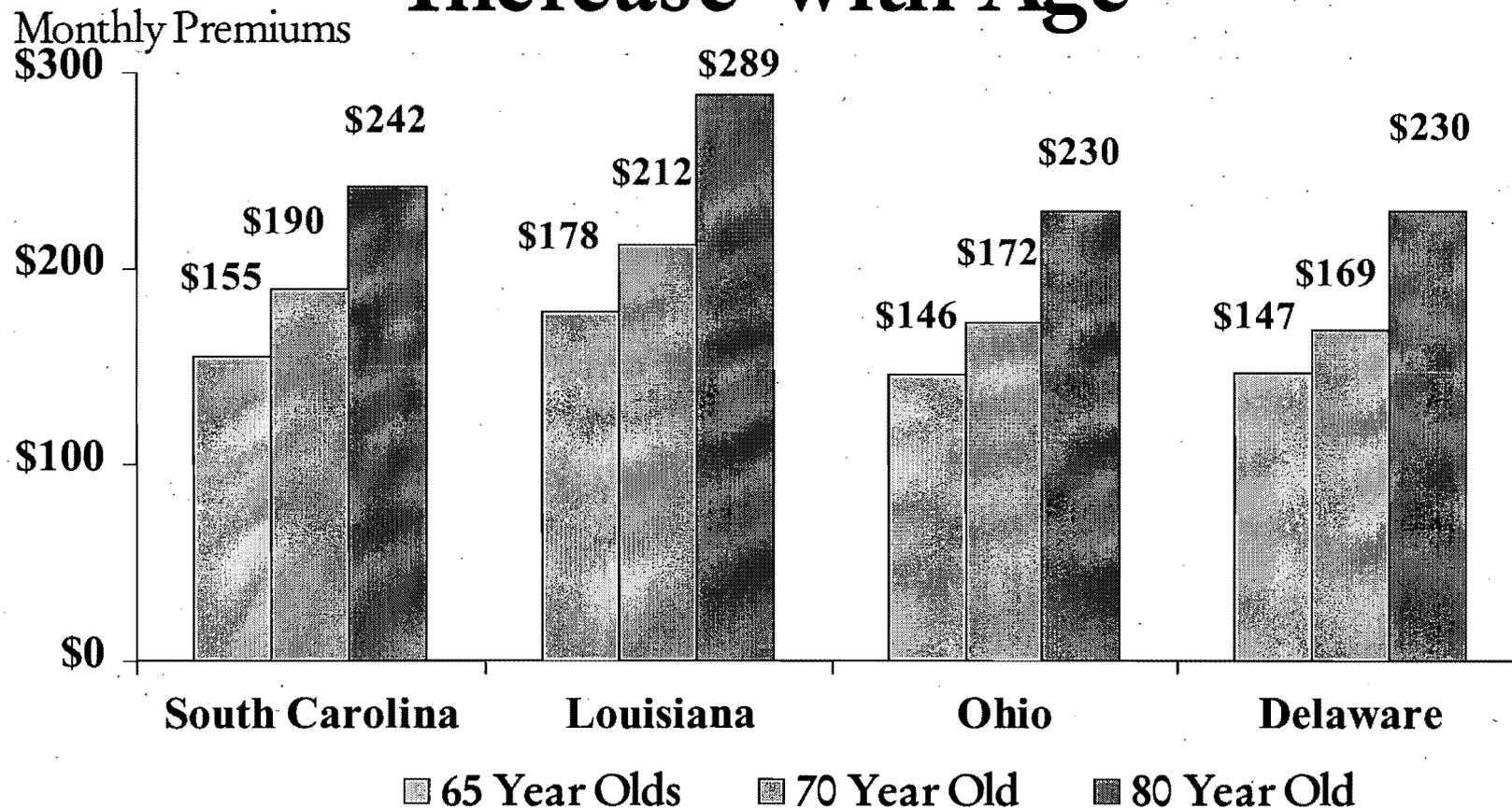


Over 3 in 5 Beneficiaries Do Not Have Dependable Drug Coverage



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

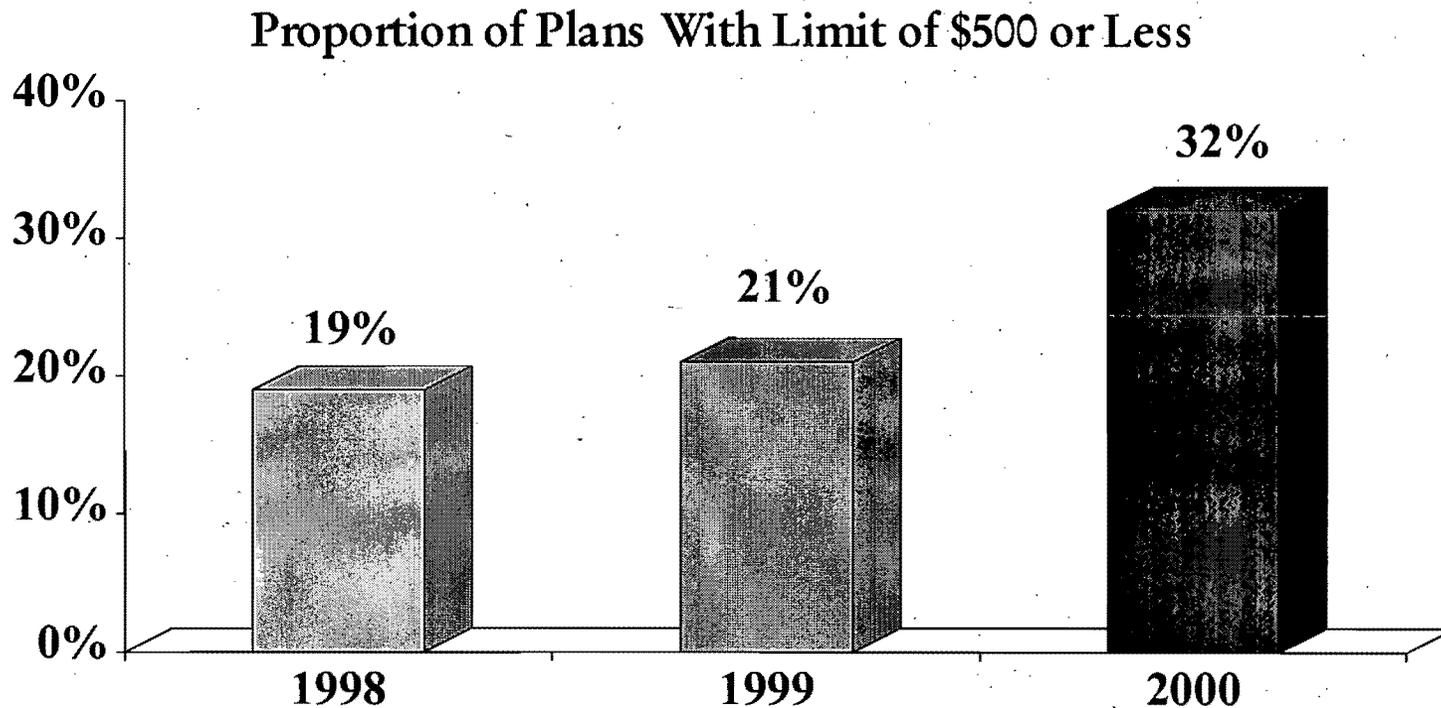
Medigap Premiums For Plans Including Drugs Are High And Increase With Age



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

Caps on Medicare Managed Care Drug Benefit Are Getting Lower

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



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

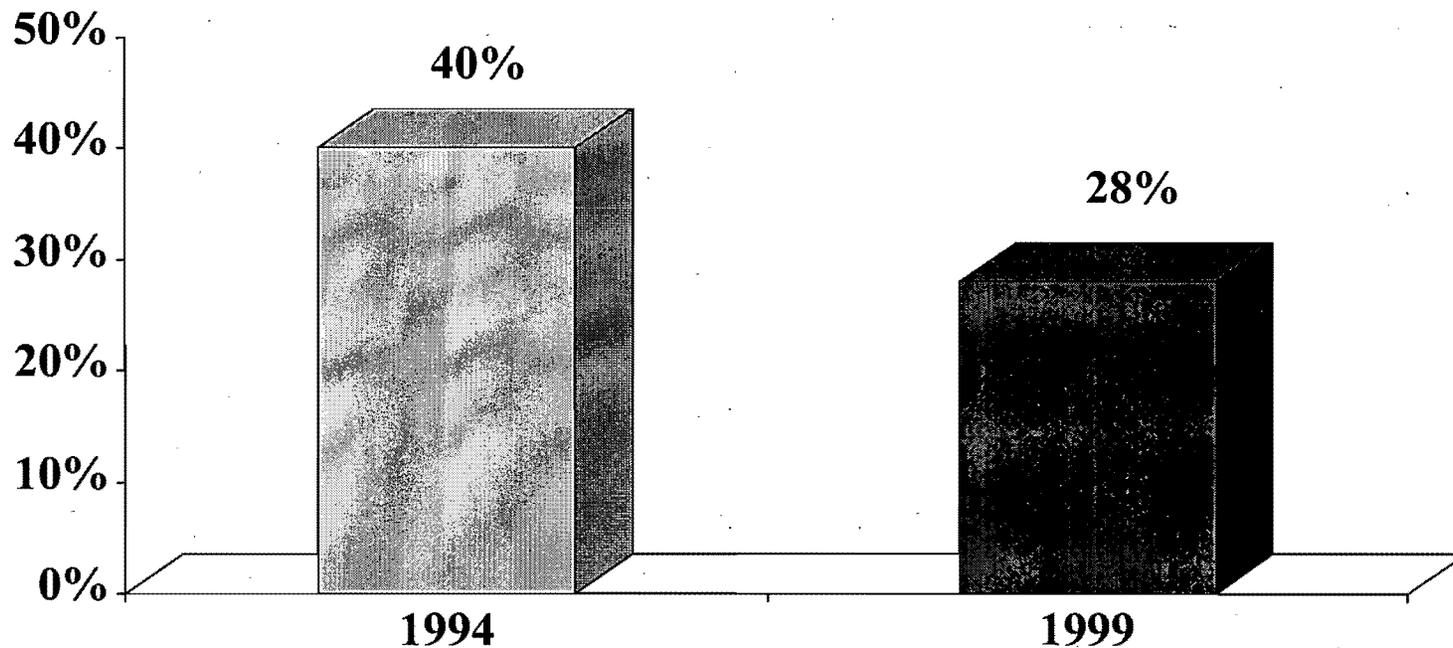
Source: HHS analysis of plan submissions for 2000; preliminary. Plans with unlimited generics and limited brand name drug spending are included with plans that cap all drug spending.

Retiree Health Coverage Is Declining

30% Fewer Firms Are Offering Retiree Health Benefits

Over Time, Will Result in Fewer Retirees Having Employer-Based Coverage

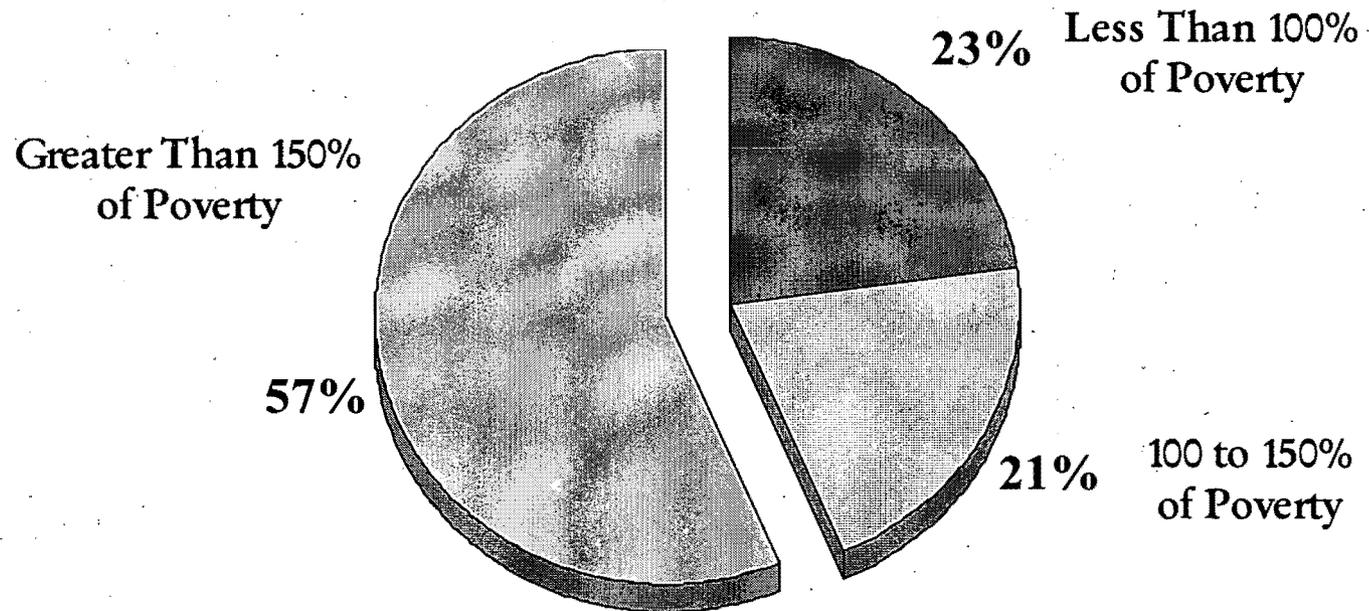
Firms Offering Retiree Health Coverage



Most Uninsured Are Not Low-Income

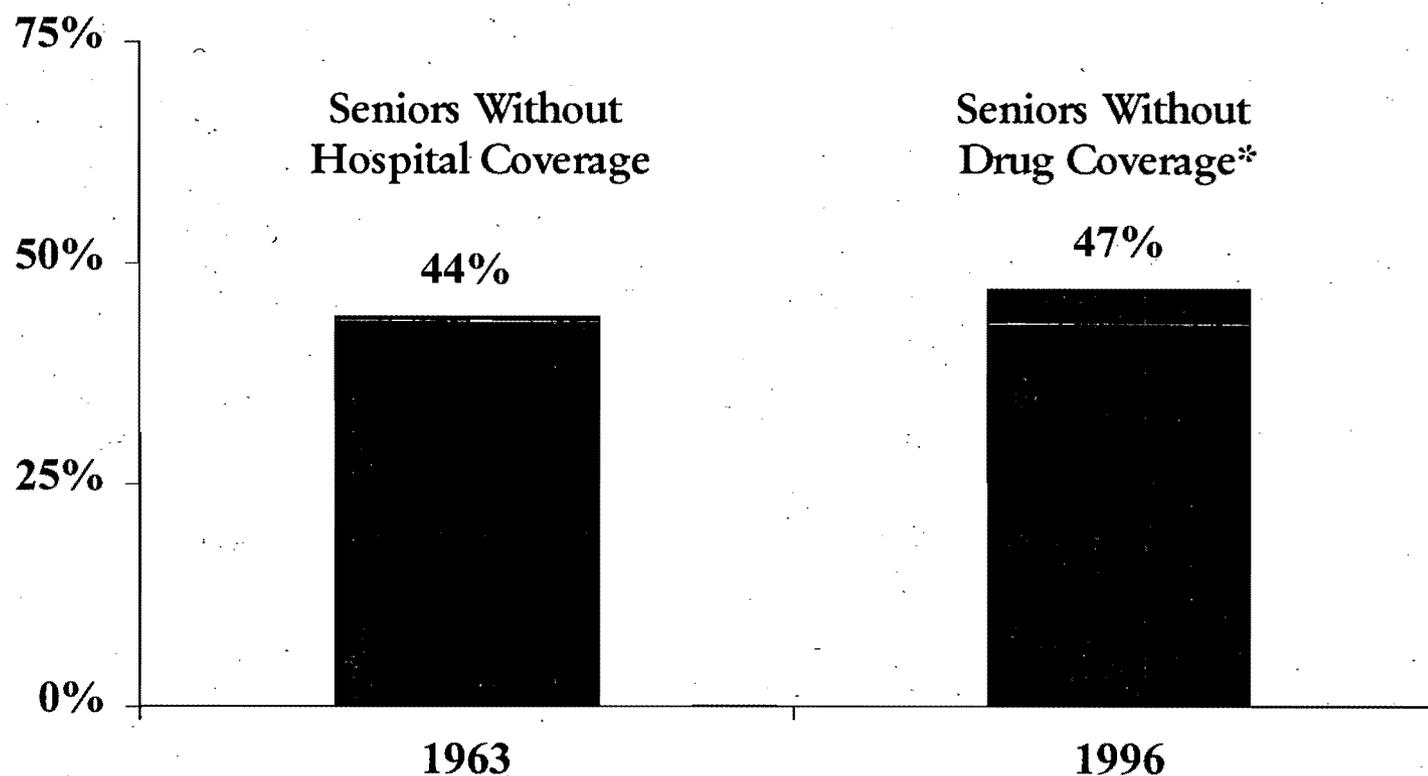
Over Half of the 12 Million Medicare Beneficiaries Who Lack Drug Coverage Have Incomes Greater Than 150 Percent of Poverty (nearly \$17,000 for a couple)

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



SOURCE: Data from DHHS (April 2000). Prescription Drug Coverage, Spending, Utilization, and Prices. Washington, DC: U.S. DHHS⁷
In 2000, 150 percent of poverty for a single person is about \$12,525, for a couple is about \$16,875

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



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

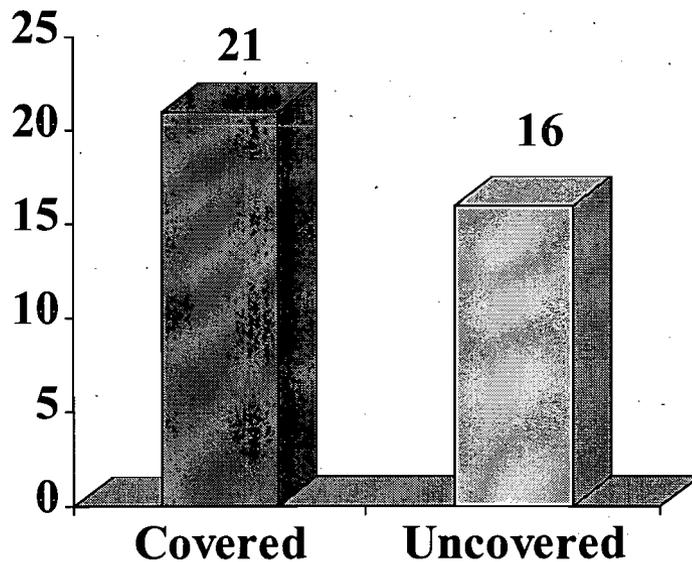
SOURCES: Moon, (1996) "What Medicare Has Meant to Older Americans," Health Care Financing Review.

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

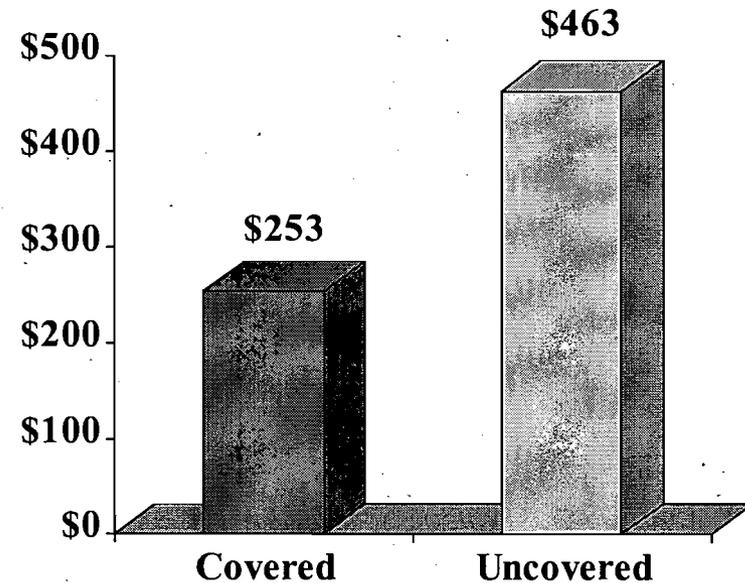
II. IMPLICATIONS OF LACK OF DRUG COVERAGE

Those Lacking Drug Coverage Pay More for Less

Uncovered Fill Nearly 30%
Fewer Prescriptions...

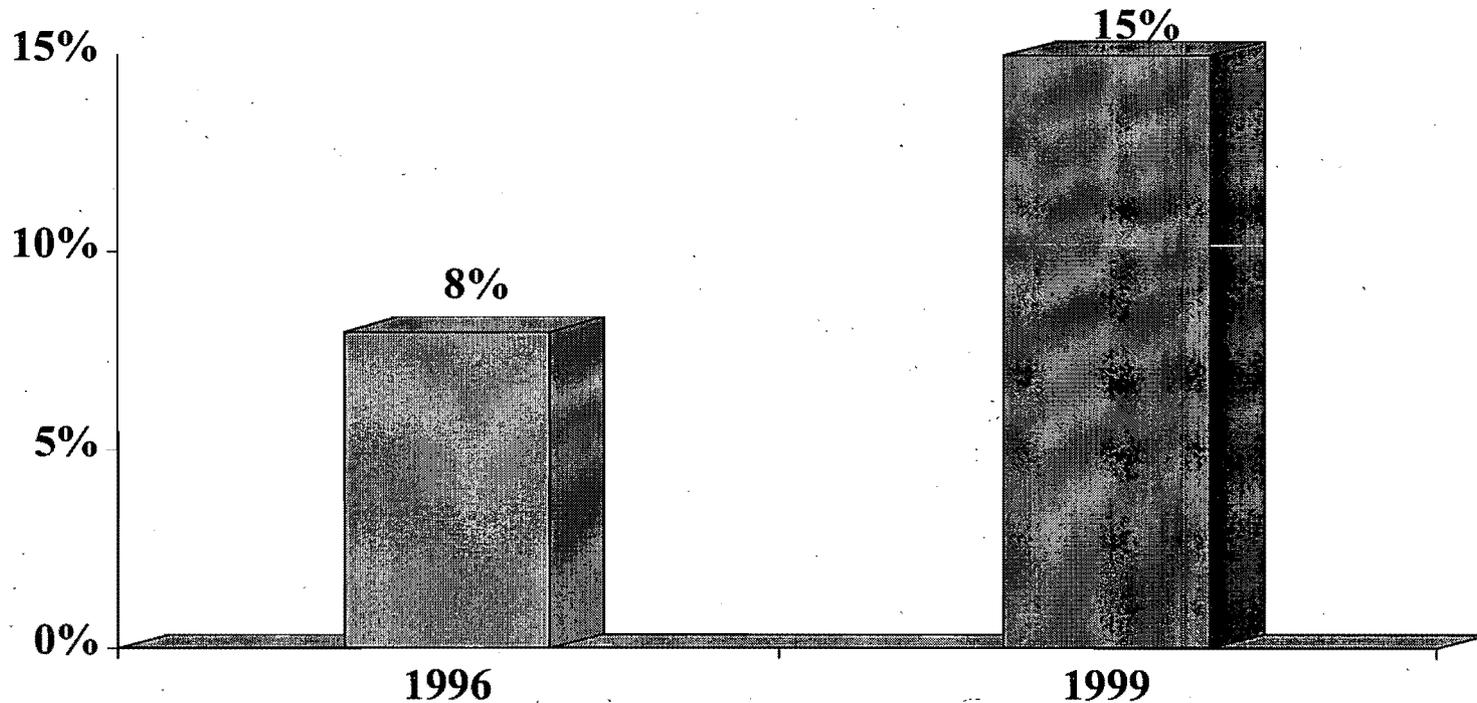


But Pay 83% More Out-Of-Pocket For Drugs



Retail Price Gap for Seniors With and Without Insurance Has Doubled

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



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

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

Similar to AARP

III. PRESIDENT'S PRINCIPLES

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

IV. DESIGN ISSUES

- **Specifics on benefit design**
 - Deductibles, copays, benefit cap
 - Level of stop-loss
 - Whether there is a gap between a benefit cap and stop-loss
- **Level of premium subsidies**
 - Higher than 50 percent premium assistance
 - Better low-income protections
 - Income-related premium
- **Nature of contracting with private benefit managers**
 - Number of regions, entities ^{could be more regions} [multiple]
 - Standards for competitive contracting (e.g., minimum requirements for managers, criteria used in awarding competitive contracts)
 - Ways to encourage innovative quality improvement and education
- **Approach to assuring managed care, retiree options**
- **Broader reforms**

V. MAJOR CONCERNS

Reliance on Private Insurance Plans

- **Access not assured:** No proposal mandates plans to participate or that participating plans accept all seniors or people with disabilities.
- **Premium subsidies are vouchers:** No proposal pays a percent of a premium for private plans, since this creates an incentive to increase premiums. Instead, they pay a fixed amount which puts beneficiaries at risk. Beneficiary premiums will vary from plan to plan and from area to area - and, without insurance reforms, by health status and age in most states. -59
- **Full risk payment for plans results in risk for beneficiaries:** Plan will either raise premiums to compensate for potential risk selection or try to avoid high-risk seniors and people with disabilities. Plans may also close formularies and restrict pharmacy access to reduce costs if at risk.
- **Breaks up purchasing pools:** Private insurance models rely on competition for beneficiaries rather than pooled purchasing power to get price discounts.

* IBM will set up market / M.J. SA ITC

Lack of A Defined Benefit (Actuarial Value)

- **Hurts high-risk beneficiaries:** Letting private insurers rather than public policy determine deductibles, copays, and stop-loss levels results in confusion and risk avoidance. This happened in Medigap prior to reforms and Medicare managed care today.
- **Hinders informed choice and competition:** Health policy experts agree that informed choices and fair competition cannot occur without some standardization of benefits.
- **“Pig in a poke”:** Beneficiaries, Congress, and taxpayers do not know what they are buying in an actuarial value model.

Inadequate Surplus Dedication

- \$40 billion over 5 years:
 - Not all for prescription drug benefit
 - No commitment to out-year funding
 - Additional surplus committed to debt reduction
- Creates false dynamic of pitting providers against a prescription drug benefit -- despite unprecedented resources.

Withdrawal/Redaction Marker

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View Related Topics

May 27, 2000, Saturday, Late Edition - Final

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LENGTH: 847 words

HEADLINE: Bipartisan Effort on Drug Coverage Is Begun

BYLINE: By ROBERT PEAR

DATELINE: WASHINGTON, May 26

BODY:

An influential Republican member of the House and a Democratic senator announced today that they would collaborate on a bipartisan effort to add **prescription drug** benefits to **Medicare** this year.

The effort, by Representative Bill Thomas, Republican of California, and Senator Ron Wyden, Democrat of Oregon, alters the politics of the issue in this election year, at least marginally increasing the chances that Congress can break the deadlock on **Medicare** coverage of **prescription drugs**.

"There needs to be a bipartisan, bicameral effort to move on this issue before the end of this session," said Mr. Thomas, who has authority over **Medicare** as chairman of the Ways and Means Subcommittee on Health.

In effect, Mr. Wyden embraced many of the principles endorsed by House Republicans as the framework for a plan to offer drug benefits to all 39 million people on **Medicare**. In return, he got a commitment from Mr. Thomas to support several Democratic goals.

For example, Mr. Thomas agreed that drug companies should pay a fee to the government whenever they develop profitable drugs by exploiting the fruits of research subsidized by the federal government.

The Thomas-Wyden collaboration is significant for several reasons. It is one of the first serious efforts by members of opposing parties to find common ground on **Medicare** drug benefits. Until now, President Clinton and Democrats have pushed their proposals and attacked Republican ideas as inadequate, while Republicans have belittled the Democratic proposals.

A Senate Democrat expressed concern about possible political consequences of today's announcement, saying, "This will blur the lines between Republicans and Democrats on what is one of the Democrats' best election issues."

Mr. Thomas and Mr. Wyden are considered experts on health policy. Each shares the politics of his party leaders and the dominant faction in his party; neither is a maverick.

Mr. Wyden has a liberal voting record and has long been an advocate for the elderly. As a young lawyer, he led the Oregon chapter of Gray Panthers. He was immersed in health care issues for 15 years as a member of the House.

Mr. Thomas has become the point man for House Republicans on health policy, the person who explains the intricacies of **Medicare**. He is an architect of a House Republican proposal, outlined last month, that would use private insurance subsidized by the government to help pay drug costs for the elderly.

John P. Feehery, a spokesman for Speaker J. Dennis Hastert of Illinois, described today's announcement

as "a welcome development." Congressional aides said the Senate Democratic leader, Tom Daschle of South Dakota, had urged Mr. Wyden to be cautious in dealing with the Republicans. But Molly Rowley, a spokeswoman for Mr. Daschle, said the joint effort could "add some sense of urgency, some traction and increase the likelihood that legislation will be passed this year."

Mr. Thomas and Mr. Wyden said they would not write a bill of their own; but would continually work with each other to push legislation. In effect, they have opened a channel for communication and cooperation between the parties.

The two lawmakers endorsed these principles:

*Coverage of **prescription drugs** should be guaranteed as "an entitlement" to any **Medicare** beneficiary who wants it. (Democrats insist on an entitlement.)

***Medicare** drug benefits should be supervised by the Department of Health and Human Services, but probably not by the Health Care Financing Administration, the much-criticized agency that now runs **Medicare**.

*The government should help pool the purchasing power of **Medicare** beneficiaries so they can obtain discounts on drugs, like the discounts negotiated by health maintenance organizations and other big buyers.

*The government should pay most of the drug costs of people with very high drug expenses. This subsidy would reduce premiums for everyone by reducing the total costs that must be covered by premiums.

*The United States should discuss drug prices as an issue in trade negotiations with Canada and other countries that regulate such prices. Such discussions might find ways to reduce the disparities, thus reducing the incentive for United States residents to cross the border to get less costly drugs.

Chris Jennings, the president's health policy coordinator, said he did not know enough about the Thomas-Wyden effort to comment. "I don't think there are any details," he said.

Mr. Thomas and Mr. Wyden did not say what premiums would be charged for drug coverage. They did agree that some of the cost should be defrayed by drug companies.

"Chairman Thomas, for the first time, has agreed to require that drug companies pay a return-on-investment fee to the **Medicare** trust fund when they profit from government-funded research," Mr. Wyden said. "Again and again, taxpayers have put up the dollars to fund the critical early research that brings blockbuster drugs to the market. It's only fair that these taxpayer investments be recognized through compensation by the company to our government."

<http://www.nytimes.com>

GRAPHIC: Photo: Representative Bill Thomas, Republican of California, right, and Senator Ron Wyden, Democrat of Oregon, announcing their plan yesterday. (Susana Raab for The New York Times)

LANGUAGE: ENGLISH

LOAD-DATE: May 27, 2000

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**PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP URGE THE CONGRESS
TO ACT NOW A MEDICARE PRESCRIPTION DRUG BENEFIT AND OTHER
NATIONAL PRIORITIES**

May 25, 2000

Today, the President will meet with the Democratic leadership of both the House and Senate to discuss how they could work together to address a number of national priorities that have been unnecessarily delayed to the detriment of the health, safety, and economic security of the nation. In addition to discussing strategies for the passage of a strong, enforceable, Patients' Bill of Rights, common sense gun safety legislation, and a simple \$1 increase in the minimum wage, they will focus on the need to pass a voluntary, affordable Medicare prescription drug benefit available to all beneficiaries. The President will underscore his strong belief that a united Democratic party can help produce a strong prescription drug benefit that receives broad based, bipartisan support, and he will emphasize that the Congress should act on all of these national priorities this year. Finally, the President will reiterate that he welcomes the Republicans' stated goal of developing a prescription drug benefit for all Medicare beneficiaries, but he will highlight why the approaches outlined to date do not achieve this goal.

**MILLIONS OF MEDICARE BENEFICIARIES HAVE NO OR UNDEPENDABLE
PRESCRIPTION DRUG COVERAGE.** Millions of seniors and Americans with disabilities have no prescription drug coverage and millions more are at risk of losing coverage. Millions of Medicare beneficiaries have no prescription drug coverage. Millions more are at risk of losing coverage or have inadequate, expensive coverage.

- **Most older Americans without prescription drug coverage are middle-class.** Over half of the millions of Medicare beneficiaries who lack drug coverage have incomes greater than 150 percent of poverty (\$12,525 for a single, nearly \$17,000 for a couple). Seniors without drug coverage fill 30 percent fewer prescriptions than those with coverage, but pay 83 percent more out-of-pocket for drugs. In addition, not even counting manufacturers' rebates, prescription drug prices for those without coverage are typically 15 percent higher than prices paid on behalf of people with coverage. This price gap almost doubled between 1996 and 1999.
- **Current prescription drug coverage is unstable and declining.** Over three in five beneficiaries do not have dependable drug coverage. The number of firms offering retiree health insurance coverage dropped by 30 percent between 1993 and 1999, and Medigap premiums have been rising at double-digit inflation. While Medicare managed care plans usually offer some drug coverage, it is typically limited. The number of plans with a drug benefit below \$500 has increased by 50 percent over the past two years. In addition, 11 million beneficiaries, who disproportionately reside in rural areas, have no access to managed care plans.

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

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

Democratic Caucus supports the passage of a new prescription drug benefit that is:

- **Voluntary and Accessible To All Beneficiaries.** A new benefit should ensure that all beneficiaries can access prescription drug coverage, whether they are in traditional Medicare, managed care, or a retiree health plan. Employers will receive financial incentives to provide retiree coverage and maintain existing coverage.
- **Designed To Give Beneficiaries Meaningful Protection.** The proposal would provide a benefit that covers half the cost of prescription drugs up to \$5,000 limit when fully implemented and would provide additional protections against catastrophic prescription drug costs. In addition, it would use market-based purchasing mechanisms to achieve discounts for the price of medications.
- **Affordable To All Beneficiaries And The Program.** Under the plans, Medicare will contribute at least 50 percent of the prescription drug premium to make it affordable for all beneficiaries. The plans will also include special protections for low-income beneficiaries; those with incomes below 135 percent of the poverty level will receive full coverage of cost sharing and premiums; and those with incomes between 135 and 150 percent of poverty will receive premium assistance on a sliding scale.
- **Administered Using Private Sector Entities And Competitive Purchasing Techniques.** Private sector entities will negotiate prices with drug manufacturers and administer the benefit, the same as most private insurers. Drugs will be purchased at privately negotiated rates, giving beneficiaries the bargaining power they lack today. As a result, beneficiaries will not only receive prescription drug coverage for the first time, they will receive better prices for their drugs.

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

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

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View Related Topics

May 29, 2000, Monday, Home Edition

SECTION: Health; Part S; Page 1; View Desk

LENGTH: 2191 words

HEADLINE: OUT OF REACH?
THE RISE IN DRUG PRICES IS CAUSING THE PUBLIC TO ASK WHY. THE REASONS
INCLUDE THE HEFTY RESEARCH COSTS, CONSUMER ADVERTISING AND THE GROWTH
OF MANAGED CARE.

BYLINE: LINDA MARSA, SPECIAL TO THE TIMES

BODY:

Dorothy and Clarence Cardella, a retired couple in their 70s living in Pasadena, pay more than \$ 300 a month out of pocket for **prescription drugs** to maintain their health. Clarence has had two heart surgeries and requires costly medications, while Dorothy takes drugs to treat her diabetes and a thyroid condition.

Medicare covers their doctor bills and any hospital visits, but the federal health program doesn't cover prescriptions. While the Cardellas' household income is fixed, the cost of their medications is anything but: The prices just keep going up.

Recently, Dorothy's doctor suggested a new insulin drug for her diabetes. It costs \$ 230 a month. The cash-strapped Cardellas can't afford it, so Dorothy's doctor has given her free samples.

"At this rate," she says, "we'll soon be broke."

The Cardellas' situation is hardly unique. **Prescription drug** prices are rising much faster than the rate of general consumer inflation. The burden for this ballooning bill falls most heavily on those who can least afford it--older Americans living on fixed incomes, and the working poor with inadequate or no health insurance.

Most Americans don't feel the rise in drug prices directly because they purchase prescription medicines through their employee health plans or their HMOs, where they don't pay the full price, often making only a \$ 10 or \$ 20 co-payment. The rise in drug prices does hit this group indirectly: Many health insurers have blamed higher drug costs as the reason behind hikes in medical premiums or restriction of benefits.

But drug inflation is felt most keenly by people like the Cardellas, who are among an estimated 15 million **Medicare** recipients who pay out-of-pocket for arthritis medications that ease their pain, or heart drugs that help them stay alive. (The Cardellas could get drug coverage by joining a **Medicare** HMO, but they have long-standing relationships with doctors who aren't in HMOs.) So they and millions of others essentially pay retail for their medications. And it is this group of people that has prompted consumer groups, politicians and the elderly to question why medicines cost so much and why prices keep going up.

Are there legitimate reasons behind this trend? Or are we just being gouged? Experts say there are a host of factors nudging prices upward, including the shift of patients into HMOs, and increased costs for advertising and research and development.

One reason why retail prices are going up is the rise of managed care, which now covers 60% of the insured population in the United States and an even higher percentage in California. Large HMOs and other managed care plans use their bargaining clout to demand discounts when they make bulk purchases of **prescription drugs**. Pharmaceutical companies, critics say, have tried to recoup some of this lost revenue by charging more to patients who have no one to bargain on their behalf--people without drug coverage who must pay full retail prices. This practice is known in the health industry as cost shifting.

Another factor is that the new generation of designer drugs is expensive to produce. When Genentech introduced Activase, a genetically engineered drug that dissolves artery clots that can cause heart attacks, the price was \$ 2,200 a dose. Company officials defended the cost, citing very high research and development expenses. Creating a complex, genetically engineered drug versus producing a conventional drug is like the difference between making a \$ 20 watch and crafting a fine Swiss timepiece.

Indeed, the process of taking a drug from the laboratory to the patient's bedside is a lengthy one, requiring as much as 15 years and costing from \$ 300 million to \$ 500 million. And success is not guaranteed. Often there is a vast difference between how a compound behaves in the test tube and how it acts on humans.

New drugs typically require three phases of tests on human subjects to demonstrate that they work and don't produce serious side effects. Most therapies founder along the way, perhaps proving less effective on humans than when tested on animals, or producing unexpected toxic effects. Only one medicine out of five makes it through human clinical tests, said Jeffrey Trewhitt, a spokesman for the Pharmaceutical Research and Manufacturers of America, an industry trade group in Washington, D.C.

For drug companies, these research duds are a necessary cost of doing business, much as a dry well is to an oil-exploration company. The drug makers argue, however, that prices for the one in five therapies that do make it to market must compensate for the costs associated with those that don't. Consequently, the successful drugs have higher prices. How exactly pharmaceutical firms set prices for a particular drug is a closely guarded trade secret; it's safe to say, however, that the price often bears little relation to development or manufacturing expenses for the that product.

When new drugs are patented, competitors are prohibited from copying the drug for 17 years. Because it may take 10 years or so from the time of patent for a new drug to reach the market, however, the patent protection may be lost several years after the drug actually goes on sale. The idea behind patent protection is that it encourages innovation by giving companies the market to themselves for a while so they can recoup their development costs.

"While drugs are under patent, pharmaceutical companies act like any other monopoly and charge what the market will bear," says Jeffrey McCombs, a pharmaceutical economist at USC. "But that doesn't make them bad guys."

And drug makers' pricing practices aren't much different from those of other industries that have a monopoly. What is different, though, is that even when rival products are introduced, prices usually don't tumble. What's more, prices of older drugs continue to rise, even after, presumably, they've made their money back. That's because a drug's effectiveness--how well it works--not cost, is the key selling point when it comes to medicine.

Consequently, the drug companies shelled out \$ 8.3 billion in 1999 for advertising and promotion in order to influence treatment decisions. Physicians are barraged by information aimed at convincing them that a particular drug is the best. Pretty soon, these new treatments become the accepted standard practice. And even when equally effective drugs that cost less are introduced, doctors tend to continue giving their patients the more expensive medicine, which means prices remain high.

In recent years, drug companies have also boosted efforts to pitch their products directly to consumers in TV, radio, magazines and newspaper ads to create brand-name awareness. In 1999, the industry spent

nearly \$ 2 billion to persuade patients to ask their doctor about products such as Zyrtec and Allegra, both allergy treatments, and Premarin, an estrogen supplement for post-menopausal women.

This strategy seems to work. According to a 1999 study by the National Institute for Health Care Management, the 10 most heavily advertised drugs accounted for about 22% of the total increase in drug spending between 1993 and 1998. But a byproduct of these promotional campaigns, says Frank Clemente of Public Citizen, a consumer health watchdog group in Washington, D.C., is that "the most heavily advertised drugs are the ones whose prices increased the most."

Consumer Groups Push for Controls

The continued rise in **prescription drug** costs has touched off intense political debate on how best to give people like the Cardellas relief. Some politicians and consumer groups have pushed for some form of price controls. Not surprisingly, drug companies oppose price regulation. They contend it would curtail innovation in an industry that invests upward of \$ 24 billion annually on research.

"The drug companies," says William S. Comanor, a pharmaceutical economist at UCLA, "are not going to spend the \$ 300 million or so it takes to develop a drug if the government is telling them what to charge."

Others, though, say this is a scare tactic.

"If there are reduced revenues, it might have some impact on research and development," says Ronald Pollack, executive director of Families USA, a consumer health group in Washington, D.C. "But the drug makers have far more latitude than they would have you believe."

Pollack and others note that the pharmaceutical industry is the most profitable industry in America--with a level of profits that is three times higher than that of many Fortune 500 companies. Drug makers insist that such hefty profits are needed to pay for research that could produce therapies or cures for cancer, Alzheimer's disease and a host of other illnesses.

Says Trewhitt of the drug industry trade group: "It's very important to get a decisive return on investments. Otherwise, people won't put their money in research-dependent ventures that have such a high failure rate."

Taxpayers Shoulder Much of the Risk

But is that accurate? The reality is that U.S. taxpayers--not the companies and their shareholders--are shouldering a lot of the risk. The federal government pays for the bulk of the research by funding studies by the National Institutes of Health and through grants to academic research centers, such as USC and UCLA. This money pays for much of the highly speculative basic scientific research that results in quantum leaps forward in our understanding of diseases. And these discoveries become the springboard for devising new therapies.

In contrast, most drug company research is aimed at developing products, not basic research, said Public Citizen's Clemente. And much of the research backed by corporations is aimed at developing "copycat" drugs to compete with successful medicines, rather than on basic research, he said.

A 1995 Massachusetts Institute of Technology study found that 11 of 14 new drugs introduced in the prior 25 years that were considered significant therapeutic advances were derived--at least in part--from government-funded research.

So are drug prices inflated? The answer depends upon whom you ask. Drug company executives and some health care economists argue that even the costliest medications are an incredible bargain. Many breakthrough drugs have revolutionized medicine, they say, enhancing the quality of life, leading to shorter and less costly hospital stays, and putting patients back on their feet faster.

The average heart disease medication, for instance, costs \$ 1,200 a year. That, however, is far cheaper than a \$ 40,000 bypass operation, not to mention the inestimable benefits of avoiding surgery.

But Dorothy Cardella, like many other older Americans, is fed up.

"The situation is really depressing," she says. "Every time I turn around, it's more bills with no end in sight."

(BEGIN TEXT OF INFOBOX / INFOGRAPHIC)

Targeting Consumers

The federal government used to prohibit the advertising of **prescription drugs** directly to the public. But several revisions to federal rules between 1985 and 1997 have led to a dramatic increase in direct-to-consumer advertising by drug companies. Here is a list of the top 10 drugs, ranked by how much money was spent on TV, newspaper, magazine and other advertisements aimed at consumers.

Rank (1999)	Product Name (use)	Consumer Advertising (in million of dollars)
1	Claritin (allergy)	\$137
2	Propecia (hair loss)	99
3	Viagra (impotence)	93
4	Prilosec (anti-ulcer)	79
5	Xenical (weight reduction)	75
6	Zyrtec (allergy)	57
7	Lipitor (cholesterol reduction)	55
8	Zyban (smoking deterrent)	54
9	Nolvadex (breast cancer)	54
10	Flonase (allergy)	53

Source: IMS Health Inc.

A Hardship on Older Americans

Older, low-income people spend a larger share of their income on medical care than do wealthier Americans. Although they would especially benefit from **prescription drug** coverage, they are also less likely to have it.

Household income	Share of older Americans without drug coverage	Income spent on health care*
Below \$10,000	35%	37%
\$10,000-\$19,999	38%	19%
\$20,000-\$29,999	32%	15%
\$30,000-\$49,000	30%	10%
\$50,000 and above	26%	6%

All 34% 13%

* (median share of household income after taxes)

Source: Health Affairs, March/April 2000, "Prescription Drugs: What's Next," Volume 19, Page 30.

Drugs Lead Rising Health Costs

Hospitals and doctors have traditionally comprised the biggest chunk of U.S. spending on health care. In recent years, however, spending on **prescription drugs** has been rising faster than other areas of health care. While **prescription drugs** accounted for about 5% of overall spending in 1992, some experts have predicted that that figure could rise to about 15% within 10 years.

GRAPHIC: PHOTO: (no caption) **GRAPHIC-TABLE:** Targeting Consumers **GRAPHIC-TABLE:** A Hardship on Older Americans **GRAPHIC:** Drugs Lead Rising Health Costs, REBECCA PERRY / Los Angeles Times

LANGUAGE: English

LOAD-DATE: May 29, 2000

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Search: General News; medicare and prescription drugs

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Example: House of Representatives

**PRESIDENT CLINTON RELEASES NEW REPORT ON THE SPECIAL
CHALLENGES FACING RURAL SENIORS WHO NEED PRESCRIPTION DRUGS
June 13, 2000**

Today, the President will release a new report from the Domestic Policy Council and the National Economic Council documenting the special challenges that the over 9 million Medicare beneficiaries living in rural communities face in accessing and affording life-saving prescription drugs. This report, prepared in response to a request from Senator Baucus (D-MT), documents that rural beneficiaries tend to have a greater need for prescription drug coverage but have fewer coverage options. Their incomes are lower, access to pharmacies more limited, and out-of-pocket spending higher. The report will highlight that the private prescription drug coverage options available to rural beneficiaries are not only severely limited, but extremely expensive. The President will stress that it makes little sense to build on flawed private options like Medigap, such as the approach reportedly being advocated by the House Republicans today. Instead, he will urge Republicans to work with him to design a meaningful Medicare prescription drug benefit that provides an affordable and dependable coverage option available to all beneficiaries.

RURAL BENEFICIARIES HAVE A GREATER NEED FOR, BUT ARE LESS LIKELY TO HAVE, PRESCRIPTION DRUG COVERAGE. Rural Medicare beneficiaries, who represent nearly one-fourth of the Medicare population, have lower incomes, more limited access to pharmacies, and higher out-of-pocket expenditures than their urban counterparts. Key findings of the report the President is releasing today include:

- **Rural beneficiaries pay more for prescription drugs than urban beneficiaries, and are more likely to go without needed medication because of cost concerns.** Rural beneficiaries are over 60 percent more likely to go without prescription medication because of cost concerns than urban beneficiaries. In addition, because rural beneficiaries pay over 25 percent more out-of-pocket on prescription drugs than urban beneficiaries, they spend a greater percentage of their income on these medications on average.
- **Rural elderly are more likely to have high out-of-pocket spending than urban seniors, even among the chronically ill.** About one-third of rural seniors versus 25 percent of urban beneficiaries have out-of-pocket spending that exceeds \$500. This difference remains even when looking only at older Americans with heart disease, hypertension, stroke and cancer: about 45 percent of these rural seniors have out-of-pocket spending that exceeds \$500 compared to 36 percent of chronically ill urban seniors.
- **Rural Medicare beneficiaries are 50 percent less likely to have any prescription drug coverage.** The proportion of rural beneficiaries who lack drug coverage for the entire year is 43 percent compared to 27 percent in urban: This lack of coverage is even more dramatic when looking those who are uninsured for part of the year. [About 57 percent of rural Medicare beneficiaries do not have prescription drug coverage for all or part of the year, compared to 44 percent of urban beneficiaries.] In addition, the oldest rural seniors are particularly vulnerable to lacking prescription drug coverage. Over half of rural seniors age 85 or older have no drug coverage – over 50 percent higher than urban seniors that age.

- **In rural America, most beneficiaries who lack prescription drug coverage are middle income.** Although rural seniors have lower income than urban seniors, about 45 percent of those without prescription drug coverage have income between 150 and 400 percent of poverty. They would have too much income to qualify for direct premium assistance in most proposed low-income benefits but do not have enough income to afford private insurance.
- **Rural beneficiaries are about one-third less likely to have retiree health insurance.** Only about one in four of rural seniors have drug coverage through employer-based retiree insurance, compared to 35 percent of urban seniors.
- **Less than 1 percent of rural beneficiaries are enrolled in Medicare managed care with a prescription drug benefit.** About 75 percent of rural beneficiaries do not have a managed care option, and no state has more than 30 percent of rural beneficiaries enrolled in managed care. Only one-third of rural managed care enrollees have a drug benefit in their basic benefit, and of those with drug coverage, nearly two-thirds have coverage limit of \$1,000 or less for brand name and/or generic drugs.
- **Due to lack of alternatives and the critical need for drug coverage, rural seniors disproportionately purchase Medigap.** About 13 percent of rural Medicare beneficiaries receive prescription drug coverage through Medigap compared to 11 percent of urban beneficiaries.
- **Premiums for Medigap for rural beneficiaries are high and increase with age.** A typical 65-year old pays about \$164 per month for a Medigap plan that includes limited prescription drug coverage. In Montana, the typical monthly premium for a Medigap plan with prescription drugs is \$126 if you are age 65, but \$184 if you are age 80 or older. On top of these high premiums, rural seniors with Medigap spend on average \$442 out-of-pocket for drug costs – 75 percent more than rural beneficiaries with retiree health coverage.

CONGRESS SHOULD WORK IN A BIPARTISAN FASHION TO DRAFT A MEANINGFUL MEDICARE DRUG BENEFIT. The President will call on the Congress to work together on a plan that is designed to cover people – not provide political cover. He will raise concerns about reports of the Republican plan being released today that would use a flawed Medigap-like model that could neither be assured to be available nor affordable to all Medicare beneficiaries.

THE PRESIDENT'S PLAN EXTENDS PRESCRIPTION DRUGS TO ALL MEDICARE BENEFICIARIES. The President will point out that his plan provides an affordable, accessible, prescription drug benefit option to all beneficiaries. It is:

- Voluntary. Medicare beneficiaries who now have dependable, affordable coverage would have the option of keeping that coverage.
- Accessible to all beneficiaries. Beneficiaries who join the program would pay the same premium and get the same benefit, no matter where they live, through a private, competitively selected benefit manager or, where available, through managed care plans.

- Designed to give beneficiaries meaningful protection and bargaining power. A reserve fund in the President's budget helps Medicare beneficiaries with catastrophic prescription drug costs. The plan also gives beneficiaries bargaining power they now lack by utilizing private prescription drug managers to negotiate discounts that can be extracted from volume purchasing.
- Affordable to all beneficiaries and the program. According to CBO, premiums would be \$26 per month in 2003. 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.

[Faint handwritten notes and scribbles, possibly including the word "coverage" and other illegible text.]

Jeanne Lambrew
told FDA not to
give their opinion
on this —

W/c Tony Podesta

Concerns.

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES
WASHINGTON, DC 20515-6348

Prescription
Drugs

FAX

DATE: 7/14/99

TO: Chris Jennings 456-5957

FROM: Debbie Curtis

Number of pages including cover sheet 4

Here's the Archer language +
our press release. Will be
around so call if you can be
of further help.

If you have difficulty receiving this fax, please call 202/225-4021

1 SEC. 507. ABOVE-THE-LINE DEDUCTION FOR PRESCRIP-
2 TION DRUG INSURANCE COVERAGE OF MEDI-
3 CARE BENEFICIARIES IF CERTAIN MEDICARE
4 AND LOW-INCOME ASSISTANCE PROVISIONS
5 IN EFFECT.

6 (a) IN GENERAL.—Subsection (a) of section 213 is
7 amended by adding at the end the following new sentence:
8 “The 7.5 percent adjusted gross income threshold in the
9 preceding sentence shall not apply to the expenses paid
10 during the taxable year for prescription drug insurance
11 coverage of a medicare beneficiary who is the taxpayer,
12 the taxpayer’s spouse, or a dependent (as defined in sec-
13 tion 152) if—

14 “(1) the Secretary certifies that, throughout
15 such taxable year, the conditions specified in sub-
16 section (e) are met, and

17 “(2) the amount paid for such coverage is ei-
18 ther separately stated in the contract or furnished to
19 the policyholder by the insurance company in a sepa-
20 rate statement.

21 Expenses to which the preceding sentence applies shall not
22 be taken into account in applying such threshold to other
23 expenses. For purposes of this subsection, the term ‘medi-
24 care beneficiary’ means an individual who is entitled to
25 benefits under part A, B, or C of title XVIII of the Social
26 Security Act.”

OF MEDI-
ARE.

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78

1 (b) CONDITIONS.—Section 213 is amended by redес-
2 ignating subsection (e) as subsection (f) and by inserting
3 after subsection (d) the following new subsection:

4 “(e) CONDITIONS FOR SEPARATE DEDUCTION FOR
5 PRESCRIPTION DRUG INSURANCE COVERAGE.—For pur-
6 poses of subsection (a), the conditions specified in this
7 subsection are met if all of the following are in effect:

8 “(1) ASSISTANCE FOR PRESCRIPTION DRUGS
9 FOR LOW-INCOME MEDICARE BENEFICIARIES.—

10 “(A) Low-income assistance to enable the
11 purchase of coverage of prescription drugs as
12 described in paragraph (2) or (3) for medicare
13 beneficiaries with incomes under 135 percent of
14 the applicable Federal poverty level, with such
15 assistance phasing out for beneficiaries with in-
16 comes between 135 percent and 150 percent of
17 such level.

18 “(B) The Federal Government provides
19 funding for the costs of such assistance.

20 “(2) SUPPLEMENTAL COVERAGE OF PRESCRIP-
21 TION DRUGS.—All policies supplemental to Medicare
22 include coverage for costs of prescription drugs.

23 “(3) STRUCTURAL MEDICARE REFORM.—Cov-
24 erage for outpatient prescription drugs for medicare
25 beneficiaries is provided only through integrated

1 comprehensive health plans which offer current
2 Medicare covered services and maximum limitations
3 on out-of-pocket spending and such comprehensive
4 plans sponsored by the Health Care Financing Ad-
5 ministration compete on the same basis as private
6 plans.”

7 (c) DEDUCTION FOR PRESCRIPTION DRUG INSUR-
8 ANCE COVERAGE ALLOWED WHETHER OR NOT TAX-
9 PAYER ITEMIZES OTHER DEDUCTIONS.—Subsection (a)
10 of section 62 (defining adjusted gross income) is amended
11 by inserting after paragraph (18) the following new para-
12 graph:

13 “(19) PRESCRIPTION DRUG INSURANCE COV-
14 ERAGE.—The deduction allowed by section 213(a) to
15 the extent of the expenses described in the second
16 sentence thereof.”

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to taxable years beginning after
19 the date of the enactment of this Act.

NEWS

Congressman Pete Stark

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California - Thirteenth District

U.S. House of Representatives

FOR IMMEDIATE RELEASE
July 14, 1999

CONTACT: Anne Montgomery
(202) 225-5065

WAYS AND MEANS REPUBLICANS REJECT PROVIDING SENIORS WITH REAL PRESCRIPTION DRUG ASSISTANCE

Rep. Pete Stark (D-CA) today offered an amendment to the Archer \$864 billion tax cut bill that would have provided Medicare beneficiaries a 50% tax credit for the purchase of prescription drugs up to \$2000 in 2002 and rising to \$5000 in 2008. The amendment essentially mirrored the President's new Medicare prescription drug proposal, but would provide the benefit through the tax code rather than through the Medicare program.

"My amendment would have redirected a small portion of this \$864 billion special interest tax cut to our nation's seniors and disabled population who now spend more on prescription drugs than any other segment of our population," said Rep. Stark. "Unfortunately, our Republican colleagues would rather help tackle box manufacturers, oil companies, and multi-millionaires, rather than enable seniors to obtain affordable prescription drugs."

"To add fury to the fire, the Republicans modified their bill late last night with a bait and switch provision to provide an above the line tax deduction for the purchase of prescription drug insurance. This new deduction would be contingent upon Congress passing a 'Premium Support' model of Medicare reform which would force seniors into shoddy, barebones HMOs."

Rep. Stark continued, "Clearly the Republicans have learned that they need to talk about prescription drug benefits for seniors and that's why they made this last minute change to their bill. Unfortunately, all they have learned is to talk about the issue. No other provision in this \$864 billion tax cut bill is based on a contingency that Congress pass specific legislation before it becomes effective."

Rep. Stark went on to say, "It should also be noted that the Joint Tax Committee places zero costs on the Republican prescription drug provision because even if this tax cut bill were to become law, they know that this contingency would never become reality."

"The fact of the matter is that the Republicans are trying to fool America's seniors into believing that they care about expanding coverage for prescription drugs. However, they are unwilling to dedicate even a small portion of this \$864 billion tax cut - that will never become law anyway - to prescription drug coverage," stated Rep. Stark.

"Don't believe the hype. If Republicans wanted to provide prescription drug coverage to seniors, they would have supported my amendment to do so," concluded Rep. Stark.

PRESCRIPTION DRUGS/ MODERNIZING MEDICARE



BACKGROUND:

On Tuesday, President Clinton unveiled his plan to strengthen and modernize Medicare. As part of a broader set of reforms for the Medicare program, the President proposed the creation of a new prescription drug benefit.

Nearly 15 million Medicare beneficiaries have no prescription drug coverage, and millions more are at risk of losing coverage or have inadequate, expensive coverage. The President's plan includes a voluntary Medicare drug benefit that would offer beneficiaries access to prescription drug coverage beginning in 2002. The new benefit would provide reliable, affordable coverage to all beneficiaries; protection for low-income beneficiaries; and private management of benefits.

House Democrats are encouraged to talk about this new prescription drug benefit over the July 4th recess. Specifically, Tuesday, July 6th is Prescription Drugs for Seniors Day. Members are encouraged to schedule an event on this day to highlight the need for a prescription drug benefit for seniors.

EVENTS:

- **MEET WITH SENIORS:** Meet with seniors at a local senior citizen center to brief them on President Clinton's proposal to modernize and strengthen Medicare. Focus on the prescription drug proposal.
- **WRITE AN OP-ED:** Submit an op-ed in your local newspapers on President Clinton's Medicare proposal. Focus on the prescription drug proposal.
- **HOST A ROUNDTABLE DISCUSSION:** Join with senior citizens and their families to discuss the Medicare proposal and the importance of a prescription drug piece.
- **VISIT THE LOCAL EDITORIAL BOARD:** Schedule an appointment to visit with your local editorial board editors. Brief them on President Clinton's Medicare proposal. Bring your local AARP President and a group of senior citizens.

- **ESTABLISH AN ADVISORY GROUP:** Establish an advisory group of senior citizens who will review President Clinton's proposal to modernize and strengthen Medicare and report back to you their findings.

BACKGROUND MATERIALS:

- Sample media advisory.
- Sample press release.
- Sample op-ed.
- Background materials on President Clinton's proposal to strengthen and modernize Medicare, prepared by the Clinton Administration, including:
 1. One-pager: "Strengthening Medicare for the 21st Century"
 2. Two-pager: "A New Prescription Drug Benefit and Cost Sharing Protections for Preventive Services"
 3. Six-pager: "President Clinton's Plan to Modernize and Strengthen Medicare for the 21st Century"
- Statements in support of President Clinton's plan:
 1. Democratic Leader Gephardt
 2. Rep. Rangel
 3. Rep. Stark
 4. AARP

For Immediate Release

July 5, 1999

**REP. _____ JOINS EFFORT TO PROVIDE
PRESCRIPTION DRUG BENEFIT THAT IS
AFFORDABLE AND AVAILABLE TO ALL SENIORS**

July 6th is Prescription Drugs for Seniors Day

Anywhere, USA --- U.S. Rep. _____ will, (insert a description of your prescription drug event) as part of Prescription Drugs for Seniors Day on Tuesday, July 6th. Prescription Drugs for Seniors Day is an effort coordinated by congressional Democrats to show their support for a prescription drug proposal as part of the effort to modernize and strengthen Medicare for the 21st century.

President Clinton's new prescription drug proposal would provide:

- Reliable, affordable coverage to all Medicare beneficiaries;
- Protection for low-income beneficiaries; and
- Private management of benefits.

The (insert your event) is one of (insert number - the DPC will have a total number of events happening nationwide by the end of the week, 5-6760) events happening nationwide during the week of July 5th. **It will be held at (insert time, location, and other details).**

Contact: (Insert name and phone number)

**REP. _____ JOINS EFFORT TO PROVIDE
PRESCRIPTION DRUG BENEFIT THAT IS
AFFORDABLE AND AVAILABLE TO ALL SENIORS**

Anywhere, USA --- As part of Prescription Drugs for Seniors Day, U.S. Rep. _____ today (insert your prescription drug event) which focused on the need for a prescription drug benefit for seniors.

"No senior citizen should have to choose between buying food and buying medicine," Rep. _____ said. "I am pleased that President Clinton proposed a prescription drug benefit as part of his plan to modernize and strengthen the Medicare program for the challenges it faces in the 21st century. This long-overdue prescription drug benefit would provide reliable, affordable coverage to all Medicare beneficiaries; protection for low-income beneficiaries; and private management of benefits."

The specifics of President Clinton's prescription drug benefits are:

- **Meaningful coverage that is available to all beneficiaries.** Medicare would cover half of drug costs from the first prescription up to \$5,000 in spending per year. The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers. For the nearly 15 million beneficiaries who have absolutely no coverage, it would provide significant financial relief. For the several million beneficiaries who rely on Medigap or Medicare managed care, this benefit would ensure that their coverage will always be there without excessive rate increases or reductions in the generosity of the benefit.
- **Affordable premiums.** Beneficiaries would pay a separate premium for Medicare Part D — an estimated \$24 per month in 2002, and \$44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded.
- **Low-income protections.** Beneficiaries with incomes up to 135 percent of poverty would pay no premiums or cost sharing.
- **Private management.** Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers or similar entities to manage the benefit. This partnership would provide beneficiaries with the same high quality benefits they expect from Medicare while allowing for more flexibility and innovation in the program management over time. NO price controls would be used.

"At a time of soaring surpluses, no senior citizen should wind up in the hospital for skimping on their medication to save money. It's the right time to provide this long-overdue prescription drug benefit and I look forward to working with Republicans and Democrats alike to make sure we reach consensus on a prescription drug benefit for seniors," Rep. _____ said.

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Note: Consider using a quote or two from the senior citizens at your event.

** Sample Op-Ed **
(VERY similar to President Clinton's statement on Tuesday)

**REP. _____ STRENGTHENING MEDICARE
FOR THE 21ST CENTURY**

"In a nation bursting with prosperity, no senior should have to choose between buying food and buying medicine. My Medicare plan is credible, sensible, fiscally responsible. It will secure the health of Medicare while improving the health of our seniors. And we can achieve it."

President Bill Clinton
June 29, 1999

On Tuesday at the White House, President Clinton unveiled his proposal to modernize and strengthen the Medicare program to prepare it for the challenges it faces in the 21st Century. This historic initiative would make Medicare more competitive and efficient; modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost-sharing protections for preventive benefits; and make an unprecedented long-term financing commitment to the program that would extend the life of the Medicare trust fund until 2027.

The stakes are high. In the 34 years since it was created, Medicare has eased the suffering and extended the lives of tens of millions of older and disabled Americans. It has given young families the peace of mind of knowing they will not have to mortgage their homes or their children's futures to pay for the health care of their parents and grandparents. It has become so much a part of America it is almost impossible to imagine life without it. Yet, life without Medicare is what we actually could get unless we act soon to strengthen this vital program.

With Americans living longer, the number of Medicare beneficiaries is growing faster than the number of workers paying into the system. By the year 2015, the Medicare trust fund will be insolvent — just as the baby boom generation begins to retire and enter the system, and eventually doubling the number of Americans who are over 65.

The Medicare plan unveiled by President Clinton includes numerous steps to extend the solvency of the Medicare Trust Fund — extending its solvency until 2027.

In addition to these steps, we also should also modernize Medicare benefits. Medical care has advanced, while Medicare has not. We have a duty to see that Medicare offers seniors the best, and the wisest, health care available.

Nobody would devise a Medicare program today without a prescription drug benefit. The plan proposed by President Clinton will offer an affordable prescription drug benefit to all Medicare recipients, with additional help to those with lower incomes, paid for largely through the cost savings outlined earlier. It will cover half of all prescription drug costs, up to \$5,000 per year, when fully phased in, with no deductible — all for a modest premium that will be less than half the price of the average private Medigap policy. It's very simple --

if you choose to pay a modest premium, Medicare will pay half of your drug prescription costs, up to \$5,000. This is a drug benefit our seniors can afford at a price America can afford. No senior should have to choose between buying food and buying medicine.

It's time to get to work in the months before the election season begins. We must protect Medicare for our children and grandchildren.

**PRESIDENT CLINTON AND VICE PRESIDENT GORE:
STRENGTHENING MEDICARE FOR THE 21st CENTURY**

June 29, 1999

"In a nation bursting with prosperity, no senior should have to choose between buying food and buying medicine... My Medicare plan is credible, sensible, fiscally responsible. It will secure the health of Medicare while improving the health of our seniors. And we can achieve it."

President Bill Clinton

June 29, 1999

Today, at the White House, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the challenges it faces in the 21st Century. This historic initiative would make Medicare more competitive and efficient; modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost-sharing protections for preventive benefits; and make an unprecedented long-term financing commitment to the program that would extend the life of the Medicare trust fund until 2027. The President called on Congress to work with him to reach a bipartisan consensus on needed reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass Medicare reforms that have saved hundreds of billions of dollars and helped to extend the life of the Medicare trust fund from 1999 through 2015. Building on this success, his new plan:

- gives Medicare new private-sector purchasing and quality improvement tools to improve care and constrain costs;
- injects true price competition among Medicare managed care plans, making it easier for beneficiaries to make informed choices about their plan options and saving money over time for both beneficiaries and the program;
- reduces average annual Medicare spending growth, ensuring that program growth does not significantly increase after most of the Medicare provisions of the Balanced Budget Act expire in 2003; and
- takes administrative and legislative action to smooth out provisions in the Balanced Budget Act which may be affecting Medicare beneficiaries' access to quality care.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefits package does not include all the services needed to treat health problems facing the elderly and people with disabilities. To address this, the President's plan:

- establishes a new prescription drug benefit that is affordable and available to all Medicare beneficiaries;
- eliminates copayments and deductibles for all preventive services covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, and mammographies;
- rationalizes cost-sharing requirements to help pay for the prescription drug and preventive benefits by adding a 20% copayment for clinical laboratory services and indexing the Part B deductible for inflation;
- reforms Medigap policies by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and
- includes the President's Medicare Buy-In proposal which provides an affordable coverage option for vulnerable Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. The elderly population will double from almost 40 million today to 80 million over the next three decades, creating a need to strengthen Medicare financing. To accomplish this, the President's plan dedicates 15% of the budget surplus to extend the life of the Medicare Trust Fund until at least 2027.

PRESIDENT CLINTON HIGHLIGHTS MODERNIZED MEDICARE BENEFITS
A New Prescription Drug Benefit and Cost Sharing Protections for Preventive
Services
June 30, 1999

Today, President Clinton met with seniors at the Chicago Cultural Center to discuss the importance of modernizing the Medicare benefit package to include a long-overdue prescription drug benefit and eliminate all cost sharing barriers for preventive care. As he summarized his plan to strengthen and modernize the Medicare program, the President emphasized that affordable prescription drug and preventive services have become essential elements of high-quality medicine. At this event, the President heard firsthand about the difficult choices and financial burdens seniors face when they do not have prescription drug coverage.

MEDICARE'S BENEFITS NEED TO BE MODERNIZED. Prescription drugs and preventive care have become central to modern medicine.

- **Millions of beneficiaries have no prescription drug coverage and millions more are at risk of losing coverage.** Nearly 15 million Medicare beneficiaries have no prescription drug coverage. And, millions more are at risk of losing coverage or have inadequate, expensive coverage. Lack of drug coverage is not just a problem for low-income beneficiaries; about 40 percent of beneficiaries without drug coverage have incomes above 200 percent of the poverty level (about \$16,000 for a single, \$22,000 for a couple). Nearly one in three of non-elderly Medicare beneficiaries, almost half of rural beneficiaries, and about 41 percent of beneficiaries older than the age of 85 do not have coverage for prescription drugs.
- **Current prescription drug coverage is unstable and declining.** About 37 percent of Medicare beneficiaries had private employer-based or Medigap insurance for drug coverage in 1995. Both sources of coverage have been declining as the cost of coverage rises. The number of firms offering retiree health insurance coverage dropped by 20 percent between 1993 and 1997, and Medigap premiums have been rising at double-digit inflation.
- **Medicare managed care plans have limited coverage and are not accessible to millions of the elderly.** While Medicare managed care plans usually offer some drug coverage, it is typically limited (e.g., \$1,000 cap). In addition, 11 million beneficiaries, who disproportionately reside in rural areas, have no access to managed care plans.
- **Opponents' arguments against a prescription drug benefit that is available to all beneficiaries resembles the opposition to the enactment of Medicare.** Although 56 percent of the elderly had insurance before Medicare, this coverage was expensive, inadequate, and unreliable – much like drug coverage today. Medicare would not have been created if this "coverage" was considered acceptable.
- **Preventive benefits are a necessary part of modern health care.** According to recent studies, Medicare preventive services are underutilized. For example, studies indicated that only one in four women in their sixties are tested as recommended for breast cancer. In the first two years that Medicare covered screening mammographies, only 14 percent of eligible women without supplemental insurance received a mammogram.

The President's plan to modernize Medicare's benefit package addresses these critical issues by:

MODERNIZING MEDICARE'S BENEFITS TO INCLUDE A NEW

PRESCRIPTION DRUG BENEFIT. The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high quality prescription drug coverage beginning in 2002. This new benefit would provide:

- **Meaningful coverage that is available to all beneficiaries.** Medicare would cover half of drug costs from the first prescription up to \$5,000 in spending per year (\$2,500 in plan payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers. For the nearly 15 million beneficiaries who have absolutely no coverage, it would provide significant financial relief. For the several million beneficiaries who rely on Medigap or Medicare managed care, this benefit would ensure that their coverage will always be there, without excessive rate increases or reductions in the generosity of the benefit.
- **Affordable premiums.** Beneficiaries would pay a separate premium for Medicare Part D -- an estimated \$24 per month in 2002, and \$44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded.
- **Low income protections.** Beneficiaries with incomes up to 135 percent of poverty (\$11,000 for singles, \$15,000 for couples) would pay no premiums or cost sharing, with the premium subsidy phased out from 135 to 150 percent of poverty. The Federal government would pay for all of the costs associated with beneficiaries with incomes above poverty.
- **Private management.** Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities to manage the benefit. This partnership would provide beneficiaries with the same high quality benefits they expect from Medicare while allowing for more flexibility and innovation in program management over time. No price controls would be used.

IMPROVING PREVENTIVE BENEFITS AND ELIMINATING COST SHARING.

This proposal, which costs \$3 billion over 10 years, would take a number of steps to make preventive services more affordable as well as to raise awareness of services. It would:

- **Eliminate all existing preventive services cost sharing.** Eliminate existing copayments and the deductible for every preventive service covered by Medicare, including hepatitis B, colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.
- **Launch a smoking cessation demonstration project.** Initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.
- **Create a new health promotion education campaign.** This new, nationwide health promotion education campaign would be targeted to all Americans over the age of 50.

**PRESIDENT CLINTON'S PLAN TO MODERNIZE AND STRENGTHEN
MEDICARE FOR THE 21st CENTURY**

June 29, 1999

Today, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st Century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the life of the Medicare Trust Fund until 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. Since taking office, President Clinton has worked to pass and implement Medicare reforms that, coupled with the strong economy and the Administration's aggressive anti-fraud and abuse enforcement efforts, have saved hundreds of billions of dollars and helped to extend the life of the Medicare trust fund from 1999 through 2015. Building on this success, his plan:

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: \$25 billion over 10 years.
- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans in Medicare. Plans would be paid for covering Medicare's defined benefits, including a new subsidized drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by providing beneficiaries with 75 cents of every dollar of savings that result from choosing lower cost plans. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: \$8 billion over 10 years, starting in 2003.
- **Constrains out-year program growth, but more moderately than the BBA 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to unsustainable growth rates, but have been developed to be more modest than those included in the BBA of 1997. This proposal would reduce average annual Medicare spending growth from 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: \$39 billion over 10 years (including interactions and premium offsets).

- **Takes administrative and legislative action to smooth out the Balanced Budget Act (BBA) of 1997 provider payment reductions.** The proposal includes a provider set-aside designed to smooth out provisions in the BBA that may be affecting Medicare beneficiaries' access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions that are designed to moderate the impact of the BBA 1997 on some health care providers' ability to deliver quality services to beneficiaries. Cost: \$7.5 billion over 10 years.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President's plan would take strong new steps to ensure that Medicare beneficiaries can access affordable prescription drug and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and reforms the current Medigap market. Finally, it integrates the President's Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. His plan:

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:
 - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending (\$2,500 in Medicare payments) when fully phased-in by 2008.
 - Ensure beneficiaries a discount similar to that offered by many employer sponsored plans (estimated to be, on average, over 10 percent) for each prescription purchased – even after the \$5,000 limit is reached.
 - Cost about \$24 per month beginning in 2002 (when the benefit starts at a \$2,000 cap) and \$44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)
 - Ensure that beneficiaries with incomes below 135 percent of poverty (\$11,000/\$17,000 single/couples) would not pay premiums or cost sharing. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well.
 - Provide financial incentives for employers to retain their retiree health coverage if they provide a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

Most Medicare beneficiaries will choose this new prescription drug option because of its attractiveness and affordability. Because older and disabled Americans rely so heavily on medications, about 31 million beneficiaries would benefit from this coverage each year. Cost: \$118 billion over 10 years, beginning in 2002.

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost \$3 billion over 10 years and would:
 - Eliminate existing copayments and the deductible for every preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.
 - Initiate a three-year demonstration project to provide cost-effective smoking cessation services to Medicare beneficiaries.
 - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.
- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save \$11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:
 - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, reduce fraud, and has been advocated by the Medicare Payment Advisory Commission.
 - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 43 percent in 1967 to about 3 percent in 1999, according to CBO.
- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program and steps to make it easier for beneficiaries to compare the cost and quality of private Medigap options; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expand the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).
- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer any American between the ages of 62-65 the choice to buy into the Medicare program for approximately \$300 per month if they agree to pay a small risk adjusted payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The \$1.4 billion cost is offset in the President's FY 2000 budget.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. The Medicare plan the President is proposing would strengthen the program and make it more competitive and efficient. However, no amount of policy-sound savings would be sufficient to address the fact that the elderly population will double from almost 40 million today to 80 million over the next three decades. Every respected expert in the nation recognizes that additional financing will be necessary to maintain basic services and quality for any length of time. Because of this and his strong belief that the baby boom generation should not pass along its inevitable Medicare financing crisis to its children, the President has proposed that a significant portion of the surplus be dedicated to strengthening the program. Specifically, his plan:

- **Extends the life of the Trust Fund until at least 2027.** Dedicating 15 percent of the surplus (\$794 billion over 15 years) to Medicare not only assures the financial health of the Trust Fund through at least 2027, but it will also eliminate the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.
- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about \$118 billion over 10 years. It would be fully financed by:
 - Savings from competition and efficiency. About 60 percent of the \$118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.
 - Dedicating a small fraction of the surplus. About 40 percent, or \$45.5 billion, of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:
 - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and
 - Less than the reduction in the Medicare baseline spending between January and June, 1999.

Policy experts advising the Congress (MedPAC, CBO, and the Medicare Trustees) have consistently underscored their belief that much of the recent decline in Medicare spending beyond initial projections is due to our success in combating fraud and waste. Reinvesting the savings that can be reasonably attributed to our anti-fraud and waste activities into a new prescription drug benefit is completely consistent with the past actions of the Congress and the Administration utilizing such savings for programmatic improvements.

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

- **Goals for Reform:**
 - Make Medicare More Competitive and Efficient
 - Modernize Medicare's Benefits
 - Strengthen Medicare's Financing for the 21st Century

PRESIDENT'S PROPOSAL		
(Dollars in Billions, Trustees' Baseline)		
	<u>00-04</u>	<u>00-09</u>
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
<i>Total</i>	<i>-5</i>	<i>-64.5</i>
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
<i>Total</i>	<i>+27</i>	<i>+110</i>
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	-22	-45.5
<i>Surplus Allocation</i>	<i>-50</i>	<i>-374</i>

* Includes \$5.7 billion in interactions/premium offset
 ** Does not count toward package

- **Reduces Medicare spending by \$72 billion over 10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.

- **Adds an optional prescription drug benefit.** This benefit would cost \$118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009.
 - Over 60 percent of the costs are offset by the proposal's savings.
 - The remaining \$45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the \$374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.

- **Extends the life of the Medicare trust fund for a quarter of a century, to at least 2027.** The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the life of the Medicare Trust Fund for a quarter century, through at least 2027. This is the best prognosis for Medicare since the program was created.

*

NEWS FROM THE HOUSE DEMOCRATIC LEADER

For Immediate Release:
June 29, 1999

House Democratic Leader Richard A. Gephardt
H-204, U.S. Capitol

Gephardt Statement on President Clinton's Plan to Modernize and Strengthen Medicare

"I applaud the President's proposal to modernize and extend the life of Medicare into the next century. These changes will help all seniors get the affordable and quality health care they deserve.

"President Clinton's initiative takes the necessary steps to increase the efficiency and stability of a program that millions of seniors depend on for their physical and financial well-being. The sensible measures included in this plan will preserve the guaranteed benefits that so many retirees depend on while making important changes for significant cost savings.

"The President's fiscally responsible prescription drug proposal will be the single greatest improvement to the Medicare program since its inception. Currently, seniors are being forced to choose between expensive medications and other necessities of life; this program will help ease the financial burden of illness and increase their financial security.

"I hope the Republican leadership will reject the views of naysayers like Tom DeLay and work with Democrats and the President to improve Medicare for all seniors -- both today and well into the next century."

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Contact: Laura Nichols/Sue Harvey (202) 225-0100

STATEMENT



FROM REPRESENTATIVE CHARLES B. RANGEL
Ranking Democrat, Committee on Ways and Means

FOR IMMEDIATE RELEASE
Tuesday, June 29, 1999

CONTACT: Dan Maffei
202/225-4021

RANGEL APPLAUDS PRESIDENT CLINTON'S LEADERSHIP ON MEDICARE

*Praises President's inclusion of strong drug benefit
and inclusion of Rangel-sponsored "safety-net" hospitals provision*

The President has seized a great opportunity provided by the budget surpluses, to not only strengthen Medicare's finances, but also improve its services.

The President's proposal contains the greatest improvement in the history of Medicare – a prescription drug benefit. By starting modestly, but then expanding the benefit as Medicare becomes financially stronger, the Administration has addressed a pressing need of our seniors in a fiscally responsible way.

I am particularly pleased that the President also included a bipartisan provision that I introduced earlier this year to give equitable treatment to the hospitals which serve a disproportionately large share of the nation's uninsured and low-income.

By including this provision, the President recognized that we cannot afford to have our nation's safety-net hospitals falling into bankruptcy themselves. Providing a Disproportionate Share Hospital (DSH) payment will put these hospitals on an even playing field with other hospitals.

- MORE -

I also like the President's approach because it avoids the terrible dangers of the Premium Support proposal, which uses higher premiums on seniors to force them into HMOs.

It does all of these things while dramatically extending the solvency of the Medicare Trust Fund. It will now be solvent to about 2030, much longer than it has ever been solvent before.

I applaud the President for his leadership. I believe both Democrats and Republicans in Congress can work together to pass this proposal this year. After all, there is nothing that we as a Congress can do that is more important than assisting our seniors in living secure and healthy lives.

#

STATEMENT OF CONGRESSMAN PETE STARK

Congratulations to the President for an excellent Medicare proposal.

I hope both parties can work together to pass this proposal this year.

The President's plan avoids the terrible dangers of the Premium Support proposal, which uses higher premiums to force seniors into skimpy, barebones HMOs.

The President's plan nearly doubles the solvency of the Medicare Trust Fund. It will now be solvent to 2027—the longest period in the Fund's history.

The plan addresses Medicare's biggest failure: lack of prescription drug insurance. It provides a drug benefit to all seniors and helps all seniors get a lower price on prescriptions.

The proposal modernizes traditional Medicare, allowing it to negotiate better prices for the beneficiary and the taxpayer. It is way past time that Medicare started using its buying power to purchase the highest quality services at wholesale prices.

Of course, there is more to be done. I would like to see more adequate catastrophic drug protection. I would like to see a higher level of protection for low-income seniors and the disabled. I also support a cap on beneficiaries' out-of-pocket liability. These are amendments that can be offered and debated in the legislative process.

Overall, it is a good plan. It is a foundation on which the parties can build together. Passing this type of plan will be a legacy not only for the President but for this Congress.

AARP NEWS



For further inquiry, contact AARP Communications
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FOR IMMEDIATE RELEASE:

June 29, 1999

CONTACT:

Steve Hahn
(202) 434-2592

**AARP EXECUTIVE DIRECTOR HORACE B. DEETS
ON THE
PRESIDENT'S MEDICARE REFORM AND PRESCRIPTION DRUG PLAN**

AARP is pleased that the President has proposed a prescription drug benefit for all Medicare beneficiaries as part of his Medicare reform plan. A prescription drug benefit for all older Americans is good medicine. Today, older Americans depend more on prescription drugs, pay more for their medications, and have less insurance to cover the cost of their drugs than any other age group in our society.

The President's proposal recognizes the importance of spreading the cost of prescription drug coverage across all Medicare beneficiaries. It also acknowledges what millions of American families know: that even many middle class older Americans find that their prescription drug costs can be unaffordable.

Since Medicare was established over 30 years ago, new and effective prescription drugs have been created and are now central to the delivery of quality health care. As a result, most health insurance plans for workers cover prescription drugs. Medicare, however, does not. The President has put a pragmatic proposal on the table – a proposal that tries to balance the need to provide meaningful coverage for Medicare beneficiaries with the requirement for fiscal constraint on Medicare's spending. It requires that Medicare beneficiaries still pay a considerable amount of the cost of their drugs, and only a vigorous public debate will tell us whether older Americans believe that the additional premium for prescription drugs is affordable.

We are also pleased that the President has put forward his ideas on broader Medicare reform. Strengthening the underlying Medicare program and making it more competitive and efficient will be essential ingredients of any reform plan.

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The President's proposal along with those being offered in the Congress will help promote a broad national debate about the future of Medicare. AARP looks forward to working with the Administration and Congress on a bipartisan basis to develop a solution that will strengthen Medicare for today's and tomorrow's beneficiaries. Financing prescription drug coverage and reforming Medicare to meet the needs of the coming "baby boomers" are two sides of the same coin. Older Americans need prescription drug coverage today, and younger Americans will want and expect that coverage as they grow older. Moreover, today's Medicare beneficiaries are paying top dollar for their medications, compared with the industry's preferred buyers who can negotiate better prices. It only makes sense that Medicare, like private business purchasers, should be able to obtain lower prices on prescription drugs for Medicare beneficiaries.

We are fortunate to be in an era in which we have a budget surplus. This provides the opportunity, indeed the responsibility, to engage in a vigorous debate about our nation's economic priorities. Quality health care coverage for Americans of all ages, and prescription drug coverage for all older Americans should rank high in that debate.

AARP urges all stakeholders – government, industry, and consumers – to engage in a serious debate on the merits of the full range of approaches to Medicare reform and prescription drug coverage. Before Medicare legislation can be enacted, older Americans and their families must understand the proposals that are under consideration and be able to assess their impact on them individually.

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