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● Aviva Steinberg

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To: Karin Kullman/OPD/EOP@EOP, Devorah R. Adler/OPD/EOP@EOP

cc:

Subject: remarks at Medicare conversation

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Subject: remarks at Medicare conversation

THE WHITE HOUSE

Office of the Press Secretary
(Lansing, Michigan)

For Immediate Release

July 22, 1999

REMARKS BY THE PRESIDENT
IN CONVERSATION ON MEDICARE

Lansing Community College
Lansing, Michigan

11:45 A.M. EDT

THE PRESIDENT: Thank you, and good morning. I would like to begin by saying I am honored to be here. I thank all of you for coming. Somebody fell out of the chair -- are you all right? (Laughter.) I wish I had a nickel for every time I've done that. (Laughter.) You okay now? Good. (Laughter.)

Well, this is appropriate. I want to thank your Attorney General, Jennifer Granholm, for joining us; and Mayor Hollister, the state legislators, county commissioners and city council members who are here. And I thank President Anderson of the Lansing Community College for making me feel so welcome here.

I love community colleges, and I'm going to go visit with some of the students after I finish here, and I'm going to tell them they should also be for this. The younger they are the more strongly they should feel about this, what we're trying to do here. (Applause.)

I would like to thank our sponsors today, the National Committee to Preserve Social Security and Medicare -- the President, Martha McSteen; the Executive Vice President, Max Richtman, are here. I thank the National Council of Senior Citizens and their Executive Director, Steve Protulis, who is here. The Older Women's League National Board President, Betty Lee Ongley; Judith Lee of the Older Women's League; John DeGostino (phonetic) of the Michigan State Council of Senior Citizens.

I'd also like to thank in her absence your Congresswoman, Debbie Stabenow, who was going to come with me today, but they're voting on an issue which is very critical to

whether we can do what I hope to do with Medicare. But she has been a wonderful supporter of our efforts to preserve Medicare and to add the prescription drug benefit. And I know she did a study here in this district on seniors' prescription drug options and cost, and some of you may have been responsible for the position she is now taking in Washington. But I am very, very grateful for it. And I know Debbie's mother, Ann Greer, is here. So I thank her for coming.

And let me say to all of you -- and I want to thank Jane for doing this. You know, I met her about three minutes ago, and I -- she's got to come out here with me and do this program. And I think the odds are she'll do better than I will. (Laughter.) So I'm not worried.

Let me say, today I want to have this opportunity to talk with all of you -- we have people of all ages here -- about the great national debate going on not only in Washington, but in our country -- a debate that we never thought we'd be having. You know, I came to Lansing first when I was running for President in 1992, and the people of Michigan have been very good to me and to Hillary and to Vice President and Mrs. Gore. I'm very grateful for that.

But it occurred to me if I had come here in '92 and I said, I want you to support me because if you do we've got a \$290 billion deficit today, but I'll be back here in six years and

we'll talk about what to do with the surplus -- (applause)-- now, I think it's fair to say that if I had said that people would have said, he seems like a nice young man, but he's terribly out of touch -- (laughter) -- he doesn't have any idea what he's talking about. This guy is too far gone to have this job. But that's what we're doing here.

Six and a half years ago, Michigan's unemployment rate was 7.4 percent. Today, it's 3.8 percent. We've gone from a \$290-billion deficit to a \$99-billion surplus. And we have done it with a strategy that focused on cutting the deficit, balancing the budget, eliminating unnecessary spending, but continuing to invest in education and training. For example, we've almost doubled our investment in education and training in the last six years while we have cut hundreds of programs and reduced the size of the federal government to its smallest point since 1962, when President Kennedy was in office. So I think that's very important. And the tax relief which has been given in the last six years is focused on families and education.

I asked the President of this college when I came in, I asked him what the tuition was, because now our HOPE Scholarship

tax credit give a \$1,500 year tax credit to virtually all the students in our country. And that makes community college free, or nearly free, to virtually all the students in community colleges in our country. It's an important thing.

But we've worked hard and the American people have worked hard. Now we have the longest peacetime expansion in history, with 19 million new jobs. We have the lowest minority unemployment rates ever recorded. And we have to ask ourselves, we've worked very hard as a country for this -- what are we going to do with it? And I have argued that, at a minimum, we ought to meet our biggest challenges -- the aging of America, the obligation to keep the economy going, and the obligation to educate and prepare our children for the 21st century.

Today, we're going to talk primarily about the aging of America and Medicare. But I want to emphasize what a challenge that is. The number of people over 65 will double between now and the year 2030 -- will double. The fastest-growing group of people in the United States in percentage terms are people over 80. Any American today who lives to be 65 has a life expectancy of about 82.

Children being born today, when you take into account all of the things that can happen -- illness, accident, crime, everything -- have a life expectancy of 77 from birth now. We expect to unlock the genetic code with the Human Genome Project in the next three to four years, and it then will become normal for a young mother taking a baby home from the hospital to have a genetic map of that baby's body which will be a predictor of that

baby's future health. It will be troubling in some ways. It will say, well, this young baby girl has a strong predisposition to breast cancer. But it will enable you to get treatment, to follow a diet, to do other things which will minimize those risks; will say, this young boy is highly likely to have heart disease at an earlier-than-normal time, but it will enable us to prepare our children from birth to avert those problems. So this is a very important thing.

The first thing I want to say to all of you and those of you who are in the senior citizens' groups will identify with this -- this is a high-class problem we have. This is a problem, the aging of America, that is a high-class problem. It means we're living longer and better. I wish all of our problems were like this. It has such -- sort of a happy aspect to them.

But it does mean that there will be new challenges for our country, and it means, among other things, that we'll have, percentage-wise, relatively fewer people working and more people

drawing Social Security and Medicare.

When you look at the Social Security system, it's slated to run out of money in about 34, 35 years. It ought to have a much longer life expectancy than that. Everybody -- it's fine for the next 35 years, but I've offered a plan to increase the life of the Social Security trust fund for at least 54 years and to go further if the Congress will go with me.

I have offered a plan to increase -- when I became President, the Medicare trust fund was slated to go broke this year. And we took some very tough actions in 1993 and again in 1997 to lengthen the life of the trust fund -- actions which, I might add, most hospitals with significant Medicare caseloads, and teaching hospitals which deal with a lot of poor folks, believe went far too far. And we're going to have to give some money back to those hospitals in Michigan and throughout the country. But we now have 15 years on the life of the Medicare trust fund. Under my proposal, we would take it out to 2027, and that will give plenty of time for future Congresses and Presidents to deal with whatever challenges develop in the Medicare program after that.

Now, to do that and to do it without cutting our commitment to education, to biomedical research, to national defense, we have to devote most of the surplus to Social Security and Medicare. We will still have funds for a substantial tax cut, but not as big as the one being offered in Washington today, which spends all the non-Social Security tax surplus funds on a tax cut.

I believe the wise thing to do is to take care of the 21st century challenge of the aging of America, to do it in a way

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I believe the wise thing to do is to take care of the 21st century challenge of the aging of America, to do it in a way

that does not require us to walk away from the education of our children; and under my plan, because we would save most of the surplus, the side benefit we'd get is that in 15 years we could actually take the United States of America out of debt for the first time since 1835. (Applause.)

Now, why is that important -- and it's more important, I would argue, than at any time in my lifetime. I was raised to believe that a certain amount of debt for a country was healthy; that just like businesses are always borrowing money to invest in new business, a certain amount of debt was healthy. The structural deficit has been terrible. The idea that we quadrupled the debt in 12 years was an awful idea, because we were borrowing money just to pay the bills.

But I'd like to ask you all to think about this,

because I don't think most Americans have focused on this part of the plan, the idea of being debt-free. We live in a global economy. Money can travel across national borders literally at the speed of light. We just move it around in accounts. Interest rates are set, therefore, in a global context. If we become debt-free and we, therefore, don't borrow any money in America just from the government, that means everybody else's interest rates will be lower. That means for businesses, lower business borrowing rates; it means more businesses, more jobs, easier to raise wages. For families it means lower home mortgage rates, lower credit card payment rates, lower car payment rates, lower college loan rates.

It means that we will secure the economic strength of America in ways that are unimaginable to us now. It means that if other parts of the world get in trouble, the way Asia did a couple of years ago, we'll be less vulnerable. And the people that are in trouble and need to borrow money will be able to get it at lower interest rates and they'll get up and go on again and be able to do business the us again.

This is a very good thing to do. But it can only be done if we set aside the vast majority of the surplus to fix Social Security and Medicare. You can still have a tax cut, focused on helping families save for their retirement or any number of the other things that have been discussed within the range we can afford, focused on helping people pay for long-term care, focused on helping working families pay for child care. And, I would hope, focused on helping us modernize our schools for the 21st century and giving business people big incentives to invest in the small towns, rural areas, urban neighborhoods and Indian reservations that still haven't gotten any new business investment in this recovery of ours.

But the fundamental decision is: Are we going to do these things? Now, there does seem to be agreement in Washington

-- let's start with the good news -- there does seem to be an agreement in Washington that we should set aside the portion of the surplus produced by your Social Security tax payments for Social Security. And if that, in fact, happens, under the way that the Republicans and the Democrats have agreed on so far, we will pay down the debt, we will continue to pay down the debt, but we won't pay it off. And we won't extend the life of the Social Security Trust Fund, as I would under my plan. But still, that's something.

There is yet no agreement in Washington over setting aside a significant portion of the surplus to save and modernize Medicare. So today, we're here to talk about that. But I wanted you to have a feeling for how the Medicare proposal fits into the

proposal to save Social Security, to keep investing in education, to have a modest tax cut, and to make the country debt-free. I want you to think about it, because the big debate is, what are we going to do with the surplus?

And I don't even agree with the timing of what's going on in Washington; I don't think we should even be talking about the tax cut until we figure out what it costs to save Social Security, what it costs to save and modernize Medicare, what we have to do to keep the government going. (Applause.)

How would you feel -- now, one of my staff members, who happens to be from Michigan, said to me the other day, this is kind of like a family sitting around the kitchen table and said, let's plan the fancy vacation of our dreams and then talk about how we're going to make the mortgage payment. (Laughter.) Hope we've got enough left over. So that's where we are.

To evaluate whether you agree or not, we need to talk about what needs to be done about Medicare. So I'd like to tell you what I think. The first thing my plan would do is to devote a little over a third of the non-Social Security portion of the surplus, \$374 billion over the next 10 years, to strengthen Medicare by extending the life of the trust fund to 2027. Now, I think that is very, very important, because, keep in mind, all the baby boomers will start turning 65 in the year 2011. That's not that far away. To young people, that may seem like a long way away. The older you get, that seems like the day after tomorrow. (Laughter.) And we've waited a long time.

The last time we had a surplus was 1969. This is a once in a lifetime opportunity we have here to deal with this. So if we run it out to 2027 and then further complications arise, or difficulties or challenges present themselves, there will be time for future Congresses and Presidents to deal with them without having to take drastic action. So that's the first thing -- run the trust fund out to 2027.

No serious expert on Medicare believes that we can

stabilize Medicare without an infusion of new revenues. The second thing we do is to employ some of the best practices in health care today: competition and other practices now in the private sector, to keep costs down that don't sacrifice quality and don't require people to be forced out of the fee-for-service Medicare plan if they don't want to be, into a managed care plan. We leave free choice open. No requirement. (Applause.)

The third thing about this plan that's gotten the least publicity but is potentially very important for our country is

that we allow people between the ages of 55 and 65 who aren't working anymore or don't have health insurance on the job and don't have retiree health insurance to buy into Medicare in a way that doesn't compromise the stability of the program. I think that is terribly important. That's a huge problem in our country today and a growing one. People who are out of the work force or working for very small businesses without employer-sponsored care, who can't get any health insurance because of their age or their previous health condition.

The fourth thing the plan does is to modernize the benefits of Medicare to match the advances of modern medicine. That means, first, encouraging seniors and disabled Medicare beneficiaries to take greater advantage of the available prevention mechanisms in our country, preventive tests for cancer, for osteoporosis, for other conditions, by eliminating the deductible and the copay from those tests and paying for it by charging a modest copay for lab tests that are often overused.

Now, why is this important? Well, if somebody develops osteoporosis, a severe case and goes to the hospital and has a prolonged medical regime under Medicare, the taxpayers pay for all of it. But very often, the prevention is not done because of the costs involved. It'll be far less expensive over the long run to spend a little more on prevention now and keep people out of the hospital and the expensive payments we're going to pay if we don't do that. Very important issue. (Applause.)

And then, we provide, for the first time, for a voluntary and affordable prescription drug benefit. Basically, we propose to start with a \$24 a month premium to pay half the drug cost, up to \$2,000, phasing up over the next five or six years to a \$5,000 ceiling, with the premium going up that way, in a graduated way. For seniors at 135 percent of poverty or less, we would waive the premium and the copay, and then the premium would be phased-in, up to 150 percent of poverty. So there would be subsidies there.

Now, there are those who say, well, this is good, but I've got a good retiree health plan with prescription drugs, and if you offer this my employer will drop it and it's better than this deal. Well, I want you to know that one of the things we've

done in here is put substantial subsidies in here to employers who offer drug benefits to their retirees. So I think it is less likely that they will drop the benefits, not more -- because they're going to get a real incentive to keep the employer-based retiree programs. The second thing I want to say, again, is this is an entirely voluntary program.

Now, the other big criticism of this program has been that, well, they say, two-thirds of the people have prescription drugs already who are retired. That is misleading. That is only accurate by a stretch, and let me explain what I mean by that. We have a report we are releasing today that shows that 75 percent of older Americans lack decent and dependable private sector coverage for prescription drugs. And the problem is getting worse.

Fewer than one in four retirees, 24 percent, have drug coverage from their former employers. Now, the number of corporations offering prescription drug benefits to retired employees has dropped by a quarter, 25 percent, just since 1994. Eight percent of the seniors have Medigap drug policies. But as all of you know, Medigap premiums explode as people get older, when they most need the benefits and can least afford the higher prices.

Here in Michigan, for example, seniors over 85 must pay over \$1,100 a year in Medigap premiums for drug coverage, not counting the \$250 deductible. Those high costs are especially hard on women, who tend to have lower incomes than men because they didn't have as many years paying into Social Security or retirement primarily. Seventy-two percent of the Americans over 85 are women. Seventeen percent of seniors have drug benefits through Medicare managed care plans. But three-fifths of these plans cap the benefits at less than \$1,000 a year.

And listen to this, in just the last two years, the percentage that capped drug benefits at only \$500 per year has grown by 50 percent. Anybody that's got any kind of medical condition at all will tell you it doesn't take very long to run through \$500.

So what does this mean? it means that the vast majority of our seniors either have no drug coverage or all, or coverage that is unstable, unaffordable and rapidly disappearing. It means, therefore, that we need a drug plan for our seniors that is simple, that is voluntary, that is available to all and that is completely dependable.

Securing and modernizing Medicare I believe is the right thing to do for our seniors, but I also think it's the right thing to do for all the young people here. And for the next generation, the young parents in their 30s and 40s. Why?

First, because it guarantees we can get out of debt by 2015 -- I explained why that's a good idea.

Second, because if we do this and we stabilize Social Security and Medicare, we will ease the burden on the children of the baby boom generation who will be raising our grandchildren. It is a way of guaranteeing the stability of the incomes of the children of the seniors on Medicare. And I think that is profoundly important.

Now, I've already explained that that's what our budget does. Today the Congress is voting, the House of Representatives is voting on the Republican tax plan which basically would spend virtually the entire non-Social Security surplus on a tax cut. And it would cost a huge amount of money, not just in this 10 years, but it triples in cost in the next 10 years; it explodes.

And you say, I don't want to think about that. I want to think about today. You have to think about that. The baby boomers will be retiring in the second decade -- in the second decade of the century we're about to begin. And we have to think about that. This plan would give us no money to stabilize or modernize Medicare, and it would require substantial cuts in education, in national defense, in biomedical research, in the environment. And I predict to you that the environment will be a bigger and bigger issue for us all to come to grips with in the years ahead.

So we have to figure out what we're going to do. I believe that this plan that's being voted on in Washington will not enable us to pay off our debt; it will not do anything to add to the life of Social Security and Medicare; it will require huge cuts in our other investments and taking care of our kids. And I will veto it if it passes. (Applause.)

But the question is what are we going to do. You all know that we fight all the time in Washington because that's what you hear about. But I would like to reiterate that we joined together to pass welfare reform -- and I did, I vetoed two bills first because they took away the guarantee of food and medicine for the poor kids. But I passed the welfare reform bill that required able-bodied people to go to work and provided extra help for child care, for transportation, for training and education for people on welfare. We now have the lowest welfare rolls in 30 years -- the lowest welfare rolls in 30 years. (Applause.)

And big majorities of both parties in both Houses of Congress voted for it. We fought over the budget for two years, but in '97 we passed a bipartisan balanced budget amendment, with big majorities in both parties of both Houses voting for it. And the results have been quite good.

So don't be discouraged. You just have to send a clear

message. We are capable of working together to do big things. Yesterday, 50 economists, including six Nobel Prize winners, released a letter supporting my approach. Maybe it's easier for me because I'm not running for election, but I don't think that's right. I trust the American people to support those people in public life who think of the long run, who tell them the truth, who say, I realize it would be popular to spend this surplus, but we've waited 30 years for it and we now have 30 years worth of challenges out there facing us and we cannot afford to squander that.

So what I hope to do today is to answer your questions and hear your stories, and let's explore whether or not we really need to do these things for Medicare, and whether or not they really will help not only the seniors, but the non-seniors in the country. And if you disagree, you ought to say that, too. But my concern now is for what America will be like in 10 years, or 20 years, or 30 years.

We've got the country fixed now, it's working fine, everybody is going to be all right now in the near-term. The economy is working, things are stable, we're moving in the right direction. But we now have a once in a generation opportunity to take care of our long-term challenges and I believe we ought to do it.

Thank you very much. (Applause.)

* * * * *

MS. SOUTHWELL: Now, with your plan, what's the period of time before it's in effect and working? Because I think -- hurry! The checking account is going down, the savings.

THE PRESIDENT: Well, it will take us -- it takes a couple of years -- first of all, we can stabilize the plan immediately. If Congress passed the law and I sign it, we'll have the funds dedicated and we can set the framework in motion today that would do all the big things.

To put the prescription drug benefit in effect, it's a complicated thing, as you might imagine, millions and millions of people involved -- it will take probably a year, maybe a little longer, two years, to actually start it.

But where we propose to start would be with a premium of \$22 a month and a co-pay of 50 percent up to \$2,000, but it would go up to \$5,000. And I think it's very important to get up to a higher level. But we have to learn to administer it and

make sure we've got the cost estimates right and all of that. So it would be fully in effect at \$5,000 about five years after we start.

MS. ALDRIDGE: And you did touch on the baby boomer question, too. Does it concern you? Have you started to think about what's going to happen in the future and what might happen when you reach your senior years?

MS. SOUTHWELL: Yes, we're already thinking about that. And my daughter-in-law just last week said, will there be Social Security when we get there. And it's up to our government.

THE PRESIDENT: The answer to that is, there certainly should be. There's no reason for us to let the trust fund run out in 2034. What I have proposed to do, just so you'll know, is -- what I propose to do is to allow the Social Security taxes that you pay, which presently have been covering our deficit since 1983 -- as big as these deficits have been, they'd have been even bigger if it hadn't been for Social Security taxes. You need to know that, because when we put the last Social Security reform in, in 1983, we did it knowing that we would be collecting more. I wasn't around then, but they did it knowing they would be collecting more than they needed, and the idea was to have the money there when the baby boomers retired, as well as to relieve the immediate financial crisis.

Now, if you do that, you can pay down the debt some. But in order to lengthen the life of the trust fund, what I have proposed to do is, as the debt goes down, the interest we pay on the debt goes down. Obviously, you know, if you've got smaller debt, you have smaller interest payments. Well, you should know that for most of the last 10 years, about 15 cents on every dollar you pay in taxes comes right off the top to pay interest on the debt.

So what I want to do, as the debt goes down, I want to take the difference in what we used to pay and what we've been paying and put that into the Social Security trust fund to run the life of the trust fund out to 2053. And I've made some other proposals and will make some more, because I'd like to see us take it all the way out to 2075. That would be, in the ideal world, we'd have 75 years in the Social Security trust fund. That's what I'd like to see and I'm working on it. But if you get over 50 years, we'll be in pretty good shape, and I'm hoping we'll do that.

THE PRESIDENT: You might be interested to know that the drug companies, a lot of them are worried about it and they've come out opposed to my plan -- even though there's no price control in my plan. But if we represent you and millions of other people like you, we'll have a lot of market power, we'll be able to bargain for better prices. And I think that's a good thing, not a bad thing.

The other thing you should know is -- maybe most of you do know this -- I didn't know this until a few years ago and my former Senator, David Pryor, who is very interested in seniors and drug prices told me this, and then when I became President and began to manage the budget, I confirmed it -- Americans sometimes pay many times higher prices for drugs than Europeans, for example, pay for the same drugs. So our companies are only too happy to sell in the European market at cost because -- much lower cost -- and they make money doing it because they recover all the cost of developing new drugs from Americans. And then the Europeans put actual price controls on them and they sell anyway.

Now, I honor the research and development of new drugs by our pharmaceutical companies. The government spends billions of dollars every year supporting such research and we should. If America is on the cutting edge, maybe it's worth a premium for it. But I also believe that elderly people on fixed incomes should not be bankrupt for doing it.

That's what this -- so what I'm trying to do is to strike the right balance here. I want to hold down future increases as much as we can, not by price controls, but by using the market power of the government. And we'll have to be reasonable because we're not going to put those companies out of business and we're not going to stop them from doing research because we'd be cutting off our nose to spite our face. We wouldn't do that. But we would be able to give people like you some protection, as well as the guarantee of coverage. And I think it will be a good thing.

MR. WITT: That's exactly what I'm getting at, Mr. President, because my sister-in-law is a nurse and they go to Texas every year and they go across the border and buy the same prescriptions at a fraction of the cost of what we're paying here in Michigan. And I read in the paper where they can do the same thing in Canada. So what I'm getting at is I think that the government should start purchasing these prescription drugs, many

of them, and make them available to seniors, the same way they are in the hospitals, at a fraction of the cost that we as seniors are paying. We're subsidizing a lot of other things out of our meager retirement income.

THE PRESIDENT: You are subsidizing the pharmaceuticals

made in America, sold in virtually every other country in the world, because they're made here and you're paying higher prices for them than people in other places.

As I said, I understand their argument -- they say, well, why shouldn't we go in there and sell if we can make some money, but we have to recover our drug development costs. I'm sympathetic to a point, but not to the point that people like you can't have a decent living. So I think this will be a good compromise and I hope the pharmaceutical companies will reconsider their opposition. It would be a good thing, not a bad thing, if we had the market power of large-bulk purchasers to hold these prices down to.

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THE PRESIDENT: You can actually figure out pretty much what this plan would do for you. If you have, let's say, \$2,000 a year in drug costs -- let's take the first year the plan goes in -- let's say you've got \$2,000 a year in drug costs, and let's say your income is over 150 percent of the federal poverty level. -- 150 percent of the federal poverty level is \$17,000 a couple for seniors -- then, you would pay \$1,000 for the drugs and \$24 a month for the premium, which is \$288 a year, which is \$1,288, so you'd save \$712 a year.

Now, if your income is under 135 percent of the federal poverty level, which is \$15,000 a couple, you would save \$2,000 a year because you wouldn't have to pay the copay or the monthly premium. We've tried to take care of the really -- the kind of people you're talking about at your complex who don't have enough to live on. I wish I knew the numbers for seniors living alone. I just don't have it in my head; I should, but maybe somebody will slip it to me before I end.

If somebody, one of the people here with me, if you'll slip me the numbers for what the 135 and the 150 percent of the poverty level is for single seniors, I'll tell you what that is, but you can figure it that way.

* * * * *

MS. FRETTELL: It's just disheartening to see people

have to choose between their dignity or their quality of life and their health. And I just feel that the program is a good start towards providing meaningful pharmacy services to older Americans. I think once older Americans have those drugs, it's very essential that they're used appropriately, because right now we're spending -- for every dollar that we pay in prescription drug costs, we're spending one dollar to treat problems because those medications are used inappropriately. And that's where my role as a pharmacist really is important, is making sure that

those medications are used appropriately, because we all know that they can save lives and improve quality of life, and decrease overall medical costs.

MS. ALDRIDGE: Are you hearing that a lot around the country?

THE PRESIDENT: A lot. And let me just say to all of you, this fine, young woman is representative of where the pharmacists of our country are. I want to -- I said that I regretted the fact that the drug manufacturers were opposing our program because they're afraid it will hold costs down too much. The pharmacists who see the real, live evidence of this problem have been, I think, the most vociferous supporters of this whole initiative of any group not directly involved in getting the benefits, and I can't thank you enough. Thank you." (Applause.)

But, wait, let me say one other thing. She made another point the I didn't make in my remarks that I would like to make to you. She said, you know, say it was your grandmother or something, if she doesn't take this medication she'll have to go to the hospital.

Now, suppose there were no Medicare program. Suppose President Johnson hadn't created Medicare 34 years ago and we were starting out today. Does anybody here even question that if we were creating Medicare today, prescription drugs would be a part of it? If we were starting all over again? Thirty-four years ago, we didn't have anything like the range of medicines we have today that could do anything like the amount of good and do anything like the amount of prolonging our lives, our quality of life, keeping us out of the hospital.

And here's the bizarre thing about this, if we manage this program right over the long run, it's going to be a cost saver because we'll be -- if you've got \$2,000 in drug costs, that's a lot -- that's what her costs are -- that \$2,000; how long does it take you to run up \$2,000 in hospital bills? A lot less than a year. A lot less than a week.

So I think that's another point that ought to be made when this debate is unfolding, that, yes, this will be -- it's a new program, so it will cost money. But eventually, particularly if Heather is right and we can make sure a higher percentage of our people use these drugs properly, you will save billions of dollars in avoided hospital stays -- which we pay for. That's the irony of this whole thing. That's the other reason I'm for all these preventive tests being provided for free, because we don't pay for the preventive tests, but when you don't get them and you go to the hospital, we do pay for that.

So I think anything we can do to make people healthier and keep them out of the hospital and keep them out of more

extensive and expensive care is a plus. So thank you very much.
(Applause.)

MS. ALDRIDGE: And it's interesting to note, since 1965, how far we have come in preventative medicine and what we would do today to maybe help somebody with a disease or a condition. It would be totally different 35 years ago.

THE PRESIDENT: It's amazing. The average life expectancy in this country is almost 77 years now. I mean, that shows you how far we've come in just 34 years.

THE PRESIDENT: First, let me say that we have made dramatic increase in medical research one of the priorities for the last two years for the millennium. We're trying to double funding for the National Cancer Institute and eventually double funding for all the National Institutes of Health.

And Vice President Gore gave a speech in Philadelphia about 10 days, or so, ago now, where all the major associations involved in the fight against cancer came to talk about long-term plans that would really give us a chance of finding cures for many, many types of cancer. I think it will be a big national priority in the years ahead. And he gave, I thought, a very good speech about what should be done to take advantage of what we already know is out there on the horizon, just by accelerating our investments and making sure we're doing the proper testing and the proper range of population.

I'm quite encouraged about it. I think a lot of the big breakthroughs will come after I leave office. But I hope that the groundwork is laid now, will bring them sooner. And I think one of the things that I hope will be a big part of the debate for all of you for all the elective offices when we come

up in the year 2000 -- I say this not in a partisan way, because, actually, we've had very good Republican as well as Democrat support for the National Institutes of Health funding -- but I think this should be a major issue and a subject of debate that all of us should talk about as Americans: What is our commitment over the long run to doing this kind of research and getting the answers as quickly as we can.

THE PRESIDENT: Let me say -- I think we're mostly talking about this prescription drug issue today. But don't forget, as important as it is, the most important thing that we're doing is securing Medicare for 27 years. We've got to get -- the basic program has to be secure, because that would literally, as many people as are terrifically burdened by this

prescription drug benefit, if anything happens to the solvency of Medicare, or we have to adopt some draconian changes that raise the cost of the program so much that it's as out of reach as the drugs are now for people, the consequences would be disastrous. So let's not forget we have two things to do. We've got to stabilize and modernize and secure the Medicare program itself for the next 27 years as well as add this drug benefit.

And you made that point very eloquently and I thank you.

MRS. SILK: What can we as citizens do to help you persuade the Congress?

THE PRESIDENT: I think tell the Congress that the country's doing well now and that, yes, you would like to have a tax cut, but you will settle for a smaller one rather than a bigger one if the money goes to save Medicare and Social Security and keep up our investment in the education of our children and pay the debt off. I think that's a simple message. (Applause.)

Let me just say this. You know, Americans are a country -- we are famously skeptical about the government, you know. All those jokes, "I'm from the government, I'm here to help you," and you slam the door and the guy says -- and I heard the debate last night in the House of Representatives, and the people that are for giving the surplus back to you in the tax cut will -- they say, it's your money, don't let them -- i.e. us -- don't let them spend it on their friends. We'll we're spending it on Medicare, Social Security and education and defense. That's us, that's all of us, that's not our friends.

I mean, I hope you're my friends, but that's -- and I

think what you have to say is that the country has become prosperous by looking to the future, by getting the deficit down, by getting our house in order, by getting this budget balanced, by investing in our people. And now, we have these big challenges.

If this debate in Washington is about, you know, my tax cut's bigger than your tax cut, well, that's a pretty hard debate to win, you know? But if the debate is, yes, our tax cut is more modest, although it's quite substantial, but the reason is we think since we've got this big aging crisis looming and since we've never dealt with the prescription drug issue, that we ought to stabilize Social Security and Medicare, save enough money to do our work in education and medical research and the environment and defense and still have a modest tax cut, I think we can win that argument, and I think -- you know, you really just need to let people know, I don't think this should be a hostile debate at all. I think you need to genuinely, in a very open and straightforward way, tell all your representatives and senators

of all parties that you believe now is the time to look to the long run.

If America were in economic trouble now, if people were unemployed, if they were having terrible trouble, maybe we should have a big tax cut to help people get out of the tights they're in. But now that the country is generally doing well, we ought to take the money and make sure we don't get in a tight in the future. If you can just say that in a nice way, I think -- I'm trying to keep the temperature down on this debate and get people to think. I want to shed more light than heat. Usually, our political debates in Washington shed more heat than light. And you can help a lot. Just be straightforward and tell people that's what you think.

MS. ALDRIDGE: And when you tell your lawmakers, write them a letter, send them an e-mail.

THE PRESIDENT: Write them a letter, send them an e-mail, send them an fax, do something to -- and say, I'm just a citizen, but I want you to know that I will support you if you save most of the surplus to fix Social Security and Medicare and make America debt-free. I will take the smaller tax cut and I don't want you to have to cut education or national defense or medical research or any of those other things. Let's do this in a disciplined way, in a common-sense way. I think you just tell him that that's what you want him to do, and don't make it a partisan issue, don't make it a -- I don't want Americans do get angry over this.

Like I said, this is a high-class problem. You would have laughed me out of this room if I had come here seven years ago and said, vote for me, I'll come back and we'll have a debate on what to do with the surplus. So let's be grown up about this and deal with it as good citizens.

* * * * *

THE PRESIDENT: Yes, I thank you for that. I agree with that. Let me say, if you think about it, every time we do a big change in this country, the people that are doing pretty well under the status quo normally oppose it. And in the 15th century, the great Italian statesman, Machiavelli, said there is nothing so difficult in all of human affairs than to change the established order of things, because the people who will benefit are uncertain of their gain, and the people who will lose are afraid of their loss.

Well, I don't think they will necessarily lose. Once they go back to what this gentleman said over here about it, and let's put what he said and what you said together. The profit margins may go down some on heavily-used drugs where we have the

power to bargain per drug; but the volume will surely go up. That's the point you're trying to make.

Look, none of us have an interest in putting the American pharmaceutical companies out of business. They're the best in the world and they're discovering all these new drugs that keep us alive longer. And I wouldn't -- we'll never be in a position where we're going to try to do that. But I've seen this time after time after time -- not just in health care, in lots of other areas. It will be fine if we just have to get the point where they can't kill it. I think the pharmacists will help us, and I think if we keep working, we'll wind up getting some pharmaceutical executives who will eventually come out for it, too, once they understand that nobody has a vested interest in driving them out of business, we all want them to do well and keep putting money into research and the increased volume -- if the past is any experience of every other change, the increased volume of medicine going to seniors who need it will more than offset the slightly reduced profit margins from having more reasonable prices.

Thank you very much.

MR. GRAHAM: My daughter is 44 years old, she has rheumatoid arthritis. She cannot get medical insurance. Now,

she is fit, she plays golf a couple of times a week, and I think she should be able to buy into Medicare because she is refused insurance.

THE PRESIDENT: But she's not designated disabled?

MR. GRAHAM: I beg your pardon?

THE PRESIDENT: Medicare covers certain -- the disability population -- she's not disabled enough to cover, to qualify.

MR. GRAHAM: Correct.

THE PRESIDENT: I don't know if I can solve that or not. I'll have to think about it. (Laughter.)

MS. ALDRIDGE: But you obviously have other people that you know that are dealing with the same type of issue that you are right now, is that correct?

MR. GRAHAM: Well, I know a lot of people that are in the same situation. Although I have supplemental insurance, there's no guarantee that that supplemental insurance will continue. Because in our retirement, that's a part of it,

but there's nothing in writing that says we're going to get it forever.

THE PRESIDENT: Let me say one thing. You said you wanted Medicare to be around another 32 years. Another point I should have made that I didn't about taking the trust fund out 27 years, you think how much health care has changed in the last 27 years. The likelihood is, it will change even more in the next 27 than it has changed in the last 27. And we may be caring for ourselves at home for things that we now think of as terminal hospital stays. They may become normal things where you give yourself medication, you give yourself your own shots, you do all the stuff that we now think of that would be unimaginable.

I think if we can get it out that far, the whole way health care is delivered will change so dramatically that the people who come along after me and the Congress and in the White House will have opportunities to structure this in a different way that will be even more satisfying to the people as well as being better for their health.

But that's why, to go back to what you said, I want us to do this prescription drug thing. I think it is critically important. But we also have to remember that we've got to

stabilize the trust fund. We've got to take it out. It ought to be more than 25 years. When you look ahead, you know it's going to be there. Thank you.

THE PRESIDENT: Well, if it was up to me, I would remove the age limits, the earnings limits on Social Security recipients, because I think that's another good thing they ought to do. But it ought to be voluntary; you shouldn't have to do it just to pay for your medicine.

I promised the lady over there who said most of the people who lived in your place were single. Now, keep in mind, we start out with the premium of \$24 a month, and that premium covers half the prescription drug costs, up to \$2,000 a year. It will go eventually to a premium of about \$44 a month that will cover half prescription drug costs up to \$5,000 a year. And I think it's important to get up above \$2,000, because a lot of people really do have big-time drug costs.

Now, the people who wouldn't have to pay the premium or the copay are people below 135 percent of poverty. That's \$14,000 for a couple, but \$11,000 for individuals. That's a lot of folks. And then, if you're up to \$12,750 for an individual or \$17,000 for a couple, your costs would be phased in, so there would be some benefit there.

But nearly everybody would be better off unless they have a good -- the only plans that are better than this, by and large, are those that you got from your employer if your employer still covers prescription drugs. This is totally voluntary. Nobody has to do this. And we also have funds in here to give significant subsidies to the employers who do this to encourage them to keep on doing it and to encourage other employers to do it. So I think it's a well-balanced program and a good way to start.

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DR. SHAHNI: -- I can tell you, Mr. President, the list is very long of these patients who are out there suffering because they cannot afford these medications. Drug costs in this nation are skyrocketing. They are having dire consequences on the health care system. We do need to do something. We strongly support your health care plan.

The second point I wanted to make, Mr. President, is the Medicare -- the payment system to the hospitals is having

dire consequences in our urban areas. The Detroit Medical Center and Henry Ford Health System are premiere centers in the state of Michigan. We are one of the best centers for taking care of health care, and they are losing money -- \$80 million to \$100 million -- and it cannot go on. If something happens to institutions like this in our area, we know the consequences on our patients are going to be very, very serious.

We urge you to look at that part of the Medicare also because if something happens to them, where will our patients go? So, thank you very much for listening to me. (Applause.)

THE PRESIDENT: I'd like to make two points after your very fine statement. First, on the second point you raised, I had a chance to discuss that yesterday at my press conference. When we passed the Balanced Budget Bill in 1997, the -- we had to say, how much are we going to spend on Medicare over the next five years. And we estimated what it would take to meet our budget target. Then, the Congressional Budget Office said, no, it will take deeper cuts than that, and we said if you do that it will cost a lot more money. But we had to do it the way they wanted.

Now, this is not a partisan attack; nobody did this on purpose. There was an honest disagreement here. But it turned out that our people were right, and so actually more money was taken out of the hospital system in America than was intended to take out. And to that extent by a few billion dollars, not an enormous amount, but the surplus in that sense is bigger than it was intended to be. And we have got to correct that. I have offered a plan that will at least partially take care of it and

we're now in intense meetings with people who are concerned about it; we are going to have to do that.

Now, let me make the point about the person you said, the gentleman who died. I was aghast -- last week, we had another health care debate on the patients' bill of rights, and one of the people who was against our position said, these people keep using stories -- you know, anybody can tell a story, that's not necessarily representative.

Well, first of all, I don't know about you, but I think people's stories are -- I mean, that's what life is all about. What is life but your story. (Applause.) And, secondly, I -- but the point I want to make is this doctor -- the most important point this doctor has made is that the man who died is not an unusual case. That is the point I want to make. And that's -- the pharmacists, Heather was making the same point -- there are lots of people like this.

And let me just use the example you mentioned. Diabetes is one of the most important examples of this, complications from diabetes can be, as you know, dire and can be fatal. And you have a very large number of older people with adult-onset diabetes that has to be managed. It is expensive, but people can have normal lives.

The patients have to do a lot of the management of diabetes. They have to do it. And if they don't do their medication, the odds that something really terrible will happen before very long are very, very high. Almost 100 percent.

But if you look at the sheer numbers of people with diabetes alone, just take diabetes, then the story is about statistics, too, big numbers of people.

I thank you very much, sir.

She says we've got to quit. You've been great. Are you going to be the heavy? I should be the heavy.

MS. ALDRIDGE: No, they told me I had to tell you to be quiet. I said, really? (Laughter.) I bet there are some Republicans that might like that job.

THE PRESIDENT: Republicans -- Hillary would like it. A lot of people would like it. (Laughter.)

MS. ALDRIDGE: We are, indeed, out of time. So sorry, but they're telling me and I have to take my cues. But, Mr. President, we want to thank you so much for being here. And did you have some closing remarks that you'd like to make to us?

THE PRESIDENT: I just wanted to say again, this is a wonderful moment. We told some sad, heart-wrenching stories today, and I wish I could hear from all of you. But keep in mind, this is a great thing. Our country is so blessed now. We've got the lowest peacetime unemployment in 40 years; the longest peacetime economic expansion in history. We've got this big surplus, the biggest one we've ever had. We think it will last for a decade or more. More, really, as long as we don't mess up the budget.

We have to decide. I already said what to me the choice is -- it is your money. If you want it back now, you can tell your elected representatives. Nobody can say you didn't pay it in, you want it back. I don't quarrel with that. But I think it is much better for you to stabilize Social Security and

Medicare, add the prescription drug benefit at a price we can afford, let people 55-65 pay into it who don't have health insurance, have a modest tax cut that doesn't undermine our ability to do that or our ability to invest in education and medical research and defense -- and get the country debt-free.

You'd be amazed how many really wealthy businessmen come up to me and say, you raised my taxes to balance the budget back in '93 -- we did the top 1 percent, 1.5 percent got an income tax increase -- and I was mad at the time, but I made so much more money in the stock market than I paid in taxes, it's not funny.

Low interest rates make people money. The flip side of that is if interest rates went up 1 percent in this country, it would cost you more money than I can give you in a tax cut if you borrow any money for anything.

So what I think we have to say -- I just want you to think about this, and then communicate your feelings. And again, do it in a friendly way. Do it in the tone we've been talking about today. Tell them the stories you know, Doctor. Every doctor, every nurse, every pharmacist, every family should sit down and take the time -- I know you think that members in the Congress and the White House, the President -- I have a thousand volunteers at the White House, most of them just read mail. And then I get a representative sample of that mail every two or three weeks. And we all calibrate that. And the members of Congress, you'd be amazed how many members of Congress actually read letters that they get. They do have an impact.

So these faxes and e-mails and letters and telephone calls, they register on people, especially if they're not done in a kind of harsh, political way, but just saying, this is what I think is right for our country. And I hope you'll do it.

Thank you and God bless you. (Applause.)

END

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THE WHITE HOUSE

Office of the Press Secretary

For Internal Release

July 22, 1999

INTERVIEW OF THE PRESIDENT
BY
MIKE CUTHBERT OF
AARP'S PRIME TIME RADIO

Lansing Community College
Lansing, Michigan

2:20 P.M. EDT

Q Hi, I'm Mike Cuthbert in Lansing, Michigan. Welcome back to Prime Time Radio. As we promised you, we'll present full and in depth discussion of the proposed changes in our health care system, with particular focus on Medicare, as the year 2000 campaign begins. But the discussion of Medicare has not waited for the campaign to start, as you know.

With us here in Lansing, Michigan, is President Clinton, who just finished having a discussion with folks from Michigan on Medicare. Mr.

President, welcome to Prime Time Radio.

THE PRESIDENT: Thank you. I'm glad to be here.

Q Back in 1992, in a long discussion about health care reform, you stopped the proceedings and you said very firmly, without wholesale health care reform we have no hope of a stabilized, long term economic recovery. The economic recovery has been long, but health care reform didn't happen. How does that impact on the Medicare plans?

THE PRESIDENT: Well, the one thing that I didn't believe that has happened that was good is that we had -- I didn't believe that we could get health care inflation down to the general rate of inflation without moving to universal coverage. And I think what happened was we got all the benefits of managed care in the early years, and we were very fortunate to do so, but now we're also living with the burdens as you hear all the horror stories that prompted me to push the patients' bill of rights.

So I think where we are now is -- where I am, at least, is I'm trying to extend health insurance coverage to discreet groups that don't have it, to try to improve the way the system works and do more preventive care and to try to modernize and stabilize the Medicare program. For example, we, two years ago, provided for funds to cover 5 million children who don't have health insurance. In this Medicare reform package we have a proposal to allow people between the ages of 55 and 65 who don't have insurance to buy into Medicare.

But the most important thing we can do now is to stabilize Medicare financially by putting some more cash into it over the next 10 years, by adopting the most modern practices and by providing more preventive services free, like testing and screenings for osteoporosis and cancer and other things, and adding a prescription drug benefit that we can afford.

So I think that this will be a very good, balanced package. It's completely voluntary. It gives seniors another choice on Medicare. But the most important thing is it stabilizes Medicare for 27 years, and that's very, very important, because all the baby boomers start retiring in -- well, they'll start retiring sooner, but the baby boomers start turning 65 in 2011. The oldest baby boomers are already in the AARP -- that seems impossible to me, but there it is. (Laughter.)

So, to me, it's very, very important that we not spend too much of this surplus on a tax cut before we do the first things first -- before we stabilize Social Security, stabilize Medicare and reform it. And, incidentally, my proposal, if it's adopted as I sent it to Congress, would also make America debt free in 15 years, for the first time in 160 years, so that would be a good thing to do, as well.

Q One thing I noticed you have done since this focus began -- and you did it again here, in Lansing -- was you always

mention Medicare and Social Security and you never fail to mention education. This program talks a lot about sandwich generation issues. What do you see and what should the American people see as the importance of that link between Medicare, Social Security and education, which seem to be appealing to two different audiences?

THE PRESIDENT: Well, I think that they tie families together and they tie the future together. For example, younger people should care a lot about stabilizing Social Security and Medicare, not just for themselves, but so that they will not be financially burdened by their parents aging. The number of people over 65 is going to double in 30 years -- double. People over 80 are the fastest growing group of Americans.

So if you're going to be -- in 10 years from now if you're going to be 45 years old and have kids going to college, you ought to be interested in this because you ought to want our programs to be strong so that your parents can support themselves with their own retirement from the Social Security, and you'll be free to raise your parents' grandchildren. So it is an inter-generational thing.

If you look at the education issue, the ability of America to sustain our economic dominance long term will rest increasingly on the ability of America to education all American kids to world-class standards so they can occupy tomorrows with jobs. And so the older people have a big vested interest in education, apart from generally caring about how their grandchildren are going to do in the world because it will stabilize and strengthen America. And we should look at America as a whole, we ought to -- we've got to deal with the aging of America, we've got to deal with the challenges to the children of America and we've got to make sure we can keep the economy going. If you do those three things I think we'll solve a lot of the other problems just on our own.

Q Critics of the surplus debate have said that nobody can guarantee the economic growth that is at the bottom of your plan. It seems to me -- and I wish you to comment on this -- that that may be the most important part of that education you're talking about, that without that education that economic growth underlying this whole thing and the surplus isn't possible.

THE PRESIDENT: Absolutely. Let me say, though, to people who say that you can't be absolutely certain the surplus will be there as projected for 10 years, or 20 years, to me that's an even stronger argument not to go out and give it away before it materializes with a big tax cut. At least if you adopt my plan you know that we're going to be saving the lion's share of it for Social Security and Medicare and paying the debt down. So if it doesn't all materialize, at least you're going to be making headway.

But I should say a little something about economic forecasting, because it relates to what you said about education. When we say the surplus will be such and such over 10 years, based on the economists' forecasts, it doesn't mean that we think every year will always be better than the next and there will never be a recession or never be an economic slow-down. What these economists do is they factor the patterns of economic performance over a long period of time and they say, if you assume the average number of downturns and the average number of upturns and the economy performs as it has been performing for the last 10 to 20 years, then this is what the surplus will be.

In other words, we have eliminated the so-called structural deficit. We never really had a big, permanent deficit in America until 1981, you know, in peacetime, just a permanent deficit. And we quadrupled the debt in 12 years. We have gotten rid of that. So now if we had, God forbid, a big downturn next year or the year after next, we might even run a little deficit because there would be fewer people working and more people getting tax money. But over the 10 year period the surplus estimate is almost certainly right.

Q Can we turn for a moment to nursing homes? They've been running ads recently in major papers across the country about the effects of the Balanced Budget Act amendment cuts, some \$2.6 billion. My mother is in a nursing home and I can see the effects on her -- less exercise periods, more difficulty getting service, more turnover in staff. How would your Medicare reforms and stabilization affect that problem, which appears to be growing?

THE PRESIDENT: Let me, first of all, describe what the problem was. When we passed the Balanced Budget Act we agreed with the Republicans we would try to achieve a certain level of savings in the Medicare program, which funds nursing homes and hospitals and home health and all that.

We then produced, from our health care experts who deal with all the providers, the list of changes we thought were necessary to achieve that level of savings. The Congressional Budget people said they thought it would require more changes than that. So under the law we had to do it. They didn't do this on purpose. What happened was they cut more than was necessary, they realized much bigger savings than they estimated. To that extent, our surplus is larger than it otherwise would be.

And we believe that it is mostly because we did too much that some of our nursing homes and hospitals and other programs are in trouble. And what I have done in extending, in taking the savings of the Balanced Budget Act from '97 out another 10 years, we have taken out of that some of the things we put in last time. And we have also set aside a fund of \$7.5 billion that can be allocated by Congress to the hospitals and the nursing homes that have been particularly disadvantaged by this, to try to alleviate

this quite difficult financial situation a lot of them found themselves in.

Q Much of the discussion here in Lansing concerned the prescription program that so featured part of your Medicare stabilization program. I have not, in all my reading and listening, been able to discern too much opposition to that. Have you?

THE PRESIDENT: Well, I think there's opposition -- the only opposition I'm aware of now is there are some in the Congress who are opposed to it, who say that -- mostly the Republicans who want to use the money for the tax cut -- they basically say, well, two-thirds of our seniors already have drug coverage. But as I pointed out today -- we produced our report today -- only about 24 percent have really good private sector drug coverage related to their former employment. The other coverage -- either they don't have coverage at all, a third of them don't have any coverage; and the rest of them have coverage that's too expensive and too unreliable and is shrinking every year. Some of them have coverage that has \$1,000 ceiling. And the most rapidly growing drug coverage has a \$500 ceiling. Well, for people with drug problems, you know, if they have \$2,000, \$3,000, \$4,000 worth of bills every year, that's not much coverage.

So we think that -- this is a purely voluntary program, but we think that people ought to have another choice. They ought to have the option to have more adequate drug coverage at a considerably lower price than you get in the Medigap policy. Medigap is just too expensive. And it also goes up as people get older. And the older you get, the less able you are to pay, normally, and the higher the premium is. So I feel that this is quite a good thing to do.

Q Speak to the fears of the people who say, if this prescription drug program comes in, my company will cut drug prescription benefits.

THE PRESIDENT: Well, we were concerned about that, because the 24 percent that have this drug coverage already, some of them actually have programs that are more generous than the one we're offering and we don't want to mess that up. So we have offered, as a part of this program, quite generous subsidies to employers to continue such programs. And I think actually it might be that more employers will be willing to provide this coverage.

What's happening now is these employers are dropping this coverage like crazy, right now -- they're dropping it anyway. And so what we want to do is to give incentives for them to keep it and then to add it back if they've dropped it. This will not aggravate this problem; this will make that problem better -- however bad or good it is, it'll be better after this because it's totally voluntary, but the employers will have no financial incentives to drop it and put their people on the Medicare

program because they're going to get direct subsidies from Medicare to keep what they've got.

Q As we'll hear in just a moment, we're going to hear from some of the folks who were at this meeting in Lansing, the people from the audience and their stories. As you said in the presentation, those who criticize stories as ineffective don't know America, we are a collection of stories.

It seemed to me that since this is your last year in the presidency -- and, as you say, you're not running for anything -- President Carter had the Habitat for Humanity, what are the chances that President Bill Clinton, after he's President, will focus on health care reform and health care issues as your next job?

THE PRESIDENT: Well, I think it's one of the things that I will do. I've tried to bring this country together politically, economically, socially, across racial and religious lines. And one of the things that I expect I will be doing is to use the center that I will establish at my library to try to find ways to close the gaps in the fabric of our American community, including the health care gaps. You know, I care a lot about it.

But I think it's very important that we recognize we can do a huge amount in the one year and five months I have left. It would be a big mistake for us to all check out here. Or, a year and six months we've got left.

Q You don't seem to be checking out.

THE PRESIDENT: No, I think we ought to bear down. I tell my friends in the Congress all the time, I say, you know, we still get a check every two weeks. People are paying us. We need to show up for work. There will be an election and time will take care of all the rest of this and then we'll all go on about our business and do other things.

But, it's funny, sometimes the pressure of an election -- a lot of people have forgotten this, but in 1996 we passed welfare reform with overwhelming bipartisan majorities in both houses, we passed an increase in the minimum wage, we did two or three other big things in '96. In '98, at the very end of the 11th hour we passed a budget that provided for a down payment on 100,000 teachers to take class size down to 18 in the first three grades. And we've already funded almost a third of them. I mean, this was a huge deal.

So if we all just stay in harness here and focus and show up for work everyday, good things can happen.

Q You said here in Lansing that you want the debate to be harmonious, you want it to be civil, you want it to be intelligent and we hope it will remain this way on this program.

We thank you for contributing to that atmosphere and the information and inspiration you've given us today. Thank you very much for being on Prime Time.

THE PRESIDENT: Thank you very much, I'm delighted to be here. Thank you.

END

2:35 P.M. EDT

Message Sent To:

Brenda M. Anders@eop
Beverly J. Barnes@eop
Nanda Chitre@eop
Douglas B. Sosnik@eop
Nancy V. Hernreich@eop
Heather M. Riley@eop
Jenny C. Long@eop
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Elizabeth R. Newman@eop
Julia M. Payne@eop
Jason H. Schechter@eop
Richard L. Siewert@eop
Barry J. Toiv@EOP
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PALMIERI_J@A1@CD@LNGTWY
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WOZNIAK_N@A1@CD@LNGTWY

**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.

THE WHITE HOUSE
WASHINGTON

July 21, 1999

CONVERSATION ON MEDICARE

DATE: July 22, 1999
LOCATION: Lansing Community College
EVENT TIME: 11:25am – 12:40pm
FROM: Bruce Reed, Gene Sperling, Mary Beth Cahill
Chris Jennings

I. PURPOSE

To participate in a discussion regarding the future of the Medicare program with Lansing and surrounding Michigan area community members.

II. BACKGROUND

You will participate in a conversation with approximately 45 Lansing and surrounding Michigan area residents. The Older Women's League, the National Council of Senior Citizens, and the National Committee to Preserve Social Security and Medicare have sponsored this forum. The audience consists of seniors from the three host organizations, senior organizations from Lansing and around the state, health care and consumer organizations, participants in senior programs across the community, and state and local elected officials.

Today, you will release 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. You will also underscore 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, you will:

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I. PARTICIPANTS

Jane Aldrich, Moderator
See attached list of discussion participants.

II. PRESS PLAN

Open Press.

III. SEQUENCE OF EVENTS

- **YOU** will be announced, accompanied by Jane Aldrich, moderator, onto the stage.
- **YOU** will proceed to the podium and make a statement.
- **YOU** will proceed to your seat on stage.
- Jane Aldrich will begin the discussion.
- Upon conclusion of the discussion, **YOU** will make a closing statement, work a ropeline and depart.

VI. REMARKS

To be provided by speechwriting.

I. ATTACHMENT

Participants List
Conversation Talking Points

CONVERSATION ON MEDICARE
DISCUSSION PARTICIPANTS

MARY AIKEY, East Lansing, MI

Mary believes that while the Medicare program has been a godsend to America's elderly, we need to modernize the benefit package and cover new things like prescription drugs and other preventive benefits. She is concerned about the instability of Medicare+Choice drug coverage, and believes that her Medigap policy does not always cover the right thing – like prescription drugs.

BARBARA AMES, Brighton, MI

Because of the services Medicare provided when her mother became suddenly ill, Ms. Ames was able to concentrate on helping her mother recover, and not the financial cost of her mother's illness. She hopes that Medicare will be there for her, and her daughter, so that a serious illness will not financially devastate the family.

MARY ARCHART, Lansing, MI

Mary, 74, feels fortunate that her supplemental coverage and investments have taken care of her to this point. However, she is afraid of what will happen down the line when her coverage is too expensive and she can no longer afford prescription drugs, which cost her \$100 monthly.

GREG BOVEE, Lansing, MI

Greg is a community pharmacist who counsels patients on their drug prescriptions and works with the appropriate caretakers to ensure that the medications are taken appropriately. He often encounters seniors who have to choose between purchasing drugs and necessities, such as food, and those who stretch out their medication because they can not afford to purchase their prescriptions regularly and end up in the hospital.

DERWOOD BOYD, Lansing, MI

Derwood, 77, has had no problems with his prescription drug coverage as he has supplemental insurance through the state. However, he does have many retired friends who are ill and have trouble keeping up with the cost of their prescription medications.

INEZ CAREY, Owoso, MI

Inez, 81, has Medicare and supplemental coverage, which does not include prescription drug coverage. Paying for her prescriptions is very difficult for her, and last year she spent between \$1600 and \$2000 on her prescriptions. She has been forced to pay for some prescriptions with her credit card, and she worries about her accruing debt.

DAVE AND DOROTHY COBB, Delta Township, MI

Dave, 65, and Dottie, 63, have supplemental coverage, and Dave now has Medicare but has not had to use it yet. He feels thankful that Medicare is there for him in case he needs it.

DUBE COULTER, Lansing, MI

Dube, age 53, and her husband assist in the care of her mother-in-law, who has recently moved into a senior apartment building. Dube worries about her own future, as retirement age is rapidly approaching, and she is not counting on Medicare being there for her. With their expenses for their 2 daughters' college education and trying to assist Thomas' mother, they are not able to save much for their own retirement.

MARY CROSBY, Lansing, MI

Mary, aged 75, and her husband, have Medicare and retiree coverage, provided by General Motors, which includes prescription drug coverage.

KAY CRUMM, Lansing, MI

Kay Crumm, Executive Director, Rocking Chair Senior Center, sees firsthand the everyday experiences and struggles of those seniors that participate with her senior center.

CURTIS DUNN, Lansing, MI

Curtis, 71, spends approximately \$120 per month on medications. He believes that the addition of a prescription drug benefit to the Medicare program is long overdue. He sees people at the grocery store and pharmacy paying for their prescriptions with their credit cards, and others who have had to take out home equity loans in order to pay their medication bills.

JOSETHINA ESTRADA, Lansing, MI

Josethina, a 69-year-old widow, is on Medicare, and has supplemental coverage, which helps pay her medical bills. With several health problems she must take many medications, and her daughter must help her pay for them.

HEATHER FRETTELL, Lansing, MI

Heather is a pharmacist who has seen many seniors who have to go without their medications because they are too expensive. She has seen some patients almost walk out of the store without any medication at all, due to the high cost.

CYNTHIA GERSTENLAUER, Lansing, MI

Cynthia Gerstenlauer has been an advance practice nurse specializing in geriatrics for 17 years. She has seen seniors, who think that they feel well enough to do without their medications, ration their medication and end up in the hospital. She has also seen older women who request a mammogram or a bone density test, and leave without receiving one because they could not afford the copayment or deductible.

LAURIE GORDON, MSW, East Lansing, MI

Laurie has been a home health social worker for 8 years, and has seen firsthand how the lack of prescription coverage can result in negative medical consequences.

LOREN AND JANETTA GRAHAM, Lansing, MI

Loren and his wife Janetta, both have Medicare and supplemental coverage through their former employer. They are very happy with the Medicare program, and have both used it regularly as cancer survivors. While they do have some prescription drug coverage, Loren knows that their insurance is not guaranteed as part of their retirement, and is concerned that at any time they could be forced into an HMO.

JO GRUBBE, Lansing, MI

Jo, 57, has three children. The company she works for does not have a pension program, and Jo believes she may have to work well beyond retirement age to cover healthcare costs as she gets older. She worries about whether Medicare will be there for her, and about how expensive supplemental insurance and medication costs will be when she needs them the most.

PHYLLIS GUTHRIE, Diamondale, MI

Phyllis has a Medigap plan, which provides coverage for prescription drugs, but would like to see a guaranteed benefit for everyone. However, she is worried that we cannot afford the cost of a prescription drug benefit.

MARY JANE HOCK, Detroit, MI

Mary Jane, 72, has Medicare and supplemental coverage, but it does not cover prescription drugs. She has begun to spend her savings on her medications, which cost her about \$250 a month.

ADONNA JORY, Haslett, MI

Adonna, 76, has Medicare and supplemental coverage. She has been happy with her Medicare coverage, but her one complaint is that there is no assistance with the cost of prescription drugs, which personally cost her \$160 a month.

ALICE KOCEL, East Lansing, MI

Alice, 79, has Medicare and a retiree benefits program from her work as a state employee which includes prescription drug coverage. She is glad to see that Medicare has been expanding its preventive services, and would like to see more done for prevention.

OLIVIA LETTS , Lansing, MI

She has Medicare and a supplemental coverage plan that takes care of prescription drugs. She sees that her friends' costs are much higher than hers are. If she did not have her supplemental coverage she believes she would not be able to afford her medications costs, and she would likely not take all of her medications regularly.

BETTY LECLEAR, Holt, MI

Betty, 74, has Medicare and supplemental coverage which covers her medication costs, that would otherwise cost more than \$300 monthly. However, she does find it difficult to afford this expensive supplemental coverage. Betty wonders whether Medicare will be there for her three children when they grow older.

BETH LOTT, Lansing, MI

Beth, 67, has Medicare and supplemental coverage, which pays for prescription drug costs. She knows that there are seniors out there that do not have the benefits she does, and believes that something must be done to add prescription drug coverage to Medicare.

PATRICIA LOWRIE, Okemos, MI

Patricia, 55, assists in the care of her parents, who live in Washington, D.C., as much as she can (flies to DC once a month. While Patricia knows her currently employer has a good retiree benefits package, she does worry about whether the employer will still be able to provide it when she retires. Patricia is married, and has one son.

FRED AND JANE PARKER, Lansing, MI

Both Fred, 72, and Jane, 70, have Medicare and supplemental coverage, which includes prescriptions. They are thankful for their healthcare coverage, which has been there for Jane through 2 breast cancer surgeries.

LORI PRENTICE, RN, Lansing, MI

Lori has been a home care nurse for 10 years. She works with seniors who, recently released from the hospital, go to the pharmacy to buy their medications and find they can not afford their prescriptions.

DONNA RILEY, Detroit, MI

Donna has studied Social Security, Medicare, and other social issues, and talks about the need to preserve social security and Medicare. She feels that Medicare is a program that should be there for the younger generation, as it has been for her grandfather's generation.

JUDY ROHM, Mason, MI

Judy, 59, and her sister-in-law help to pay for the health care costs of her mother, who lives in assisted living. While Grayce has Medicare and supplemental insurance, if her daughters did not help out with these costs she would not be able to make it. However, assisting her mother is a hardship for Judy herself, who takes expensive medications for her recovery from a bout with cancer, which forced her to retire.

DR. KRISHNA SAWHNEY, Detroit, MI

Dr. Sawhney has been a surgeon in Detroit for almost 20 years. He has seen a patient die because he could not afford to purchase his medication regularly. He has also encountered a patient who came in for a mammogram but could not afford the copayment or deductible and ended up leaving without the test.

MILDRED SCOTT, Detroit, MI

Mildred, 75, has Medicare and supplemental coverage which does not provide for prescription drugs. She has been lucky to have doctors who will provide her with medication samples, as she would not be able to purchase her medications on her own.

DOROTHY SILK, East Lansing, MI

She has been on Medicare for years, and has been very happy with it. She has a Medigap plan that has a good drug benefit, but she worries about those seniors who can not afford a Medigap plan like she can.

SUE SMITH, Lansing, MI

Sue, 76, and her husband, Norm, have Medicare and supplemental coverage through a retiree program. However, this coverage is very expensive for them, and Sue wonders how long they will be able to afford it as the cost is forcing them to start using their savings.

JANICE SOUTHWELL, Mason, Michigan

Janice's father and stepmother have a Medigap plan that does not cover prescription drugs, and their medication costs are approximately \$2400 annually. She is 53 years old and is healthy, but does worry about what would happen if she and her husband lost the health insurance coverage her husband's employer is providing and she was solely dependant on the Medicare program.

GLORIA STAMBAUGH, Holt, MI

Gloria, 55, cares for her "adopted" grandmother, Annie, who is 71 years old. Annie has high prescription drug costs, and is only covered by Medicare. Annie is forced to scrimp to make it by, and Gloria does all she can to help her out.

DANIEL THOMPSON, Saginaw, Michigan

Daniel, 73, is a former GM worker of 53 years. He and his wife have Medicare and supplemental coverage, but have no prescription drug coverage and \$300 in medication costs monthly. His wife, Cloteal, has cancer, and takes a cancer drug that is very expensive. They had to remortgage their home to pay for their escalating health care costs and their prescription drugs.

FLOYD WALLACE, Leslie, MI

Floyd, 81, and his wife, Rosemary, don't know what they would do without Medicare. Rosemary has had surgery, and uses medical supplies that would often be difficult to pay for out of their own pocket. They have Medicare and a supplemental insurance, but no prescription drug coverage, and have about \$100 a month in medication costs.

FRANKIE WATTS, Lansing, MI

Frankie, 81, is on Medicare and supplemental coverage that includes a prescription drug benefit. However, due to her low income and the fact that a lot of small copayments eventually add up, she is often forced to let some of her bills go unpaid longer than she would like.

MARCIE WILSON, Mason, MI

Marcie and her husband have a Medigap plan, and say that it would have been impossible to pay their medical bills if they didn't. However, because their co-payments, premiums, and expenditures on prescription medications are all increasing, she does not know how long she will be able to sustain her current out of pocket costs.

SHERRY WILSON, Williamston, MI

Sherry has two sons, one in college, aged 18, and one aged 13 in the 8th grade. She is concerned about the funding gap of taking care of older parents, and knows that she can not afford to stop working if her elderly parents become ill. She saw her parents put her grandfather in a nursing home and she does not want that to happen to her parents.

JOHN AND BARBARA WILLSON, Delta Township, MI

John and Barbara have Medicare and supplemental coverage through his state employee retirement program. They do not have to sacrifice because they have good health insurance coverage, but know others that are not able to do as much as they do. He wonders whether Medicare will be there in the future, and has a son who has taken both Social Security and Medicare out of the equation when figuring out the finances for his future.

JACK WITT, Lansing, MI

Jack Witt, 75, spends approximately \$100 per month in prescription drug costs with no prescription drug coverage. He feels very strongly that everyone should be able to access a prescription drug benefit, and that we have a social responsibility to address this problem. He knows that if he were to suffer a financial hardship, his children would probably not be able to help that much, and wants to be able to maintain his pride in his old age.

~~1997~~ Mid Session
Review (1997)
File

MEDICARE SAVINGS IN THE MIDSESSION REVIEW

Q: In 1995, the President vetoed the Conference Agreement in part because of CBO-scored Medicare cuts of \$270 billion over 7 years. This year, the President's budget includes Medicare changes estimated by the Administration to total the exact same \$270 billion over 7 years. Doesn't this mean that the President signed onto the very same level of savings that he said would wreak havoc on the Medicare program in the 1996 campaign?

A: Not at all. The 1995 bill contained a range of policies and a level of cuts that the President thought were wrong then and wrong now for Medicare and for older Americans.

The savings are much smaller than the budget that the President vetoed.

An apples-to-apples comparison shows that CBO scores \$200 billion over 7 years for the budget that the President signed into law. CBO scored the budget that he vetoed at \$270 billion in savings -- 35 percent more than what he signed into law this year.

Second, the Administration has consistently produced savings estimates 20 to 30 percent higher than CBO for the exact same Medicare policies. Had the Administration scored the Republican proposal, it would likely have been well over \$300 billion over seven years.

Third, the Republican budget that the President vetoed had combined Medicare and Medicaid reductions of over \$430 billion over 7 years, according to CBO. The combined savings from these two program in this year's budget is about \$220 billion over 7 years -- almost half of the vetoed bill's reductions.

There are major differences between the bill that the President signed and the one he vetoed:

The vetoed bill would have raised the Part B premium to 31.5% of costs immediately.

The vetoed bill allowed doctors to "balance bill" far above Medicare approved rates without any consumer protections.

The vetoed bill had an open-ended MSA that threatened to allow massive numbers of healthier and wealthier beneficiaries to leave Medicare.

And, moreover, the vetoed 1995 bill combined this provision with a proposal to block-grant Medicaid and eliminate the guarantee of health care for millions of children and older Americans.

Withdrawal/Redaction Marker

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. briefing paper	Meeting With Senate Finance Democrats (6 pages)	7/16/99	P5

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

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

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- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
- b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
- b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

MEDICARE SAVINGS IN THE MIDSESSION REVIEW

Q: In 1995, the President vetoed the Conference Agreement in part because of CBO-scored Medicare cuts of \$270 billion over 7 years. This year, the President's budget includes Medicare changes estimated by the Administration to total the exact same \$270 billion over 7 years. Doesn't this mean that the President signed onto the very same level of savings that he said would wreak havoc on the Medicare program in the 1996 campaign?

A: Not at all. The 1995 bill contained a range of policies and a level of cuts that the President thought were wrong then and wrong now for Medicare and for older Americans.

The savings are much smaller than the budget that the President vetoed.

An apples-to-apples comparison shows that CBO scores \$200 billion over 7 years for the budget that the President signed into law. CBO scored the budget that he vetoed at \$270 billion in savings -- 35 percent more than what he signed into law this year.

Second, the Administration has consistently produced savings estimates 20 to 30 percent higher than CBO for the exact same Medicare policies. Had the Administration scored the Republican proposal, it would likely have been well over \$300 billion over seven years.

Third, the Republican budget that the President vetoed had combined Medicare and Medicaid reductions of over \$430 billion over 7 years, according to CBO. The combined savings from these two program in this year's budget is about \$220 billion over 7 years -- almost half of the vetoed bill's reductions.

On the issue of policy, there are major differences between the bill that the President signed and the one he vetoed.

The vetoed bill raised the Part B premium to 31.5% of costs. In today's budget, that means premiums would be \$200 per year higher in 2002.

The vetoed bill allowed doctors to "balance bill" far above Medicare approved rates without any consumer protections.

The vetoed bill had an open-ended MSA that threatened to allow massive numbers of healthier and wealthier beneficiaries to leave Medicare.

And, moreover, the vetoed 1995 bill combined this provision with a proposal to block-grant Medicaid and eliminate the guarantee of health care for millions of children and older Americans.

July 9, 1999

MEETING WITH CONGRESSIONAL LEADERS

DATE: Monday, July 12, 1999
LOCATION: Oval Office
TIME: 5:30 pm – 6:30 pm
FROM: Larry Stein
Gene Sperling
Chris Jennings

I. PURPOSE

To make a strong case to the Congressional leadership that your Medicare plan should be enacted this year.

II. BACKGROUND

As the Congressional tax-writing committees begin marking-up their tax bills under Reconciliation deadlines of July 16 for the House and July 23 for the Senate, we need to reaffirm with the bipartisan Congressional leadership the “first things first” message you laid out last week. Prior to laying out your new framework for the surplus, we correctly assumed that the reflex Republican response to significantly increased surplus projections would be to sop up the entire “on budget” surplus with a risky, irresponsible tax cut. Our pre-emptive strike was designed to accomplish three major things: use the increased surplus to co-opt the on-budget/off-budget formulation already adopted by both parties in Congress; re-establish a requirement for extending the solvency of the Social Security Trust Fund; and, most important, establish our Medicare reform proposal and our Children and Education Trust Fund and military readiness as the necessary legislative precursors to any tax cutting.

Our Medicare plan was particularly successful in dominating public discourse with its three central elements: injecting efficiency and competition into the system; modernizing it with an attractive, affordable prescription drug benefit; and extending its solvency through surplus infusions to the year 2027 – the longest period of solvency since it was created. We expect that this summer could evolve into a direct conflict between Republican tax cuts and our comprehensive Medicare package. Since the Ways and Means Committee will start marking up its tax bill on Wednesday of next week, the Monday meeting is a perfect opportunity to lay down the Medicare marker with clarity.

OMB is now projecting a \$1.1 trillion surplus over 10 years. CBO's corresponding number is \$996 billion. According to press accounts, Chairman Archer will be marking up a 10 year tax cut costing \$864 billion. Chairman Roth is expected to stick with the Senate Reconciliation instruction of \$778 billion over 10 years. Our analysis shows that in the Archer plan the cost to finance the debt will rise \$47 billion over the President's plan to \$179 billion – meaning that the Republicans would be in on-budget deficit with no money for Medicare; \$198 billion less than you for Defense and a 27% cut in education and domestic discretionary spending. Our allocation of the \$1.1 trillion over 10 breaks down as follows: \$374 billion for Medicare solvency, prescription drugs and reduced debt; \$328 billion for discretionary investment including military readiness and the "Children and Education Trust Fund"; \$250 billion for our U.S.A Accounts savings-oriented tax cut; and \$132 billion in financing costs. Clearly, tax cuts of the size contemplated by both Senate and House Republicans would wipe out any possibility for reforming Medicare and providing the very popular prescription drug benefit. They would also constrain the funding of general government to levels that are at best unrealistic and at worst irresponsible.

Medicare (and, to a lesser extent our discretionary investments) serves as both a necessary policy priority and a bar to fiscal irresponsibility.

Your Medicare package has been well received – even by some of the usual skeptics in the elite validator community. As such, it has served as a unifying force within the Democratic party and could well become a viable vehicle for Medicare reform that serves as the catalyst for an eventual agreement on the allocation of the surplus and an overall budget agreement. If this occurs, you would not only succeed in extending the life of the Trust Fund and providing for a prescription drug benefit but also significantly limiting the amount of surplus wasted on unnecessary and ill-advised tax cuts.

We hope that the Leaders leave your meeting with four messages. The first is that you believe that we should be doing enough on Social Security, Medicare, and debt reduction. The second is the urgency of addressing Medicare's problems. Its problems are not only the demographics that affect Social Security as well as Medicare, but also lack of a prescription drug benefit, its outdated payment systems, and the short-term effects of the Balanced Budget Act on providers. The emphasis should be on the imperative to act now. Third, you should convey to them the merits of your plan. It is a detailed, serious, structural reform plan that builds on what's best about Medicare while modernizing its payment systems and benefits. It includes a dedication of part of the surplus for solvency, which is necessary to avoid future, excessive cuts, and a prescription drug benefit that is essential to modern medicine and paid for in this plan. Finally, we want you to explicitly signal that you would oppose a large tax cut plan that does not address Medicare. Our goal is to repeatedly link the Medicare plan to the tax cut debate, in recognition that we cannot afford Medicare reform if all of the surplus is spent on a large tax cut. These messages are framed in the attached talking points.

III. PARTICIPANTS

Members of Congress

Senator Tom Daschle (D-SD)

Senator Trent Lott (R-MS)

Speaker Dennis Hastert (R-IL)

Representative Richard Gephardt (D-MO)

Representative Dick Armey (R-TX)

IV. PRESS PLAN

Closed Press.

V. SEQUENCE OF EVENTS

As usual.

VI. REMARKS

Talking Points Attached.

VII. ATTACHMENTS

- I. Talking Points
- II. Background Sheet on Medicare Plan

TALKING POINTS

- **URGENCY OF ACTING NOW.** Like Social Security, Medicare enrollment will double over the next three decades, causing severe financial strain on the program's ability to provide high-quality health care. For the following reasons, we have an historic opportunity—and I believe responsibility – to act now. Medicare:
 - **Becomes insolvent nearly 20 years before Social Security** (2015 versus 2034).
 - **Benefits have not kept pace with modern medicine** – no preventive benefits, cost sharing for preventive benefits. If created today, Medicare would certainly contain a prescription drug benefit. This is as important as hospital or physicians' care.
 - **Lacks competitive incentives and private sector cost-containment / quality improvement tools.**
 - **Balanced Budget Act provisions may be threatening providers' ability to provide high-quality health care to Medicare beneficiaries.**
 - **Unprecedented surplus can help avoid fiscal crisis associated with the baby boom generation retirees.**
- **MEDICARE PLAN RESPONDS TO CHALLENGES:**
 - **Making Medicare more competitive and efficient.** My plan (1) gives traditional Medicare new private sector purchasing and quality improvement tools; (2) extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program; and (3) takes actions to smooth out the BBA provider payment reductions while constraining Medicare's out-year costs.
 - **Modernizing Medicare's benefits.** It is absolutely essential that we prepare Medicare for the next century by covering prescription drugs for all beneficiaries. It is fiscally responsible, has no price controls and is affordable both to the program and beneficiaries. As important as prescription drugs are to treating and curing diseases, millions of beneficiaries lack coverage or have expensive or unstable coverage.
 - **Strengthening Medicare's financing for the 21st century.** Finally, as I said in my State of the Union, we cannot pass onto our children the financial crisis that is looming in Medicare. My proposal to dedicate 15 percent of the surplus to strengthening Medicare will help extend Medicare's solvency to 2027 and fund a prescription drug benefit.

NO SURPLUS-FUNDED TAX CUT WITHOUT MEDICARE REFORM. I will actively oppose tax cuts funded through the surplus without substantial investment and reforms in Medicare, including adding a prescription drug benefit to Medicare. Such a tax cut would pass on Medicare's inevitable crisis to our children and future beneficiaries. This is why I believe that our first priority must be to strengthen Medicare and Social Security.

OVERVIEW:
**PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE
FOR THE 21ST CENTURY**

On June 29, 1999, President Clinton unveiled his plan to modernize and strengthen the Medicare program to prepare it for the health, demographic, and financing challenges it faces in the 21st century. This historic initiative would: (1) make Medicare more competitive and efficient; (2) modernize and reform Medicare's benefits, including the provision of a long-overdue prescription drug benefit and cost sharing protections for preventive benefits; and (3) make an unprecedented long-term financing commitment to the program that would extend the estimated life of the Medicare Trust Fund until at least 2027. The President called on the Congress to work with him to reach a bipartisan consensus on needed reforms this year.

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

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

- **Takes administrative and legislative action to smooth out the BBA provider payment reductions.** The proposal includes a 7.5 billion “quality assurance fund” to smooth out provisions in the BBA that may be affecting Medicare beneficiaries’ access to quality services. The Administration will work with Congress, outside groups, and experts to identify real access problems and the appropriate policy solutions. The plan also includes a number of administrative actions to moderate the impact of the BBA on some health care providers’ ability to deliver quality services to beneficiaries. Finally, it contains a legislative proposal to better target disproportionate share hospitals. Cost: \$7.5 billion over 10 years.

MODERNIZING MEDICARE’S BENEFITS. The current Medicare benefit package does not include all the services needed to treat health problems facing the elderly and people with disabilities. The President’s plan would take strong new steps to ensure that Medicare beneficiaries have access to affordable prescription drugs and preventive services that have become essential elements of high-quality medicine. It also would address excess utilization and waste associated with first-dollar coverage of clinical lab services and would reform the current Medigap market. Finally, it integrates the FY 2000 President’s Budget Medicare Buy-In proposal to provide an affordable coverage option for vulnerable Americans between the ages of 55 and 65. Specifically, his plan:

- **Establishes a new voluntary Medicare “Part D” prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:
 - Have no deductible and pay for half of the beneficiary’s drug costs from the first prescription filled each year up to \$5,000 in spending (\$2,500 in Medicare payments) when fully phased-in by 2008.
 - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the \$5,000 limit is reached.
 - Cost about \$24 per month beginning in 2002 (when the coverage is capped at \$2,000 in spending) and \$44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)
 - Ensure that beneficiaries with incomes below 135 percent of poverty (\$11,000/\$15,000 single/couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.
 - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

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

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost \$3 billion over 10 years and would:
 - Eliminate existing copayments and the deductible for preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.
 - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.
 - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.
- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save \$11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:
 - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.
 - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.
- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).
- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately \$300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately \$400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The \$1.4 billion cost over 5 years is offset in the President's FY 2000 budget.

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

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

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

**Estimated SMI Premium Rates for the President's Medicare Reform Package
("6/25/99 Absolute Final" Version)**

	Calendar year										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Monthly Premiums:											
Present Law.....	\$48.50	\$52.30	\$56.50	\$61.50	\$66.30	\$69.90	\$74.80	\$80.00	\$85.00	\$90.30	\$95.50
President's Budget Package..	\$48.10	\$51.90	\$56.10	\$61.00	\$65.80	\$69.50	\$74.30	\$79.60	\$84.60	\$89.90	\$95.10
Medicare Reform:											
Standard Premium.....	\$48.40	\$52.20	\$55.90	\$60.00	\$64.30	\$67.60	\$72.10	\$77.20	\$81.90	\$86.90	\$91.80
Drug Premium.....	\$0.00	\$0.00	\$24.15	\$24.94	\$31.04	\$32.26	\$37.61	\$39.13	\$44.10	\$46.57	\$49.35
Total.....	\$48.40	\$52.20	\$80.05	\$84.94	\$95.34	\$99.86	\$109.71	\$116.33	\$126.00	\$133.47	\$141.15

Note: Estimates are based on the intermediate assumptions from the 1999 Trustees Report.

The President's Plan to Modernize and Strengthen Medicare*

(Source: OMB. FY Cash estimates, 1999 Trustees Report baseline, \$ in billions)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total	
											2000-04	2000-09
Reforms												
Competitively Defined Benefits Proposal	0.0	0.0	0.0	0.0	-0.5	-1.0	-1.5	-1.8	-2.0	-2.2	-0.4	-8.9
Traditional Medicare Modernization	0.0	-0.4	-1.0	-1.7	-2.5	-3.3	-3.6	-3.9	-4.1	-4.4	-5.4	-24.8
Provider Savings	0.0	0.0	-0.1	-1.4	-2.8	-4.5	-6.0	-7.9	-10.1	-12.3	-4.3	-45.0
Quality Assurance Fund	0.4	1.7	0.9	0.6	0.5	0.5	0.6	0.6	0.7	0.8	4.2	7.4
Clinical Lab Cost Sharing and Indexed Deductible	0.0	0.0	-0.6	-1.0	-1.2	-1.3	-1.4	-1.6	-1.8	-2.1	-2.8	-11.1
Eliminate Cost-sharing for Preventive Benefits	0.0	0.0	0.2	0.3	0.4	0.4	0.4	0.4	0.4	0.5	0.9	3.0
Premium Offset	-0.1	-0.1	0.0	0.1	0.3	0.4	0.4	0.5	0.6	0.7	0.2	2.8
Interactions	0.0	0.0	0.0	0.0	0.2	0.4	0.6	0.7	0.8	0.9	0.2	3.5
Subtotal	0.4	1.2	-0.5	-3.0	-5.6	-8.5	-10.5	-13.0	-15.5	-18.1	-7.5	-73.1
Prescription Drug Benefit and low-income protections, federal costs	0.0	0.0	5.0	11.0	12.7	14.3	16.1	17.8	19.9	22.0	28.7	118.8
Contribution to HI Solvency	4.7	0.3	11.9	5.4	6.8	10.6	30.4	59.7	83.6	114.3	29.1	327.7

HCFA Actuary HI insolvency date: 2027

* Estimates have been revised slightly since initial plan release.

MEDICARE PLAN SCORING

(Dollars in billion, FY)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2000-04	2000-09
PACKAGE 1. (No Nursing Home Copay, No Part B Deductible Indexing, No Income-Related Premium)												
Managed Care Reform	0.0	0.0	0.0	0.0	0.0	-0.4	-1.0	-1.4	-1.8	-1.9	0.0	-6.5
Traditional Medicare Modernization	0.0	-0.4	-0.9	-1.3	-2.0	-2.7	-2.8	-3.1	-3.3	-3.6	-4.5	-20.1
Provider Savings	0.0	0.0	0.1	-1.1	-2.7	-4.4	-6.2	-8.2	-10.8	-13.4	-3.7	-46.7
Provider Set-Aside **	0.4	1.7	1.1	0.7	0.5	0.6	0.6	0.7	0.7	0.8	4.4	7.7
Cost Sharing	0.0	0.0	-0.7	-1.2	-1.4	-1.5	-1.7	-1.9	-2.2	-2.5	-3.3	-13.1
Drop Nursing Home Copay	0.0	0.0	0.3	0.4	0.5	0.5	0.6	0.7	0.7	0.8	1.2	4.5
Drop Part B Deductible Indexing	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.3	0.4	0.2	1.4
Income-Related Premium	-	-	-	-	-	-	-	-	-	-	0.0	0.0
Interactions	0.0	0.0	-0.1	-0.1	0.0	0.0	0.1	0.0	0.3	0.1	-0.2	0.3
Premium Offset ***	0.0	-0.1	0.1	0.2	0.4	0.7	1.0	1.3	1.4	1.8	0.7	6.8
TOTAL	0.4	1.2	-0.1	-2.3	-4.5	-7.2	-9.2	-11.7	-14.7	-17.5	-5.3	-65.7
PACKAGE 2. (No Nursing Home Copay)												
Managed Care Reform	0.0	0.0	0.0	0.0	0.0	-0.4	-1.0	-1.4	-1.8	-1.9	0.0	-6.5
Traditional Medicare Modernization	0.0	-0.4	-0.9	-1.3	-2.0	-2.7	-2.8	-3.1	-3.3	-3.6	-4.5	-20.1
Provider Savings	0.0	0.0	0.1	-1.1	-2.7	-4.4	-6.2	-8.2	-10.8	-13.4	-3.7	-46.7
Provider Set-Aside **	0.4	1.7	1.1	0.7	0.5	0.6	0.6	0.7	0.7	0.8	4.4	7.7
Cost Sharing	0.0	0.0	-0.7	-1.2	-1.4	-1.5	-1.7	-1.9	-2.2	-2.5	-3.3	-13.1
Drop Nursing Home Copay	0.0	0.0	0.3	0.4	0.5	0.5	0.6	0.7	0.7	0.8	1.2	4.5
Income-Related Premium	0.0	-0.7	-3.0	-2.5	-2.7	-2.8	-3.0	-3.3	-3.5	-3.8	-8.9	-25.3
Interactions	0.0	0.0	-0.1	-0.1	0.0	0.0	0.1	0.0	0.3	0.1	-0.2	0.3
Premium Offset ***	0.0	-0.1	0.1	0.2	0.4	0.7	1.0	1.3	1.4	1.8	0.7	6.8
TOTAL	0.4	0.5	-3.1	-4.9	-7.3	-10.1	-12.4	-15.2	-18.5	-21.7	-14.4	-92.4
PACKAGE 3. (No Provider Set-Aside)												
Managed Care Reform	0.0	0.0	0.0	0.0	0.0	-0.4	-1.0	-1.4	-1.8	-1.9	0.0	-6.5
Traditional Medicare Modernization	0.0	-0.4	-0.9	-1.3	-2.0	-2.7	-2.8	-3.1	-3.3	-3.6	-4.5	-20.1
Provider Savings	0.0	0.0	0.1	-1.1	-2.7	-4.4	-6.2	-8.2	-10.8	-13.4	-3.7	-46.7
Provider Set-Aside	-	-	-	-	-	-	-	-	-	-	0.0	0.0
Cost Sharing	0.0	0.0	-0.7	-1.2	-1.4	-1.5	-1.7	-1.9	-2.2	-2.5	-3.3	-13.1
Income-Related Premium	0.0	-0.7	-3.0	-2.5	-2.7	-2.8	-3.0	-3.3	-3.5	-3.8	-8.9	-25.3
Interactions	0.0	0.0	-0.1	-0.1	0.0	0.0	0.1	0.0	0.3	0.1	-0.2	0.3
Premium Offset ***	0.0	-0.1	0.1	0.2	0.4	0.7	1.0	1.3	1.4	1.8	0.7	6.8
TOTAL	0.0	-1.2	-4.4	-6.0	-8.3	-11.1	-13.7	-16.6	-19.9	-23.3	-20.0	-104.6

** Placeholder: includes: (1) IME at 6.5% for 00-01; (2) OPD transition costs; (3) add-on to SNF RUGs; (4) therapy caps at \$2,000.

*** Increased by 10%/ not completely estimated by actuaries.

NOTE: Not completely estimated by actuaries/subject to change.

MAJOR MEDICARE POLICIES UNDER CONSIDERATION

POLICY	BREAUX-THOMAS	STATUS
<p>Increasing Competition in Medicare</p> <p>Allowing traditional Medicare to use competitive, efficient private payment policies</p> <p>Adopting premium support to make HMO & traditional plan payments more competitive</p>	<p>Yes</p> <p>Yes</p>	<p>Recommending yes: Includes a series of good management items</p> <p>Recommending reject Breaux-Thomas model but considering options that protect traditional Medicare</p>
<p>Reducing Medicare's Costs</p> <p>Raising Medicare's eligibility age</p> <p>Extending/modifying BBA policies</p> <p>Ending Medicare funding / liability for graduate medical education</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Recommending no</p> <p>Considering addressing concerns of providers while still achieving savings</p> <p>Considering including all-payer proposal</p>
<p>Modernizing Medicare's Benefits</p> <p>Adding a voluntary Medicare prescription drug benefit</p> <p><u>Rationalizing cost sharing</u></p> <p>Adding copays:</p> <ul style="list-style-type: none"> Home health (10% coinsurance) Laboratory services (20% coinsurance) Nursing homes (20% coinsurance) <p>Reducing copays:</p> <ul style="list-style-type: none"> Preventive services Hospital copays after 60 days <p>Changing Medicare's deductibles</p> <p>Prohibiting Medigap deductible coverage</p> <p>Offering unsubsidized Medigap option</p> <p>Coordinating care for dual Medicaid eligibles</p> <p>Medicare buy-in for certain 55 to 65 year olds</p> <p>Reformed review process for approving new technology/alternative therapies</p>	<p>No (Medicaid)</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>No</p> <p>No</p> <p>No</p> <p>Yes</p>	<p>Recommending yes (multiple designs under consideration)</p> <p>Recommending yes, but with lower, capped home health copay and lower nursing home copay</p> <p>Recommending yes on preventive, no on hospital copays, since affects few people & savings needed for drugs</p> <p>Under consideration</p> <p>Under consideration</p> <p>Under consideration; in Reischauer plan</p> <p>Under consideration; may be in Breaux bill</p> <p>In budget, assumed in plan</p> <p>Recommending administrative actions, but not recommending HCFA overhaul</p>
<p>Improving Medicare's Financing</p> <p>Dedicating part of surplus for Medicare</p> <p>Adding income-related premium</p> <p>Additional tobacco revenue/ Medicare suit</p>	<p>No</p> <p>No</p> <p>No</p>	<p>In budget, assumed in plan</p> <p>Recommending yes</p> <p>Under consideration (Wyden, Snowe)</p>

MEDICARE OPTIONS

(Dollars in billion, 2000-2009)

Last POTUS meeting before unveiling.
Bob Rubin's

07-25-99?

ERR

Signature on right

OPTION 1	OPTION 2	OPTION 3	OPTION 4
Savings:	Savings:	Savings:	Savings:
Managed Care Competition -8	Managed Care Competition -8	Managed Care Competition -8	Managed Care Competition -8
Modernize Traditional MCR -25	Modernize Traditional MCR -25	Modernize Traditional MCR -25	Modernize Traditional MCR -25
Provider Savings* -42	Provider Savings* -42	Provider Savings* -42	Provider Savings* -42
Set-aside for BBA fixes <u>7.5</u>	Set-aside for BBA fixes <u>7.5</u>	Set-aside for BBA fixes <u>7.5</u>	Set-aside for BBA fixes <u>10</u>
No Preventive Copays +3	No Preventive Copays +3	No Preventive Copays +3	No Preventive Copays +3
Add 20% Lab Copay -9	Add 20% Lab Copay -9	Add 20% Lab Copay -9	Add 20% Lab Copay -9
Income-Related Premium: <u>Drop</u>	Income-Related Premium: <u>8</u> \$100/120,000 phased down to 50% subsidy	Income-Related Premium: <u>Drop</u>	Income-Related Premium: <u>19</u> \$100/120,000 phased down to 25% subsidy
Subtotal: -\$73.5	Subtotal: -\$81.5	Subtotal: -\$75.5	Subtotal: -\$90.0
Drug Benefit:	Drug Benefit:	Drug Benefit:	Drug Benefit:
\$5,000 limit in 2006 +118	\$4,000 limit in 2006 +112	\$4,000 limit in 2006 +112	\$5,000 limit in 2006 +118
Premiums: \$24/mo in 2002; \$41/mo in 2006	Premiums: \$24/mo in 2002; \$38/mo in 2006	Premiums: \$24/mo in 2002; \$38/mo in 2006	Premiums: \$24/mo in 2002; \$41/mo in 2006
Low-income assistance +6	Low-income assistance +6	Low-income assistance +6	Low-income assistance +6
Subtotal: +\$124	Subtotal: +\$118	Subtotal: +\$118	Subtotal: +\$124
Surplus: -\$50.5	Surplus: -\$36.5	Surplus: -\$57.5	Surplus: -\$34.0
<i>Savings to surplus ratio</i> 1.5 to 1	<i>Savings to surplus ratio</i> : 2.2 to 1	<i>Savings to surplus ratio</i> 1.8 to 1	<i>Savings to surplus ratio</i> : 2.6 to 1

*Includes interactions and premium offsets

Conrad
Brough

- Bill Gross
- New Dem for deductible?
- For ~~set-aside~~ income related premium

→ No income related premium
right thing to do

MEDICARE OPTIONS

(Dollars in billion, 2000-2009)

OPTION 1	OPTION 2	OPTION 3	OPTION 4
Savings:	Savings:	Savings:	Savings:
Managed Care Competition -8	Managed Care Competition -8	Managed Care Competition -8	Managed Care Competition -8
Modernize Traditional MCR -25	Modernize Traditional MCR -25	Modernize Traditional MCR -25	Modernize Traditional MCR -25
Provider Savings* -42	Provider Savings* -42	Provider Savings* -42	Provider Savings* -42
Set-aside for BBA fixes +7.5	Set-aside for BBA fixes +7.5	Set-aside for BBA fixes +7.5	Set-aside for BBA fixes +10
No Preventive Copays +3	No Preventive Copays +3	No Preventive Copays +3	No Preventive Copays +3
Add 20% Lab Copay -9	Add 20% Lab Copay -9	Add 20% Lab Copay -9	Add 20% Lab Copay -9
Income-Related Premium: Drop	Income-Related Premium: -8	Income-Related Premium: Drop	Income-Related Premium: -19
Part B deductible?	\$100/120,000 phased down to 50% subsidy	Part B Deductible Index -2	\$100/120,000 phased down to 25% subsidy
Subtotal: -\$73.5	Subtotal: -\$81.5	Subtotal: -\$75.5	Subtotal: -\$90.0
Drug Benefit:	Drug Benefit:	Drug Benefit:	Drug Benefit:
\$5,000 limit in 2006 +118	\$4,000 limit in 2006 +112	\$4,000 limit in 2006 +112	\$5,000 limit in 2006 +118
Premiums: \$24/mo in 2002; \$41/mo in 2006	Premiums: \$24/mo in 2002; \$38/mo in 2006	Premiums: \$24/mo in 2002; \$38/mo in 2006	Premiums: \$24/mo in 2002; \$41/mo in 2006
Low-income assistance +6	Low-income assistance +6	Low-income assistance +6	Low-income assistance +6
Subtotal: +\$124	Subtotal: +\$118	Subtotal: +\$118	Subtotal: +\$124
Surplus: -\$50.5	Surplus: -\$36.5	Surplus: -\$42.5	Surplus: -\$34.0
<i>Savings to surplus ratio: 1.5 to 1</i>	<i>Savings to surplus ratio: 2.2 to 1</i>	<i>Savings to surplus ratio: 1.8 to 1</i>	<i>Savings to surplus ratio: 2.6 to 1</i>

*Includes interactions and premium offsets

Done with \$500