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LOW-INCOME PRESCRIPTION DRUG PLANS:

AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

Prepared by:

THE NATIONAL ECONOMIC COUNCIL / DOMESTIC POLICY COUNCIL

THE WHITE HOUSE

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LOW-INCOME PRESCRIPTION DRUG PLANS: AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

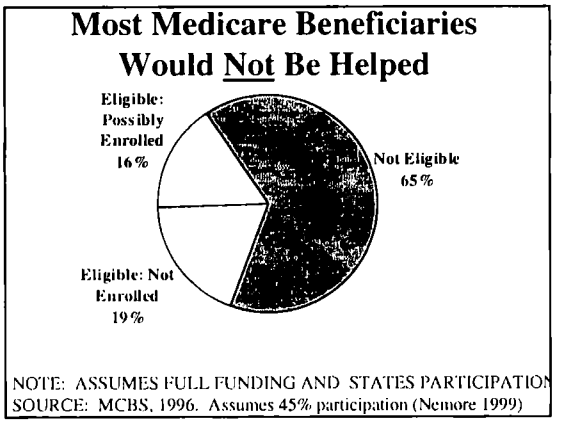
Executive Summary

The Senate Republican Leadership and some Republicans in the House have proposed state block grant proposals to provide prescription drug coverage for low-income seniors and people with disabilities. This study examines these low-income proposals, analyzes their shortcomings, and compares them to the President's voluntary Medicare prescription drug proposal. It concludes that the low-income proposals not only would exclude all middle-income Medicare beneficiaries from any assistance but would fail to achieve their stated objective: to provide meaningful assistance to low-income beneficiaries. Specifically, they would deny eligibility to about 25 million Medicare beneficiaries – most of whom lack affordable, dependable prescription drug coverage today. Due to notoriously low enrollment in state programs, the plans would inevitably not assist more than half of eligible low-income seniors. Even the minority of Medicare beneficiaries who overcome these hurdles and actually sign up for coverage would be enrolled in programs that could cap enrollment and/or the number and types of drugs covered. Furthermore, despite the proposals' goal of providing assistance immediately, it would take years to implement programs in all 50 states and, because funding is time-limited and insufficient, some states may not participate at all. Finally, a low-income program would delay enactment of a workable and meaningful Medicare prescription drug benefit that would more quickly be implemented nationwide and more effectively cover low-income beneficiaries.

CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PLANS

- **Explicitly exclude at least 25 million – two-thirds of – Medicare beneficiaries.** Although high drug costs and lack of drug coverage are not just problems for low-income beneficiaries, the most generous Senate Republican plan restricts block grant funding to those who are not eligible for Medicaid and have income below 175 percent of poverty (about $14,600 for singles, $19,700 for couples). Nearly 5 million people would be excluded because they are Medicaid-eligible and another 20 million have income above the eligibility cut-off. In 16 states, 75 percent or more of Medicare beneficiaries would be excluded while in 5 states, 80 percent or more of seniors would not be eligible. Specifically, the proposal would:

    - Exclude three-fifths (60 percent) of all seniors and people with disabilities who have absolutely no coverage for prescription drugs;
    - Exclude three of five Medicare beneficiaries with the highest drug costs;
    - Exclude three-fifths of the seniors who purchase Medigap private insurance, which is expensive and provides a limited benefit;
    - Exclude most Medicare managed care enrollees with unreliable and limited drug coverage that they are at risk of losing from year to year.



- **Less than half of the low-income Medicare beneficiaries that the plan purports to help would likely get drug coverage, even if fully implemented in all states.**

  - 55 percent of low-income Medicare beneficiaries currently do not enroll in Medicaid even though they are eligible. Medicaid provides prescription drug coverage for the lowest-income seniors and helps pay for Medicare premiums for those with income below 135 percent of poverty. However, 50 percent or more eligible beneficiaries are not enrolled in Medicaid in 30 states and more than two-thirds do not participate in 7 states. In contrast, 98 percent of eligible people nationwide enroll in Medicare.

  - Less than 800,000 seniors are enrolled in state pharmacy assistance programs. These state-initiated programs have low participation rates and exclude more than 90 percent of Medicare beneficiaries in 8 of the 14 states operating such programs in 1999.

  - Enrollment barriers are common. States have not made the strides in simplifying enrollment for the elderly that they have for children. To sign up for Medicaid, eligible seniors and people with disabilities must fill out long, complex applications (in 26 states); meet extensive documentation requirements for income and assets (in 41 states); and sign up through welfare offices (34 states have no outstationed eligibility workers).

  - Many seniors reject "welfare" programs. Complex enrollment procedures contribute to the belief that state assistance is "welfare," only for "poor people" and could jeopardize the financial well-being of spouses and children. Despite efforts to overcome this, these negative perceptions remain and serve as a significant barrier to enrollment.

- **Empty promise for those who actually enroll.** The Republican plans provide no assurance of what drug coverage beneficiaries receive; what you get depends on where you live.

  - Types of drugs covered and number of prescriptions filled may be limited. States could extend their current Medicaid or state drug assistance program benefits. Five state programs limit drug coverage to specific conditions or maintenance drugs. Fourteen programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only 3 prescriptions per month.

  - No guaranteed access to needed drugs or local pharmacies. Under most low-income plans, there is no guarantee that, when a doctor prescribes a particular drug as medically necessary, the patient would get it. And, there is no assurance that seniors could continue to access local pharmacies.

  - Enrollment would inevitably be capped. With the Senate's $1.3 billion in 2001, states would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries. Much of this Federal funding would be used to replace current state funding (about $700 million in 1999), leaving at most only $119 per eligible low-income senior per year compared to average annual spending that exceeds $1,000. As such, states would inevitably have waiting lists.

- **Implementation issues would delay low-income assistance – and a long-overdue Medicare prescription drug benefit.**

  - Would not provide prescription drug coverage to low-income seniors nationwide in 2001. It is extremely unlikely that all states would implement new prescription drug programs under this plan next year. Not only does the National Governors' Association oppose taking responsibility for prescription drugs, but the time-limited and inadequate funding in most plans would give states little incentive to invest in setting up new programs. Even if states did support this approach, it would take time to implement. The last three states started enrolling children in the bipartisan, state-supported Children's Health Insurance Program just this year -- 3 years after enactment. Finally, the Federal "default plan" to provide coverage in states that do not participate could not be operational in 2001 because new systems for income-based eligibility would be needed.

  - Low-income block grants would fail to help low-income beneficiaries but would succeed in delaying implementation of a Medicare prescription drug benefit. If enacted, the next Congress would likely spend more energy on fixing this flawed low-income plan than establishing an affordable, meaningful, and accessible Medicare prescription drug benefit option. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would be available to all Medicare beneficiaries in 2002 and more effectively help low-income enrollees.

CLINTON-GORE ADMINISTRATION PLAN FOR MEDICARE DRUG BENEFIT

- **Ensures a Medicare prescription drug benefit option for all Medicare beneficiaries – including low-income seniors.** The President's plan would, beginning in 2002, offer all Medicare beneficiaries the option of reliable prescription drug coverage through traditional Medicare, managed care, or a retiree plan if available. It would help many more low-income beneficiaries than a block grant since 98 percent all people eligible for Medicare enroll.

- **Provides a meaningful benefit at an affordable premium**. Participants would pay a monthly premium of $25 in 2002 (no premium for the lowest-income beneficiaries) for coverage that has no deductible, pays for half of costs up to $5,000 when phased in, and limits the amount that a senior or person with disabilities pays for drugs to $4,000. All participants would benefit from privately-negotiated price discounts for all their drug costs.

- **Guarantees coverage of prescriptions that beneficiaries need at the pharmacies that they trust**. Because Medicare beneficiaries often have multiple, complex health problems, the President's plan would cover any drug that a doctor certifies is medically necessary, even if it is "off formulary." Also, recognizing the importance of using accessible, familiar pharmacies, the President's plan ensures access to all qualified community pharmacies.

- **Adequately financed and part of a plan to improve Medicare.** Extending Medicare solvency, improving efficiency, and restoring provider payments are important elements of the President's plan to modernize Medicare. Additionally, enough budget surplus should dedicated to finance a prescription drug benefit and take the Medicare trust fund off-budget.

LOW-INCOME PRESCRIPTION DRUG PLANS: AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

PROBLEM OF THE LACK OF PRESCRIPTION DRUG COVERAGE

Prescription drugs have become central to health care, contributing to preventing, managing, and curing diseases. They are even more important to the elderly and people with disabilities on Medicare. However, Medicare does not cover outpatient prescription drug costs. Consequently, nearly half of beneficiaries go without coverage for part or all of the year[1] – about the same percentage as those who lacked hospital insurance when Medicare was created in 1965. Older Americans and people with disabilities without drug coverage typically pay 15 percent more than insurers who negotiate price discounts for the same prescription drug. As a result, uncovered Medicare beneficiaries purchase one-third fewer drugs but pay nearly twice as much out-of-pocket.[2] The situation is even worse for rural Medicare beneficiaries, who are over 60 percent more likely to fail to get needed prescription drugs due to cost.[3] Medicare beneficiaries with disabilities face unique challenges, being less likely to have private coverage but needing more and different types of prescriptions than the elderly.[4] The absence of prescription drug coverage is also a barrier for people with disabilities who want to return to work.

CONGRESSIONAL REPUBLICAN LOW-INCOME PRESCRIPTION DRUG PROPOSALS

On September 7, 2000, Senator Roth (R-DE) introduced two similar bills (S. 3016 and S. 3017) to address the lack of prescription drug coverage for Medicare beneficiaries.[5] S. 3017, entitled the "Medicare Temporary Drug Assistance Act," would provide $29 billion in block grants to states for four years[6] to voluntarily provide prescription drug coverage to certain low-income Medicare beneficiaries. Senate Majority Leader Lott (R-MS) and Senate Majority Whip Nickles (R-OK) co-sponsored the less generous version of the proposal (S. 3016).

Under the more generous proposal, states would have the option of receiving time-limited Federal grants to provide prescription drug coverage to Medicare beneficiaries who are, in general, not eligible for full Medicaid (approximately above 75 percent of poverty) and have incomes below 175 percent of poverty ($14,600 for singles, $19,700 for couples). States could set the upper eligibility limit anywhere in this range, impose an assets test, and set caps on enrollment.

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[1] Stuart B; Shea D; Briesacher B. (January 2000). *Prescription Drug Costs for Medicare Beneficiaries: Coverage and Health Status Matter.* New York: The Commonwealth Fund.

[2] Assistant Secretary for Planning & Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Prices: Report to the President.* Washington, DC: U.S. Department of Health & Human Services.

[3] White House National Economic Council / Domestic Policy Council. (June 13, 2000). *Prescription Drug Coverage For Rural Beneficiaries: A Critical Unmet Need.*

[4] White House National Economic Council / Domestic Policy Council. (July 31, 2000). *Disability, Medicare and Prescription Drugs.*

[5] For the purpose of this paper, we have focused on S. 3017. S. 3016 sunsets on December 31, 2003, limits eligibility to those below 150 percent of poverty ($12,500 for singles, $16,900 for couples) and provides $17 billion.

[6] S. 3017 provides $1.3 billion in FY2001, $4.6 billion in FY2002, $9.7 billion in FY2003, $13.0 billion in FY2004.

States not only would have discretion to participate and to set eligibility rules under this proposal but could design their own drug benefit package. There are only two requirements. First, the drug benefit must be equal (or be equivalent) to a "benchmark" drug plan or an alternative plan approved by the Secretary of Health and Human Services. The benchmarks include the prescription drug coverage of: (a) the state Medicaid program; (b) the Blue Cross-Blue Shield Standard Option under the Federal Employees Health Benefits Program; (c) the health plan for state employees; (d) the largest HMO in the state; and (e) the state's low-income pharmacy assistance program. Second, states could not require premiums or cost-sharing for beneficiaries below 100 percent of poverty ($8,400 for singles, $11,300 for couples) and premiums or cost-sharing that exceeds 5 percent of family income for beneficiaries between 100 and 175 percent of poverty. The bill includes no requirement that the Federal funding be used for plans that cover all therapeutic classes of drugs, ensure access to medically necessary prescription drugs, a managed benefit with protections against adverse drug reactions, or guarantee access to local pharmacies.

The Federal government would distribute the proposal's annual funding through state-specific capped annual allotments, allocated on the basis of a state's proportion of Medicare beneficiaries below 175 percent of poverty. States must spend their annual allotment by the end of each year or the remaining funds are returned to the Treasury. Federal matching rates under these allotments would be 100 percent for assistance to those below 135 percent of poverty ($11,300 for singles and $15,200 for couples). For beneficiaries between 135 percent and 175 percent of poverty, states must contribute the same percentage matching payments that they do under the State Children's Health Insurance program (SCHIP). States may cap enrollment if funding runs out because eligible beneficiaries are not entitled to the benefits they receive under these programs. States may use this new Federal funding to replace current state funding for program beneficiaries receiving coverage under a state pharmacy assistance program.

Since states are not required to offer prescription drug coverage, the Senate Republican plan includes a Federal "default plan." The Health Care Financing Administration (HCFA), which runs Medicare, would contract with a pharmacy benefit manager (PBM) to provide a drug benefit in a state that declines to participate. This coverage would be equivalent to Federal employees' Blue Cross-Blue Shield Standard Option drug coverage and would be restricted to those who are ineligible for Medicaid and have incomes below 135 percent of poverty (HCFA may set a lower eligibility level if funding is insufficient). HCFA would receive 90 percent of the funds otherwise available to the state and would pay for administrative costs from that amount. This year, states would notify HCFA by December 31st about their intent to participate; if they do not, then HCFA would have to start coverage in that state one day later, by January 1, 2001. In subsequent years, states must give HCFA one month's notice.

Congressman Bilirakis (R-FL) has introduced a companion bill, H.R. 5151, in the House of Representatives that is very similar to the Senate Republican drug proposal. It provides for $36.9 billion in block grants to states for four years and expressly holds that states currently providing a pharmacy assistance program are under no obligation to continue their program or maintain the same effort or spending levels.

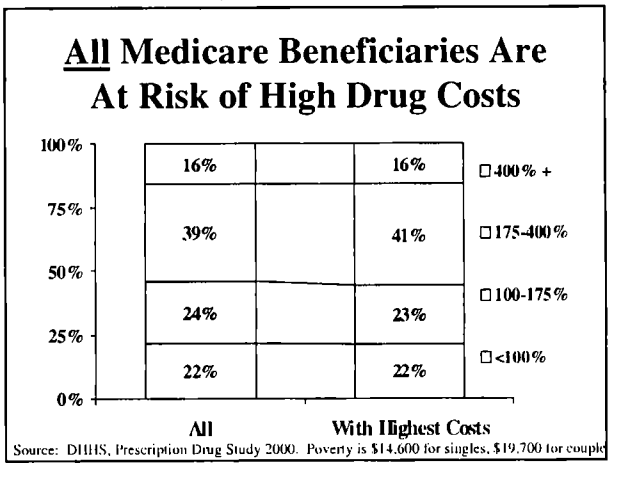
CONCERNS ABOUT LOW-INCOME PRESCRIPTION DRUG PROPOSALS

EXPLICITLY EXCLUDES AT LEAST 25 MILLION – TWO-THIRDS OF – MEDICARE BENEFICIARIES. Most low-income block grant plans restrict funding to those who are ineligible for Medicaid and have income below 175 percent of poverty (about $14,600 for singles, $19,700 for couples). Nearly 5 million would be excluded because they are Medicaid-eligible and another 20 million have income above the eligibility cut-off.[7] States do not have to expand to 175 percent of poverty, so the number of beneficiaries excluded would likely be higher. While Medicare's lack of prescription drug coverage disproportionately affects low-income beneficiaries who can least afford prescription drugs, it is not exclusively – or even disproportionately – a low-income problem. Medicare beneficiaries with no or inadequate coverage are scattered throughout the income distribution. The risk of having high prescription drug costs is also insensitive to income.

Vast majority of seniors excluded in most states. Forty states would have at least 70 percent of their seniors ineligible for assistance under the Senate Republican low-income block grant. In 16 states, the percent of excluded seniors is 75 percent or more, and in 5 states, the percent excluded is 80 percent or more.[8] (See Table 1).

Most of those who lack prescription drug coverage today would be excluded. About three-fifths (55 percent) of all Medicare beneficiaries who now have no coverage for prescription drugs throughout the year would be ineligible assistance under a low-income plan. Unlike the lack of health insurance among the non-elderly, the lack of drug coverage is not concentrated among those with low-incomes. The difference in the rate of lack of drug coverage among middle-income elderly (income greater than 300 percent of poverty) and poor elderly is 35 versus 24 percent. In contrast, the rate of uninsured children is nearly four times higher among poor children than those in families with income above 300 percent of poverty: 26 versus 7 percent.[9] Seniors and people with disabilities – even when they have adequate income – cannot always access and/or afford drug coverage from private health insurance. This is a particular problem for rural beneficiaries and the oldest seniors who are most likely to lack drug coverage.

Little relief for seniors and people with disabilities with high drug costs. Nearly three in five of Medicare beneficiaries with the highest prescription drug costs (57 percent) would not qualify for assistance under a low-income plan. In fact, the income distribution of the 20 percent of Medicare beneficiaries with the highest total drug spending is almost identical to that of all Medicare beneficiaries.[10] This shows that middle-income beneficiaries are at equal risk of having high prescription drug costs as those with low-income.



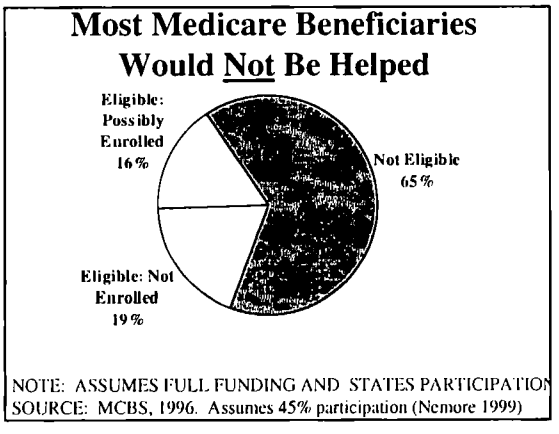
[7] Analysis of the 1996 Medicare Current Beneficiary Survey.
[8] Average Current Population Survey March 1997-99 for elderly with income between 75-175 percent of poverty.
[9] Analysis of the 1996 Medicare Current Beneficiary Survey for elderly; March 1999 CPS for uninsured children.
[10] Assistant Secretary for Planning & Evaluation. (April 2000). *Prescription Drug Coverage, Spending, Utilization, and Price: Report to the President.* Washington, DC: U.S. Department of Health & Human Services.

Excludes millions of Medicare beneficiaries with inadequate, expensive, and unreliable managed care or private insurance plans. Less than one-third of all Medicare beneficiaries have prescription drug coverage through a retiree health plan.[11] This leaves many middle-income seniors and people with disabilities who need prescription drug coverage only the choice of private Medigap insurance or, if available, a Medicare managed care plan. Premiums for private Medigap insurance with prescription drug coverage can be $100 more per month – and much higher for those over the age of 80.[12] Yet, three-fifths of the seniors who purchase Medigap private insurance have income above 175 percent of poverty.[13] In addition, low-income drug plans do nothing to help those who join Medicare managed care plans for prescription drug coverage since they would not directly reimburse plans for such coverage. Thus, those who remain in Medicare+Choice plans remain at risk of losing drug coverage.

LESS THAN HALF OF THE LOW-INCOME MEDICARE BENEFICIARIES THAT THE PLAN PURPORTS TO HELP WOULD LIKELY GET DRUG COVERAGE. The second, major concern with the low-income prescription drug proposals is that they build on state programs that have failed to effectively help low-income seniors and people with disabilities.

Most (55 percent) low-income Medicare beneficiaries eligible for Medicaid do not receive assistance. The lack of prescription drug coverage is not Medicare's only benefit gap. Medicare's benefits are less generous than 80 percent of large employers' fee-for-service health plans.[14] Thus, Medicaid assists the elderly and people with disabilities qualifying for Supplemental Security Income (SSI) and certain others who spend down their resources. In addition, states are required to cover Medicare premiums for those with income below 135 percent of poverty and its cost sharing for those with income below 100 percent of poverty. Despite their need for such assistance, about 55 percent of eligible low-income Medicare beneficiaries are not enrolled in Medicaid.[15] While the participation rate varies by state, it is 50 percent or less in 30 states and less than one-third in 7 states.[16] (See Table 1). Medicare beneficiaries who do not enroll in Medicaid tend to be older women who live alone and Hispanics.[17]

Combining the percent of Medicare beneficiaries who are eligible for any assistance with a 45 percent participation rate, only 16 percent of Medicare beneficiaries are likely to get any assistance under the low-income block grant plan (assuming full funding and full state participation).



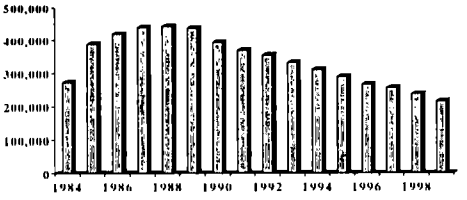
[11] Mercer-Foster Higgins (1999). The number of large firms providing retiree coverage dropped 25% from 1994-98.
[12] U.S. General Accounting Office. (March 1, 2000). *Medigap: Premiums for Standardized Plans that Cover Prescription Drugs.* Washington, DC: US GAO/HEHS-00-70R.
[13] Analysis of the 1996 Medicare Current Beneficiary Survey.
[14] Komisar HL; Reuter JA; Feder J.(June 1997). *Medicare Chart Book.*Washington, DC: Kaiser Family Foundation.
[15] Nemore PB. (December 1999). *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update.* Washington, DC: Kaiser Family Foundation. GAO (1999) GAO/HEHS-99-61.
[16] Families USA. (July 1998). *Shortchanged: Billions Withheld for Medicare Beneficiaries.* Washington, DC: Families USA.
[17] Barents Group LLC. (April 7, 1999). *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries.* Baltimore, MD: U.S. DHHS, Health Care Financing Administration.

State pharmacy assistance programs have not covered a meaningful number of seniors. Rather than extending Medicaid coverage to additional low-income elderly, a number of states have created partially to totally independent, state-funded programs to cover prescription drugs. Fourteen states had programs running in 1999, two states began programs this year, and six states are planning to but have not yet begun to enroll seniors. Benefit design, eligibility, and integration with the Medicaid prescription drug benefit vary by state. However, there is one constant: enrollment in these programs is low. Nationally, less than 800,000 seniors are enrolled in state pharmacy assistance programs. (See Table 1) In eight of the 14 state programs, 10 percent or fewer Medicare beneficiaries are enrolled. [18]

ENROLLMENT TRENDS IN PACE

In 1999, the Pennsylvania PACE program – the largest in the nation -- served 50 percent fewer Medicare beneficiaries (217,103) than in 1988 (443,518). Although the Governor expanded the program in 1996 and aimed to cover an additional 75,000 seniors, fewer people were enrolled overall in 1999, and his new PACENET program has covered less than 20,000 since 1996.

Enrollment in PACE



Source: Pennsylvania Department of Aging (2000); Pennsylvania Legislature.

Enrollment barriers exist in many state programs for the elderly. Another reason why state programs have not reached their enrollment goal is the difficulty of the enrollment process. States have not made the same strides in simplifying Medicaid enrollment for the elderly as they have for children. To sign up for Medicaid, eligible seniors and people with disabilities must fill out long, complex applications (in 26 states); meet extensive documentation requirements for income and assets (in 41 states); and go to welfare offices (34 states have no outstationed eligibility workers). Also, at least 18 states recover Medicare cost sharing payments from the estates of deceased beneficiaries, causing fear that their estates will be tapped when they die.[19] In contrast, states have employed a number of strategies to simplify enrollment for uninsured children.[20] And, unlike Medicare, Medicaid requires redetermination of eligibility at least once a year, and two state pharmacy assistance programs require participants to re-enroll on a monthly basis.[21]

Lack of awareness – and reluctance to participate in perceived "welfare program" – limit enrollment. Studies have found that beneficiaries are frequently unaware of state-based low-income assistance programs or their eligibility for them. It also appears that the social stigma of enrolling in Medicaid-related programs ("poor people's programs") and misperceptions about the effect of enrollment on immigration status and inheritance for spouses and children prevent enrollment. Despite concerted efforts by the Clinton-Gore Administration, advocates and some states, these negative perceptions persist.[22]

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[18] General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U. S. GAO; GAO/HEHS-00-162.

[19] Nemore PB. (December 1999). *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update.* Washington, DC: The Henry J. Kaiser Family Foundation.

[20] Cox L; Cohen Ross D. (April 2000). *Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey.* Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[21] General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U. S. GAO; GAO/HEHS-00-162.

[22] General Accounting Office. (April 1999). *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment.* Washington, DC: U.S. GAO/HEHS-99-61.

LIMITATIONS ON PRESCRIPTION DRUG COVERAGE IN STATE PROGRAMS

LIMITS ON NUMBER OF PRESCRIPTIONS*	LIMITS ON TYPES OF DRUGS**
Arkansas	Illinois
Florida	Maine
Georgia	Maryland
Michigan ***	Rhode Island
Mississippi	Vermont
Nebraska	
North Carolina	
Oklahoma	
South Carolina	
Tennessee	
Texas	
West Virginia	
Wisconsin	
Wyoming (state & Medicaid program)	

*Some Medicaid programs limit number of prescriptions that may be filled per month. **Non-Medicaid programs. ***State program; limits coverage to 3 months per year.
Sources: CCH; NGA 2000; National Pharmaceutical Council 1998; GAO

EMPTY PROMISE FOR THOSE WHO ACTUALLY ENROLL. For those seniors and people with disabilities who qualify for coverage and apply, additional barriers to meaningful drug coverage remain under the low-income proposal.

Permits limits on types of drugs covered and the number of prescriptions that can be filled. Despite the fact that virtually all of the funding for coverage in low-income plan is Federal, states have discretion to design the scope of the drug benefit. They could use block grant funds to extend their current Medicaid or state drug assistance program benefits. Five of the 14 state pharmacy assistance programs limit drug coverage to specific conditions or maintenance drugs (e.g., Maryland only covers maintenance drugs). In addition, 14 state programs limit the number of prescriptions that can be filled. For example, Texas, Oklahoma, and Wisconsin permit only 3 prescriptions per month.

Permits states to limit access to medically necessary drugs. Low-income proposals generally allow states to limit the ability of a doctor to prescribe a medically necessary drug. Specifically, they would permit burdensome appeals or prior authorization requirements. Thus, a senior with cancer who is eligible and enrolls may not get coverage for needed prescription drugs.

Could restrict access to a local pharmacy. The Senate Republican bill provides no assurance that beneficiaries could continue to use their local pharmacies. Local pharmacies play an important role in quality of care for the elderly and people with disabilities who tend to use a large number of medications that interact and can cause complications. In addition, Medicare beneficiaries are not as mobile as other Americans so geographical access is important.

Enrollment would inevitably be capped. States would have the discretion to set the upper eligibility limit under this program at any level above Medicaid and below 175 percent of poverty. They could also impose assets tests. Most disturbingly, states could – and would probably – cap enrollment. States would not be able to provide prescription drug coverage to even the limited group of eligible beneficiaries with the Senate Republican's $1.3 billion in 2001. While average annual spending on prescription drugs exceeds $1,000, this funding would provide at most only $119 per year per eligible senior (see Table 1). This would be even lower when taking into account people with disabilities. Much of this Federal funding would be used to replace existing state funding. In 1999, 12 states spent about $700 million on non-Medicaid drug programs.[23] Four of these states (Connecticut, Maryland, New Jersey, Pennsylvania) could entirely substitution their state spending with their Federal funding under this plan. Another three states (Illinois, Maine, New York) could use more than half of their Federal allotment to replace all of their state spending. This does not take into account potential substitution in Medicaid. Thus, even if a state were to effectively encourage low-income seniors to apply, those seniors would inevitably end up on waiting lists.

[23] General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U. S. GAO; GAO/HEHS-00-162.

IMPLEMENTATION ISSUES WILL DELAY LOW-INCOME ASSISTANCE – AND A LONG-OVERDUE MEDICARE PRESCRIPTION DRUG BENEFIT. While there is general agreement that Medicare beneficiaries need a prescription drug benefit as soon as possible, the Congressional block grant plans would not provide prescription drug coverage to low-income beneficiaries nationwide in 2001. The proposals would be more effective at delaying implementation of a meaningful Medicare prescription drug benefit than at helping low-income seniors immediately.

States generally oppose filling in Medicare's gaps – and specifically oppose taking responsibility for prescription drug coverage. The Clinton-Gore Administration has worked successfully with states on a number of policy initiatives, most notably the creation and implementation of the State Children's Health Insurance Program. These initiatives have succeeded due to state and bipartisan Congressional support. The same does not hold true for the Senate Republican block grant proposal for prescription drugs. States have generally opposed increasing their role in filling in gaps in Medicare. They are specifically concerned about prescription drugs given these rapidly growing costs.

NATIONAL GOVERNORS' ASSOCIATION:
CONCERNS ABOUT STATE PRESCRIPTION DRUG PLAN

- **On Medicare:** "The Governors want to ensure that elderly beneficiaries receive the best possible care, but the Medicare program is a federal program and the federal government should bear all of the costs of serving this dually-eligible population, including full federal responsibility for prescription drug costs." (HR-16-3-9)
- **On Prescription Drugs:** "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." (HR-39)
- **On Time-Limited Programs (SCHIP funding is for 10 years; Senate Republican drug plan is for 4 years)** "The design, development, and implementation of a health insurance program such as S-CHIP takes time. For states to enroll children, educate families about the benefits of a managed care delivery system, ensure that necessary services are received, and ensure that claims are submitted and subsequently paid, Governors must be confident that a stable funding stream will be available to provide health care services to beneficiaries." (HR-15-4)

Low-income proposals make it even more unlikely that states expand drug assistance programs. The low-income proposals' Federal funding is time-limited, inadequate, and capped – features which would discourage states from participating. States without pharmacy assistance programs today would have to pass enabling legislation, develop administrative systems, hire and train eligibility workers, develop claims payment systems, and conduct outreach campaigns to raise awareness. State officials would be concerned about launching such an initiative if Federal funding is temporary, since states would inevitably have to continue to provide such coverage if efforts to pass a Medicare prescription drug benefit fail. In fact, if states provide assistance, there could be less pressure to enact a Medicare drug benefit, leaving states permanently responsible. In addition, the Federal allotments under the Senate Republican plan are small, and may not be sufficient to justify the start-up costs. Finally, Federal responsibility and liability are capped. Given the rapidly rising costs of prescription drugs, states would be put in the untenable position of cutting back on either enrollment or benefits if cost growth exceeds Federal funding growth.

Even if states unanimously supported a low-income prescription drug proposal -- as they did with the State Children's Health Insurance Program (SCHIP) -- it would take significant time to implement. The legislation providing funding for SCHIP was passed on August 5, 1997. States began receiving funding on October 1, 1997. Twenty states did not begin enrollment in the first

year, and three of these states only began enrollment in 2000 -- nearly 3 years after enactment.[24] Thus, even under the best case scenario – where all states support the approach and it is fully funded -- it is virtually impossible that low-income seniors nationwide would have access to this new prescription drug coverage in 2001.

Federal "default plan" may be impossible to implement – and definitely could not be operational in 2001. Recognizing that some (and perhaps most) states would not want to expand prescription drug coverage, most low-income proposals would require the Health Care Financing Administration (HCFA), which runs Medicare, to establish a prescription drug benefit for low-income seniors and people with disabilities in states that opt out. Medicare has no history of or ability to selectively provide benefits based on beneficiaries' income. It would likely take Medicare longer to develop such systems than states and could, under no scenario, be operational and enrolling low-income beneficiaries on January 1, 2001, as the law requires.

Creating a new state program would divert energy and resources from implementing a Medicare prescription drug benefit. The Federal and state effort needed to make a low-income prescription drug proposal a success would likely exceed that which is needed to create a Medicare prescription drug option. If the Senate Republican proposal were enacted, the next session of Congress would more likely focus on fixing this flawed, state-based low-income program rather than creating a Medicare prescription drug benefit. More importantly, this interim step is not needed: Congress could pass a meaningful Medicare prescription drug proposal this year that would go into effect for all Medicare beneficiaries in 2002. It would be more effective at covering low-income beneficiaries since 98 percent of seniors participate in Medicare. This low-income proposal would be more effective at diverting attention from and delaying a meaningful Medicare prescription drug option than it would be in assisting the low-income seniors that it purports to help.

CLINTON-GORE ADMINISTRATION PRESCRIPTION DRUG PROPOSAL

The Clinton-Gore Administration would establish a Medicare prescription drug benefit that is optional, affordable, meaningful, and accessible for all seniors and eligible people with disabilities beginning January 1, 2002. The benefit would have no deductible and pay for half of the costs of drug costs up to $5,000 when fully phased in. Participants would pay no more than $4,000 in out-of-pocket drug costs annually. Premiums for this coverage would be $25 per month starting in 2002 while low-income beneficiaries (with incomes below 150 percent of poverty, $12,500 for singles, $16,900 for couples) would pay no to lower premiums and cost sharing. The Congressional Budget Office estimates that 100 percent of Medicare beneficiaries without prescription drug coverage – including all low-income beneficiaries – would participate. According to the HCFA Actuary, the cost of the program is $253 billion over 10 years.

This Medicare drug benefit option would be integrated into beneficiaries' health plan choices, so that eligible seniors could choose to get their prescriptions through the traditional fee-for-service program, managed care, or a retiree health plan if available. Beneficiaries in traditional fee-for-

[24] U.S. Health Care Financing Administration (HCFA). (January 2000). *The State Children's Health Insurance Annual Enrollment Report, October 1, 1998 - September 30, 1999.* Washington, DC: U.S. DHHS.

service would receive their drug coverage through pharmacy benefit managers (PBMs) in the same way that most privately insured Americans do. PBMs would negotiate drug discounts on behalf of Medicare beneficiaries. Seniors who have retiree health insurance that provides drug coverage at least as good as the President's benefit could choose to keep that coverage. Medicare would contribute to part of its premium subsidy to employers in order to encourage them to maintain retiree coverage. In addition, for the first time in program history, Medicare managed care plans would receive direct payments for the provision of a prescription drug benefit. This should stabilize the Medicare managed care market and contribute towards making it more competitive. In fact, in 2001, plans will be paid to provide to their enrollees a drug benefit that is similar to the President's benefit, until the benefit is implemented one year later.

Regardless of their plan choice, all Medicare beneficiaries enrolled in the prescription drug option would have access to all prescriptions deemed medically necessary by a physician, even if not on the formulary of their PBM or managed care plan. In addition, beneficiaries would continue to be able to receive their prescriptions from their community pharmacies.

COMPARISON OF THE CLINTON-GORE AND REPUBLICAN LOW-INCOME PLAN

Middle-income widow with annual income of $18,000. An 85-year old widow, with annual income of $18,000 (just over 200 percent of the poverty limit), has lived independently for the 15 years since her husband died. She currently does not qualify for Medicaid prescription drug coverage and cannot afford Medigap prescription drug coverage. However, she has developed congestive heart failure which, along with her arthritis, costs her $9,000 per year – half of her income.

- *Republican Low-Income Plan* would exclude this elderly widow from eligibility because her income is too high. She would receive no assistance under this plan.
- *Clinton-Gore Plan* would offer her a premium of $25 per month in 2002 for a price discount of at least $900 and coverage of $4,100 for savings (net of premiums) of $4,700.

Low-income person with disabilities with Parkinson's disease. A 46-year old electrician has been developed Parkinson's disease. He had to stop working at the age of 43 and became eligible for Medicare at the age of 45. He can no longer work. A new medication that helps control muscle tremors that would enable him to return to work has been developed. However, it costs $600 per month – on top of his $250 per month for prescriptions to alleviate his related conditions. His annual total prescription drug costs are $10,200 and are not covered by Medicare. His income from part-time work is $5,000 per year.

- *Republican Low-Income Plan* would allow the state that this person resides in to limit the types of drug covered. This state could decide not to cover this new drug that would enable this electrician to return to work full time. As such, if he decided to enroll, he could get assistance for $3,000 of his $10,200 in drug costs – the uncovered prescription drug costs would still exceed his annual income.

- *Clinton-Gore Plan* would not charge this person premiums or cost sharing and would pay for all of his prescription drug costs, enabling him to take the new drug and return to work. He would save the full $10,200 per year.

Low-income retired couple. The Smiths, a married couple in their late seventies, have an annual income of $15,190. Mr. Smith has diabetes and poorly controlled hypertension. They live in a state that has implemented the new low-income prescription drug program, but only 30 percent of the eligible population has enrolled in the program, because it has not been well advertised. The Smiths would apply for assistance, but they don't know about the program. They are spending more than one-third of their income on Mr. Smith's medications.

- Even though the *Republican low-income* plan should help this couple, it does not. Because of the difficulty of reaching out to a low-income population, confusing, complicated, and overly burdensome application process, and the strict income-based enrollment requirements, state-based programs have limited success in identifying and enrolling eligible seniors. Unfortunately, even though they should be helped by this program, the Smiths are just two of the millions of older Americans that receive no assistance from the Republican proposal.

- *Clinton-Gore Plan* would provide the Smiths with a comprehensive prescription drug benefit, eliminating all of the couple's out-of-pocket medication expenses. In addition, because the application process would be modeled after the one used to enroll in Medicare Part B, which covers 98 percent of all seniors, the Smiths would be able to access the assistance for which they are eligible.

Low-income single adult who receives assistance under the Republican plan. Mr. Jones, a 75-year old senior with an annual income of $14,195, is enrolled in his state's prescription drug benefit program. Although he found the application process burdensome and humiliating, as he is embarrassed about participating in a welfare program, he enrolled because the cost of his heart medication was too much for him to handle on his own. He is concerned about his sister, who also has high prescription drug costs. She has the same income as he does, but she lives in a different state that has limited the benefit to seniors with annual incomes of less than $8,350, and so she is ineligble for assistance. They feel this is very unfair.

- *Republican Low-Income Plan* creates 50 separate state programs with a patchwork of benefits and different eligibility levels. Many seniors, like Mr. Jones, suffer from the welfare stigma associated with a benefit limited to low-income seniors. And his sister – even though states have the option to cover seniors at her income level – is not guaranteed coverage.

- *Clinton-Gore Plan* would ensure that both Mr. Jones and his sister receive a guaranteed, comprehensive prescription drug benefit that is easy to access because the application process would be modeled after the one used to enroll in Medicare Part B, which covers 98 percent of all seniors. Because it is a Medicare benefit, there is no welfare stigma associated with enrolling in the program, and both Mr. Jones and his sister do not have to be ashamed about the assistance they receive.

SIDE-BY-SIDE COMPARISON OF PRESIDENT'S MEDICARE PRESCRIPTION DRUG BENEFIT VERSUS REPUBLICANS' STATE BLOCK GRANT PLAN

	Clinton/Gore & Democrats	Republican Low-Income Block Grant
Who's Covered	**All** seniors and people with disabilities who lack reliable drug coverage today would gain coverage under this plan	**Fewer than one-third** of seniors and people with disabilities would be eligible and **less than half** of those would likely participate
What Do You Get	**Defined Benefit**: No deductible, 50 percent coinsurance up to $5,000 in costs when phased in. Out-of-pocket spending limited to $4,000	**Unknown**. States determine benefit that could include restrictions on the number and types of drugs covered
How Much Does it Cost	No premium for those with income below 135 percent of poverty; sliding scale premium for those with income between 135 and 150 percent of poverty; $25 per month in 2002 for all other participants	**Unclear**: No premium below those with 100 percent of poverty; state-defined premium, not to exceed 5 percent of income for beneficiaries between poverty and the state-defined upper eligibility limit
Are Seniors and People with Disabilities Ensured Choice	**Plans**: Yes. In fee-for-service, managed care, or retiree plans if eligible **Drugs**: Yes. Doctor-prescribed drugs are guaranteed without going through insurer or HMO **Pharmacies**: Yes. All local, qualified pharmacies would be accessible	**Plans**: No. States would not have to pay managed care or retiree plans that offer seniors drug coverage. **Drugs**: No. The legislation provides no guarantees of access to needed drugs **Pharmacies**: No. States could restrict participating pharmacies
Start-Date	**2002**	**Unknown**
Part of Larger Plan to Reform Medicare	**Yes**	**No**

TABLE 1. STATE DATA

	EXCLUDED	LOW PARTICIPATION		LIMITED COVERAGE	STATE FUNDING		
	Percent of Seniors Not Eligible	Percent of Eligible Medicare Benes. NOT in Medicaid	Seniors Enrolled in State Programs	Medicaid or State Program Drug Limits	Allotments (Millions)	Current Non-Medicaid $ (Millions)	New Dollars Per Eligible Elderly
Alabama	69%	48%			$28.6		$159
Alaska	81%	na			$6.5*		$1,089*
Arizona	75%	63%			$19.4		$140
Arkansas	64%	53%		Number	$18.5		$144
California	75%	12%			$121.0		$146
Colorado	80%	21%			$10.7		$153
Connecticut	79%	43%	29,969		$13.7	$15.7	$0
DC	72%	67%			$6.5*		$312*
Delaware	74%	61%			$6.5*		$255*
Florida	74%	50%		Number	$90.8		$134
Georgia	75%	42%		Number	$32.3		$176
Hawaii	81%	49%			$6.5*		$215*
Idaho	71%	46%			$6.5*		$163*
Illinois	75%	70%	49,186	Type	$50.1	$34.1	$48
Indiana	71%	65%			$26.0		$130
Iowa	74%	15%			$13.3		$135
Kansas	74%	60%			$13.8		$143
Kentucky	70%	39%			$23.1		$163
Louisiana	61%	48%			$26.3		$134
Maine	72%	44%	25,000	Type	$7.6	$4.7	$64
Maryland	78%	64%	33,185	Type	$20.1	$26.9	$0
Massachusetts	74%	52%	27,492		$28.1	$6.3	$112
Michigan	74%	52%	12,968	Number	$43.6	$5.2	$125
Minnesota	72%	54%	1,200		$17.4	$1.2	$122
Mississippi	59%	15%		Number	$19.2		$154
Missouri	76%	59%			$25.4		$145
Montana	76%	63%			$6.5*		$264*
Nebraska	67%	69%		Number	$9.0		$126
Nevada	73%	66%			$6.6		$120
New Hampshire	75%	76%			$6.5*		$196*
New Jersey	74%	44%	195,005		$32.7	$248.0	$0
New Mexico	72%	57%			$9.4		$167
New York	72%	40%	113,000		$92.0	$77.8	$22
North Carolina	70%	32%		Number	$42.9		$161
North Dakota	65%	80%			$6.5*		$218*
Ohio	74%	67%			$53.0		$143
Oklahoma	71%	61%		Number	$20.1		$157
Oregon	78%	49%			$13.8		$160
Pennsylvania	74%	65%	235,758		$64.1	$209.3	$0
Rhode Island	64%	72%	29,776	Type	$7.4	$2.3	$91
South Carolina	65%	36%		Number	$23.9		$165
South Dakota	72%	59%			$6.5*		$230*
Tennessee	70%	19%		Number	$29.4		$162
Texas	69%	59%		Number	$84.1		$147
Utah	83%	47%			$6.5*		$203*
Vermont	71%	40%	9,428	Type	$6.5*		$342*
Virginia	77%	59%			$29.9		$168
Washington	81%	59%			$16.7		$171
West Virginia	63%	63%		Number	$14.9		$136
Wisconsin	73%	53%		Number	$20.1		$124
Wyoming	72%	53%	491	Number	$6.5*	$0.6	$389*
TOTAL	**73%**	**48%**	**762,458**	**19**	**$1,297.0**	**$632.1**	**$119**

* States with statutory minimum allotments rather than allotments based on formula.

NOTES ON STATE DATA.

Column 1. Three-year average number of elderly with income below 75 and above 175 percent of poverty. Does not include people with disabilities. Medicare beneficiaries with disabilities have lower income which lowers the percent of all Medicare beneficiaries excluded.

Column 2. Percent of Medicare beneficiaries eligible for the Medicaid QMB / SLMB programs who are not enrolled. From: Families USA. (July 1998). *Shortchanged: Billions Withheld for Medicare Beneficiaries.* Washington, DC: Families USA. About 98 percent of people eligible for Medicare participate.

Column 3. Number of participants in state programs in 1999. General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U.S. GAO; GAO/HEHS-00-162.

Column 4. Limits on prescription drug coverage. "Number" indicates that a participant's number of covered prescription is limited; "type" indicates that prescriptions only for certain conditions / types of drugs are covered. Note that Michigan limits the number of months per year that a senior qualifies for prescription drug coverage. Source: CCH; NGA 2000; National Pharmaceutical Council 1998.

Column 5. Estimates of state allotments under S. 3017, calculated using the five-year average number of Medicare enrollees with income below 175 percent of poverty. Includes territory set-aside and floors. States with asterisks get the minimum allotment of $6.5 million.

Column 6. Estimate of non-Medicaid State spending net of rebate. Note that not all states get the entire amount of the rebate; state spending is likely somewhat higher. General Accounting Office (September 2000). *State Pharmacy Programs: Assistance Designed to Target Coverage and Stretch Budgets.* Washington, DC: U.S. GAO; GAO/HEHS-00-162.

Column 7. State allotments divided by number of seniors with income between 75 and 175 percent of poverty. Before calculating amount per eligible elderly, current net state prescription drug spending is subtracted. States that currently have state spending that exceeds their allotments are assumed to use the entire amount of the allotments to replace state spending. Note that states that get the minimum allotment of $6.5 million have much higher dollars per eligible elderly person than they would have received without this minimum allotment.

Thanks to U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, Health Care Financing Administration, and Office of Management and Budget for help in preparing this report.

REPUBLICAN BLOCK GRANT FOR PRESCRIPTION DRUGS: AN UNWORKABLE PRESCRIPTION FOR AMERICA'S SENIORS

EXCLUDES 25 MILLION -- TWO-THIRDS -- OF MEDICARE BENEFICIARIES

- **About 25 million Medicare beneficiaries would get absolutely no help and have no option for basic prescription drug benefit under this plan.** Two-thirds of seniors and eligible people with disabilities have income above 175 percent (about $14,600 for a single) or are eligible for Medicaid [MCBS 1996] and would not qualify for the plan's basic drug benefit.

- **Half of Medicare beneficiaries without <u>any</u> drug coverage today would receive no help from the Republican block grant plan.** The lack of prescription drug coverage among Medicare beneficiaries is not a low-income problem; 48 percent of those without drug coverage have incomes above 175 percent of poverty and would not qualify [MCBS 1996]. For example, an 85-year old with Alzheimer's disease and $18,000 in income would be excluded.

- **Leaves out middle-income seniors who frequently need help as much – if not more – than low-income seniors.** High drug costs hit seniors of all incomes, not just the low income. A widow with $15,000 in annual income and $5,000 in annual out-of-pocket drug spending needs help more than an elderly couple with $12,000 in income that has only $1,000 in out-of-pocket drug spending – yet only that couple would qualify for help under the Republican plan.

ONLY A FRACTION OF LOW-INCOME SENIORS WOULD GET COVERAGE

- **Shifts responsibility for Medicare drug coverage to states – that do not want it.** Most of the nation's governors agree with seniors and people with disabilities: that gaps in Medicare coverage should be a Federal responsibility – not run by or financed by states. In fact, the National Governors' Association has explicitly rejected state-based drug plans: "If Congress decides to expand prescription drug coverage to seniors, it should not shift that responsibility or its costs to the states." [NGA resolution HR-39]

- **On average, less than half of Medicare beneficiaries eligible for state-based programs are enrolled.** Only 45 percent of poor Medicare beneficiaries who qualify for Medicaid drug coverage and cost sharing assistance programs actually enroll. Existing state Medicaid programs typically have complex applications that differ from state to state; long waits in welfare offices; extensive documentation requirements of income and assets; and poor education efforts [Kaiser Family Foundation, 1999]. Similarly, enrollment in the 15 non-Medicaid state pharmacy assistance programs has been very low, helping only 700,000 to 1.2 million seniors [AARP 1999; NGA 2000].

- **In contrast, 98 percent of eligible seniors participate in Medicare.** Seniors trust and rely on Medicare, and, as a result virtually all who are eligible join this voluntary program.

EMPTY PROMISE FOR THOSE WHO ACTUALLY ENROLL

- **Permits limits on types of drugs covered, the number of prescriptions that can be filled, and where the drugs can be purchased.** States could offer coverage consistent with their current Medicaid or state drug assistance program benefits – some of which have strict limits. This means that seniors may only get coverage for certain diseases (Illinois, Maryland, North Carolina) or be allowed to fill only 3 prescriptions per month (e.g., Texas, Oklahoma, Wisconsin), forcing seniors to play Russian roulette with their medications. There is no guarantee that, when a doctor feels a particular drug is medically necessary, that the patient gets it. There is no assurance that seniors could continue to use their local pharmacies. And, unlike Medicare, what you get depends on where you live.

- **Enrollment would inevitably be capped.** The Republicans allows states to use Federal dollars to replace any current spending for prescription drugs above Medicaid coverage – which, nationwide, is about $1.1 billion [NGA, 2000]. This inadequate and capped funding will result in waiting lists and uncertainty about whether eligible seniors and people with disabilities would get coverage at all.

STEP AWAY FROM – NOT TOWARDS – MEDICARE PRESCRIPTION DRUG BENEFIT

- **Would be quicker to cover all seniors through Medicare than low-income seniors through states.** It would take far longer to establish 50 separate state programs and enroll all eligible low-income seniors and people with disabilities than it would take to establish a nationwide Medicare option. States have to pass enabling legislation, determine the program design, set up systems for enrollment, hire new staff, and educate Medicare beneficiaries of the new option. In contrast, a Medicare benefit can use its existing systems, not require new or complicated applications, and integrate the benefit into current plan choices.

- **Step away from, not towards, Medicare benefit.** Diverting resources and energy towards a new, separate state-based program for prescription drug coverage will seriously delay the addition of a reliable, efficient, meaningful prescription drug benefit in Medicare. As one editorial said, "the step back from government that they proposed would create at least as many problems as it would solve." [*Washington Post*, 9/7/00]

- **Rejection of Medicare approach is political, not practical.** The problem is not that it will take time to set up a Medicare benefit -- it is, for Republicans, Medicare itself. The same party that rejected the creation of Medicare in 1965 and advocated for a welfare program instead are taking the same approach today.

    - Ronald Reagan and Bob Dole opposed creating Medicare. As one historian wrote, Reagan "saw Medicare as the advance wave of socialism, which would 'invade every area of freedom in this country.'" [As quoted in *New York Times*, 9/7/00] Newt Gingrich hoped that, by not improving Medicare and capping its funding, Medicare would "wither on the vine."

    - And as recently as last year, Congressional Republicans supported a low-income benefit, not because it is quicker to implement, but it because they oppose a Medicare benefit: "It isn't a matter of whether there ought to be a prescription drug benefit offered by Medicare, but whether we're going to help those who need it most or launch a "universal" program we don't need and can't afford." [Sen. Phil Gramm, *USAToday*, 6/30/99]

THE PRESIDENT TRIPLES HIS LONG-TERM CARE TAX CREDIT AND URGES CONGRESS TO PASS A LONG-TERM CARE INITIATIVE IN 2000
January 18, 2000

Today, the Clinton Administration confirmed that the President's budget will include a $3,000 tax credit for people with long-term care needs or their caregivers -- tripling the credit over last year's proposal and increasing the total investment in long-term care to $28 billion over 10 years. This credit is the centerpiece of the President's historic long-term care initiative that has won praise from senior groups and health policy experts. The initiative tackles the complex problem of long-term care that affects millions of elderly, people with disabilities and families who care people in need. In addition to the (1) tax credit, the initiative will (2) provide funding for services which support family caregivers of older persons; (3) improve equity in Medicaid eligibility for people in home- and community-based settings; (4) encourage partnerships between low-income housing for the elderly and Medicaid; and (5) encourage the purchase of quality private long-term care insurance by Federal employees. This initiative complements the Administration's effort, spearheaded by the Vice President, to improve the quality of care in nursing homes. The President will commend Congress on giving this initiative serious consideration in the last session and urged it to finish the job this year.

MILLIONS OF AMERICANS HAVE LONG-TERM CARE NEEDS

- **An increasing number of Americans have a range of long-term care needs.** Over five million Americans have significant limitations due to illness or disability and thus require long-term care. Approximately, two-thirds are older Americans. Also, millions of adults and a growing number of children have long-term care needs because of health condition from birth or a chronic illness developed later in life.

- **The aging of Americans will only increase the need for quality long-term care options.** The number of Americans age 65 years or older will double by 2030 (from 34.3 to 69.4 million), so that one in five Americans will be elderly. The number of people 85 years or older, nearly half of whom need assistance with everyday activities, will grow even faster.

FINANCIAL AS WELL AS SUPPORT SERVICES ARE NEEDED

- **Families, who are the primary caregivers for people with long-term care needs, pay a big price for this care.** Although it is difficult to quantify, one study found that the economic value of care giving for families ranges from $4,800 to $10,400 per caregiver. As such, this new $3,000 tax credit could cover up to 60 percent of families' costs.

- **Many family caregivers need supportive services to ensure that they do not place themselves at risk.** Families and friends caring for people with long term care needs often need information and assistance in getting to supportive resources. Most of those who are the primary caregivers of older persons who have limitations in their level of functioning are elderly themselves. Frequently, these caregivers are providing physically demanding and psychologically exhausting care which places their own health and mental health at risk. These stresses tend to be even more severe for families of persons with Alzheimer's Disease, who generally have greater demands placed on their personal time, experience family conflicts, lack adequate sleep, and are faced with financial hardships because of jobs sacrificed or employment curtailed or compromised.

- **Private insurance is an important but relative new and untested option**. Only about 4 million Americans -- 1.5 percent of all Americans -- have private long-term care insurance. Employers are only beginning to learn how to provide these benefits to their workers.

PRESIDENT'S LONG-TERM CARE INITIATIVE. The Clinton Administration's long-term care initiative, which invests $10 billion over 5 years and $28 billion over 10 years, includes:

- **Supporting families with long-term care needs through a $3,000 tax credit.** This initiative acknowledges and supports millions of Americans with long-term care needs or the family members who care for and house their ill or disabled relatives through a $3,000 tax credit. This credit would be phased in beginning with $1,000 in 2001 and rising in $500 increments, so eligible people would receive $3,000 in 2005 and thereafter. The credit would be phased out beginning at $110,000 for couples and $75,000 for unmarried taxpayers. This new tax credit supports the diverse needs of families by compensating a wide range of formal or informal long-term care for people of all ages with three or more limitations in activities of daily living (ADLs) or a comparable cognitive impairment. It would provide needed financial support to about 2 million Americans, including 1.2 million older Americans, over 500,000 non-elderly adults, and approximately 250,000 children per year. It costs about $8.8 billion over five years and $26.6 billion over 10 years.

- **Establishing a commitment to provide services to assist family caregivers of older persons.** Recent studies have found that services like respite care can relieve caregiver stress and delay nursing home entry, and that support for families of Alzheimer's patients can delay institutionalization for up to a year. This nationwide program would support families who care for elderly relatives with chronic illnesses or disabilities by enabling states to utilize a visible, reliable network to provide: quality respite care and other support services; critical information about community-based long-term services that best meet a families' needs; and counseling and support, such as teaching model approaches for caregivers that are coping with new responsibilities and offering training for complex care needs, such as techniques to manage wandering and agitated behavior in late-stage Alzheimer's Disease. This program, which costs more than $1.25 billion over 10 years, would assist approximately 250,000 families nationwide.

- **Improving Equity in Medicaid eligibility for people in home- and community-based care settings.** Historically, Medicaid policy and practice has inadvertently discriminated against people with long-term care needs who want to live in the community by making it much easier to provide coverage in nursing homes than in the community. This proposal would enable states to provide services to nursing-home qualified beneficiaries at 300 percent of the Supplemental Security Income (SSI) limit (about $15,000) without requiring a complicated and frequently time-consuming Federal waiver. This proposal contributes towards this goal of giving people with long-term care needs the choice of re-maining in their homes and communities. It costs $140 million over 5 years, $370 million over 10 years.

- **Encouraging partnerships between low-income housing for the elderly and Medicaid.** This proposal would provide $100 million in competitive grants to qualified low-income elderly housing projects (Section 202 projects) to convert some or all units into assisted living, so long as Medicaid home and community-based services and services for non-Medicaid residents are readily available. As people living in these housing facilities age, their need for long-term care services rises, often leaving them with no choice but to move to a nursing home. This proposal would allow such people to "age in place" by funding the conversion of their units or the buildings that they live in into assisted living facilities. Only sites that agree to bring Medicaid home and community-based services into their converted assisted living facilities would qualify for grants, to ensure that low-income elderly have access to this opportunity.

- **Having the Federal government serve as a model employer by offering quality private long-term care insurance to Federal employees.** The Office of Personnel Management (OPM) to use its market leverage and set a national example by offering non-subsidized, quality private long-term care insurance to all federal employees, retirees, and their families at group rates. This proposal will provide employers a nationwide model for offering quality long-term care insurance. OPM anticipates that approximately 300,000 Federal employees would participate in this program.

Terry Edmonds <aedmonds1@Home.com>
04/28/2000 09:44:42 AM

Record Type: Record

To: "Gottheim@aol.com" <Gottheim@aol.com>, Joshua S. Gottheimer/WHO/EOP

cc:
Subject: my edits -- it is now at about 760 words. about right.

Josh: I made these edits this morning. Let's discuss when I get in. Good job. Looks like the formatting may be f'd up. But I will try to decipher when I get in.

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON PATIENTS BILL OF RIGHTS AND PRESCRIPTION DRUGS
THE WHITE HOUSE
April 28, 2000

Good morning. Next week, when Congress returns from its Easter recess, there will be less than eight months left for it to complete its work and make this 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 get back to Washington. This critical health care legislation is long overdue.

The 160 million Americans who use managed care have waited too long for a strong, enforceable patient?s bill of rights. You deserve the right to see a specialist if your doctor recommends; the right to keep your doctor through a treatment -- even if your employer changes HMO coverage; the right to emergency room care whenever and wherever you need it; and the right to hold health care plans accountable for harmful decisions.

Last year, the House passed a strong patients? bill of rights that provides the right protections all Americans need and deserve. And it?s a bill that I would sign. But more than six months later, the bill is still languishing in Congress, where the Republican majority has stripped it of the provisions that would make it both real and enforceable. And a right that cannot be enforced isn?t a right at all ? it?s just a request.

This isn?t a partisan issue anywhere in America, and it shouldn?t be in

Washington. We need a bill that covers all Americans ? not one that provides cover for the special interests. Now?s the time for Congress to act, and the Republican leadership shouldn?t stand in the way of progress.

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 American seniors still lack affordable and dependable prescription drug coverage. Our seniors deserve better. They should not have to forgo or cut back on life-saving medication just because they can?t afford the cost.

Just this week we saw further evidence of the unacceptable burden the growing cost of prescription drugs is placing on seniors and disabled Americans. According to a report by the non-profit group, Families USA, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years running. That?s a burden that falls hardest on seniors who lack drug coverage -- because they simply don?t receive the price discounts that most insurers negotiate.

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. My budget includes a comprehensive plan that is part of an overall effort to strengthen and modernize Medicare.

I?m pleased that there is growing bipartisan support for tackling this challenge. Earlier this month, Republican leaders in the House put forth the outlinesof a plan that offers, as a stated goal, access to affordable coverage for all seniors. Unfortunately, their plan falls short of meeting that goal. 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 the plan would provide direct 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.

Conventional wisdom says that nothing substantive can get done in an election year. But if you?re a member of a managed care plan or a senior who depends on life-saving drugs to keep you out of the hospital, you don?t care about partisan politics. You just care about getting well and staying well.

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Federal News Service April 26, 2000, Wednesday

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April 26, 2000, Wednesday

SECTION: WHITE HOUSE BRIEFING

LENGTH: 2043 words

HEADLINE: STAKEOUT BRIEFING WITH SENATE MINORITY LEADER SENATOR TOM DASCHLE (D-SD), HOUSE MINORITY LEADER REPRESENTATIVE RICHARD **GEPHARDT** (D-MO), RON POLLACK, EXECUTIVE DIRECTOR OF FAMILIES USA, AND OTHERS FOLLOWING A MEETING WITH THE PRESIDENT

TOPIC: PHARMACEUTICAL PRICE INCREASES

LOCATION: THE WHITE HOUSE DRIVEWAY, WASHINGTON, D.C.

TIME: 10:14 A.M. EDT

BODY:
SEN. DASCHLE: We had a very good meeting today with the president.

Families USA, as they always do, have energized us once again about the importance of addressing in an effective and comprehensive way the **prescription drug** need for Medicare beneficiaries around the country. Their report is stunning. It's breath-taking.

We're very pleased to have Ron Pollack, the executive director of Families USA, with us, who can talk about some of the details of the report.

But it should serve as a reminder that we must pass a meaningful **prescription drug** benefit this year. The president has laid out his plan. Soon Dick and I will be working in tandem in producing a Democratic version of the president's plan that we hope will enjoy broad-based bipartisan support. We need to get this done, and this report demonstrates once again why it's important to do so.

REP. **GEPHARDT:** Let me, before Ron says a word, again thank Families USA for this great piece of work. Their work and their research confirms what Tom and I hear every time we go back to our home states, and that is that senior citizens are very concerned about being able to pay for their **prescription drugs.**

I said a moment ago that in 1963 half the seniors in the country didn't have health insurance. Now we have Medicare. We've solved that problem. But now half the seniors don't have **prescription drug** coverage, and they need it and want it, and we need to solve that problem. And as Tom said, we need to do it this year.

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We look forward to working on a bipartisan bill. We're glad the Republicans are finally talking about this problem for the first time. We now look forward to working out a bill that will solve the problem.

I'd like Ron just to give you an update on the information that was contained in the report.

MR. POLLACK: Thank you, Leader **Gephardt** and Leader Daschle.

I'm going to give you a quick rundown of that the key findings are in the report. What we did was we took a look at what's happened to the prices of the 50 most used **prescription drugs** by senior citizens, and the prices continue to rise rather substantially.

You'll see here in this chart, of the top 50 drugs, the good news is that 12 of the drugs did not rise faster than inflation; however, 33 of the 50 rose at least 1-1/2 times inflation; half of them, 25, rose more than double inflation; 16 rose three times inflation or more; and 11 rose at least four times the rate of inflation.

We also have the numbers over a period of time from 1994, when we first compiled these numbers, because we did a report about the five- year numbers last year, so we added a sixth year, and you'll see of the top 50 drugs that were sold to seniors, 39 of them were on the market throughout that entire six-year period. Of those 39, 37 out of 39 rose faster than inflation; three-quarters of them, 30 out of 39, rose at least 1-1/2 times inflation; over half, 22 out of 39, rose more than two times inflation. And you can see the other numbers. And you've got even six out of 39 that rose more than five times inflation.

Now, the last two charts I just want to show you really give you a sense of the difference between the bill proposed by the president and the proposal by the House Republicans. You will see that the House Republicans end their subsidy for seniors at 150 percent of poverty, unlike the administration's proposal, which would provide a benefit for all senior citizens through the Medicare program.

Now, 150 percent of poverty for a widow or widower is only $12,525 a year of income. Now, take two situations that this widow or widower will face. It's often that a senior has multiple health conditions. We took three of the most common health conditions -- diabetes, hypertension and cholesterol -- and the annual cost for such a widow could be as much as $2,295, or 18.3 percent of her income. One out of every six dollars being spent just on the prescriptions they need for diabetes, hypertension and cholesterol.

For a widow who just has problems with her gastrointestinal system and has acid reflux disease, she might take only one pill -- actually, the second most popular pill to senior citizens, Prilosec -- and this will cost her 11.6 percent of her income.

Obviously, the House Republican proposal, which ends at 150 percent of poverty, in terms of its subsidy, will leave a lot of seniors with a great deal of difficulties.

We've even shown these same numbers for a widow or widower at 200 percent of poverty. And under those circumstances, the cost would be as much as 13.7 percent of income or 8.7 percent of income.

So as you can see, the House Republican proposal leaves a lot to be desired with respect to moderate-income seniors, who will find the costs of these **prescription drugs** simply unaffordable.

Thank you. I guess we'll take questions.

Q Congressman **Gephardt,** there was a discussion in there about **prescription drugs** and Medicare, but I don't think -- I heard a hardly a word about comprehensive Medicare reform. Can **prescription drugs** be done in the absence of that now? Is it time to forget about the larger reform picture?

REP. **GEPHARDT:** The president is interested in doing both. He's had proposals out there to do both. I think you can do them together or you can do them separately.

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The good news about Medicare is that we have recent reports that say that the length of Medicare, without change, without having problems, is now out much further in the future. So that's good news.

We still need to deal with future problems, and we should do that. We should do it all this year. And we encourage the Republicans to bring up basic reform and a Medicare **prescription drug** benefit.

SEN. DASCHLE: I would just also say that **prescription drug** benefits ARE reform. You need to recognize that health care delivery today is vastly different than it was 30 years ago, when Medicare was created. And because it's so vastly different, so much of what is provided in health care today is through **prescription drugs.** So this recognizes the need for reform and, I think, is one of the most important first steps.

Q Both of you have called for a bill this year, but there are many in your party who have said they'd much prefer that the Republicans not compromise. Then you could carry this to November and use it in the election.

SEN. DASCHLE: I think it's important to get the job done. This president has expressed a willingness to work with the Republicans to see that we do that. I think that it's good politics and good government and it ought to be done. We can do it this year, and we should do it this year.

REP. **GEPHARDT:** John, the seniors that I talked to last week in Missouri all said we need this now. If you're a senior citizen and you're on life-saving drugs to keep out of the hospitalization, you don't care about politics, you don't care about elections, you care about getting well now and staying well. And we owe it to them to get this done as fast as we can. If the Republicans will come to the table and compromise and get to a moderate, sensible proposal, we'll do it this year.

Q The two of you have both said you're willing to work on a bipartisan solution with Republicans, yet you had a lot of criticism today for the Republican proposal on the House, and likewise the Republicans had a lot of criticism for the president's plan. How can you go about doing this? Do you think it's really possible? And have there been any steps taken, have there been any indications that you can do this?

REP. **GEPHARDT:** We don't talk with the minority a lot in the House; we don't get the chance. But if we're given the chance, we'd be happy to sit down and negotiate an outcome here that we could live with.

The big problem is coverage. We can't leave out, as Ron said, most of the nation's seniors. Most of my seniors are above $12,000 a year in income, but they still can't afford their **prescription drugs.** It seems crazy to leave out the lower middle-income seniors who need these drugs as much as anybody else. You also need to have a way to get the price down on these drugs. You can't just turn it over to individual insurance coverage, you've got to use the clout and the leverage of Medicare's large buying pool to get prices down, at least to the price that the rest of us pay in HMOs. I think that's only fair.

Those are the two major sticking points and items that we'd have to work out. But I've got to believe we can work it out.

SEN. DASCHLE: Republicans are coming farther and farther in our direction. They wouldn't talk about it six months ago. Now they're not only talking about it, they've introduced some principles, as we did several months ago. So I think that they have now recognized the importance of this issue, the importance of moving forward. And I'm hopeful that before the end of the year they'll come even farther in the direction of finding compromise.

Q Senator Lott is calling for an investigation into Saturday night's raid in Miami -- (off mike.) Do you think an investigation is warranted? Secondly, do you think the administration's actions were justified in going into the house late that night?

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SEN. DASCHLE: Well, I think if you look at the end result -- the safe retrieval of Elian Gonzalez -- you'd have to recognize that, indeed, this was a very successful operation.

With regard to the hearings, I'm really disappointed, and I think the American people are disappointed. The father has been united with the son. This is a legal and judicial issue. The Republicans appear to be far more comfortable investigating than legislating. There are a lot of things we could be legislating on, and yet they insist on investigating -- investigating, investigating, investigating. I think the people are tired of it.

Q Senator, you said you're pleased at the end result of the raid, but do you feel like the ends justified the means, and the use of force, going in camo with M-16s and so forth.

SEN. DASCHLE: Well, I would draw the distinction between the use of force and the show of force. I think the officials properly showed force so they didn't have to use force. I think there really is an important distinction there. And it was the show of force that precluded the need for anything more dramatic or drastic.

REP. **GEPHARDT:** I think you've got to look at the result. They got the result they were seeking. They followed the law. They got the young man -- the young boy out without injury to anyone. So it was a mission accomplished. And I think at some point we've got to give people some credit for doing their job and getting the job done well.

As to the investigations, all I can say is the same group that brought us impeachment is now going to bring us Elian hearings. The American people are tired of this. They want us to be doing things like **prescription drugs,** things like a patients bill of rights, campaign finance reform, minimum wage increase, more teachers and more buildings for schools. These are the issues people want us to be talking about, not carrying out endless investigations down here into everything, and then investigating the investigations. Enough already! Let's get to the work the people want us to be doing.

Q On **prescription drugs,** a critical difference between the Democratic plan and what Republicans want is that theirs is means tested and the president's plan is not. Will you insist that any **prescription drug** plan that comes along be universal, as the larger Medicare program is?

REP. **GEPHARDT:** We have two principles: universal, voluntary. We simply think that you've got to offer this to everybody. There are a lot of seniors who don't have **prescription drug** coverage and can't get it, can't afford it, and we ought to offer it to them. These are the same arguments that were made in 1965 about Medicare, by the same party. The Republican Party said, make Medicare only for the poor, let's not have it for everybody. We made it for everybody. We made that fundamental decision. It's one of the best decisions this country's ever made. It's why people are living longer, better lives. Thank God for Medicare. Let's now have a **prescription drug** coverage that's the same.

SEN. DASCHLE: Thank you all.

REP. **GEPHARDT:** Thank you.

END

LANGUAGE: ENGLISH

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April 26, 2000, Wednesday

TYPE: MEDIA AVAILABILITY

LENGTH: 2669 words

HEADLINE: U.S. SENATOR TOM DASCHLE (S-SD) HOLDS MEDIA AVAILABILITY ON **PRESCRIPTION DRUG** BENEFITS WITH REPRESENTATIVE **GEPHARDT;** WASHINGTON, D.C.

SPEAKER:
U.S. SENATOR TOM DASCHLE (S-SD),

BODY:
DEMOCRATIC CONGRESSIONAL LEADERS HOLD NEWS CONFERENCE ON

FAMILIES USA ON **PRESCRIPTION DRUG** REPORT

APRIL 26, 2000

SPEAKERS: U.S. SENATOR THOMAS DASCHLE (D-SD), SENATE

MINORITY LEADER

U.S. REPRESENTATIVE RICHARD **GEPHARDT** (D-MO), HOUSE

MINORITY LEADER

RON POLLACK, EXECUTIVE DIRECTOR, FAMILIES USA

*

(JOINED IN PROGRESS)

DASCHLE: Families USA, as they always do, have energized us once again about the importance of addressing in an effective and comprehensive way the **prescription drug** needs for Medicare beneficiaries around the country. Their report is stunning. It's breath-taking. We're very pleased to have Ron Pollack, the executive director of Families USA, with us who can talk about some of the

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The president has laid out his plan. Soon Dick and I will be working in tandem in producing a Democratic version of the president's plan that we hope we'll enjoy broad-based bipartisan support. We need to get this done, and this report demonstrates once again why it's important to do so.

GEPHARDT: Let me, before Ron says a word, again thank Families USA for this great piece of work. Their work and their research confirms what comment I hear every time we go back to our home states, and that is that senior citizens are very concerned about being able to pay for their **prescription drugs.**

I said a moment ago that in 1963 half the seniors in the country didn't have health insurance, now we have Medicare, we've solved that problem. But now half the seniors don't have **prescription drug** coverage and they need it, and want it; and we need to solve that problem. And as Tom said, we need to do it this year.

We're looking forward to working on a bipartisan bill. We're glad the Republicans are finally talking about this problem for the first time. We now look forward to working out a bill that will solve the problem.

I'd like Ron just to give you an update on the information that was contained in the report.

POLLACK: Thank you, Leader **Gephardt** and Leader Daschle.

I'm going to give you a quick run down of what the key findings are in the report. What we did was we took a look at what's happened to the prices of the 50 most used **prescription drugs** by senior citizens and the prices continue to rise rather substantially.

You'll see here in this chart of the top 50 drugs, the good news is that 12 of the drugs did not rise faster than inflation. However 33 of the 50 rose at least one and a half times inflation, half of them, 25, rose more than double inflation, 16 rose three times inflation or more and 11 rose at least four times the rate of inflation.

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Now the last two charts I just want to show you, really give you a sense of the difference between the bill proposed by the president and the proposal by the House Republicans. You will see that the House Republicans end their subsidy for seniors at 150 percent of poverty, unlike the administration's proposal which would provide a benefit for all senior citizens through the Medicare program.

Now 150 percent of poverty for a widow or widower is only $12,525 a year of income. Now take two

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situations that this widow or widower will face: It's often that a senior has multiple health conditions. We took three of the most common health conditions, diabetes, hypertension and cholesterol, and the annual costs for such a widow could be as much as $2,295 or 18.3 percent of her income, $1 out of every $6 being spent just on the prescriptions they need for diabetes, hypertension and cholesterol.

For a widow who just has problems with her gastrointestinal system and has acid reflux disease, she might take only one pill -- actually the second most popular pill for senior citizens, Prilosec, and this will cost her 11.6 percent of her income. Obviously, the House Republican proposal, which ends at a 150 percent of poverty in terms of its subsidy, will leave a lot of seniors with a great deal of difficulty.

We've even shown these same numbers for a widow or widower at 200 percent of poverty, and under those circumstances the cost would be as much as 13.7 percent of income or 8.7 (ph) percent of income. So as you can see the House Republican proposal leaves a lot to be desired with respect to moderate-income seniors who will find the cost of these **prescription drugs** simply unaffordable.

Thank you.

I guess, we'll take questions.

QUESTION: Senator **Gephardt,** there was a discussion in there about **prescription drugs** and Medicare, but I don't think I heard hardly a word about comprehensive Medicare reform. Can **prescription drugs** be done in the absence of that now? Is it time to forget about the larger reform picture?

GEPHARDT: The president is interested in doing both. He's had proposals out there to do both. I think you can do them together or you can do them separately.

The good news about Medicare is that we have recent reports that say that the length of Medicare without change, without having problems is now out much further in the future. So that's good news.

We still need to deal with future problems and we should do that. We should do it all this year, and we encourage the Republicans to bring up basic reform and a Medicare **prescription drug** benefit.

DASCHLE: I would just also say that **prescription drug** benefits are reform. We need to recognize that health care delivery today is vastly different than it was 30 years ago when Medicare was created. And because it's so vastly different, so much of what is provided in health care today is through **prescription drugs.** So this recognizes the need for reform and I think is one of the most important first steps.

QUESTION: Both of you call for a bill this year, but there are many in your party who say they'd much prefer that the Republicans not compromise, and you could carry this to November into the elections.

DASCHLE: I think it's important to get the job done. This president has expressed a willingness to

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work with the Republicans to see that we do that. I think that it's good politics and good government and it ought to be done. We can do it this year and we should do it this year.

GEPHARDT: The seniors that I talked to last week in Missouri, all said, We need this now. If you're a senior citizen and you're on life-saving drugs to keep out of the hospitalization, you don't care about politics, you don't care about elections, you care about getting well now and staying well. And we owe it to them to get this done as fast as we can.

If the Republicans are come to the table and compromise and get to a moderate, sensible proposal, we'll do it this year.

QUESTION: (OFF-MIKE) both said you're willing to work on a bipartisan commission with the Republicans (inaudible). There's been a lot of criticism today about the Republicans' proposal in the House and likewise the Republicans had a lot of criticism for the president's plan. How can you go about doing this? Do you think it's really possible? And have there been any steps taken? Has there been any indications that (inaudible)?

GEPHARDT: We don't talk with the minority (sic) a lot in the House, we don't get the chance. But if we're given the chance we'd be happy to sit down and negotiate an outcome here that we can live with.

The big problem is coverage. We can't leave out, as Ron said, most of the nation's seniors. Most of my seniors are above $12,000 a year in income, but they still can't afford their **prescription drugs.** It seems crazy to leave out the lower-middle-income seniors who needs these drugs as much as anybody else.

You also need to have a way to get the price down on these drugs. You can't just turn it over to individual insurance coverage. You got to use the clout and the leverage of Medicare's large buying pool to get prices down at least to the price that the rest of us pay in HMOs. I think that's only fair.

Those are the two major sticking points and items that we'd have to work out. But I've got to believe we can work it out.

DASCHLE: Republicans are coming farther and farther in our direction. They wouldn't talk about it six months ago. Now they're not only talking about it, they've introduced some principles as we did several months ago. So I think that they have now recognized the importance of this issue, the importance of moving forward, and I'm hopeful that before the end of the year, they'll come even farther in the direction of finding compromise.

QUESTION: (OFF-MIKE) Secondly, do you think the administration's action are justified (inaudible)?

DASCHLE: Well, I think if you look at the end result, the safe retrieval of Elian Gonzalez, you'd have to recognize that indeed this was a very successful operation.

With regard to the hearings, I'm really disappointed and I think the American people are disappointed. The father has been united with the son, this is a legal and judicial issue. The Republicans appear to be far more comfortable investigating than legislating. There are a lot of

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things we could be legislating on and yet they insist on investigating, investigating, investigating, investigating. I think the people are tired of it.

QUESTION: (OFF-MIKE)

DASCHLE: Well, I would draw the distinction between the use of force and the show of force. I think the officials properly showed force so they didn't have to use force. I think there really is an important distinction there and it was the show of force that precluded the need for anything more dramatic or drastic.

GEPHARDT: I think you got to look at the result. They got the result they were seeking. They followed the law. They got the young man -- the young boy out without injury to anyone, so it was a mission accomplished. And I think at some point we got to give people some credit for doing their job and getting the job done well.

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The same -- these are the same arguments that were made in 1965 about Medicare by the same party. The Republican Party said, Make Medicare only for the poor. Let's not have it for everybody. We made it for everybody, we made that fundamental decision, it's one of the best decisions this country's every made. It's why people are living longer, better lives. Thank God for Medicare. Let's now have a **prescription drug** coverage that's the same.

DASCHLE: Thank you all.

GEPHARDT: Thank you.

POLLACK: Thank you.

END

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NOTES:
Unknown - Indicates speaker unknown.
Inaudible - Could not make out what was being said.
off mike - Indicates could not make out what was being said.

LANGUAGE: ENGLISH

PERSON: RICHARD A **GEPHARDT** (96%); THOMAS A DASCHLE (94%);

LOAD-DATE: April 26, 2000

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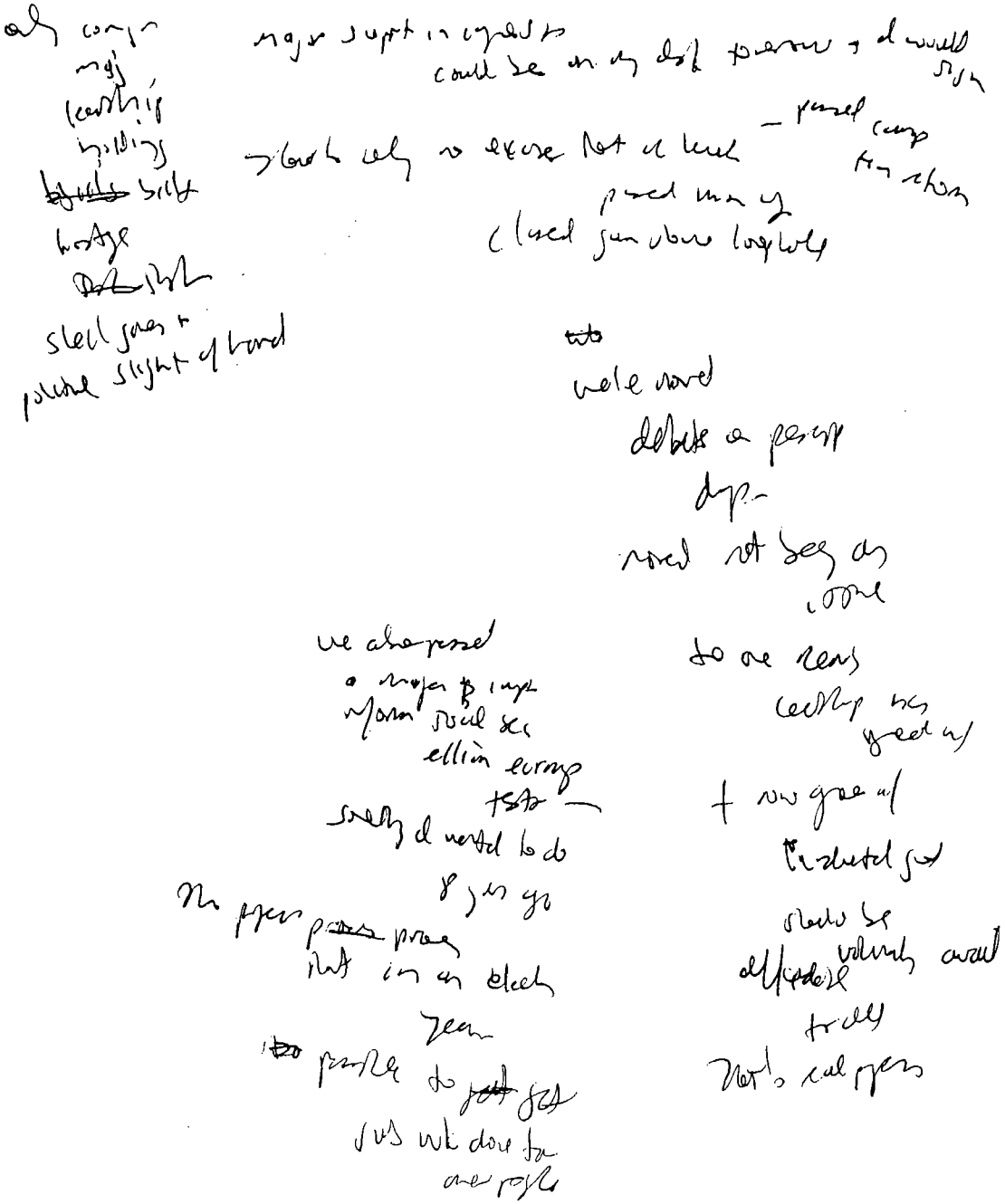

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We need to act from that same vital center to pass other important legislation.

First, to honor work and strengthen our families, we should raise the minimum wage. People who work 40 hours a week should have to raise their children in poverty. The last time we increased the minimum wage, in 1996, our opponents said it would be a "job killer." Since then we've *created* over 10 million new jobs. There is not a single reasonable argument against raising the minimum again by a dollar over two years. In fact, a bipartisan majority in the House voted to do so earlier this month. But Republican leaders held that pay raise for working families hostage to tax breaks for the wealthiest Americans—tax breaks that could make it impossible to pay down the debt or strengthen Social Security and Medicare. I will veto that bill if it comes to my desk. And I say to Congress: send me a clean straightforward bill that raises the minimum wage by a dollar over two year, and I will sign it.

Second, to renew our democracy and stem the rising tide of campaign spending, we must pass strong campaign finance reform. Finally, after years of debate, a majority of lawmakers in both parties agree about this. The House has already passed campaign finance reform, and the votes are there in the Senate. But Republican Senate leaders won't let it come up for a vote. That's wrong. Let the Senate vote, up or down, on campaign finance reform. If it passes -- and I believe it will -- I will sign it.

Third, to protect the interest of 160 million Americans who use managed care, we should pass a strong, enforceable and bipartisan patients' bill of rights. If you're in an HMO, you ought to have the right to see a specialist; to be taken to the nearest emergency room; to keep the same doctor throughout a treatment; and to have the ability to enforce your rights in court. This is not a partisan issue anywhere in America. Republicans get sick just as surely as Democrats and Independents do. Over 200 medical and consumer organizations have endorsed this patients' bill of rights, and a bipartisan majority in the House passed it. But Republican leaders in the Senate won't let it come up for a vote because the health insurance lobby is against it. I say, let everybody vote his or her conscience on the patients' bill of rights. If it passes--and it will--I will sign it.

Fourth, to help stop 12 children a week from losing their lives to gun violence, we must pass common-sense gun legislation. We need to make it harder for criminals and children to get their hands on guns and reduce the staggering toll of gun violence in America. We must require child safety locks; ban the importation of large ammunition clips; close the gun show loophole, and hold adults accountable when they allow young people to get their hands on deadly guns. The American people want this. Responsible gun makers, like Smith and Wesson, want this. It's time for Congress to get this done. Send me this legislation and I will sign it.

Fifth, to make sure the benefits of Medicare keep pace with the benefits of modern medicine, we must reform Medicare and add a voluntary prescription drug benefit. Nobody designing Medicare today would leave out prescription drugs. Yet two out of

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36 Weekly Comp. Pres. Doc. 184

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Public Papers of the Presidents

Public Papers of the Presidents

January 29, 2000

CITE: 36 Weekly Comp. Pres. Doc. 184

LENGTH: 691 words

HEADLINE: The President's **Radio Address**

BODY:

Good morning. Two nights ago, in my State of the Union Address, I asked the American people to heed the advice of President Theodore Roosevelt at the dawn of the last century and take "the long look ahead." The long look ahead to the great challenges we face and the great opportunities we can seize in the 21st century. That requires us to set new goals for our Nation and take the right first steps to achieve them.

We must ensure that every child begins school ready to learn and graduates ready to succeed. We must help every family succeed at home and at work -- and that no child is raised in poverty. We must make America the world's safest big country, lead the world toward shared peace and prosperity and to the far frontiers of science and technology. And we must do all this while maintaining the fiscal discipline that brought us to this rare and promising moment we enjoy.

Seldom in our Nation's history, never in my lifetime, have we enjoyed so much prosperity and social progress with so little internal crisis or so few external threats, with 20 million new jobs, the fastest economic growth in 30 years, the lowest unemployment in 30 years, the lowest poverty rates in 20 years, the lowest minority unemployment rates on record, the first back-to-back surpluses in 42 years. And next month, the longest economic growth in our history.

It's important to remember how this happened. It began in 1993 with a new economic plan that cut the deficit while making investments in our people and our future. When deficits fell, interest rates came down, mortgage payments came down, lower car and student loan payments resulted, there was greater business investment, more jobs, more economic growth. So this fiscal discipline has moved us from record budget deficits and high unemployment to record budget surpluses and unimagined economic strength. Now is not the time to change course.

In the well of the House of Representatives 2 nights ago, I challenged Congress to move forward on important priorities without giving up this fiscal discipline. If we will stay this course, we can pay the country's debt off for the first time since 1835, over the next few years.

Today I am pleased to announce that congressional leaders from both parties and both houses of Congress have accepted my invitation to come to the White House next Tuesday to discuss how we can move forward together.

Let me say again, first and foremost, I hope we can agree on my plan to pay down the debt entirely over the next 13 years and make America debt-free for the first time since Andrew Jackson was

President in 1835, and then to use the benefits of debt reduction to preserve Social Security and Medicare; and specifically to make a bipartisan down payment on Social Security reform by crediting the interest savings from debt reduction to the Social Security Trust Fund. That'll keep it strong and sound for 50 years and take in the lifespan of the baby boom generation.

We also ought to agree to reserve a third of the surplus to further reduce the debt so we have the resources in the future to protect Medicare. I want to dedicate nearly $ 400 billion of this projected surplus to keep Medicare solvent past 2025 and to add a voluntary **prescription drug** benefit. And as I said a couple of nights ago, we can't forget the unfinished business of the last Congress. They need, still, to pass a real Patients' Bill of Rights, commonsense gun safety legislation, campaign finance reform, hate crimes legislation, a raise in the minimum wage.

The state of our Union is the strongest it's ever been. This gives us the opportunity and the responsibility of a lifetime to shape the future of our dreams for our children. Our chance to do good has never been so great. Let us join together to seize this moment.

Thanks for listening.

Note: The address was recorded at 2:41 p.m. on January 28 in Suite 180 at the Granite Bank Gallery in Quincy, IL, for broadcast at 10:06 a.m. on January 29. The transcript was made available by the Office of the Press Secretary on January 28 but was embargoed for release until the broadcast.

LANGUAGE: ENGLISH

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Jeanne
~~CEA~~ — I need to cut approx 150-175 words - Appreciate any suggestions.
Thanks
Josh

Draft 04/17/00 11:50pm
Josh Gottheimer

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON PATIENTS BILL OF RIGHTS AND PRESCRIPTION DRUGS
THE WHITE HOUSE
April 28, 2000

Good morning. For several years now, I have been arguing that we ought to use this historic moment of economic strength and prosperity to meet our nation's long-term challenges. Today I would like to discuss with you two issues that are vital to the health care of all Americans – both young and old: The need to pass a strong, enforceable patients bill of rights -- and to provide a voluntary prescription drug benefit. And with Congress coming back into session next week, there is no better time than now to act on long overdue healthcare legislation.

First, we should pass a strong, enforceable patient's bill of rights, that ensures the critical protections for the 160 million Americans who use managed care: from the right to see a specialist if your doctor recommends it ... to the right to keep your doctor through a treatment – even if your employer changes HMO coverage ... to the right to emergency room care whenever and wherever you need it ... to the right to hold health care plans accountable for harmful decisions.

[Through executive action, our Administration has already extended the full protection of a Patients' Bill of Rights to the 85 million Americans who get their health care through federal plans. But] no state law and no executive action can do what Congress alone has the power to accomplish.

Last year, the House passed a strong patients' bill of rights that provides the right protections all Americans need and deserve. And it's a bill that I would sign. But more than six months later, the bill is still languishing in Congress, where the Republican majority has stripped it of the provisions that would make it both real and enforceable. And a right that cannot be enforced isn't a right at all – it's just a request.

I will not sign legislation that is a Patients' Bill of Right in name only. It is not a real Patients' Bill of Rights if it has a weak appeal process that's tilted against patients – if it doesn't include a strong enforcement mechanism to hold a plan accountable – or if it leaves more than 100 million Americans without basic protection. This isn't a partisan issue anywhere in America, and it shouldn't be in Washington. We need a bill that covers all Americans – not one that provides cover for the special interests. Now's the time for Congress to act, and the Republican leadership shouldn't stand in the way of progress.

We also have an obligation to strengthen Medicare and modernize it with a voluntary affordable prescription drug benefit -- one that is open, affordable, and accessible to all. And my budget does that. 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. Yet more than three in five American

seniors still lack affordable and dependable prescription drug coverage. Our seniors deserve better. They should not have to forgo or cut back on life-saving medication just because they can't afford the cost.

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

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. My budget includes a comprehensive 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 our burden when the baby boom generation retires.

I'm gratified to see growing bipartisan support for adding a prescription drug benefit to Medicare – an issue I raised last year. Earlier this month, Republican leaders in the House put forth the outlines of a plan that offers, as a stated goal, access to affordable coverage for all seniors. I am pleased they now agree with our goal. Unfortunately, the plan they proposed falls short of meeting that goal. 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 the plan would provide direct 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.

Conventional wisdom says that nothing substantive can get done in an election year. But if you're a senior, and you're depending on life-saving drugs to keep you out of the hospital, you don't care about politics, you don't care about posturing, you just care about getting well and staying well.

So I say to Congress, don't squander this historic moment of prosperity and opportunity. With nearly 21 million new jobs, rising wage, and the longest economic expansion in history, there will never be a better time to act. But time is running out. So I say to the Republican leaders: There's no reason we can't work together to pass a strong and enforceable patients bill of rights. And there's no reason we can't come to an agreement on the details of adding a voluntary prescription drug benefit to Medicare. These are not Democratic issues or Republican issues. They are American issues. It's time we get them done.

Thanks for listening.

Draft 04/28/00 9am
Josh Gottheimer

PRESIDENT WILLIAM J. CLINTON
RADIO ADDRESS ON PATIENTS BILL OF RIGHTS AND PRESCRIPTION DRUGS
THE WHITE HOUSE
April 28, 2000

Good morning. Next week, when Congress returns from its Easter recess, there will be less than eight months ~~left for it to complete its work and~~ to make this 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 get back to Washington. This critical health care legislation is long overdue.

The 160 million Americans who use managed care have waited too long for a strong, enforceable patients' bill of rights. They deserve the right to see a specialist ~~if their doctor recommends~~; the right to keep their doctor through a treatment -- even if their employer changes HMO coverage; the right to emergency room care whenever and wherever they need it; and the right to hold health care plans accountable for harmful decisions.

Last year, the House passed a strong patients' bill of rights that provides the right protections all Americans need and deserve. And it's a bill that I would sign. But more than six months later, the bill is still languishing in Congress. The Republican majority has stripped it of the provisions that would make it strong; they've weakened the appeals process; they've weakened the enforcement mechanism; and they would leave more than 100 million Americans without basic protection. They call their bill a patients' bill of rights, but a right that cannot be enforced isn't a right at all – it's just a request.

We need a bill that protects all Americans -- not one that provides cover for the special interests. ~~Now's the time for Congress to act, and the Republican leadership shouldn't stand in the way of progress.~~

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 American seniors still lack affordable and dependable prescription drug coverage. Our seniors deserve better. They should not have to forgo or cut back on life-saving medication just because they can't afford the cost.

Just this week we saw further evidence of the unacceptable burden the growing cost of prescription drugs is placing on seniors and disabled Americans. According to a report by the non-profit group, Families USA, the price of the prescription drugs most often used by seniors has risen at double the rate of inflation for six years running. That's a burden that falls hardest on

stripped it of the provisions that would make it both real and enforceable. And a right that cannot be enforced isn't a right at all - it's just a request.

I will not sign legislation that is a Patients' Bill of Right in name only. It is not a real Patients' Bill of Rights if it has a weak appeal process that's tilted against patients - if it doesn't include a strong enforcement mechanism to hold a plan accountable - or if it leaves more than 100 million Americans without basic protection. This isn't a partisan issue anywhere in America, and it shouldn't be in Washington. We need a bill that covers all Americans - not one that provides cover for the special interests. Now's the time for Congress to act, and the Republican leadership shouldn't stand in the way of progress.

We also have an obligation to strengthen Medicare and modernize it with a voluntary affordable prescription drug benefit -- one that is open, affordable, and accessible to all. And my budget does that. 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. Yet more than three in five American seniors still lack affordable and dependable prescription drug coverage. Our seniors deserve better. They should not have to forgo or cut back on life-saving medication just because they can't afford the cost.

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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. My budget includes a comprehensive 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 our burden when the baby boom generation retires.

I'm gratified to see growing bipartisan support for adding a prescription drug benefit to Medicare - an issue I raised last year. Earlier this month, Republican leaders in the House put forth the outlines of a plan that offers, as a stated goal, access to affordable coverage for all seniors. I am pleased they now agree with our goal. Unfortunately, the plan they proposed falls short of meeting that goal. 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 the plan would provide direct 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.

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I'm pleased that there is growing bipartisan support for tackling this challenge. Earlier this month, Republican leaders in the House put forth the outlines of a plan that offers, as a stated goal, access to affordable coverage for all seniors. Unfortunately, their plan falls short of meeting that goal. 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 the plan would provide direct 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.

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So I say to Congress, when you get back to Washington next week, let's get back to work on a strong and enforceable patients bill of rights. Let's get back to work on a voluntary Medicare prescription drug benefit. The healthcare of Americans is too important to be sidetracked by politics. It's time to get this job done.

Partisan

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Thanks for listening.

Nen cap

2 impt n.c. other few notes

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~~[illegible]~~

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PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP HIGHLIGHT NEW STUDY DOCUMENTING PRESCRIPTION DRUG PRICE INCREASES THAT DOUBLE INFLATION RATES

Families USA Report Validates the Need for a Medicare Prescription Drug Benefit

April 26, 2000

President Clinton today, along with Senator Tom Daschle and House Democratic Leader Dick Gephardt, will join Families USA in releasing a new report on prescription drugs. 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. While praising the House Republican leadership for endorsing the principle of the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. He will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option.

NEW ANALYSIS INDICATES THAT PRESCRIPTION DRUG PRICES WILL CONTINUE TO RISE. While senior citizens generally live on fixed incomes that are adjusted to keep up with the rate of inflation, a new report by Families USA entitled *Still Rising* demonstrates that prescription drug costs have risen at double that rate over the past six years – and are expected to continue to rise. Key findings of the Families USA report include:

- **In 1999, the prices of the prescription drugs most commonly used by seniors increased at almost double the rate of inflation.** The report found that prices of the 50 prescription drugs most frequently used by the elderly rose by nearly two times the rate of inflation during calendar year 1999. On average, the prices of these drugs reportedly increased by 3.9 percent from January 1999 to January 2000 (versus 2.2 percent for general inflation).

- **Moreover, these increases are part of a trend: Over the past six years, the prices of the prescription drugs most commonly used by seniors also increased by twice the rate of inflation.** The report finds that the price of the 50 prescription drugs most commonly used by older Americans increased by 30.5 percent since 1994 – twice the rate of inflation. More than half of the most commonly used drugs that were on the market for the entire six year period had price increases that were double the rate of inflation. In addition, the Families USA report concludes that more than 20 percent of these prescription drugs increased in price by three times the rate of inflation over that time period.

- **Seniors with common chronic illnesses are often forced to spend well over 10 percent of their income on prescription drugs.** The new Families USA study demonstrates that a widow with diabetes, hypertension, and high cholesterol, living on an annual income of $12,525 (150 percent of the poverty level) will spend 18.3 percent of her annual income on prescription medications. The same woman with an annual income of $16,700 (200 percent of the poverty level) will spend 13.7 percent of her income on these medications. This finding, which is consistent with the conclusions of studies conducted by HHS, clearly demonstrates that failure to provide a voluntary, affordable, and accessible Medicare prescription drug benefit will impose a continuing and growing burden on middle-class older Americans and people with disabilities.

PRESIDENT CLINTON CHALLENGES THE REPUBLICAN LEADERSHIP TO MODIFY THEIR POLICY TO MATCH THEIR STATED GOALS. While praising the House Republican leadership for recognizing the need for an affordable, optional prescription drug benefit available to all Medicare beneficiaries, the President will note that the policy advocated by the House Republicans does not achieve their stated goals. Their current approach is underfunded, unlikely to be available to all beneficiaries, and would almost inevitably be unaffordable to millions of seniors and people with disabilities, even if it is available in some places. In addition, because of its lack of details, it raises more questions than it answers, including how much the premiums are, what the benefit would be, and how much it will cost. The President will challenge the Republicans to move swiftly to amend their proposal to assure that all Medicare beneficiaries have access to an affordable prescription drug benefit option. The House Republican proposal:

- **Reneges on funding commitments for a meaningful prescription drug benefit.** Earlier this year, the Republicans indicated they would commit $40 billion for a prescription drug benefit, but their budget resolution dedicated as little as $20 billion to improve the Medicare program to include a prescription drug benefit. Moreover, the lack of their willingness to release 10-year numbers on their prescription drug proposal raises serious concerns that their tax policy consumes virtually all revenue necessary to adequately fund a drug benefit into the future.

- **Does not assure availability of prescription drug coverage.** Because the Republican plan relies on private insurers to offer a drug-only benefit voluntarily, this policy cannot be guaranteed to be available to all seniors in need of a drug benefit. In testimony before the Congress, the insurance industry itself has expressed skepticism about the effectiveness of the Republican approach.

- **Not affordable for most seniors, even if it is available.** Furthermore, because it provides direct premium assistance only to beneficiaries with annual incomes of under $12,600, the Republican benefit will almost certainly fail to be an affordable option even if it's available. If enacted, the Republican proposal would mark the first time in the program's history that Medicare would not provide universal premium assistance for benefits, and it would undermine the social insurance concept of the program. Finally, because of the proposals reliance on the Medigap insurance market, which frequently does not negotiate lower prices on behalf of its enrollees, it casts doubt on whether beneficiaries would have access to market-leveraged discounts.

PRESIDENT CLINTON AND THE DEMOCRATIC LEADERSHIP HIGHLIGHT NEW STUDY DOCUMENTING PRESCRIPTION DRUG PRICE INCREASES THAT DOUBLE INFLATION RATES

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