

MEDICARE PRESCRIPTION DRUG BENEFIT

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2003. This benefit would cost about \$160 billion over 10 years.

- **Meaningful coverage.** Beginning in 2003, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:
 - No deductible – coverage begins with the first prescription filled and
 - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

The benefit would be limited to \$5,000 in costs (\$2,500 in Medicare payments) in 2008. It would phase it a \$2,000 for 2002-03; \$3,000 for 2004-05; \$4,000 for 2006-07; and \$5,000 in 2008 (indexed to inflation in subsequent years).

The President's budget includes a \$35 billion reserve fund that could be used to enhance this benefit to protect beneficiaries with catastrophic drug costs. If Congress and the Administration cannot come to agreement on this, it would be used for debt reduction.

- **Affordable premiums.** Beneficiaries would pay a separate premium for Medicare Part D -- an estimated \$26 per month in 2003. This premium represents 50 percent of program costs. Enrollment would be optional and would occur, after an initial open enrollment for all beneficiaries, when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would be deducted from Social Security checks.
 - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty (\$17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty (\$15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.
- **Private management.** Beneficiaries in managed care plans would receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract out with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award one contract per area. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.
- **Incentives to develop and retain retiree coverage.** To encourage employers to choose to offer or continue retiree drug coverage, Medicare would pay for part of their premium costs. Specifically, Medicare would contribute 67 percent of its premium subsidy for the Medicare benefit, less than what it would pay if the beneficiary enrolled in Medicare.

ADVANTAGES OF THE PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT

- **Accessible and affordable to all beneficiaries.** This proposal would make prescription drug coverage accessible and affordable to all Medicare beneficiaries.
 - Broad-based need. Beneficiaries across the income, geographic, and socio-demographic spectrum have trouble accessing affordable prescription drugs. About 40 percent of beneficiaries who lack drug coverage have income over 200 percent of poverty (\$16,000 for singles, \$22,000 for couples). Only about half of rural beneficiaries have any drug coverage. Moreover, private coverage is expensive and declining, and Medicare managed care plans are beginning to restrict their coverage of prescription drugs.
 - Important to all beneficiaries – not just low-income. All workers pay taxes to support Medicare, and, as a result, all should have access to any new benefit. Medicare is built on the premise that all elderly and people with disabilities develop health problems at some point. It does not, for example, pay for hospital care only for the low-income. Limiting access to critical coverage of prescription drugs – especially when there are no guaranteed private sector alternatives – contradicts the principles that have made Medicare and Social Security strong and successful programs.
- **Addresses shortcomings of fragmented system of coverage.** The prescription drug benefit in the President's plan would provide stable, affordable protection against the high costs of prescription drugs. 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 assure that their coverage will always be there, without excessive rate increases or reductions in the generosity of the benefit. Low-income beneficiaries who do not qualify for Medicaid would gain new and expanded access to the Medicare benefit. And, Medicare beneficiaries with retiree coverage would worry less since employers would have a new incentive to continue offering coverage.
- **New management for new benefit.** The prescription drug benefit would be created as a public-private partnership – with the government responsible for assuring that beneficiaries who opt for Part D get high-quality, meaningful, affordable benefits. The private benefits managers would be responsible for using the latest, most effective tools for managing costs and improving quality. This partnership would both provide beneficiaries with the same high-quality benefits that they expect from Medicare while allowing for more flexibility and innovation in program management over time. No price controls would be used.
- **Fiscally responsible.** The prescription drug benefit is designed to be affordable and fully paid for through policies in this proposal. Beneficiaries would be equal partners in its costs, paying half of the premium and half of the drug costs. Government payments would be limited, both in dollar amounts and in growth, to ensure that the financing sources are adequate in the near and long-term. And, an incentive program would be included to prevent wholesale substitution for private retiree coverage.

DRAFT: PRESCRIPTION DRUG BENEFITS

	PRESIDENT'S	BREAUX-FRIST	SNOWE-WYDEN
Eligibility	All	All choosing high-option coverage *	All
Enrollment	Limited options (open enrollment in 2002; at Medicare enrollment)	Unlimited options; study of limiting options by 2002	Annual open enrollment
Premium subsidy: General	50 percent of cost of benefit	25 percent of cost of benefit; subsidy is considered income for tax purposes**	25 percent of cost of benefit, subject to limit of trust fund (capped)
Premium subsidy: Low-income	< 135% poverty: 100 percent of cost 135-150% poverty: Sliding scale from 100 to 50 percent	< 135% poverty: 100 percent of cost in low-cost plan only 135-150% poverty: Sliding scale from 50 to 25 percent	< 150% poverty: 100 percent of cost 150-175% poverty: Sliding scale from 100 to 25 percent, subject to trust fund limit.
Cost sharing: General	50 percent of discounted price	Plans allowed to vary	Plans allowed to vary, subject to minimums set by SPICE board
Cost sharing: Low-income	None below 135 percent of poverty	None below 100 percent of poverty	Not specified
Financing of low-income protections	< 100 % of poverty: Medicaid match rate > 100% of poverty: 100 percent Federal	Medicaid match rate	100 percent Federal
Benefit limit	\$2,000 in 2002; \$5,000 in 2008, increased annually by general inflation	\$800 actuarial value in 2003, increased annually by drug cost growth	No standard; minimum benefits to be determined by Board, NAIC
Access to drug discounts once limit is reached	Plans must allow continued access	No provision	No provision
Drugs covered	All therapeutic classes and medically necessary drugs, with certain exceptions	Not specified	To be determined by NAIC, subject to SPICE board approval
Delivery for FFS enrollees	Private or public entity that is competitively selected for designated area (multiple areas throughout the nation)	Any private entity that meets Medicare Board criteria and approval, for whatever area they select	Private Medigap or retiree health plans, approved by SPICE board
Cost containment strategies	Formularies; not allowed to limit qualified pharmacists	Formularies; selective contracting with pharmacists	Formularies; silent on pharmacist access
Employer-sponsored coverage	Partial subsidy may go to employer	No explicit provision	Full subsidy may go to employer

*The proposal requires that plans offer standard coverage (current Medicare benefits with flexibility in cost sharing) and "high-option" coverage, which includes at least prescription drug coverage and stop-loss coverage for cost sharing for standard coverage (not drugs). This stop-loss coverage limits out-of-pocket spending on cost sharing for Medicare benefits to \$2,000; it is not subsidized.

**Because beneficiaries cannot purchase the subsidized drug benefit without also purchasing the unsubsidized catastrophic coverage, the effective premium subsidy would be well below 25 percent.

**DISTURBING TRUTHS AND
DANGEROUS TRENDS:**

**The Facts About Medicare Beneficiaries and
Prescription Drug Coverage**

*National Economic Council
Domestic Policy Council*

July 22, 1999

**DISTURBING TRUTHS AND DANGEROUS TRENDS:
The Facts About Medicare Beneficiaries and Prescription Drug**

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OVERVIEW

DISTURBING TRUTHS AND DANGEROUS TRENDS: The Facts About Medicare Beneficiaries and Prescription Drug

This report describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. This report shows that the accessing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance – it is an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

- Prescription drug coverage is good medicine.
 - Part of modern medicine. Prescription drugs serve as complements to medical procedures, such as anti-coagulants, used with heart valve replacement surgery; substitutes for surgery, such as lipid lowering drugs that reduce the need for bypass surgery; and new treatments where there previously were none, such as medications used to manage Parkinson's disease. In addition, as our understanding of genetics grows, the possibility for breakthrough pharmaceutical and biotechnology will increase exponentially.
 - Medicare beneficiaries are particularly reliant on prescription drugs. Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.
 - The lack of drug coverage has led to inappropriate use of medications which can result in increased costs and unnecessary institutionalization. Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. The consequence of inappropriate and underutilization of prescription drugs has also been found to double the likelihood that low-income beneficiaries entering nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.
- About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drug coverage.
 - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage.

- Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare’s basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans’ Affairs and other public programs.
- Private trends: Decline in coverage and affordability.
 - The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.
 - Medigap premiums for drugs are high and increase with age. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the President. Moreover, unlike the President’s proposal, premiums substantially increase with age as virtually every Medigap plan “age rates” the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach. This cost burden will particularly affect women, who make up 73 percent of people over age 85.
- Public drug coverage trends: managed care benefits reduced.
 - The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below \$1,000 in the year 2000. This is part of a troubling trend of plans to severely limit benefits through low caps. In fact, the proportion of plans with \$500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.
 - Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about \$6,000 for a single, \$8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent. This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries. Inadequate outreach and welfare stigma contributes to these low participation levels and raise serious questions about the feasibility and advisability of using the Medicaid program to provide needed coverage for a population at higher income levels.

- **Millions of beneficiaries have no drug coverage.**
 - At least 13 million Medicare beneficiaries have absolutely no prescription drug coverage. The number of the uninsured is not concentrated among the low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels.
 - More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately \$17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

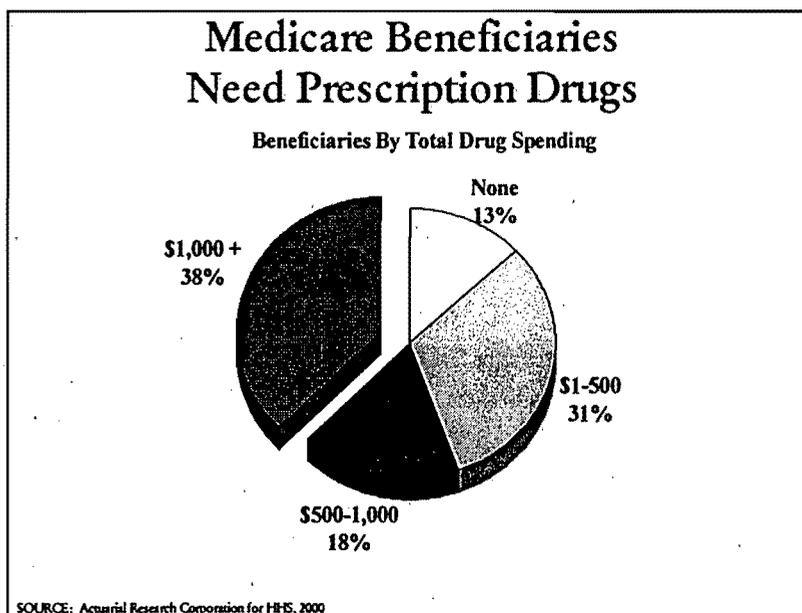
- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures (e.g., anti-coagulants with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV and Parkinson's). Some of the major advances in public health – the near eradication of polio and measles and the decline in infectious diseases – are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.
- **Greatest need for prescription drugs.** The elderly and people with disabilities are particularly reliant on prescription drugs. Not only do they experience greater health problems, but these problems tend to include conditions that respond to drug therapy. As a result, about 85 percent of beneficiaries fill at least one prescription a year. Some examples of common conditions include:
 - **Osteoporosis:** Over 1 in 5 older women have osteoporosis and about 15 percent have suffered a fracture as a result.¹ It is a leading risk factor for hip fractures, which affects 225,000 people over the age of 50. Estrogen replacement can reduce the risk of osteoporosis as well as that of cardiovascular disease. One commonly used drug costs \$20 per month, \$240 per year.
 - **Hypertension:** About 60 percent of people over age 65 have hypertension.² African Americans are more likely to have hypertension. For a person over age 55, hypertension increases the risk of a heart attack or other heart problem over 10 years by 10 percent.³ Hypertension roughly doubles the risk of cardiovascular disease and is the leading factor for stroke. According to one study, treatment results in a one-third reduction in the probability of stroke and a one-quarter reduction in the probability of a heart attack.⁴ ACE inhibitors which typically cost \$40 per month, \$480 per year are commonly prescribed to control hypertension, and are frequently used in combination with diuretics and /or beta-blockers.
 - **Myocardial Infarction (Heart Attack):** Heart disease is the leading cause of death for persons 65 and over. About 1.5 million Americans each year have heart attacks, which are fatal in about 30 percent of patients. Since people who survive heart attacks are much more likely to have subsequent attacks, disease management including drugs can significantly improve health and longevity. For example, a study of the use of a lipid lowering drug by people who had an acute myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.⁵ A common lipid reduction drug costs about \$85 per month, \$1,020 per year. A beta-blocker costs about \$30 per month, \$360 per year, and can reduce long-term mortality by 25 percent.⁶
 - **Adult-Onset Diabetes:** About 1 in 10 elderly have Type I or II diabetes.⁷ Diabetes can lead to blindness, kidney disease and nerve damage. Glucose (blood sugar)

control can prevent or delay these conditions. Commonly used medications include cost around \$60 per month, \$720 per year.

- Depression: An estimated 1 in 10 to 1 in 20 community-based elderly experience depression.⁸ Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.⁹ New therapies can cost from \$130 to \$290 per month or \$1,560 to \$3,480 per year.
- Many beneficiaries need drugs but do not use them as prescribed because they do not have well managed, affordable drug insurance. Most research has found that drug coverage influences use of needed drugs:
 - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.¹⁰ Many elderly must choose between prescriptions and other basic household needs.¹¹
 - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.¹²
 - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs. One study which classified the geriatric admissions to a community hospital found that drug-related hospitalization accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.¹³

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

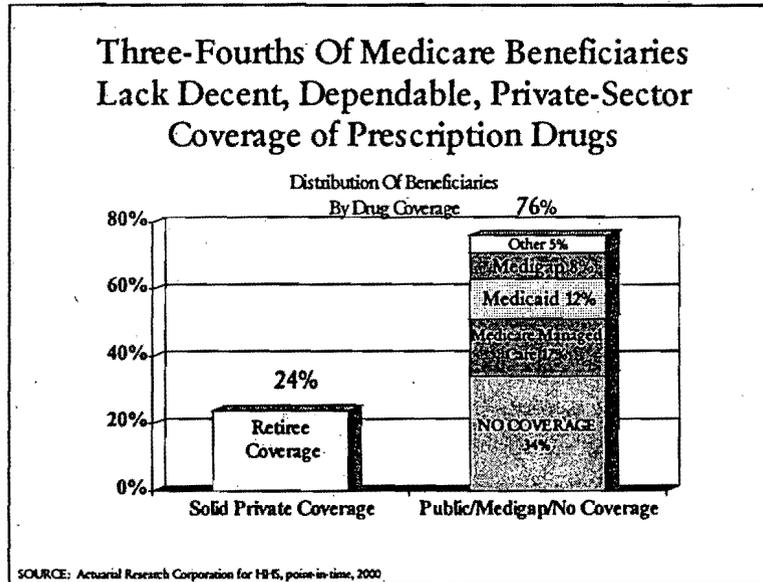
- Because of their greater need, the elderly and people with disabilities have greater health care costs. The elderly's per capita spending on drugs is over three times higher than that of non-elderly adults. While only 12 percent of the entire population, the elderly account for about one-third of drug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



- Over one-third (38%) of Medicare beneficiaries will spend more than \$1,000 on prescription drugs. Less than 5 percent will spend more than \$5,000.
- The average total drug costs for Medicare beneficiaries is estimated to approach \$1,100 in 2000. Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than \$500.
- Spending is higher for women. Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.
- Out-of-pocket spending is also high. In 2000, Medicare beneficiaries are estimated to spend about \$525 on prescription drugs out-of-pocket. This spending is linked to insurance coverage – it is much higher for those with no coverage (\$800) and people with Medigap (\$650) than those with retiree coverage (\$400).

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

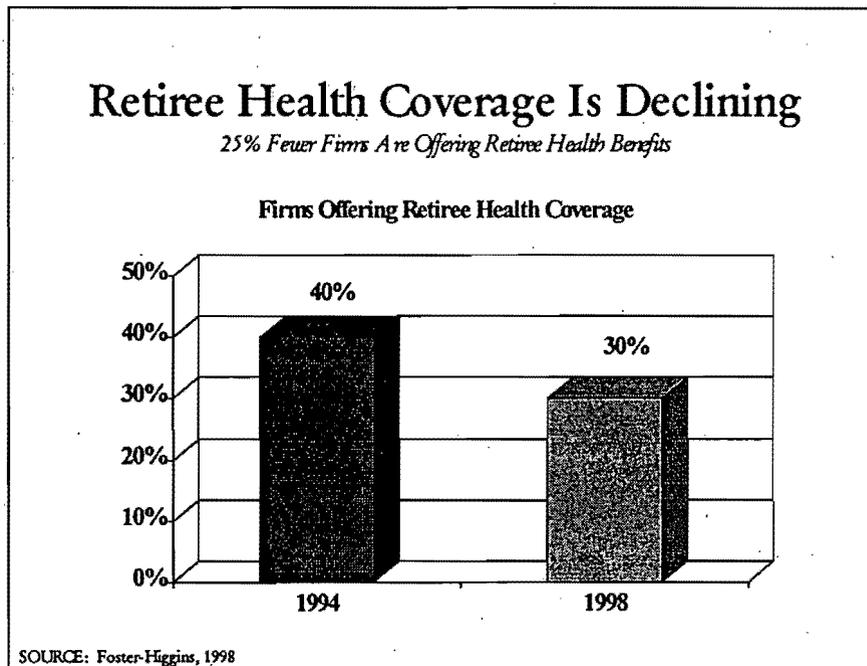
- Unlike virtually all private health insurance plans, Medicare does not cover prescription drugs. As a result, a fragmented, unstable system of coverage has emerged as beneficiaries attempt to insure against the costs of medications.



- Only one-fourth of Medicare beneficiaries have retiree drug coverage. Employers provide health insurance for most Americans under the age of 65, but pay for supplemental coverage for only a fraction of their elderly retirees. When available, this coverage tends to have reasonable cost sharing and affordable premiums.
- About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs. These beneficiaries include those with:
 - Medigap. About 8 percent of beneficiaries purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries.
 - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.
 - Medicaid and other public programs. Medicaid covers about 12 percent of beneficiaries and programs like the Veterans' Administration cover another 5 percent of beneficiaries. Eligibility for these programs is very restrictive.
 - No coverage at all. 34 percent of Medicare beneficiaries has no drug coverage.

RETIREE HEALTH COVERAGE

- About one in four Medicare beneficiaries has prescription drug coverage through their retiree health plan. These employer-based plans offer decent, affordable coverage.



- Firms offering retiree health coverage have declined by 25 percent in the last four years.¹⁴ Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage.
 - The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.
- Most serious effect will occur when the baby boom generation retires. Although there are employers who are dropping health coverage for current retirees, most are restricting coverage for future retirees. This means that the access problems that are emerging now could be more severe in the future.
- Firms are increasingly moving their retirees to Medicare managed care. To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in 1996.¹⁵

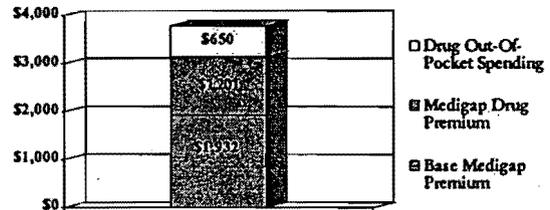
MEDIGAP PRESCRIPTION DRUG COVERAGE

- Because of its high cost relative to its benefit, less than one in ten Medicare beneficiaries purchases a Medigap plan with prescription drugs. Three of the ten standardized Medicare supplemental plans, (plans H, I, and J) include prescription drug coverage. All three plan types have a \$250 deductible for the drug benefit and require 50 percent coinsurance. The H and I plans have a cap on drug benefits of \$1,250 while the J plan caps the benefit at \$3,000. The typical premium for a plan with the lower cap costs about \$90 per month or \$1,080 per year.
- Medigap is expensive, inefficient, and often uses higher prices to discriminate against the oldest beneficiaries.

- Expensive. Medigap policies that cover prescription drugs are expensive relative to comparable policies that do not cover drugs. Additionally, premiums vary tremendously from place to place, and from beneficiary to beneficiary. Finally, a beneficiary cannot only pay for prescription drugs – they must also buy the other benefits in the package.

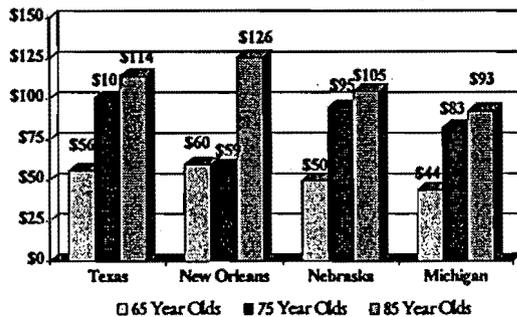
Beneficiaries With Medigap Still Pay High Out-Of-Pocket Drug Costs

Medigap Annual Premiums And Out-Of-Pocket Spending



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

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



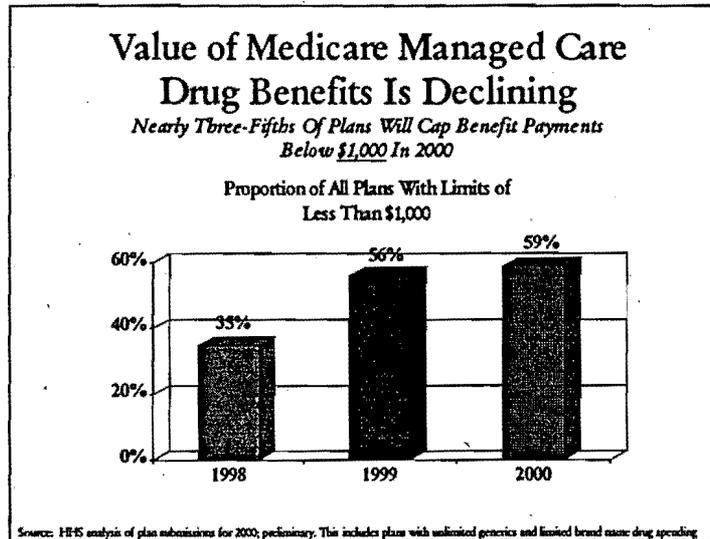
Sample Premiums for 1999. Difference between Plan I (\$1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost \$24 per month.

Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

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

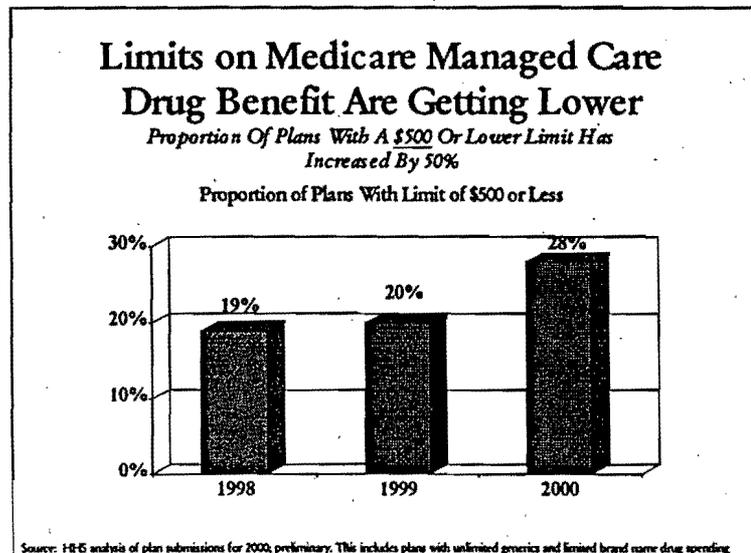
MEDICARE MANAGED CARE

- The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent. Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.
- Drug coverage under Medicare+Choice is unstable. Managed care plans are not required to offer a drug benefit, but can do so with any excess Medicare payments or by charging a premium. This results in wide variation across areas, since payments vary by area, and over time.



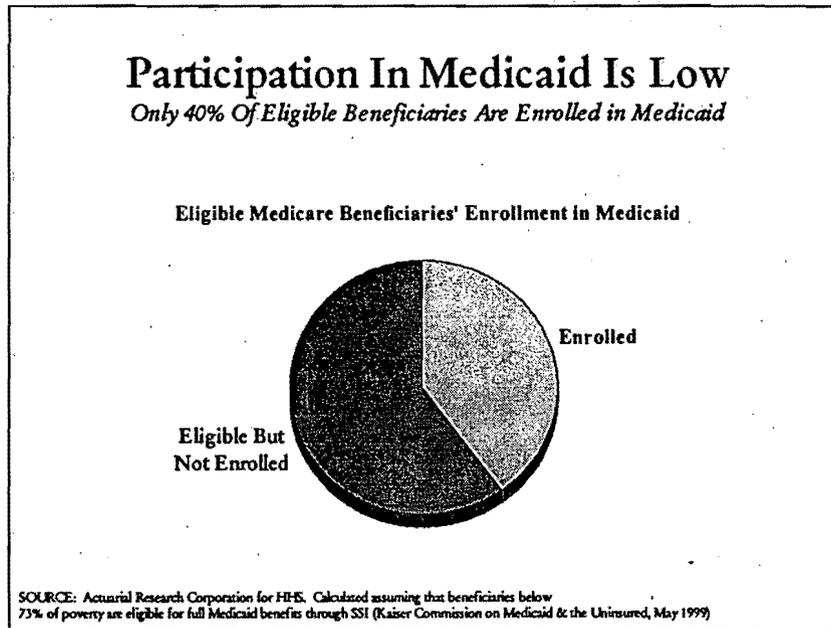
- The value of Medicare managed care drug benefits is declining. Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below \$1,000 in the year 2000. The proportion of plans with \$500 or lower benefit caps will increase by over 50 percent between 1998 and 2000. This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

- Plans dropping out of Medicare limit access to drugs. Nearly 50,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.



MEDICAID

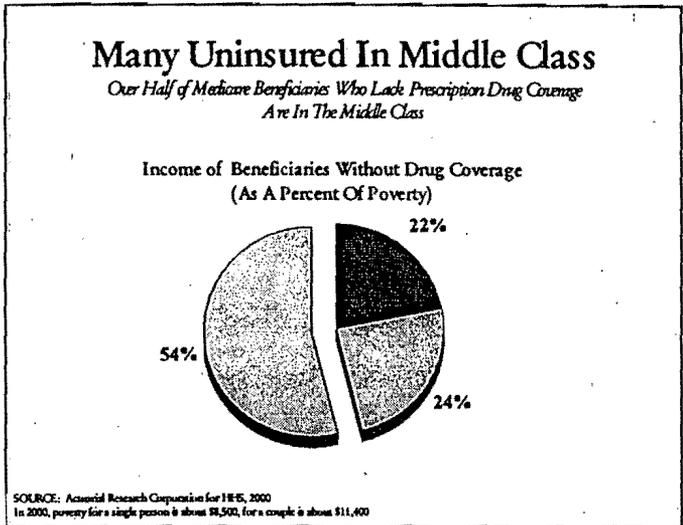
- About 12 percent of Medicare beneficiaries are also fully eligible for Medicaid and its drug benefit. Most of these “dual eligibles” qualify for Medicaid because they receive Supplemental Security Income due to low income (on average, about 73 percent of poverty -- \$6,200 for a single, \$8,300 for a couple in 2000). States have other options for covering the elderly and disabled, including “medically needy” or “spend-down” programs that extend eligibility to sick and/or institutionalized people.



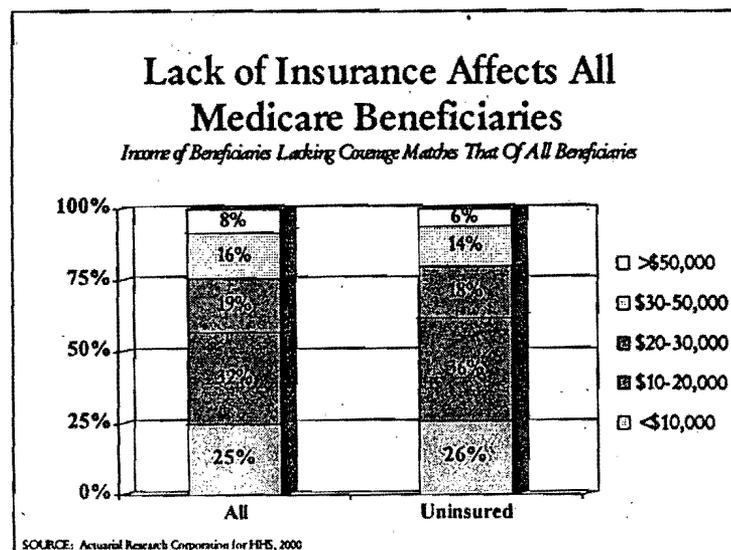
- Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about \$6,000 for a single, \$8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.
 - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.
 - This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries.

BENEFICIARIES LACKING DRUG COVERAGE

- At least 13 million or 34 percent of Medicare beneficiaries have no insurance coverage for prescription drugs. These beneficiaries pay retail prices for prescription drugs, which can often be significantly more expensive than what large firms or public programs pay for the same drugs.
- More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately \$17,000 for couples. This indicates that targeting a drug benefit only to the low-income cannot address even half of the problem.



- The income distribution of beneficiaries lacking drug coverage closely parallels that of all beneficiaries. This lack of difference suggests that everyone is at risk of losing their health insurance.



PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

The President's plan to modernize Medicare would include a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002. This benefit would cost the Federal government about \$118 billion from 2000 to 2009. It would be fully offset, primarily through savings and efficiencies in Medicare and, to a small degree, from the surplus amount dedicated to Medicare.

- **Meaningful coverage.** Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:
 - No deductible – coverage begins with the first prescription filled and
 - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

The benefit would be limited to \$5,000 in costs (\$2,500 in Medicare payments) in 2008. It would phase it a \$2,000 for 2002-2003; \$3,000 for 2004-2005; \$4,000 for 2006-2007; and \$5,000 in 2008 (indexed to inflation in subsequent years).

- **Affordable premiums.** Beneficiaries who opt for Part D would pay a separate premium for Medicare Part D -- an estimated \$24 per month in 2002, and \$44 per month in 2008 when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and, after an initial open enrollment for all beneficiaries in 2001, would occur when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would generally be deducted from Social Security checks.
 - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty (\$17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty (\$15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.
- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.
- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

APPENDIX: METHODOLOGY & ENDNOTES

Methodology. The Actuarial Research Corporation under contract with the Department of Health and Human Services conducted most of the analysis. The basis for the estimates is the Medicare Current Beneficiary Survey (MCBS) for 1995. These data were aged to CY 2000, converted to a point-in-time estimate, and adjusted for the increase in managed care enrollment. This enrollment increase was estimated by moving beneficiaries from retiree health coverage, Medigap and the uninsured to managed care in proportion to their enrollment in those plans.

Endnotes.

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 - ¹⁴ Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.
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Annual Process under the Competitive Defined Benefit Program

Under the new competitive defined benefit (CDB) program, payments to Medicare+Choice organizations would be based on their bids rather than on statutory formulas. The amount of that bid paid for by the beneficiary is determined below.

1. HCFA announces the benchmark amounts for each payment area as well as health status and demographic adjustment factors. The benchmark for each area is equal to the greater of the payment rate that would have applied under the Balanced Budget Act of 1997 (BBA) or 96% of national average fee-for-service costs, adjusted to reflect differences in total Medicare spending for the geographic area.
2. Based on that information, each Medicare+Choice organization informs the Secretary of its intent to offer a plan in the following year and the service area of the plan.
3. Later in the year, each Medicare+Choice organization submits a bid for each plan it is offering, including the reduction in cost sharing for Medicare benefits included in the bid (up to 15% of the value of covered services). Each organization also submits information on supplemental benefits offered under each plan (which are not included in the bid).

HCFA calculates the beneficiary premium for Part A and Part B benefits by comparing the plan's risk adjusted bid to its benchmark:

- If the bid is less than the benchmark, the beneficiary would receive 75 percent of the savings – first, in the form of a Part B premium rebate, second, in the form of cost-sharing reduction if there is no more Part B premium to buy down.
 - A beneficiary choosing a plan whose bid is higher than the benchmark would pay all of the difference directly to the plan as a basic plan premium, in addition to paying the Part B premium.
4. In November, the coordinated open enrollment period takes place. Enrollments are effective in January.
 5. Beginning in January, Medicare+Choice organizations receive monthly payments for the full amount of their bids (subject to risk adjustment). These payments either come directly from HCFA or in combination from HCFA and beneficiary premiums.

**PRESIDENT'S COMPETITIVE DEFINED BENEFIT PROPOSAL
FLAWS IN THE CURRENT MANAGED CARE PAYMENT SYSTEM**

- **Medicare pays a flat rate, set by a complex statutory formula, that has nothing to do with managed care plan prices.** Under current law, Medicare pays a flat rate to managed care plans. One rate is set for every county based on complicated statutory rules. These rates build in a modest discount of 4 percent relative to the average traditional program costs to approximate the lower cost of delivering care in managed care settings. All managed care plans, regardless their actual costs, get paid the same rate by Medicare. As a result, the only way that Medicare can save from managed care is when a beneficiary switches from the traditional program to a private plan. Medicare does not save when a beneficiary chooses to move from one managed care plan to a more efficient plan, since it pays all plans the same.
- **Even after the Balanced Budget Act changes, experts still think that plans are overpaid.** Before 1997, experts agreed that the discount built into managed care payment rates was not enough to account for managed care efficiencies and selection of healthy beneficiaries, resulting in overpayments. Although the BBA took steps to correct for this, a June 1999 report from the General Accounting Office found that managed care plans still appear to be overpaid. For example, managed care plans in Los Angeles can provide the traditional Medicare benefits package for 79 percent of what they are currently paid.
- **Today, the only way that plans can compete for beneficiaries is by providing attractive extra benefits.** Managed care plans must use government overpayments to offer extra benefits – they are not allowed to offer savings to beneficiaries by providing the same benefits at a reduced premium. The 7 million beneficiaries in managed care join plans in part because of these benefits. Under today's system, where prescription drug coverage can be otherwise unaffordable or inaccessible for many beneficiaries, managed care may be the only way to get this coverage. However, this competition in extra benefits has several flaws:
 - **Hard to compare benefits.** The unstandardized, additional benefits offered by managed care plans makes it difficult for an apples-to-apples comparison that is needed for true price and quality competition. For example, it is not clear whether an uncapped drug benefit with a \$50 premium is more valuable than a capped benefit, with no premium and extensive preventive services. Moreover, beneficiaries cannot choose their extra benefits – the plan designs the package and beneficiaries take it or leave it.
 - **Easy to manipulate benefits to attract healthy/discourage sick beneficiaries from enrolling.** Managed care plans can currently offer benefits like coverage of medical emergencies when travelling abroad or prevention that may be attractive to healthier seniors, but not services like personal assistance needed by people with chronic illness.
 - **Unfair to subsidize benefits only in high-cost areas.** Over 11 million beneficiaries nationwide, including nearly 75 percent of rural Medicare beneficiaries, do not have access to any Medicare managed care plan. Even though these beneficiaries pay the same Part B premium, they do not have access to extra benefits. Another 5 million beneficiaries have access to only one plan which typically offers few extra benefits.

PROPOSED COMPETITIVE DEFINED BENEFIT PROPOSAL

- **Competitive managed care payment system.** This proposal would complement the President's proposed modernization of the traditional program by injecting price competition into managed care payments to give Medicare beneficiaries the benefit of market forces. It would begin in 2003, when Medicare's risk adjustment system is almost fully implemented. It would save about \$8 billion from 2003-09 for the Medicare program and over twice as much for beneficiaries. Specifically, this plan includes:
 - **Managed care payments based on price competition, not fixed rates.** Managed care plans would be paid based on their competitively-bid prices, not a flat rate set by the government. The lower the price, the less beneficiaries would have to pay to enroll in the plan. When beneficiaries choose these lower cost plans, both beneficiaries and the government would save. As such, Medicare spending would be reduced through competition, not by artificially lowering managed care payment rates.
 - **Beneficiaries' premiums based on their managed care choice.** Beneficiaries could, for the first time, reduce their Part B premiums by choosing a low-cost managed care plan. They also could remain in traditional Medicare and pay the same premium that they would under current law. Thus, unlike other competitive proposals, it would encourage beneficiaries to choose more efficient plans using a "carrot" of allowing them to share in the savings rather than the "stick" of raising premiums for traditional Medicare which may force beneficiaries to opt for plans that are not suited for them.
- **Encourages competition on price and quality.** Price and quality competition would replace today's practice of managed care plans competing solely on how many and what type of extra benefits they can offer. Beneficiaries enrolling in lower cost plans would have a lower Part B premium. They could choose to keep these savings or use them to purchase extra benefits from their managed care plan.

The ability of this competition to work effectively is strongly linked to the President's plan to add a prescription drug benefit to Medicare, which creates a level playing field between traditional Medicare and managed care plans, and frees beneficiaries from seeking out managed care plans only because they need prescription drug coverage.

- **How the managed care competitive payment system would work:**
 1. **Managed care plans would set their prices.** Managed care plans would set their prices based on the cost of providing Medicare's defined benefits, including the new prescription drug benefit and other benefit improvements contained in the President's plan (plans would have a separate price for beneficiaries who do not choose the voluntary drug benefit). Plans could include in their prices the cost of lower Medicare cost sharing, so long as the cost of that reduction does not exceed 10 percent of the value of the base package. Because the premium that beneficiaries pay is based on their price, plans would have an incentive to reduce this price while providing high-quality benefits to attract enrollees.

2. Prices would be compared to traditional Medicare to set beneficiary premium.

This system is intended to promote fair competition between managed care and traditional fee-for-service. Three simple rules would be used to assess how much beneficiaries pay in premiums:

- Plans priced about the same as traditional Medicare: Beneficiaries choosing a plan whose price is slightly less than traditional Medicare's cost would pay the current law Part B premium. This discount is intended to continue the current policy of allowing the government to share in the savings from managed care (the 4 percent discount is the amount that is estimated to be built into the rates in 2003), and it might be eliminated if savings from competition permit.
- High-priced plan: Beneficiaries choosing a plan whose price is above that of 96 percent of the traditional Medicare costs would pay all of the additional price.
- Low-priced plan: Beneficiaries choosing a plan whose price is below 96 percent of traditional Medicare's would pay a lower premium. Specifically, they could keep 75 percent of the difference between traditional Medicare's average costs and the plan's price. This would buy down the Medicare Part B premium, so that beneficiaries choosing plans whose prices are below about 80 percent of traditional program costs would pay no Part B premium.

3. Government payments are determined by plan price. In general, the government would pay the difference between the plan price and the beneficiary premium. For high-price plans, the government would pay managed care plans what it pays today: the discounted average costs of traditional Medicare. For low-price plans, the government would get a 25 percent share of the savings (beneficiaries get 75 percent). As such, both the government and beneficiary save when low-price plans are chosen.

- **Risk adjustment.** To ensure that competition is based on price, a risk adjustment system would need to be in place at the start of this proposal. Risk adjustment raises or lowers private plan payments based on the likelihood that a beneficiary will develop costly health problems. It reduces the incentive for private plans to attract healthy beneficiaries and avoid sick beneficiaries. The plan assumes implementation of the risk adjustment system required under the Balanced Budget Act of 1997 which will be fully phased in by 2004.
- **Geographic adjustment.** The proposal would adjust the government's share of managed care payments to account for geographic cost differences. Since there is one, nationwide premium for traditional Medicare, this adjustment is needed to ensure that premiums for managed care are comparable to traditional Medicare in all areas. The government would pay an amount reflecting the full geographic costs in high-cost areas, which is higher than current law. In low-cost areas, the plan payments would reflect a blend of local and national rates included in the BBA, which increases payments to these low-cost areas.

EXAMPLE: HOW COMPETITIVE DEFINED BENEFIT SYSTEM WOULD WORK

The table below shows how this system would work in an average cost area. It assumes that the Part B premium is \$50 per month (it is projected to be \$48.50 per month in 2000).

- Low-price plan. If the managed care plan's price were \$67 or 17 percent lower (\$433), then the beneficiary would have no premium payment.
- Medium-price plan. A beneficiary choosing a medium-price managed care plan which costs \$10 less (\$490) would keep 75 percent of that savings, or \$7.50. As a result, his or her premium would be \$42.50 rather than the \$50 Part B premium. The government payments would also be reduced, by 25 percent of the savings. Its payment would be \$447.50 rather than \$450 (a savings of \$2.50 per month).
- Equal to 96% of Traditional Plan. A beneficiary choosing a managed care plan whose bid is slightly less than traditional Medicare (\$500) would pay the same premium that he or she would pay to stay in traditional Medicare -- \$50. The government would make the same managed care payment in this case as under the current system (total payments to plans equal 96% of traditional program costs).
- High-price plan. A beneficiary choosing a managed care plan whose price is higher than 96 percent of traditional Medicare (\$520) would pay \$70 per month. The government would pay \$450 -- the maximum that it would pay for any higher priced plans.

Example: Competitive Defined Benefit Proposal

Option	Plan Price (monthly)	Split of Plan Payments	
		<i>Beneficiary</i>	<i>Government</i>
Low-Price Plan	\$433.33	\$0.00 0%	\$433.33 100%
Medium-Price Plan	\$490.00	\$42.50 9%	\$447.50 91%
Price Equals 96% Of Traditional Costs	\$500.00	\$50.00 10%	\$450.00 90%
High-Price Plan	\$520.00	\$70.00 13%	\$450.00 87%

NOTE The beneficiary premium rate is \$0 for managed care plans whose price is about 80 percent of traditional Medicare program costs (the exact level where this occurs would depend on what percentage the Part B premiums is of total Medicare when the system goes into effect).

ADVANTAGES OF THE PRESIDENT'S PROPOSAL FOR COMPETITIVE DEFINED BENEFIT

- **Saves through competition, not through legislated rate reductions.** This proposal produces Medicare savings by paying managed care plans based on their prices and encouraging competition on price and quality for Medicare's defined set of benefits. By aligning beneficiary incentives to choose low-price plans with Medicare payment rates, Medicare spending would be lowered as a result of beneficiaries' choices, not due to legislated rate reductions. In the long-run, this should make Medicare more efficient.
- **Maintains a strong, viable, competitive traditional Medicare program.** The President is committed to strengthening and improving the traditional program, which serves over 80 percent of all Medicare beneficiaries. By giving it private sector cost containment and quality improvement tools, this proposal would reduce traditional Medicare's costs and make it a sustainable, reliable option for beneficiaries in this competitive system, further strengthening competition in Medicare. Moreover, the premium for traditional Medicare would be set as it is currently and in fact would be lower than current law due to the savings in the proposal. This keeps traditional Medicare as an affordable option in this more competitive system.
- **Assures that the government payments for managed care keep pace with inflation.** Unlike restructuring options that fix the government contribution at a particular rate and then index its growth, this proposal would base the government payment on the traditional program costs. Thus, over time, the maximum government payment would grow at the same rate as the traditional program. This would protect beneficiaries from assuming an increasing share of the premium over time. However, if the traditional program growth rises excessively, beneficiaries would have an even greater incentive to enroll in managed care, if managed care plan costs fall relative to traditional Medicare. This would put pressure on traditional Medicare to reduce its cost growth.
- **Promotes fair competition between managed care and traditional Medicare.** This proposal bases its price competition on a central concept: beneficiaries choosing a managed care plan whose price is about the same as the traditional program would pay the same Part B premium as those in the traditional program. Those choosing more expensive plans would pay more, and those choosing less expensive plans would pay less. This encourages fair competition between managed care and traditional Medicare, but does not penalize beneficiaries that believe that traditional Medicare best fits their needs. Additionally, the government payments would be geographically adjusted to assure that premiums within each market are different only due to efficiency and quality, not higher local costs.
- **Begins in 2003, assuring an adequate transition.** Any restructuring proposal is that it is too ambitious and causes too much disruption in a short period of time can have costs that outweigh its long-term benefit. This proposal would begin in 2003, when the implementation of Medicare risk adjustment is nearly complete. This would also allow time for beneficiary and managed care plan education as well as preparation and systems changes to assure efficient administration.



DATE: February 23, 2000

FROM: Richard S. Foster
Office of the Actuary

SUBJECT: Request from Representative Stark Regarding Proposed "Medicare Preservation and Improvements Act of 1999"

TO: Bill Vaughan
Ways and Means Health Subcommittee Minority Staff

This memorandum is in partial response to Representative Stark's request of December 1, 1999, for actuarial information regarding S. 1895, the "Medicare Preservation and Improvements Act of 1999," as introduced by Senators Breaux and Frist. Please convey my apologies to Mr. Stark for the delay in our response. At this time, we are still working on estimates of the impact of the Breaux-Frist bill on Medicare revenues and expenditures. Estimation of beneficiaries' choices of plans, as well as what plans would be offered, is complicated by the high- and low-option provisions of the bill and the constraints placed on plans' cost-sharing rules. We will, however, try to answer Mr. Stark's other questions on a preliminary basis.

Mr. Stark asked to what extent the proposal would increase premiums for fee-for-service beneficiaries relative to present law. The premium formula specified in S. 1895 is essentially the same as the one developed by the staff of the National Bipartisan Commission on the Future of Medicare. As an incentive for beneficiaries to enroll in more efficient plans, it would reduce premiums for plans with below-average costs and increase them for plans with above-average costs (including the traditional fee-for-service Medicare plan). The increase for fee-for-service beneficiaries would depend on (i) the proportion of beneficiaries in private plans (since greater private enrollment results in a lower weighted average premium), and (ii) the average cost for enrollees in private plans relative to fee-for-service beneficiaries, after adjustment for geographic and health-status differences. The comparison is also affected by the 12-percent factor used in the premium formula, as described below.

If the proposal had *no* impact on beneficiary enrollment in private plans, compared to present law enrollment in 2003, then we estimate that the standard-option fee-for-service premium would be about 47 percent greater than the SMI premium under present law. This increase can be allocated as follows:

Increase due to operation of premium formula.....	25%
Increase due to use of 12% factor in premium formula, versus estimated 9.8% beneficiary cost under present law in 2003	22%
Total impact.....	<u>47%</u>

As noted above, we have not yet been able to estimate the impact of S. 1895 on the proportion of beneficiaries enrolled in private plans; therefore the impact on fee-for-service premiums shown

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

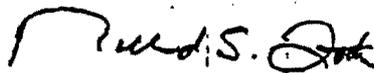
As indicated above, a substantial part of the illustrative increase in fee-for-service premiums is due to the 12-percent factor in the premium formula, rather than the actual level of SMI premiums as a percentage of total Medicare costs (currently estimated to be 9.8 percent in 2003). The Medicare Commission's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

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

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

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

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


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

DRAFT 2/8/00

MEDICARE:

ITS LONG-TERM CHALLENGES

THE BREAUX-FRIST PROPOSAL

CLINTON-GORE PLAN FOR MODERNIZING AND
STRENGTHENING MEDICARE

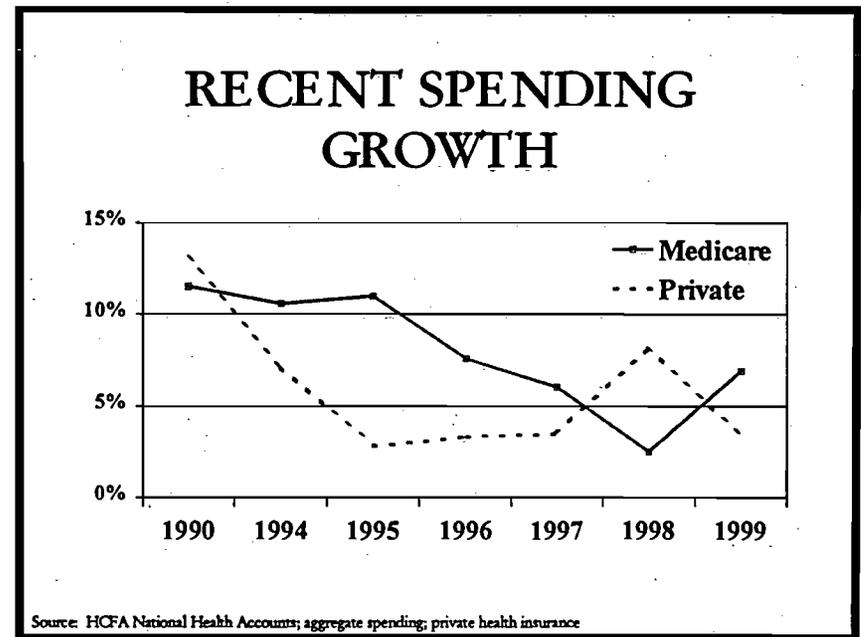
I. OVERVIEW

IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans.** About 34 million elderly and 5 million people with disabilities receive Medicare.
- **Helps many who would otherwise be uninsured.** Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65 and recent declines in retiree coverage, this problem would inevitably be worse today.
- **Improves life expectancy, access to care and reduces poverty.** Since 1965:
 - Life expectancy of people at age 65 has increased by 20 percent (from age 79 to 82);
 - Access to care has increased by one-third (elderly seeing doctors: 68 to 90 percent); and
 - Poverty has declined by nearly two-thirds (29.0 to 10.5 percent).

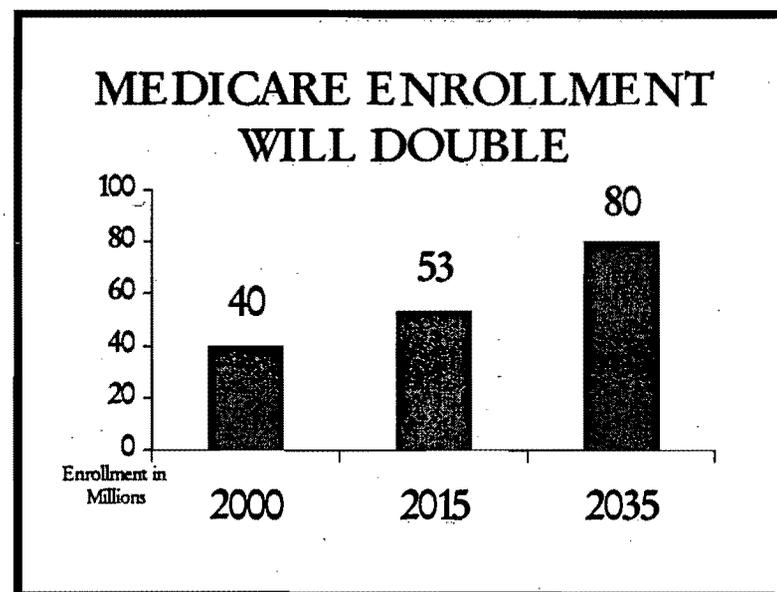
MEDICARE'S FINANCIAL STATUS HAS IMPROVED

- **Trust Fund strengthened.** In 1993, when President Clinton took office, the Hospital Insurance (HI) Trust Fund was projected to be exhausted in 1999. However, due to policy changes, good management, a strong economy and aggressive efforts to reduce fraud and waste, Medicare spending growth has slowed. As a consequence, the Trust Fund now is projected to be solvent until 2015.
- **Cost growth slowed.** Medicare spending is now growing at a slower rate than the private sector. The Federal Employee Health Benefits Program, considered a good indicator of private trends, experienced an average premium increase of over 9 percent in each of the last several years— double that of Medicare's per capita cost growth.



CHALLENGES FACING MEDICARE: CHANGING DEMOGRAPHICS & HEALTH CARE

- **More beneficiaries.** Enrollment in Medicare will climb when the baby boom generation retires: from around 40 to 80 million by 2035 - from 14 percent to about 22 percent of the population.
- **Fewer workers.** The ratio of workers who support Medicare beneficiaries is expected to decline by nearly 40 percent by 2030 (3.4 workers per beneficiary in 2000; 2.3 in 2030).
- **Cost growth will rise.** Although cost growth in Medicare has recently been reined in, it is expected to rise. Average annual per capita cost growth is projected to nearly double for the 2003-2010 period compared to 1998-2002 (5.1 v. 2.6 percent). This could be compounded by advances in medical science that have great potential to improve the quality and length of life, but could come at a high cost.



INFLEXIBLE PAYMENT SYSTEMS, INADEQUATE REVENUES

- **Insufficient flexibility in traditional Medicare to adopt best private sector practices to reduce costs and increase quality.** Medicare is governed by statutory constraints that limit its ability to adopt innovative payment, management and quality improvement strategies.
- **Medicare pays managed care plans through a complex statutory formula that has nothing to do with health plan prices.** Instead of competing on prices, plans compete by providing extra, specialized benefits. This system:
 - Overpays managed care plans according to most independent experts;
 - Makes it hard for beneficiaries to comparison shop for the plan that offers the best value;
 - Unfairly subsidizes extra benefits for the subset of beneficiaries in high payment areas. About 75 percent of rural beneficiaries living in low payment areas have no managed care option and thus no extra benefits.
- **New revenues needed even with reforms.** Today's financing structure for Medicare, created in 1965, was not designed to account for the retirement of the baby boomers which will double enrollment. Even with reforms that substantially slow cost growth, experts agree that there is no way that Medicare's current revenue base can meet its future needs.

ADDITIONAL CHALLENGES FACING MEDICARE LACK OF PRESCRIPTION DRUG COVERAGE

- **More than three in five Medicare beneficiaries lack dependable drug coverage.**
 - More than one-third of beneficiaries have no coverage at all. Prescription drugs have become central to modern medicine, yet at least 13 million Medicare beneficiaries have no coverage. Over half (54 percent) of beneficiaries without drug coverage have income above 150 percent of poverty (about \$12,750 for a single, \$17,000 for a couple).
 - Medigap coverage has grown very expensive and less common. Medigap policies with drug benefits cover only about 8 percent of beneficiaries. Medigap benefits are limited (\$250 deductible, low cap) and premiums have been rising and increase dramatically with age.
 - Medicare managed care plans provide only limited access. Only 16 percent of beneficiaries get their drug coverage through managed care plans. The value of Medicare managed care drug benefits is declining – nearly three-fourths of plans are capping drug spending at or below \$1,000 in 2000. The proportion of plans with caps of \$500 or less increased by 50 percent between 1999 and 2000.
- **While about 25 percent of beneficiaries are covered through private retiree health plans, this coverage is declining.** The number of firms offering retiree health insurance coverage dropped by 25 percent from 1994-1998. This trend will almost inevitably continue.

II. THE BREAUX-FRIST PROPOSAL

- “**Competitive Premium System.**” Virtually identical to the Breaux-Thomas premium support, this plan caps the government payments for each beneficiary at the national weighted average premium. Beneficiaries’ Part B premium would depend on the relationship between their plan’s total costs or “bid” and the weighted average. Traditional Medicare would operate as a private health plan: its premiums would depend its bid compared to average and its annual funding would be capped at the level of its bid.
- “**High-Option” and Prescription Drugs.** All Medicare plans would offer a “high-option.”
 - Benefits: The high-option includes both prescription drug coverage, designed by insurers and approved by the Board, that has an actuarial value of at least \$800 and a \$2,000 stop-loss for Medicare cost sharing (not for drugs). Beneficiaries cannot buy drugs alone (must also by stop-loss).
 - *In managed care*, operates like today: enrollees could get reduced cost sharing, other benefits.
 - *In traditional Medicare*, beneficiaries would get their drug benefit from any private insurer willing to offer coverage (no Medicare-sponsored option). They would not be allowed to purchase Medigap for the Part A deductible, etc. and the high option would not include extra benefits.
 - Premium assistance: Beneficiaries choosing the high-option plan would receive premium assistance equal to 25 percent of the value of the drug part of the benefit (more for low-income beneficiaries). Most beneficiaries would pay for 75 percent of the drug cost plus 100 percent of the stop-loss cost.

- **Medicare Trust Funds.** The Part A and Part B Trust Funds would be merged, combining current HI revenues, plus enrollee premiums and certain user fees. It would draw on general revenues for any shortfall, so long as this contribution does not exceed 40 percent of benefit payments. Congress would have to authorize additional funding beyond the 40 percent level to assure that the Medicare Board could continue making payments to plans, including traditional Medicare, to provide benefits.
- **Medicare Board.** A seven-member Board would be established as an independent federal agency (eventually financed through user fees from plans) to:
 - Administer the competitive premium system and oversee the operations of all Medicare plans, including enrollment, contract oversight, and beneficiary education; and
 - Approve and authorize payments for all plans, including traditional Medicare.

The Health Care Financing Administration (HCFA) would be reorganized into two divisions: one that runs the new health plan operating Medicare fee-for-service and a second that would manage graduate medical education, Medicaid, the State Children's Health Insurance Program, and other functions. Rather than explicitly modernizing the traditional program, the proposal would have HCFA submit a business plan to directly to Congress every year, beginning in 2002, for approval.

CONTRIBUTIONS OF THE BREAUX-FRIST PROPOSAL

- Continues the focus on the need for long-overdue reforms to prepare Medicare for this new century's financial and demographic challenges.
- Injects competition into Medicare managed care payments.
- Improves upon the Breaux-Thomas Medicare reform proposal by:
 - Rejecting a drug benefit that focuses only on low-income beneficiaries. Such approaches leave out millions of Medicare beneficiaries who do not have affordable, accessible access to prescription drug coverage.
 - Not raising the eligibility age for Medicare. Most experts agree that this policy will inevitably increase the number of uninsured Americans since there are few alternative sources of coverage for this vulnerable population.

SHORTCOMINGS OF BREAUX-FRIST PROPOSAL DOES LITTLE TO IMPROVE MEDICARE'S FINANCIAL OUTLOOK

- Does not address Medicare's long-term financing shortfall. The Breaux-Frist proposal limits rather than increases the amount of funding available for Medicare. It places a cap on the general revenue contribution to Medicare (40 percent of benefit costs), making its Trust Fund problem worse at a time when additional funding is clearly needed. Also, the cost of the drug benefit premium assistance may exceed the overall plan savings, increasing the drain on funding.
- Does not significantly slow Medicare spending growth.
 - The only explicit savings proposal in the bill is the competitive premium system. There are no specific policies to reduce fraud, improve quality, or keep cost growth in line with private sector growth.
 - Much of the government savings would come from increased beneficiary premiums, not reduced spending. Beneficiaries would pay higher premiums for any plan whose cost is higher than the average of all plans. Since most managed care plans have costs below the traditional program, its costs will be higher than the average. As such, the premium to stay in traditional Medicare would go up. Since four in five beneficiaries are in traditional Medicare, most savings from this system would likely come from beneficiaries – not a reduction in overall Medicare spending growth.

FLAWED PRESCRIPTION DRUG BENEFIT

- **Drug benefit may not be available to all beneficiaries.** Although the plan suggests that all beneficiaries would have access to a drug benefit, it relies solely on private insurers to deliver it. Representatives of the Health Insurance Association of America have indicated that their health plans have strong reservations about participating in this policy design (for fear of ending up with the sickest beneficiaries). As a consequence, private plans may not offer the benefit in all areas. The Board, charged with assuring access, would have to come up with an as-yet unspecified solution.
- **Drug benefit premiums would not be affordable for all Medicare beneficiaries.** Since the plan provides a low amount of assistance for only the drug portion of the total high-option premium, the amount that the beneficiary would pay could be quite high. Moreover, the low-income protections may not extend to the entire high-option premium (only to the drug part).
- **Design could increase costs to beneficiaries and taxpayers.** Under this plan, insurers would probably compete more on attracting healthy beneficiaries than price, efficiency and quality since they could design coverage (deductibles, copays, caps) and participate wherever they like, with Board approval. This would increase costs and probably lower discounts.

OTHER SHORTCOMINGS

- **Puts commitment to the guarantee of Medicare services at risk.** In the course of a year, if the costs of providing services exceeds capped payments and its reserve fund, then traditional Medicare would have to limit provider payments (e.g., reduce special payments to rural hospitals), limit services (e.g., reduce the number of nursing home days covered), or increase beneficiaries' cost sharing.
- **Dilemma for rural beneficiaries.** A special provision in the competitive premium system would allow beneficiaries with no private plan options to pay a premium for traditional Medicare that is lower than in areas with managed care plans. As a result:
 - Medicare beneficiaries would pay different premiums for the same traditional Medicare depending on where they live.
 - Beneficiaries with as few as one private plan option would be forced to choose between paying a higher premium to remain in the traditional plan or enrolling in managed care.
- **Creates unaccountable bureaucracy for Medicare.** The Breaux-Frist plan creates a Board that is independent of executive branch oversight. Not only would this add to administrative costs and beneficiary confusion, but would lessen the accountability that Medicare now has to the Administration, Congress and others.

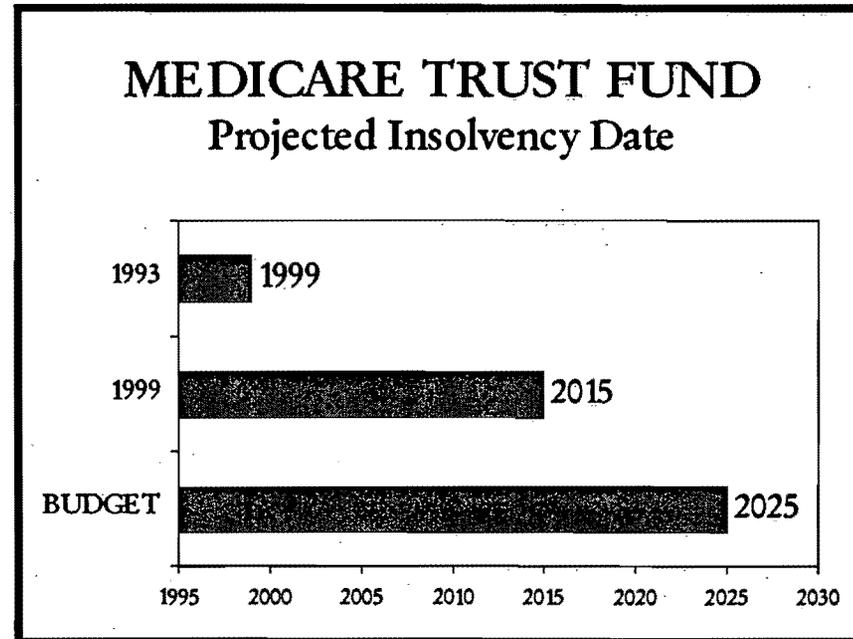
III. CLINTON-GORE PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

- The Administration's FY 2001 budget dedicates \$432 billion over 10 years to strengthen and modernize Medicare. This is equivalent to over half of the on-budget surplus. This dedication is part of a comprehensive plan that extends the life of the Trust Fund by a decade to 2025, and:
 - Makes Medicare more competitive, efficient and fiscally sound. This includes:
 - Surplus dedication to the Medicare Trust Fund;
 - Providing traditional Medicare with private-sector purchasing and quality improvement tools;
 - Improving price competition through the Competitive Defined Benefit program; and
 - Continuing to ensure program integrity and keep Medicare growth in line with the private sector.
 - Modernizes Medicare's benefits. This includes:
 - Adding a long-overdue, voluntary prescription drug benefit;
 - Improving Medicare's preventive benefits; and
 - Rationalizing Medicare's cost sharing.

MAKING MEDICARE MORE EFFICIENT, COMPETITIVE AND FISCALLY SOUND

- **Dedicates nearly three-fourths of the amount dedicated to Medicare to its Trust Fund.** To address the future financing shortfall, the budget dedicates \$299 billion of the non-Social Security surplus to Medicare over 10 years – which not only helps to extend the financial health of the Trust Fund through 2025, but reduces publicly held debt since these funds will not be available for tax cuts or other spending.
- **Gives traditional fee-for-service Medicare new private-sector purchasing and quality improvement tools.** The President’s plan would provide authority for competitive pricing within the existing Medicare program, use of disease management to improve quality, coordination of care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing and quality improvement mechanisms.
- **Improves price competition in Medicare through the “Competitive Defined Benefit” program.** This proposal would inject true price and quality competition into Medicare. While keeping the same Part B premium for those remaining in the traditional program, the policy allows beneficiaries to pay lower premiums for choosing efficient private plans. 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.

- Constrains out-year Medicare spending growth and continues to ensure program integrity.** Despite a strong recent record of reducing fraud and waste in Medicare, experts suggest that average annual Medicare spending growth per beneficiary will nearly double for 2003-2010 compared to 1998-2002. The FY 2001 budget includes the anti-fraud and waste proposals from the FY 2000 budget and moderated out-year savings proposals to protect against a return to excessive growth rates.
- Savings from Medicare total \$70 billion over 10 years.** The budget preserves its commitment to the Balanced Budget Refinement Act, recognizing that in some cases its payment reductions were excessive. This budget's savings are only about \$3 billion in the first two years, and over 33 percent less than the budget and reform plan savings proposed last year (hospital payment reductions are over 50 percent less than last year's proposals).



MODERNIZING MEDICARE BENEFITS

Prescription Drug Benefit

- Establishes a new voluntary Medicare prescription drug benefit that is affordable to all beneficiaries and the program. The drug benefit 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 with no premiums for low-income beneficiaries. Provides privately-negotiated discounts for all drug expenses. Has no deductible and pays for half of spending up to \$5,000 when 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. Beneficiaries ensured access to medications off formulary if physician deems medically necessary. Managers use best quality improvement tools.
- Creates a \$35 billion reserve fund to add protections for catastrophic drug costs. This reserve permits the Administration to work with Congress to design protections for catastrophic drug costs. If no consensus emerges, the reserve would be used for debt reduction.

Improving Preventive Benefits and Rationalizing Cost Sharing

- **Promoting prevention for Medicare beneficiaries.**
 - Eliminating all preventive services cost sharing. This includes eliminating the deductible for colorectal cancer screening and diabetes self-management benefits and copays for screening mammography, hepatitis B vaccinations, and prostate cancer screening.
 - Improving Medicare preventive benefits. This includes a smoking cessation demonstration and a U.S. Preventive Services Task Force study on seniors' needs.
- **Rationalizing Medicare cost sharing.** The plan would change Medicare cost sharing by:
 - Reinstating a 20 percent clinical laboratory coinsurance. This makes lab services consistent with other Part B benefits and could cut down on fraud and help reduce over-use. Lab services would also count toward the Part B deductible.
 - Indexing the Part B deductible to inflation. Medicare's Part B deductible of \$100 would be indexed annually to inflation so its value does not decline over time.
 - Reforming Medigap. The plan would add a new plan option with nominal cost sharing, update existing plan options, and improve access for those losing managed care.

REMARKS BY TREASURY SECRETARY LAWRENCE SUMMERS
AT THE URBAN INSTITUTE PANEL DISCUSSION

SUBJECT: MAKING COMPETITION WORK FOR MEDICARE
THE URBAN INSTITUTE
WASHINGTON, D.C.

8:40 A.M. EDT
THURSDAY, SEPTEMBER 9, 1999

SEC. SUMMERS: (Applause.) Thank you very much. Thank you very much, Marilyn, and I'm very glad to be here. Before I say anything else, I want to echo what Bill Gorham said about Herb Stein. Probably more than any other individual I can think of, Herb Stein graced fora like this for many, many years in this city. Whatever the issue was, whatever the challenge was, Herb Stein was a voice of conspicuous clarity, constant good humor, and frequent -- almost always spoke the real truth. He was for many, many of us -- and I remember the first few times that I had the chance to come to Washington as a young academic; he was a tremendous example of what it meant to be a policy economist in the best sense of that term. He always spoke the truth, even when the truth was inconvenient to the position that he was advocating. He always, to use a phrase that the president uses often in a different context, put progress ahead of partisanship, and he did an enormous amount to advance our understanding of the many public policy challenges that are ahead of us.

It is satisfying to me that he did live to see the United States budget go into surplus, he did live to see us in a position to start to think rationally about what our national priorities were as we allocated our budget. And he does live on in the influence that he has had on so many of us who attempt to imitate the clarity which he brought to public policy discussions.

Marilyn, I appreciate your organizing this event, and I appreciate all of the Urban Institute and the other organizations' work in this area.

The remarkable advances in science, in techniques of health care delivery, have given us a health care system today at the end of this century that is dramatically different from the one that existed in 1965, when Medicare was introduced. Clearly, a health care system -- a health care program that was right for beneficiaries 34 years ago is unlikely to be right for Americans today, but I think we can all agree that having the right Medicare system, one that guarantees America's senior and disabled citizens high-quality health care, is today more important than ever.

I want in that regard to commend Representative Thomas, who will be here in a few moments, and Senator Breaux, for their leadership in the bipartisan Medicare commission. That group has advanced the debate over how to improve the health care

and social safety net for older and disabled Americans. Their efforts and those of others, including Senate Finance Committee Chairman Roth and Ranking Member Moynihan and many others, have given rise to an atmosphere where meaningful bipartisan reform seems possible.

Yesterday in New York, I had an opportunity to reflect on what seemed to me the crucial factors behind our economic strength in this country and to reflect on the priorities that seemed most important going forward. Broadly, I highlighted two things. I highlighted the absolute centrality of fiscal responsibility to the strength of our economy, and the importance of addressing problems by harnessing market forces in order to address them, what one might call a helping-hand approach that replaced what has too often been a traditional heavy-handed approach to public policy in the past. At the same time, I noted that public actions to support the market system are essential if we are to maximize the results that market competition delivers for the American people.

I believe that it is these themes -- fiscal responsibility, competition, proper management of that competition to assure that it actually works for people -- that need to guide us as we debate how best to modernize Medicare. Indeed, the administration's approach to Medicare reform has stressed two crucial principles, that we must protect the elderly and disabled Americans who rely on Medicare for their health coverage and that by enhancing the level of competition within Medicare we can improve the quality and efficiency of the program without higher premiums for these beneficiaries.

I'd like to focus my remarks on these two points before briefly discussing the fiscal virtues of our proposal and the importance of adding a Medicare prescription drug benefit. Let me say that I am here to make the case that Medicare reform that is good health and social policy can also be good and right economic policy, and it is because the use of the right economic tools can make such a contribution to policy in this area that the Treasury Department has been a very active participant in the design of the administration's Medicare proposal.

The administration firmly believes that adequate protections must be afforded to beneficiaries as we move into a more competitive environment. Traditional Medicare now provides the central care for 84 percent of all beneficiaries and it should not become less affordable for our most vulnerable citizens, even as we do make changes in the program. Perhaps a third or more of elderly and disabled citizens have serious, chronic illnesses and impairments, and their very survival may depend on continuing access to specialized care.

That is why we consider it critical that any reform allow beneficiaries to stay in traditional Medicare for the same monthly premium as under current law, now about \$45 a month. While this would protect the elderly and the disabled, in no way would it exempt Medicare from competition. Let me be clear. It is not necessary, in our judgment, to raise premiums in traditional Medicare in order to have real competition.

The collective efforts of the president, the Medicare Commission and others have given rise to an emerging bipartisan consensus -- bipartisan consensus on the need to act to strengthen and modernize Medicare and that now is the right time. At the same time, one of the greatest concerns that the administration has about the Breaux-Thomas plan and some of the other Medicare reform proposals that have been put forth is that the benefits of competition might be obtained at too high a cost, in terms of exposure of beneficiaries to increased risk. Monthly Medicare premiums are already expected to increase substantially over the next decade, simply because growth in forecast health-care costs will continue.

Against this backdrop, it is especially important that we prevent an extra premium increase from accompanying the transition to a more competitive system, because it wouldn't be right as social policy and frankly because of the damage that it could do to the case and acceptability of more competitive and market-oriented approaches. We believe that it's crucial to select an approach that encourages robust competition among health care providers in Medicare, while preserving the vitality of the social safety net that is so important to many of our citizens.

And I might just note that it was the case, at least as of several years ago -- and, I imagine, the case today -- that while American life expectancy did not stand out in international comparison, American life expectancy, starting at the age of 65, did stand out in the international comparison, and that that is much more prominently the case today than it was in the mid-1960s, before Medicare had taken effect. And that just illustrates that these protections are not just abstractions, and they are not just something financial, but they are something very real for our aged citizens, for many of our parents, for many of our children's grandparents.

The administration believes that the proper approach to Medicare reform would have all plans in the program and traditional Medicare engage in head-to-head competition, while at the same time protecting beneficiaries' premiums.

To be sure, there is a kind of competitive element in Medicare right now. Under the current program, payments to private plans are determined by regulated prices, rather than competitive bidding. And since each beneficiary pays the same basic premium, regardless of plan choice, plans compete primarily by offering extra benefits, rather than on price. These additional benefits vary widely in content and perceived value, so it is difficult for seniors to make apples-to-apples comparisons based on plan costs and quality.

In many ways it's analogous to the situation before airline deregulation where airlines could compete, they could compete vigorously with each other, it's just one thing they couldn't do in an effort to attract customers -- reduce their prices. That led to quite inefficient service mix, it reduced the pressure for efficiency. And that is the difficulty with the kind of competition that we have in Medicare today.

There is yet another problem. If one has competition that can only take place on dimensions of service provided rather than on price, one maximizes the potential for cherry picking, for designing the mix of services so as to compete by selecting the right patients rather than by providing the most important care.

Under the president's approach, private health plans participating in Medicare would submit a competitive bid at the price at which they're willing to cover an average senior citizen. These bids would then be compared to the costs in traditional Medicare to determine the price for a beneficiary of enrolling in that plan.

As under current law, a participant choosing a private plan which costs about the same as traditional Medicare would pay the same premium. But under our proposal -- and this is the crucial point -- someone who opts for a plan that is less expensive would pocket three-quarters of the savings, with the remainder accruing to the Medicare trust fund. As a result, all beneficiaries would have strong new incentives to choose efficient plans, and plans would have strong incentives to deliver the most value for money because if they let their costs grow excessively or their quality slip, enrollment would fall.

The introduction of competition in this way is expected to result in \$9 billion in savings for the government over the next 10 years, and \$22 billion in savings to beneficiaries. At the same time, it will enhance the range of options available to participants, leaving them free to select a plan that could reduce or possibly eliminate their monthly premium.

Let me just say that in health care perhaps more than any other area, I'm sure if Herb Stein were here he would counsel a certain humility in projecting the way in which the system will evolve, in judging the consequences of interventions.

The approach that we have laid out seems to me to be a prudent start down the competitive road. Coupled with the introduction of risk adjustment, it offers the prospect of making competition more vigorous and starting to give people something back when they successfully economize. I don't think any of us can know what the full benefits will be down the road. My judgment, all things considered and given the tremendous costs that our country has paid for fiscal lack of discipline, the scorekeepers in this area are probably correct to be very careful about scoring speculative -- possibly speculative -- benefits from the introduction of greater degrees of competition. I think that is the right, conservative way for us to make policy.

On the other hand, I would just advise that everything that I know as an economist and almost every experience that we have looked at suggests that greater competition brings about more efficiencies, brings about more changes, brings about changes along dimensions that would not have been forecast at the time the competition was introduced, and so I suspect that over time, those estimates might well prove to be underestimates of the benefits that result from introducing a more competitive element.

Some would respond to that by saying, Why not introduce a more forceful, vigorous competition that goes directly at challenging the core Medicare benefit? That, in our judgment, is just too great a risk at this point and it is, therefore, one that we cannot support.

The president's approach recognizes that, as important as they are, these structural reforms and the cost savings that we can bring back, after making appropriate adjustments where problems have shown up, are not likely to generate enough savings to meet the costs of caring for the baby boom generation when it retires. This group knows the facts of that situation better than most.

With an elderly population set to double from 40 million to 80 million over the next three decades, it is clear that additional financing will be necessary to maintain basic health care services and quality for any length of time.

Now, in a real sense, there is only one way in which an economy can provide for its future. Accounting alone does not achieve that objective. The only way an economy can provide for its future is by saving more, and it is clear from our recent experience that the most potent and reliable way to increase our national savings is to raise the amount that we save, raise public savings in our country.

And that is why we believe that it is important to use this moment of budget surplus, this moment of unique economic strength, to take a portion of that surplus, assure that it is not dissipated through new spending -- through new spending programs or through tax cuts, but instead contributes to extra national saving that can be used to reduce future interest costs, raise the size of our national economy in the future, with the benefits earmarked for what are our rising commitments. And that is the essence of the administration's proposal to dedicate more than \$300 billion in on-budget surpluses over the next 10 years to extend the Medicare trust fund solvency beyond 2025.

Let me emphasize what is crucial about this proposal is not accounting. What is crucial is that we take steps today that make room in the federal budget in the future by reducing interest costs, that make room for our economy by increasing national savings and that we do not commit those resources to new uses until we have assured that our existing obligation to pay for our own retirement health care costs is met.

Let me highlight one final aspect of the president's program that I also believe is good economics. As the president has said, nobody would devise a Medicare program today, if we were starting all over, without including a prescription drug benefit. A drug benefit is not just good health policy, it's good economics. The investment in improved and lengthened lives yields benefits that easily justify its costs. And while no economist has yet figured out how to put a price on peace of mind, all current and future seniors will gain peace of mind, knowing that they have a reliable source of meaningful insurance.

Drug therapies have become an ever-larger and more important part of the arsenal of modern medicine, providing more effective and lower-cost treatments for many illnesses that used to result in disability, hospitalization, and death.

But prescription drugs are only effective when they're utilized. Of the estimated 20 million women in this country who could benefit from treatments for osteoporosis, I am told that only about 3 million are treated, even though replacement therapies and other drugs maintain bones that -- help bones maintain their strength are currently widely available. There are many reasons for that gap -- many, many reasons for that gap. But there is no question that one of those reasons is cost and that that is a very shortsighted economy when one considers the costs of treating broken hips down the road.

The president's plan makes needed drugs more accessible to the three-quarters of seniors and the disabled who do not have dependable and affordable drug coverage today. When fully implemented, the drug benefit would cover half a beneficiary's drug expenses, up to \$5,000 a year, at a cost to them that is one-half to one-third as much as a typical Medigap drug plan.

The president's plan does so without price controls. We do adopt best private-sector purchasing practices. But I assure you that we are very mindful of the need to purchase drugs in a reasonable and fair way, that preserves what is absolutely crucial to the future of our health economy, the ability to innovate going forward.

The president's program also provides new subsidies to encourage employers to provide or retain high-quality coverage for their retirees. And let me stress -- because I did not emphasize it, and it's really a crucial part of why this plan is fiscally responsible -- that most of the drugs benefit's costs to the government will be offset by sensible reforms, including the proposal to create true price competition that I have spoken about.

In the time ahead, we have a historic opportunity to reform Medicare in a way that will strengthen our economy and our health system and our future. We look forward to working with Representative Thomas and other members of Congress to enact Medicare reform that we can all support. None of us, I think, have all the answers, but I think we are making progress in coming to a shared recognition of the absolute importance of protections that Medicare provides and the appropriateness of assuring that they are provided in as modern, competitive, and fiscally prudent a way as we possibly can. With this moment, we have a rare opportunity and I hope and trust that we can seize it.

Thank you very much. (Applause.)

**PRESIDENT CLINTON RELEASES NEW STATE-BY-STATE REPORT
DEMONSTRATING URGENT NEED FOR MEDICARE REFORM**

February 29, 2000

President Clinton today will release a new report, called *America's Seniors and Medicare: Challenges for Today and Tomorrow*, providing a state-by-state snapshot of the unprecedented demographic and health care challenges confronting Medicare. It documents the success of the current program and provides new information about its impact on women, Americans over the age of 85, and rural beneficiaries. With this report in hand, the President will urge Congress to move ahead this year to modernize and strengthen Medicare and include in its reforms a long overdue voluntary prescription drug benefit. Among the findings of today's report:

MEDICARE HAS BEEN AN IMPORTANT ANTI-POVERTY PROGRAM FOR MILLIONS OF AMERICANS. Poverty among the elderly has been reduced by nearly two-thirds since Medicare was created. Medicare has contributed to this dramatic improvement by helping seniors pay for the potentially devastating cost of care when they can least afford it.

MEDICARE PROVIDES CRITICAL HEALTH CARE TO 38 MILLION AMERICANS. Over thirty-three million seniors and almost 5 million people with disabilities rely on Medicare. About 11 percent, or 4 million, of Medicare beneficiaries are over the age of 85, and 24 percent, or 9.1 million of them live in rural areas.

- **Women beneficiaries outnumber men in all states.** Over 57 percent of these Americans – about 22 million – are women. This distribution of women to men is consistent across all states, ranging from 51 to 59 percent.
- **10 percent of beneficiaries in 40 states are age 85 or older.** These 4 million beneficiaries over 85 have spent almost a quarter of their lives on Medicare. States in the upper Midwest, including North and South Dakota, Minnesota, Nebraska, Kansas, and Iowa, have the highest proportion of seniors over the age of 85.
- **In 15 states, more than half of Medicare beneficiaries live in rural areas.** In fact, in Mississippi, Montana, North and South Dakota, Vermont and Wyoming, over two-thirds of beneficiaries live in rural areas. The 9 million beneficiaries nationwide living in rural America typically have few to no options for managed care or prescription drug coverage.

MEDICARE PROGRAM ENROLLMENT WILL SURGE, INCREASING THE PRESSURE TO REFORM. About 62 million Americans will be age 65 or older in 2025, compared to 35 million today.

The Medicare Program Continues to Face Demographic Challenges

- **In 2025, there will be 30 states with an elderly population that is at least 20 percent of the total population – compared to no states today.** In Florida, where 18 percent of state residents are elderly today, about 5.5 million people – over 25 percent of residents – will be elderly in 2025 as the baby boom generation retires. Nationwide, this demographic increase is over 75 percent from 2000 to 2025, and is over 100 percent in 15 states.

- **Many older Americans are uninsured or have undependable health insurance.** There are 6 million people nationwide age 55 to 65 who have no or undependable health insurance. In eight states, these individuals are more than one third of the population age 55 to 65. They are the fastest growing group of uninsured – and are at great risk of becoming sick. As the baby boom generation turns 55, there will be an even greater access problem.

Medicare Beneficiaries Need a Prescription Drug Benefit

- **Retiree health coverage is declining.** Sixteen states have 20 percent or fewer firms offering health insurance to retirees. Nationally, 22 percent of firms offer health insurance to retirees older than age 65. No state has more than 30 percent of firms offering coverage. This will be lower in the future, as 25 percent fewer firms offered retiree health coverage in 1998 than 1994, so that very few seniors will get prescription drug coverage through former employers.
- **Individual Medigap insurance with prescription drug coverage costs twice as much in high-cost states.** The average premium for a 65-year old for Medigap Plan H that includes drug coverage among other benefits is about \$135 but exceeds \$150 per month in 9 states. The part of the premium that is attributable to drugs alone can be \$90 per month or \$1,080 per year – for coverage that is limited to \$1,250 per year with a \$250 deductible. Moreover, in most states, insurers “age rate” or increase premiums as people get older, making insurance more expensive when seniors can least afford to pay for it.
- **Most seniors are middle income and would not benefit from a low-income prescription drug benefit.** About 15.6 million or half (49 percent) of all elderly have incomes between \$15,000 and \$50,000. Only in the District of Columbia, Louisiana, Mississippi, New Mexico, Rhode Island, South Carolina, and Texas are there more low income than middle class seniors. Nationwide, over half of beneficiaries without drug coverage have incomes above 150 percent of poverty (\$12,750 for a single, \$15,000 for a couple). Thus, a prescription drug benefit targeted to low-income beneficiaries will not help most seniors.

Health Care Providers Depend on Medicare

- **Health care providers depend on over \$200 billion a year in Medicare spending, accounting for one-fifth of all funding.** This does not even count beneficiary payments which comprise nearly half of their total health spending. Medicare spending exceeds 20 percent of all health spending in 12 states. Nationwide, over 5,100 hospitals, 800,000 physicians and nearly 15,000 nursing homes care for Medicare beneficiaries.

THE NEED IS CLEAR FOR THE PRESIDENT’S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE. The President’s FY 2001 budget dedicates \$432 billion over 10 years – the equivalent of over half of the non-Social Security surplus – to Medicare. This plan makes Medicare more fiscally sound, competitive and efficient, and modernizes the program’s benefits by including a long-overdue prescription drug benefit.

- **Making Medicare more competitive and efficient.** Since taking office, President Clinton has worked to reduce Medicare growth and fraud and extend the life of the Medicare Trust Fund from 1999 to 2015. He has proposed to build on these efforts and save \$71 billion over

10 years by: 1) expanding anti-fraud policies; 2) making Medicare more competitive, efficient and high quality; and 3) constraining out-year program growth.

- **Dedicating \$299 billion over 10 years to Trust Fund solvency.** It is impossible to pay for a doubling in Medicare enrollment through provider savings or premium increases alone. To address the future financing shortfall, the budget dedicates \$299 billion of the non-Social Security surplus to Medicare, helping extend the Trust Fund through 2025, and reducing publicly held debt by preventing funds from being used for tax cuts or new spending.
- **Modernizing Medicare's benefits.** Unlike virtually all private health plans, Medicare does not cover prescription drugs, and over three in five beneficiaries lack dependable prescription drug coverage. The President's plan:
 - **Establishes a new voluntary Medicare prescription drug benefit that is affordable to all beneficiaries and the program.** The drug benefit, which costs \$160 billion over 10 years, would be accessible and voluntary, affordable for beneficiaries, and competitively and efficiently administered. It would also provide high-quality, necessary medications.
 - **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 for 2006-2010, to design protections for beneficiaries with extremely high drug spending. The Administration plans to work with Congress to design this enhanced prescription drug benefit. Absent consensus, the reserve will be used for debt reduction.
 - **Improves preventive benefits in Medicare.** This proposal would: eliminate the existing deductible and copayments for preventive services, such as colorectal cancer screening, bone mass measurements, and mammographies.
- **Creates health insurance options for people ages 55 to 65.** The plan would allow people age 62 through 65 and displaced workers age 55 to 65 to buy into Medicare. It would require employers who drop previously promised retiree coverage to give early retirees with limited alternatives access to COBRA coverage until they are 65 and can qualify for Medicare. To make this policy more affordable, the President proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in and a similar credit for COBRA.

PRESIDENT REBUFFS DRUG INDUSTRY ADS, ORDERS STUDY ON DRUG COSTS, AND ANNOUNCES NEW SURPLUS RESERVE FOR MEDICARE

October 25, 1999

Today, the President will make a series of announcements to refocus the nation and the Congress on the need to strengthen and modernize Medicare, including the provision of a long-overdue prescription drug option. He will: (1) criticize the pharmaceutical industry for its multi-million dollar campaign designed to kill a Medicare drug benefit for all beneficiaries; (2) direct HHS to produce its first study on drug costs and trends, documenting problems faced by Medicare beneficiaries; and (3) announce that his Social Security legislation will reserve one-third of the non-Social Security surplus for Medicare and challenge Congress to pass it. Last Friday, Vice President Gore also expressed his concern about the inability of older and disabled Americans to access affordable prescription drugs. Today, the President will:

- **Criticize the destructive, multi-million dollar, industry-sponsored campaign against a Medicare prescription drug benefit.** Despite widespread support among Republicans and Democrats for some type of prescription drug benefit for Medicare beneficiaries, no action has been taken in this Congress – in part because of the deceptive, multi-million dollar advertising campaign launched by opponents. Citizens for Better Medicare, a group organized and primarily funded by the pharmaceutical industry, is sponsoring TV, radio and print advertisements that include several myths about the President's plan for a prescription drug benefit. These myths include:
 - **“Big government in my medicine cabinet.”** This is false. The President's proposal assures that all classes of drugs are covered – and that any doctor can prescribe a drug that is medically necessary without constraints. No government restrictions would be imposed, nor does the President's plan include price controls. It relies on private benefit managers, chosen through a competitive process, to structure the coverage policies. This is exactly the way that the best-managed private employers pay for drugs. In fact, the President's plan would actually increase, not decrease, choice of medicines since it would give the tens of millions of Medicare beneficiaries with undependable, expensive coverage, or no coverage at all the option to buy basic coverage at an affordable price.
 - **“All seniors will be forced into a government-run plan.”** Again, this is a false claim intended to scare seniors. The President's drug benefit is purely optional – if beneficiaries want to keep their current coverage, they can. Unfortunately, very few seniors have decent, dependable options today. In just the past four years, the number of firms offering retiree coverage dropped by 25 percent. The President's plan actually provides employers over \$10 billion in incentives to offer and continue prescription drug coverage. And the plan is not “government-run” since beneficiaries choose coverage through either private drug benefit managers or Medicare managed care plans.

The President will urge the drug industry to be more constructive as he works to forge a consensus on critical Medicare reform legislation. He will emphasize that America's elderly deserve more than the industry's evasive scare tactics.

- **Direct HHS to produce its first study on prescription drug costs and trends.** The President will direct the Secretary Donna Shalala to produce the first-ever Health and Human Services (HHS) study of prescription drug costs and trends for Medicare beneficiaries with and without coverage. The study, which will be released within 90 days, will investigate:
 - Price differences for the most commonly used drugs for people with and without coverage;
 - Drug spending by people of different ages, as a percentage of income and as a percentage of total health spending; and
 - Trends in drug expenditures by people of different ages, as a percentage of income and total health spending.

This study will build on two Administration studies released in 1999 that examined coverage patterns and trends for Medicare beneficiaries and decreases in Medicare managed care plan coverage of prescription drugs. The President will also announce that he has directed his staff to produce a state-by-state analysis of the need for Medicare reform. These reports will lay the foundation for an informed public debate about prescription drug coverage.

- **Announce that today he will send Congress legislation to reserve one-third of the non-Social Security surplus for Medicare and challenge the Congress to pass it.** In his radio address on October 23, the President announced that he would send to Congress legislation that protects the Social Security surplus, extends the solvency of Social Security through 2050, and pays off the debt. Today, he will announce that this legislation will also reserve one-third of the non-Social Security surplus for Medicare. This reserve can be used to extend Medicare's solvency and help fund a prescription drug benefit. The precise allocation of these reserved funds will be left open to provide flexibility to develop a broad-based Medicare reform proposal that can generate bipartisan support. The President will challenge Congress to pass the legislation he is submitting this week, emphasizing that it lays the foundation for necessary Medicare and Social Security reforms next year.

**THE CLINTON-GORE ADMINISTRATION HIGHLIGHTS THE IMPORTANCE OF
THEIR PLAN TO STRENGTHEN AND MODERNIZE MEDICARE TO WOMEN**

July 27, 1999

Today, at the White House, President Clinton and First Lady Hillary Rodham Clinton joined the Older Women's League (OWL) in releasing a report entitled "*Medicare: Why Women Care*," which includes a new analysis documenting why strengthening and modernizing Medicare is particularly important to women of all ages. The President and the First Lady also underscored the importance of taking advantage of the historic opportunity to dedicate a significant portion of the surplus to secure the life of the Medicare trust fund for a quarter century. In releasing this report, OWL stated its strong support for the President's vision of dedicating the surplus to strengthen Medicare, adding a prescription drug benefit, and improving preventive services.

The Vice President later joined the Democratic leadership and released a new analysis on the greater challenges that beneficiaries in rural America face in accessing prescription drug coverage. He pointed out that, although representing fewer than one-fourth of the Medicare population, beneficiaries living in rural areas account for over one in three of all beneficiaries lacking prescription drug coverage. Today, the Clinton-Gore Administration:

UNVEILED A NEW REPORT BY THE OLDER WOMEN'S LEAGUE. Nearly 60 percent of Medicare beneficiaries are women and this proportion rises with age – over 4 in 5 people over age 100 are women. Moreover, older women tend to have more chronic illness and lower incomes, making Medicare even more important as a health and financial safety net. Since it was created in 1965, Medicare has contributed to lengthening older women's lives by 20 percent and reducing their poverty rate dramatically. Yet, the 21st century brings with it challenges that will affect all beneficiaries.

Key findings of the report include:

- **In the next 30 years, the number of Medicare beneficiaries will double – most of them will be women.** In 2035 alone, there will be nearly 40 million elderly women and fewer than 34 million older men. This large enrollment increase is a major factor in the projected exhaustion date of the Medicare trust fund by 2015 and in the need for more revenue to avoid devastating cuts to the program.
- **Total prescription drug spending for women on Medicare averages \$1,200 – nearly 20 percent more than that of men.** Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about \$12,750 for a single, \$17,000 for a couple), despite older women's lower average income.
- **Medicare's preventive benefits are underused by older women.** Financial and information barriers prevent older women from using critical preventive services. In recent years, just 1 in 7 women have taken advantage of Medicare-covered mammograms.

Other key findings include:

MEDICARE, A SOURCE OF FINANCIAL AND HEALTH CARE SECURITY FOR OLDER WOMEN, IS AT RISK.

- **Most elderly Americans covered by Medicare are women.** Twenty out of the 34 million elderly Americans covered by Medicare are women, who comprise nearly 3 out of 5 older Americans. The proportion of the elderly who are women rises with age; about 71 percent of people age 85 or older are women. Eighty-three percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years.
- **New revenue is necessary to ensure that the Medicare trust fund is solvent when women in the baby boom generation retire.** Since most women turning 65 today are expected to live through 2018, the projected insolvency of the Medicare Trust Fund will occur within their lifetime.
- **Women have greater health care needs and lower income.** Older women are more likely to need Medicare's health care services. About 73 percent have two or more chronic illnesses compared to 65 percent of men. Women's incomes are lower than men's incomes, and they must stretch fewer financial resources over longer lives. Seven out of 10 Medicare beneficiaries living below poverty are women. The increased likelihood that women will live alone in their later years places them at increased risk of poverty.

WOMEN FACE GREATER COST BURDENS – AND BARRIERS TO HEALTH CARE – BECAUSE OF MEDICARE BENEFIT LIMITATIONS. As important as Medicare coverage is to women, its benefits are outdated.

- **Higher out-of-pocket health spending.** The combination of greater health problems and lower income results in women on Medicare spending 22 percent of their income on health care compared to 17 percent for men. Lower income women spend an even greater share of their limited incomes on health care – 53 percent for the poorest.
- **Total prescription drug spending averages \$1,200 for women on Medicare – 20 percent more than that of men.** Older women tend to have more chronic illnesses that require medication to manage.
- **For most women, existing coverage is unstable, unaffordable and declining.** Medigap routinely increase premiums with age – at age 85, premium for a Medigap plan with drug coverage up to \$1,250 costs from \$300 to \$400 per month -- \$3,600 to \$4,800 per year. This discriminates against women, who comprise nearly three-fourths of people in this age group. It also charges more at a time where income has declined.
- **About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs.** Despite their lower average income, fully half of these women, without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people of all age groups.

- **Out-of-pocket payments for preventive services also constitute a barrier to health.** In recent years, just one in seven women without supplemental insurance used Medicare-covered mammograms. One study found that in 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

EMPHASIZED GREATER PROBLEMS FACING RURAL BENEFICIARIES IN ACCESSING PRESCRIPTION DRUG COVERAGE. The Vice President also released new facts on the challenges facing rural beneficiaries. Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries. This reflects the lower access to Medicare managed care and retiree health coverage for these beneficiaries. The Vice President also released information documenting that lack of access to prescription drug coverage occurs throughout the income spectrum – 45 percent of rural beneficiaries with income above \$50,000 lack prescription drug coverage compared to 25 percent of all beneficiaries.

HIGHLIGHTED THE IMPORTANCE OF INVESTING IN THE FUTURE OF THE MEDICARE PROGRAM. Today, the President, First Lady and Vice President underscored the fact that there will not be a debate about how to strengthen Medicare or how to provide a prescription drug benefit if all of the surplus is invested in a large tax cut. They stated their strong belief that the Congress and the American public face an important decision: to invest in a stronger Medicare program for our mothers and grandmothers or give away the entire surplus on a risky and irresponsible tax scheme.

**PRESIDENT CLINTON HIGHLIGHTS HIS PLAN TO
STRENGTHEN AND MODERNIZE MEDICARE
FOR THE 21st CENTURY**

*Releases New Report That Documents That Three Out of Four Medicare Beneficiaries
Lack Decent, Dependable, Private-Sector Coverage of Prescription Drugs
July 22, 1999*

Today, the President met with community representatives in Lansing, Michigan to discuss the future of the Medicare program. At this meeting, he released a new report entitled, "*Disturbing Truths and Dangerous Trends: The Facts About Medicare Beneficiaries and Prescription Drug Coverage*," which describes the inadequate and unstable nature of the prescription drug coverage currently available to Medicare beneficiaries. The President also underscored the importance of seizing this historic opportunity to strengthen and modernize the Medicare program by making it more competitive and efficient; modernizing and reforming its benefits, including the provision of a long-overdue prescription drug benefit; and making an unprecedented long-term financing commitment to Medicare that would secure Medicare's financing for the next quarter century. Today, the President:

UNVEILED NEW REPORT DOCUMENTING THE DANGEROUS TRENDS IN PRESCRIPTION DRUG COVERAGE FOR MEDICARE BENEFICIARIES. Prescription drugs have never been more important, but the people who rely on them most – the elderly and people with disabilities – increasingly find themselves uninsured or with coverage that is becoming more expensive and less meaningful. Today's report documents that the cost of purchasing essential prescription drugs is not only a problem for the millions of Medicare beneficiaries without any insurance, but is also an increasing challenge for beneficiaries who have coverage. Key findings of the report include:

✓ **THREE OUT OF FOUR MEDICARE BENEFICIARIES LACK DECENT, DEPENDABLE, PRIVATE-SECTOR COVERAGE OF PRESCRIPTION DRUGS.**

- **Only one-fourth of Medicare beneficiaries has retiree drug coverage, which is the only meaningful form of private coverage.**
- **Over three-fourths of beneficiaries have no coverage, inadequate Medigap coverage or public coverage for prescription drugs.** At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. Medicaid picks up 12 percent of the lowest income and sickest beneficiaries. The remaining 5 percent are in Veterans' and other public programs.

✓ **PRIVATE TRENDS: DECLINE IN COVERAGE AND AFFORDABILITY.**

- **Firms offering retiree health coverage have declined by 25 percent in the last four years.** Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.
- **Medigap premiums for drugs are high and increase with age.** Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the President. Moreover, unlike the President's proposal, premiums substantially increase with age as virtually every Medigap plan "age rates" the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach. This will particularly affect women, who make up 73 percent of people over age 85.

✓ **PUBLIC DRUG COVERAGE TRENDS: MANAGED CARE BENEFITS REDUCED.**

- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below \$1,000 in the year 2000. This is part of a troubling trend of plans to severely limit benefits through low caps. In fact, the proportion of plans with \$500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.
- **Participation by Medicaid eligible populations remains low.** Millions of Medicare beneficiaries under 75 percent of poverty (about \$6,000 for a single, \$8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only 40 percent. This contrasts with an almost 100 percent participation rate in Medicare Part B. Inadequate outreach and welfare stigma contributes to these low participation levels and raise serious questions about the feasibility and advisability of using the Medicaid program to provide needed coverage for a population at higher income levels.

✓ **MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE.**

- **At least 13 million Medicare beneficiaries have absolutely no prescription drug coverage.** The number of the uninsured is not concentrated among the low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels.
- **More than half of Medicare beneficiaries without drug coverage are middle class.** Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately \$17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.

✓ **PRESCRIPTION DRUG COVERAGE IS GOOD MEDICINE.**

- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures, such as anti-coagulants, used with heart valve replacement surgery; substitutes for surgery, such as lipid lowering drugs that reduce the need for bypass surgery; and new treatments where there previously were none, such as medications used to manage Parkinson's disease. In addition, as our understanding of genetics grows, the possibility for breakthrough pharmaceutical and biotechnology will increase exponentially.
- **Medicare beneficiaries are particularly reliant on prescription drugs.** Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.
- **The lack of drug coverage has led to inappropriate use of medications which can result in increased costs and unnecessary institutionalization.** Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. The consequence of inappropriate and underutilization of prescription drugs has also been found to double the likelihood that low-income beneficiaries entering nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.