

**JOSH GOTTHEIMER BOX #15**

Patient's Bill of Rights, 5/16/00  
China 5/10/00  
Lands Legacy, 9/18/00  
Long Term Care  
Michael Jordan 1/3/99  
Guns MD Bill Signing, 4/11/00  
Bob Hope  
Gun Violence  
Paul Coverdale 6/19/00  
NAACP 7/13/00  
NGA 7/10/00  
July 4, 2000  
Radio Actualities 2/25/00  
Videos 3/98  
Videos 12/7/98  
Videos 1/12/99  
Videos 7/10/00

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Final 05/16/00 10:30am  
Heather Hurlburt

**PRESIDENT WILLIAM J. CLINTON  
STATEMENT ON PRESCRIPTION DRUG BENEFIT  
FOR MILITARY RETIREES  
THE WHITE HOUSE  
WASHINGTON, DC  
May 16, 2000**

Good afternoon. Before we start, I want to say something about Helen Thomas, who has decided today to leave UPI after fifty-seven years. Presidents come and go, but Helen has been here for nearly forty years, covering eight Presidents and showing the ropes to countless young reporters -- and more than a few press secretaries. Change is a good thing, most often. And we hope that this change will bring Helen new rewards and fulfillment. Whatever she decides to do, I hope that she'll still spend plenty of time here at the White House. After all, without her saying "thank you, Mr. President," our news conferences might never end.

In my State of the Union address this year, I said that we could not in good conscience let another year pass without finding a way to offer voluntary prescription drug coverage to every older American. I believe we are beginning to make progress toward that goal. We are here today to support one step in the right direction -- a Congressional proposal, scheduled for a vote this week in the House, to extend prescription drug coverage to all retired military personnel over age 65.

Keeping faith with the men and women of our Armed Forces is a sacred obligation. That is why we have raised military pay by more than 8 percent over the last two years. It is why we are working to provide our troops with better housing. And it is why we are taking steps to improve access to medical care for all military personnel, families and retirees.

We ask these men and women to risk their lives for our freedom; and in return, we pledge them the support of a grateful nation. Part of that promise is a medical network that helps provide prescription drugs at reasonable cost. Some senior retirees are able to take advantage of that network. But prescription drugs are out of reach for as many as three out of four of them.

This proposal makes sure we meet our promise to the more than one million older military retirees across our nation. It will provide every one of them with a prescription drug benefit. And it will share with them the price discounts that the military negotiates with drug companies. At this time of unprecedented national prosperity, there is absolutely no reason for military retirees to go without the prescription drugs they need to live longer, healthier lives. We need to show the men and women of our armed forces that they count -- and that they can count on us.

I believe this initiative is another important step toward finding a way to offer every older American voluntary prescription drug coverage and affordable prescription drugs.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

May 10, 2000

REMARKS BY THE PRESIDENT  
AT CALL TO ACTION FOR  
MEDICARE AND PRESCRIPTION DRUG REFORM

The Rose Garden

10:40 A.M. EDT

THE PRESIDENT: Well, good morning. Please be seated. I'm sorry you had to stand up so long, but that's the fastest one group of politicians ever walked through another group. I'm delighted to see you all here. I want to thank Senator Daschle and Senator Gephardt and their colleagues -- Secretary Shalala, the Elder Women's League, those who represent the aging-disability consumer, and other health advocates who are here. I want to thank Betty Dizik, who will talk in a moment to explain what this is really all about.

We are here together today to announce the support of the Democratic Caucus in the Senate and the House for legislation to provide affordable prescription drug coverage for every older American. For our seniors, prescription drugs are not a luxury, they can mean the difference between life and death; between years of anguish and years of fulfillment. At this time of historic prosperity and strength, there is absolutely no reason that we should force seniors to make a choice between their health and their food or their daily existence.

I am profoundly grateful to Congressman Gephardt and Senator Daschle and their colleagues for developing an approach that the Democrats can rally behind. In a few moments, I will ask them to share the details of the efforts we will make together. But we all know we can't achieve our efforts without bipartisan support in the Congress. That's why, just as we are trying to do with the patients' bill of rights, we want to reach across the aisle to encourage Republican support, as well.

This can, and should be, a truly bipartisan effort. But I want to make it clear first why America's seniors and people with disabilities cannot afford to wait any longer for prescription drug coverage.

Today, more than three in five older Americans lack affordable and dependable prescription drug coverage. The burden is getting worse. According to Families USA, the price of prescription drugs most often used by seniors has risen at double the rate of inflation for six years in a row now.

Two groups in particular bear a tremendous burden -- rural Americans and women. As Senator Daschle knows so well, people in rural areas are much less likely to secure prescription

drug coverage. According to a study released today by the Older Women's League, almost eight out of 10 women on Medicare use prescription drugs regularly, and most of them pay for these medications out of pocket. In total, women spend 13 percent more than men do for prescription drugs, in spite of the fact that on average, their incomes are 40 percent lower.

America's seniors, men and women, deserve better. No one should be forced to take a bus trip to Canada to get medicines made in the U.S. at a lower price. We desperately need a comprehensive plan to provide a prescription drug benefit that is optional, affordable, accessible to all, based on competition, not price controls, to boost seniors' bargaining power to get the best possible price; and one that addresses the devastating burden of catastrophic coverage.

We will have, in our budget, especially with the improved economy, the funds to deal with catastrophic coverage as well, and we absolutely should do that.

The budget I have presented to Congress will continue our efforts to pay down the debt and pay it off by 2013, will be able to provide protection against catastrophic costs, and will provide voluntary prescription drug coverage to all Americans.

Adding the voluntary prescription drug coverage to Medicare is the smart and the right thing to do. I will say this one more time: We would never think of creating Medicare today without it, and it is high time we fixed it.

Now, let me say without getting into a fight over the legislation that's been proposed, I don't think it's enough to stop at \$15,000 income limit to give help on prescription drugs. Half the people who need the help fall within the income limits of \$15,000 to \$50,000. I don't think we should write a plan that basically is designed to please the people who are selling the drugs instead of the people who are buying the drugs.


And as long as we are trying to make the price competition system work, and give bargaining power to seniors, we ought to do this right and cover the people who need it. This is not about winning a political fight. It's about giving people a chance to fight for a good long life.

And I want to introduce now Betty Dizik, someone who know firsthand the enormous burdens of prescription drugs. She's had to make some very hard choices in order to afford the drugs that she desperately needs, and she is Exhibit A for why we are all here today.

Betty, come on up here, and tell us your story. Give her a hand. Thank you.

\* \* \*

THE PRESIDENT: Thanks to Congressman Gephardt's consideration, none of you will have to spend your hard-earned money to buy prescription drugs to treat your cold that you got from being flooded out here. But let me thank you, Betty, thank you, Secretary Shalala, and



thank all the members of Congress. Look at our legislation. We need some Republican support. This is a good bill, it will make a big difference.

Thank you and bless you all. Get in here before you get wet.

END 11:00 A.M. EDT



Today more than three in five American seniors lack such coverage. Too many are spending huge percentages of their income on prescription drugs; too many have to choose every month between filling their prescriptions and filling their grocery carts; and too many are simply not getting the medicines they need.

If we were creating Medicare today, we would certainly include a prescription drug benefit, to give older Americans and people with disabilities access to the most cost-effective health care there is. Prescription drugs help keep seniors mobile and healthy; they help prevent expensive hospital stays and surgical procedures. And they promote the dignity that every single retired person is entitled to – the quality of life that we all want for our parents and for ourselves.

We should act this year to make sure all seniors have access to prescription drug coverage. In my budget, I have proposed a comprehensive plan to provide a Medicare benefit that is optional, affordable and available for all. A plan based on price competition, not price controls; a plan that will boost seniors' bargaining power to get the best prices possible; a plan that is part of an overall effort to strengthen and modernize Medicare, so we will never have to ask our children to shoulder the burden when the baby boom generation retires.

I'm glad that there is growing bipartisan support for providing affordable coverage to all Medicare beneficiaries. Both sides say they want to get this done; unfortunately, the proposals put forward by the majority in Congress will not achieve this goal. They would provide no assistance for middle-income seniors – nearly half of all those who now lack coverage. And they would subsidize private insurance plans that the industry itself says it will not offer. That won't get the job done.

But the bipartisan spirit of this proposal for military retirees shows us the way forward. In reaching out to extend coverage to older military retirees, Congress has recognized that high prescription drug costs are a burden for every senior; and that we owe every military retiree a dignified, healthy retirement. Both parties have now agreed that prescription drug coverage should be available and affordable to every older American. There's no reason on Earth that we can't come to an agreement on the details of how to provide it. We all want America's seniors to live longer, healthier, richer lives. And I'm very glad that here, as so often before, our armed forces will lead the way.

# # #

That is why we desperately need a comprehensive plan to provide a prescription drug benefit that is optional, affordable, and accessible to all. A plan based on price competition, not price controls. A plan that will boost seniors' bargaining power to get the best prices possible. A plan that is part of an overall effort to strengthen and modernize Medicare -- so we won't have to ask our children to shoulder our burden when we retire.

Adding a voluntary prescription drug benefit is not just the right thing to do. Medically speaking, it's the smart thing to do. No one creating a Medicare program today would even think of excluding coverage for prescription drugs. Thanks to stunning advances in medicine, drugs now can accomplish what once could be done only through surgery -- with less pain, fewer complications, and lower cost.

But older Americans will never see the benefits of these advances if we don't work together, across party lines, to do the right thing. I'm gratified to see growing bipartisan support for creating a new prescription drug benefit. Earlier last month, leaders in the House put forth the outlines of a plan with the stated goal of providing access to affordable coverage for all seniors. Unfortunately, however, that plan does not measure up. Instead, it would subsidize insurance companies to offer prescription-drug-only policies for middle-income seniors -- policies the insurance industry itself has already said it will not offer.

And because their plan would provide direct premium support only to low-income seniors and disabled Americans, it would do nothing for those with modest incomes between \$15,000 and \$50,000. Nearly half of all the Medicare beneficiaries who lack prescription drug coverage fall into this category. Any prescription drug plan that is not available to all and not affordable to all is not a real plan at all.

Again, this is not about winning a political fight. It's about fighting for the millions of older Americans who are simply seeking the prescription drug coverage they need. It's about who we are as a people and as a nation. It's about giving our parents and grandparents a chance not only to live as long as they can but also as well as they can. After all they have done for us and for America, we owe them that chance.

I'd now like to introduce Betty Dizik, someone who knows first hand the enormous burden that prescription drug costs can impose on America's seniors. Betty has had to make difficult choices in order to afford the prescription drugs she desperately needs. Betty, I want to thank you for being here and invite you to say a few words...

*[After Rep. Gephardt speaks, you will return to the podium and say a brief word of closing.]*

Final 5/9/00 9:30pm  
Silver/ Weiss

**PRESIDENT WILLIAM J. CLINTON  
REMARKS ON PRESCRIPTION DRUG BENEFIT  
THE WHITE HOUSE  
May 10, 2000**

Acknowledge: Sen. Daschle; Rep. Gephardt; Older Women's League; aging, disability, consumer and other health advocates; Betty Dizik.

Good morning. I am pleased to be here this morning to announce that the Democratic caucus has lined up to support our effort to secure affordable prescription drug coverage for every older American. Prescription drugs are not a luxury for seniors. They can mean the difference between life and death...between years of anguish or fulfillment. There is no reason, in this time of historic prosperity and strength, that we should force seniors to make that choice.

I am extremely grateful to Rep. Gephardt and Sen. Daschle for doing their part to develop an approach that all Democrats can rally behind. And in a few minutes, I will ask them to share the details of our united effort. But we all know that we can't achieve our goal without bipartisan support. That's why, just as we have done with the Patients' Bill of Rights, we want to reach across the aisle to encourage Republican support as well. We believe this can and should be a truly bipartisan effort.

I want to make it clear why America's seniors and people with disabilities cannot afford to wait any longer for the prescription drug coverage that they deserve. Today, more than three in five older Americans lack affordable and dependable prescription drug coverage. And the burden is only getting worse. According to Families USA, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years in a row.

Two groups in particular bear a tremendous burden – rural Americans and women. As Sen. Daschle knows well, people in rural areas are much less likely to be able to secure prescription drug coverage. And, according to a study released today by the Older Women's League, almost eight out of ten women on Medicare use prescription drugs regularly, and most of them pay for those medications out of pocket. In total, women spend 13% more than men do for prescription drugs – despite the fact that their incomes average 40% less.

America's seniors – men and women – simply deserve better. No senior should ever have to forgo or cut back on life-saving medication because he or she can't afford the cost. And no one should be forced to take a bus trip to Canada, where medicines made in the U.S. are often sold for much less.

4/25/00 9:00 p.m.  
Glastris

**PRESIDENT WILLIAM J. CLINTON  
DEPARTURE STATEMENT  
PRESCRIPTION DRUGS REPORT  
THE WHITE HOUSE, WASHINGTON DC  
April 26, 2000**

Before I leave, I want to say a few words about an important new study that Senator Daschle, Congressman Gephardt and I have just been briefed on, regarding the growing costs of prescription drugs, and the burden these costs are placing on senior and disabled Americans. The study is from Families U.S.A. It is a careful and compelling piece of work, and I want to thank the Families U.S.A President Ron Pollack for providing it.

For over a year now, I have been arguing that we as a nation ought to use this historic moment of strength and prosperity to meet America's long-term challenges—especially the challenge of helping all seniors afford prescription drugs that can lengthen and enrich their lives. More than three in five American seniors today lack affordable and dependable prescription drug coverage. Today's report shows that the burden on these seniors is getting worse.

According to the report, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years, including this past year. The burden of these rapidly rising prices falls hardest on seniors who lack drug coverage, because they do not receive the benefits of price discounts that most insurers negotiate. Indeed, the gap between drug prices for people with insurance versus those without insurance nearly doubled, from 8 to 15 percent, between 1996 and 1999.

Seniors living on fixed incomes simply cannot continue to cope with these kinds of price increases. That is why we must take action to help them—not next year or the year after that, but this year.

In my budget, I have proposed a comprehensive plan to provide a prescription drug benefit that is optional, affordable, and accessible for all. A plan based on price competition, not on price controls. A plan that will boost seniors' bargaining power to get the best prices possible. A plan that is part of an overall effort to strengthen and modernize Medicare – so we will never have to ask our children to shoulder our burden when we retire.

I am gratified to see growing bipartisan support for adding a prescription drug option to Medicare since I raised the idea last. Earlier this month, Republican leaders in the House put forth the outlines of a plan that has, as a stated goal, providing access to affordable coverage for all seniors. It's good if the leadership now agrees with our goal. Unfortunately, their current plan won't meet that goal. It would subsidize insurance companies to offer prescription-drug-only policies for middle-income seniors—policies the insurance industry itself has already said it won't offer.

And because the plan would provide direct premium support only to low-income seniors and disabled Americans, it would do nothing for those with modest, middle-class incomes between \$15,000 and \$50,000. Nearly half of all Medicare beneficiaries who lack prescription drug coverage fall into that category. For them, rising drug prices are eating away at their financial independence. For instance, according to this new report, a widow taking medication for diabetes, hypertension, and high cholesterol, who lives on \$16,700 a year must spend about \$2000 a year--nearly 14 percent of her income--on those prescription drugs. That's not unusual--and for a nation that cares about its seniors, it's unacceptable.

Moreover, the majority's plan is a phantom as long as the leadership insists on moving forward with a budget resolution that would spend every dime of the surplus and then some over the next ten years on tax cuts. If the irresponsible and unrealistic spending cuts this budget calls for don't materialize, then the tax cuts will make it impossible to pay down the debt, and would leave nothing left for a prescription drug benefit. Any prescription drug plan that is not adequately financed, is not available to all, and is not affordable to all, is not a real plan at all.

The balanced budget I have proposed would provide a voluntary drug benefit for all seniors, with plenty left over to pay down the debt; lengthen the life of Social Security and Medicare; and increase investments in education and other areas. It provides a prescription drug benefit all seniors can afford, in a way America can afford.

I am truly encouraged by the progress we have made on this issue. Both parties have come to support the idea of adding a voluntary prescription drug benefit to Medicare. Both parties have agreed to the principle that this benefit should be available and affordable to all Americans. There is no reason we can't come to an agreement on the details of how to provide it. Because fundamentally, this is not a Democrat or Republican issue. It's an American issue.

I want to thank my good friends Sen. Daschle and Rep. Gephardt for their support on this, and I want to invite them to say a few words. First, Rep. Gephardt.

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## **Clinton Presidential Records Digital Records Marker**

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This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

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### **POTUS Remarks**

Divider Title: \_\_\_\_\_

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**Jeffrey A. Shesol**

04/24/2000 08:10:02 PM

Record Type: Record

To: Paul D. Glastris/WHO/EOP@EOP, Mara A. Silver/WHO/EOP@EOP  
cc: Joshua S. Gottheimer/WHO/EOP@EOP  
Subject: drugs

Paul -- What follows is both the revised final, which got a little sidetracked by a topper on the minimum wage, and the previous final, which didn't. Hope it's helpful. -- Jeff (PS -- Glad you're back yet?)

Revised Final 03/09/00 10:30am  
Jeff Shesol

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

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

Before I begin, I want to say a few words about another important issue – the minimum wage – and a vote the House will take today. The Republican leadership has derailed a simple vote on the minimum wage with a maximum of political maneuvering. The vote has yet to be taken, but the results are already in. Special interests will win – the national interest will wait.

Let me be clear: we will raise the minimum wage, but not with this Republican bill that stacks the deck against American workers. Their bill is loaded up with poison pills that penalize workers and with risky tax cuts that threaten our prosperity and the future of Social Security and Medicare. I will veto this bill. Congress should send me a bill I can sign – a clean, straight-forward bill that raises the minimum wage by one dollar over two years. That's what American workers deserve.

By the end of the day, two things will be clear: when it comes to raising the minimum wage, we have the votes to pass it, but Republican leaders have the power to kill it. But today's vote is not the final word. I will continue to work with the bipartisan majority in Congress that supports a real raise in the minimum wage.

Let me say a few words on the issue Senator Daschle just addressed. Today, Senate

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

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

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

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

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

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

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

Senator Daschle, thank you. To the other Senators who join us here today, thank you

as well for your hard work on this important issue.

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Lowell A. Weiss  
05/08/2000 02:02:25

Record Type: Record

To: Mara A. Silver/WHO/EOP@EOP

cc:

Subject: thanks!!

Draft 3/13/00 9:40am

Lowell Weiss

**PRESIDENT WILLIAM J. CLINTON  
REMARKS ON PRESCRIPTION DRUG BENEFIT  
CLEVELAND, OH  
March 13, 2000**

Acknowledge: introducer Wanda Golias [go-LEE-as]; 76-year old widow Alice Katchianes [kat-CHI-ness]; City Public Library Dir. Andrew Venable, Jr.; Sec. Shalala and Edna Shalala; Reps. Gephardt, Stephanie Tubbs Jones, Dennis Kucinich, Sherrod Brown; Former Rep. Louis Stokes; Mayor Michael White; State Rep. Jack Ford, County Commissioner Jimmy Dimora; seniors, senior leaders, and health care providers here with us today.

I always love coming to Cleveland. This city and this state have been very good to me. And it seems like half my cabinet and staff has ties to the Cleveland area. You've already heard from Sec. Shalala. Steve Ricchetti, who's from Westlake, is also here with me today. Right as you walk into Steve's office, you see a photograph from opening day at Jacobs Field in 1994. It's of a big southpaw from Arkansas throwing out the first pitch to Sandy Alomar. Frankly, I think I did pretty well for a guy who played in the band.

Every time I have the pleasure of visiting Cleveland, I'm just amazed by all the signs of renaissance in this city. It's more than just beautiful new museums and sports stadiums. It's a remarkable surge in civic pride. This is a great time in the life of this great American city.

This is also a great time in the life of our nation. Never in my lifetime have we had, at once, so much prosperity with so little internal crisis and so few external threats. Never before have we had such a blessed opportunity – and therefore, such a profound obligation – to take on the big challenges we face as a country.

Today, we're here to talk about one of those big challenges – helping all seniors afford the medicines that can lengthen and enrich their lives. More than three in five American seniors lack affordable and dependable prescription drug coverage. To make matters worse, those seniors without coverage are being charged the highest prices of any group anywhere in

the world. America's seniors deserve better. They should not have to forgo or cut back on life-saving medication because they just can't afford the cost. And no senior in Cleveland should be forced to take a three-hour bus trip to Canada, where medicines made in the U.S. are often sold for much less.

That is why my budget includes a comprehensive plan to provide a prescription drug benefit that is optional, affordable, and accessible for all. A plan based on price competition, not on price controls. A plan that will boost seniors' bargaining power to get the best prices possible. A plan that is part of an overall effort to strengthen and modernize Medicare – so we won't have to ask our children to shoulder our burden when we retire.

Adding a voluntary prescription drug benefit is not just the right thing to do. Medically speaking, it's the smart thing to do. No one creating a Medicare program today would even think of excluding coverage for prescription drugs. Thanks to stunning advances in medicine, drugs now can accomplish what once could be done only through surgery – with less pain, fewer complications, and lower cost.

We already pay for doctor and hospital benefits under Medicare, but we let many of our seniors go without prescription drugs and preventive screenings that could keep them from having to undergo expensive treatments in the first place. It just doesn't make sense. It's as penny-wise and pound-foolish as paying a mechanic \$4,000 to rebuild your engine because you refused to spend \$25 to get your oil and filter changed.

In recent months, I have been encouraged that the Republicans seem interested in joining with us to provide a prescription drug benefit. But so far, their proposals have come up very short. Some Republicans, for example, are proposing a block grant to help only the poorest seniors. This kind of plan would leave middle-income seniors to fend for themselves. Here in Ohio, 53% of all seniors have middle incomes – and none of them would be covered by the block grant.

In 1965, during the debate over the original Medicare legislation, some in Congress used the arguments we are hearing again today. They said Medicare should be a welfare program just for the poor. They were wrong then. They are wrong now. Today, more than half of the seniors without any prescription drug coverage at all are middle class Americans. On average, middle-class seniors without coverage seniors buy 20% fewer prescription drugs than those with coverage – not because they are healthier but because they are struggling with the expense. And even though they buy 20% less medication, their out-of-pocket burden is 75% higher. So let me be clear: any prescription drug plan must cover all seniors, not just the poorest.

Other Members of Congress are proposing a tax deduction to help subsidize the cost of buying private Medigap insurance. But this approach would benefit the wealthiest seniors without providing much help at all for low- middle-income seniors. And it would rely on a Medigap marketplace that is already deeply flawed. Today, the General Accounting Office is releasing an analysis that shows that Medigap drug coverage starts out expensive and gets

prohibitively so as seniors get older. On average, it costs about \$164 per month for a 65-year old to buy a Medigap plan with drug coverage – and premiums rise sharply from there. For example, here in Ohio, 80-year olds pay 50% more than 65-year olds for the same coverage. Even those who offer Medigap plans say this approach would not work. It would force Medigap providers to charge excessively high premiums or to refuse to participate at all.

There is another reason to be worried about the Republicans' proposals. Just last week, they passed budget resolutions that allocate nearly half a trillion dollars to risky tax cuts – leaving little room to meet the crying need for affordable prescription drug coverage. In effect, a tax cut of this size would “just say no” to prescription drugs.

These tax cuts would also crowd out our efforts to save Social Security, strengthen Medicare, and pay down the debt by 2013. They would hamstring vital investments in improving education, fighting crime, and protecting the environment. I say to the Republican leaders: Let's not squander this moment of prosperity and confidence. Let's work together to take care of first things first.

A hundred years from now, people will look back on a 21st century shaped in so many ways by the decisions we make today. I hope they will be able to see that our generation was willing to join together to make the best use of the enormous opportunities before us. I thank all of the leaders who are doing so here and now in Cleveland – by strengthening this all-American city, improving the lives of our seniors, and helping us to seize this golden moment in history. Thank you and God bless you. # # #

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

April 29, 2000

RADIO ADDRESS BY THE PRESIDENT  
TO THE NATION

The Oval Office

THE PRESIDENT: Good morning. Next week, when the full Congress returns from Easter recess, they'll have less than 75 working days left to make this year a year of real progress for the American people. There is no more important critical piece of unfinished business than our need to ensure that every American, young and old, has adequate, affordable health care.

Today I want to again urge the Congress to step up to this challenge by making the passage of a strong patients' bill of rights and the provision of a voluntary Medicare prescription drug benefit top priorities when they return to Washington.

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

Last year, in an overwhelmingly bipartisan vote, the House passed a strong patients' bill of rights that provides the right protections all Americans need and deserve. It's a bill I would sign. But more than six months later the bill is still languishing in Congress. Despite their pledge to complete a real bill, the Republican majority has not only delayed action, it's actually considering legislation that would leave tens of millions of Americans without federal protections.

A right that can't be enforced isn't a right at all, it's just a request. We need a strong bill that protects all Americans and all plans, not one that provides more cover for the special interests than real coverage for American patients.

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

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

Seniors and people with disabilities living on fixed incomes simply cannot continue to cope with these kinds of price increases. That's why we must take action to help them -- not next year or the year

after that, but this year. My budget includes a comprehensive plan to modernize Medicare and provide for a long overdue prescription drug benefit for all beneficiaries.

I'm pleased there's growing bipartisan support for tackling this challenge. Earlier this month Republican leaders in the House put forth an outline of a plan that offers as a stated goal access to affordable coverage for all older Americans. Unfortunately, their plan falls short of meeting the goal. It would do virtually nothing for seniors with modest middle-class incomes between \$15,000 and \$50,000 a year. Nearly half of all Medicare beneficiaries who lack prescription drug coverage fall into that category.

It's not too late to give all our seniors real prescription drug coverage this year. We can work together on a plan that's affordable, dependable, and available to all older Americans.

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

Thanks for listening.

END

THE WHITE HOUSE

Office of the Press Secretary  
(Cleveland, Ohio)

For Immediate Release

March 13, 2000



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

City Public Library  
Cleveland, Ohio

*shortest speech*

*let's get a byline on paper*

2:55 P.M. EST

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

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

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

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

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

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

Alomar catching a ball which he was convinced would go into the dirt. I thought I did pretty well for a guy who played in the band, myself. (Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And then we come to the issue at hand. Now, what's this about, this prescription -- you all know what it's about. If we were starting -- suppose I came here today as President and I were in my first year as President and I proposed Medicare, just like President Johnson did in 1965, in the first full year after he was elected -- and I told you in 1965 what he said, it would be fine. But in 2000, if I said, okay, I'm going to set up this health care program for senior citizens, and you can see a doctor and we'll pay for your hospital care, but even though

we could save billions of dollars a year keeping people out of hospitals and out of emergency rooms by covering the medicine, we're not going to cover medicine.

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

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

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

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

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

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

There are two different proposals basically coming out of the Republicans. Some of them propose giving a block grant to the states to help only the poorest seniors, those below the poverty line. That would leave the middle-income seniors, including those that are lower-middle-income, just above the poverty line, to fend for themselves. And here in Ohio, 53 percent of all the seniors are middle-income seniors. None of them would be covered by this plan.

In 1965, when Medicare was created, some in Congress used these very same arguments. They said, we should only pay for hospital and medical care for the poorest seniors. They were wrong then, and they're wrong now. More than half the seniors today without any prescription drugs at all are middle-class seniors. I want to say that again. More than half the seniors without any prescription drug at all are middle-class seniors. On average, middle-class seniors without coverage

buy 20 percent less drugs than those who have coverage, not because they're healthier, but because they can't afford it.

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

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

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

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

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

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

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

Now, let me tell you why this is such a big deal. The average 65-year-old in America today has a life expectancy of 82 to 83 years. The average 65-year-old woman has a life expectancy higher than that. The fastest-growing group of American seniors are those over 85. So to knowingly lock ourselves into a program that would get 50 percent more expensive as you got older and older, and needed more and more medicine and had less and less money does not make much sense.

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

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

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

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

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

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

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

Thank you and God bless you. (Applause.)

END 3:17 P.M. EST

THE WHITE HOUSE  
Office of the Press Secretary

For Immediate Release

April 26, 2000

REMARKS BY THE PRESIDENT  
ON PRESCRIPTION DRUGS BENEFITS

The Roosevelt Room

9:55 A.M. EDT

THE PRESIDENT: Thank you very much. Thank you. I am on my way to North Carolina for another leg of our New Markets tour to close the digital divide. But before I leave I want to say a few words about an important study that Senator Daschle, Congressman Gephardt and I have just been briefed on regarding the growing cost of prescription drugs and the burden these costs are placing on seniors and on disabled Americans.

The study is from Families USA. It is a careful and compelling piece of work. And I thank Families USA president Ron Pollock for providing it and for being here with us today.

For over a year now I have been arguing that we as a nation ought to use this historic moment of strength and prosperity to meet our long-term challenges, especially the challenge of helping all our seniors afford prescription drugs that can lengthen and enrich their lives. More than three in five American seniors today lack affordable and dependable prescription drug coverage. Today's report shows that the burden on these seniors is getting worse.

According to the report, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years now, including this past year. The burden of these rapidly rising prices falls hardest on seniors who lack drug coverage because they don't receive the benefits of price discounts that most insurers negotiate. Indeed, the gap between drug prices for people with insurance versus those without insurance nearly doubled from 8 to 15 percent between 1996 and 1999.

Seniors living on fixed incomes simply can't cope with these kinds of price increases forever. That's why we should take action to help them and do it now. In my budget, I propose a comprehensive plan to provide a prescription drug benefit that is optional, affordable, and accessible for all. A plan based on price competition, not price controls; a plan that will boost seniors' bargaining power to get the best prices possible; a plan that is part of an overall effort to strengthen and modernize Medicare so we will never have to ask our children to shoulder our burden when the baby boom generation retires.

I'm gratified to see growing bipartisan support for adding a prescription drug benefit to Medicare. But earlier this month, leaders in the House put forth the outlines of a plan that has as a stated goal providing access to affordable coverage for all seniors. It's good if we agree on the

goal. Unfortunately, the plan they propose won't achieve the goal. Instead it would subsidize insurance companies to offer prescription drug only policies for middle-income seniors, for policies the insurance industry itself has already said it will not offer.

And because the plan would provide direct premium support only to low-income seniors and disabled Americans, it would do nothing for those seniors with modest middle-class incomes between \$15,000 and \$50,000. Nearly half of all the Medicare beneficiaries who lack prescription drug coverage fall into this category. For them, rising drug prices are eating away at financial independence.

For example, according to this new report, a widow taking medication for diabetes, hypertension and high cholesterol, who lives on \$16,700 a year, must spend about \$2,000 a year, or 14 percent of income, on these drugs. That's not unusual, and for a nation that cares about seniors, it's not acceptable. A person like that should be covered in our initiative.

The majority's plan also is a phantom as long as the leadership insists on moving forward with a budget resolution that would spend every dime of the surplus, and then some, over the next 10 years on tax cuts. If the responsible and unrealized realistic spending cuts this budget calls for don't materialize, the tax cut will make it impossible to pay down the debt, it would leave nothing left for prescription drug benefit. Any prescription drug plan that is not adequately financed, if not available in fact, is not affordable to all, and therefore, is not a real plan at all.

The balanced budget I propose would provide a voluntary benefit for all seniors, with plenty left over to pay down the debt, lengthen the life of Social Security and Medicare, and increase investments in education, as well as finance a responsible tax cut. It provides a prescription drug benefit that all seniors can afford in a way America can afford.

I'm encouraged by the progress we've made on this issue. Now both parties have come to support the idea of adding voluntary prescription drug benefits to Medicare. Both parties have agreed to the principle that the benefits should be available and affordable to all Americans. There's no reason we can't come to an agreement on the details of how to provide it. Fundamentally, again, as with so many of the things we deal with here in Washington, this should not be a Republican or a Democratic partisan issue. It should be an American issue.

I want to thank Senator Daschle and Representative Gephardt for their support and their leadership on this issue, and I'd like to ask them now to say a few words, beginning with our leader in the House, Mr. Gephardt.

REPRESENTATIVE GEPHARDT: Thank you, Mr. President. Welcome, everyone. We have just received a briefing from Ron Pollock of Families USA, with new numbers on drug prices. The new numbers are, frankly, bad news for America's senior citizens. As you've just heard, on average, the prices of the top 50 drugs taken by seniors increased by nearly twice the rate of inflation in 1999, and this is just the average. Nearly one-third of the drugs rose at three times inflation, and one-fifth of them rose at four times inflation.

We've been saying it for several years now, seniors are having serious trouble paying for their prescription drugs. What we have today is more evidence that the problem is not going to go away by itself. Seniors need help affording their prescriptions, and they deserve help. And we're here today to reaffirm the Democrats are determined to give them that help.

We propose offering any senior -- any senior -- who wants it a new Medicare prescription drug benefit, coverage that will use the clout of volume discounts to end price discrimination against seniors, and make needed prescriptions affordable for all seniors. This is a benefit that is the most efficient and cost-effective when offered through Medicare.

It's sometimes hard to remember, but in 1963, before we enacted Medicare, half the senior citizens in the country had no health insurance. Democrats responded, often over the prolonged opposition of Republicans, by creating Medicare. In the more than 30 years since, Medicare has dramatically improved the lives and the quality of lives of all of our seniors. Today about half the seniors have no prescription drug coverage, just like half the seniors in 1963 had not health insurance coverage.

Democrats have responded once again, over Republican opposition, with a proposal to update Medicare with a drug benefit. Such a benefit would offer real help to the majority of seniors who don't have meaningful coverage today. The most recent Republican proposal, as the President said, would not.

Apparently, we're close enough to the election next fall that Republicans have decided that they can't continue simply to stonewall on prescription drug coverage. Unfortunately, their program is fundamentally flawed. They propose to over inadequate subsidies to a limited number of seniors to buy an undefined private policy that, if you listen to the insurance industry, probably won't be offered anyway. And they've yet to prove that they're serious about paying for any benefit at all. Their budget was an empty gesture, but their massive tax cuts show us where their priorities really are.

Talk is cheap; prescription drugs are not. They're expensive, and they're getting more expensive every day. Seniors need help now. Every time I'm home, as I was last week, I have senior citizens come up to me and say, can you get this bill passed this year? If you're a senior and you need prescription drugs that you can afford now, you need it now. You can't wait for next year. If congressional Republicans will agree to work with us in a meaningful way to make compromises, to do the hard work to achieve a consensus between the parties and between the views, we can get a bill done this year -- in fact, this summer.

We look forward to that. And I look forward to the day we can meet here with the President with a bill that gets the job done.

I'd like to now call on Tom Daschle.

SENATOR DASCHLE: I want to thank the President for making time today to hold this very important conference, and thank him for his continued efforts to highlight the need for

dependable, affordable prescription drug coverage for all Americans, especially our older Americans.

I also want to thank Families USA for this eye-opening report. The rising cost of prescription drugs is on the list of concerns of just about every older American. By showing how fast those costs are escalating, you are helping move affordable prescription drugs higher up on Congress' list of priorities.

You almost need to take a nitroglycerin tablet just to read this report. Some of the numbers are truly shocking. In one year, from January of 1999 to January of 2000, prices for the 50 prescription drugs most commonly used by seniors rose twice as fast as inflation. One drug, a potassium replacement medication, rose 20 times faster than inflation. Price increases like these could be difficult for many people to absorb, but for seniors living on fixed incomes, they are an even bigger hardship.

The bottom line is there has never been a great need for an affordable Medicare prescription drug benefit than now. Fortunately, there is also never been a greater opportunity than we have right now because of the surplus to create such a benefit.

Mr. President, you have done your part. You have presented Congress with your plan for a Medicare prescription drug benefit and asked us either to work with you to pass your plan or to come up with one of our own. On behalf of Senate Democrats and working with House Democrats, I am pleased to inform you that we will do our part as well.

We are in the final stages of developing our own plan to add a voluntary, affordable and universal Medicare prescription drug benefit. Our plan is similar in many ways to the one that you have proposed. We hope to unveil it in the very near future. We hope our Republican colleagues will work with us to come up with a plan that we can all support and pass this year.

A year ago, prescription drugs weren't even on their agenda. We think it's a sign of progress the Republicans are at least now talking about prescription drugs. We're concerned, though, that their actions, as the future Speaker said, don't match their words. On the Senate floor, Republicans refused even to offer amendments that would provide for a Medicare drug benefit. Ironically, they have even referred to our prescription drug amendments as "poison pills" in their effort to pass more tax breaks for the wealthy.

At the same time, they've proposed a budget that uses virtually every penny of the surplus for tax cuts, leaving nothing for prescription drugs. It's still early in the budget process; we hope the numbers in this report will persuade Republicans to rethink the numbers in their budget.

We need to put an affordable prescription drug benefit ahead of even bigger tax cuts for those who need them least. More importantly, we hope this report will bring about the consensus we need -- a consensus on this important health benefit this year.

THE PRESIDENT: Thank you very much. Before I close I would just like to ask all of you to join me in expressing our appreciation to Ron Pollock and Families USA. They've been

there on these issues year in and year out. I don't think they get as much acknowledgement as they deserve. But this is further evidence that the proposal we have is right for America from a source that everybody can trust.

Thank you, Ron.

END 10:15 A.M. EDT

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The New York Times♦ [View Related Topics](#)**May 11, 2000, Thursday, Late Edition - Final****SECTION:** Section A; Page 28; Column 1; National Desk**LENGTH:** 812 words**HEADLINE:** Drug Benefits For Medicare Are Proposed By Democrats**BYLINE:** By ROBERT PEAR**DATELINE:** WASHINGTON, May 10**BODY:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<http://www.nytimes.com>

**GRAPHIC:** Photo: **President** Clinton hugged Betty Dizik, a Medicare recipient, yesterday after she spoke at the White House about the high cost of **prescription drugs**. Speaking in support of Mr. Clinton's plan to offer drug benefits through Medicare, Ms. Dizik said she would vote for the **president** again if she could. (Paul Hosefros/The New York Times)

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**May 11, 2000, Thursday, PM cycle****SECTION:** State and Regional**LENGTH:** 348 words**HEADLINE:** Democrats unveil Medicare prescription drug plan**BYLINE:** By JAMIE STENGLE, Associated Press Writer**BODY:**

Rep. Marion Berry, D-Ark., says a new Medicare **prescription drug** plan proposed by Democrats will help elderly citizens who are burdened with the high costs of drugs.

"Our senior citizens are thrown into abject poverty because of this," Berry said.

**President** Clinton and congressional Democrats unveiled details Wednesday of a Medicare **prescription drug** plan to provide optional coverage to elderly citizens.

Arkansas ranks first in the nation in poverty among residents ages 65 and older, said Sen. Blanche Lincoln, D-Ark.

Under the plan, 46 percent of low-income seniors would qualify for either free or reduced-cost prescription drug assistance. The remaining 54 percent would have the option of enrolling in the program. First year premiums would be \$25 per month or \$300 per year for coverage, she said.

"Our senior citizens have worked hard all their lives. No senior should have to travel to Canada to get affordable prescription drugs," Lincoln said. "Adding prescription drug coverage modernizes Medicare to reflect the true health needs of seniors today."

The program is expected to cost \$125 billion over 10 years. For those who do not qualify for free coverage, the government will pay half of a person's monthly premiums and half of their annual drug costs, up to a certain limit.

"We have got a situation where our senior citizens and all Americans are being overcharged by at least twice for prescription drugs," Berry said.

Lincoln said about 363,000 Arkansans are over the age of 65 and the population is expected to double by 2025. Currently, only 14 percent of Arkansas businesses offer retiree health insurance. And, on average, seniors in Arkansas pay \$1,900 per year for coverage, she said.

"A prescription drug program is not only good medical policy, it's good fiscal policy," Lincoln said. "Many seniors rely on prescription drugs to help manage long-term disabilities and prevent acute hospital care. If we provide them with the medicines they need, we can prevent more costly and extensive medical care down the road."

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April 23, 2000, Sunday, Late Edition - Final

**SECTION:** Section 1; Page 1; Column 1; National Desk**LENGTH:** 5957 words**HEADLINE:** MEDICINE MERCHANTS: Birth of a Blockbuster;  
**Drug** Makers Reap Profits On Tax-Backed Research**BYLINE:** By JEFF GERTH and SHERYL GAY STOLBERG**BODY:**

On Jan. 7, 1982, in a laboratory at Columbia University, a little-known science professor, Laszlo Z. Bito, finished a nine-month experiment on the eyes of cats. In his handwritten data, carefully charted in gray hardcover notebooks, lay the origins of what every pharmaceutical company longs for: a blockbuster **drug**.

**The drug** is Xalatan, a best-selling eyedrop for glaucoma. With \$507 million in sales last year -- and the potential for billions more, most of it pure profit -- the four-year-old medicine is the equivalent of liquid gold for its manufacturer, the Pharmacia Corporation. The eyedrop earned Columbia University about \$20 million in royalties last year, and it has made a millionaire of Dr. Bito as well.

Yet there are other, unseen, partners in the creation of Xalatan: the American taxpayers, who backed Dr. Bito's work with \$4 million from the National Institutes of Health. The taxpayers have reaped no financial return on their investment; their reward, government officials say, is the eyedrop itself.

Xalatan costs patients \$45 to \$50 for a tiny bottle that lasts six weeks. That price -- about \$1 a day for a **drug** that staves off blindness -- may not seem excessive. But the key ingredient in that daily dose costs Pharmacia only pennies to make, and Americans, who live in the only industrialized nation that lacks government restraints on **drug** prices, pay more than twice what European patients pay for the **drug**.

That puts Xalatan out of reach for patients like Albert Russell, a retired optician and part-time blues singer from Prince George's County, Md. Mr. Russell, whose glaucoma has left him nearly blind, lives on an \$832-a-month Social Security check. He is among the one-third of elderly Americans who lack prescription **drug** coverage, and when he talks about Xalatan, he uses the word "outrageous" to describe its price.

To officials at Pharmacia, the price is fair. "We are bringing forth innovation," said Dr. Anders Harfstrand, the company's vice president for ophthalmology, "and innovation always brings a

premium."

In this election year, the cost of prescription medicines is at the center of the political debate. With the biomedical revolution yielding a flood of new therapies, **drugs** are now the fastest-growing component of the nation's trillion-dollar-a-year medical bill. As Congress contemplates expanding Medicare to include prescription **drug** coverage, and some states move to bring **drug** prices more in line with those in foreign countries, the industry is struggling to fend off federal regulation that might limit its ability to set prices.

At the heart of the fight is Dr. Harfstrand's contention that the price of medication is justified by the extreme risk of failure and high cost of **drug** discovery -- an average of \$500 million per **drug**, by the industry's estimate. It is an argument that the pharmaceutical industry, one of the world's most lucrative and secretive businesses, has relied on for more than 40 years. But it has rarely been put under a microscope, because the industry will not divulge the costs of researching and developing a particular **drug**.

To shed light on the subject, The New York Times examined Xalatan, from its genesis in Dr. Bito's laboratory to its arrival in the medicine cabinets of patients in 57 countries. Pharmacia declined to disclose specific financial information about the making of the **drug**. But through interviews with key participants and an analysis of publicly available documents, the examination found, among other things, that Pharmacia spent no more than \$150,000 to buy the rights to Dr. Bito's invention from Columbia. Though it later spent tens of millions of its own money to develop the **drug**, the company acknowledges that Dr. Bito, with the taxpayers' support, provided it an "uncut diamond" that later became Xalatan.

The industry's reliance on taxpayer-supported research -- characterized as "a subsidy" by the very same economists whose work the industry relies on -- is commonplace, the examination also found. So commonplace, in fact, that one industry expert is now raising questions about the companies' arguments.

The expert, Dr. Nelson Levy, a former head of research and development at Abbott Laboratories, who now works as a consultant for industry and the federal government on **drug** development, bluntly challenged the industry's oft-repeated cost of developing a **drug**. "That it costs \$500 million to develop a **drug**," Dr. Levy said in a recent interview, "is a lot of bull."

Finally, the examination found, federal officials have abandoned or ignored policies that could have led to lower prices for medicines developed with taxpayer dollars. That is partly because the government has lost track of what **drugs** are invented with its money, and partly, officials say, because the industry resisted government efforts to get involved in pricing.

As Dr. Bernadine Healy, a former director of the National Institutes of Health, said in a recent interview, "We sold away government research so cheap."

### Going Against the Standard

Like many scientific discoveries, the invention of Xalatan began with a hunch. It was the mid-1970's, and Dr. Bito, a hard-driving researcher who bucked the eye-research establishment with his unconventional ideas about glaucoma treatment, had been named an assistant professor of ophthalmology at Columbia University.

Born in Budapest, he was conscripted into a forced labor coal mining camp at 18. In 1956, the year the Communists quashed a rebellion in his homeland, he escaped, eventually fleeing for the United States. His passion was writing, but he abandoned it for a career in science, particularly the study of the eye.

Dr. Bito was interested in a family of chemicals produced by the body, prostaglandins, and how

they might affect the eye, particularly the fluid, known as aqueous humor, that nourishes the cornea and the lens. In glaucoma, the aqueous humor does not drain quickly enough, causing an increase in intraocular pressure inside the eye. This pressure can damage the optic nerve, causing vision loss and ultimately blindness.

An estimated two million Americans have glaucoma, and every year, 120,000 Americans go blind from the disease. The elderly, African-Americans, and people with family histories of the disease are at greatest risk. Glaucoma is often called "the sneak thief of sight." Often, by the time the patient notices vision loss, glaucoma can only be halted, not reversed.

When Dr. Bito began his research, ophthalmologists had already concluded that prostaglandins raised intraocular pressure, and were therefore dangerous. But Dr. Bito, along with a student at Columbia Medical School, Carl Camras, suspected otherwise; they thought that if prostaglandins were given in extremely small doses, they could actually reduce the pressure.

In 1977, after a series of studies on the eyes of rabbits, they published a paper showing just that. "It was blasphemy," Dr. Camras said.

Dr. Bito continued the work with monkeys, cats, and even himself, squirting the chemical in his own eye to gauge how much redness and irritation it caused. The studies were paid for by the National Eye Institute, a branch of the health institutes.

Within weeks of the cat experiment's conclusion in 1982, administrators at Columbia University had steered Dr. Bito to a patent lawyer; in May of that year, he applied for a patent.

It felt strange, he said, but it signified the changing culture of the ivory tower. As a professor, Dr. Bito was accustomed to publishing his work in journals and talking about it at scientific meetings. Patenting, to him, represented secrecy, the culture of industry, not academia.

"It was looked down on," Dr. Bito said. "It was too commercial."

#### Law Behind the Companies

Commerce, however, was exactly what Congress had in mind when, in late 1980, it passed legislation that directed federally financed researchers like Dr. Bito to patent their inventions, or risk losing control of them to the government.

Ronald Reagan had just won election on a platform to make America strong again. Japan's electronic industry was out-competing the United States in its own backyard. Determined not to lose, Congress passed Public Law 96-517, known as the Bayh-Dole Act after Senators Birch Bayh of Indiana and Bob Dole of Kansas.

The law was designed to push federally financed research from the university laboratory into the marketplace. Scientists who made discoveries using taxpayer money were required to file invention reports with the government. Universities were directed to license patented inventions to companies that would commercialize them.

The law was originally passed to aid small businesses, but later it was modified so that even big companies like Pharmacia could benefit. If a company did not develop a product quickly enough, the government could revoke the company's license and hand the job over to a competitor. It could also take control of an invention to alleviate "health or safety needs," the law said.

Once an invention is on the market, the law grants the government the right to buy it without paying customary royalties. At the same time, say patent experts in the Clinton administration and at the National Science Foundation, other laws enable federal agencies to put taxpayer-financed inventions out to competitive bidding. For example, the government, which buys Xalatan, could give companies other than Pharmacia the opportunity to manufacture the eyedrop and sell it at a

lower price -- but only to the government.

So, these experts say, the Bayh-Dole law, in conjunction with other provisions, could result in lower **drug** prices for the Department of Veterans Affairs and the National Institutes of Health, two major purchasers of medicines.

But in the 20 years since the Bayh-Dole bill became law, the government has not taken advantage of these provisions, say officials at the health institutes. One reason, said Dr. Wendy Baldwin, a deputy director at the agency, is that the government already buys **drugs** cheaply by purchasing them in bulk. But even if federal officials wanted to use the Bayh-Dole Act to get medicines at still cheaper prices, they could not because they do not keep track of products, including **drugs**, that are invented with taxpayer money.

That failure has drawn criticism from the General Accounting Office, the investigative arm of Congress, which last year conducted a review of the government's invention reporting system. "Inaccurate, incomplete and inconsistent," the accounting office concluded.

Also, last year, a preliminary report by the inspector general's office of the Department of Health and Human Services found that as many as 22 percent of discoveries financed by the health institutes were not reported by universities, as is required. More than 2,000 inventions developed with government money were reported to the health institutes last year, but Dr. Baldwin and other agency officials said in interviews that they had no idea which, if any, companies had licensed those inventions, or how they were being used.

As for the issue of what consumers pay for **drugs**, the health institutes has concluded it should stay out of it. When Dr. Healy was director of the agency in the early 1990's, she insisted that companies interested in developing **drugs** that had been invented by government scientists sign contracts agreeing to "reasonable pricing" for those medicines.

The companies balked at the reasonable-pricing clause. "I was persona non grata for it," said Dr. Healy, who now heads the American Red Cross. The provision was dropped in 1995 by Dr. Harold Varmus, her successor; at the time, he said the policy was discouraging collaboration by driving industry away.

In the end, said Dr. Baldwin, the official designated by the N.I.H. to answer questions for this article, taxpayers may not get lower **drug** prices. Still, she said: "The current policies are actually bringing **drugs** to market. It's a huge advance, a wonderful accomplishment."

Going Abroad for Help

If the federal government leaves it to companies to decide how much consumers pay for taxpayer-backed inventions, universities are even less concerned about the prices. The Bayh-Dole Act has meant a windfall in revenues from licensing and royalties for them, none more than Columbia.

Last year, Columbia earned \$96 million in licensing fees and royalties under the Bayh-Dole law, ranking it first among universities in royalties from inventions, said Jack Granowitz, who runs Columbia's program to commercialize university inventions. Roughly \$20 million of that money was from Xalatan; one-fifth goes to Dr. Bito and the university keeps the rest.

When Dr. Bito first filed his patent application in 1982, no **drug** company in the United States would touch it; most glaucoma experts remembered well the studies showing prostaglandins could only hurt people with the disease. Dr. Bito recalled: "They said, 'It's crazy. You can't put prostaglandins in the eye.' "

So Dr. Bito approached another Hungarian eye researcher who knew people at Pharmacia, at the

time one of Sweden's largest **drug** companies. (The company, now of Peapack, N.J., has since undergone two mergers, one with Upjohn in 1995, and another this year, with Monsanto.) Within a year, Dr. Bito said, Pharmacia had bought exclusive rights to his idea, paying Columbia between \$100,000 and \$150,000. The government received no fees; the law did not require it.

For Pharmacia, which was already marketing a cataract therapy developed by Dr. Bito's Hungarian friend, it was a nice fit. It was also a way for the company to hedge the risky bets it made on **drug** development.

The industry's own studies show that **drug** research is riskiest in the early stages, when a company has no way to tell if a given compound is a blockbuster or a dud. The companies often build on basic scientific findings that emerge from taxpayer-financed studies, underwriting the applied science themselves. But in some cases, as with Xalatan, those studies actually produce a practical discovery that can be licensed, allowing companies to step in when profits seem more assured.

No one knows precisely how many medicines result from such licensing arrangements, but they are not unusual. For example, Trusopt, a glaucoma eyedrop by Merck, was taken to the market in similar fashion, after researchers at the University of Florida, with backing from the National Eye Institute, discovered how to convert a related **drug** from pill to drop form. As Dr. Carl Kupfer, the institute's director, said, "A pharmaceutical company wouldn't take over the **drug** unless the animal testing looked very feasible."

Still, Pharmacia was hardly getting a finished product. "An uncut diamond" is how Dr. Harfstrand described Dr. Bito's work. Using the natural prostaglandins Dr. Bito had identified, Pharmacia had the task of developing a synthetic molecule that could be given safely to people.

It was a tall order. As Dr. Bito well knew from squirting the chemicals into his own eyes, the prostaglandins caused redness and irritation. One of Sweden's leading eye experts, Dr. Anders Bill, remembered informing the company that Dr. Bito's idea was "next to ridiculous," and giving it only a 5 percent chance of success. The **drug** industry's trade association says for every 250 compounds that emerge from a laboratory to enter this kind of pre-clinical testing, only one makes it to market.

By 1985, two years into the Pharmacia's contract with Columbia, the company's research was progressing slowly. Dr. Bito persuaded Mr. Granowitz to write a letter to the company reminding it that, under the Bayh-Dole law, the government could step in and take control of the invention. The next year, Pharmacia hired a new manager for the project, a Swedish pharmacologist, Johan Stjernschantz.

By 1988, Dr. Stjernschantz had found what Pharmacia was looking for: a family of chemical cousins to Dr. Bito's prostaglandins that also lowered pressure but without the troubling irritation. From this family, Dr. Stjernschantz said, he selected latanaprost, the key ingredient for the compound that would later take the trade name Xalatan.

The uncut diamond was now a sparkling gem.

#### Government's Silent Role

How much was Dr. Bito's government-supported work worth to Pharmacia? Only company officials know, and they won't say.

That kind of secrecy is typical, making it difficult for outsiders to examine **drug** pricing issues. Nonetheless, experts characterize work like Dr. Bito's as an extremely valuable subsidy for a business that is already receiving government help in other areas, such as tax credits for research and development.

Dr. Levy, the former Abbott Laboratories executive, says preclinical research could account for as much as 20 to 25 percent of a company's research and development budget for a particular **drug**.

"N.I.H.-supported research represents a subsidy to pharmaceutical development," said Dr. Louis Lasagna, an expert in **drug** development at Tufts University whose studies are widely cited by the industry. "But you need a midwife, the companies, to bring it to market."

The word subsidy, not surprisingly, rankles **drug** industry officials, who say other businesses, including the medical device industry, also benefit from public science.

Yet it is clear that the government plays an important, and an increasing, role in **drug** development, both through inventions like Dr. Bito's and more basic scientific research on which the companies can build. A 1995 study by the Massachusetts Institute of Technology found that, of the 14 new **drugs** the industry identified as the most medically significant in the preceding 25 years, 11 had their roots in studies paid for by the government.

"The general pattern is that industry is building enormously heavily on basic research supported by N.I.H.," said Dr. Francis Narin, president of C.H.I. Research, a consulting firm that has analyzed patents as a way of measuring the role public science plays in industry.

In a 1997 study commissioned by the National Science Foundation, C.H.I. looked at the most significant scientific research papers cited in medicine patents. It found that half the cited studies were paid for with United States public funds, primarily from government and academia; only 17 percent were paid for by industry. (The rest came from public and private foreign sources.)

And in a study with the National Eye Institute, published in 1996, C.H.I. found that 41 percent of patented eye-care technology was linked to research financed by the health institutes, including Dr. Bito's studies, which have been cited in 15 patents, including Xalatan's.

"I think that is very typical," Dr. Narin said of Dr. Bito's work. "If you find any good advanced biomedical patent, and you look at its science references, most of them are going to be public," meaning from publicly financed research.

The industry's estimate for the average cost of developing a **drug** -- \$500 million -- is drawn from a study published in 1991 by Dr. Lasagna and Dr. Joseph DiMasi, an economist at Tufts, and adjusted to reflect inflation and the additional testing **drug** companies have begun doing to obtain F.D.A. approval for their medicines. Only a small percentage of the \$500 million represents the actual cost of developing a particular medicine, Dr. DiMasi said. The rest is the cost is attributed to lost opportunities: years spent going down scientific "dry holes" and research money that could have generated interest had it been invested instead.

Dr. Levy, the **drug** development expert, says the Bayh-Dole law has altered that equation. In the past, Dr. Levy said, "academia was coming up with concepts, not molecules" for **drug** development. Today, university scientists are more commercially oriented; many are spinning off their own biotech companies to develop their ideas. That, in turn, has enabled companies like Pharmacia to shift resources away from in-house research and development and toward outside collaborations, a strategy known as "external innovation."

For instance, Pharmacia shut down Dr. Stjernschantz' prostaglandin lab after Xalatan went on the market in 1996, instead giving Dr. Stjernschantz a grant to continue his research at a nearby university. And last year, Pharmacia spent \$650 million to buy Sugen, a biotech concern in San Francisco that is collaborating with the National Cancer Institute on clinical trials of its two leading **drugs**. The company's co-founder, Dr. Joseph Schlessinger, is a New York University scientist whose initial financing included a nine-year grant from the cancer institute, N.I.H. records show.

So the pharmaceutical companies have become more efficient, in part because university

researchers are more efficient. As Dr. Levy put it, the companies are "not having to dig as many dry holes."

### Drawback in Development

Once Dr. Stjernschantz had identified the latanaprost molecule, Pharmacia needed a place to produce it in large amounts for testing in people. It takes 110 raw materials, 32 separate chemical reactions and three months to make a batch of latanaprost, and few companies had the technical know-how.

Among those that did was the Chinoin Pharmaceutical and Chemical Works, in Dr. Bito's hometown, Budapest. The 88-year-old company, owned until recently by the Hungarian Communist government, sits hard by the railroad tracks in a drab corner of the city, a vast array of 100 low-slung buildings connected by a maze of steel pipes.

Dr. Bito knew Chinoin's chemists well. He introduced them to officials at Pharmacia, and after some testy east-west negotiations, clinical trials were under way by the early 1990's in three countries, with Chinoin producing the key ingredient.

Dr. Camras, the young medical student who worked with Dr. Bito at Columbia, was brought in to run the United States arm of the final study; by this time he had become an ophthalmologist, with an academic appointment at the University of Nebraska.

Human testing is typically the most expensive part of the **drug** development process. Clinical trials usually consist of three phases; the first study tests safety and looks for the proper dose; if the **drug** is safe, it moves to the second phase to test effectiveness in a limited number of patients. The costliest clinical trial is the last one, the large Phase 3 study to prove the **drug** is safe and effective, proof that is necessary for the Food and **Drug** Administration approval. Depending on the **drug** and the amount of medical care involved, experts say the cost of a Phase 3 trial can range from \$10,000 to \$20,000 per patient.

The Phase 3 study of Xalatan was relatively small, just 829 people. The company will not say what it spent on that study, or any other. But Dr. Stjernschantz, the project manager, said the total costs for all trials was significantly less than \$30 million, an estimate that, a Columbia researcher said, Pharmacia provided to the university before the testing had begun.

The trials gave the company precisely what it was looking for: proof that Xalatan, given once a day, lowered intraocular pressure as much as the gold standard of glaucoma treatment, timolol.

But the studies turned up a worrisome, and unique, side effect: Xalatan caused 7.2 percent of patients' eyes to darken, changing from blue or green to brown. The company nearly pulled the plug on the project. "That was a very terrible crisis," Dr. Stjernschantz said.

In the end, the pigmentation issue led to less-than-wholehearted backing from the F.D.A., which approved the **drug** on June 6, 1996, with a caveat: Xalatan, it said, should be used only as backup therapy when all other **drugs** have failed, and not as a "first-line" treatment. It was a setback, but hardly a fatal one.

Today, Xalatan is approved for sale around the world, from the United States to Japan, Australia and all across Europe. The key ingredient is still being manufactured at Chinoin in Budapest, although the Hungarian company has since become a subsidiary of Sanofi, the French pharmaceutical giant.

The Chinoin-Pharmacia partnership has been a profitable one. Chinoin is making a 50 percent return on its prostaglandin investment, company officials said. And Pharmacia pays Chinoin slightly more than \$5 million a year for the manufacturing of latanaprost, said Tibor Szabo, who directs the

prostaglandin business unit at Chinoi.

That amounts to roughly one one-hundredth of Xalatan's \$507 million in annual sales last year. Or, to put it another way, the cost of making the key ingredient is just 1 percent of the revenue Xalatan generates.

#### Pricing Around the World

Between Dr. Bito, the National Institutes of Health and Pharmacia, 20 years and many millions of dollars were spent getting Xalatan to a point where it could be sold to the public. But those costs bear little relationship to the price of the **drug**.

Nor is the price based on what the company spends to make and sell Xalatan, which includes not only the \$5 million paid to Chinoi but also the cost of diluting, bottling and shipping the **drug**, the royalties paid to Columbia, and other costs, such as marketing.

Globally, there can be scores of prices for the same **drug**, as Xalatan shows.

In the United States, where there are no government restrictions, the basic price set by the company is determined by what the market will bear, taking into consideration the competition, the **drug's** side effects, and the patient population.

Xalatan is the first and only prostaglandin-based glaucoma **drug**, which gives it a competitive edge. It is taken only once a day; other drops must be taken more often. And aside from the eye pigmentation, it has fewer side effects. In the United States, the company sells the **drug** for about \$36 a bottle wholesale, far more expensive than the cheapest generic, but roughly in line with other brand-name glaucoma medications, according to industry data and experts.

That price changes from customer to customer. Large health maintenance organizations, as well as the government, can often wring discounts out of manufacturers, while people with no prescription **drug** coverage must pay the full price. The Department of Veterans Affairs, for instance, pays \$25 a bottle for Xalatan, about half what uninsured patients like Mr. Russell pay. And there are even different prices within the government; smaller federal agencies pay \$29 a bottle for Xalatan.

Overseas, price controls make for a different story.

In Dr. Bito's home country, Hungary, where the government pays for approved medications, Pharmacia receives a negotiated price of \$17.50 a bottle for Xalatan, said Katalin Szutrelly, who runs Pharmacia's Hungarian branch. Because the **drug** is so costly, she said, obtaining government approval to market it was difficult. One selling point was Dr. Bito himself. "We were proud of him being the inventor," she said, "and we used his name."

That does not mean the **drug** is reaching a lot of patients in Hungary. A panel of Hungarian eye doctors recommended Xalatan as a first-line treatment, Ms. Szutrelly said, but the government pays for it only when doctors can prove all other eyedrops have failed. As Ms. Szutrelly said, "If you don't have the reimbursement, you cannot sell the **drug**."

Back in Washington, the debate revolves around dueling sets of statistics about why Americans often pay more. Some say the price of new medicines is driving up health care costs. Kaiser Permanente, the health maintenance organization, says it spent \$4.7 million on glaucoma **drugs** in 1995, the year before Xalatan was introduced. Last year, Kaiser's expenditures for glaucoma reached \$20.4 million, \$9 million of it on Xalatan.

To counter such numbers, industry officials argue that Xalatan and other new medicines may be saving money as well, by reducing the need for doctors' visits and also for surgery. At the same time, they say the American free market provides the companies with the profits they need to plow

back into research, so that patients can benefit from the next generation of **drugs** like Xalatan.

"I'm worried about low prices in Europe," Dr. Harfstrand said. "It discourages innovation."

And because more prescription **drugs** are made and sold in the United States than any other country, the thought of regulation is especially troubling to the companies. In the case of Xalatan, for instance, more than half the **drug's** sales are in the United States.

"The U.S. has been the only major free market for pharmaceuticals," Fred Hassan, Pharmacia's chief executive, said in a company newsletter last fall, "and that has benefited patients as well as our industry."

#### Science vs. Selling

As Xalatan's inventor, Dr. Bitto likes to think of the **drug** as a triumph of science. But at Pharmacia, they speak proudly of Xalatan as a triumph of marketing.

The F.D.A.'s recommendation of Xalatan as only a backup therapy presented a considerable challenge to the company: How to persuade doctors to turn to their **drug** before other glaucoma medications. The company pursued an aggressive strategy, according to the **drug** agency's records and interviews with eye doctors, leaving the impression but not stating explicitly that Xalatan should be considered as a first-line therapy. The **drug's** growing sales suggest the strategy has worked; in an advertisement announcing its merger with Monsanto, Pharmacia proudly called Xalatan "the new gold standard for treatment of glaucoma."

Company documents show Pharmacia spent 40 percent of its overall revenue on marketing and administrative expenses last year, more than twice what it spent on research. In the last year alone, it increased its global sales force by 30 percent to 6,500 people, including scores of "detail men" who make door-to-door visits to doctors. Last year, company officials say, those detail men gave away more than a million free samples of Xalatan to doctors.

Companies gauge a product's success by its gross-profit margin -- the money left from sales after expenses, but before taxes. The Pharmaceutical Research and Manufacturers Association says only three out of 10 medicines recover their research and development costs. But those that do, like Xalatan, can be hugely profitable.

A reconstruction of Xalatan's profitability, based on outside experts and company documents, suggests its profit margin is likely higher than the company's average of 76 percent, perhaps as high as 90 percent. The company, however, will not talk about Xalatan's earnings.

As Dr. Harfstrand said, "We never comment on gross margins on individual products."

#### Easy and Effective

To spend a day in the examining room with Dr. Harry Quigley, director of the glaucoma service at the Wilmer Eye Institute at Johns Hopkins University, is to see why Xalatan is popular with both doctors and patients. As one of the nation's best-known eye specialists, Dr. Quigley sees as many as 40 patients on any given day, and these days, it seems, he is prescribing Xalatan to most.

He likes the **drug** for the obvious reason: It reduces intraocular pressure. His patients like it, too; in interviews, several said it caused less redness and irritation than other glaucoma drops, and they preferred its once-a-day formula. Other **drugs** to combat glaucoma must be taken as often as four times a day. For Dr. Quigley, convenience is hardly a side issue; the once-a-day regimen, he said, means patients are more likely to take their eyedrops.

In October of 1996, a few months after Xalatan was on pharmacy shelves, Dr. Quigley prescribed it to Mr. Russell, the retired optician, who is blind in his right eye and nearly blind in the left. The **drug** worked to perfection, lowering Mr. Russell's intraocular pressure to well within normal range. "It was fantastic," he said.

The only problem was the price. "Forty-five bucks," Mr. Russell exclaimed, cradling a bottle of Xalatan in his hand. "I flinch every time I think about it."

Like many older people, Mr. Russell takes other medications that run up his monthly prescription **drug** bill. For a time, he said, he paid out of pocket for Xalatan. Then his wife, Millie, discovered that Pharmacia runs a prescription assistance program for patients with "short-term financial hardship." Under the program, the company provides **drugs**, with patients typically making a \$5 co-payment to the pharmacy, for six months, and then patients can reapply.

Mr. Russell was approved for the program. But last August, he received a letter from Pharmacia telling him his discounted supply of Xalatan would run out in November, and urging him to find another, more permanent, way to pay for the **drug**.

But Mr. Russell did not have another way to pay. So Dr. Quigley proposed an alternative that Medicare would pay for: surgery to lower the intraocular pressure. It was not the optimal solution, Dr. Quigley said, because Mr. Russell's glaucoma was well controlled with the drops and the operation meant a two to three percent risk that he would lose sight in his only good eye, plus a continuing risk of infection.

"The best way to take care of Mr. Russell would have been to continue his medications," the doctor said. "That was not practical, so we did the next best thing."

For Dr. Quigley, the situation was hardly extraordinary. Too many of his patients, he said, are "being forced to choose between paying the rent, buying food and taking expensive medicine." And he is irritated that Pharmacia offers patients only short-term help. "If somebody is going to start taking medication," he said, "they are going to need it indefinitely, and they are unlikely to be poor for only 6 or 12 months."

Also troubled is Dr. J. William Doyle, a University of Florida ophthalmologist who has studied company assistance programs and found them often inaccessible to patients. "It's a hassle," he said, and many patients choose cheaper, less effective medicines rather than jumping through the bureaucratic hoops necessary to get **drugs** at reduced prices.

At Pharmacia, officials will not divulge information about how many patients receive help from the medication assistance program, or how much the company spends on it.

Mr. Russell, for one, says he is quite familiar with the pharmaceutical industry's arguments about the cost of prescription **drugs**, and he does not believe them.

"They say the extra price is for research," he said. "That's hard to believe."

Though it is not the most often-prescribed glaucoma **drug**, Xalatan brought in more revenue last year than any of its competitors, and was Pharmacia's best-selling product prior to the company's merger with Monsanto. Pharmacia, which had \$7 billion in revenue last year, before the merger, forecasts \$750 million in annual sales for Xalatan by 2002. But the patent is due to expire in 2011, according to the company, and competitors are busy developing rival products. Pharmacia is busy, too; it is already seeking F.D.A. approval of a new product, a combination of Xalatan and timolol, the leading generic competitor, that could extend the life of the patent.

As for Dr. Bito, he has closed down his lab at Columbia and is back in Budapest, living in a spacious apartment with high ceilings and wood floors and a large picture window that looks out on the Roman Catholic church he attended as a boy. Despite the millions he has earned from Xalatan,

he lives relatively modestly, driving around hills above the Danube in an 18-year-old Russian car. He has finally achieved his dream of becoming a novelist; his latest book, "Abraham & Isaac," has made the best-seller list in Hungary.

<http://www.nytimes.com>

**GRAPHIC:** Photos: Albert Russell is almost blind from glaucoma but he can not afford Xalatan, a best-selling eyedrop to fight the disease. (Marty Katz for The New York Times)(pg. 26); This **drug** to fight glaucoma, developed with government help, is not cheaper because of it. (pg. 1)

Charts: "From the Lab To the Pharmacy"

The process by which an idea moves from the lab to the drugstore shelf is long and complex. A look at the process for a particular **drug**, Xalatan, reveals that taxpayers can play a substantial financial role.

#### **DRUG DISCOVERY**

Basic research, which can last from 2 to 12 years, is conducted to gain knowledge about diseases. It is frequently financed by public agencies.

Dr. Laszlo Bito, a Columbia University professor, receives grants from the N.I.H. to conduct research on a treatment for glaucoma.

#### TRANSLATIONAL RESEARCH

Transition from basic research to applied pharmaceutical research. Financed primarily by pharmaceutical companies, but public agencies may be involved.

#### XALATAN

After successful tests with animals, Dr. Bito applies for a patent, assigning the rights to Columbia University, which eventually licenses the rights to Pharmacia, a pharmaceutical company.

#### PRECLINICAL TESTING

Actual development and testing of medicines. Financed primarily by pharmaceutical companies.

#### XALATAN

Dr. Johan Stjernschantz, a Pharmacia official, adapts Dr. Bito's invention so that it can be safely delivered to humans.

#### CLINICAL TRIALS: PHASE 1

Small trials (20-80 healthy volunteers) to evaluate **drugs** for safety.

#### CLINICAL TRIALS: PHASE 2

These trials (100-300 volunteer patients) focus on efficacy and side effects.

#### CLINICAL TRIALS: PHASE 3

These large trials (1,000 - 5,000) are typically the costliest. Tests for all adverse reactions to long-term use.

#### XALATAN

Xalatan's Phase 3 study includes 829 people and lasts six months. Pharmacia discovers that the **drug** can cause patient's eyes to change color.

#### F.D.A. REVIEW, APPROVAL

Submission for approval to manufacture, distribute and market a **drug** in the U.S.

#### XALATAN

Pharmacia submits Xalatan to the F.D.A., which approves it as a backup therapy one year later.

**PHASE 4: ADDITIONAL POST-MARKET TESTING**

Pharmaceutical companies report adverse reactions not present during trials. The FDA evaluates the reports for trends and implications.

**XALATAN**

Pharmacia continues to test Xalatan on patients while pursuing an aggressive marketing strategy. Xalatan becomes highly profitable.

(pg. 26)

**Chart: "AT ISSUE: Going Without"**

Medicare does not cover the cost of prescription **drugs** outside the hospital. But some beneficiaries have coverage under other plans, and those without coverage are less likely to fill prescriptions.

Medicare beneficiaries, 1996

**NO DRUG COVERAGE:** 31%

**DRUG COVERAGE:** 69%

Prescriptions filled

Average number per person, 1996

Beneficiaries in poor health

**WITH DRUG COVERAGE:** 38

**NO DRUG COVERAGE:** 27

Beneficiaries with incomes below the poverty level

**WITH DRUG COVERAGE:** 25

**NO DRUG COVERAGE:** 14

Total prescriptions filled per Medicare beneficiary (on average)

**WITH DRUG COVERAGE:** 21

**NO DRUG COVERAGE:** 16

(Source: Kaiser Family Foundation)(pg. 26)

**Chart: "UP CLOSE: One Company"**

A pharmaceutical giant and a top prescription **drug**.

Chart shows total profits for Pharmacia & Upjohn and annual sales of Xalatan.

Who pays what for Xalatan

For a six-week supply

\$17.50 -- Hungarian wholesaler (direct from manufacturer)

\$18.78 -- French patient

\$25.37 -- N.I.H., Veterans Admin. and other federal agencies (direct from manufacturer in bulk)

\$25.65 -- Japanese patient

\$29.44 -- Canadian patient

\$29.64 -- Other federal agencies (direct from manufacturer)

\$36.02 -- American wholesaler (direct from manufacturer)

\$38.44 -- Leesburg, Va., pharmacy (from wholesaler)

\$42.10 -- American patient (online-Drugstore.com)

\$44.85 -- American patient (Leesburg, Va., pharmacy)

\$49.69 -- American patient (CVS Pharmacy)

(Sources: Pharmacia & Upjohn annual reports (Pharmacia & Upjohn expenses and profits); IMS

Health (Annual U.S. sales))(pg. 26)

Graph: "TRENDS: **Drugs** and Prices Rising"

Prescription **drug** prices are rising, and doctors are prescribing more **drugs**.

Graph tracks U.S. prescription **drug** prices and average cost of filling a prescription since 1990.

Pharmaceutical company sales and expenditures

Pharmaceutical sales are rising, but expenditures for research and development are rising at a faster rate.

Graph tracks U.S. domestic sales and R&D since 1995.

(Sources: National Association of Chain **Drug** Stores, Pharmaceutical Research and Manufacturers of America)(pg. 27)

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The Washington Post♦ [View Related Topics](#)**March 31, 2000, Friday, Final Edition****SECTION:** A SECTION; Pg. A01**LENGTH:** 789 words**HEADLINE:** Rosier Future For Medicare Is Forecast; Report Could Sway Congress To Enact New Drug Benefit**BYLINE:** Glenn Kessler , Washington Post Staff Writer**BODY:**

A booming economy and a slowdown in Medicare spending have extended the financial life of the old-age health program by eight years, to 2023, the most upbeat assessment by the program's trustees in a quarter-century.

The report could increase pressure on Congress to add new benefits to the Medicare program without bothering to tackle fundamental changes that would deal with the looming retirement of the baby boom generation, lawmakers said. Both Democrats and Republicans have offered bills that would add a **prescription drug** benefit to the Medicare program, which covers 39 million Americans.

The trustees issued an almost equally positive evaluation of the Social Security trust fund, projecting that it would remain solvent for another three years past earlier projections, until 2037.

Administration officials and several members of Congress warned that the reports should not delay action on dealing with the baby boom retirement crisis, when the number of workers per beneficiary is expected to drop from 3.4 today to just over 2 in 2030.

Baby boomers, who were born between 1946 and 1964, will begin to retire by the end of the decade, and the Medicare report projects enrollment will double, to 81 million, by 2035. When that happens, the trustees warn, the cost of taking care of those retirees will overwhelm the system as it is currently structured.

"There is one downside to this year's good news," said Health and Human Services Secretary Donna E. Shalala, one of the trustees. "It invites complacency--and complacency is a prescription for disaster."

President Clinton, speaking to several hundred people at an event at the Austin Street Senior Center

in the New York borough of Queens, said the reports demonstrated progress, but he also pressed for his proposed **prescription drug** benefit.

But Sen. John Breaux (D-La.), a leading advocate of a major overhaul of the big entitlement programs, warned that prolonged solvency does nothing to address long-term needs of Medicare and Social Security and could undermine efforts to put the two programs on a sounder financial footing.

"Extending the solvency of Medicare and Social Security for a couple more years does nothing to modernize the structure of both these vital programs and, in fact, reduces the sense of urgency that improvements need to be made soon to protect the 77 million baby boomers who start retiring in the next 10 years," Breaux said.

Sen. Bill Frist (R-Tenn.), another proponent of restructuring Medicare, suggested that the new solvency projections might make it easier to add **prescription drug** benefits to Medicare but urged that they be tied to more fundamental reform.

"**Prescription drugs** and reform must still go hand-in-hand if we are to weather the upcoming demographic shift," he said.

If anything, the trustee reports--which took many budget experts by surprise--show how good economic news and a little luck can radically change the financial picture of these retirement programs, which account for nearly 40 percent of the federal budget. Just four years ago, the trustees predicted the Medicare trust fund, which pays for hospital costs, would become insolvent next year. (A separate Medicare account that pays doctor bills is mostly funded year by year through premiums and general revenue.)

But a combination of factors has pushed the date of reckoning farther into the future. As unemployment plunged and companies went begging for workers, the government collected more of the payroll taxes that fund both Medicare and Social Security. Medicare hospital spending slowed and actually fell last year--to a total of \$ 128.8 billion--in part because of cuts imposed by the 1997 budget agreement and also because of a federal crackdown on fraud and waste. .

The Medicare and Social Security trust funds have little in common with private pension funds since they do not actually hold funds--but merely IOUs from the government.

Currently, payroll tax revenue is high enough to cover Medicare's and Social Security's obligations. But if there comes a time when payroll taxes no longer exceed obligations--as will happen in 2015 with Social Security--then the government likely will have to either raise taxes, cut benefits or borrow the money to keep the programs going. Few doubt that Congress would act quickly if it faced the prospect of not having the cash to keep the programs afloat.

Henry Aaron, a health care and budget expert at the Brookings Institution, said projections are likely to change again. "There is a kind of naive faith in the latest projection as real and hard and as something we can take to the bank."

Staff writer Helen Dewar contributed to this report.

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The New York Times♦ [View Related Topics](#)**March 15, 2000, Wednesday, Late Edition - Final****SECTION:** Section A; Page 16; Column 1; National Desk**LENGTH:** 924 words**HEADLINE:** Democrats Devise an Alternative to Clinton's Drug Plan**BYLINE:** By ROBERT PEAR**DATELINE:** WASHINGTON, March 14**BODY:**

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

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

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

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

White House officials welcomed Mr. Graham's effort.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

<http://www.nytimes.com>

**GRAPHIC:** Photo: Senator Bob Graham of Florida, right, discussed health care yesterday with residents of Tallahassee. (Michael Burchfield/Associated Press for The New York Times)

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The New York Times♦ [View Related Topics](#)**April 10, 2000, Monday, Late Edition - Final****SECTION:** Section A; Page 15; Column 1; National Desk**LENGTH:** 984 words**HEADLINE:** White House Challenges Drug Companies for Charging Higher Prices to the Uninsured**BYLINE:** By ROBERT PEAR**DATELINE:** WASHINGTON, April 9**BODY:**

The White House attacked the pricing policies of the drug industry today, saying drug companies charged higher prices to uninsured customers than to people with insurance, and President Clinton announced plans to hold a conference this summer to investigate how pharmaceutical companies set their prices.

The actions came as Mr. Clinton tried to fire up public support for Medicare coverage of **prescription drugs**, one of his top goals in his last year in office.

A new study, to be unveiled by Mr. Clinton on Monday, found that elderly people without insurance for drug costs typically pay 15 percent more than people with insurance for the same medicines. Moreover, it said, this gap has more than doubled in the last four years.

"Individuals without drug coverage pay a higher price at the retail pharmacy than the total price paid on behalf of those with drug coverage," said the report, which Mr. Clinton requested last October. "Seniors without drug coverage not only lack insurance against high costs, but do not have access to the discounts and rebates that insured people receive."

Medicare, the federal health insurance program for 39 million people who are elderly or disabled, generally does not cover **prescription drugs** for people outside the hospital. Many beneficiaries have some type of supplemental insurance to help pay drug costs, but the White House said such coverage was shrinking and was unreliable.

In its new study, the White House said that Medicare beneficiaries without drug insurance spent twice as much of their own money on prescriptions, but bought one-third fewer drugs than people with coverage. Health maintenance organizations and other large health insurance plans can obtain discounts for their members that are not generally available to individuals paying cash for **prescription drugs**, the report said.

Spokesmen for the drug industry said they agreed with the government's finding that insurance could

help consumers get discounts on **prescription drugs**. And that, they said, was why they wanted the government to subsidize private insurance to cover such costs for Medicare beneficiaries.

"Expanded drug coverage is the answer," said Alan F. Holmer, president of the Pharmaceutical Research and Manufacturers of America, the trade group. "But the president's plan is the wrong solution. Seniors need to be able to choose the private insurance plan that's best for them, not a big government one-size-fits-all scheme."

Federal officials said drug prices were determined by a complex process that involved discounts, rebates and other financial arrangements among drug manufacturers, wholesalers, pharmacists and insurers.

The drug industry regards the details of those arrangements as proprietary information. But the White House said the conference on "**prescription drug** pricing practices" would investigate such rebates and discounts.

Chris Jennings, the White House health policy coordinator, said the administration and Congress needed information about drug discounts and rebates to help them design **prescription drug** benefits for Medicare.

"There is a basic need for policy makers to understand how this works," Mr. Jennings said in an interview.

"Medicare should use the best techniques of the private sector and should extract similar discounts from the pharmaceutical industry."

The Clinton administration's efforts to obtain such data are sure to cause apprehension among drug companies, which already fear that the White House wants to regulate drug prices, despite its protests to the contrary.

The White House said, "Our analysis tends to understate the ultimate price differences for insured and uninsured customers," because the government could not get data on rebates. Drug makers pay such rebates to benefit management companies that enhance their "market share" by including their products on a list of recommended drugs.

In the last month, the House and the Senate have endorsed budget blueprints that would provide up to \$40 billion over five years for Medicare drug benefits. But President Clinton has not begun serious negotiations with Congress on how to design such a benefit.

These are some of the obvious questions: How much should the beneficiary pay in premiums, deductibles and co-payments? How much of each prescription should the government pay? Should Medicare provide special protection to people needing very expensive drugs? Should the government subsidize drug benefits even for high-income people?

The new report, "**Prescription Drug** Coverage, Spending, Utilization and Prices," makes these points:

\*Spending for **prescription drugs** is growing more than twice as fast as other health spending. From 1993 to 1998, drug spending increased an average of 12 percent a year, compared with an increase of about 5 percent a year for all other types of health spending.

\*Ten percent of Medicare beneficiaries without drug coverage reported that they needed a prescription medicine in the last year but did not get it because they could not afford it. Only 2 percent of beneficiaries with drug coverage reported having had such an experience.

\*About one-third of Medicare beneficiaries have no insurance to help them buy **prescription drugs**. Forty-seven percent of beneficiaries are uninsured for at least one month of the year; 53 percent have drug coverage for the entire year.

\*Nearly one-fourth of Medicare beneficiaries with incomes exceeding four times the poverty level -- more than \$45,000 a year for a couple -- have no insurance coverage for **prescription drugs**. "This contradicts the belief that lack of coverage is a problem only for those with low incomes."

In addition, the White House said, the oldest Medicare beneficiaries are most likely to lack drug coverage. About 37 percent of beneficiaries 85 and older lack coverage, compared with 28 percent of beneficiaries age 65 to 69.

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The New York Times♦ [View Related Topics](#)**April 11, 2000, Tuesday, Late Edition - Final****SECTION:** Section A; Page 28; Column 1; Editorial Desk**LENGTH:** 345 words**HEADLINE:** Drug Prices and Medicare**BODY:**

The Department of Health and Human Services issued a report yesterday that highlighted alarming disparities in **prescription drug** costs for Medicare beneficiaries. The Medicare recipients who lack drug coverage are charged significantly more -- and are thus forced to do without medicine more often -- than Medicare recipients who have obtained drug coverage one way or another.

Currently, about a third of Medicare beneficiaries have no drug coverage at all. The rest have drug coverage through plans provided by former employers, Medigap plans that they buy themselves, Medicaid, or through Medicare health maintenance organizations that provide drug benefits.

The new study found that Medicare recipients without drug coverage were typically charged 15 percent more for the same drug at the pharmacy than were individuals whose drug costs had been negotiated by insurers or by pharmacy benefit managers, companies that administer and negotiate drug prices for health plans. That is because those large entities are able to obtain price discounts for drugs from pharmacy chains. The report does not even take into account direct rebates from manufacturers that insurers and benefit managers can get for increasing a manufacturer's market share in a particular drug field. Such rebates can further reduce the price of **prescription drugs** between 2 and 35 percent.

The price disparities make a persuasive case for providing a drug benefit for all Medicare beneficiaries. A key part of President Clinton's Medicare drug benefit plan would allow those currently without drug coverage to get lower drug prices by using pharmacy benefit managers to negotiate with retailers and manufacturers. Several competing proposals in Congress also include contracting with private benefit managers to get group price discounts, though the plans differ in details.

The market is working unfairly against the elderly who have no drug coverage. Medicare reform must give them the means to use their collective purchasing power in getting better prices on **prescription drugs**.

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The Washington Post♦ [View Related Topics](#)**April 10, 2000, Monday, Final Edition****SECTION:** A SECTION; Pg. A05**LENGTH:** 878 words**HEADLINE:** Medicare Patients Pay 15% More for Drugs; HHS Study Finds Growing Gap in Prescription Costs for the Insured and Others**BYLINE:** Juliet Eilperin , Washington Post Staff Writer**BODY:**

The Clinton administration is releasing a study today documenting that Medicare recipients pay an average of 15 percent more for **prescription drugs** than patients whose insurers have negotiated discounts, in an effort to pressure Congress to enact a universal drug benefit for senior citizens this year.

President Clinton, who ordered the Department of Health and Human Services last fall to conduct the survey, is scheduled to announce today that the White House will hold a conference on drug pricing this summer that will include representatives from the pharmaceutical industry.

The move comes as lawmakers debate whether to provide **prescription drug** coverage for the elderly before Congress adjourns this fall. Seniors are a key swing vote in the November elections, and Democrats are seeking to make drug benefits a pivotal question, with Senate candidates from Michigan to Montana transporting seniors across the border to Canada so they can fill their prescriptions for less money.

Even Republican Sen. Slade Gorton, who is seeking reelection from Washington state this year, is proposing that drug companies be prohibited from charging more for drugs in the United States than they do in Mexico and Canada. As many as 50 House Democrats are planning to hold **prescription drug**-related events in their districts during this month's spring recess.

White House officials said the study, which also shows that the gap between drug prices for people with and without insurance doubled between 1996 and 1999, demonstrates why Congress should adopt the president's plan to provide prescription coverage for all Medicare recipients. Clinton's plan would cover half of all drug costs up to \$ 5,000 a year per person once it was fully implemented in 2009 and includes \$ 35 billion for seniors with catastrophic drug costs during the last five years of the plan.

"The report underscores the need for a voluntary **prescription drug** care benefit for all Medicare

beneficiaries, not only because it would provide needed insurance coverage but because it would utilize private sector negotiating practices to achieve discounts and rebates that would accrue to the benefit of seniors," said a White House official who asked not to be identified. "The president believes it just provides more attention to the need for prompt action by the Congress to pass legislation in this area."

House Republicans are planning to unveil their own **prescription drug** proposal this week, though their plan differs markedly from the president's. GOP lawmakers are focusing on providing private drug coverage to low-income seniors, and they have put aside \$ 40 billion in the budget over the next five years to pay for a benefit and broader reforms in the Medicare program.

Rep. Bill Thomas (R-Calif.), who chairs the House Ways and Means health subcommittee and is helping to draft the GOP's plan, noted that in 2003 Clinton's plan applies to just \$ 2,000 in drug costs, forcing seniors to shoulder the rest of their expenses.

"The point is all of this data clearly indicates that what seniors need is a private drug insurance plan that protects seniors from high out-of-pocket costs," Thomas said in an interview yesterday. "The president's plan doesn't do that, and we will present one that does."

Insurance industry representatives such as Health Insurance Association of America President Chip Kahn have objected to a stand-alone **prescription drug** benefit, saying they will be blamed once health insurance costs rise dramatically as a result. But Thomas said insurers were "just being typical naysayers" and added the GOP plan includes a proposal for "Medicare modernization" that would make it more affordable than the president's over the next decade. According to Congressional Budget Office estimates, Clinton's plan would cost \$ 149 billion over 10 years.

The HHS study takes direct aim at Republican assertions that the elderly poor are most in need of drug coverage, stating that one in four Medicare beneficiaries with annual income four times above the poverty level, or roughly \$ 45,000 for a couple, lack drug coverage each year.

The report emphasizes that because seniors and people with disabilities cannot take advantage of the discounts and rebates that other insured Americans enjoy, they often fail to purchase the drugs they need. About 10 percent of Medicare recipients without drug coverage reported in the last 12 months they did not fill a prescription because they could not afford it, compared to 2 percent who had coverage.

**Prescription drug** spending is increasing at an annual rate of 12 percent, twice as fast as other health spending, according to the report.

But Pharmaceutical Research and Manufacturers of America President Alan F. Holmer said rising drug costs do not justify administering a new drug benefit through the Medicare program.

"Expanded drug coverage is the answer, but the president's plan is the wrong solution," Holmer said in a statement yesterday. "Seniors need to be able to choose the private insurance plan that's best for them, not a big government, one-size-fits-all scheme. Momentum is growing in the Congress for a private sector approach, and we hope the president joins in that initiative."

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April 5, 2000, Wednesday, Final Edition

**SECTION:** A SECTION; Pg. A02**LENGTH:** 416 words**HEADLINE:** Clinton Makes Medicare Drug Benefit a Priority; 'Sensible Tax Cuts' Could Follow New Coverage**BYLINE:** John F. Harris , Washington Post Staff Writer**BODY:**

President Clinton, who for two years has held off Republican tax-cut plans with his mantra of "save Social Security first," joined Democrats yesterday to announce a similar strategy on Medicare, the other expensive-but-popular entitlement program for senior citizens.

Following a White House meeting with Senate Democrats, Clinton appeared before a labor group to endorse a budget amendment that Clinton said calls for "sensible tax cuts"--but only after passage of a new **prescription drug** benefit for Medicare.

Clinton also denounced Republicans who say they want to limit the cost of the new benefit by making the Medicare drug benefit available only to the most needy. Clinton said everybody should get subsidized drugs. "That's what made Medicare work in the first place; that's what made Social Security work in the first place," he told the Building and Construction Trades Department of the AFL-CIO. "It was a universal program that helped middle-class people as well as low-income people."

Clinton also touted Democratic proposals to help school districts build new schools, complaining that he was "very frustrated by those who say in the majority in Congress that this is not a national responsibility. . . . The school districts of this country do not have the money or the means right now to do what our children need."

He said many aging schools--in Philadelphia, for instance--are in such decrepit condition that they cannot be wired for Internet access. This point coincided with the other theme of Clinton's day--closing the "digital divide" in which poor people are not benefiting equally from technological gains.


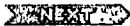
Clinton told a White House conference that technology has "truly explosive" potential for helping the poor, if made accessible to people. The forum kicked off a series of events this month on a similar theme. Clinton plans a tour, starting in Silicon Valley, moving to a Navajo settlement in a remote

part of New Mexico, and ending at a computer convention in Chicago, to promote technology's role in lifting the neediest.

At yesterday's conference, he announced that more than 400 companies and community groups have been enlisted in the effort, including a \$ 1 million contribution by Yahoo! to advertise a new program by AmeriCorps volunteers to serve as computer tutors. Clinton also said 3Com has agreed to a \$ 3 million, three-year partnership with the YWCA to encourage technology entrepreneurs to serve as mentors to teenage girls.

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April 26, 2000, Wednesday 12:00 AM, Eastern Time

**SECTION:** NATIONAL DESK**LENGTH:** 286 words**HEADLINE:** President Clinton, Democratic Leadership Highlight Study Documenting **Prescription Drug** Price Increases**DATELINE:** WASHINGTON, April 26**BODY:**

The following was released today by the White House:

--

PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP  
HIGHLIGHT NEW STUDY DOCUMENTING **PRESCRIPTION DRUG** PRICE INCREASES  
NEARLY DOUBLE THE RATE OF INFLATION

--

The Roosevelt Room, The White House  
April 26, 2000

Today, President Clinton will join Families USA in releasing a new study on **prescription drugs** titled "Still Rising: Drug Price Increases for Seniors 1999-2000." The report shows that, on average, the price for the 50 drugs most commonly used by seniors increased at nearly twice the rate of inflation during 1999. The President will point out that this finding, combined with the recent HHS report showing that the price differential for older and disabled Americans with and without coverage has nearly doubled, underscores the need for a voluntary Medicare **prescription drug** benefit.

The President will be joined at the statement by Health and Human Services Secretary Donna Shalala, Sen. Thomas Daschle (D-S.D), Rep. Richard Gephardt (D-MO), and Ron Pollock, Executive Director of Families USA.

Based in Washington DC, Families USA is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health and long-term care for all Americans. Working at the national, state and community levels, we have earned a national reputation as an effective voice for health care consumers for over 15 years.

Order of Speakers: President Clinton Rep. Richard Gephardt (D-MO) Sen. Thomas Daschle (D-SD)  
White House Press Office, 202-456-2100

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The New York Times♦ [View Related Topics](#)**April 26, 2000, Wednesday, Late Edition - Final****SECTION:** Section A; Page 14; Column 5; National Desk**LENGTH:** 745 words**HEADLINE:** Administration Using Study To Push Elderly Drug Plan**BYLINE:** By ROBERT PEAR**DATELINE:** WASHINGTON, April 25**BODY:**

Prices for the 50 drugs most frequently used by older Americans increased last year at nearly twice the rate of inflation, a study to be issued on Wednesday at the White House says.

The study found a similar trend over the last six years.

President Clinton planned to cite the data in arguing that drug costs constitute a growing burden for the elderly and that Congress should pass legislation to reduce the burden.

The Democratic leaders of Congress, Senator Tom Daschle of South Dakota and Representative Richard A. Gephardt of Missouri, intend to join Mr. Clinton at the White House. The three will press Republicans in Congress to reach a compromise and make drug coverage available to all 39 million Medicare beneficiaries.

The study of the top-selling drugs was done by Families USA, a consumer group, and by the Prime Institute at the University of Minnesota, which specializes in the economics of **prescription drugs**.

The institute is one of the nation's leading centers for research on pharmaceutical economics and has been tracking drug prices since it was established in 1991.

A White House official said the administration was giving its imprimatur to the study because "it's consistent with our findings."

But Jackie Cottrell, a spokeswoman for the Pharmaceutical Research and Manufacturers of America, a trade group, took issue with the report, which she described as "a political study by Families USA."

Government statistics suggest that the wholesale prices of **prescription drugs** rose less than did the wholesale prices of most other finished goods in 1999, Ms. Cottrell said.

Representatives for several drug companies did not deny increasing their prices, but said their

products still offered excellent value.

The study makes these points:

\*Prices of the 50 top-selling drugs used by the elderly rose an average of 3.9 percent from January 1999 to January 2000, or nearly twice the overall rate of inflation in that period.

\*Prices for 16 of the 50 drugs rose at least three times the rate of inflation.

\*In the last six years, prices for the 50 drugs most often used by the elderly rose an average of 30.5 percent or double the inflation rate for that period.

Ronald F. Pollack, who is executive director of Families USA and a co-author of the study, said, "Increasing numbers of elderly Americans will find **prescription drugs** unaffordable unless they gain access to drug coverage through Medicare."

The study said that new drugs to treat conditions afflicting the elderly often cost more than the drugs they replace. While the new drugs may be more effective, they also increased the share of an elderly person's income devoted to buying drugs, the study said.

The report said the price of Synthroid, a synthetic thyroid hormone, rose four times as much as the Consumer Price Index last year, while the price of Premarin, an osteoporosis drug, increased five times as much as the index, and the price of Pravachol, a cholesterol-lowering drug, three times as much as the index.

Veronica M. Apostolico, a spokeswoman for the Knoll Pharmaceutical Company, which makes Synthroid, said: "This product represents an excellent value. It costs only 30 cents a day. It's the least expensive of the top 10 most frequently dispensed **prescription drugs** in the country."

Audrey Ashby, a spokeswoman for Wyeth-Ayerst Laboratories, which makes Premarin, said: "The percentage price increases are not as important as the daily cost. Therapy with Premarin costs a patient less than 60 cents a day. That's a small price to pay for preventing osteoporosis, which costs the U.S. health care system \$10 billion a year."

Patrick D. Donohue, a spokesman for Bristol-Myers Squibb, which makes Pravachol, said, "This product is moderately priced, compared with other cholesterol-lowering drugs, and it has tremendous medical benefits."

Moreover, Mr. Donohue said, "Singling out this drug doesn't tell the whole story. If you look at our full portfolio of drugs, you'll see that the average price rose less than the Consumer Price Index in the last six years."

As drug prices rise, the study said, the demand for discounts by hospitals and health maintenance organizations increases, and this in turn tends to push up prices for individuals who are unable to get such discounts.

The difference in drug prices paid by people with and without insurance to cover drug costs has widened in the last three years, the report said.

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The New York Times♦ [View Related Topics](#)**April 12, 2000, Wednesday, Late Edition - Final****SECTION:** Section A; Page 18; Column 4; National Desk**LENGTH:** 822 words**HEADLINE:** Maine Will Cap Drug Prices With a Groundbreaking Law**BYLINE:** By CAREY GOLDBERG**BODY:**

In a slap to the pharmaceutical industry and a rebuke to Congress, the Maine Legislature on Tuesday became the first in the country to approve a bill that would clamp sweeping price controls on medications sold in the state.

The Act to Establish Fairer **Prescription Drug** Prices would immediately establish a pricing board to set suggested lower prices. If the prices did not fall, then as of Oct. 1, 2001, the board would mandate that all drugs sold in the state cost no more than they would in Canada.

The bill must still go to the governor, Angus King, an independent who has remained neutral on it, but it passed today by veto-proof margins in both chambers, 23 to 9 in the Senate and 102 to 47 in the House. It is expected to face legal challenges, in particular on the grounds that it hinders interstate commerce, but the state attorney general has testified that he believes the bill can withstand them, in part because the commerce clause in the United States Constitution allows an exception for states protecting the basic health and safety of their citizens.

"This makes Maine the first state to say, 'Americans shouldn't be subsidizing low prices for **prescription drugs** around the world,'" Senator Chellie Pingree, the Senate's Democratic majority leader and the bill's primary sponsor, said. "The pharmaceutical industry worked extra hard against this bill, but they had no argument and this is a huge national issue."

The rising cost of medications is particularly an issue in border states like Maine. There, residents can cross into Canada, which has national health insurance, and reap the benefits of the discount the Canadian government negotiates with drug companies.

The Vermont State Senate recently passed a similar bill with "fair pricing of **prescription drugs**" in its title, though it has yet to be voted on in the State House of Representatives. The New England states have also formed a coalition to try to present a united front on drug prices, whether through local price controls or the pooling of their residents to demand mass discounts. The legislative leaders in the coalition argue that virtually every other country negotiates a low price for their drugs with the industry, so Americans end up footing the bill for all the research that benefits everyone.

"Our goal," said Peter Shumlin, president pro tem of the Vermont Senate, "is to have a number of states move forward simultaneously to send a message to the pharmaceutical industry that people in New England are sick and tired of paying a 60 to 80 percent premium for drugs made in America, and -- I think we share this view with our friends in Maine -- as long as the pharmaceutical industry remains the top donor to members in both parties in Congress, not much will happen there."

To backers of the pharmaceutical industry, that goal is deeply misguided, as is the Maine bill.

"It sounds like they're claiming this is a win for the Legislature, but I think it's a detrimental blow to patients in Maine who need access to medicine," said Gabrielle Williams, a spokeswoman for Pharmaceutical Research and Manufacturers of America, the trade association, based in Washington. "It could have significant impacts on access to certain medications in Maine."

Delays in setting prices could bring delays in access to new drugs, she said. Also, price controls remove the financial incentive for creating new drugs, she added.

Some fear that manufacturers would refuse to sell drugs in Maine. But the bill's backers say that would be a public relations disaster for the companies.

There has been plenty of local opposition to the bill in Maine as well. On Monday, a group of doctors, biotechnology backers and senior citizens' groups held a news conference, saying they worried that price controls might restrict access to drugs.

Others sounded like Clyde E. Dyar, the economic and community development director for the town of Fairfield, Me., who worried that the bill would chill investment in the state's small biotechnology industry.

"If we put price controls on in Maine, and we don't do it nationally, then it puts an onus on companies not to do business in Maine," he said.

On the floor of both chambers today, Senator Pingree said, debate of the bill was lengthy largely because so many lawmakers wanted to share what they and their constituents had experienced buying medicine. Ultimately, support for the bill crossed party lines.

The Maine bill sets aside \$200,000 for its legal defense. It lays out the composition of an 11-member pricing board, which would include a senior citizen and a disabled person. It also lays out several interim measures meant to reduce prices, such as increased **prescription drug** benefits for low-income seniors, potential purchasing alliances with other states and incentive payments to health care providers to encourage them to prescribe cheaper products.

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Terms: [prescription drugs](#) ([Edit Search](#))*U.S. Newswire April 26, 2000, Wednesday*Copyright 2000 U.S. Newswire, Inc.  
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April 26, 2000, Wednesday 12:00 AM, Eastern Time

**SECTION:** NATIONAL DESK**LENGTH:** 2683 words**HEADLINE:** White House Background Briefing on **Prescription Drugs****DATELINE:** WASHINGTON, April 26**BODY:**

Following is a transcript of a White House background briefing held today on **prescription drugs**:

The James S. Brady Press Briefing Room

10:30 A.M. EDT

SENIOR ADMINISTRATION OFFICIAL: I just wanted to give you a quick heads-up on some of these issues. I think the report speaks for itself, so I won't bore you with a reiteration of the numbers that you've heard before. I think what's most important is to talk about our strong belief that this year it is very possible, in fact, it should occur, that we pass a bipartisan Medicare reform initiative that includes the provision of a voluntary, affordable, accessible **prescription drug** benefit for all Medicare beneficiaries.

The President feels that we have probably an unprecedented opportunity this year to get things done. We've noted that the Republican leadership has been moving in a significant direction from not really talking too much about this issue to acknowledging it truly is an issue, to rejecting a block grant approach to states to moving towards what they say is a Medicare drug benefit that meets principles that sound familiar and similar to those that we have advocated -- i.e., that it is voluntary, affordable and accessible, and utilizes market-oriented principles to negotiate -- and practices -- to negotiate prices and rebates and discounts, much like the private sector does -- actually, exactly like the private sector does.

The issues that we've raised to you, some of you recently, that we feel quite strongly about is that we think specific answers must be provided to major questions about the short-comings of the Republican plans. And that includes the adequacy of the financing for the drug benefit, both short-and long-term; the assurance that it is going to be available to all beneficiaries, because, obviously, if you only provide a direct premium assistance to 150 percent of poverty, and you utilize a private sector drug-only benefit that the insurance industry itself continually raises serious objections to and concerns about, we really question whether you can say it will be accessible to all beneficiaries,

let alone affordable.

And the affordability issue, even if in some areas of the country this policy is available, it may well, in fact, it likely will not be affordable. And there are a number of reasons why. One, of course, is the direct premium assistance is just 150 percent of poverty, which is just over \$12,500 for an individual; and secondarily, it uses a market that historically hasn't negotiated discounts or rebates. The Medigap market, because it's so small, unreliable, and expensive, has attracted very small participation in the Medicare program -- by that I mean, for those who buy a Medigap option with a **prescription drug** benefit. As a consequence, we're utilizing an unreliable, expensive approach that the industry itself has raised major concerns about.

What we would really like to get to is an agreement on the policy. We think that we've moved towards getting closer to an agreement on the principles and the goals of any reforms, and that's not insignificant, because if we can all agree on that, then we believe that there is the possibility for working out a bipartisan consensus on reforms that include a **prescription drug** benefit.

Why don't I close with that, because I think I will just take any questions you have about both the issue itself, the report, and any other issues you have around Medicare reform and the chances for passage this year, which we still think are quite good.

Q Would you define "voluntary"?

SENIOR ADMINISTRATION OFFICIAL: Certainly. A voluntary benefit means that if I, at age 65, become eligible for the Medicare program, I have the choice of opting for a **prescription drug** benefit or not; if I have a retiree health plan, if I'm comfortable with my not having coverage, if I'm comfortable with a Medigap option, I can retain that. But we believe that every Medicare beneficiary should have access to that option at age 65.

We also believe, by the way, that because of the trend in retiree health care plans being dropped by employers, that if someone makes a decision to not have coverage at age 65, that they should have the ability to opt into the Medicare program if their plan is subsequently dropped, which our plan does provide for.

Q Have you had to revise your cost estimates for the President's plan based on the information that you're releasing today?

SENIOR ADMINISTRATION OFFICIAL: No, and it's obviously the Families USA report, but we've had two estimates on the President's plan. We've had the OMB and administration estimate, which is \$195 billion over 10 years -- we need to include the \$35 billion catastrophic. CBO had scored the base benefit, which we scored at \$160 billion -- they scored that at \$150 billion. So they actually are scoring our proposal, at least without the catastrophic option, at slightly less -- \$10 billion less over 10 years than our policy.

Obviously, CBO and OMB have had access to the same type of pricing trends that Families USA has. The findings today don't surprise us. We do believe that if you utilize private negotiating practices, as does the insurance industry, you will have the benefit of rebates and discounts that all private insurers do, and we think the Medicare population should have access to a similar option.

Q So is the difference between the House Republican plan and your plan \$120 billion, or what --

SENIOR ADMINISTRATION OFFICIAL: Their numbers they say is up to \$40 billion over 5 years. They have not released the 10-year numbers, which is quite troubling to us. And the reason why it's quite troubling is that it appears that if you look at the tax cuts assumed in the budget resolution, and you see their unrealistic growth rate assumptions that

they're contemplating, that the tax cuts will eat up all available resources and more, leaving little to nothing for a **prescription drug** benefit in the second five years. And so we want to make sure that one of the answers to the questions we raise is, is it adequately financed for the short-and the long-term, and is it more than an empty promise.

Right now, the Republicans, unlike in the past, the Senate has not released its 10-year numbers. They will, under the budget rules, be required to do so when they actually vote on the budget and we'll have a better sense as to how many resources are available.

But I would say, in terms of your specific question about what else, the only difference is -- I mean, I think that we're encouraged about the principles. We're encouraged that they are saying that they want to dedicate significant resources to this issue. What we're discouraged about is whether or not those resources are adequate, and secondly, the structure of the benefit, which does not achieve the principles. Because if you use a drug-only benefit that is administered by the private insurance industry, who continually and consistently raise concerns about that option, we don't believe that you can say and look into the eyes of all beneficiaries and say that that would be available for all of you, even if it's affordable.

But the second point is, even if it is available in some areas of the country, it won't be affordable because in the first time in their program's history, they are providing direct premium assistance only to 150 percent of poverty. We don't do that with any other benefit in the Medicare program. And our strong feeling is that this isn't the time to change course.

But other than that, we're making progress.

Q At the same time that the President was in the Roosevelt Room, Vice President Gore was in Hartford, Connecticut, and he went with Shirley Kindle, a 65-year-old Social Security recipient, to a pharmacy where she got her prescriptions filled. The druggist made a big show of ringing each one up, and it was like \$506. How much coordination is there between the White House and the Vice President's presidential campaign on an issue like this?

SENIOR ADMINISTRATION OFFICIAL: Well, I can tell you that we don't talk on the political side of it significantly with the Vice President's office. He was aware through the internal process of policy announcements that we were going to be making the announcements. He was briefed on the Families USA report that was going to be released yesterday. And I think this was a -- as I recall, this has been scheduled for a few days, so he knew that we were going to be doing something on **prescription drugs**, and I think he wanted to amplify the message. But it was not something that we say, hey, we're doing this, you should do that. They make their own decisions about what they do in their campaign, and it has very little to do with what we do here, as far as I can tell.

Q Can you walk through the scenario -- you said, chances are quite good for passage this year -- between now and whenever the summer is, June or August, of something actually being signed? How is that going to work? Who is going to compromise? How is that going to come together?

SENIOR ADMINISTRATION OFFICIAL: Well, I think it's important to look at the evolution of where the Republican leadership has gone. We've been talking about the **prescription drug** benefit for years, but in -- and last year no one wanted to talk about this issue at all on that side of the party. They now have moved towards saying they want to move forward to a **prescription drug** benefit that is available to all beneficiaries. I think that's a significant move. It's not -- it's something that should be acknowledged. I think it's important to acknowledge that they're dedicating some significant resources, at least for the short-term.

We believe that just as that has evolved from where they were to where they are today, it's similarly can evolve to a better policy in the future, in the next couple of months. In terms of timing, it's our understanding the Finance Committee is hoping to mark up their legislation -- their Medicare reform legislation -- which is not just a drug benefit only option, but it is a Medicare reform initiative -- sometime later in May. So sometime next month.

If we can get a bipartisan consensus for moving that forward, then we would have a bill on the floor, hopefully sometime in June, that can be debated and amended, and hopefully that will influence the House to move forward as well. If they do, we will still have two months of real good legislative time to get something done this summer.

I think if it doesn't get done this summer, it's going to be more challenging, obviously. But we do believe it is very viable right now. I mean, it is clearly one of the most compelling health policy issues I've seen in a long time, and I think members of both sides understand that we should start addressing it.

Q A financial question. How much does the more optimistic report of the trust fund help you out? In other words, it defers the argument for overall reform before you try to do a drug benefit.

SENIOR ADMINISTRATION OFFICIAL: Well, I think that it gives greater confidence to those who want to provide for a voluntary optional drug benefit, that we can and should do that within the Medicare program. But I don't think in any way it reduces the argument for, or the incentive to have some reforms in the program that make the program more competitive.

And I would just say that, although everyone says it can be either-or, it is -- and I've said this before -- I don't see the Senate Finance Committee reporting out a bill on **prescription drug** benefit only. I think they will be talking about other reforms to the program, and I think with that in mind, we'll see both occurring, mostly because many members, both Democrats and Republicans, think we should have at least a down payment on some reforms. Now, whether it's absolutely comprehensive and everything we want to see or everything that some of the Republicans would want to see, I'm not sure. But I do believe there will be a down payment reform in addition to a Medicare **prescription drug** benefit.

Q On a different issue, when are you going to send an Internet pharmacy proposal to Congress?

SENIOR ADMINISTRATION OFFICIAL: You know, it's my understanding that that legislation has been sent up to the Hill. I don't know if it's been introduced, but it has been sent up. And if I'm wrong on that, I will call you later. But I know it is virtually, if not completely, done, and I had understood it has been conveyed to the Hill -- to the Labor Committee.

Q Why are you so encouraged by what the Republicans have done? After all, you, or Mr. Sperling in the briefing the other day, criticized them for putting forward a pretty measly plan. They've obviously had a lot of time to think about this. Doesn't that suggest to you that maybe it's a political document and not a real step forward?

SENIOR ADMINISTRATION OFFICIAL: Well, I think the principles are a real step forward, but the policies are not. And I don't think that my comments today are in any way inconsistent with what we talked to you about, which is to say that we need to make sure that the policy matches up to the stated goals and principles. Their current policy does not do that. As such, it would be unacceptable.

But I think if you look at this in the context of how their policy positions and their stated public position has evolved over the last several months, that there's no reason to contemplate that that can't

continue to evolve and we can get a strong benefit.

So we tend to be a half-cup full type group over here in the White House, and I think it's because we think that as long as you push for a policy that's based on solid -- has solid grounding, has strong public support, and is long overdue, you have the opportunity to get something as long as you keep pushing, which clearly we will be doing throughout the course of the year.

Q And also, you say that they're not providing enough funding because their budget assumptions are unrealistic and there are too much taxes, but that's their budget. And they're not going to pass another budget for you for **prescription drugs**. How should they address that financing issue if there's not going to be the money for that?

SENIOR ADMINISTRATION OFFICIAL: Well, it's not impossible to amend -- I used to work in the Senate, you're not constrained by law to modify your dedicated stream of dollars. You certainly can do that. It requires 60 votes. So we think that there's a very solid group of Democrats who will provide the vast majority of those votes, and I think that many Republicans are starting to think that they need to move forward on an adequately financed drug benefit.

So I don't think it's precluded at all. And hopefully we'll find out over the next month or two that they will continue to evolve their position to something we can support.

Thank you very much.

END 10:55 A.M. EDT

White House Press Office, 202-456-2100

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April 26, 2000, Wednesday 11:40 AM Eastern Time

**SECTION:** GENERAL NEWS**LENGTH:** 311 words**HEADLINE:** Clinton pushes **prescription drug** benefit**DATELINE:** WASHINGTON, April 26**BODY:**

Again prodding Republicans to add a **prescription drug** benefit for Medicare, President Clinton cited a new report Wednesday that showed the prices of the 50 most common drugs for seniors rose nearly twice the rate of inflation last year.

Clinton squeezed in the plug for his proposal to add the popular benefit at the White House before heading off to North Carolina for another leg of his poverty tour.

With the Democratic congressional leaders at his side, Clinton said the new study by Families USA that showed the need is growing, with the prices of the 50 **prescription drugs** most frequently used by the elderly rising on average by 3.9 percent from January 1999 to January 2000, compared to 2.2 percent for general inflation.

"Today's report shows the burden on seniors is getting worse," Clinton said.

He also jabbed at an alternative Republican proposal, which he said would omit coverage for lower- and middle-income seniors earning from 15,000-50,000 a year, which make up about half of the U.S. citizens in Medicare.

House Democratic leader Dick Gephardt of Missouri was even more blunt. He insisted Republicans on Capitol Hill have yet to prove how they will fund their plan to provide a **prescription drug** benefit, an issue growing in popularity as the election approaches.

"Talk is cheap; **prescription drugs** are not," Gephardt said.

And if Republicans choose to negotiate, he predicted, "We can get a bill done this year -- in fact, this summer."

Daschle said Senate Democrats would soon to put forward their own proposal, one he said was "very similar" to Clinton's. The White House says Republican have proposed including \$40 billion for a **prescription drug** benefit, but their budget resolution dedicates only about half that amount.

Clinton has proposed making the drug coverage available to all 39 million Medicare beneficiaries.

**LANGUAGE:** ENGLISH

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April 26, 2000; Wednesday 2:49 PM, Eastern Time

**SECTION:** Washington - general news**LENGTH:** 665 words**HEADLINE:** Some Drug Prices Top Inflation Rate**BYLINE:** KAREN GULLO**DATELINE:** WASHINGTON**BODY:**

Prices for drugs that older Americans use most often jumped higher than the rate of inflation last year, says an advocacy group's study. President Clinton cited the findings today to promote his proposal to add **prescription drug** coverage to Medicare.

"Seniors living on fixed incomes simply can't cope with these kinds of price increases forever," Clinton said. "That's why we should take action to help them, and do it now."

Clinton and Democratic congressional leaders released the report at the White House to highlight soaring drug prices and call on Congress to pass legislation giving all Medicare beneficiaries coverage for their medicines an idea opposed by Republicans, who say aid should go to the neediest seniors.

Clinton said the GOP proposal does not go far enough. "It would do nothing for those seniors with modest, middle-class incomes between \$15,000 and \$50,000," he said in a Roosevelt Room ceremony flanked by Senate Minority Leader Tom Daschle, D-S.D., and House Minority Leader Dick Gephardt, D-Mo.

"When you are dealing with drug prices increasing two, three times the rate of inflation, the impact is extraordinary, especially for a population that is living on a fixed income," said Ron Pollack, president of Families USA, which commissioned the study. The group, which advocates universal health coverage for all Americans, supports Clinton's drug benefit proposal.

The study shows that wholesale prices for 50 prescriptions frequently used by seniors rose by 3.9 percent last year, faster than the overall rate of inflation at the retail level, which the government reported at 2.7 percent.

Prices for all **prescription drugs** jumped 5.8 percent in 1999, government figures show.

Drugs common to seniors have soared 30 percent on average since 1994, according to the group's study.

Drug industry officials said the report exaggerates drug price increases. A government measure of wholesale prices found that prices for all **prescription drugs** went up only 1.3 percent last year, said Jackie Cottrell, spokeswoman for the Pharmaceutical Research and Manufacturers of America, an industry group.

Families USA zeroed in on medicines most important to seniors to highlight what Pollack says is the need for a broad drug insurance program that will help all elderly Americans who are living longer and whose doctors are increasingly treating with drugs to deal with soaring prices at the pharmacy window.

The study showed the wholesale price for a year's supply of furosemide, a generic used to treat hypertension and congestive heart failure, doubled to \$57 as of January compared to its price a year before.

The cost of a year's supply of Klor-Con 10, used as a potassium replacement, jumped nearly 44 percent to \$286 from \$199, the report said. Yearly price increases for other drugs cited in the report include:

\_Glucophage, a diabetes drug, rose to \$708 from \$661.

\_Procardia, a hypertension drug, increased to \$901 from \$874

\_Premarin, used for estrogen replacement, rose to \$208 from \$186.

Clinton wants to add drug coverage to Medicare as an option for all Americans age 65 or older. Administration officials say rising drug prices are a problem for all seniors and want a broad plan \_ costing \$195 billion over 10 years for 39 million Medicare beneficiaries.

They are locked in a heated debate with congressional Republican leaders who believe drug coverage should go to low-income Americans who need it most. Republicans say there's no reason to give drug benefits to the millions of Medicare beneficiaries who already have some type of coverage through HMOs or retirement plans.

GOP leaders earlier this month unveiled the outlines of a drug proposal calling for private health plans to offer drug benefits and government subsidies to pay drug costs for low-income seniors. Most of the \$40 billion they have earmarked for a five-year overhaul of Medicare would go toward the drug plan, GOP lawmakers said.

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**Statistics**

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## STATISTICS ON PRESCRIPTION DRUGS

- About 40 million people are covered by Medicare (including those over 65 and the disabled of all ages. Because this group is so dependent on medications, about 31 million people a year would benefit from the coverage proposed by the White House. (Drug Benefit Proposed, *Morning Star*, June 30, 1999, pg. 1A).
- The average annual drug expense for seniors was \$637 in 1997. (Need for Drug Plan Doubted, *Augusta Chronicle*, June 30, 1999, pg. A14)
- Nationally, an estimated one in three Medicare recipients pays more than \$500 a year out of pocket for prescriptions. Fourteen percent spend more than \$1,000 and 4 percent more than \$2,000 a year. (Medicare Plan Eases Rx Burden, *Atlanta Journal and Constitution*, June 30, 1999, pg. 1A)
- Senior citizens spend 21 percent of their disposable income health care compared with 8 percent on average for other Americans. (Need for Drug Plan Doubted, *Augusta Chronicle*, June 30, 1999, pg. A14)
- Nearly 80 percent of seniors take at least one pill a day. (Who Will Swallow Medicare's Bitter Pills?, *Time*, July 5, 1999, pg. 39)
- About 78 percent of Medicare beneficiaries have incomes below \$25,000. (Need for Drug Plan Doubted, *Augusta Chronicle*, June 30, 1999, pg. A14)
- The number of medications in development for diseases associated with the elderly has grown from 225 a decade ago to 648 today. (Who Will Swallow Medicare's Bitter Pills?, *Time*, July 5, 1999, pg. 39)
- Spending for prescription drugs in the U.S. has passed \$80 billion annually, increasing by 11 percent to 14 percent every year since 1995. (Border pharmacies lure seniors grappling with increasing drug costs, *Associated Press*, June 1, 1999)
- An estimated 35 percent of Medicare enrollees have no drug coverage. (Really a Huge Issue For Seniors, *Arizona Republic*, June 30, 1999, pg. A1)
- In the past five years, national spending for all prescription drugs has increased almost 60 percent and that paces is expected to continue. (Who Will Swallow Medicare's Bitter Pills?, *Time*, July 5, 1999, pg. 39)
- About 6 million of the nation's 40 million recipients of Medicare are in HMOs. (Medicare HMO Members to See Rise in Drug Costs, *Los Angeles Times*, pg. 6)



- U.S. prices are often twice as much as drugs abroad. For example, the average retail price of the antidepressant Prozac is \$34 a month abroad and \$72 in the U.S. A month's supply of the cholesterol-lowering Zocor is \$44 abroad and as much as \$104 in the United States. (Border pharmacies lure seniors grappling with increasing drug costs, *Associated Press*, June 1, 1999)
- Medigap premiums ranged from \$233 annually for minimal coverage to \$2,205 for comprehensive coverage. (Need for Drug Plan Doubted, *Augusta Chronicle*, June 30, 1999, pg. A14)
- 15 years ago, pharmaceuticals comprised about 5 percent of health care costs. In the next couple of years, they're expected to surpass 20 percent. (Medicare Plan Eases Rx Burden, *Atlanta Journal and Constitution*, June 30, 1999, pg. 1A)
- Managed care companies report their drug costs are climbing an average of 15 percent per year. (Medicare Plan Eases Rx Burden, *Atlanta Journal and Constitution*, June 30, 1999, pg. 1A)
- Medigap policies often pay 50 percent of drug costs up to a maximum payout of between \$1,000 and \$3,000 a year, depending on premium costs. A policy costing \$70 a month at age 65 can cost \$130 a month at age 85. (Really a Huge Issue For Seniors, *Arizona Republic*, June 30, 1999, pg. A1)
- The top five medicines prescribed to patients over the age of 65: 1. Lasix Oral (used for hypertension); 2. Cipro (for infections); 3. Norvasc (for heart disease and hypertension); 4. Lanoxin (for heart failure and heart rhythm disorders); 5. Prednisone Oral (for inflammatory and allergic disorders). (Who Will Swallow Medicare's Bitter Pills?, *Time*, July 5, 1999, pg. 39)
- According to a study done by the minority staff of the Committee on Government Reform, senior citizens in Sonoma County, California pay twice as much, on average, for prescription drugs as do the drug companies' largest customers. (Congresswoman's study elderly overcharged for prescription, *Associated Press*, May 10, 1999).

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Morning Star (Wilmington, NC)

June 30, 1999, Wednesday

SECTION: Front Page; Pg. 1A, 7A

LENGTH: 1078 words

HEADLINE: DRUG BENEFIT PROPOSED; Clinton unveils details on Medicare overhaul

BYLINE: L.A. Times News Service

BODY:

WASHINGTON - President Clinton proposed far-reaching changes Tuesday in the Medicare program, including a new \$ 1,000-a-year prescription drug benefit.

Congressional Republicans signaled they will fight the Clinton plan because two-thirds of the elderly already have some form of prescription coverage. But they indicated their support for a more modest drug benefit.

"Why would you want to make it available to many people who already have it?" asked Senate Majority Leader Trent Lott, R-Miss.

Although the president's plan contains measures to save money for Medicare through competitive bidding and other reforms, the focus of the political debate will be on his proposal to add drug coverage, which would be the biggest new benefit since Medicare was created in 1965.

The president said he plans to use \$ 794 billion from the ballooning budget surplus to extend Medicare solvency through 2027, when millions of baby boomers will be collecting benefits.

The administration believes the issue of prescription drug coverage will have more political appeal to Americans over the age of 65 - who are more likely to vote than members of any other age group - than the abstractions of the budget surplus.

In announcing his Medicare plan at the White House, the president focused primarily on prescription drug coverage.

"The original Medicare law was written at a time when patients' lives were more often saved by scalpels than by pharmaceuticals," Mr. Clinton said. "Many of the drugs we now routinely use to treat heart disease, cancer, arthritis, did not even exist in 1965."

If the president's proposal is approved by Congress, Medicare beneficiaries initially would pay \$ 24 a month for the prescription coverage, starting in the year 2002. There would be a 50 percent co-payment for each prescription, with coverage limited to \$ 2,000 a year for the first two years of the plan. That means a person with \$ 2,000 in yearly drug expenses would pay \$ 1,000 out of pocket, while Medicare pays the rest.

After 2002, the coverage and premiums would rise in stages to an annual maximum of \$ 5,000 in 2008 (with Medicare paying \$ 2,500) and a premium of \$ 44 a month.

The benefit would be free for individuals with incomes less than \$ 11,000 a year and couples with incomes less than \$ 17,000.

About 40 million people are covered by Medicare, including those over 65 and the disabled of all ages. Because this group is so dependent on medications, about 31 million people a year would benefit from the coverage, the White House said. The new program would cost about \$ 118 billion over 10 years.

The premium of \$ 24 a month would be in addition to the current premium of \$ 45.60 a month paid by Medicare recipients for their Part B coverage, which helps pay for doctor bills and home health care.

Politicians from both parties seem to agree prescription drug coverage under Medicare is an idea whose time has come.

But the Republicans and some Democrats prefer the proposal by the Medicare Reform Commission issued earlier this year. That plan called for delivering drug prescriptions through HMOs and managed-care organizations and subsidizing the new drug benefit for low-income beneficiaries. Supporters argue that because most older Americans already have some degree of coverage, either from their former employer or through supplemental insurance, a new universal benefit would be an unreasonable burden on taxpayers.

"If you're adding something for the first time, it's appropriate to look at linking it to incomes, said Sen. John Breaux, D-La., who served as co-chairman of the Medicare commission.

The pharmaceutical industry favors "improving drug coverage for all seniors," but companies are worried that a Medicare benefit could lead to government restrictions on prices. Pharma, the industry's trade association, said it would study the plan and posed a series of eight questions, asking whether Mr. Clinton's proposal would "lead to inevitable price controls on drugs, discouraging life-extending medical research."

With the 2000 campaign season drawing near, the likelihood of a bipartisan deal on prescription drugs seems slim.

"The president's proposal will probably help Medicare reform in the long run, but in the short run I don't think it's going to happen," Tom Scully, president of the Federation of American Health Systems, which represents for-profit hospitals.

"There will be a great debate about Medicare and tax cuts, but in the end it won't come together because the trust really isn't there between the two parties," Mr. Scully said.

For the long run, the biggest financial threat to Medicare comes from the sheer size of the baby boom generation, the 76 million Americans born in the years 1946 through 1964. The president's proposed solution is to use 15 percent

of the anticipated budget surplus, or \$ 794 billion, to bolster the trust fund.

#### Medicare primer

##### PRESCRIPTION DRUGS

\* Establishes a voluntary plan to cover 50 percent of prescription drug costs. The government's share would be up to \$ 1,000 of costs in 2002 and \$ 2,500 in 2008. - The prescription benefit would cost about \$ 24 a month in 2002 and \$ 44 a month by 2008.

\* Beneficiaries with incomes below 135 percent of the poverty level (currently \$ 11,000 for an individual, \$ 17,000 for a couple) would not pay any drug premium or cost sharing.

##### PREVENTIVE CARE

\* Eliminates copayments and deductibles for all preventive services covered by Medicare, including cancer screenings, mammographies and diabetes-management benefits.

##### MEDICARE COMPETITION

\* Gives Medicare new authority to seek competitive prices for services.

\* Requires managed care organizations to offer a package of 'core benefits' which Medicare will cover.

\* Offers beneficiaries an incentive to go into lower cost managed care plans by reducing premiums 75 cents for each dollar below the average amount charged by a plan.

\* Extends provisions of the 1997 Balanced Budget Act that reduce payments to Medicare providers. The provisions are scheduled to expire in 2003.

##### COST SHARING

\* Indexes the \$ 100 deductible for Part B, which covers physicians and related services, for inflation.

\* Adds a 20 percent copayment for laboratory services.

##### MEDICARE BUY-IN

\* Allows people 62 to 65 to 'buy into' the Medicare program for about \$ 300 a month. Displaced workers between 55 and 62 could buy in for \$ 400 a month.

89TH STORY of Level 1 printed in FULL format.

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The Augusta (Ga.) Chronicle

June 30, 1999, Wednesday, FINAL EDITION

SECTION: NEWS, Pg. A14

LENGTH: 756 words

HEADLINE: NEED FOR DRUG PLAN DOUBTED  
CRITICS SAY MOST SENIOR CITIZENS HAVE INSURANCE; CLINTON SUPPORTERS SAY IT'S  
LARGELY INADEQUATE

BYLINE: Robert A. Rankin; Knight Ridder

DATELINE: WASHINGTON

BODY:

Two economic questions lay at the heart of debate Tuesday about President Clinton's plan to greatly expand Medicare and its costs.

First, do most of America's senior citizens really need an expensive new government subsidy to pay for prescription drugs? After all, critics note, about two-thirds already have some prescription-drug subsidy, either from employers or their private insurance.

More fundamentally, is Mr. Clinton's approach to Medicare reform sound economically? The program is projected to go bankrupt in 2015. And 76 million baby boomers begin to retire in 2010, which will force the cost of benefits already promised under current law to skyrocket.

Those inescapable financial and demographic facts led a majority of a bipartisan study commission in March to propose trimming benefits in an effort to curtail future costs.

Now, Mr. Clinton proposes instead to spend an extra \$ 794 billion on Medicare over the next 15 years - and to expand two costly benefits as well:

\* His prescription-drug subsidy would cost an extra \$ 118 billion over 10 years, the White House estimates.

\* He also proposes to eliminate fees such as co-payments and deductibles paid by Medicare beneficiaries for preventive-care services, such as colorectal screening, pelvic exams and prostate-cancer screening. The White House estimated the cost of that change at \$ 3 billion over 10 years.

Liberals cheered, conservatives jeered and economists questioned the numbers.

The biggest number of all - the one that finances Mr. Clinton's expensive new plans - is an extra \$ 1 trillion in surplus revenues that his budget experts trumpeted Monday.

The Augusta (Ga.) Chronicle, June 30, 1999

The White House now expects surpluses of \$ 5.9 trillion to flood into the Treasury over the next 15 years, thanks to America's bountiful economy. That's 20 percent more than expected in February. Mr. Clinton wants to channel \$ 794 billion of it into Medicare.

'It all hinges very heavily on the surplus that has yet to be realized,' summed up Gail Wilensky, who ran Medicare's finances from 1990 to 1992 as head of the Health Care Financing Administration. 'When you count on financing not only existing promises - as well as a large portion of his new promise (for prescription drugs) - by counting on a surplus in the future, that's got to be a high-risk gamble. . . .

'What he's doing is implanting the costs now and hoping the revenues will be there in the future,' Ms. Wilensky said.

'If everything turns out terrific and we have all those surpluses, it may not have been too bad a gamble, but the expenditures will be there regardless,' she said. 'And if there are any hiccups along the way. . . .'

Senate Majority Leader Trent Lott, R-Miss., and Senate Banking Committee Chairman Phil Gramm, R-Texas, led critics on Capitol Hill in focusing on Mr. Clinton's proposed prescription-drug benefit. Why federalize something that two-thirds of senior citizens have now from the private sector, they wondered?

Some 65 percent of senior citizens have private drug insurance coverage, according to the National Center for Policy Analysis, a conservative think tank in Dallas.

The average annual drug expense for seniors was \$ 637 in 1997, the center says, citing data from the U.S. Bureau of Labor Statistics.

But defenders of Mr. Clinton's proposal argue that today's private drug insurance is grossly inadequate. The average senior citizen takes four prescriptions daily and fills an average of 18 prescriptions a year, according to the National Committee to Preserve Social Security and Medicare.

About 78 percent of Medicare beneficiaries have incomes below \$ 25,000.

Medigap premiums ranged from \$ 233 annually for minimum coverage to \$ 2,205 for comprehensive coverage, the Century Foundation reports. Senior citizens spend 21 percent of their disposable income on health care, compared with 8 percent on average for other Americans, it said.

'They have some sort of drug benefit, but it is limited to the point that if they take a couple of expensive drugs, they may wind up paying out of their own pockets. They have very high deductibles,' argued Dr. Sidney Wolfe, director of Public Citizen's Health Research Group, a liberal lobby.

Those who rely on drug insurance from their former employers are under pressure. Many companies are asking retirees to pay more for such benefits, said Craig Copeland, a researcher in this field for the Employee Benefit Research Institute. Many also are canceling such benefits for existing employees.

LANGUAGE: ENGLISH

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The Atlanta Journal and Constitution

June 30, 1999, Wednesday, CONSTITUTION EDITION

SECTION: News; Pg. 1A

LENGTH: 1465 words

SERIES: Home

HEADLINE: Medicare plan eases Rx burden;  
Rural Georgians and the poor would see benefits if Medicare overhaul passes.

BYLINE: Diane Lore, Staff

BODY:

Guthrie Foster, in a black jumper and a khaki broad-brimmed hat, braved the rain Tuesday to stop by King's Drugs in Buckhead. As she stood near rows of bath soaps, heating pads, cards and candles, the 86-year-old praised President Clinton's proposal to change Medicare.

Foster depends on Medicare, the government health care plan for the elderly. She has additional coverage through a Medigap policy that covers expenses such as deductibles or hospital emergency room visits.

But like thousands of other elder Georgians, Foster must pay for her prescriptions, which total about \$ 100 a month for blood pressure and bone medications.

"It seems I just pay and pay and pay," said the Buckhead resident. " Anything that could reduce the cost would be wonderful."

Clinton has proposed that Medicare include a benefit that would split the cost of prescriptions for most senior citizens. Critics say the price to taxpayers would be too high, pointing out that private insurers and public health plans offering such benefits have been struggling to contain costs in recent years.

But the benefit could help many of the 870,000 Georgians who depend on Medicare, although it's unclear to what extent. Already a majority of Medicare recipients receive some type of drug benefit.

Almost 315,000, for example, get up to five prescriptions a month free of charge through Medicaid, the government health plan for the poor. Almost 60 percent have insurance plans through former employers or have joined HMOs, which often require only co-payments of \$ 10 to \$ 15 per prescription.

James Dudley, who qualifies for Medicare, said he pays \$ 250 a month in premiums for drug benefits tied to his former employer's health insurance policy. The premiums allow Dudley, who opposes the Clinton plan, to pay only \$ 12 to \$ 25 per prescription.

But untold thousands of older Georgians --- especially lower middle income and rural seniors --- are shelling out hundreds of dollars every month without any discounts, advocates for the elderly say. And those older patients, experts say, could be greatly helped by the Clinton proposal.

"There are definitely people who have trouble paying for prescriptions," said Ellyn Jeager of the Georgia Council on Aging. "Even if they're not living day-to-day, medications can be very expensive, especially when you're taking five, six or eight a day."

Nationally, an estimated one in three Medicare recipients pays more than \$ 500 a year out of pocket for prescriptions. Fourteen percent spend more than \$ 1,000 and 4 percent spend more than \$ 2,000 a year, according to the American Association of Retired Persons.

In Georgia, one of the 10 poorest states for the elderly, almost one in four is classified as making less than 135 percent of the federal poverty level, which is \$ 8,200 for one person. That means many fail to qualify for Medicaid, yet are unable to afford private plans or out-of-pocket expenses for medication.

"It is not uncommon here to see the little old lady in front of you (in a pharmacy) ask whether she can buy four or five pills instead of the entire prescription," said Mary Jo Nickodem, state coordinator for the AARP Vote program. "It's not hard to figure out what happens if they can't take the medication they need. We end up with greater health costs and higher hospitalization bills."

Steve Anderson, owner of King's Drugs, said his elderly customers often complain about the high price of their prescriptions. Many are on fixed incomes and can't afford newer medications that work better and cost more.

Additionally, one in three Georgians live in rural areas and don't have access to HMOs and other health plans that include drug benefits. Only seven insurers offer Medicare HMOs in Georgia, with most being concentrated in urban centers like metro Atlanta, according to the state's Insurance Department.

Under the federal plan outlined Tuesday, beneficiaries could receive up to \$ 1,000 a year for purchasing medication, with the premium for drug coverage starting at about \$ 24 a month. It would then climb in subsequent years to about \$ 44 a month. The government would pay half the cost of the prescription drugs, with a maximum cap of \$ 2,000. Anything above \$ 2,000 would be paid by the beneficiary.

Seniors could dovetail the benefits with other plans they might pick or already have. The advantage, advocates say, is many elderly people would no longer be driven to high-priced insurance plans merely for the drug benefits.

But critics say Clinton's plan would prove too costly, particularly as baby boomers age.

"Fifteen years ago, pharmaceuticals comprised about 5 percent of health care costs. In the next couple of years, they're expected to surpass 20 percent," said Charles "Chip" Cangialose, a health economist in Emory University's Center

for Clinical Evaluation Sciences. "They're becoming a much larger part of the health care dollar . . . and if you add the benefit, you're going to add --- dramatically --- to the cost" of Medicare.

Some studies say it would cost \$ 15 billion to \$ 25 billion a year to add drug benefits to Medicare, according to the American Association of Health Plans in Washington. Managed care companies report their drug costs are climbing an average of 15 percent per year, said Karen Ignagni, spokeswoman for the association.

"Clearly, drug costs are problematic," said Charlie Harmon, vice president for public affairs at Blue Cross/Blue Shield of Georgia, which offers Blue Choice Platinum, the Medicare HMO that has the largest membership in the state. "We are very concerned about the president's initiative."

Georgia's Medicaid program has also seen a steady increase in costs. Last year, more than \$ 119 million was spent for drugs on 110,000 Georgia residents 65 and older who also qualified for Medicare.

Experts aren't sure whether Medicaid costs would dip if Medicare offered a drug benefit. But in some cases, Medicaid might pick up the cost of the premiums for drug benefits offered through Medicare, if the president's proposal is adopted.

In the meantime, many seniors --- and their doctors --- said they will wait to learn more.

"We always want our patients to get and take the medications they need," said Dr. John Ed Fowler, president of the Medical Association of Georgia. " But we'll need to see whether this proposal conflicts with reality."

Waiting in line at King's Drugs, Foster, a former dean of the Atlanta College of Art, agreed, saying she would like to know more details about the plan before giving her full support.

"I'm not having to pick between food and my medications," Foster said. "But I certainly can't be extravagant, either."

He could save hundreds a year

Starr Miller says he'd like to see Congress approve President Clinton's proposal for Medicare to cover a larger share of prescription drug costs. He figures it'd save him hundreds of dollars a year.

The 78-year-old former college administrator, who lives in Newnan, receives Medicare, but also purchases a supplementary Medigap health plan that covers up to \$ 500 a year in drug costs.

But that's not nearly enough.

"There have been months when my wife and I have had to spend \$ 450 to \$ 500 for drugs," says Miller. "We both have a good number of needs in that area."

Miller, who has had coronary bypass surgery, takes cholesterol medication that "runs \$ 1.50 a pill, and that's just one of the many, many we have to

take."

His wife, Luine, 63, takes medication for arthritis, but isn't yet eligible for Medicare.

"It's been a real struggle for us, it really has," she says. "I bought some medicine today that was \$ 5 a pill. Between the two of us, it's a lot."

--- Bill Hendrick

Monthly medicine tab runs only \$ 10

Mortimer Cox, 80, doesn't see much personal benefit to President Clinton's Medicare plan to pick up more of the tab for prescription drugs. The Iwo Jima veteran says he pays \$ 10 for every prescription, but only has one a month --- a blood pressure medication.

"It isn't a problem with me, I can pay," says Cox, an Atlanta resident. " But I know some people who pay \$ 150 or much more a month."

Cox says his Social Security benefits cover his medical costs and he doesn't have a supplemental plan, also called a Medigap policy.

Cox opted to have \$ 565 a year in Social Security payments earmarked to pay the premiums for a Medicare health maintenance organization --- requiring him to pony up only a \$ 10 copayment for his prescriptions, with his insurer picking up the balance of the cost.

Now retired, Cox said his wife's medical needs are covered by a state merit system retirement plan, which is sufficient.

"We don't have anything to complain about," he says.

--- Bill Hendrick

GRAPHIC: Photo

"It seems I just pay and pay and pay," Buckhead retiree Guthrie Foster says of her prescription costs. She said she would welcome the savings offered by President Clinton's plan. / JEAN SHIFRIN / Staff

Photo

Starr Miller / BEN GRAY / Staff

Photo

Mortimer Cox

LOAD-DATE: June 30, 1999

25TH STORY of Level 1 printed in FULL format.

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Time

July 5, 1999

SECTION: NATION; Pg. 39

LENGTH: 906 words

HEADLINE: Who Will Swallow Medicare's Bitter Pills?;  
The next political battle suddenly swings into sight: covering ever more costly prescription drugs

BYLINE: John Dickerson

BODY:

Lorene Chandler's day begins with a pale green plastic tray and a glass of water. Popping the top of one of the tray's compartments, each marked for a day of the week, she pours out a handful of pills. Capoten, for blood pressure, comes first, on an empty stomach, and then come nine others, with coffee and orange juice and her Grape-Nuts cereal. Like many seniors, Chandler, 79, takes part in another regimen at the end of each month: she gets a ride from her home in Corrigan, Texas, to the drugstore where she sometimes pays as much as \$ 300 to keep her trays--she has a second one for bedtime doses--filled with Atenolol, Imipramine, Norvasc and other drugs. When she is done, much of her Social Security check is gone. "There's not very much left for food," she says. "But growing up during the Depression, it learned me how to save on groceries."

What you have just read is not a political ad--at least not yet. But by the end of the summer, Chandler may well have film crews in her living room. She and the nearly 40 million other Medicare recipients whose drug bills are not covered by the government's health plan for the elderly will be at the center of a high-profile joust between the President and Republicans. Both sides plan to introduce some kind of prescription-drug benefit into the Medicare system while retrofitting the 34-year-old program to keep it from collapse. Even before Clinton could formally announce his plan, scheduled for this week, the Republicans attacked his proposed premium increase as a tax hike, labeling the whole plan another sneaky attempt at government control of health care. Many Democrats are spoiling for a fight, hoping a messy display might win back the hearts of seniors who embraced the G.O.P. in the past two elections.

Nearly 80% of seniors take at least one pill a day, according to a recent survey. The number of medications in development for diseases associated with the elderly has grown from 225 a decade ago to 648 today. The increased number of prescriptions and the rising cost per pill mean seniors are on a treadmill of ever increasing expenditures. In the past five years national spending for all prescription drugs increased almost 60%. That pace is expected to continue. As seniors become more dependent on these remedies, they are also subjecting themselves to the increasing cost of the medicines. While only a third of

Time, July 5, 1999

Medicare recipients are completely without drug coverage of any kind, many of those who buy supplemental insurance through former employers, Medicaid, HMOs or Medigap must still pay a stiff part of their drug costs.

Medicare was a treacherous battlefield before anyone suggested a new entitlement. Most experts agree that adding items and fundamentally reforming Medicare will require some kind of sacrifice by beneficiaries, either paying higher premiums or delaying the eligibility age. But suggesting such reforms may carry a high political price. "There are some in both parties who want the election to be based on whose fault it is we did nothing about Medicare," says Democratic Senator John Breaux, whose yearlong Medicare commission failed to come to consensus largely over the issue of how much coverage to provide for drugs. Says Breaux: "Republicans want to blame Democrats for how badly the system works, and Democrats want to say that Republicans are cutting your benefits."

For many Democrats, it will be tempting to dangle cheaper prescription drugs to win back elderly voters who were once a fundamental part of their voting base. Exit polls after the 1998 election show that elderly voters picked G.O.P. candidates by 55% to 45%. In polls measuring the 2000 presidential race, Al Gore trails George W. Bush by 20 to 30 points with a group of voters who tend to pick Reagan rather than F.D.R. as their political hero. Strategists from both parties suggest that a reason for the shift may be recent headlines. As one Democratic puts it, "When it's about Social Security and Medicare, we win. When the debate is about Monica, we lose."

Republicans read the same polls and are prepared to pry seniors and the Democrats further apart with the G.O.P.'s own plan, which they have yet to design but which they promise will cover the poor and acutely ill. With strong backing by drug manufacturers, most in the G.O.P. will fight any plan to provide a universal benefit of the kind Clinton is suggesting, as well as other measures being offered by Democrats that would lower the cost of prescription drugs for Medicare patients. The only way such a system could work, they say, is through price controls set by Washington bureaucrats--and that, the G.O.P. argues, would ultimately drain drug companies of the profits that allow them to finance research that leads to even better products.

The proposals will not make downing those pills any easier for Lorene Chandler, but they can do something to keep her trip to the pharmacy from leaving her with almost no money for anything else in her life.

BOX STORY:

DRUGS FOR THE ELDERLY Here are the top five medicines prescribed to patients over the age of 65:

1. LASIX ORAL (furosemide) Used for hypertension
2. CIPRO (ciprofloxacin hydro chloride) For infections
3. NORVASC (amlodipine besylate) For heart disease and hypertension
4. LANOXIN (digoxin) For heart failure and heart rhythm disorders
5. PREDNISONE ORAL (prednisone) For inflammatory and allergic disorders

536TH STORY of Level 1 printed in FULL format.

The Associated Press State & Local Wire

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June 1, 1999, Tuesday, PM cycle

SECTION: State and Regional

LENGTH: 806 words

HEADLINE: Border pharmacies lure seniors grappling with increasing drug costs

BYLINE: MINERVA CANTO, Associated Press Writer

DATELINE: TIJUANA, Mexico

BODY:

Nearly \$ 200 worth of prescription drugs bulged from Barry Villafana's blue backpack after he left Farmacia Americana, one of a dozen drugstores drawing elderly Americans and retirees across the border.

He drives 480 miles roundtrip from his Santa Barbara home to Tijuana every two months to stock up on medicine for his high cholesterol and arthritis.

"The amount of drugs I could have bought with this money back home would barely fill a fanny pack," said Villafana, a 69-year-old retired factory worker.

Americans have long crossed into Mexico for inexpensive car repairs, discount clothes and cheap liquor. Now they're driving over the border to fill prescriptions, too, most notably the elderly. The issue is money.

"The reason we're seeing a growing trend for seniors to go across the border to purchase their prescriptions is that it costs a lot less," said state Assemblyman Martin Gallegos, who chairs the Assembly Committee on Health.

"They're trying every way possible to cut the out-of-pocket expenses for their medications," he said.

Older Americans tend to need more prescription drugs to treat chronic or long-term illnesses, but for those relying on Social Security, they often are the least able to afford them. Medicare does not pay for drugs. And although border officials have no figures on the visits, they say the trend appears to be growing.

Former teacher's aide Dottie Mason, 68, began making the 280-mile roundtrip from her Los Angeles home to border pharmacies two years ago after the cost of her diabetes medication increased so much she had trouble paying her bills.

"I was trying to do some hard scrunching with the numbers, mailing payments

until the last possible minute," Mason said.

Spending for prescription drugs in the United States has passed \$ 80 billion annually, increasing by 11 percent to 14 percent every year since 1995, according to a recent federal study. Analysts say the reasons range from an aging population using more medicine, more new drugs on the market that have no generic competition and a lack of price controls in the United States.

U.S. prices are often twice as much as drugs abroad, according to the advocacy group Public Citizen. For example, the average retail price of the antidepressant Prozac is \$ 34 a month abroad and \$ 72 in the United States; a month's supply of cholesterol-lowering Zocor is \$ 44 abroad and as much as \$ 104 in the United States.

"People who are weak and defenseless are the ones who are hurt the most," said Alan Sager, a Boston University health care economist. "Virtually no American is wealthy enough to be pharmaceutically secure to afford the medications."

Those looking for a bargain don't have to go far.

Colorful, billboard-size signs written in English lure people to a string of pharmacies just 100 yards from the border, touting the best deals on everything from Viagra to Prozac. A five-minute taxi ride takes visitors to Avenida Revolucion, a major thoroughfare, where pharmacies advertise medications for diabetes, arthritis, heart conditions and other illnesses.

Pharmacy workers wearing white coats stand at the entrance of shops, beckoning customers to come inside. Most pharmacies are small, tidy shops lined wall-to-wall with hundreds of small boxes of pharmaceuticals and a few toiletries. Mexican and American customers of all ages rub elbows, but Americans usually buy in bulk.

"These older people are good customers," said Florencio Maria Cortez, a clerk at one border pharmacy. "We know they come back regularly and so sometimes we even have their packages waiting for them."

Getting back home with the medications is also easy since U.S. law allows Americans to buy foreign-made drugs as long as they are prescribed by a U.S. doctor, intended for personal use and transported in the original container, U.S. Customs spokesman Vince Bond said.

"Those agents don't give me any hassles. I have all my paperwork in order," said 73-year-old Ernest Ruffino of San Juan Capistrano, patting his jacket pocket as he left a pharmacy where he bought medicine to treat his arthritis.

But Gallegos warned that cheaper drugs may also mean cheaper quality, creating a health risk for the consumer.

"Is that what we want in the United States? And especially because we can't provide a program to meet their needs as society?" asked Gallegos. He is sponsoring a bill that would offer prescription drugs at wholesale prices to Medicare recipients whose health insurance doesn't cover prescriptions.

Villafana fits the profile.

He's a senior covered by Medicare and lives on a fixed income of about \$ 800 a month, money barely enough to cover his \$ 500 rent and other bills.

"Believe me, this isn't any sightseeing trip," Villafana said, minutes before hailing a cab to the border, where he parked his car.

LANGUAGE: ENGLISH

LOAD-DATE: June 1, 1999

82ND STORY of Level 1 printed in FULL format.

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THE ARIZONA REPUBLIC

June 30, 1999 Wednesday, Final Chaser

SECTION: FRONT; Pg. A1

LENGTH: 770 words

HEADLINE: 'REALLY A HUGE ISSUE FOR SENIORS'

BYLINE: By Kerry Fehr-Snyder, The Arizona Republic; Republic writers Ryan Konig and Richard C. Black contributed to this article.

BODY:

Virginia Williams isn't sure what ails her or how the drugs she takes soothe her aches and pains.

But she can tell you how much she pays: \$800 to \$900 a year for herself and her husband.

The annual outlay puts a dent in the Williamses' fixed income, and for that reason, she favors President Clinton's proposal to extend Medicare coverage to prescription drugs.

"They're just too expensive," said the 85-year-old retiree, demonstrating outside a central Phoenix pharmacy how she keeps track of her running prescription bill on the back of a paper bag.

Clinton's proposal would provide some pain relief by offering cheaper prescription drugs for seniors. Targeted are the 15 million senior and disabled Americans who have no supplemental private insurance coverage for drugs.

"Prescriptions are really a huge issue for seniors," said Mary Lynn Kasunic, executive director of the Area Agency on Aging, a senior advocacy group in Maricopa County.

Kasunic estimated the agency receives up to 25 calls a week from seniors who are struggling to pay their prescription drug bills. Many say they are forced to drive to Mexico to buy generic drugs because they can't afford brand-name drugs sold in Arizona and other states.

Even those who buy supplemental coverage often run into trouble when they hit their annual payout cap. Some often switch from insurance plan to insurance plan to get around the problem.

If the president's proposal is approved by Congress, Medicare beneficiaries would have the option of paying \$24 a month for the prescription coverage, starting in the year 2002.

The plan would pay for half of all drug costs up to \$2,000 a year. The premium would rise to \$44 a month and cover half of all drug costs up to \$5,000

when the program was fully implemented by 2008.

The prescription benefit would be free for lower income beneficiaries - individuals with incomes up to \$11,000 a year and couples with incomes up to \$17,000.

The prescription premiums and limited coverage are an improvement for many. Some seniors report having to choose between filling their prescriptions and covering other basic costs of living, such as food.

"I've heard of some people who are buying medicine rather than food because they don't have the money for both," said Betty Barron, a longtime Youngtown resident. "This proposal would certainly help an awful lot of elderly people."

Fred Shabec of Sun City West also said he favors the proposal because prescription drug bills have created a hardship for seniors like himself on fixed incomes.

"Between my wife and myself, I wouldn't be a bit surprised if we are pushing \$200 a month for prescriptions," he said. "I've got one prescription alone that runs \$110, and that one's only good for 30 days at a time."

The No. 1 prescribed drug for those over age 55 is Lasix, used to treat heart disease and other problems, according to IMS Health, a pharmaceutical market research group. For all senior age groups, Premarin, an estrogen replacement medicine to treat osteoporosis, is the most frequently prescribed drug, according to the journal American Druggist.

Drugs to treat hypertension and depression also are common among the elderly.

While some drugs are prescribed for minor ailments, many are a matter of life and death.

Jim Guidry, director of clinical pharmacy at Desert Samaritan Medical Center in Mesa, said extending Medicare coverage could help solve the problem of patients refusing to take prescribed drugs because they can't afford them.

"So much of the drug costs right now is out of pocket," he said. "I think people would be more likely to have their prescription filled."

Although Guidry did not know what percentage of prescribed drugs go unfilled, he said, "I would be surprised if half of them are ever taken."

That's been Bernice Sherman's story for the past year.

A former schoolteacher, Sherman said she cannot afford the \$200 monthly tab for drugs needed to treat her high cholesterol and gastrointestinal problems.

"I just don't have enough money for them," she said. After food, rent, utilities and other costs, Sherman said, there's not much left from her \$900 in Social Security and retirement income.

"I'm supposed to be taking other things, too," she said. "But these are the ones that are really important."

Sherman said she is frustrated by the current system and worries about her health.

"It seems to me that prescription drugs are a necessity," she said. "It doesn't do me any good to even go to a doctor. In fact, I had an appointment yesterday and canceled it because I know I can't afford the medicine."

GRAPHIC: Chart

Color photo by Dave Cruz/The Arizona Republic

; \* Many Medicare beneficiaries now receive prescription benefits through privately purchased supplemental insurance known as 'Medigap' policies or through health maintenance organizations. However, an estimated 35 percent of Medicare enrollees have no drug coverage.

\* 'Medigap' policies often pay 50 percent of drug costs up to a maximum payout of between \$1,000 and \$3,000 a year, depending on premium costs. A policy costing \$70 a month at age 65 can cost \$130 a month at age 85.

Virginia Williams says she pays \$800 to \$900 per year in prescriptions for herself and her husband. The 85-year-old favors President Clinton's Medicare drug proposal.

LANGUAGE: ENGLISH

LOAD-DATE: July 3, 1999

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Los Angeles Times

July 1, 1999, Thursday, Home Edition

SECTION: Part A; Page 6; National Desk

LENGTH: 659 words

HEADLINE: MEDICARE HMO MEMBERS TO SEE RISE IN DRUG COSTS;  
HEALTH CARE: EXPECTED INCREASES IN 2000 ADD URGENCY TO THE DEBATE IN CONGRESS  
OVER INCLUDING PRESCRIPTIONS IN THE TRADITIONAL PROGRAM.

BYLINE: ROBERT A. ROSENBLATT, TIMES STAFF WRITER

DATELINE: WASHINGTON

BODY:

Millions of senior citizens enrolled in Medicare health maintenance organizations will face significantly higher costs next year for prescription drugs.

Today is the deadline for HMOs to file their coverage plans for 2000, and they have told federal officials to expect increases in co-payments and deductibles for drugs and tighter spending limits on annual benefits.

Prices of popular drugs are growing at the rate of 10% to 20% a year, far above the rate of inflation, and companies have said they cannot maintain their bottom line without a price increase.

The industry also has said that the government is not paying enough to care for Medicare beneficiaries in HMOs, an assertion disputed by the federal government. "We always said we could compete and do better than the traditional program for less, but we never said we could work miracles," one industry source said.

The price hikes for drugs, which would take effect Jan. 1, could add a new urgency to the debate in Congress over whether to include prescription drug coverage in the traditional Medicare program. Clinton called Tuesday for a new \$ 1,000-a-year benefit, to be financed with a \$ 24 monthly premium paid by beneficiaries. But even if enacted, the Clinton plan would not start until 2002.

At Kaiser Permanente, California's largest HMO, co-payments for drugs, which currently range between \$ 5 and \$ 15 for each prescription, depending on a beneficiary's plan, will increase by \$ 3 to \$ 5, a spokesman said Wednesday. Co-payments for doctor visits, which are set at \$ 5 or \$ 10, depending on the region, will rise by \$ 5.

Los Angeles Times July 1, 1999, Thursday,

PacifiCare Health Systems, parent of Secure Horizons, the nation's biggest Medicare HMO, warned Wednesday that because of rising drug costs "co-payments may be increased and annual limits may be established."

Some HMO executives are saying privately that "prescription benefits are too generous and are not sustainable from a business perspective," said Nancy-Ann DeParle, director of the Health Care Financing Administration, which runs the Medicare program. The executives are complaining that HMO costs are "rising and their revenues aren't," she said.

HMO members give up traditional Medicare--and the option of choosing any doctor or hospital--and enroll in a network with a fixed list of doctors in return for coverage of drugs and eyeglasses.

About 6 million of the nation's 40 million recipients of Medicare, which serves those 65 and older and the disabled of all ages, are in HMOs. The Medicare HMOs are particularly strong in Los Angeles and Orange counties. About 35% of Medicare recipients in California have joined HMOs, far above the national rate of 15%.

Secure Horizons, for instance, has 991,000 members nationwide, including 611,000 in California. It dominates the Southern California market, with 155,000 members in Los Angeles County and 55,000 in Orange County.

Another big player, Health Net, is taking a close look at the drug benefit, reviewing co-payments and deductibles, said Lisa Haines, a spokeswoman for Foundation Health Systems, the parent of Health Net. Drug prices "are one of the biggest drivers of health care costs," she said.

Cigna Healthcare spokesman Howard Drescher said that his company is looking at trimming its prescription drug benefit. "One of the things we're looking at is drugs--prescription costs are a driving factor in medical costs, not the only thing, but an important one."

Kaiser said that some beneficiaries can expect higher costs in addition to the increased drug expenses. Of the 750,000 Kaiser Medicare members, about 45,000 will have to pay a premium beyond what they now pay for Medicare to belong to the HMO. For most it would be no more than \$ 1 to \$ 10 per month, but for about 15,000 beneficiaries, it could be more than \$ 50 per month, said Matthew Schiffgens, a Kaiser spokesman.

\*

Times staff writer Alissa J. Rubin contributed to this story.

LANGUAGE: English

LOAD-DATE: July 1, 1999

581ST STORY of Level 1 printed in FULL format.

The Associated Press State & Local Wire

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May 10, 1999, Monday, AM cycle

SECTION: State and Regional

LENGTH: 749 words

HEADLINE: Congresswoman's study says elderly overcharged for prescriptions

BYLINE: By WILLIAM SCHIFFMANN, Associated Press Writer

DATELINE: SAN FRANCISCO

BODY:

Senior citizens in Sonoma County pay more than twice as much, on average, for prescription drugs as do the drug companies' largest customers, according to a study released Monday by Rep. Lynn Woolsey.

At a news conference, the Petaluma Democrat called it a "national disgrace."

But analysts said the results of the study weren't surprising.

"I don't think that is anything different from any other business," said Hemant Shah, a drug company analyst with HKS & Co. inc. Warren, N.J. "Retail customers always pay more than wholesale customers. That's not much of a surprise."

Woolsey said the recently introduced Prescription Drug Fairness for Seniors Act (HR 664) would make drug companies sell prescription drugs to pharmacies at the lowest price any federal government agency pays, or at the company's best price, as defined in the Social Security Act.

The study was done by the minority staff of the Committee on Government Reform. It looked at the five drugs most often sold to seniors in the county - Zocor, to combat high cholesterol, from Merck; Procardia XL, from Pfizer Inc., for heart problems; Prilosec, an ulcer treatment from Astra/Merck; Zoloft, a Pfizer drug for depression; and Norvasc, another Pfizer drug, used to treat high blood pressure.

The most dramatic difference was in Zocor, where most favored customers - large insurance companies, health maintenance organizations and the federal government - paid \$ 34.80 for a quantity of the medication, compared to \$ 118.86 for the same amount purchased at retail by seniors.

Similar conditions exist in neighboring Marin County, the report said.

## The Associated Press State &amp; Local Wire

"It appears that drug companies are engaged in a form of 'discriminatory' pricing that victimizes those who are least able to afford it," the report says. "Large corporate, governmental and institutional customers with market power are able to buy their drugs at discounted prices.

"Drug companies then raise prices for sales to seniors and others who pay for drugs themselves to compensate for these discounts to the favored customers."

The report agreed that some differential could be expected. But it said the difference was far greater than for other products checked; while the drug differential was an average of 145 percent, other products averaged about 22 percent. The other products were not identified.

It also pointed out the elderly often have the hardest time paying for prescriptions, because Medicare doesn't cover prescription drugs except while a patient is hospitalized and an estimated 35 percent of Medicare recipients don't have outside insurance covering prescriptions.

"The report is comparing wholesale prices that include a federally mandated discount to a retail price," said Brian McGlynn, a spokesman for Pfizer. "That sort of comparison is just invalid.

"It's unfortunate that some citizens, for one reason or another, do not have insurance coverage or other ways to purchase the medicine they need," he added. He said Pfizer has several programs which provide prescription medicine for free to those who meet certain standards, including a lack of insurance coverage and income guidelines.

He said the company gave about \$ 91 million worth of prescription drugs to nearly 500,000 people enrolled in the programs in 1998.

"The methodology is seriously flawed," said Jeff Trehitt, a spokesman for the Pharmaceutical Research and Manufacturers of America, a Washington, D.C.-based industry group. "It exaggerates the difference between prices paid by senior citizens to pharmacies and prices paid to manufacturers by buyers who have government-mandated rebates."

He said the report doesn't account for the fact that 25 percent of the price differential comes from wholesale and retail markups, which are not under the control of drug companies.

He also said the study "appears to be biased" in that it looks at some of the most expensive medicines used by senior citizens instead of looking at a wide range of drugs, including those with lower prices.

"Ironically, the bill (supported by Woolsey) would not help most of the targeted individuals," he said. "If heart medicine is \$ 100 a month, taking the government 24 percent rebate and negotiating might bring you down to \$ 70. But the sad fact is that people who can't afford \$ 100 a month probably can't afford \$ 70 either."

The solution, he said, is to get them covered under an improved Medicare program.

A telephone call to Merck seeking comment was not returned.

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**Real People**

Divider Title: \_\_\_\_\_

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THE INDIANAPOLIS STAR

July 6, 1999 Tuesday CITY FINAL EDITION

SECTION: CITY/STATE; Pg. C01

LENGTH: 673 words

HEADLINE: Clinton's Medicare drug plan has some seniors worried

BYLINE: DOUG SWORD; THOMAS P. WYMAN; STAFF WRITERS

BODY:

It's come to the point where Mayme Anderson pays more for health care and prescription drugs than she does for rent.

That makes for quite a financial squeeze on someone trying to get by on less than \$ 700 a month from Social Security.

Anderson is among the seniors who hope President Clinton's plan to add a drug benefit to Medicare will win support in Congress and provide them with needed relief.

The 83-year-old Indianapolis woman spends \$ 70 a month on prescriptions.

Without help, Anderson said, the annual increases in her Medicare supplemental insurance and the ever-escalating costs of drugs would push her to make some tough choices.

"Like I told my doctor," she says, "I'll have to cut down on what I pay for groceries."

The president's proposal calls for the government to pay for half of a Medicare patient's prescription drug costs. Initially, the plan is limited to a \$ 1,000 benefit; to enroll, seniors would have to pay \$ 24 a month.

The monthly premium would rise gradually, reaching \$ 44 in 2008, while the maximum benefit would increase to \$ 2,500 a year.

Other seniors, though, don't share Anderson's optimism that the plan would be helpful.

At a lunch program last week, some Downtown seniors at Barton Apartments were worried about the Clinton proposal. They'd come for the free lunch provided by Second Helpings to stretch their meager incomes.

Several of the seniors there rely on Medicaid, the health care program for the poor which pays for the prescription drugs that

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The Virginian-Pilot (Norfolk, VA)

July 6, 1999, Tuesday, FINAL EDITION

SECTION: FRONT, Pg. A1

LENGTH: 1286 words

HEADLINE: MEDICINE OR FOOD? ;  
CLINTON'S MEDICARE PROPOSALS DRAW ATTENTION TO PREDICAMENT OF OLDER PEOP;  
WITH LIMITED INCOMES, EXPENSIVE PRESCRIPTIONS

BYLINE: BY ELIZABETH SIMPSON, STAFF WRITER

BODY:

Each month, 77-year-old Ann Hagerty of Portsmouth faces a tough choice: buy groceries, or buy \$ 200 worth of medications for her arthritis, allergies and high blood pressure.

'Next month is groceries because I haven't been to the grocery store in two months,' Hagerty said.

Put Hagerty down for a great, big 'in favor of' regarding the proposal by President Clinton to expand Medicare to pay for prescription drugs.

Cecilia Gray, 78, of Norfolk also can vouch for the high cost of drugs. The medication she takes for atypical tuberculosis runs \$ 350 a month, 80 percent of which is paid by her supplemental health insurance. She puts the balance on credit cards, and it's building up fast.

She's less sure about Clinton's proposal. She doesn't trust him and worries about the long-term security of Medicare. 'If they don't watch it, it's going to run dry,' she said.

Gray is a so-called 'notch baby' - people born between 1917 and 1926 who, because of changes in the benefits formula, receive smaller Social Security checks than those born before or after. She thinks that injustice needs to be corrected before Medicare is expanded.

While opinions vary on the president's plan to revamp the federal insurance for the elderly and disabled, everyone can agree on this: The cost of prescription drugs has skyrocketed over the past decade, and it's hitting the older population hardest.

Regardless of whether Clinton's proposal becomes reality, the high-profile debate has highlighted a number of factors and trends.

Older people are more likely to be on a fixed income, and also are more likely to need prescription drugs on an ongoing basis for chronic illnesses such

as heart disease, arthritis, lung disease and diabetes. They're also apt to need several different drugs to treat multiple health problems.

"It's not uncommon for someone to be on five or six medications," said Dr. William N. Hovland, a geriatrician with the DePaul Medical Group. "As we go through life, we collect things - lung disease, heart disease, diabetes, hypertension. Those people can spend \$ 500 or \$ 600 a month. Unless you're wealthy, that's a lot of money."

People are also living longer, which means they need the medicines over longer periods of time. And new and improved drugs come out every day, with higher price tags.

"Some of these drugs are so new, the cheaper, generic equivalents have not come out," Hovland said. "And it's not a matter of the drug industry gouging the public. These are drugs that are expensive to investigate and develop."

Many Medicare recipients have supplemental insurance policies to cover expenses that Medicare won't. But not all of them cover prescription drugs, and those that do won't always cover the entire cost. Plus, the more coverage supplemental insurance provides, the greater the cost of monthly premiums.

The people most likely to get caught in a financial bind are those who can't afford supplemental insurance but who make too much to qualify for assistance programs such as Medicaid - insurance for the poor - and food stamps.

Hagerty said she gets \$ 537 a month from Social Security. Out of that comes her rent, electric bill, telephone bill and food. A supplemental insurance plan through Medicaid helps her with deductibles and co-payments for doctor visits, but not with prescription drugs.

In the months when she buys food, she puts her five prescription drugs on her credit card. "But that puts me in debt. I don't go anywhere, no dinner out. This is the only recreation I get," she said, sitting at a table at Senior Station, a senior center at Tower Mall.

Clinton's proposal would cost seniors \$ 24 a month and pay for half of all drug costs up to \$ 2,000 a year. The premium would rise to \$ 44 a month and cover half of all drug costs up to \$ 5,000 by 2008. The benefit would be free for low-income seniors.

But the plan also has elements that make some seniors wary. Patients would have to start paying 20 percent of the cost of medical laboratory tests. And the amount of money people would have to pay each year before the program began covering their doctor bills would rise to keep pace with inflation.

Still, Hagerty believes that the proposal could help her.

"I wouldn't mind paying a percentage," Hagerty said about her drug bills. "It would still be cheaper than \$ 200 a month."

Jennifer Rebbly, a Jewish Family Services case manager who helps older people manage their finances, said Hagerty's situation is common, and that many seniors pay even more for their medications.

Many of those people face no-win choices. They may try to make their medications last longer by reducing the dosage, hence losing the desired effect of the drugs. They may stop taking them altogether at times, which lands them in the emergency room or hospital. Or they buy the drugs and skimp on food.

"They'll buy frozen dinners that are high in salt and sugar, so then their blood pressure shoots up, or their cholesterol level goes up," Reby said. Some save money by staying at home, which can be isolating.

Some cities and foundations have special funds to help people pay for prescription drugs. Carla Alligood helps people through a program called Pharmacy Connection, which was established by the Virginia Health Care Foundation.

She works from the office of Senior Services of Southeastern Virginia, and helps older people fill out forms to send to pharmaceutical companies. Most of those companies have funds to help indigent patients pay for drugs.

The paperwork, however, can be daunting. A typical case, Alligood said, can take five or six hours of work. Each company has a different form, and different requirements for applying, all of which can discourage many people from completing the paperwork.

"Some of the people have as many as 20 medications," Alligood said. "The average is eight to 10."

So far this year, Alligood has helped about 150 people fill out the forms, and more are waiting. "I have a desk full of requests that need to be finished," she said. "People come in every day."

John Skirven, executive director of Senior Services of Southeastern Virginia, hopes the president's plan will result in some kind of relief for these seniors.

A letter on Skirven's desk reminds him every day of the urgency of the situation. The letter was written by a 70-year-old Portsmouth woman in April. She mailed it to President Clinton, and the letter was forwarded to Skirven in May.

The woman said she receives a pension of \$ 705 a month. She was diagnosed with congestive heart failure in March, and will probably be on medications the rest of her life. Her doctor gave her as many free samples of her medication as he could, but she ran out and couldn't afford to pay for more. She called Social Services, but she was over the income limit for assistance. Then she missed three doctor appointments because she couldn't afford the taxi fare.

The letter ended with: "Thank you Mr. President for reading this and for any help you can give."

Senior Services linked the woman with the Pharmacy Connection and also provided transportation to her doctor appointments.

Skirven knows that for every letter he gets, there are other people who are reluctant to ask for help, and others on long waiting lists to get free rides to

The Virginian-Pilot (Norfolk, VA), July 6, 1999

doctors, and free drug prescriptions.

And while politicians argue about the Medicare expansion plan on Capitol Hill, many people will quietly struggle to buy the medications they need.

"I'm worried that politics will get in the way of policy," Skirven said. "And that older people's health care will become a political football."

GRAPHIC: THE PROBLEM;

Older people, who are more likely to be on a fixed income, are more likely to need several different prescription drugs regularly for chronic illnesses.; The costs can reach \$ 600 a month, and because many of the drugs are new, cheaper generic equivalents aren't available.;

(Color Photo);

MARK P. MITCHELL;

The Virginian-Pilot;

Each month, Ann Hagerty, 77, of Portsmouth must decide whether to buy groceries or medications for her arthritis, allergies and high blood pressure.

LOAD-DATE: July 8, 1999

534TH STORY of Level 1 printed in FULL format.

The Associated Press State & Local Wire

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June 2, 1999, Wednesday, PM cycle

SECTION: State and Regional

LENGTH: 574 words

HEADLINE: Drug legislation pushed by Mississippi congressman

BYLINE: By GINA HOLLAND, Associated Press Writer

DATELINE: JACKSON, Miss.

BODY:

Expensive medicines keep Lois Shaw in poverty, and a new study shows many other Mississippi senior citizens are in the same situation.

Shaw, who has arthritis, emphysema and osteoporosis, said her government assistance does not pay for all her prescription drugs.

"When you have to pay \$ 70-something here and \$ 50-something there, what do you have left? There's none left for food," said the 66-year-old Shaw, who hopes Congress will be able to help.

U.S. Rep. Ronnie Shows, D-Miss., said a government study of drug prices at 10 pharmacies in his 4th District shows older Mississippians are paying high drug prices. Shows supports legislation in Washington that would give senior citizens the same price break that volume buyers, such as the government and insurance companies, receive from drug makers.

Jeff Trehitt, a spokesman for Washington-based Pharmaceutical Research and Manufacturers of America, said the proposal would limit future research and may not help many aging Mississippians. He said Congress should instead expand drug coverage through Medicaid.

Shows said his office gets calls regularly from senior citizens overwhelmed by drug costs.

"These so-called golden years they're supposed to have, they're not actually having," Shows said. "It's a shame people have to decide between buying food and the necessities to live and prescription medicine."

Jackson pharmacist Randy Calvert said customers routinely ask how much a prescription will cost, then say "give me \$ 10 worth, give me \$ 20 worth."

With Calvert's drug store as a backdrop, Shows on Tuesday unveiled results of

the congressional study which found much higher prices charged to regular customers compared to those with "favored" status, such as HMOs, that buy in bulk.

The drugs were priced at pharmacies in Brookhaven, Ellisville, Jackson, Laurel, McComb, Natchez, Petal, and Seminary.

The price differential ranged from 218 percent higher for Zocor, a drug for cholesterol, to 96 percent higher for Zoloft, used to treat depression. Other drugs in the survey were Procardia XL, for heart problems; Norvasc, for high blood pressure; and Prilosec for ulcers.

The study found that the Mississippi pharmacies had "relatively small markups" and generally charged the manufacturers' suggested price.

"This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers," the study said.

But Trewhitt said the survey was limited to only a few higher-priced drugs and "compares apples to oranges."

Shows did not know when Congress may vote on requiring drug companies to give the same price reductions to senior citizens.

"It's something that's long overdue," said Calvert, a pharmacist for nearly 20 years.

Shaw, who takes seven medicines routinely and more at other times, said that could save her more than \$ 100 a month.

"I'd buy a new dress. I'm wearing slippers now because I can't afford a pair of good shoes that fit. I'd have a hey day in the grocery store," said Shaw, a retiree.

James Blunt, 77, who lives in the same government-subsidized housing complex in Clinton as Shaw, hasn't been to the doctor in years because he says he can't afford medicines. He spends \$ 300 a month on his wife's drugs.

"I've got to cut corners," said Blunt, who said he watches the family grocery budget closely. "I may want a steak, but I get a pack of bologna."

LANGUAGE: ENGLISH

LOAD-DATE: June 2, 1999

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The Associated Press State & Local Wire

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May 29, 1999, Saturday, BC cycle

ADVANCED-DATE: May 28, 1999, Friday, BC cycle

SECTION: State and Regional

LENGTH: 691 words

HEADLINE: Lawmakers push for cheaper prescriptions

BYLINE: AP MISSOURI PANORAMA, By LIBBY QUAID, Associated Press Writer

DATELINE: WASHINGTON

BODY:

For 64-year-old Wendall Dowdy of Dexter, Mo., his income can't keep up with climbing prescription drugs costs.

After open-heart surgery a dozen years ago, Dowdy said, his insurance premiums went through the roof. And his policies don't cover such expenses as his recent blood-check and physical at his Cape Girardeau, Mo., doctor's office, a visit that cost about \$ 100, he said.

"It's a shame a guy has to work all his life and then eats up his savings for medication," said Dowdy, a retired maintenance supervisor and church janitor. "I know there have got to be a lot of people like me out there."

Those folks, lawmakers say, have inspired legislation aimed at trimming prescription drug prices by changing laws that force American consumers to pay more than do Canadians, Mexicans and residents of other countries.

It's illegal for distributors or pharmacists to travel abroad and return with lower-cost drugs; only pharmaceutical companies may re-import such products originally made in the United States. Supporters say the bill would allow pharmacies, wholesalers and distributors to buy drugs at lower prices and then pass along the savings.

The measure is the best idea thus far to lower costs without illegally fixing prices, said Rep. Jo Ann Emerson, a Republican sponsor of the bill whose district includes Dowdy's hometown. Other sponsors include Democratic Rep. Marion Berry, D-Ark., and Independent Rep. Bernie Sanders of Vermont.

"Missourians are landlocked," Emerson said. "We just don't have the same

opportunities to cross into Canada or Mexico to access more affordable prescription drugs."

While it's illegal for Americans to do so, congressional staffers said, U.S. Customs Service agents often allow travelers to return to the United States with small amounts of prescription drugs for personal use.

The pharmaceutical industry, however, says the idea raises a host of safety concerns and fixes a symptom, not the problem. Changing the law would allow into this country drugs that may have been tampered with, mislabeled or improperly stored or transported.

"What is most needed to improve access to medicine is drug coverage," said Jackie Cottrell, spokeswoman for the Pharmaceutical Research and Manufacturers of America. The best way to do that, she said, is by expanding drug coverage in a Medicare system that relies on the private sector to generate competition and choice.

The trade group also argues the bill would open the door to medicines that are not yet approved by the Food and Drug Administration.

But Emerson argues, "there are plenty of safeguards actually within the law today."

In addition to logging hundreds of letters from constituents about expensive prescriptions, Emerson said she has ample personal experience, too: Her mother recently had a lung biopsy and can't afford her prescriptions, either.

Luckily, she said, her insurance policy covered medication when her late husband, longtime Rep. Bill Emerson, was undergoing chemotherapy for lung cancer. He died in 1996.

Elderly folks from Berry's northeast Arkansas district, which borders Missouri, have written him about high drug costs, too.

"I am writing to you to tell you that I am 67 years old and I only get \$ 348 Social Security a month and by the time I pay my supplement insurance, I don't have enough to live on," wrote Mary Ann Jones of Mountain View, Ark.

"My prescription bills run around \$ 400 month and I have to work to pay them."

Berry, a licensed pharmacist, said: "American medicine is not a free-market situation. It's not like buying milk or bread or gasoline. We don't have that kind of choice."

The lawmakers provided data showing the average Medicare beneficiary will spend \$ 942 this year on prescription drugs. Senior citizens receiving only Social Security get about \$ 780 each month, the lawmakers said.

On a Social Security income of about \$ 1,200 each month, Dowdy and his wife pay more than \$ 300 for prescription drugs and another \$ 350 or so for Dowdy's insurance.

"What really hurts is everything keeps coming up, but our Social Security

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The Associated Press State & Local Wire

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June 1, 1999, Tuesday, AM cycle

SECTION: State and Regional

LENGTH: 607 words

HEADLINE: Drug legislation pushed by Mississippi congressman

BYLINE: By GINA HOLLAND, Associated Press Writer

DATELINE: JACKSON, Miss.

BODY:

Lois Shaw's wardrobe tells the story of a woman with big medical bills and little spare change.

Shaw, who said she hasn't bought a new dress in the 1990s and wears secondhand bedroom slippers, has arthritis, emphysema and osteoporosis, among other things. Her government assistance does not pay for all her prescription drugs.

"When you have to pay \$ 70-something here and \$ 50-something there, what do you have left? There's none left for food," said the 66-year-old Shaw, who hopes Congress will be able to help.

U.S. Rep. Ronnie Shows, D-Miss., said a new study of drug prices at 10 pharmacies in his 4th District shows older Mississippians are paying exorbitant drug prices.

Drug companies, not the pharmacies, are responsible, according to the study.

Shows supports legislation in Washington that would give senior citizens the same price break that volume buyers, such as the government and insurance companies, receive from drug makers.

Jeff Trehwitt, a spokesman for Washington-based Pharmaceutical Research and Manufacturers of America, said the proposal would limit future research and may not help many aging Mississippians. He said Congress should instead expand drug coverage through Medicaid.

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"These so-called golden years they're supposed to have, they're not actually having," Shows said. "It's a shame people have to decide between buying food and



the necessities to live and prescription medicine."

Jackson pharmacist Randy Calvert said customers routinely ask how much a prescription will cost, then say "give me \$ 10 worth, give me \$ 20 worth."

With Calvert's drug store as a backdrop, Shows on Tuesday unveiled results of the congressional study which found much higher prices charged to regular customers compared to those with "favored" status, such as HMOs, that buy in bulk.

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The study found that the Mississippi pharmacies had "relatively small markups" and generally charged the manufacturers' suggested price.

"This indicates that it is drug company pricing policies that appear to account for the inflated prices charged to older Americans and other customers," the study said.

But Trewhitt said the survey was limited to only a few higher-priced drugs and "compares apples to oranges."

Shows estimates the legislation, which is just being debated, could save elderly Mississippians up to 50 percent in their out-of-pocket drug expenses.

"It's something that's long overdue," said Calvert, a pharmacist for nearly 20 years.

Shaw, who takes seven medicines routinely and more at other times, said that could save her more than \$ 100 a month.

"I'd buy a new dress. I'm wearing slippers now because I can't afford a pair of good shoes that fit. I'd have a hey day in the grocery store," said Shaw, a retiree from the arts and crafts business.

James Blunt, 77, who lives in the same government-subsidized housing complex in Clinton as Shaw, hasn't been to the doctor in years because he says he can't afford medicines. He spends \$ 300 a month on his wife's drugs.

"I've got to cut corners," said Blunt, who said he watches the family grocery budget closely. "I may want a steak, but I get a pack of bologna."

LANGUAGE: ENGLISH

LOAD-DATE: June 1, 1999

Medicare doesn't cover.

It was the \$ 100-a-month price tag for pills to treat her ulcers that pushed Birtie Richardson into the Medicaid program in the first place. If Clinton's plan passes, she wonders if she'll lose her Medicaid eligibility and will have to pay for the expensive drugs again.

"They pay \$ 50 and you pay \$ 50, that ain't helping at all," she said.

"Mine's already taken care of" by Medicaid, Mary Tyler said of her prescriptions, which include drugs to manage her diabetic condition.

So the White House plan could make her situation worse instead of better if it affects Medicaid eligibility, said Tyler, 60, who became eligible for Medicare because of her disability.

Those might not be unrealistic fears.

"There's so much unknown at this point," said Andrew Stoner, spokesman for the Indiana Family and Social Services Administration, which oversees the state's Medicaid program.

Republicans, Democrats and interest groups will be fighting about the details of the proposal, and depending on what comes from that tussle, the Barton residents could be justified in their fears, he said.

For poorer seniors, Medicare provides the primary benefits and then Medicaid kicks in to pick up costs not covered.

The Barton residents' question about how Clinton's plan would effect Medicaid eligibility is one that doesn't seem to have been answered yet, said Vicki F. Perry, vice president and general manager of Maxicare Indiana, which serves seniors through its Max 65plus plan.

"That's a very interesting question," she said.

The president's proposal comes at a time when health plans that supplement Medicare coverage are trimming their drug benefits. But the industry's reaction to escalating drug costs and profit pressures varies across the country, Perry said.

In the Midwest, the trend has been to increase premiums for the benefit, she said.

"Senior citizens do need relief because the cost of medication is going up exponentially, but that's because we're getting better and better medicines," Purdue University pharmacologist Charles O. Rutledge said.

Those high costs explain why Northside resident David Bonner

likes Clinton's plan. The 76-year-old said he doesn't spend anything on prescription drugs now, but that could change.

"I've talked to so many people around my age who have to have medicine every day (for) the rest of their lives," he said.

"I need nothing now, but who knows, beginning tomorrow, I might. "

GRAPHIC: COLOR PHOTO; UNCERTAINTY:Mary Tyler, 60, says the president's proposal could make her situation worse instead of better.; PATTY ESPICH

LOAD-DATE: July 07, 1999

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THE ARIZONA REPUBLIC

June 30, 1999 Wednesday, Final Chaser

SECTION: FRONT; Pg. A1

LENGTH: 770 words

HEADLINE: 'REALLY A HUGE ISSUE FOR SENIORS'

BYLINE: By Kerry Fehr-Snyder, The Arizona Republic; Republic writers Ryan Konig and Richard C. Black contributed to this article.

BODY:

Virginia Williams isn't sure what ails her or how the drugs she takes soothe her aches and pains.

But she can tell you how much she pays: \$800 to \$900 a year for herself and her husband.

The annual outlay puts a dent in the Williamses' fixed income, and for that reason, she favors President Clinton's proposal to extend Medicare coverage to prescription drugs.

"They're just too expensive," said the 85-year-old retiree, demonstrating outside a central Phoenix pharmacy how she keeps track of her running prescription bill on the back of a paper bag.

Clinton's proposal would provide some pain relief by offering cheaper prescription drugs for seniors. Targeted are the 15 million senior and disabled Americans who have no supplemental private insurance coverage for drugs.

"Prescriptions are really a huge issue for seniors," said Mary Lynn Kasunic, executive director of the Area Agency on Aging, a senior advocacy group in Maricopa County.

Kasunic estimated the agency receives up to 25 calls a week from seniors who are struggling to pay their prescription drug bills. Many say they are forced to drive to Mexico to buy generic drugs because they can't afford brand-name drugs sold in Arizona and other states.

Even those who buy supplemental coverage often run into trouble when they hit their annual payout cap. Some often switch from insurance plan to insurance plan to get around the problem.

If the president's proposal is approved by Congress, Medicare beneficiaries would have the option of paying \$24 a month for the prescription coverage, starting in the year 2002.

The plan would pay for half of all drug costs up to \$2,000 a year. The premium would rise to \$44 a month and cover half of all drug costs up to \$5,000

when the program was fully implemented by 2008.

The prescription benefit would be free for lower income beneficiaries - individuals with incomes up to \$11,000 a year and couples with incomes up to \$17,000.

The prescription premiums and limited coverage are an improvement for many. Some seniors report having to choose between filling their prescriptions and covering other basic costs of living, such as food.

"I've heard of some people who are buying medicine rather than food because they don't have the money for both," said Betty Barron, a longtime Youngtown resident. "This proposal would certainly help an awful lot of elderly people."

Fred Shabec of Sun City West also said he favors the proposal because prescription drug bills have created a hardship for seniors like himself on fixed incomes.

"Between my wife and myself, I wouldn't be a bit surprised if we are pushing \$200 a month for prescriptions," he said. "I've got one prescription alone that runs \$110, and that one's only good for 30 days at a time."

The No. 1 prescribed drug for those over age 55 is Lasix, used to treat heart disease and other problems, according to IMS Health, a pharmaceutical market research group. For all senior age groups, Premarin, an estrogen replacement medicine to treat osteoporosis, is the most frequently prescribed drug, according to the journal American Druggist.

Drugs to treat hypertension and depression also are common among the elderly.

While some drugs are prescribed for minor ailments, many are a matter of life and death.

Jim Guidry, director of clinical pharmacy at Desert Samaritan Medical Center in Mesa, said extending Medicare coverage could help solve the problem of patients refusing to take prescribed drugs because they can't afford them.

"So much of the drug costs right now is out of pocket," he said. "I think people would be more likely to have their prescription filled."

Although Guidry did not know what percentage of prescribed drugs go unfilled, he said, "I would be surprised if half of them are ever taken."

That's been Bernice Sherman's story for the past year.

A former schoolteacher, Sherman said she cannot afford the \$200 monthly tab for drugs needed to treat her high cholesterol and gastrointestinal problems.

"I just don't have enough money for them," she said. After food, rent, utilities and other costs, Sherman said, there's not much left from her \$900 in Social Security and retirement income.

"I'm supposed to be taking other things, too," she said. "But these are the ones that are really important."

Sherman said she is frustrated by the current system and worries about her health.

"It seems to me that prescription drugs are a necessity," she said. "It doesn't do me any good to even go to a doctor. In fact, I had an appointment yesterday and canceled it because I know I can't afford the medicine."

GRAPHIC: Chart

Color photo by Dave Cruz/The Arizona Republic

; \* Many Medicare beneficiaries now receive prescription benefits through privately purchased supplemental insurance known as 'Medigap' policies or through health maintenance organizations. However, an estimated 35 percent of Medicare enrollees have no drug coverage.

\* 'Medigap' policies often pay 50 percent of drug costs up to a maximum payout of between \$1,000 and \$3,000 a year, depending on premium costs. A policy costing \$70 a month at age 65 can cost \$130 a month at age 85.

Virginia Williams says she pays \$800 to \$900 per year in prescriptions for herself and her husband. The 85-year-old favors President Clinton's Medicare drug proposal.

LANGUAGE: ENGLISH

LOAD-DATE: July 3, 1999

76TH STORY of Level 1 printed in FULL format.

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The Washington Post

July 1, 1999, Thursday, Saturday, Final Edition

SECTION: A SECTION; Pg. A10

LENGTH: 847 words

HEADLINE: Medicare Drug Plan Applauded; Clinton Tells Seniors 'We Have the Money'

BYLINE: William Claiborne, Washington Post Staff Writer

DATELINE: CHICAGO, June 30

BODY:

President Clinton took his Medicare reform proposals on the road today, telling 350 cheering senior citizens that "no American should have to choose between fighting infection and fighting hunger."

In a pitch aimed at Congress as much as to the outwardly grateful seniors gathered in an ornate hall in Chicago's downtown Cultural Center, Clinton said, "This is not a political issue anywhere in America, and it should not be a political issue in Washington."

He said his aim is to start giving older Americans federal help in buying prescription drugs and change the way private health plans compete for elderly patients in a way that seniors can afford and "constructed in a way that America can afford."

Clinton made his remarks during his first stop in a daylong Midwest swing that combined policy initiatives with political fund-raising. Clinton also watched four innings of a Chicago Cubs game at Wrigley Field, where he met with Sammy Sosa after the slugger hit his 30th home run of the year.

The most enthusiastic response to the Medicare speech came when Clinton outlined his plan for providing beneficiaries with prescription drug coverage. Under the plan, recipients would pay a \$ 24 monthly premium in 2002, increasing to \$ 44 by 2008. In exchange, the government would pay half the cost of drugs up to a limit beginning at \$ 1,000 and eventually rising to \$ 2,500.

Clinton said the the most depressing aspect of the Medicare system is aged beneficiaries having to choose between medicines that prolong their lives and the essentials that sustain their quality of life.

He said he was moved by the narrative of Hanna Bratman, a 79-year-old Chicago widow and asthma sufferer who told him that the inhalers upon which she depends for easy breathing are not covered by Medicare. Bratman said she spends \$ 2,800

a year -- 10 percent of her annual income -- on asthma medication.

"The Medicare program we came to rely on is not there for us," Bratman said. "Most seniors would be happy to pay a modest premium for drug coverage."

The prescription drug plan also drew praise from those sitting in the audience, including Epperson Bond, 76, a retired Veterans Administration research chemist. Before Clinton's speech, she said: "I'm for it 100 percent because it will provide prescription drugs for those who have to choose between buying food and buying medicine."

Linda Esposito, a pharmacist from Cicero, Ill., who specializes in geriatric medicine, described how some patients are forced to hoard their drugs and stretch out the doses longer than their prescriptions call for in order to make ends meet.

"These people literally fall between the cracks," Esposito said. "Having to watch people make those kinds of decisions is extremely hard."

Clinton said that because of an expected \$ 99 billion budget surplus this fiscal year and a booming economy, there is an "unprecedented opportunity" to strengthen Medicare, which he said would be bankrupt by 2015 without reforms. All told, Clinton wants to tap \$ 794 billion in projected surpluses over the next 15 years to strengthen the program.

"The sooner you deal with these issues the easier it is," the president said. He said his plan would extend Medicare's solvency to 2027, long enough to take in almost the entire baby boom generation.

"If we were creating Medicare today, no one would ever consider not having a prescription drug benefit," Clinton said. "We have the money. This is simply a matter of choice."

Back in Washington, the basic idea of helping make medicine more affordable has widespread support, but health policy experts are giving mixed reviews to the specific approach the White House has in mind.

While the administration believes that much of the drug coverage could be paid for through savings elsewhere in the program, Gail Wilensky, who chairs a council that advises Congress on Medicare policy, said it is risky for Clinton to rely partly on anticipated budget surpluses. "No matter how you slice and dice it, this is a new entitlement . . . that has some questionable financing in the future," said Wilensky, a former administrator of the agency that runs Medicare.

On the other hand, economist Robert D. Reischauer, a senior fellow at the Brookings Institution, praised the plan as "bringing the Medicare benefit package into the 20th century as we enter the 21st century." In fact, Reischauer said, Clinton's proposal does not go as far as most private insurance policies for younger Americans because it includes no limit on how much patients with particularly large pharmaceutical bills would have to pay out of pocket.

Tonight, Clinton attended a \$ 5,000-a-head fund-raising dinner for 100 Democratic supporters at the Lincoln Park home of telecommunications executive Lewis Manilow and his wife, Susan.

Staff writer Amy Goldstein in Washington contributed to this report.

President Clinton said the prescription drug plan for Medicare "is not a political issue anywhere in America, and it should not be a political issue in Washington."

GRAPHIC: PH, ,AFP/PAUL J. RICHARDS

LANGUAGE: ENGLISH

LOAD-DATE: July 01, 1999

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June 30, 1999, Wednesday, CONSTITUTION EDITION

SECTION: News; Pg. 1A

LENGTH: 1465 words

SERIES: Home

HEADLINE: Medicare plan eases Rx burden;  
Rural Georgians and the poor would see benefits if Medicare overhaul passes.

BYLINE: Diane Lore, Staff

BODY:

Guthrie Foster, in a black jumper and a khaki broad-brimmed hat, braved the rain Tuesday to stop by King's Drugs in Buckhead. As she stood near rows of bath soaps, heating pads, cards and candles, the 86-year-old praised President Clinton's proposal to change Medicare.

Foster depends on Medicare, the government health care plan for the elderly. She has additional coverage through a Medigap policy that covers expenses such as deductibles or hospital emergency room visits.

But like thousands of other elder Georgians, Foster must pay for her prescriptions, which total about \$ 100 a month for blood pressure and bone medications.

"It seems I just pay and pay and pay," said the Buckhead resident. " Anything that could reduce the cost would be wonderful."

Clinton has proposed that Medicare include a benefit that would split the cost of prescriptions for most senior citizens. Critics say the price to taxpayers would be too high, pointing out that private insurers and public health plans offering such benefits have been struggling to contain costs in recent years.

But the benefit could help many of the 870,000 Georgians who depend on Medicare, although it's unclear to what extent. Already a majority of Medicare recipients receive some type of drug benefit.

Almost 315,000, for example, get up to five prescriptions a month free of charge through Medicaid, the government health plan for the poor. Almost 60 percent have insurance plans through former employers or have joined HMOs, which often require only co-payments of \$ 10 to \$ 15 per prescription.

James Dudley, who qualifies for Medicare, said he pays \$ 250 a month in premiums for drug benefits tied to his former employer's health insurance policy. The premiums allow Dudley, who opposes the Clinton plan, to pay only \$ 12 to \$ 25 per prescription.

But untold thousands of older Georgians --- especially lower middle income and rural seniors --- are shelling out hundreds of dollars every month without any discounts, advocates for the elderly say. And those older patients, experts say, could be greatly helped by the Clinton proposal.

"There are definitely people who have trouble paying for prescriptions," said Ellyn Jaeger of the Georgia Council on Aging. "Even if they're not living day-to-day, medications can be very expensive, especially when you're taking five, six or eight a day."

Nationally, an estimated one in three Medicare recipients pays more than \$ 500 a year out of pocket for prescriptions. Fourteen percent spend more than \$ 1,000 and 4 percent spend more than \$ 2,000 a year, according to the American Association of Retired Persons.

In Georgia, one of the 10 poorest states for the elderly, almost one in four is classified as making less than 135 percent of the federal poverty level, which is \$ 8,200 for one person. That means many fail to qualify for Medicaid, yet are unable to afford private plans or out-of-pocket expenses for medication.

"It is not uncommon here to see the little old lady in front of you (in a pharmacy) ask whether she can buy four or five pills instead of the entire prescription," said Mary Jo Nickodem, state coordinator for the AARP Vote program. "It's not hard to figure out what happens if they can't take the medication they need. We end up with greater health costs and higher hospitalization bills."

Steve Anderson, owner of King's Drugs, said his elderly customers often complain about the high price of their prescriptions. Many are on fixed incomes and can't afford newer medications that work better and cost more.

Additionally, one in three Georgians live in rural areas and don't have access to HMOs and other health plans that include drug benefits. Only seven insurers offer Medicare HMOs in Georgia, with most being concentrated in urban centers like metro Atlanta, according to the state's Insurance Department.

Under the federal plan outlined Tuesday, beneficiaries could receive up to \$ 1,000 a year for purchasing medication, with the premium for drug coverage starting at about \$ 24 a month. It would then climb in subsequent years to about \$ 44 a month. The government would pay half the cost of the prescription drugs, with a maximum cap of \$ 2,000. Anything above \$ 2,000 would be paid by the beneficiary.

Seniors could dovetail the benefits with other plans they might pick or already have. The advantage, advocates say, is many elderly people would no longer be driven to high-priced insurance plans merely for the drug benefits.

But critics say Clinton's plan would prove too costly, particularly as baby boomers age.

"Fifteen years ago, pharmaceuticals comprised about 5 percent of health care costs. In the next couple of years, they're expected to surpass 20 percent," said Charles "Chip" Cangialose, a health economist in Emory University's Center

for Clinical Evaluation Sciences. "They're becoming a much larger part of the health care dollar . . . and if you add the benefit, you're going to add --- dramatically --- to the cost" of Medicare.

Some studies say it would cost \$ 15 billion to \$ 25 billion a year to add drug benefits to Medicare, according to the American Association of Health Plans in Washington. Managed care companies report their drug costs are climbing an average of 15 percent per year, said Karen Ignagni, spokeswoman for the association.

"Clearly, drug costs are problematic," said Charlie Harmon, vice president for public affairs at Blue Cross/Blue Shield of Georgia, which offers Blue Choice Platinum, the Medicare HMO that has the largest membership in the state. "We are very concerned about the president's initiative."

Georgia's Medicaid program has also seen a steady increase in costs. Last year, more than \$ 119 million was spent for drugs on 110,000 Georgia residents 65 and older who also qualified for Medicare.

Experts aren't sure whether Medicaid costs would dip if Medicare offered a drug benefit. But in some cases, Medicaid might pick up the cost of the premiums for drug benefits offered through Medicare, if the president's proposal is adopted.

In the meantime, many seniors --- and their doctors --- said they will wait to learn more.

"We always want our patients to get and take the medications they need," said Dr. John Ed Fowler, president of the Medical Association of Georgia. " But we'll need to see whether this proposal conflicts with reality."

Waiting in line at King's Drugs, Foster, a former dean of the Atlanta College of Art, agreed, saying she would like to know more details about the plan before giving her full support.

"I'm not having to pick between food and my medications," Foster said. "But I certainly can't be extravagant, either."

He could save hundreds a year

Starr Miller says he'd like to see Congress approve President Clinton's proposal for Medicare to cover a larger share of prescription drug costs. He figures it'd save him hundreds of dollars a year.

The 78-year-old former college administrator, who lives in Newnan, receives Medicare, but also purchases a supplementary Medigap health plan that covers up to \$ 500 a year in drug costs.

But that's not nearly enough.

"There have been months when my wife and I have had to spend \$ 450 to \$ 500 for drugs," says Miller. "We both have a good number of needs in that area."

Miller, who has had coronary bypass surgery, takes cholesterol medication that "runs \$ 1.50 a pill, and that's just one of the many, many we have to

take."

His wife, Luine, 63, takes medication for arthritis, but isn't yet eligible for Medicare.

"It's been a real struggle for us, it really has," she says. "I bought some medicine today that was \$ 5 a pill. Between the two of us, it's a lot."

--- Bill Hendrick

Monthly medicine tab runs only \$ 10

Mortimer Cox, 80, doesn't see much personal benefit to President Clinton's Medicare plan to pick up more of the tab for prescription drugs. The Iwo Jima veteran says he pays \$ 10 for every prescription, but only has one a month --- a blood pressure medication.

"It isn't a problem with me, I can pay," says Cox, an Atlanta resident. " But I know some people who pay \$ 150 or much more a month."

Cox says his Social Security benefits cover his medical costs and he doesn't have a supplemental plan, also called a Medigap policy.

Cox opted to have \$ 565 a year in Social Security payments earmarked to pay the premiums for a Medicare health maintenance organization --- requiring him to pony up only a \$ 10 copayment for his prescriptions, with his insurer picking up the balance of the cost.

Now retired, Cox said his wife's medical needs are covered by a state merit system retirement plan, which is sufficient.

"We don't have anything to complain about," he says.

--- Bill Hendrick

GRAPHIC: Photo

"It seems I just pay and pay and pay," Buckhead retiree Guthrie Foster says of her prescription costs. She said she would welcome the savings offered by President Clinton's plan. / JEAN SHIFRIN / Staff

Photo

Starr Miller / BEN GRAY / Staff

Photo

Mortimer Cox

LOAD-DATE: June 30, 1999

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Copyright 1999 Times Mirror Company  
Los Angeles Times

July 1, 1999, Thursday, Home Edition

SECTION: Part A; Page 4; National Desk

LENGTH: 536 words

HEADLINE: CLINTON PITCH ON MEDICARE A HIT WITH SENIORS

BYLINE: JAMES GERSTENZANG, TIMES STAFF WRITER

DATELINE: CHICAGO

BODY:

President Clinton pitched his Medicare overhaul plan Wednesday to an easy audience--a group of senior citizens--as he began a campaign to win political support for his proposal.

He framed the debate as one of choices over how best to spend the fruits of a booming economy.

Under the president's plan, \$ 794 billion of the nation's anticipated budget surplus would be earmarked to provide prescription drugs and make other changes in Medicare. "We can afford this," he said. "If this is not done, it is because somebody made a different decision to do something else with the money."

That "somebody," in this case, would be Congress, where Republicans hold a majority. Some Republicans in Congress oppose the drug benefit because, they say, two-thirds of the elderly already are covered by some form of prescription insurance.

Clinton's proposal, unveiled Tuesday, is built around the prescription drug benefit, which initially would pay for as much as \$ 1,000 in pharmaceuticals each year. It would infuse the program with cash from the budget surplus to keep it solvent through 2027 and would seek to cut costs by imposing competitive bidding and other reforms.

Under Clinton's plan, Medicare beneficiaries would pay \$ 24 a month for the prescription coverage when it goes into effect in 2002. A 50% co-payment would be charged for each prescription. Thus, someone whose yearly drug expenses are \$ 2,000 would pay \$ 1,000 for those drugs, while Medicare would pay the rest.

The coverage and premiums would increase in stages to an annual maximum of \$ 5,000 in 2008. Medicare would pay up to \$ 2,500, and the monthly premium would be \$ 44.

Los Angeles Times July 1, 1999, Thursday,

There would be no premium charged to individuals with annual incomes below \$ 11,000 and couples with incomes of less than \$ 17,000.

Hanna Bratman, a 79-year-old widow from Chicago, spelled out for Clinton the difference prescription coverage would make for her.

Her white hair forming a halo barely visible behind the presidential lectern she used as she introduced him, Bratman said that Medicare paid for her late husband's heart-bypass surgery and other health care needs. But when it comes to the three inhalers on which she is dependent for treatment of asthma, she said, "I'm on my own."

"I have to pay for it, and, Mr. President, I want to tell you, it is expensive," she said. Each year, she said, she spends \$ 2,800 on the medications--10% of her income.

"My husband and I worked hard all our lives. We saved. We scrimped. We did the right things," she said, to murmurs of recognition and support from the audience. Now, she said, "the Medicare program we've come to rely on is not there for us."

Clinton, mentioning Bratman frequently during the half-hour speech he gave after her introduction, predicted that, as drug prices rise and private insurers drop drug coverage programs, about 15 million elderly people will have no prescription coverage.

"This is not the way to honor people after a lifetime of work and good citizenship," he said. "No American should have to choose between fighting infections and fighting hunger, between skipping doses and skipping meals. . . . We are now prosperous enough to do better than that."

LANGUAGE: English

LOAD-DATE: July 1, 1999

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Copyright 1999 The Austin American-Statesman  
Austin American-Statesman

June 29, 1999, Tuesday

SECTION: Metro/State; Pg. B1

LENGTH: 707 words

HEADLINE: Area seniors say they like Medicare drug plan; Clinton's new proposal

BYLINE: Andrew Park

BODY:

With eight different medications to treat everything from her bad knees to her high blood pressure, Sophie Llanas spends a big chunk of her Social Security check at the drugstore -- and she's one of the luckier ones.

Millions of elderly and disabled Americans don't have supplemental insurance policies to cover what Medicare doesn't and must pay out of their own pockets for prescription drugs. Llanas, 65, carries a policy that covers much of her drug costs. Still, her premium and her copayments approach \$150 a month.

Today, President Clinton will unveil a plan to beef up Medicare and add prescription drugs to its range of health benefits, a plan that could cost billions of dollars but is likely to play well with many cash-strapped seniors.

"If they OK'd a prescription on Medicare, I would be in heaven," Llanas said after lunch Monday at Conley-Guerrero Senior Activity Center in Austin. "I think a lot of people here would be."

Medicare covers 39 million Americans and about 80,000 of the elderly and disabled people in Travis, Williamson and Hays counties. The government-run plan pays for drugs dispensed while patients are in the hospital but not once they go home. Supplemental plans, also called Medigap insurance, charge \$50 to \$100 per month to cover a portion of drug costs after a deductible is met, up to a yearly limit. For the poorest elderly people, Medicaid covers drugs, and some employee retirement plans also cover drugs at no charge.

But those who can't afford Medigap and go without prescription drug coverage say the government is bordering on cruelty by not giving them a hand, especially with so many new drugs on the market and with prices having risen 15 percent to 20 percent last year. Drug costs are expected to go up again this year, accounting for much of the steady rise in health-care costs. Prescriptions for some chronic conditions can easily run \$200 or \$300 a month.

"You always wonder if you have enough money after you pay the doctor," said Raymond Jackson, 59, an Austinite who has diabetes and high blood pressure and receives Social Security and Medicare because of his disabilities.

Clinton is expected to propose that Medicare beneficiaries have the option of buying into drug coverage for about \$25 a month.

Paul Pratt, 60, who retired from IBM to live at Sun City in Georgetown, said Clinton's plan would be a good investment to prevent illnesses that the government would end up paying to treat anyway.

"It's cheaper than it is to take care of the people after they get sick," he said.

Since floating the idea of a Medicare drug benefit earlier this month, though, Clinton has run into opposition from Republicans and Democrats who believe his plan will cost too much and jeopardize the government's ability to balance the federal budget in the future. Citing a price tag estimated as high as \$24 billion a year, they say they believe Clinton might be trying to promise too much.

Waiting for friends to round out their bridge foursome at the Sun City Social Center on Monday, Ken and Marge Toeniskoetter said they were skeptical, too.

"I'm wondering where they're going to get the money to pay for it," said Ken Toeniskoetter, 69, who said he and his wife have supplemental coverage from Scott & White Health Plan that pays for most of his drug costs. "We've got that or better right now."

"They should just cut the debt and save some money for our grandkids," said Marge Toeniskoetter.

At one point, Clinton considered compromising and proposing drug coverage only for Medicare beneficiaries below a certain income level, but that idea has been abandoned for political reasons.

That should please Aline Henderson. At 80, Henderson has had surprisingly little experience paying for prescription drugs. She took her first pill a year ago, she says.

But she'd like to see Medicare pay for prescriptions, and pay for them for everyone, even wealthy seniors who may not need the benefit.

"I don't think people should be judged based on how much money they have," said Henderson, who lives in Austin. "I know people who are rich who use Medicare. Well, why not? They paid for it."

You may contact Andrew Park at [apark@statesman.com](mailto:apark@statesman.com) or 912-2506.

GRAPHIC: Sophie Llanas, 65, of Austin, who spends about \$150 a month on medications, said Monday that including prescription drugs in Medicare coverage would help. Elva Arambula is in the background.

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171ST STORY of Level 1 printed in FULL format.

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The Tampa Tribune

June 30, 1999, Wednesday, FINAL EDITION

SECTION: NATION/WORLD, Pg. 1

LENGTH: 488 words

HEADLINE: Bay area seniors struggle to cover rising drug costs;

BYLINE: LINDSAY PETERSON and MIKE STOBBE, of The Tampa Tribune;

BODY:

TAMPA - Olga Valdez is accustomed to coping with the high cost of prescription drugs. She cuts her pills in half sometimes to make them last longer.

But she was floored when her drugstore recently charged her \$ 186 for a 30-day supply of stomach medicine.

"I told the pharmacist, "What do you have in these pills? Gold dust?" " she said.

That's why Valdez welcomed the news Tuesday that President Clinton wants Congress to approve an annual drug benefit of up to \$ 1,000 for people on Medicare. It would cost \$ 24 a month.

It's one of a half-dozen changes Clinton proposed in the federal health care program for people 65 and older.

Medicare spends \$ 210 billion a year on its 40 million recipients, but it covers prescription drugs only for hospital visits - even though the average senior takes four to six such drugs a day.

Most seniors have supplemental or corporate health insurance or belong to managed care plans that help pay for medications. But 14 million have no such coverage, according to the AARP.

Thousands of seniors lost drug benefits last year when four Medicare HMOs pulled out of Polk and other Florida counties.

One of those seniors, Bill Van Nunen, is trying to leave his Lakeland mobile home for a place in Hillsborough County, where Medicare HMOs remain available.

He easily handles the expense of his blood thinner. But next year his wife,

Patricia, will turn 65 and go on Medicare. She no longer will be covered by a policy that pays for medications for her chronic gastrointestinal disease.

Van Nunen favors the president's plan, even if it involves a monthly premium. Political opponents say it's unnecessary because two-thirds of seniors have at least some drug coverage through private policies.

In Valdez's case, though, coverage is limited to \$ 600 a year by her Medicare HMO. With eight medications between her and her husband, Lenine, the Tampa couple reached that limit by April.

Likewise, Reno and Flavia Torano of Tampa have prescription insurance that barely makes a dent in monthly drug bills of \$ 150 to \$ 200. That leaves them unable to afford one heart medication Reno's doctor recommended.

"He tries to do what he can on his own," his wife said. "He watches his diet and walks on the treadmill."

But this aggravates his asthma, which also is costly to treat, she said.

"It's a heavy load," agreed Margaret Magee of Brandon, whose husband, Eugene, takes 14 pills each day for heart and lung problems.

"We don't go out. We don't buy clothes. We don't go on vacations," she said.

And the costs continue to rise. One prescription jumped recently from \$ 46 to \$ 61 a month. His total medical expenses exceed \$ 1,000 a year, Magee said. "We'll take any help we can get." Lindsay Peterson covers aging and can be reached at (813) 259-7834. Mike Stobbe covers health care and can be reached at (813) 259-7562.

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Gannett News Service

June 30, 1999, Wednesday, FINAL EDITION

SECTION: Pg. ARC

LENGTH: 1230 words

HEADLINE: Seniors anxious for government action on prescription costs

BYLINE: BRIAN TUMULTY; Gannett News Service

DATELINE: WASHINGTON

BODY:

WASHINGTON - The prescription drug plan for Medicare recipients unveiled Tuesday by President Clinton immediately would translate into an \$ 83-a-month savings for 80-year-old Adeline Lanz even after she pays the proposed monthly premium of \$ 24.

"It sounds better than what we have," said Lanz, who lives at the Good Shepherd senior citizens housing complex in Sauk Rapids, Minn.

Without federal help, Lanz expects her spending on prescription drugs will continue rising from the \$ 300 a month she pays now. "Chances are, I may have to take more prescriptions," she explained.

Congressional Republicans and Democrats have been discussing how to reduce the cost of prescription drugs for seniors since the 1980s.

But the possibility of enacting legislation has increased this year because the issue has become high profile. Prescription drug benefits are included in all of the major plans for fixing Medicare's financial problems, including the president's.

Even if the Republican-controlled Congress and the administration fail to reach agreement on a Medicare overhaul this year, lawmakers could enact one of the less ambitious proposals for containing prescription drug costs.

"I think there's a lot of pressure building for this," said Sen. Paul Wellstone, D-Northfield.

The administration wants to cover half of the first \$ 2,000 in prescription drug costs starting in 2002 for senior citizens and disabled Medicare recipients. To qualify, they would pay a monthly premium of \$ 24 that would rise to \$ 44 by 2008 when the ceiling on coverage would rise to \$ 5,000.

While prospects for an agreement have improved, some lawmakers remain pessimistic. "We've been around the horn on this issue for the 24 years I've been in Congress," said Rep. Jim Oberstar, D-Chisholm.

Oberstar noted that he voted for a Medicare prescription drug benefit 11 years ago as part of catastrophic health care insurance legislation that was repealed a year later. Although Medicare recipients with incomes under \$ 47,000 would have had no change in their monthly premiums, the program was controversial and misunderstood, said Oberstar, one of 12 House members to vote against its repeal.

Meanwhile, Rep. Collin Peterson, D-Detroit Lakes, said he's cautious about Clinton's proposal because it would spend part of future budget surpluses to help Medicare. "Until we get Social Security and the other trust funds off budget, I won't know for certain whether there is a surplus," he said.

Sen. Rod Grams, R-Anoka, said using future budget surpluses - which are uncertain - might set the stage for eventual tax increases. "President Clinton doesn't want (people) to see the price tag," said Grams. "Let's not sugarcoat this and make it look like there's no cost."

"This is just laying the groundwork for national health insurance," said Grams, who prefers a more limited prescription drug benefit targeted at lower-income senior citizens.

Peterson said he favors making prescription drug coverage available to middle-income Medicare recipients - low-income retirees already qualify for coverage under Medicaid - but he's worried about the impact of Clinton's plan on Medigap policies or retirement benefits paid by an employer. "If a lot of people drop that coverage, we're going to be picking up costs we don't need to," he said.

Some senior citizens and members of Congress, on the other hand, favor the federal government paying the entire cost as part of a nationwide, single-payer health insurance system.

Ken Christianson, president of the Central Region of the Minnesota Senior Federation, says his organization is convinced the long-term answer is universal health insurance for Americans of all ages.

"We're calling it Medicare for all," said Christianson.

Wellstone also advocates universal health insurance. But he's pessimistic that even a more limited health care overhaul that is focused on senior citizens and Medicare can be enacted this year. "There's such a huge disagreement, I don't see any major change right now," he said.

That's why Wellstone and Oberstar think that legislation limited

to the issue of the high cost of prescription drug costs may have the best chance for enactment in 1999.

Oberstar is a cosponsor of a bill authored by Rep. Thomas Allen, D-Maine, that would require pharmaceutical firms to sell prescription drugs to pharmacies at the same low prices negotiated by large volume customers such as the Veterans Administration and health-maintenance organizations.

Allen's bill could bring down out-of-pocket costs for Medicare recipients by 40 percent, the sponsors say.

Another proposal - authored by Wellstone and Sens. Byron Dorgan, D-N.D., and Olympia Snowe, R-Maine - would ease import restrictions on federally approved prescription drugs, allowing them to be sold to U.S. wholesalers at the same low prices they are sold in Mexico, Canada and Europe.

Wellstone said the import legislation might most easily gain Republican support. "It's intriguing to me because people could save up to 50 percent and it's not the federal government spending money," he said. "We have vetted this with a lot of consumer organizations that have said yes."

At a recent meeting at the Whitney senior center in St. Cloud, many of the two dozen senior citizens attending agreed federal action reducing prescription drug costs could make a big difference in their household costs.

"There was a time I had to decide between giving to my church or buying prescription drugs," recalled Marie Mehr of St. Cloud, who was left with large health bills from her husband's cancer treatments after he died 11 years ago. She ended up selling her house and moving into a smaller one.

"If I could save on drugs, I would have more to save for the winter in Florida where two of my 14 grandchildren live," said Mehr, 71, who takes drugs for blood pressure and cholesterol.

Margaret Lentner, a 74-year-old widow from Sartell, said her \$ 482 monthly Social Security check is her only income and she must use part of it to pay for prescription drugs for her diabetes. She blames local retailers and pharmaceutical companies for taking advantage of people.

"I think they are really making out because diabetics have no choice," Lentner said. "They will put the price up high because they know you have to buy it."

Lanz already spends more for prescription drugs than her \$ 266-a-month rent.

There's the \$ 89 bottle of 30 cancer-fighting tamoxifen pills she has had to buy every month since her breast cancer surgery. And the \$ 139 for 30 Prilosec pills to control stomach acid, \$ 43 for

GANNETT NEWS SERVICE, June 30, 1999

eye drops to treat her glaucoma and \$ 20 for her blood pressure drug.

It would be nice if the government paid everything, she agreed. "But if they can't, this would help some." Her monthly savings eventually would increase from \$ 83 to \$ 150 under Clinton's phased-in plan.

About two-thirds of senior citizens in Minnesota have no prescription drug benefit even if they have supplemental health insurance.

Lanz, for example, pays \$ 384 every three months for a Medigap policy through Blue Cross-Blue Shield, but it only pays for physician visits and hospitalization costs not covered by Medicare.

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LANGUAGE: ENGLISH

LOAD-DATE: July 01, 1999

25TH STORY of Level 1 printed in FULL format.

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July 5, 1999

SECTION: NATION; Pg. 39

LENGTH: 906 words

HEADLINE: Who Will Swallow Medicare's Bitter Pills?;  
The next political battle suddenly swings into sight: covering ever more costly prescription drugs

BYLINE: John Dickerson

BODY:

Lorene Chandler's day begins with a pale green plastic tray and a glass of water. Popping the top of one of the tray's compartments, each marked for a day of the week, she pours out a handful of pills. Capoten, for blood pressure, comes first, on an empty stomach, and then come nine others, with coffee and orange juice and her Grape-Nuts cereal. Like many seniors, Chandler, 79, takes part in another regimen at the end of each month: she gets a ride from her home in Corrigan, Texas, to the drugstore where she sometimes pays as much as \$ 300 to keep her trays--she has a second one for bedtime doses--filled with Atenolol, Imipramine, Norvasc and other drugs. When she is done, much of her Social Security check is gone. "There's not very much left for food," she says. "But growing up during the Depression, it learned me how to save on groceries."

What you have just read is not a political ad--at least not yet. But by the end of the summer, Chandler may well have film crews in her living room. She and the nearly 40 million other Medicare recipients whose drug bills are not covered by the government's health plan for the elderly will be at the center of a high-profile joust between the President and Republicans. Both sides plan to introduce some kind of prescription-drug benefit into the Medicare system while retrofitting the 34-year-old program to keep it from collapse. Even before Clinton could formally announce his plan, scheduled for this week, the Republicans attacked his proposed premium increase as a tax hike, labeling the whole plan another sneaky attempt at government control of health care. Many Democrats are spoiling for a fight, hoping a messy display might win back the hearts of seniors who embraced the G.O.P. in the past two elections.

Nearly 80% of seniors take at least one pill a day, according to a recent survey. The number of medications in development for diseases associated with the elderly has grown from 225 a decade ago to 648 today. The increased number of prescriptions and the rising cost per pill mean seniors are on a treadmill of ever increasing expenditures. In the past five years national spending for all prescription drugs increased almost 60%. That pace is expected to continue. As seniors become more dependent on these remedies, they are also subjecting themselves to the increasing cost of the medicines. While only a third of

Time, July 5, 1999

Medicare recipients are completely without drug coverage of any kind, many of those who buy supplemental insurance through former employers, Medicaid, HMOs or Medigap must still pay a stiff part of their drug costs.

Medicare was a treacherous battlefield before anyone suggested a new entitlement. Most experts agree that adding items and fundamentally reforming Medicare will require some kind of sacrifice by beneficiaries, either paying higher premiums or delaying the eligibility age. But suggesting such reforms may carry a high political price. "There are some in both parties who want the election to be based on whose fault it is we did nothing about Medicare," says Democratic Senator John Breaux, whose yearlong Medicare commission failed to come to consensus largely over the issue of how much coverage to provide for drugs. Says Breaux: "Republicans want to blame Democrats for how badly the system works, and Democrats want to say that Republicans are cutting your benefits."

For many Democrats, it will be tempting to dangle cheaper prescription drugs to win back elderly voters who were once a fundamental part of their voting base. Exit polls after the 1998 election show that elderly voters picked G.O.P. candidates by 55% to 45%. In polls measuring the 2000 presidential race, Al Gore trails George W. Bush by 20 to 30 points with a group of voters who tend to pick Reagan rather than F.D.R. as their political hero. Strategists from both parties suggest that a reason for the shift may be recent headlines. As one Democratic puts it, "When it's about Social Security and Medicare, we win. When the debate is about Monica, we lose."

Republicans read the same polls and are prepared to pry seniors and the Democrats further apart with the G.O.P.'s own plan, which they have yet to design but which they promise will cover the poor and acutely ill. With strong backing by drug manufacturers, most in the G.O.P. will fight any plan to provide a universal benefit of the kind Clinton is suggesting, as well as other measures being offered by Democrats that would lower the cost of prescription drugs for Medicare patients. The only way such a system could work, they say, is through price controls set by Washington bureaucrats--and that, the G.O.P. argues, would ultimately drain drug companies of the profits that allow them to finance research that leads to even better products.

The proposals will not make downing those pills any easier for Lorene Chandler, but they can do something to keep her trip to the pharmacy from leaving her with almost no money for anything else in her life.

BOX STORY:

DRUGS FOR THE ELDERLY Here are the top five medicines prescribed to patients over the age of 65:

1. LASIX ORAL (furosemide) Used for hypertension
2. CIPRO (ciprofloxacin hydro chloride) For infections
3. NORVASC (amlodipine besylate) For heart disease and hypertension
4. LANOXIN (digoxin) For heart failure and heart rhythm disorders
5. PREDNISONE ORAL (prednisone) For inflammatory and allergic disorders

34TH STORY of Level 1 printed in FULL format.

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THE BALTIMORE SUN

July 3, 1999, Saturday ,FINAL

SECTION: BUSINESS ,9C

LENGTH: 737 words

HEADLINE: HMO cutbacks create Medicare crisis for thousands of seniors; Many elderly cast adrift as insurers quit unprofitable areas; Health care

BYLINE: M. William Salganik

SOURCE: SUN STAFF

BODY:

About two years ago, Bea Myers of Hagerstown joined United HealthCare's Medicare HMO.

Then United pulled its Medicare HMO out of Washington County. After looking at various options, she switched to an HMO called MediCareFirst, offered by CareFirst BlueCross BlueShield.

This week, CareFirst announced it, too, is leaving Washington County at the end of the year -- and 16 other Maryland counties, where, it says, federal payments are too low.

She isn't sure where she'll turn next for coverage. "I haven't decided," she said yesterday. "It all just hit me."

Bea Myers isn't the only one who's uncertain. Several national HMOs announced plans to cut back on Medicare services this week, leaving an estimated 250,000 seniors nationally to find new coverage and perhaps 1 million facing additional premiums or lesser benefits.

The actions by the HMOs -- after cutting service to 400,000 seniors last year -- also create uncertainty over the role of managed care in the Medicare program.

Bea Myers is one of about 100,000 Marylanders -- and more than 6 million seniors nationally -- who were attracted to HMOs because, despite their tighter controls over care, they offered prescription drug coverage, no out-of-pocket costs for hospitalization and other benefits not provided by traditional Medicare.

Medicare changes in recent years were designed to increase the number of options for seniors, particularly through HMOs -- which, the government hoped, would control costs.

"Just the opposite is happening -- the choices are being narrowed," complained Susan Pisano, a spokeswoman for the American Association of Health

The Baltimore Sun, July 3, 1999

Plans, the HMO trade group.

The government, she said, "isn't keeping the bargain"; it pays much less to HMOs than it pays to care for beneficiaries in traditional, fee-for-service Medicare.

"The way I look at it," countered Joe Baker, associate director of the Medicare Rights Center, an advocacy group in New York, "it's the HMOs who have reneged on their promise to provide savings."

In seeking congressional action, Baker said, "The HMOs are positioning themselves for a piece of the surplus. But to pay them more money, willy-nilly, is not the solution."

The federal government once paid HMOs 95 percent of the cost of caring for an average fee-for-service patient in each county. That's why rural rates are lower than urban or suburban ones, and why the rural counties have been dropped by CareFirst and other Maryland HMOs.

The 95 percent rate proved profitable for HMOs, which began recruiting seniors aggressively in the mid-1990s. The recruitment drew some sicker seniors, making the plans less profitable.

And the federal government, concerned that HMOs had been making excess profits, began holding down rate increases. Rapidly rising prescription costs compounded the pressure on the HMOs' bottom lines.

"The health plans are being forced out" by the lower rates, Pisano said yesterday. If Congress doesn't act this year to fix the rates, she said, "There will be a debacle next year."

Others, however, view the exits of HMOs as part of natural evolution of the market.

Some plans had too few members in a given market to work efficiently, so they left the market, said Marilyn Moon, a senior fellow at the Urban Institute in Washington. "When you're relying on the market for competition, that's exactly what you'd expect."

In addition, Moon said, HMOs shy away from rural areas because there are relatively few doctors and hospitals, so the health plans cannot rely on competition among providers to negotiate discounts on rates.

All this, she said, may result in a more efficient system but means "a lot of disruption" for seniors, "having to change doctors and learn new rules" as plans come and go.

Rep. Benjamin L. Cardin said the Medicare system cannot rely on HMOs for cost savings. "Private insurance is an important part of our system, but understand that the insurers are in it for a profit, and caring for seniors is expensive," said the Maryland Democrat.

He believes -- as President Clinton recommended this week -- that fee-for-service Medicare needs to include some prescription drug coverage. He thinks there is a chance of congressional action on that this fall.

The Baltimore Sun, July 3, 1999

"It's important for seniors to have access to prescription drugs," he said.  
" Because of HMOs pulling out, that's going to be denied to many seniors."

LOAD-DATE: July 5, 1999

43RD STORY of Level 1 printed in FULL format.

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The Buffalo News

July 2, 1999, Friday, CITY EDITION

SECTION: VIEWPOINTS, Pg. 3C

LENGTH: 596 words

HEADLINE: LET MEDICARE PROVIDE PRESCRIPTION DRUGS

BYLINE: Carl Rowan

BODY:

During this most dreadful of allergy seasons, my doctor instructed me to buy a little canister of a widely advertised nasal spray. My druggist told me that, after a \$ 6.20 "senior citizen" discount, the spray would cost me \$ 55.76.

Once I got my eyeballs back in their sockets, I reminded him that under private insurance, I had a co-pay plan. So my insurance company paid \$ 36.54, and I got the nasal spray for just \$ 9.14. (You will notice that the total cost here is only \$ 45.68 because a further discount was given once the insurance company was involved.)

Some 15 million senior Americans who have no private insurance would have had to shell out the full \$ 55.76, or simply go without the medicine and endure the ravages of raging pollen.

This is just one of the many inequities of the health care system in America. And that is why President Clinton is proposing to revise Medicare to let it pay half the cost of a modest amount of prescription medicines -- thus ensuring that all seniors can get the medication they need.

They need a lot, for their arthritis, high blood pressure, high cholesterol, heart problems, stomach ailments and myriad other aches and pains. So this would be a costly change for Medicare. And that's just one reason why the nation will plunge into another brutal health care debate.

A lot of Republicans and some Democrats already are screaming that when Medicare already is going bankrupt, it would be foolish to add such a costly new program. Clinton says part of the cost would be raised by charging an extra Medicare premium to all but the poorest seniors. But some will want to raise premiums only for families with incomes above, say, \$ 150,000 a year, and that will be bitterly controversial.

Already the Pharmaceutical Research and Manufacturers of America are running newspaper ads warning against "a government-run plan where politicians influence decisions about prescription drug policy" and about "government price controls that chill research and limit availability."

Let's face it. If Medicare, in effect, becomes the single largest purchaser of medicines in the land, Uncle Sam will not -- and ought not -- pay \$ 55.76 or

The Buffalo News, July 2, 1999

anything close to it for a little canister of nasal spray. Forty million seniors won't be popping pills that cost a king's ransom, because the feds will negotiate sane prices. So, directly or indirectly, Medicare will set drug prices. But the pill makers will still reap bonanzas, because with the drugs available to all seniors, the volume of purchases will rise dramatically, giving pharmaceutical companies the same or greater profits.

There surely will be cries about how this Medicare scheme will deliver the nation deeper into the throes of "socialized medicine." Already there are warnings that it will take the choice of prescription medicine away from doctor and patient and give it to "government bureaucrats and their agents."

The debate is far from trifling, or mere partisan politics. Because it is these drugs that have extended the life spans of Americans dramatically. The gut-line question is whether affluent Americans are willing to share the cost of extending the blessings of medical science to poorer seniors, so they too can know reasonable health and comfort in their sunset years.

I look at the probable cost, which will be high, and at all the hazards being proclaimed, and I come down on the side of restructuring Medicare so that it provides prescription drugs to seniors who cannot pay, but at some cost to those who can. North America Syndicate

LANGUAGE: ENGLISH

LOAD-DATE: July 4, 1999

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The Associated Press State & Local Wire

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June 1, 1999, Tuesday, PM cycle

SECTION: State and Regional

LENGTH: 806 words

HEADLINE: Border pharmacies lure seniors grappling with increasing drug costs

BYLINE: MINERVA CANTO, Associated Press Writer

DATELINE: TIJUANA, Mexico

BODY:

Nearly \$ 200 worth of prescription drugs bulged from Barry Villafana's blue backpack after he left Farmacia Americana, one of a dozen drugstores drawing elderly Americans and retirees across the border.

He drives 480 miles roundtrip from his Santa Barbara home to Tijuana every two months to stock up on medicine for his high cholesterol and arthritis.

"The amount of drugs I could have bought with this money back home would barely fill a fanny pack," said Villafana, a 69-year-old retired factory worker.

Americans have long crossed into Mexico for inexpensive car repairs, discount clothes and cheap liquor. Now they're driving over the border to fill prescriptions, too, most notably the elderly. The issue is money.

"The reason we're seeing a growing trend for seniors to go across the border to purchase their prescriptions is that it costs a lot less," said state Assemblyman Martin Gallegos, who chairs the Assembly Committee on Health.

"They're trying every way possible to cut the out-of-pocket expenses for their medications," he said.

Older Americans tend to need more prescription drugs to treat chronic or long-term illnesses, but for those relying on Social Security, they often are the least able to afford them. Medicare does not pay for drugs. And although border officials have no figures on the visits, they say the trend appears to be growing.

Former teacher's aide Dottie Mason, 68, began making the 280-mile roundtrip from her Los Angeles home to border pharmacies two years ago after the cost of her diabetes medication increased so much she had trouble paying her bills.

"I was trying to do some hard scrunching with the numbers, mailing payments

until the last possible minute," Mason said.

Spending for prescription drugs in the United States has passed \$ 80 billion annually, increasing by 11 percent to 14 percent every year since 1995, according to a recent federal study. Analysts say the reasons range from an aging population using more medicine, more new drugs on the market that have no generic competition and a lack of price controls in the United States.

U.S. prices are often twice as much as drugs abroad, according to the advocacy group Public Citizen. For example, the average retail price of the antidepressant Prozac is \$ 34 a month abroad and \$ 72 in the United States; a month's supply of cholesterol-lowering Zocor is \$ 44 abroad and as much as \$ 104 in the United States.

"People who are weak and defenseless are the ones who are hurt the most," said Alan Sager, a Boston University health care economist. "Virtually no American is wealthy enough to be pharmaceutically secure to afford the medications."

Those looking for a bargain don't have to go far.

Colorful, billboard-size signs written in English lure people to a string of pharmacies just 100 yards from the border, touting the best deals on everything from Viagra to Prozac. A five-minute taxi ride takes visitors to Avenida Revolucion, a major thoroughfare, where pharmacies advertise medications for diabetes, arthritis, heart conditions and other illnesses.

Pharmacy workers wearing white coats stand at the entrance of shops, beckoning customers to come inside. Most pharmacies are small, tidy shops lined wall-to-wall with hundreds of small boxes of pharmaceuticals and a few toiletries. Mexican and American customers of all ages rub elbows, but Americans usually buy in bulk.

"These older people are good customers," said Florencio Maria Cortez, a clerk at one border pharmacy. "We know they come back regularly and so sometimes we even have their packages waiting for them."

Getting back home with the medications is also easy since U.S. law allows Americans to buy foreign-made drugs as long as they are prescribed by a U.S. doctor, intended for personal use and transported in the original container, U.S. Customs spokesman Vince Bond said.

"Those agents don't give me any hassles. I have all my paperwork in order," said 73-year-old Ernest Ruffino of San Juan Capistrano, patting his jacket pocket as he left a pharmacy where he bought medicine to treat his arthritis.

But Gallegos warned that cheaper drugs may also mean cheaper quality, creating a health risk for the consumer.

"Is that what we want in the United States? And especially because we can't provide a program to meet their needs as society?" asked Gallegos. He is sponsoring a bill that would offer prescription drugs at wholesale prices to Medicare recipients whose health insurance doesn't cover prescriptions.

Villafana fits the profile.

He's a senior covered by Medicare and lives on a fixed income of about \$ 800 a month, money barely enough to cover his \$ 500 rent and other bills.

"Believe me, this isn't any sightseeing trip," Villafana said, minutes before hailing a cab to the border, where he parked his car.

LANGUAGE: ENGLISH

LOAD-DATE: June 1, 1999