MEDICARE BRIEFING

PHOTOCOPY
PRESERVATION

If Elaine would prefer this document in another format, we can work on that next week. This is the best we could get from Laura Tyson over the weekend.

Call me at 505-820-6721 to discuss.

Marybeth Schubert

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Date: Sat, 22 May 1999 12:04:54 -0700
From: Laura Tyson <tyson@haas.berkeley.edu>
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BRIEFING MATERIALS ON MEDICARE FOR VICE-PRESIDENT GORE
PREPARED BY LAURA D. TYSON
MAY 23, 1999

OVERVIEW
This briefing document is divided into three main sections:
Section I. Background Discussion of the Challenges Confronting Medicare
Section II. Discussion of Alternative Democratic Approaches for Reforming Medicare
Section III. Policy Recommendations and Discussion

SECTION I: THE CHALLENGES CONFRONTING MEDICARE
Despite its accomplishments, the Medicare system confronts four distinct but related problems:
1. INADEQUACY OF BENEFITS PACKAGE

The Medicare benefits package, designed according to the medical and insurance practices prevalent in the mid 1960s, is woefully inadequate and out-of-date. Medicare does not include prescription drug coverage, catastrophic coverage, or coverage for many preventive services, all features of most private health care plans. And Medicare?s deductibles and co-payments for inpatient hospital services are far higher than those of most private plans. At the same time, Medicare?s fee-for-service structure gives its recipients far greater choice among providers than the private plans in which most Americans are enrolled before retirement.
The bottom line is that compared to private health insurance plans, Medicare?s benefits package is parsimonious, not generous. The same conclusion applies to a comparison of Medicare?s benefits package with health insurance coverage for the elderly in the other advanced industrial societies.
If the purpose of Medicare is to cover the health care needs of the elderly in ways that are consistent with the scope, quality and structure of insurance available to the rest of the population, then the Medicare benefits package should be reformed to conform more closely the benefits package offered by private plans.

2. INEQUITIES IN MEDICARE

As a result of gaps in the Medicare benefits package, Medicare covers only about 50% of total health care spending by the elderly, leaving them exposed to large out-of-pocket expenses. The access of many elderly Americans to necessary health care is limited by their income, and poorer households are forced to devote a much larger fraction of their income to health spending than are richer ones. Overall, Medicare is regressiveit is a generous program only for the elderly with incomes in the top 25 percentile.
Recognition of the financial burden of the Medicare system on poorer beneficiaries is the reason behind the development of low-income protection programs of MedicaidQMBs and SLMBsto help such individuals cover their Medicare premiums, co-pays, and deductibles and to provide limited coverage for prescription drugs. Participation in these programs has been limited to the poorest beneficiaries, and participation among those eligible has been incomplete and variable across states. A recent article in the New England Journal of Medicine found that even with such low-income protections, inadequate coverage for costly drug prescriptions for the low-income elderly and disabled remains a serious problem in the nation?s health care system.

3. FINANCING PROBLEMS OF MEDICARE

Even with its parsimonious benefits package and with the reforms introduced by the 1997 BBA, Medicare faces a large and growing gap between anticipated revenues and expenditures, in part because of the aging of the population and in part because of continued rapid growth in health care spending driven by technological breakthroughs and growing intensity of use. The best available estimates indicate that even if future Medicare spending were to grow at the same rate as the economyimplying a slowdown unprecedented for both Medicare and private health care spendingthe Medicare program as currently financed would become insolvent by 2020, well before the time at which most Baby Boomers join the ranks of the elderly.

During its existence, Medicare spending per capita has grown at about the same average rate as private health care spending per capita. There is no justification for assuming or requiring that Medicare spending per capita will grow markedly more slowly than private health care spending per capita in the future. In the absence of major reforms in the private health care system or unforeseen cost-reducing technological improvements, private health care spending will continue to grow faster than the economy over the next twenty-five years; it follows that Medicare spending will rise both as a share of GDP and as a share of the federal budget and that Medicare?s revenues will be inadequate to cover its expenditures.

4. INEEFICIENCIES OF MEDICARE

Medicare?s current structure, which relies on extensive price controls to control costs, fosters inefficiencies in the practice and utilization of medical services. Providers face strong financial incentives to encourage the utilization of services to compensate for their controlled prices while beneficiaries face weak financial incentives to use Medicare services in a cost-sensitive manner. It is impossible for Congress and HCFA to adjust the

prices of tens of thousands of medical services to reflect rapidly changing market and technological conditions in a timely way. As a result, Medicare prices can diverge from market prices for the same product or service for substantial periods of time, resulting in a serious misallocation of resources. And as with any system that relies on price controls to control spending, there is a strong inducement for fraud within the Medicare system.

In addition, current law prevents Medicare from using such efficiency-enhancing measures as competitive bidding, selective contracting with preferred providers, and disease and case management techniques to control coststechniques which are regularly used in the private health care system. Efforts to reform current law to allow Medicare to use such techniques are actively and usually successfully opposed by many provider and hospital groups.

Perhaps the most telling evidence of inefficiencies in the Medicare system is the existence of large and persistent regional differences in Medicare costs per beneficiary that cannot be explained by either regional differences in living costs or regional differences in demographics. According to experts, at least one-quarter of the four to one regional differences in Medicare spending per capita is the consequence of regional differences in intensity of use and practice patterns, with no observable effects on regional health outcomes. In other words, Medicare beneficiaries in high-spending regions use more health services and spend more per capita on such services, but do not enjoy better health than their counterparts in low-spending regions.
If Medicare reforms encouraged all regions to move toward the intensity and practice patterns of the low-cost regions of the country, a substantial fraction of the financing problems of the Medicare system would be resolved. Unfortunately, provider groups in high-cost regions actively and usually successfully oppose Medicare reforms which would have this effect.

II. ALTERNATIVE DEMOCRATIC APPROACHES FOR REFORMING MEDICARE

Two basic approaches for addressing the challenges confronting Medicare have been suggested by health care experts and advocates within the Democratic Party. At the risk of simplification, these two approaches can be defined in the following way.

1. Incremental Approach

This approach would build on Medicare?s current structure in which the government through HCFA pays providers of Medicare services at controlled prices and in which the majority of Medicare?s beneficiaries would continue to enroll in Medicare?s traditional fee-for-service indemnity plan.
Incremental proposals include the following: restraining provider payments by reducing updates for payments to hospitals, physicians, and other providers; adopting prospective payment systems for certain types of services to be reimbursed on the basis of anticipated costs rather than controlled prices; allowing Medicare the flexibility to negotiate prices with preferred providers and to use competitive bidding for some services; changing the structure of the Medicare fee-for-service benefits package, for example by raising Medicare deductibles, co-pays, or premiums or by adding a drug benefit to the basic fee-for-service package; raising the age of eligibility for Medicare; and ameliorating the regressive features of Medicare by expanding low-income protections and/or by income-relating beneficiary premiums.
Incremental approaches to reform usually also call for reform of the private

Medigap insurance market. Medigap insurance, which covers Medicare co-pays and deductibles, increases the demand for Medicare services and hence Medicare spending without increasing premium payments for Medicare. Correction of this so-called ?first-dollar coverage problem? created by Medigap would ease Medicare?s financial difficulties, but both the elderly and the insurance industry oppose fundamental changes in Medigap options and prices.

An incremental approach was supported by a majority of the Democratic appointees to the National Commission on the Future of Medicare (the Breaux-Thomas Commission), although no formal proposal by these appointees was developed for consideration by the Commission.

2. Premium-Support Approach

This approach would restructure Medicare to allow beneficiaries to choose between the Medicare fee-for-service program operated by HCFA and modified by some or all of the incremental reforms listed above and a variety of competing private health care plans. Medicare would make a contribution toward the payment of the premium of the plan chosen by each Medicare beneficiary, with the remainder of the premium paid by the beneficiary. The government contribution would be calculated as a certain percentagefixed and adjusted by law over timeof the weighted average premium for all of the plans, including the HCFA traditional fee-for-service Medicare plan, competing for Medicare beneficiaries. The Medicare contribution would not be set by in dollar amountsthat is, Medicare would not operate as a defined contribution programbut would be set as a percentage of the weighted average of the costs of all plans certified to compete for Medicare beneficiaries. Increases in these costs over time would result in increases in both Medicare?s premium contributions and the premiums paid by Medicare beneficiaries.

Medicare would continue to operate under an open-ended federal spending commitment, but the risks and burdens of increases in the costs of services covered by Medicare would be automatically shared by a set percentage between Medicare and its beneficiaries. Over time, the government?s premium contribution and the beneficiaries? premium payment would be expected to increase at about the same pace as the costs of overall health services to the general populationin other words, the risk of rising costs would be borne by both the government and by the elderly according to a given sharing rule..

In a premium-support approach, all plans competing for Medicare beneficiaries would be required to offer at least the same standard benefits package as the fee-for-service package offered by HCFA, and this benefits package would continue to be established by law. The standardization of benefits across plans is necessary in a premium-support approach to encourage plans to compete on price and efficiency rather than on benefits, and to reduce the likelihood of biased selection whereby less generous plans would compete to attract the healthiest beneficiaries, driving up the price of the plans available to the sickest and neediest.

A premium support approach was supported in principle by Breaux, Kerry, Tyson, and Altman, among the Democratic appointees of the National Medicare Commission and by all of the Republican appointees. But neither Tyson or Altman supported the specific version of the premium support approach drafted by the Commission?s majority because the proposal did not provide an adequate drug benefit for Medicare, did not provide adequate safeguards, and did not provide a credible long-term financing plan for Medicare.

III. POLICY RECOMMENDATIONS AND CONCLUSIONS

1. There are several basic principles that should guide reform of Medicare:

Over time, the quality and delivery system of Medicare should not differ materially from the quality and delivery system of private health insurance plans available to the non-elderly.

Medicare should be structured in ways that provide incentives for the provision of the highest quality services at the lowest cost. To the extent that Medicare dollars can be spent more efficiently through reform, it will be easier to address Medicare?s other challenges. The potential savings from greater efficiency can be used to expand benefits, to increase low-income protections, and to cover projected gaps in Medicare finances. But the magnitude of these potential savings is highly uncertain.

Most experts in the health care field believe that even under the most optimistic assumptions about potential efficiency gains, additional revenues will be required to cover the costs of current benefits and any benefit expansions. In short, the likely efficiency improvements in Medicare from a premium-support approach will not be large enough to eliminate the necessity of dedicating additional revenues to cover Medicare?s costs over time.

Over time, Medicare costs per beneficiary should be expected to rise at about the same pace as private per capita health care spending. If private per capita health care spending continues to grow more rapidly than the overall economy in the future as it has done in the past, then Medicare spending will rise as a share of the economy, as a share of payroll taxes, and as a share of the budget. Reform proposals which call for arbitrary numerical caps on such shares and require that per capita Medicare costs grow more slowly than private per capita health care spending would erode the quality and availability of Medicare services over time. And there is no economic justification for such proposalsthe economy can absorb the projected increases in Medicare spending, even in the absence of further reform. The justifiable reason for Medicare reform is not to save the economy from such increases, but to address Medicare?s inadequacies, its inequities, its inefficiencies, and its financing challenges.

Health care spending for the elderly is financed by several interrelated programs, the most important of which are Medicare, Medicaid, and Medigap. Moreover, these programs have evolved over time in an interdependent way: Medicaid provides low-income protections for the poor elderly in Medicare and Medigap provides first-dollar coverage and drug coverage for the elderly who can afford to purchase Medigap policies. In addition, about one-third of all elderly have employer-based health policies that supplement Medicare. Since health care spending on the elderly comes from many public and private sources through interrelated programs, a piecemeal approach to reform will not be as effective as an integrated approach which makes complementary adjustments in Medicare, Medicaid, and Medigap. In addition, an inevitable consequence of expanding benefits in either Medicare or Medicaid will be some reduction in private dollars spent on the same benefitsfor example, adding a prescription drug benefit to Medicare will reduce drug coverage offered by employer-provided supplementary insurance.

2. There are two promising approaches to enhancing Medicare?s efficiency, both of which should be used:

First, giving HCFA both the responsibility and statutory authority to adopt management innovations developed in private health plans including flexible purchasing authority, competitive bidding, negotiating pricing authority, selective contracting with preferred providers and disease and case management techniques. In return for its greater discretion, HCFA should be held to a higher standard of accountability and reporting requirements for cost and quality outcomes.

Second, establishing a premium support system that would allow private plans to compete with one another and with the fee-for-service Medicare program operated by HCFA for the provision of a standards benefits package established by law. Competition among plans would slow the growth of program costs over time; in addition, a premium support system would be better able to weed out unscrupulous providers and restrict provider participation than the current system in which virtually any licensed professional or facility can offer Medicare service and in which decisions to exclude participation are subject to political pressure.

(Both of these approaches are discussed in greater detail in two recent reports from the National Academcy of Social Insurance: Transforming Traditional Medicare, January 1998; and Structuring Medicare Choices, April 1998)

3. There are several technical issues that would have to be resolved to develop a premium support model with adequate safeguards for beneficiaries.

First, an appropriate sharing rate would have to be determined to set the government share of the premium price of a participating plan and the beneficiary share. The government?s share would have to be large enough to insure that an adequate benefits package is available and affordable to all beneficiaries regardless of income, health status, or location. (In the particular premium support proposal of the majority of the National Medicare Commission, the government share was set at 88% of the weighted average premium price, based on the fact that under the current Medicare system, government revenues cover about 88% of the total costs of providing the Medicare benefits package.)

Second, geographic adjusters would be required to make sure that beneficiaries did not pay more for the same package of services because they lived in high-cost regions or because of the market power of providers available in their region. In other words, the government premium payments for individual beneficiaries would have to be adjusted to make sure than they are held harmless against higher prices in their regions stemming from these two factors.

Third, risk adjusters would be required to make sure that beneficiaries did not pay more for the same package of services because of their age, sex, disability status, or other health risk indicators. A risk adjustment mechanism would adjust the government?s premium contribution to participating plans on the basis of the risk characteristics of the individuals they enroll but would not affect the beneficiary contribution. Specifically, a risk adjustment factor based on beneficiary characteristics would adjust the premium for each plan based on its typical beneficiary, and the government would pay the difference between this adjusted premium and the beneficiary premium.

Fourth, while the principles behind the need for risk adjusters and geographic adjusters in a premium-support approach are understood, the development of such

adjusters is still in its rudimentary stage. Therefore, the transition to a premium-support will have to be gradual; in the transition phase, the government?s premium contribution to a particular plan could be based on its costs of delivering the Medicare benefits package at Medicare?s controlled prices rather than on the weighted average bid of plans competing to deliver such services.

Fifth, as in the Medicare Choice Model introduced in BBA 1997, a premium-support model would require that the elderly commit to stay in the plan they chose until the next open enrollment period, and the minimum lag between such periods should be one year. Allowing more frequent switches would aggravate the already complicated risk selection problems of the Medicare system.

(For a more detailed discussion of the technical issues involved in a premium-support model, see a recent report from the Henry J. Kaiser Family Foundation by Mark Merlis: Medicare Restructuring: The FEHBP Model, February 1999)

4. As indicated earlier, Medicare has become a distinctly regressive system with the poorer elderly paying a larger fraction of their disposable income for health than the richer elderly and with the poorer elderly utilizing medical services less extensively than the richer elderly. As a result of the weakening of some of the low-income protection programs by the BBA of 1997, Medicare is likely to become even more regressive over time. The regressive nature of Medicare is a justification for introducing a degree of means-testing or income-testing into Medicare?s premiums. But the income-related premium must not be set so high and the ?high-income? threshold for paying a higher premium must not be set so low that Medicare ceases to function as a social insurance entitlement program and becomes primarily a program for the poor. Additional Medicare revenues earned from higher premium payments by ?high-income? individuals should be used to finance an expansion of low-income protections, not to reduce overall Medicare spending.

5. An increase in the Medicare eligibility age should be considered cautiously because of its potential to leave many older Americans with no other opportunity to obtain health insurance. Almost 1 in 8 Americans aged 62-64 have no insurance today and that number is rising. At a minimum, increasing the eligibility age should be coupled with a buy-in option for 65-66 year olds along the lines of the Administration•s earlier proposed buy for 62-64 year olds. If the goal is to make Medicare eligibility parallel Social Security eligibility, then such an early eligibility buy-in could be extended to 62-64 year olds.

6. Carving out funding for Direct Medical Education from the Medicare program would reduce its projected spending. But this approach begs the question of how to guarantee teaching hospitals with the support they need not only to provide education and research in medicine but also to cover the cost of their treatment of difficult medical cases and uninsured patients. One promising approach is to move funding for DME out of Medicare into a dedicated trust fund financed by a special fee paid by all providers, on the grounds that they benefit from the creation of knowledge and training by the teaching hospitals.

7. Democratic supporters of both the incremental approach and the

premium support approach agree on the need for broadening Medicare•s benefit package to include a prescription drug benefit. When the Medicare program was enacted more than thirty years ago, drugs were not as important in medical treatment as they are today, and drug coverage was not the norm in private health care plans. As the effectiveness and cost of drug therapies have increased, elderly Americans have been forced to find sources other than Medicare to cover their prescription drug needs or forego them altogether. The resulting patchwork system for covering the drug needs of the elderlyincluding Medicaid support for some of the poorest Medicare beneficiaries, employer-provided retiree health insurance for some of the richest Medicare beneficiaries, and increasingly expensive and inadequate supplementary insurance packages offered by private insurersis riddled with inequities, inefficiencies, and wasteful administrative costs. These problems were left unsolved by the proposal for drug coverage offered in the majority report of the National Medicare Commission. This proposal included a limited drug subsidy for the poorest Americansthose with incomes of less than $11000 per yearbut failed to offer any subsidy toward the purchase of prescription drug coverage for the majority of Medicare beneficiaries. The Democratic appointees believe that such a subsidy is required on both equity and efficiency grounds.

The equity grounds are straight-forwardMedicare is a social insurance program for all elderly Americans, not just the poorest. The efficiency grounds are less obvious but equally compelling. Estimates by the federal government actuary for Medicare indicate that a 50% government subsidy toward the premium for a drug benefit would be adequate to encourage the vast majority of Medicare beneficiaries to opt to purchase such a benefit. With lower subsidy rates, a progressively smaller share of the Medicare population would opt for such a benefit. Those who chose to forego purchase of a drug benefit would generally be younger beneficiaries who do not anticipate significant drug expenditures in the near term and for whom the premium they would have to pay would exceed the value of the drug coverage to them perhaps for several years. Those who chose to purchase the drug benefit would be those most likely to need it, and this in turn would drive up the premium of the benefit, pricing it out of reach for many of those who need it the most.

On the other hand, there is no reason why the government•s subsidy rate for a new drug benefit has to be the same as the government•s subsidy rate on the current Medicare benefits package. And in light of the substantial cost of a meaningful drug benefit and the financing challenges confronting Medicare on its current benefits package, it is advisable to set the government subsidy rate for a drug benefit significantly lower--no larger than the 50% necessary to encourage the majority of beneficiaries to participate.

On policy grounds, a catastrophic drug benefit, which has a large upfront deductible but no overall cap, is preferable to a capped drug benefit with a small deductible. A catastrophic approach would direct the coverage to those who need it the most and would discourage demand for non-essential drugs, a problem which the HMOs have encountered. However, a front-end approach is likely to more popular with beneficiaries and with a low overall cap would cost less than a catastrophic approach.

The cost of adding a meaningful drug benefit to the Medicare programeven a limited front-end onewould be substantialin the order of $10 billion to $24 billion a year. (According to recent analysis of five possible drug benefits by the non-partisan and respected National Academy of Social Insurance, the costs to Medicare in the first full year of the drug benefit would be between $17 billion and $24 billion.) There is no credible evidence that

efficiency-enhancing reforms of Medicare would generate enough savings to pay for a new drug benefittherefore, some additional source of revenue would be required. (I support the Administration•s proposal of dedicating a fraction of projected surpluses to pay for new drug coverage.)

The addition of a drug benefit to Medicare would raise concerns from the drug industry about the imposition of price controls on its productsafter all, if the government controls the prices it pays for all other Medicare benefits, then it follows that the government will try to control the prices of a new drug benefit. To ease such concerns and the opposition they engender, a Medicare drug benefit should be designed and managed in ways comparable to private managed care plan coverage. In particular, HCFA drug payments should based on payments and formularies available in the private market, without recourse to price controls or rebates.

schub@socrates.berkeley.edu on 05/24/99 12:07:19 PM

To: Lynn Akin/FS/KSG
cc:
Subject: Returned mail: User unknown (fwd)

I'm guesssing here... Please call me if you or Professor Kamarck have
questions about the attached.

Marybeth Schubert, 505-988-3659

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The original message was received at Sat, 22 May 1999 13:28:28 -0700 (PDT)
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----- The following addresses had permanent fatal errors -----
<linn_akin@Harvard.Edu>

----- Transcript of session follows -----
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>>> RCPT To:<linn_akin@Harvard.Edu>
<<< 550 <linn_akin@Harvard.Edu>... User unknown
550 <linn_akin@Harvard.Edu>... User unknown

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Return-Path: <schub@socrates.berkeley.edu>
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22 May 1999 13:28:28 -0700 (PDT)
Date: Sat, 22 May 1999 13:28:28 -0700 (PDT)
From: <schub@socrates.berkeley.edu>
X-Sender: schub@socrates
To: linn_akin@Harvard.Edu
cc: elaine_kamarck@Harvard.Edu
Subject: Forwarded mail....
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Linn:

Comparison of Competitive Options

April 13, 1999

Economist Views on Price Competition

Two principles of desirable price competition supported by most health economists and policy experts as a mechanism for limiting growth in Medicare costs*:

1) Beneficiary premiums should reflect differences in plan prices: more expensive plans should cost beneficiaries more, and less expensive plans should cost less.

2) Beneficiaries should receive adequate support for their health insurance costs: support should be tied to increases in health insurance costs (unlike a voucher program), while still discouraging excessive cost growth.

Both the OMB and Treasury options are much more consistent with these principles than current law – and do so in a way that provides far greater beneficiary protections than the Breaux-Thomas "premium support" proposal.

They differ in the extent to which they fulfill these principles, in ways that are likely to make the Treasury option more appealing to those who advocate competition and to those concerned about the effects of reform on traditional Medicare.

* If competition among plans is encouraged, then the prices that plans bid will tend to mirror their costs – so plans will be competing on the basis of cost and quality of the required benefits.

First Principle: Beneficiary Pays More for More Costly Plan

Fulfillment of this principle depends on the extent to which all plans follow the same payment schedule; "exceptions" to price competition weaken this principle, especially if they are open-ended.

– Price competition does not depend on whether payments are tied to the weighted-average premium (WAP). The maximum government contribution could be tied to any number.

– Indeed, Aaron, Reischauer, Newhouse, Tyson, and Altman make no mention of the weighted-average premium in their articles in support of price competition in Medicare. Instead, they emphasize that the same schedule for support should apply to all plan choices, so that beneficiaries "see" price differences when choosing.

– FEHB: Until 1999, government support depended on premiums of selected key plans, in order to keep these plans affordable while still encouraging price competition.

– Otherwise, link between what a plan costs in total and what beneficiary pays for it can be tenuous.

How well do the competitive options (OMB, Treasury) meet this principle?

Treasury option: same schedule applies to all plans, but – building on current law – a small "slant" favors traditional Medicare.

- Beneficiaries would pay 3% more for a private plan that costs the same as traditional Medicare, but would keep 75% of the savings from lower-cost plans.

- Slant could be reduced or phased out, if and when improved risk adjustment works and savings from competition permit.

- Payment schedule based on traditional Medicare costs without the "slant" is the only way to create consistent price incentives for all plans while still guaranteeing an affordable traditional Medicare safety net.

OMB option: different rules - traditional Medicare excepted from support schedule used for all other plans.

- Could be much greater than 3% slant, depending on how traditional Medicare cost differs from the WAP, and on the share of beneficiaries in traditional Medicare.

Example 1: Base Case

Comparison of how the beneficiary contributions vary with plan bids / costs under Breaux-Thomas, OMB, and Treasury proposals...

– Assumes FFS costs $6,000, average private plan costs $5,500, and 75% of beneficiaries are in FFS (so WAP = $5,875).

– Under all options, private plans are always paid just what they bid; payment schedules merely determine what part is paid by beneficiary and by government.

– Payment schedule influences beneficiary choices, and thus influences the cost and quality decisions by competing plans.

Figure 1 shows that all three proposals meet first principle to some extent: beneficiary pays more for more expensive plan.

Table 1 shows the numbers behind the graph – beneficiary premiums and government contributions to representative plans under each option. It also compares beneficiary premiums under each option with what they would be under current law.

How Beneficiary Premiums Are Determined Under Each Option

Breaux-Thomas. Beneficiary in plan costing WAP pays 12% ($705), and FFS costs $830 ($110 more than current law). For less expensive plans, beneficiary saves 80 cents on the dollar (so plan costing $5,500 – $375 less than WAP – has beneficiary premium of $405). For more expensive plans, beneficiary pays full difference above the WAP.

OMB. Same as Breaux-Thomas for private plans. But FFS is excluded from private plan payment formula: beneficiary pays 12% ($720).

Treasury. Beneficiary in FFS pays 12% ($720), and premium in private plan depends on how price compares to FFS costs. In private plan costing the same as FFS ($6,000), beneficiary pays 15% ($900). For less expensive private plans, beneficiary saves 75 cents on the dollar – so private plan bidding $5,500 would charge beneficiary $405. For more expensive private plans, beneficiary pays full difference.

Comments on Options

Breaux-Thomas: Figure 1 and Table 1 show key problem in "premium support" proposal: beneficiaries pay more to stay in FFS. Reduced government payments for FFS is basis for most of the estimated savings to the government ("direct" effects). Some savings from higher prices encouraging more beneficiaries to switch to private plans ("indirect" effects).

OMB: No "direct" savings from higher FFS premiums. Also, as under Breaux-Thomas, net government contribution to private plans is often higher than under current law (84% of FFS). Less price incentive for savings from beneficiaries switching to private plans, since FFS excepted from payment schedule.

Treasury: No "direct" savings from higher FFS premiums. Government contributions to private plans is no higher than current law: beneficiary in private plan costing 96% as much as FFS ($5,760) pays $720. "Indirect" savings from beneficiary response to price incentives to switch to less expensive private plans.

Incentives for Efficiency/Disincentives Against Excessive Cost Growth:

Key question for economists: What happens if a plan raises its cost?

Private plans: Under all proposals, if a private plan raises its cost by $100, the plan's beneficiary premium would rise by $75-$100 – so only those cost increases that reflect quality improvements valued by beneficiaries can be sustained.

Traditional Medicare: Not straightforward to see under any option. Table 2 illustrates case where FFS costs increase by $100 – thus bringing WAP up to $5,950 – and other assumptions and plan characteristics are the same as Table 1.

Comments on Table 2: When a Plan Raises Costs, What Does Beneficiary See?

Last column shows how much of the cost increase the beneficiary "sees" -- and thus how the beneficiary's incentive to switch plans increases as a result.

Breaux-Thomas. Private plan costing $5,500 was $425 cheaper for beneficiary than FFS under base case (see Table 1); now it's $510 cheaper. So amount beneficiary saves by switching from FFS to this plan increases by $85 - beneficiary "sees" 85% of the $100 cost increase.

OMB. Private plan costing $5,500 was $315 cheaper for beneficiary than FFS under base case; now it's $378 cheaper. So amount beneficiary saves by switching from FFS to this plan increases by $63 - beneficiary "sees" 63% of cost increase.

Treasury. Private plan costing $5,500 was $195 cheaper for beneficiary than FFS under base case; now it's $267 cheaper. So amount beneficiary saves by switching from FFS to this plan increases by $72 - beneficiary "sees" 72% of cost increase.

Current law. Beneficiary "sees" 12% higher cost in all plans, and private plan payments go up by $96 (may be converted into extra benefits geared toward healthy types).

What if...?

Preceding differences may not have seemed that compelling – so what if beneficiary sees 85%, 63%, or 72%? All of these price incentives are similar in the "base case."

But the price incentives under OMB become significantly weaker if the share of enrollees in FFS declines, even modestly, and if the difference between the FFS premium and the average premium of the private plan grows.

Table 3 shows example: Only assumption changed from Table 2 is that FFS enrollment drops from 75% to 70%. WAP becomes $5,920 as a result.

Breaux-Thomas. Price incentive to switch plans increases modestly – because FFS premium now rises by more relative to weighted average.

OMB. Price incentive to switch plans decreases – because OMB option protects FFS, while lower WAP means beneficiary gets less savings from choosing a private plan. Beneficiary now sees half of the $100 cost increase or less.

Treasury. Price incentive to switch plans unaffected because WAP is not used. Beneficiary still sees the same share (72%) of the $100 cost increase.

Extent of "Slant" or "No-Man's Land" Favoring FFS

Examples show that, in base case, Treasury option has an 1% greater "slant" favoring FFS than OMB option (in order to guarantee some savings to government). The Treasury slant does not change as circumstances change.

Breaux-Thomas. No "slant": FFS and identical private plan always cost the same to beneficiary, but only because of unacceptable increase in beneficiary premium for FFS.

OMB. Modest changes in shares, or in price differences from private plans, lead to significantly larger "slant": Private plan that is identical to FFS costs $110 more in "base case" (Table 1), but this grows to $158 with only 5% greater private plan enrollment (Table 3).

Treasury. Identical private plan starts out costing $180 more (Table 1), and this difference changes only slightly (by $3) under alternative scenarios (Table 3).

Conclusions on Price Competition

Treasury option provides consistent incentives for price competition. Regardless of weighted-average premium and share of beneficiaries in traditional Medicare, incentives for all plans to avoid excessive cost increases are very similar to those in Breaux plan (and, unlike Breaux, traditional Medicare faces similar not stronger incentives).

- It provides similar incentives to private plans and FFS – in both cases beneficiaries generally see 70% or more of cost increases – while protecting FFS.

OMB option is a substantial improvement over current law, and is similar to Treasury under the most likely short-term scenario, but it creates price incentives that are much less reliable under other scenarios.

Second principle: Adequate support without encouraging excessive cost growth

Support based on weighted average of all plans or on a dominant plan (traditional Medicare) both "insure" most beneficiaries against unpredictable growth in health care costs.

Question is whether they provide excessive protection - would cost growth be greater under one option versus another?

How well do the competitive options (Treasury, OMB) address this principle?

– If past experience of private and Medicare growth rates is a guide, would expect comparable growth in government costs regardless of which option is used.

– Many economists would argue that, in a system where <u>all</u> plans face better incentives to limit unnecessary cost growth, spending growth will be slowed. Treasury plan provides stronger, more consistent incentives to limit cost growth.

Adverse Selection

What about "adverse selection" spiral? Even if incentives exist to limit unnecessary cost growth, costs could still rise in traditional Medicare if it faces adverse selection.

– Didn't a similar approach lead to rapid growth in government costs in FEHBP a decade ago?

FEHBP situation in 1980s differed in important ways:

– Selection exacerbated by use of two "high option" plans (identical to other plan choices except lower coinsurance and out-of-pocket limit) in contribution formula – "high option" is very vulnerable to selection.

– No risk adjustment.

– More recently, government spending growth in FEHB has been in line with private sector.

In addition, we all agree that we must protect traditional Medicare under reform- an adverse selection "death spiral" is simply not an acceptable outcome.

Limiting Adverse Selection in Traditional Medicare Under Competitive Reform

Risk adjustment and restrictions on supplemental benefits favored by healthy beneficiaries reduces incentives for adverse selection compared to current law.

But if this turns out to be inadequate, do the options help limit adverse selection?

Suppose additional healthy beneficiaries leave traditional Medicare and join private plans – as a result, the average cost of private plans falls and the average cost of traditional Medicare rises by $100.

OMB. The WAP is unchanged. Beneficiary premium in FFS rises by $12, but government support for private plans does not rise – protecting FFS beneficiaries but doing little to change the pressures for further selection and to bring FFS and private premiums back in line.

Treasury. Premium rises by $12 in FFS, and also falls in private plans. Sicker beneficiaries in FFS can thus get a higher quality private plan for their premium, encouraging them to switch, dampening selection pressures on FFS, and helping to keep the traditional program viable by discouraging a divergence between private and public Medicare.

Conclusions on "Good" Beneficiary Protection Against Health Care Cost Growth

Both OMB and Treasury options provide adequate support, and (unless price competition reduces cost growth) will probably lead to similar growth of government spending.

Treasury plan has other desirable long-term properties, such as discouraging private/public dichotomy in Medicare and doing more to discourage cost increases that are not worthwhile.

Sarah Abigail Bianchi

DRAFT

DISCUSSION OF COMPETITION IN MEDICARE

MAY 2, 1999

→ Weds. briefing for leadership → staff. →

→ Managed care currently is.

→ Tues 5:30 Deputies

→ Wed. principals.

I. **Current System**

II. **Breaux-Thomas Premium Support**

how to be for something

III. **Principles for Alternatives**

→ how to ensure won't cause more problems.

→ cost-sharing

→ premium support

→ drugs.

→ surplus.

Repealing → price and supplemental benefits.

I. CURRENT SYSTEM → better system

- **Traditional Medicare:**
  - Secretary has virtually no flexibility to negotiate or competitively price services, even when it saves money.
  - Most academic commissions (e.g., National Academy of Social Insurance Study Panel on Fee-For-Service Medicare) advocate for additional authority to adopt private sector approaches to managing costs
  - Congress has repeatedly rejected proposals to expand this authority → opposition from provider community
  - Implementing durable medical equipment demonstration in Florida [need greater details] → moving ahead

MEDICARE MANAGED CARE

- **Government payments have nothing to do with plan costs**:
  - Rates loosely based on local traditional program costs. Until the Balanced Budget Act of 1997, this represented overpayment.
  - Since Medicare pays a flat rate, there are no government savings if beneficiaries choose low-cost plans.
- **Plans compete on offering supplement benefits, <u>but</u>**:
  - **Only helps beneficiaries in managed care.**
    - Most of the 9 million rural Medicare beneficiaries do not have access to managed care. Over half of those who do have only one option. Studies show that plans without competition do not offer as many extra benefits.
    - Beneficiaries with chronic illness, with limited plan choices or whose doctor is not in the private plan may not want to enroll in managed care. These people may have no other affordable options for supplemental benefits.
  - **Makes it easier for plans to "cream skim".** Beneficiaries often do not know the value of supplemental benefits. This makes it easier for plans to selectively offer benefits to attract the youngest and healthiest beneficiaries.

MEDICARE BENEFICIARIES IN RURAL AMERICA: ACCESS TO PRIVATE HEALTH PLANS, 1999

State	Access to Private Medicare Plans						
	No Plans	One Plan	Two Plans	Total	No Plans	One Plan	Two Plans
Alabama	232,657	20,142	-	**252,799**	92%	8%	0%
Alaska	17,326	-	-	**17,326**	100%	0%	0%
Arizona	-	54,969	39,020	**93,989**	0%	58%	42%
Arkansas	219,305	24,272	22,909	**266,486**	82%	9%	9%
California	86,566	73,704	13,955	**174,225**	50%	42%	8%
Colorado	67,794	18,668		**86,462**	78%	22%	0%
Connecticut	-	-	16,028	**16,028**	0%	0%	100%
Delaware	30,595	-		**30,595**	100%	0%	0%
District of Columbia	-	-	-	**-**	0%	0%	0%
Florida	133,232	47,812	43,600	**224,644**	59%	21%	19%
Georgia	345,562	-	18,269	**363,831**	95%	0%	5%
Hawaii	-	8,284	36,201	**44,485**	0%	19%	81%
Idaho	98,557	9,899	-	**108,456**	91%	9%	0%
Illinois	291,938	56,313	6,121	**354,372**	82%	16%	2%
Indiana	253,315	13,569	-	**266,884**	95%	5%	0%
Iowa	307,031	-	-	**307,031**	100%	0%	0%
Kansas	207,977	-	-	**207,977**	100%	0%	0%
Kentucky	354,152	-	-	**354,152**	100%	0%	0%
Louisiana	46,885	76,984	44,618	**168,487**	28%	46%	26%
Maine	80,920	19,716	-	**100,636**	80%	20%	0%
Maryland	-	60,561	-	**60,561**	0%	100%	0%
Massachusetts	-	3,508	11,698	**15,206**	0%	23%	77%
Michigan	285,731	17,719	-	**303,450**	94%	6%	0%
Minnesota	253,719	6,983	4,595	**265,297**	96%	3%	2%
Mississippi	297,190	-	-	**297,190**	100%	0%	0%
Missouri	317,151	12,155	-	**329,306**	96%	4%	0%
Montana	106,015	-	-	**106,015**	100%	0%	0%
Nebraska	153,338	-	-	**153,338**	100%	0%	0%
Nevada	26,196	-	-	**26,196**	100%	0%	0%
New Hampshire	45,781	11,356	-	**57,137**	80%	20%	0%
New Jersey	-	-	-	**-**	0%	0%	0%
New Mexico	80,925	19,848	7,217	**107,990**	75%	18%	7%
New York	121,033	65,309	56,795	**243,137**	50%	27%	23%
North Carolina	370,305	21,270	59,943	**451,518**	82%	5%	13%
North Dakota	70,730	-	-	**70,730**	100%	0%	0%
Ohio	90,589	147,134	96,599	**334,322**	27%	44%	29%
Oklahoma	94,075	51,786	98,371	**244,232**	39%	21%	40%
Oregon	74,010	53,097	49,256	**176,363**	42%	30%	28%
Pennsylvania	-	80,726	269,423	**350,149**	0%	23%	77%
Rhode Island	-	-	-	**-**	0%	0%	0%
South Carolina	191,551	-	-	**191,551**	100%	0%	0%
South Dakota	88,022	-	-	**88,022**	100%	0%	0%
Tennessee	183,512	104,243	30,100	**317,855**	58%	33%	9%
Texas	267,882	170,517	87,904	**526,303**	51%	32%	17%
Utah	57,030	-	-	**57,030**	100%	0%	0%
Vermont	66,710	-	-	**66,710**	100%	0%	0%
Virginia	297,732	99,684	52,726	**450,142**	66%	22%	12%
Washington	59,214	37,012	69,339	**165,565**	36%	22%	42%
West Virginia	156,429	48,607	-	**205,036**	76%	24%	0%
Wisconsin	287,242	-	12,536	**299,778**	96%	0%	4%
Wyoming	45,082	-	-	**45,082**	100%	0%	0%
Puerto Rico	84,066	-	-	**84,066**	100%	0%	0%
TOTAL	**6,861,006**	**1,435,847**	**1,147,223**	**9,444,076**	**73%**	**15%**	**12%**

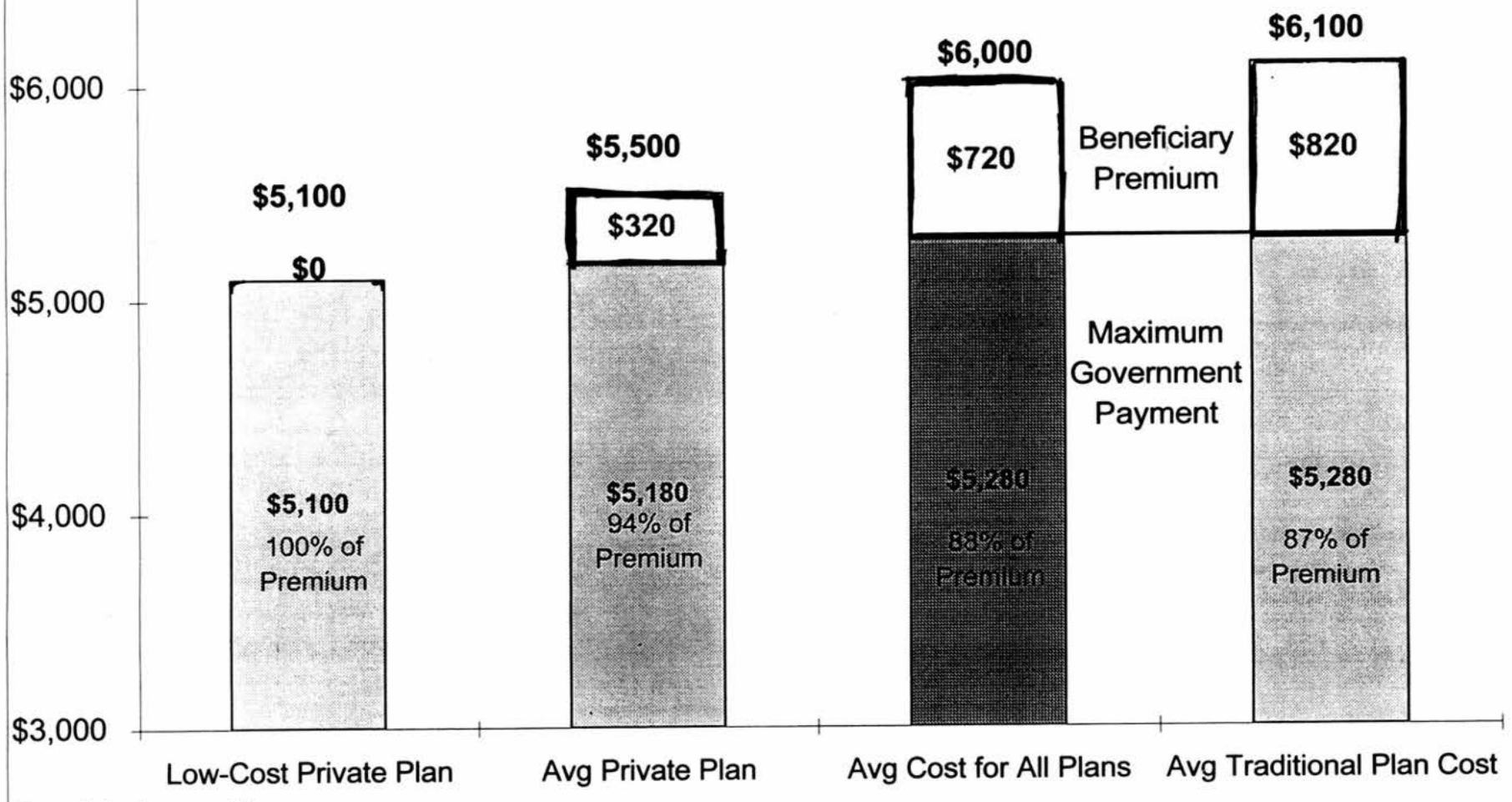
II. BREAUX-THOMAS PROPOSAL

- **Makes Traditional Medicare More Competitive**: The proposal include provisions such as:
  - Competitive pricing for services like medical supplies;
  - Selectively contracting with lower-cost, high-quality providers; and
  - Use preferred provider organizations to get better prices;
  - Paying one price for a specific conditions (e.g., diabetes or heart attacks) rather than on a service-by-service basis.

- **Saves about $14 billion over 10 years**, adding about a year of life to the Medicare Trust Fund.

Breaux-Thomas Premium Support Proposal

Gov't Contribution to the Traditional Medicare is Capped



Beneficiaries would pay about $720 under current law

Total Annual Bid for Medicare Services

PREMIUM SUPPORT

- **Limits Government Payments to Percent of Average Cost of All Plans:** Medicare's payments for health plans would be limited -- beneficiaries would pay more if they chose plans higher than average, less if they chose plans below the national average cost.

- **Reasons for savings:**

  - Higher premiums for traditional Medicare, since it would be a "high-cost plan" and require higher premiums;

  - Lower payments for lower-cost private plans (today, Medicare pays a flat payment rate regardless of plan costs); and

  - Increased enrollment in private plans lowers average cost, which is the basis for the maximum government contribution, thus reducing Federal costs.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries**: The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

- **Dilemma for rural beneficiaries.** Medicare beneficiaries in rural areas would pay differential premiums for the same traditional Medicare for the first time ever. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their health care needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even just one plan enter the area.

- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries, who generally have access to managed care, would not be protected against higher traditional program premiums. They would also likely pay more for private plans, since plans would raise premiums for beneficiaries to compensate for government payments that do not fully account for local costs, which are higher in most urban areas.

- **Unclear commitment to defined guarantee of benefits**: Allowing a board to approve benefit variations could erode Medicare's promise of a defined benefit package.

- **Unfunded mandate for states.** Since traditional Medicare premiums would rise under this proposal, so, too, would Medicaid costs since states pay for premiums for low-income beneficiaries

III. PRINCIPLES FOR ALTERNATIVE

- **Goal**: Improve competition and efficiency without achieving savings through traditional plan premium increases

- **Principles:**

  - No premium increases for traditional Medicare

  - Guarantees defined set of benefits, including prescription drug benefit

  - Replaces competition on extra benefits with price competition (as under all competitive options, including Breaux-Thomas)

  - Phases in to avoid disruption and only when risk adjustment is fully phased in

→ Liam Lippman

Jamie Nunn

MEDICARE OPTIONS
April 28, 1999

I. STATUS OF POLICIES

II. SOURCES & USES

III. BBA POLICIES / MODIFICATIONS

IV. INCOME-RELATED PREMIUM

Gephardt/
→ Senate Democrats
work common competitive
policy.
→ Competen dff Sen/House.
Sense of whole plan
lots of other issue
some of these savings
° issues.
sources & uses.
balanced budget

I. DECISIONS / UPCOMING MEETINGS

• **BBA Strategy**	Today
• **Income-Related Premium**	Today
• **Phased-In Drug Estimates**	Circulated ASAP
• **Graduate Medical Education Carve-Out**	Next Meeting
• **Cost Sharing Rationalization**	Next Meeting
• **Competitive Models**	Possibly Late Next Week
• **Financing Issues**	Possibly Late Next Week

II. SOURCES & USES

(Dollars in billions, fiscal years)

SOURCES	Savings (10 yrs)	USES	Costs (10 yrs)
Providers			
Balanced Budget Act extension/fixes	-25-40		
Modernizing traditional Medicare	-14		
Competitive private plan payments	-5-10**		
SUBTOTAL	**-44-64**		
Beneficiaries		**Beneficiaries**	
Income-related premium	-22-40	Voluntary drug benefit	+150-200
Cost sharing savings *	*	Cost sharing investments *	*
SUBTOTAL	**-22-40**	**SUBTOTAL**	**+150-200**
TOTAL	**-66-104**	**TOTAL**	**+160-225**
Medicare anti-fraud	-4	**Medicare buy-in**	+4
Surplus	-343		
ADDITIONAL FINANCING			
Cost sharing	-10		
Other (e.g., tobacco)	x		

All estimates preliminary / not all estimates from the HCFA actuaries

* Cost sharing changes will either be budget neutral or add to the savings

** Placeholder – not yet estimated by the actuaries

III. BBA POLICIES / MODIFICATIONS

- **Major Contributor to Balancing the Budget**. Roughly 40 percent of all spending reductions in the Balanced Budget Act of 1997 came from Medicare.

- **Extended Medicare Solvency**. At the time of the BBA, the actuaries estimated that these changes would extend the life of the Medicare Trust Fund for a decade. Combined with the strong economy and successful anti-fraud efforts, the Medicare Trust Fund is now solvent through 2015, and its spending growth per person is below the private sector.

- **Structural Reforms.** In several service categories, the savings came from restructuring:

  - **Managed care:** Reformed payment system
  - **Home health:** Prospective payment system
  - **Skilled nursing facilities:** Prospective payment system
  - **Hospital outpatient departments:** Prospective payment system

- **Payment Reduction.** In most other service areas, savings came from reduced payments and/or updates on payments. Most of these policies expire after 2002. As a result, Medicare spending growth is projected to rise beginning in 2003.

MEDICARE SAVINGS IN THE BALANCED BUDGET ACT OF 1997
(CBO 1997 estimates, dollars in billions)

PROVIDER	5 yrs	10 yrs
Hospitals	-35	-72
Managed Care	-22	-96
Home Health	-16	-50
Skilled Nursing Facilities	-10	-32
Physicians/ Nurses	-5	-8
Other Part B Providers *	-8	-23
Medicare as secondary payer	-8	-20
Part B Premiums	-15	-93
Preventive Benefits	+4	+9
TOTAL	**-115**	**-385**
For reference: Breaux-Thomas	-1	-102

* Includes: Labs, therapy caps, oxygen providers, etc.

CONCERNS ABOUT BBA

- **HOSPITALS:**
  - Repeal transfer policy
  - Limit impact of outpatient prospective payment system
  - Carve out disproportionate share hospital payments from managed care
  - Eliminate indirect medical education cuts in BBA

- **NURSING FACILITIES:**
  - Eliminate or allow exceptions to the therapy caps
  - Develop an outlier policy for medically complex patients
  - Exclude non-therapy ancillary services from prospective payment
  - Restore baseline spending ($9 billion)

- **HOME HEALTH:**
  - Develop an outlier policy for medically complex patients
  - Eliminate FY 2000 15 percent reduction in limits
  - Increase home health per visit cost limits to 112 % of mean
  - Restore full market basket update (reduced last fall for fix)

- **MANAGED CARE**
  - Delay implementation of risk adjustment; implement budget neutral
  - Increase rates

TOTAL COST: $30-40 billion over 10 years.

OPTIONS FOR BBA EXTENDERS / MODIFICATIONS

Straight extenders: Include policies in Breaux-Thomas proposal

- **PROS:**
  - Cover from the Medicare Commission
  - Hands-off approach to extenders / provider payment reductions in general

- **CONS**
  - Dead on arrival
  - Could jeopardize provider support / send them to Republicans who are working on fixes

Extenders with specific modification: Include specific modifications and/or administrative fixes.

- **PROS:**
  - More realistic since Congress is unlikely to pass the unmodified extenders
  - Explicitly addresses some of the providers' most pressing concerns

- **CONS**
  - Any modifications could risk our plan being considered serious structural reform
  - Providers not helped will complain; those helped will say it is not enough

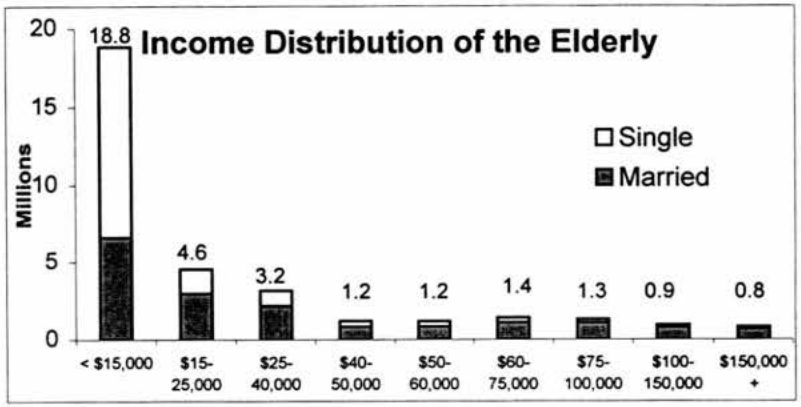
Extenders with general commitment for modification: Include funds but not specific policies.

- **PROS:**
  - Indicates willingness to deal with providers without committing to specific policies

- **CONS**
  - Lack of detail would lead to criticism that our proposal is more a political than policy document

IV. INCOME-RELATED PREMIUM

- **Currently, all beneficiaries pay the same Part B premium**. This premium represents only 25 percent of Part B costs – the government pays for 75 percent. Given the looming financial crisis in Medicare, proposals have been made to reduce the premium subsidy for the wealthiest.



- **Previous support for income-related premium.** In 1992, 1994, and 1997, the President has supported proposal or indicated support for a well-designed income-related premium that:
  - Does not fully phase out the subsidy (keeps 25 percent subsidy for the highest income)
  - Indexes the income thresholds to inflation
  - Is administered by Treasury.

- **Options:** The major question is when to begin phasing down the subsidy:
  - **$90,000 for singles, $115,000 for couples** (1 million people): $8 b over 5 / $22 b over 10
  - **$75,000 for singles, $90,000 for couples**: (2.4 million people) $10 b over 5 / $29 b over 10
  - **$50,000 for singles, $75,000 for couples** (4 million people): $15 b over 5 / $40 b over 10

MEDICARE:

ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

April, 1999

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MEDICARE: ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Medicare Commission

III. President's Plan for Strengthening Medicare

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans**: About 34 million elderly and 5 million people with disabilities receive Medicare.

- **Helps those who would otherwise be uninsured**: Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.

- **Improves life expectancy, access to care and reduces poverty**: Since 1965:

  - Life expectancy of people at age 65 has increased by 20 percent (79 to 82 years)

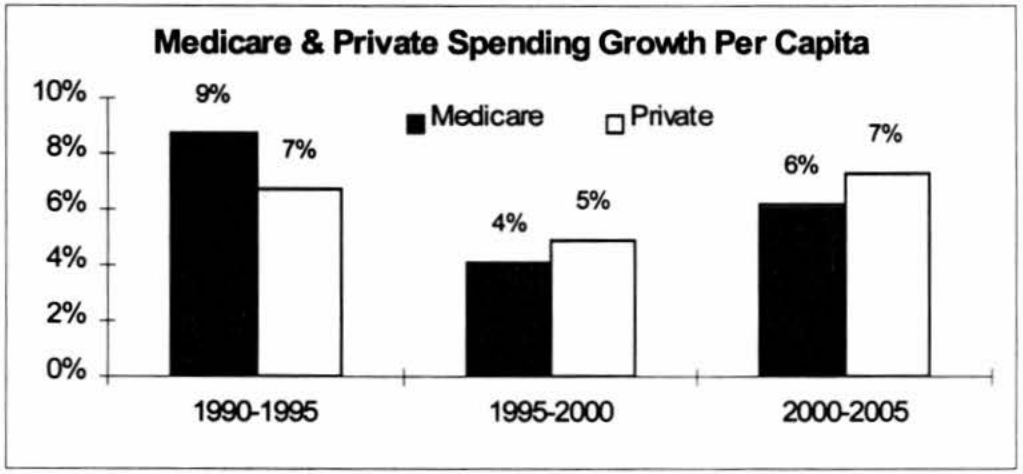
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)

  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

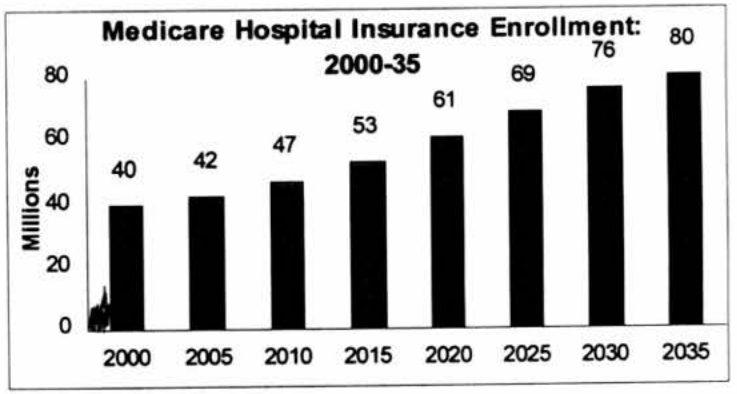
- In 1993, when President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999. Through commitment to a strong economy, coupled with actions that improve Medicare benefits while constraining cost growth, the trust fund now is projected to be solvent until 2015.

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. However, due to the policy changes in 1993 and 1997, as well as aggressive efforts to reduce fraud, Medicare spending growth has slowed. The slow Medicare spending growth is expected to continue through 2002 -- when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires: from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.



- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (3.6 workers per beneficiary in 2010; 2.3 in 2030).

- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare trust fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE

- **Inadequate benefits:** Medicare's benefits are not very generous. In particular:

  - No prescription drug coverage: Even though pharmaceuticals are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.

  - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a $768 deductible for hospital care, and $192 per day after two months, when beneficiaries are the sickest.

  - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.

  - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries pay for expensive and inefficient Medigap coverage.

- **Insufficient private tools for reducing costs:** Current law does not permit Medicare to adopt the most effective private sector tools to increase competition and save Medicare money.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal:** Its centerpiece is a "premium support" proposal which saves a net of $53 billion (Commission staff estimates) over 10 years. Most of the proposal's savings come from other policies, including:

  - Modernizing traditional Medicare
  - Extending the BBA savings proposals
  - Adding an unlimited home health copay
  - Raising Medicare's eligibility age to 67

- **Savings small relative to the size of Medicare's problem.** Commission staff claims $102 billion in net savings (including the $36 billion GME shift). This is:

  - One-fourth of BBA 1997 savings (CBO: $386 billion over 10 years); and
  - One-third of amount from committing 15 percent of the surplus to Medicare ($343 billion over 10).

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL
(Dollars in Billions, Commission estimates)

	00-04	00-09
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare Plus Extenders	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	-3	-102
BUDGET SAVINGS*	*+6*	*-66*

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare:** The year-long deliberations of the Medicare Commission, along with President's call for Medicare reform in the State of the Union, helped highlight the challenges facing the Medicare program.

- **The Breaux-Thomas proposal has advanced the debate.** The plan has recommended a number of ideas worth serious consideration, including:

  - Making Medicare's traditional plan more competitive: It recommends that Medicare adopt many of the competitive management tools that are used in the private sector.

  - Rationalizing Medicare's complicated, confusing cost sharing: It takes important steps like eliminating cost sharing for preventive services.

  - Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries**: The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

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Breaux-Thomas Premium Support Proposal

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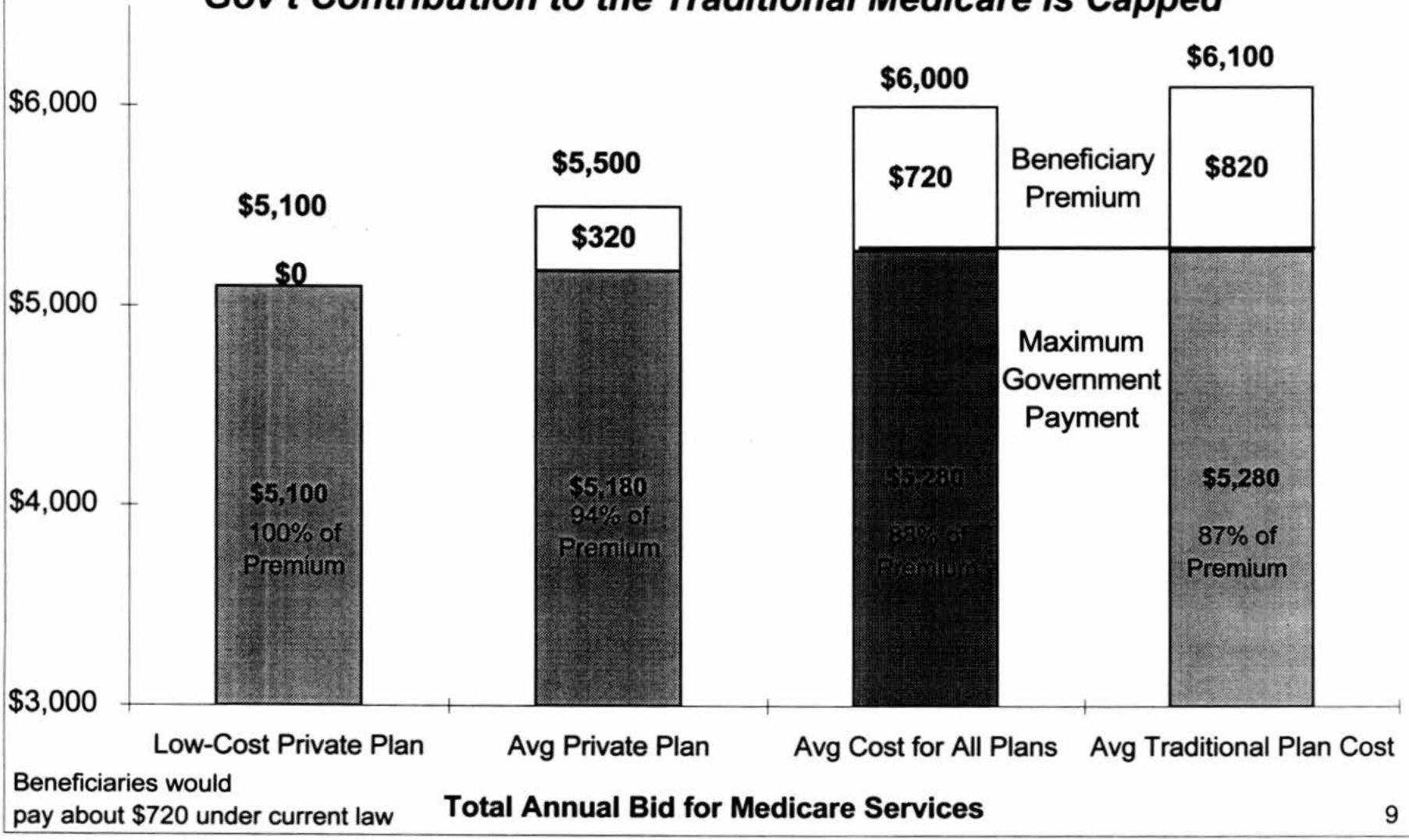


Beneficiaries would pay about $720 under current law

Total Annual Bid for Medicare Services

INADEQUATE & INEFFICIENT PRESCRIPTION DRUG BENEFIT

- **Not a Medicare benefit.** One of Medicare's strengths is that it provides health services to all beneficiaries, regardless of their residence, income or health status. By not providing a drug benefit through Medicare, the Breaux-Thomas proposal does not modernize Medicare. Instead, it restricts eligibility to beneficiaries with incomes below 135 percent of poverty (about $11,000 a year for a single senior) through a means-tested, Medicaid benefit.

  - **Helps only a fraction of beneficiaries without drug coverage:** Nearly 60 percent of beneficiaries without any drug coverage would not qualify. For example, a widow with $11,500 in income would not qualify for assistance for coverage. Nor would millions more beneficiaries who have expensive and/or extremely poor coverage.

  - **Fewer people enroll in Medicaid programs:** Experience with Medicare premium assistance programs shows that only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the voluntary Part B program.

- **Medigap and unsubsidized options are unworkable.** The Breaux-Thomas proposal would also require all Medigap plans, private managed care plans, and traditional Medicare to offer drug coverage. However, without premium assistance, the costs would likely be high, so that only those with high drug costs would sign up. This, in turn, would raise costs even more, so that over time benefits would become more restrictive, much more expensive, or it would become impossible to offer the coverage altogether.

OTHER SHORTCOMINGS OF THE BREAUX-THOMAS PLAN

- **Does not address Medicare's long-term solvency**: The Breaux-Thomas proposal ignores the need for new revenues to finance the care of the growing numbers of beneficiaries. According to Commission staff, the plan's net Medicare savings of around $100 billion over 10 years would extend Medicare's solvency for about 4 years. Probably about half of that effect results from the shift of graduate medical education out of Medicare Part A. Waiting to address Medicare's financing makes the problem much harder to solve and shifts more of the burden to our nation's children.

- **Raises the age eligibility for Medicare**: The most rapidly growing group of the uninsured is ages of 55 to 65. Raising the Medicare eligibility age without a policy to prevent even more uninsured would exacerbate this problem.

- **Includes an unlimited home health copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits. For the over 1 million beneficiaries who have more than 60 visits per year, this copay would represent a large financial burden.

- **Removes Direct Medical Education from Medicare:** Shifts funding for direct medical education from Medicare to an unspecified part of the budget. This does not produce Federal budget savings and does not assure that teaching hospitals are funded to continue their important mission.

- **Creates new bureaucracy:** A separate Board would oversee premium support, using new staff to approve benefits packages and rates in every single plan, decide on service areas, enforce financial and quality standards among other activities. Not only would it have little accountability to Congress, it would remove billions of taxpayer dollars from traditional government oversight.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare:**
  Neither the President nor his four appointees to the Commission could endorse all of aspects of the Breaux-Thomas proposal. However, the President is committed to working with Congress to develop and pass a plan this year to strengthen Medicare for the next century. To that end, he has instructed his advisors to develop a plan that conforms to the principles that he outlined in January:

  - Making Medicare more efficient and competitive;
  - Maintaining and modernizing Medicare's guaranteed benefits, including a prescription drug benefit; and
  - Assuring adequate financing by dedicating 15 percent of the surplus to Medicare.

MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

- **Providing private sector purchasing tools for traditional Medicare**: Medicare should be allowed to use the same, effective practices that private health insurers use to constrain costs, including:

  - Competitive pricing for services like medical supplies; and

  - Selectively contracting with lower-cost, high-quality providers.

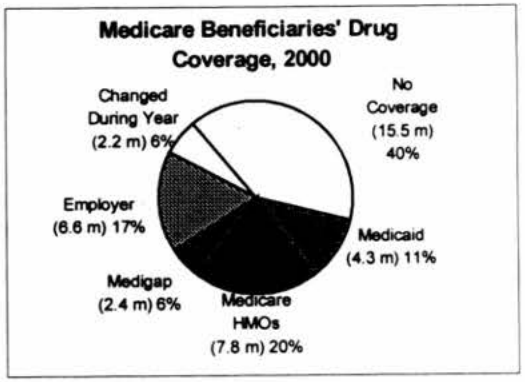
- **Examining other policies to reduce overpayment and increase competition**: The Administration will also examine specific options to reduce fraud, constrain costs and make both the traditional program and managed care payments more competitive and efficient.

MAINTAINING AND MODERNIZING MEDICARE'S GUARANTEED BENEFITS

- **Ensuring that Medicare's guarantee is strong**: Medicare protects some of our most vulnerable citizens -- the elderly and people with disabilities -- from excessive health care costs. Proposals to strengthen Medicare must not do so at the expense of this guarantee to a defined set of benefits.

- **Providing a long-overdue prescription drug benefit:**

  - Critical to modern medicine: Nearly all Medicare beneficiaries use prescription drugs, and their costs are over three times as high as that of other adults, and nearly 10 times that of children.



  - Existing coverage is unstable and expensive: Those beneficiaries who have private coverage are vulnerable, since employers are dropping retiree coverage and Medigap is becoming more costly and less accessible.

  - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable.

DEDICATING PART OF THE SURPLUS TO MEDICARE

- **Providing new financing by dedicating part of the surplus to Medicare**: The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years. This amount would equal $686 billion over the period and extend the life of the trust fund for another decade.

  - Investing now prevents larger problem later: Even though the Medicare shortfall is projected to accumulate to over $1 trillion over the next quarter century, the President's $686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing later.

  - One-time, fixed contribution: The plan does not create an unlimited tap on general revenues. Instead, it invests a fixed proportion of the surplus in Medicare to cover the temporary but overwhelming influx of retirees.

  - Funded by the baby boom generation -- not tomorrow's workers: The surplus was largely created by the baby boom generation, and makes sense as a one-time funding source for Medicare. In contrast, waiting until future generations are faced with raising taxes to support Medicare would shift this burden to younger and low-income workers.

MEDICARE:

ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

April, 1999

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MEDICARE: ITS LONG-TERM CHALLENGES, THE BREAUX-THOMAS PROPOSAL, AND THE PRESIDENT'S APPROACH TO REFORM

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Medicare Commission

III. President's Plan for Strengthening Medicare

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans**: About 34 million elderly and 5 million people with disabilities receive Medicare.

- **Helps those who would otherwise be uninsured**: Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.

- **Improves life expectancy, access to care and reduces poverty**: Since 1965:

  - Life expectancy of people at age 65 has increased by 20 percent (79 to 82 years)

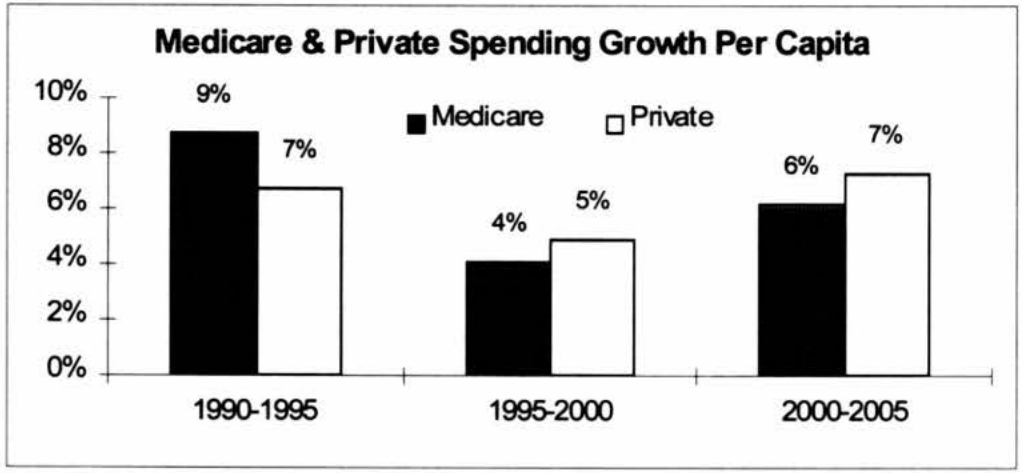
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)

  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

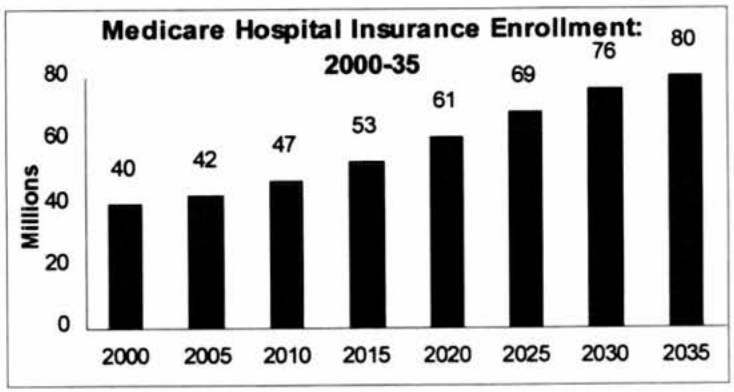
- In 1993, when President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999. Through commitment to a strong economy, coupled with actions that improve Medicare benefits while constraining cost growth, the trust fund now is projected to be solvent until 2015.

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. However, due to the policy changes in 1993 and 1997, as well as aggressive efforts to reduce fraud, Medicare spending growth has slowed. The slow Medicare spending growth is expected to continue through 2002 -- when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries:** Enrollment in Medicare will climb when the baby boom generation retires: from 39 to 80 million by 2035 -- from 14 percent to about 22 percent of the population.



- **Fewer workers:** The ratio of workers who support Medicare beneficiaries is expected to decline by over 40 percent by 2030 (3.6 workers per beneficiary in 2010; 2.3 in 2030).

- **Cost growth will rise:** Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare trust fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE

- **Inadequate benefits:** Medicare's benefits are not very generous. In particular:

  - No prescription drug coverage: Even though pharmaceuticals are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.

  - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a $768 deductible for hospital care, and $192 per day after two months, when beneficiaries are the sickest.

  - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.

  - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries pay for expensive and inefficient Medigap coverage.

- **Insufficient private tools for reducing costs:** Current law does not permit Medicare to adopt the most effective private sector tools to increase competition and save Medicare money.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal:** Its centerpiece is a "premium support" proposal which saves a net of $53 billion (Commission staff estimates) over 10 years. Most of the proposal's savings come from other policies, including:

  - Modernizing traditional Medicare
  - Extending the BBA savings proposals
  - Adding an unlimited home health copay
  - Raising Medicare's eligibility age to 67

- **Savings small relative to the size of Medicare's problem.** Commission staff claims $102 billion in net savings (including the $36 billion GME shift). This is:

  - One-fourth of BBA 1997 savings (CBO: $386 billion over 10 years); and
  - One-third of amount from committing 15 percent of the surplus to Medicare ($343 billion over 10).

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL
(Dollars in Billions, Commission estimates)

	00-04	00-09
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare Plus Extenders	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	-3	-102
*BUDGET SAVINGS**	*+6*	*-66*

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare:** The year-long deliberations of the Medicare Commission, along with President's call for Medicare reform in the State of the Union, helped highlight the challenges facing the Medicare program.

- **The Breaux-Thomas proposal has advanced the debate.** The plan has recommended a number of ideas worth serious consideration, including:

  - Making Medicare's traditional plan more competitive: It recommends that Medicare adopt many of the competitive management tools that are used in the private sector.

  - Rationalizing Medicare's complicated, confusing cost sharing: It takes important steps like eliminating cost sharing for preventive services.

  - Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries**: The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

- **Dilemma for rural beneficiaries.** Medicare beneficiaries in rural areas would pay differential premiums for the same traditional Medicare for the first time ever. Beneficiaries with as few as one private plan option would either have to pay a higher premium to remain in the traditional plan or opt for a private plan that might not contract out with their physician or otherwise meet their health care needs. Beneficiaries with no private plans would pay the current premium for traditional Medicare but would be vulnerable to an abrupt premium increase should even just one plan enter the area.

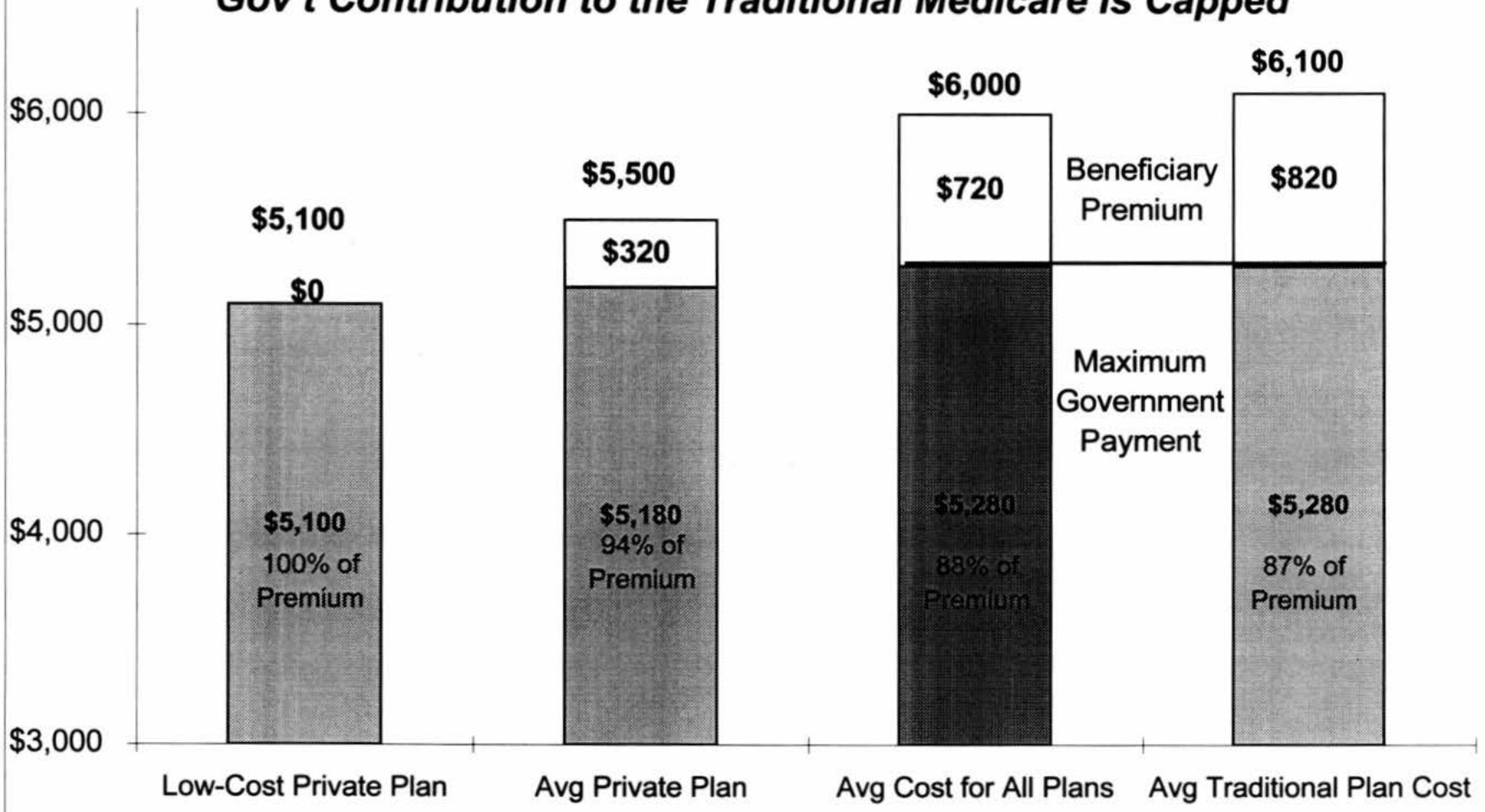
- **Lose-lose situation for urban beneficiaries.** Urban beneficiaries, who generally have access to managed care, would not be protected against higher traditional program premiums. They would also likely pay more for private plans, since plans would raise premiums for beneficiaries to compensate for government payments that do not fully account for local costs, which are higher in most urban areas.

- **Unclear commitment to defined guarantee of benefits**: Allowing a board to approve benefit variations could erode Medicare's promise of a defined benefit package.

- **Unfunded mandate for states.** Since traditional Medicare premiums would rise under this proposal, so, too, would Medicaid costs since states pay for premiums for low-income beneficiaries.

Breaux-Thomas Premium Support Proposal

Gov't Contribution to the Traditional Medicare is Capped



Beneficiaries would pay about $720 under current law

Total Annual Bid for Medicare Services

INADEQUATE & INEFFICIENT PRESCRIPTION DRUG BENEFIT

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AGENDA: DEPUTIES' MEETING

I. Review Drug Estimates, Discuss Presentation

II. GME

Idea of carving out, reducing the surplus contribution commensurately

Pros and Cons

III. Board

Review budget proposal

Anything new

Response to Breaux-Thomas

IV. Medicare High Options?

Offering supplemental coverage through Medicare

ESTIMATES OF PRESCRIPTION DRUG BENEFITS

(Dollars in billions; cash basis, fiscal years)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	00-04	00-09	01-05	01-10
* $1,000 ded, 0% coins	0	0.4	19.0	24.8	28.5	32.3	36.4	41.1	46.2	52.1	59.5	**72.7**	**280.8**	**105.0**	**340.2**
$0 cap		***$10***	***$19***	***$21***	***$24***	***$26***	***$29***	***$32***	***$36***	***$39***	***$44***				
* $2,000 ded, 0% coins	0	0.1	9.0	13.0	15.4	17.8	20.4	23.4	26.7	30.6	35.5	**37.5**	**156.3**	**55.3**	**191.8**
$0 cap		***$3***	***$10***	***$11***	***$13***	***$15***	***$17***	***$19***	***$21***	***$24***	***$27***				
* $0 ded., 50% coins	0	10	19.6	20.8	22.4	24.1	25.8	27.9	30.1	32.5	35.4	**72.8**	**213.2**	**96.9**	**248.6**
$2000 cap		***$16***							*7/1/01 Effective Date:*			**64.0**	**204.0**		
* $0 ded., 50% coins	0	10.6	20.7	22.3	24	26.0	28.1	30.4	33	35.8	39.3	**77.6**	**230.9**	**103.6**	**270.2**
$3000 cap		***$16***													
* $0 ded., 50% coins	0	10.9	21.5	23.1	25	27.2	29.5	32.1	34.9	38.1	42	**80.5**	**242.3**	**107.7**	**284.3**
$5000 cap		***$17***							*7/1/01 Effective Date:*			**70.0**	**232.0**		
Phased-In Benefit Caps															
$5,000 by 2008:	*Cap:*	*$1,000*	*$2,000*	*$2,000*	*$3,000*	*$3,000*	*$4,000*	*$4,000*	*$5,000*	*indexed*					
* $0 ded., 50% coins	0	0.6	19.5	20.7	23.3	25.8	28.5	31.2	34.3	37.7	41.5	**64.1**	**221.6**	**89.9**	**263.1**
Phased-In $5000 cap (7/1/01 eff date)		***$15***	***$16***	***$16***	***$19***	***$20***	***$22***	***$24***	***$26***	***$27***	***$29***				
$3,000 by 2008:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$1,500*	*$2,000*	*$2,000*	*$2,500*	*$3,000*	*indexed*					
* $0 ded., 50% coins	0	0.5	16.7	17.8	19.6	22.3	24.4	27.2	30.7	33.7	36.9	**54.7**	**193.0**	**77.0**	**229.9**
Phased-In $3000 cap (7/1/01 eff date)		***$15***	***$12***	***$15***	***$15***	***$18***	***$19***	***$21***	***$23***	***$24***	***$26***				
$2,500 by 2008:	*Cap:*	*$1,000*	*$1,000*	*$1,250*	*$1,500*	*$1,750*	*$2,000*	*$2,250*	*$2,500*	*indexed*					
* $0 ded., 50% coins	0	0.5	16.7	17.1	19.2	21.6	24.1	26.7	29.4	32.1	35.0	**53.5**	**187.4**	**75.1**	**222.4**
Phased-In $2,500 cap (7/1/01 eff date)		***$15***	***$12***	***$14***	***$15***	***$17***	***$19***	***$20***	***$22***	***$23***	***$24***				
$3,000 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$2,000*	*$2,500*	*$3,000*	*indexed*								
* $0 ded., 50% coins	0	0.5	16.7	18.9	22.3	25.1	27.4	29.7	32.1	34.8	38.1	**58.4**	**207.6**	**83.5**	**245.7**
Phased-In $3000 cap (7/1/01 eff date)		***$15***	***$12***	***$16***	***$18***	***$20***	***$21***	***$22***	***$24***	***$25***	***$27***				
$2,500 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*indexed*								
* $0 ded., 50% coins	0	0.5	16.7	17.8	20.9	24.0	26.3	28.5	30.8	33.3	36.3	**55.9**	**198.8**	**79.9**	**235.1**
Phased-In $2,500 cap (7/1/01 eff date)		***$15***	***$12***	***$15***	***$17***	***$19***	***$20***	***$21***	***$23***	***$24***	***$25***				
$3,000 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$3,000*	*indexed*								
* $0 ded., **33% coins.**	0	0.7	20.5	21.7	26.1	32.2	36.6	39.8	43.0	46.5	50.8	**68.9**	**267.0**	**101.1**	**317.7**
Phased-In $3000 cap (7/1/01 eff date)		***$19***	***$14***	***$18***	***$22***	***$27***	***$28***	***$30***	***$32***	***$33***	***$36***				
$2,500 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*indexed*								
* $0 ded., **33% coins.**	0	0.7	20.5	21.7	26.1	30.9	34.3	37.1	39.9	43.2	47.0	**68.9**	**254.2**	**99.8**	**301.2**
Phased-In $2,500 cap (7/1/01 eff date)		***$19***	***$14***	***$18***	***$22***	***$25***	***$26***	***$28***	***$29***	***$31***	***$33***				
Kennedy-Rockefeller. Note caps indexed to drug, not gen'l inflation															
* $200 ded., 20% coins, $1200 cap	0.7	21.4	23.1	25.5	28.4	31.6	35.1	39.0	43.4	48.3	54.4	**99.0**	**296.4**	**129.9**	**350.1**
$3000 OOP limit, Medicaid wrap	***$16***	***$16***	***$18***	***$19***	***$21***	***$23***	***$26***	***$28***	***$30***	***$33***	***$36***				
* $200 ded., 20% coins, $1200 cap	0.6	19.1	19.9	21.9	24.4	27.3	30.4	33.8	37.7	42.0	47.4	**86.0**	**257.1**	**112.6**	**303.9**
No catastrophic, Medicaid wrap	***$15***	***$15***	***$16***	***$18***	***$19***	***$21***	***$23***	***$26***	***$28***	***$30***	***$33***				

ESTIMATES OF PRESCRIPTION DRUG BENEFITS

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	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	00-04	00-09	01-05	01-10
* $1,000 ded, 0% coins	0.0	0.2	12.7	16.5	19.0	21.5	24.3	27.4	30.8	34.8	39.7	48.5	187.3	70.0	226.9
$0 cap		***$20***	***$38***	***$43***	***$48***	***$53***	***$59***	***$65***	***$71***	***$79***	***$88***				
* $2,000 ded, 0% coins	0.0	0.1	6.0	8.6	10.3	11.8	13.6	15.6	17.8	20.4	23.7	25.0	104.2	36.9	127.9
$0 cap		***$7***	***$20***	***$23***	***$26***	***$30***	***$34***	***$38***	***$42***	***$47***	***$53***				
* $0 ded., 50% coins.	0.0	6.7	13.1	13.9	14.9	16.1	17.2	18.6	20.1	21.7	23.6	48.6	142.2	64.6	165.8
$2000 cap		***$32***							*7/1/01 Effective Date:*			42.7	136.1		
* $0 ded., 50% coins.	0.0	7.1	13.8	14.9	16.0	17.3	18.7	20.3	22.0	23.9	26.2	51.8	154.0	69.1	180.2
$3000 cap		*$32*													
* $0 ded., 50% coins.	0.0	7.3	14.3	15.4	16.7	18.1	19.7	21.4	23.3	25.4	28.0	53.7	161.6	71.8	189.6
$5000 cap		***$34***							*7/1/01 Effective Date:*			46.7	154.7		
Phased-In Benefit Caps															
$5,000 by 2008:	*Cap:*	*$1,000*	*$2,000*	*$2,000*	*$3,000*	*$3,000*	*$4,000*	*$4,000*	*$5,000*	*indexed*					
* $0 ded., 50% coins.	0.0	0.4	13.0	13.8	15.6	17.2	19.0	20.8	22.9	25.1	27.7	42.7	147.8	59.9	175.5
Phased-In $5000 cap (7/1/01 eff date)		***$29***	***$31***	***$33***	***$38***	***$40***	***$45***	***$47***	***$51***	***$55***	***$59***				
$3,000 by 2008:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$1,500*	*$2,000*	*$2,000*	*$2,500*	*$3,000*	*indexed*					
* $0 ded., 50% coins.		0.4	11.2	11.9	13.1	14.8	16.3	18.2	20.4	22.5	24.6	36.5	128.7	51.3	153.4
Phased-In $3000 cap (7/1/01 eff date)		***$29***	***$24***	***$29***	***$31***	***$36***	***$37***	***$42***	***$46***	***$49***	***$52***				
$2,500 by 2008:	*Cap:*	*$1,000*	*$1,000*	*$1,250*	*$1,500*	*$1,750*	*$2,000*	*$2,250*	*$2,500*	*indexed*	0				
* $0 ded., 50% coins.		0.4	11.2	11.4	12.8	14.4	16.0	17.8	19.6	21.4	23.3	35.7	125.0	50.1	148.3
Phased-In $2,500 cap (7/1/01 eff date)		***$29***	***$24***	***$27***	***$31***	***$34***	***$37***	***$40***	***$44***	***$46***	***$49***				
$3,000 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$2,000*	*$2,500*	*$3,000*	*indexed*	*$0*	*$0*	*$0*	0				
* $0 ded., 50% coins.		0.4	11.2	12.6	14.8	16.7	18.3	19.8	21.4	23.2	25.4	39.0	138.5	55.7	163.9
Phased-In $3000 cap (7/1/01 eff date)		***$29***	***$24***	***$32***	***$36***	***$40***	***$42***	***$45***	***$47***	***$50***	***$54***				
$2,500 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*indexed*	*$0*	*$0*	*$0*	0				
* $0 ded., 50% coins.		0.4	11.2	11.9	13.9	16.0	17.6	19.0	20.5	22.2	24.2	37.3	132.6	53.3	156.8
Phased-In $2,500 cap (7/1/01 eff date)		***$29***	***$24***	***$29***	***$34***	***$38***	***$40***	***$43***	***$45***	***$48***	***$51***				
$3,000 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$3,000*	*indexed*	*$0*	*$0*	*$0*	0				
* $0 ded., **33% coins.**		0.5	13.6	14.4	17.4	21.5	24.4	26.5	28.7	31.0	33.9	46.0	178.1	67.4	211.9
Phased-In $3000 cap (7/1/01 eff date)		***$37***	***$28***	***$36***	***$43***	***$53***	***$56***	***$60***	***$63***	***$67***	***$71***				
$2,500 by 2005:	*Cap:*	*$1,000*	*$1,000*	*$1,500*	*$2,000*	*$2,500*	*indexed*	*$0*	*$0*	*$0*	0				
* $0 ded., **33% coins.**		0.5	13.6	14.4	17.4	20.6	22.8	24.7	26.6	28.8	31.3	46.0	169.6	66.6	200.9
Phased-In $2,500 cap (7/1/01 eff date)		***$37***	***$28***	***$36***	***$43***	***$50***	***$53***	***$56***	***$59***	***$62***	***$66***				
Kennedy-Rockefeller: Note caps indexed to drug, not gen'l inflation															
* $200 ded., 20% coins, $1200 cap	0.0	14.2	15.4	17.0	18.9	21.1	23.4	26.0	28.9	32.2	36.3	65.6	197.3	86.7	233.5
$3000 OOP limit, Medicaid wrap		***$32***	***$35***	***$39***	***$43***	***$47***	***$51***	***$56***	***$61***	***$66***	***$73***				
* $200 ded., 20% coins, $1200 cap	0.0	12.7	13.3	14.6	16.3	18.2	20.3	22.6	25.1	28.0	31.6	56.9	171.1	75.1	202.7
No catastrophic, Medicaid wrap		***$29***	***$32***	***$35***	***$39***	***$43***	***$47***	***$51***	***$56***	***$61***	***$67***				

DRAFT

Sarah Bianchi

→ Misbranding → illegal to sell pres. drug

→ reimportation (Dingell)

DOJ - fraud - (mail fraud)

CJ
1. high priority
2. guidance - draft → to FTC.
3. interagency database appealing - board of pharm
→ list of companies
→ licensed appropriate
→ state boards have some authority but is an interstate issue.

→ domestic side

product promoted
FDA → our authority activities

→ not approved, not safe - we can take act

→ promoting → labeling →
FTC - advertising
) fraud → justice

→ misbranding

→ promotional advertising → Industry wants clarifying guidance.

never said that we had jurisdiction over the internet.

labeling / guidance

enforcement.

home
site map

CVS pharmacy

now at your Convenience

Pharmacy Information

visit our store
health care services
corporate info
investor info
employment
talk to us

Care that touches everyone... one at a time.

Thank you for visiting the CVS website. We're very proud to offer you, our friends and customers, value and excellent service that you deserve.

They're Here!

Introducing Health*Tracker* The Personal Medical Record

On-Line Refills

Purchase your American Greetings cards on-line

Store Locator

Photo Center

visit our store | health care services | corporate info | investor info | employment | talk to us | site map

For web site questions/comments, send e-mail to webmaster@cvs.com

Online Refill

CVS Pharmacy Store Number

Rx Numbers (up to 6) All scripts must be from above pharmacy.

1) 2) 3)

4) 5) 6)

First Name (as it appears on label)

Last Name (as it appears on label) Jr. or Sr.

E-mail Address Home Phone Number - -

Pickup Month-Day-Year-Time please allow at least 2 hours for processing prescriptions.

Comment to your pharmacist

Submit Clear Form

PRO-MARK

Pharmacies

**"Pro-Mark's Family
Helping Other Families"™**

PHARMACIES
Infertility Pharmacy
Impotence Pharmacy
Kidney Health Newsletter
Kidney Health Pharmacy
AIDS Medication
Compounded Prescriptions
Home Infusion Pharmacy
Hospice Pharmacy
Oxygen Respiratory
Viagra

MEDICAL AIDS
DISEASE MANAGEMENT
HOME HEALTH CARE
INFERTILITY
BREAST PROSTHESIS
INFUSION SERVICES

Mail Order Form
Contact Us
Ask Our Pharmacists
Join Our ListBot

What's New
Gallup Poll Pharmacists #1
Company Information
What People Say About Us

Translate

to German

**Looking for something in particular?
Call us and ask - we probably stock it.**

1-800-728-3815

VISA

**Mail Service Pharmacy
P.O. Box 29897
San Antonio, Texas 78229-0897**

Viagra

PHARMACIES
Impotence Pharmacy
Viagra

MEDICAL AIDS
DISEASE MANAGEMENT
HOME HEALTH CARE
INFERTILITY
BREAST PROSTHESIS
INFUSION SERVICES

Mail Order Form
Contact Us
Ask Our Pharmacists
Join Our ListBot

What's New
Gallup Poll Pharmacists #1
Company Information
What People Say About Us

Translate

to German

Please Scroll Down for Complete Information and Pricing

Viagra now in stock for prescription delivery!
(United States, Canada, Mexico)
We can ship to other countries if we have a prescription from an American, Canadian or Mexico doctor
We also ship penile injections and all other medications and supplies needed to treat erectile disfunction

Prescriptions may be faxed to:
(210) 614-3819
24 hours a day

or have your doctor call us at (800) 728-3815!

Pro-Mark is now taking prescription orders for Viagra!
Click Here to Order
Extra special web pricing! Please tell us you saw this on our web page.

All strengths same low price!

10 Tabs - $089.97
20 Tabs - $170.95
30 Tabs - $252.92
Plus $1.00 shipping charge (regular mail)
Click Here to Order

(800) 728-3815

(210) 614-3819 - Fax

VIAGRA™
(sildenafil citrate)
Tablets

DESCRIPTION

Home || References || Company Information

PRO-MARK® PHARMACIES

Scroll Down for Easy Order Prescription Form

800-728-3815
ProMarkRx@aol.com

Please Scroll Down to View Complete Order Form

Viagra Specials

Refill Prescription(s)

Order with this form. Simply enter the prescription refill numbers at end for form, along with the other information requested.

New Prescription(s)

Please mail the original prescription to us. If you need faster service, just send us your doctor's name, phone number (with area code), and the name of the medication you need. We will do the rest!

(800) 728-3815

Transferred Prescription(s)

Just enter in the box at the end of this form the name and phone number (with area code) of your current pharmacy along with the prescription number(s) to be refilled.

We will do the rest!

Price Quotes

(Please give drug name, strength and quantity in the box at the end of this form)

Patient Name

Your E-mail Address (Important!)

Insurance Plan or Prescription Drug Card Name

Group Number and Social Security Number

Name on Credit Card

MasterCard

Name of Credit Card

Credit Card Number

Expires (mm/yy)

Mailing Address

City

State

ZIP

Area Code and Phone Number

Enter Prescription Refill Numbers, New Prescription Request, Transfer Request, Non-Prescription Drug Order, Questions, Comments, or Requests for Price Quotes Below!

Clear

Please Submit Your Order or Request

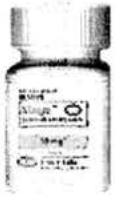
ProMarkRx@aol.com

Home || References || Company Information

Online Consultation
and Prescription for

Viagra ®

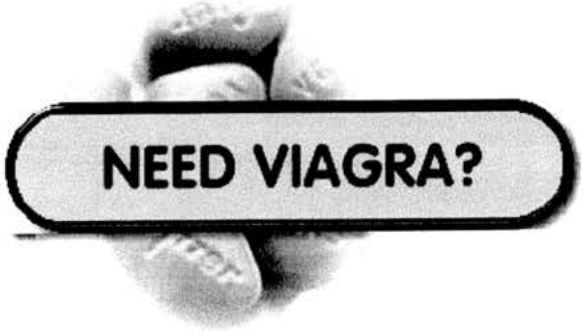
Express Rx
VIAGRA PRESCRIPTIONS ONLINE



ORDER
INFO
REFILL
CONTACT

Viagra ® has recently been approved for sexually dysfunctional or impotent men. *Express Rx* provides a *secure, confidential, and simple* way for you to be evaluated for Viagra ® use and purchase your Viagra ® prescription on-line.
Click here to order Viagra

It has been estimated that up to 30 million men in the U.S. suffer from sexual dysfunction (impotence). Until recently, sexual dysfunction has been effectively treated with injections, surgery, and other procedures, many of which are painful and embarrassing. In March 1998, the FDA announced that Viagra ® a new drug from Pfizer, Inc., has been approved as treatment for male sexual dysfunction. This revolutionary treatment has been shown to help about 70% of men with impotency problems. We highly recommend you familiarize yourself with all aspects of Viagra ® at www.viagra.com. Also you may wish to read our Viagra® Review.



To complete your Viagra consultation via fax, call 1-800-586-1719
Ask for Operator "W"

It's Easy to Order!

1: Agree to the Waiver of Liability
2: Complete **online consultation form***
3: Provide payment and **shipping information**
4: Receive your Viagra within **24-48 hours**

*Our physician's consultation fee is $75. If you are approved for Viagra, you may order up to three additional Viagra refills. If you are not approved, there will be NO charge for the consultation.

Online Consultation and Prescription for Viagra ®

Express Rx

Secure Order Form

You are at

STEP 2

Personal and Payment Info

Please provide the following information as completely and accurately as possible. All information must be provided to process your consultation. The following information is transmitted to us using a SSL secure connection.

Directions

- Please fill out all fields completely.
- **You will not be charged the $75.00 Consultation fee if you are not approved.**

Name:	
Address:	
City:	
State:	
Zip Code:	
Country:	
Phone:	
Email:	

If I am approved for Viagra ®, I would like my prescription to be charged to my credit card and dispensed by ExpressRX Services. This initial prescription is good for a total of 120 Viagra ® tablets. You may order as many as you wish at this time and the balance in the future with no further consultation fee. For patients who select the 100mg dose, ExpressRX Services is offering a FREE pill splitter.

Splitting the 100mg dose can result in a cost of only $4.95 per dose!!

I Request the following pill prescription

50 mg	100 mg

Send my prescription as follows

- (•) Within the U.S.A, Federal Express (overnight) $18.00
- ( ) Outside the U.S.A., Federal Express (2-4 days) $47.00

Attention: International Orders. By asking us to ship to another country, you are assuming all liability for any customs, duties, or tariffs. Should customs seize the shipment, we cannot refund your cost. If it is returned to us, you will be charged for shipping both ways. ☑ **I Agree**

Credit Card Information

Notes:

- All amounts are in **US currency**.
- If the address and zip code you listed above are the same as the address and zip code that your credit card statement is sent to, then don't enter anything for billing address and zip code.
- For expiration dates in the year 2000 and above enter 00 for 2000, 01 for 2001, etc.

Name of Credit Card Holder:

Enter Credit Card Number:

Billing Address:

Billing Zip Code:

Expiration (MM/YY):

By submitting this consultation form

	Agree
I certify that I am 18 years of age or older.	☐
I am permitted by law to receive these products in my region/country/locale .	☐
I understand the side-effects of this drug.	☐
I do not have a current prescription for Viagra® from another physician.	☐
I certify that I am allowed by law to use the credit card I have selected below.	☐
I understand that my credit card will be billed for this consultation and that if I choose to have Viagra ®	☐

dispensed from ExpressRx., this too will be billed to my account if my consultation is approved.
I certify that I will answer all the questions truthfully. ☐

Medical History

STEP 3

Your Medical History informs us of any possible medical contraindications you may have to taking Viagra®. This information would be required before any physician could treat you for any illness or condition.

What is your height (in inches)? ☐ Sex? ◉ male ○ female

What is your current weight (in lbs)? ☐ What is your month and year of birth? ☐ (MM/YY)

Are you taking any of the following?

☐ Nitroglycerin	☐ Nitrek (transdermal)	☐ Nitro-Bid®
☐ Nitrodisc	☐ Nitro-Dur®	☐ Nitrogard™
☐ Nitroglyn	☐ Nitrlingual Spray®	☐ Nitrol® Ointment (Apoll-Kit)®
☐ Nitrong	☐ Nitro-Par	☐ Nitrostar®
☐ Nitro-Time	☐ Transderm-Nitro®	☐ Isosorbide Mononitrate
☐ Imdur®	☐ Ismo®	☐ Monoket®
☐ Isosorbide Dinitrate	☐ Dilarate®-SR	☐ Isordil®
☐ Sorbitrate®	☐ Erythatyl Tetranitrate	☐ Pentaerythritol Tetranitrate
☐ Sodium Nitroprusside	☐ Deponit® Transdermal	

Do you have any of the following medical problems?

☐ Coronary Artery Disease	☐ Congestive Heart Failure	☐ Valvular Heart Disease
☐ Anatomic Deformation of the Penis	☐ Peyronie's Disease	☐ Multiple Myeloma
☐ Obesity	☐ Hypertension	☐ Diabetes Mellitus
☐ Prostate Cancer	☐ Enlarged Prostate	☐ Low Testosterone
☐ Thyroid Disease	☐ Atherosclerosis	☐ Liver Disease

☐ Kidney Disease	☐ Stroke	☐ Depression
☐ Anxiety	☐ Schizophrenia	☐ Spinal Cord Injury
☐ Endocrine Disorders	☐ Sickle Cell Anemia	☐ Leukemia

Have you had a complete physical exam with blood tests within the last year?	○ yes ○ no
Do you consume more than 2 servings a day of alcohol?	○ yes ○ no
Do you smoke cigars or cigarettes?	○ yes ○ no

List current medications and any medical problems.

Are you unable to achieve and sustain an erection that is adequate for penetration until orgasm? ○ yes ○ no

Have you ever been evaluated for erectile dysfunction? ○ yes ○ no

I feel that I am incapable of having normal satisfying sex without prescription medication. ○ true ○ false

Where did you hear about us?

Please Specify Which Newspaper

Please only click the Complete Consultation Button **ONCE**.
It may take a moment to check your information.

Complete Consultation | Exit

If you have any questions, please call
ExpressRx.,
1-800-435-2668 Ask for operator "W"

ONLINE

WELCOME TO THE PILL BOX PHARMACY

Established in 1971,
The Pill Box Pharmacy has always stood for quality health care at affordable prices.

As we head into the 21st century, we look forward to extending that very same commitment to excellence to you and to all of our new web friends.

Please take some time to explore our site. We promise to keep you updated with important information, timely tips and money saving specials.

This Month's Special

click for VIAGRA,this month's special

Propecia™ via Secure Server at The Pill Box Pharmacy click here

Click to Buy Propecia

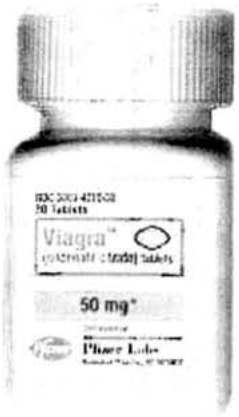
Home | Products | About Wellness | Contact Us
FAQ's | Tips | Links | About Us

site by 123 SolveIt

Viagra® (sildenafil),
The First Oral Treatment for Male Impotence.

Translate to German

courtesy AltaVista Translation Services



It's official. The FDA has approved Viagra.
The wait is over!

CLICK HERE for Bulk Purchases
(over 90 pills)

CLICK HERE for Retail Purchases
(90 pills, or less)

Viagra is available only by prescription. If you would like an Online Consultation with a licensed physician to obtain a Viagra Prescription, if appropriate to your medical condition and history, CLICK HERE to go to www.MedicalCenter.net. If approved for a Viagra prescription, MedicalCenter.net will send us your prescription so that we can ship your Viagra directly to you.

Frequently Asked Questions
about Viagra:

What is Viagra?
Viagra, is a new drug from Pfizer for use in the treatment of male impotency. It is the first oral treatment for male impotence filed with the U.S. Food & Drug Administration and the European Medicines Evaluation Agency. It was approved by the FDA, 3/27/98.

Is there Prescribing Information I can read?
Yes, full prescribing information has now been published. Visit http://www.viagra.com for full details.

How does Viagra work?
Viagra is taken orally and is a known as a phosphodiesterase 5 (PDE5) inhibitor. By inhibiting the PDE5 enzyme, which is found mainly in the penis, Viagra allows the chemical produced during sexual stimulation, cyclic GMP, to persist. The longer cyclic GMP persists, the better chance for increased blood flow and thereby, an erection.

MEDICALCENTER.net
bringing Medical Resources to the World

Consultation Form for Patients requesting Viagra prescription.

Approved Viagra prescriptions are valid for your original order and will also be refillable TWO (2) additional times without a further consultation fee.

IMPORTANT: If you have ordered from us before **AND you have REFILLS remaining** on your prescription, CLICK HERE to order from the refill page.

If this is your first visit, or if your refills have been used up, please continue on this page to request an online consultation for a physician to prescribe Viagra. There will be an $85.00 charge for this physician consultation only if the doctor determines that Viagra IS appropriate for your condition. There will be NO CHARGE if the doctor determines that Viagra IS NOT appropriate for your condition.

There are 3 steps to this process:

- Step 1. Agree to the Waiver of Liability below.
- Step 2. Select quantity of Viagra.
- Step 3. Answer the medical questionnaire.
  If approved for a Viagra prescription, we will have your Viagra shipped to you by The Pill Box Pharmacy.

The medical information you provide will be **Encrypted, (via secure server) Secure, Confidential, and subject to all patient/doctor privilege laws.**

Or, if your browser has trouble with the secure server, you may CLICK HERE for a consultation form you can print and fax back.

STEP 1: Waiver of Liability.

I hereby release S & H Drug Mart, Inc. DBA The Pill Box Pharmacy and DBA MedicalCenter.net and all of their employees and contractors including physicians from any and all liability whatsoever associated or connected with my Viagra Consultation and/or my use of Viagra. I hereby state that I am an adult and that I am aware of the potential side effects associated with Viagra as listed by Pfizer at: http://www.viagra.com/. I understand that falsifying information in order to obtain prescription medication is a violation of both State and Federal U.S. law. I hereby agree to answer truthfully all of the medical questions on my questionnaire.

I understand that no doctor, nurse, or administrative personnel can guarantee that Viagra, even if prescribed, will provide the results I seek. Further, I understand that even if prescribed, I may suffer adverse effects from Viagra. I hereby release MedicalCenter.net and all of its employees and contractors including physicians from any and all liability whatsoever associated with any

adverse effects I may suffer from my use of Viagra. I also fully understand that if I have failed in any way to furnish MedicalCenter.net with my complete and accurate medical history, or become aware of any changes in the future of which I have not notified MedicalCenter.net then I cannot hold MedicalCenter.net responsible for any adverse effects I may suffer.

I am submitting this questionnaire at my own choice, at my own expense, and my own liability and assume all responsibility for my use of Viagra. I fully understand that it is my responsibility to have an annual physical examination, including any suggested laboratory tests, to ensure that I have no disease which might make Viagra inappropriate for my condition. I further agree that I have consulted with my present physician and/or pharmacist and hereby warrant that I am not taking any medications or combination of medications that are on the published list of medications which would make Viagra contraindicated. CLICK HERE to read this list. I further agree to immediately notify any doctor whose present care I am under that I have chosen to take Viagra so that they may advise to continue or discontinue use. Should I engage a new doctor's care in the future, I further agree to immediately notify said doctor of my use of Viagra.

I further agree that I have read the MedicalCenter.net patient education page on Viagra and erectile dysfunction. CLICK HERE to read this patient education page. It is important that you understand that while Viagra may control your erectile dysfunction it does not treat possible underlying causes of your erectile dysfunction, such as diabetes, etc. Reading this page is an important part of this consultation.

If after review of my questionnaire, a doctor determines that Viagra is the appropriate treatment for my condition, I hereby authorize a charge of $85.00 to be charged to my credit card for this Doctor Consultation and understand that this charge is in addition to the cost of the medication (Viagra).

In order to continue - you must agree
to the Waiver of Liability above.
Please Click Either:

NO, I DO NOT AGREE

or:

YES, I AGREE

If you agree, you will taken
to a secure server for your consultation.

Or, if you prefer, you may CLICK HERE for a form
you can print and fax back.

Home Viagra Propecia Claritin Links Contact Us

MedicalCenter.net is an Internet marketing and administrative agency owned by The Pill Box Pharmacy. Our goal is help you find products, services, and information you desire from our compiled list of international resources, including clinics, physicians, and pharmacies. CLICK HERE to join our resource list.

PRINT, ANSWER ALL QUESTIONS and FAX back to: **210.509.6438**

Full Name: _____

Street Address: _____

_____

State/Prov: _____ Country _____ Zip/PC: _____

Phone: _____ Fax: _____ E-mail: _____

Date of Birth: _____ Sex: MALE FEMALE **(circle one)**

Height _____ Weight: _____

Known Allergies: _____

Conditions for which you are currently receiving treatment: _____

_____

Current Medications: (Please list all medications you are taking, even occasionally)

_____

Do you take any medication classified as a nitrate in any form?
YES NO (circle one)

Do you have a problem achieving and/or maintaining an erection sufficient for sexual intercourse?
YES NO (circle one)

Have you suffered a myocardial infarction, stroke, or life-threatening arrhythmia within the last two years? Do you have resting hypotension (BP<90/50/) or hypertension (BP>170/100)?
Do you have cardiac failure or coronary artery disease causing unstable angina?
Do you have retinitis pigmentosa?
YES to one or more. NO to all.(circle one)

How did you hear about us? _____

Credit Card: **VISA MASTERCARD AMEX DISCOVER (circle one)**

Name on Card:(if different than above): _____

Cardholder Address: (if different than above) _____

_____

Credit Card Number: _____ Exp Date: _____

Shipping Address: (if different than above) _____

_____

I would like a prescription for Viagra:
Circle Strength requested or Rx will be for 50mg.
25mg 50mg 100mg

___ 10 Tablets $105.09 | Make Checkmark
___ 20 Tablets $204.69 | next to number
___ 30 Tablets $304.39 | of Tablets requested.

I certify that I have answered all questions truthfully and that I have read and agree to the Waiver of Liability (http://www.medicalcenter.net/viagrawaiver.htm) agree to the $85.00 consultation fee and I am legally entitled to receive Viagra. I also understand that The Pill Box Pharmacy shipping charges are in addition to my calculated totals and will vary with destination and will range from: **Inside U.S. $9.00 (waived for orders inside U.S. of 20 tablets, or more). Canada $18.00 and Outside the U.S. $50.00 to $79.00, and I am responsible for all import charges.**

Signature: _____ **Date:** _____

the Pill Box global Pharmacy

This is our Wholesale Order Page.

Translate to German

courtesy AltaVista Translation Services

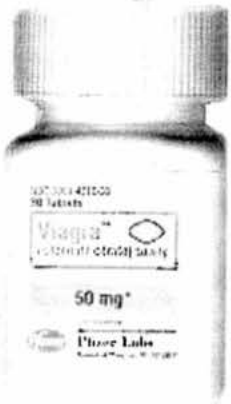
This page should be used by domestic and international companies wishing to make wholesale purchase(s) of our products, including Viagra.

If you are only ordering 90 pills (or less) of Viagra, CLICK HERE to order using the Retail Order Page.

Notice: All International shipments are subject to U.S. export laws and the import restrictions of the destination country.

To Order, please follow these two steps:
Step 1: Complete the form below:
Step 2: We will contact you (via e-mail) regarding volume pricing, shipping costs, and your payment options.

Please Select from the following Products:



VIAGRA

mfg: Pfizer

At wholesale, each bottle contains 30 tablets

Minimum Wholesale Order is 4 bottles. For less, please CLICK HERE to order using the Retail Order Page.

Please Select Quantity desired:

Viagra 25mg [ ] bottles / tablets
Viagra 50mg [ ] bottles / tablets
Viagra 100mg [ ] bottles / tablets

If you have not done so already, you may wish to CLICK HERE to review the Frequently Asked Questions regarding Viagra, or visit http://www.viagra.com for prescribing information, including contraindications.

Propecia

mfg: MSD

Wholesale Propecia is available by the case.
Each case contains 6 bottles of 30 pills each.
Price: $355.74 per case (additional volume discounts may apply)
Please select the number of cases: 0

Please list any Other Products for which you would like a price quote:

Shipping Instructions

(all fields are required for proper submission - thank you)

Company:

First Name:

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E-Mail

Your complete Shipping Address including Country:

Phone:

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SwissPharma
Laboratories - Zurich

High effective treatments and products

for

Psoriasis, Herpes, Dandruff, Impotence (Viagra), Arthritis, etc

Express to
VIAGRA

Enter here

SwissPharma Laboratories Ltd.
32 Vulkanstrasse , Zurich - Switzerland / Tel.:+ 41 1 274 2038 - Fax: +41 1 274 2343
201 North Dupont Parkway, New Castle, DE 19720 - USA / Tel.:+1 888 866 4804 - Fax:+1 703 995 0360

Home page / Available treatments / Who are we? / Order here / VIAGRA page

Retail Order form

No more than 10 pills

PRODUCTS	Qty ..... Price
VIAGRA 25mgr	NOT AVAILABLE
VIAGRA 50mgr	NOT AVAILABLE
VIAGRA 100mgr	Choose quantity
Handling & Delivery	US$ 25.00

- SECOND: Your name and address

* = Required field to process your order	
First name *	
Last name *	
Company	
Street / Suite # *	
City *	
State *	
Zip code *	
Country *	>
Phone number *	
Fax number	
E-mail address Please make sure this is a working address! *	All correspondence will be sent to this E-mail address
CODE of the SwissPharma agent assigned to you	If you do not know the CODE ask your agent or leave it blank

Pfizer and the Health Authority recommend obtaining a medical history and cardiovascular status of the patients prior to initiating any treatment. In order to issue the prescription for your order we ask you to answer the following questions. (This is a free prescription. If you have one from your own physician you can send it by fax). **(You should answer all questions)**	
Your genre is.....	○ Male - ○ Female
Your age is.....	Choose your age
Do you / did you suffer any heart disease?	○ Yes - ○ No
Are you under any medical treatment with organic nitrates? (If you are not sure please ask your physician)	○ Yes - ○ No
Do you take nitrates that are inhaled for recreational use (including amyl nitrate/nitrite or "poppers")?	○ Yes - ○ No
Are you affected by any anatomical deformation of the penis? (such as angulation, cavernosal fibrosis or Peyronie's disease)	○ Yes - ○ No
Do you have conditions which may predispose to priapism (such as sickle cell anemia, multiple myeloma, or leukemia).	○ Yes - ○ No
The recommended dose is 50 mgr taken, as needed, approximately 1 hour before sexual activity. However, VIAGRA may be taken anywhere from 4 hours to 0.5 hour before sexual activity. Based on effectiveness and toleration, the dose may be increased to a maximum recommended dose of 100 mgr or decreased to 25 mgr . The maximum recommended dosing frequency is once per day. **Have you understood this?**	○ Yes - ○ No
There is a degree of cardiac risk associated with sexual activity; therefore, you should consider your cardiovascular status prior to taking this medicine. If you have taken Viagra during last 8 hours you should advise anybody who is trying to administer you any medicine or treatment. **Have you understood this?**	○ Yes - ○ No
Do you suffer any illness / disease?. State it, please.	

- **THIRD: Delivery address** (Do not fill if same than above- POBoxes not accepted)

First name	
Last name	
Company	
Street / Suite #	
City	
State	
Zip code	
Country	>
Phone number	

- FOURTH: Payment

We only accept credit cards.	
Type of credit card *	Visa
Card no. e.g.,1234-5678-9876-5432 * (Please double check your card number)	
Expiration date (MM-YY) *	
Name on the card *	
Cardholder's address *	

If you don't want to submit your credit card information through the Internet, write " **I will send later**" instead of the number, fill out this order form, and click the **"SUBMIT NOW"** button bellow.

Then just fax your credit card number and Name to:
USA / CANADA: Phone/Fax 703 995 0360 or
Toll FREE Phone/Fax: 888 866 4804
SWITZERLAND , ZURICH Fax: + 41 (1) 274 2038
(We do not give live operator assistance)

Or

You can write in this form the first half of your credit card number and send the remaining half by e-mail to: Orders@SwissPharma.com

Any comment you'd like (max. 30 words)	

To send your order press the SUBMIT NOW button below
(please click only once and wait for the confirmation)

SUBMIT NOW (click once) START OVER

To SwissPharma | VIAGRA home page | ORDER HERE | Pfizer information | Consumer information | Frequently asked questions | US FDA information | Letter to Doctors |

Wholesale Order form

10% discount apply to orders over 5 bottles

PRODUCTS	Number of 30 pills bottles
VIAGRA 25mgr	NOT AVAILABLE
VIAGRA 50mgr	NOT AVAILABLE
VIAGRA 100mgr (Bottle 30 pills)	1 US$ 510 per bottle + US$ 25 handling and delivery

SECOND: Your name and address

* = Required field to process your order	
First name *	
Last name *	
Company	
Street / Suite # *	
City *	
State *	
Zip code *	
Country *	>
Phone number *	
Fax number	
E-mail address Please make sure this is a working address! *	All correspondence will be sent to this E-mail address
CODE of the SwissPharma agent assigned to you	If you do not know the CODE ask your agent or leave it blank

- THIRD: Delivery address (Do not fill if same than above)

First name	
Last name	
Company	
Street / Suite #	
City	
State	
Zip code	
Country	>
Phone number	

- FOURTH: Payment

Accepted ways of payment are:

- Swift or Transfer to SwissPharma bank account
- Money order (It can take 20 to 30 days to clear up funds)
- Bank check (It can take 30 to 45 days to clear up funds)

Indicate your selected way of payment: Swift / transfer

We will send to your E-mail address the confirmation of the order, total price and instructions to proceed to the payment

SwissPharma Ltd.

USA / CANADA: Phone/Fax 703 995 0360 or
Toll FREE Phone/Fax: 888 866 4804
SWITZERLAND , ZURICH Fax: + 41 (1) 274 2038

Any comment you'd like (max. 30 words)	

To send your order press the SUBMIT NOW button below
(please click only once and wait for the confirmation)

SUBMIT NOW (click once) START OVER

Problems with

Dandruff,

Seborrhoea, and

Psoriasis ?

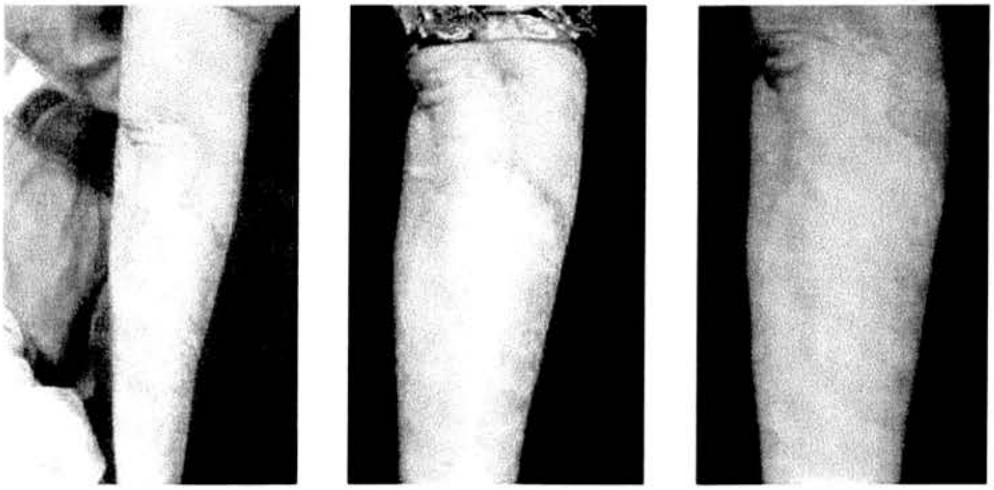
The solution

SKIN-CAP

No more flakes or itching

In less than a month this cosmetic product will put an end to the inflammation , itching, redness of the skin and flakes. Thanks to its activation principle, **SKIN-CAP** will achieve these results:

Psoriasis and seborrhoea



1st week 2nd week 3rd week

Dandruff

First day Second day Fourth day

This is what some Skin-Cap users say. They have offered their telephone numbers if you want to ask them something about their experience.

- I've used Skin-Cap and it is the ONLY product to ever cleared up my psoriasis completely without a trace. It is a miracle product. I was devastated when the FDA made the remove it from the US market for strictly political reasons. I was so happy to find you and that I can now receive it again, and clear up a case of psoriasis that no product before or after I found Skin Cap. My eternal gratitude for helping me heal again. Best regards, Jeff Shiverdaker
  Phone: USA 408 870-0638 , Email : theshiv@usa.net

- I have had psoriasis that covers portions of my body for the last 25 years and have learned to live with it.
  My scalp is another problem. Hair does not hide the flakes. Just a movement of my head

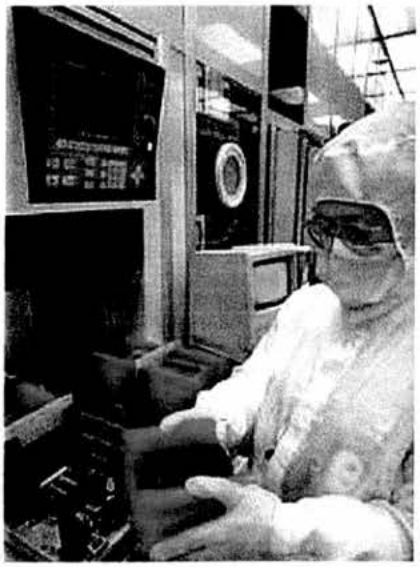
and the air is full of falling skinflakes. My doctor tells me it will never go away and has prescribed derma smoother which only provided a slight relief.
Personally I tired of wearing the shower cap so often. I tried Skin-Cap and it started working right away. I was elated with the product until my pharmacy stopped stocking it.
Thank You SwissPharma for understanding and providing something that really works.
Tessa Markovich
Phone : USA 510-614-9655 Time availability : afternoon
Email : ivanho@earthlink.net

- It was July of 1997 when I first tried the product. It worked better than anything I have ever used before. I have had psoriasis for about 19 years. When I found this product I gave it a try I figured I had nothing to lose and to my amazement it worked!
  Calvin Kreider
  Phone : USA 806-665-7720 - Time availability : evening
  Email : forrest@hpnts.net

- For SKIN-CAP usage and data sheet **CLICK HERE**
- If you are not aware of "SKIN-CAP controversy" **we strongly** recommend to CLICK HERE
- For additional extraordinary SKIN-CAP Testimonials CLICK HERE

CLICK HERE TO ORDER NOW!

MONEY BACK GUARANTEE: If after 1 month treatment you are not satisfied with this product please contact your AGENT or fax SwissPharma with your first and last name, product you bought, and number and expiration date of the credit card through which you made the payment. We shall refund your money to your credit card account.



Biological studies at SwissPharma lab

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Home Page

Quality Health, Inc.

Pharmaceutical Products

Updated 30 March 1999

Alphabetical Product Index

Click on item to view it.

GoTo Index returns you to this Index.

More Information takes you off-site. Please bookmark this page to make your return easier.

Ampamet (aniracetam)

Ref:	20 tabs x 750mg		
45	UK £ 23.28	US $ 37.25	Sfr 57.07

NEW Details This product works in the same way as Piracetam but is more potent. Tests are being conducted with this medicine as a possible treatment for Alzheimer's disease.

Do not take if you are pregnant, breast-feeding, are under the effect of alcohol and/or amphetamines.

GoTo Index More Information

Diphantoine (Phenytoin)

Ref:	100 tabs x 100mg		
24	UK £ 4.53	US $ 7.25	Sfr 11.11

This product is known as a treatment for epilepsy but studies have shown it to be effective in treatments of drug addiction, alcoholism, hypoglycemia and depression. It works by stabilizing electrical activity at the cell membrane.

Do not take if you are pregnant, breast-feeding, have cardiac or renal problems.

GoTo Index More Information

GH3 (Original Aslan Formula)

Ref:	25 tabs x 100mg		
43	UK £ 10.00	US $ 16.00	Sfr 24.51

NEW GH3 is a MAO inhibitor. According to Smart Drugs and Nutrients Volume I by Morganthaler and Dean, people using GH3 report increased energy levels, alertness, and improvement in mood.

Do not take if you are pregnant, breast-feeding, or are taking other medicines that should not be taken with a MAO inhibitor.

GoTo Index More Information

Hydergine (Ergoloid Mesylates)

Ref:	28 tabs x 4.5mg		
22	UK £ 11.56	US $ 18.50	Sfr 28.35

This product is an ergot preparation used in the treatment of poor memory, confusion, depression and lack of motivation. It stimulates brain cell metabolism to increase the use of oxygen and nutrients.

Do not take if you are pregnant, breast-feeding, or have low blood pressure.

GoTo Index More Information

Hydergine FAS

Quality Health, Inc.

Supplements Products

Updated 30 March 1999

Alphabetical Product Index

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Cat's Claw

Ref:	100 caps x 400mg		
50	UK £ 4.06	US $ 6.50	Sfr 9.96

Researchers have reported that the herb Cat's Claw (Uncaria tomentosa) contains six unique alkaloids that can provide benefits for a host of conditions. Of particular interest is its reported ability to cleanse the entire intestinal tract which could be very helpful for those suffering with stomach, bowel and ulcer disorders. Cat's Claw has also been noted for its ability to boost the immune system.

As Cat's Claw stimulates the immune system and helps in the rejection of foreign matter, it should not be taken by organ transplant patients or those persons considered candidates for a transplant.

Not recommended for pregnant or nursing women.

GoTo Index More Information

Choline

Ref:	100 caps x 250mg		
55	UK £ 4.37	US $ 7.00	Sfr 10.72

Choline supplements appear to protect against age-related decline in memory capacity and precision. Dr. Christina Williams, an associate professor in the Department of Experimental Psychology, has discovered that giving extra choline to rats at certain developmental stages leads to changes in the brain and improvement in memory.

No known contraindications.

GoTo Index More Information

Chromium Picolinate

Ref:	100 caps x 200mcg		
60	UK £ 4.06	US $ 6.50	Sfr 9.96

A study presented at the 1996 American Diabetes Association meeting in San Francisco suggests an enhanced role for the nutritional supplement Chromium Picolinate in the treatment of diabetes. Picolinic acid, which occurs naturally within the body, has been found to be the most effective chelator of metal ions. Chromium Picolinate is 10 times more absorbable than chromium chloride used in many multiple vitamin and mineral supplements and many times more absorbable than the chromium found in most foods.

No known contraindications.

GoTo Index More Information

Co-Enzyme Q10

Ref:	30 caps x 60mg		
65	UK £ 8.44	US $ 13.50	Sfr 20.68

Coenzyme Q10 is a critical component of the electron transport pathway in the energy producing mitochondria. Without sufficient CO-Q10, highly reactive electrons may cause damage to the lipids, proteins and DNA contained in the mitochondria. This may lead to energy insufficiency in tissues with high energy consumption such as the heart.

No known contraindications.

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Special discounts available on larger orders!

Anadrol 50 (Oxymetholone)	$2.50 per tablet.	BUY 200 TABLETS FOR $450
Spiropent (Clenbuterol Hydrochloride)	$0.75 per 20m.c.g. tablet.	BUY 60 FOR $100
Depovirin 250 (Testosterone Cypionate)	$18 per ampule.	$15 PER AMP. ON ORDERS OVER 10.
Deca Durabolin (Nandrolone Undeconate)	$150 per box.	Organon 50mg. ampule @ 10 per box
Anabol (Methandienone) Pink Dianabol 5mg	$1.00 per tablet.	
Nolvadex (Tamoxifen Citrate) 10mg.	$2.00 per tablet.	
Clomid (ClomiphenCirate)50mg	$2.00 per tablet.	
Testo 25 (Methyl Testosterone) 25mg.	$0.75 per tablet.	Minimum 100 tablets
Aldactone (Spironolactone) 25mg	$1.00 per tablet.	
Lasix (Furosemide) 20 mg.	$1.00 per tablet.	
Capril (Captopril) 25mg	$1.00 per tablet.	
Comthyroid (Levothyroxine Sodium .05mg. Liothyroxine Sodium .0125 mg.)	$0.75 per tablet.	
Menoferil (Cyclofenil) 200mg.	$2.00 per tablet.	
Human Chiorionic Gonadatropin	$25.0 per ampuoule (HCG 5000 i.u.)	
Accutane (Isotretinion 10 mg.)	$2.00 per tablet.	
Cetabon (Stanozolol) Winstrol	$1.00 per tablet.	Contains Vitamin B (2 mg).

Dianabol and Depovorin samples are available for a $10 shipping and handling charge. All tablets are marked and scored. All ampuoules are foil sealed and properly labelled. Most orders come with inserts but in some cases bulkier bottles and packaging will not be sent.

ORDERING INSTRUCTIONS

Payment must be made in U.S. dollars.Please do not send checks or money orders as they cannot be processed. Send high denomination bills in a carbon-lined envelope or wrap it in carbon paper. Send your payments via GLOBAL PRIORITY POST. Initial orders can be smaller ($100-$200 range) to determine the quality of our products. But we would prefer larger orders as a general rule. All orders totalling over $500 U.S.D. will have a bonus 10% of their req uested product added to the shipment .Be sure to include your return address with the order. Your parcel will arrive via regular post.We cannot use an express courrier as they are more closely scrutinized at customs and usually require your signature. You will NOT have to sign any type of receipts. All ampuoules will be sent in small padded envelopes, tablets will be sent flat in small-siz ed envelopes. We follow strict packaging guidelines to ensure that you will receive your order without delay. To date, ALL shipments have passed customs.

SEND ALL ORDERS TO:

Mr. Kim
KEO BOX 1501
SEOUL,KOREA.
110

If you have any questions, comments, or suggestions email

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LINKS EXPRESS

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Asthma | Glaucoma | HIV/AIDS | Hypertension and Heart Disease
Migraine | Osteoporosis

ASTHMA

- **Allergy, Asthma & Immunology On-Line**
- **Allergy and Asthma Web Pages**
- **Joint Council of Allergy, Immunology and Asthma**
- **Children's Asthma Tutorial**
- **National Jewish Center for Immunology and Respiratory Medicine**
- **Interasthma/Asmanet**
- **The Asthma Foundation of Victoria**
- **Asthma Management Handbook**

GLAUCOMA

- **The Glaucoma Foundation**
- **Glaucoma Research Foundation**
- **International Congress of Ophthalmology**

HIV/AIDS

General Information

- **AIDS Information For The Well Informed**
- **The Body**
- **CDC National AIDS Clearinghouse**
- **HIV Sequence Database WWW Home Page**
- **JAMA HIV/AIDS Information Center**
- **JRI Health InfoWeb**
- **Spiderwoman's AIDS Information Page**
- **UNAIDS - Joint United Nations Programme on HIV/AIDS**

- HIV/AIDS Resources

International Sites

- SIDA/HIES: AIDS Information

Conferences

- XI International Conference on AIDS
- AIDS98 Home Page
- Infectious Diseases Society of America

HYPERTENSION AND HEART DISEASE

- American Heart Association
- American Heart Association Scientific Publishing
- American Society of Hypertension
- Hypertension, Dialysis and Clinical Nephrology Information Server
- Hypertension Center

MIGRAINE

- Migraine Headaches
- American Academy of Neurology

International Sites

- Migraine Association of Australia
- Institute of Neurology, London

OSTEOPOROSIS

- National Osteoporosis Foundation
- Osteoporosis & Related Bone Diseases ~ National Resource Center (ORBD~NRC)
- Menopause: Another Change in Life
- Clinical Trials: Osteoporosis
- AACE (American Association of Clinical Endocrinologists) Clinical Guidelines
- Women's Medical Health Page
- The Bone Measurement Institute

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American Heart Association®
Fighting Heart Disease and Stroke

Welcome to the American Heart Association dedicated to providing you with education and information on fighting heart disease and stroke.

Be sure to visit the
American Stroke Association,
a division of the American Heart Association.

Send a message to Congress about strong tobacco control legislation and other important healthcare initiatives.

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The information contained in this American Heart Association (AHA) Web site is not a substitute for medical advice or treatment, and the AHA recommends consultation with your doctor or health care professional.

UltraNutrition

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Health and Fitness Links

Welcome to the DHEA home page!

The Fitness Partner Connection

The Internet's Fitness Resource

The Rejuvenation And Longevity Foundation

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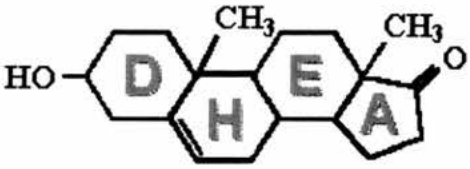
Toll Free: 800.658.1673
E-Mail: sales@ultranutrition.com
Mail: PO Box 841
Agoura Hills, CA 91376-0841



Dehydroepiandrosterone

Welcome to the DHEA home page! This page was created as an initiative to spread information about DHEA (dehydroepiandrosterone), a human hormone. Currently we are offering the following:

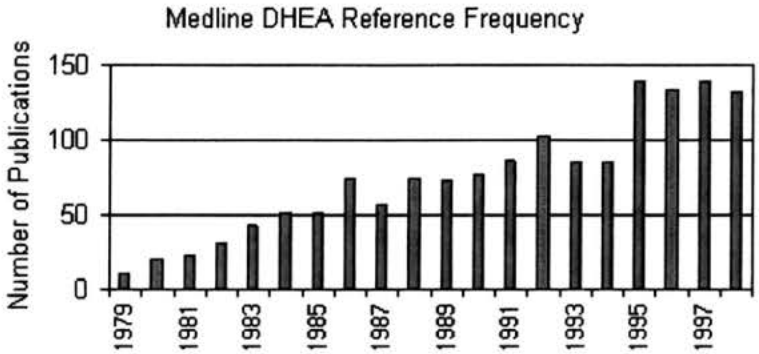
New Theory of Human Evolution Involving DHEA, Melatonin, and Testosterone
New Theory of AIDS
DHEA, Melatonin, and Chronic Fatigue Syndrome
DHEA, Melatonin, and Sleep Mechanisms **(contains information about AIDS)**
Testosterone and Sleep: Support for Sleep Theory **(above)**
DHEA, Melatonin, and Schizophrenia
A New Theory of SIDS, Melatonin, DHEA, and Testosterone
Multiple Sclerosis: A Theory
DHEA, Migraine and Epilepsy
New Theory of Reflex Sympathetic Dystrophy
A Theory of the Evolution of Eukaryotes, Crossing Over and Sex
Etiology of Male Homosexuality and Current Rise of Male Homosexuality
Explanation of New Report of a Connection in Breast Cancer, Stress, and the Immune System
A Potential Explanation of Tourette's Syndrome
Cocaine Overdose Mortality Increased During Hot Days
Increasing Low Birth Weight in America
Evolution of the Chin
Testosterone and Socioeconomic Differences in Mortality
Increasing Obesity in Americans
DHEA, Depression, and Physical Decline of Old Age
Soy Products, Breast Cancer, and Other Diseases
"Disfiguring" Protease Inhibitor Syndrome due to Loss of DHEA
Why HIV is so Prevalent in Africa
Lung Cancer Surgery, Radiation Therapy, and DHEA
Explanation of Postpartum Depression and Postpartum Psychosis
Civilopathy and the Decline of America
Sudden Infant Death Syndrome, Blood Pressure, and DHEA
The "Melatonin - DHEA Cycle" and Calorie Restriction
Chimpanzees, AIDS, CCR5, DHEA and Testosterone
Explanation of the Flynn Effect
An Explanation of Cancer and the Increase in Cancer Formation

DHEA, Testosterone and Viral and Bacterial Infections

MEDLINE Reviews for Melatonin **(prior to 1995)**
MEDLINE Reviews for DHEA **(prior to 1995)**
Search Usenet using Deja News **for** DHEA **or** Melatonin

Search MEDLINE for DHEA using Entrez for [ ] and return. . .
◉ 25 | ○ 50 | ○ 100 records per page. Do Search!

Or, download zipped Medline search results for 1976-1980 (32K), 1981-1985 (51K), 1986-1990 (94K), 1991-1993 (142K), 1994-1996 (135K). If you need an unzipping program, use the free Info-Zip UnZip.



Questions about the theory presented in the above articles may be directed to J. M. Howard, 1037 N. Woolsey, Fayetteville, AR 72701, USA.

 visitors since 2/22/97.

RELATED **SITES**

Related Sites

The following sites will open in a separate browser.

IFIC (International Food Information Council)

GMA (Grocery Manufacturers of America)

Heinz on the NYSE

Prevent Cancer

Lycopene

LYCOPENE

Welcome to the **lycopene.org** web site.
Your primary source of information on lycopene.

- **General Information**
- **Q&A**
- **Media Releases**
- **Research Updates**
- **Lycopene Content**
- **Recipes**
- **Scientific Abstracts**
- **Related Links**
- **Contact Us**

FRANÇAIS

This site best viewed using Netscape or Explorer 2.5 or higher.

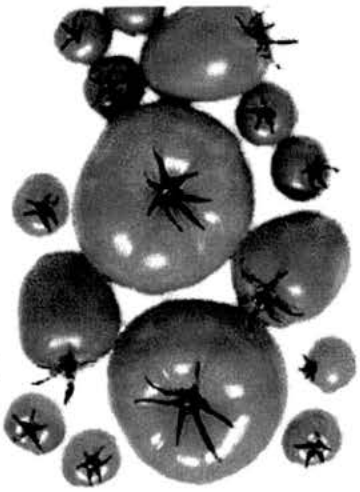
LYCOPENE

General Information

Lycopene: The Facts

- Lycopene is an open-chain unsaturated carotenoid that imparts red colour to tomatoes, guava, rosehip, watermelon and pink grapefruit.
- Lycopene is a proven anti-oxidant that may lower the risk of certain diseases including cancer and heart disease.
- Research shows that lycopene in tomatoes can be absorbed more efficiently by the body if processed into juice, sauce, paste and ketchup. The chemical form of lycopene found in tomatoes is converted by the temperature changes involved in processing to make it more easily absorbed by the body.
- The health benefits of lycopene can be enjoyed by drinking as little as 540 mL (about two glasses) of tomato juice a day.
- In the body, lycopene is deposited in the liver, lungs, prostate gland, colon and skin. Its concentration in body tissues tends to be higher than all other carotenoids.
- Regular high consumption of fruits and vegetables is recommended as part of healthy eating. Epidemiological studies have shown that high intake of lycopene-containing vegetables is inversely associated with the incidence of certain types of cancer. For example, habitual intake of tomato products has been found to decrease the risk of cancer of the digestive tract among Italians.
- In one six-year study by Harvard Medical School and Harvard School of Public Health, the diets of more than 47,000 men were studied. Of 46 fruits and vegetables evaluated, only the tomato products (which contain large quantities of lycopene) showed a measurable relationship to reduce prostate cancer risk. As consumption of tomato products increased, levels of lycopene in the blood increased, and the risk for prostate cancer decreased. The study also showed that the heat processing of tomatoes and tomato products increases lycopene's bioavailability.
- Ongoing research suggests that

lycopene can reduce the risk of macular degenerative disease, serum lipid oxidation and cancers of the lung, bladder, cervix and skin.



- Studies are underway to investigate other potential benefits of lycopene - including the H.J. Heinz Company sponsored research at the University of Toronto and at the American Health Foundation. These studies will focus on lycopene's potential in the fight against cancers of the digestive tract, breast and prostate cancer.

REF.: Stahl, W. and Sies, H. **lycopene: a biologically important carotenoid for humans?** Arch. Biochem. Biophys. 336: 1-9, 1996

Gerster, H. **The potential role of lycopene for human health.** J. Amer. Coll. Nutr. 16: 109-126, 1997

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This site best viewed with Netscape 2.x or Explorer 2.x with monitor set at true (24bit) colour.

current regulations defined too narrowly
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TO: BONNIE W. Mike H GARY C. RICH T JANE H — MARK McC MARK M

FROM: CHRIS + JOANNE

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THIS will likely change -

- #s are being revised
- we may only discuss Medigap + Board in First Part.

Comments by early afternoon would be appreciated.

MEDICARE PRINCIPALS' MEETING
DRAFT: MAY 24, 1999

I. Budget Neutral / Paid-For Options

- Medicare Buy-In
- Medicare "Medigap" Option
- Medicare Board
- Coordinated Care for Dual Eligibles [May be Dropped]

II. Base Package and Additions

I. BUDGET-NEUTRAL OPTIONS
MEDICARE "MEDIGAP" OPTION: BACKGROUND

- **Limited benefit causes beneficiaries to purchase supplemental insurance:** Medicare's benefits are less generous than 4 of 5 private employers' since it lacks prescription drug coverage, has a high hospital deductible, and has no catastrophic cost protection. For this reason, about 85 percent of Medicare beneficiaries have additional sources of health insurance coverage. Some beneficiaries – one fourth of Medicare managed care enrollees and one-seventh of those in retiree health plans – also buy Medigap, resulting in duplication of coverage.

- **Expensive and declining**: The typical Medigap premium for a 65-year old is from $80 to $100 per month (without drug coverage). It can be much higher in certain areas or for older or sicker people. The proportion of beneficiaries covered by Medigap declined by one-fourth in the last decade. Although more affordable, retiree health coverage has also been declining, and premiums paid for by beneficiaries has been increasing.

- **Supplemental insurance is inefficient**: Individual supplemental insurance typically has mark-ups of 30 percent, compared to 10 percent for employer insurance and 2 percent for Medicare. Moreover, Medigap provides first-dollar coverage, resulting in higher Medicare use and costs than beneficiaries in retiree plans which usually have some type of cost sharing.

MEDICARE MEDIGAP OPTION

- **New Medicare Option:** Optional Medicare policy that:
  - Eliminates hospital deductible and copays, since hospitalization is rarely optional
  - Reduces most cost sharing from 20 percent to nominal levels (e.g., $10 per physician visit, $15 per nursing home day); and
  - Caps out-of-pocket cost sharing liability at $2,500 per year.

  Premium: $50 to $60 per month according to preliminary estimates

  Enrollment: When they become eligible for Medicare; when they transition out of other forms of supplemental coverage (private Medigap, retiree coverage).

  Private Medigap: Allowed to offer same plan in addition to existing options (which may have to be modified to reflect cost sharing changes).

- **Pros**:
  - Affordable, rationale alternative to expensive, inefficient Medigap
  - Mitigates against cost sharing increases
  - Viewed as structural reform – one of major points for premium support advocates and economists. Moves towards private sector benefits package

- **Cons**:
  - Opposed by insurers and conservatives as a government take-over
  - Complicated policy that may not be worth the political pain

MEDICARE BOARD

- **Commission Proposal: Medicare Board**. Stemming from IRS-like concerns about HCFA, the Commission proposed to create a new Board outside of Medicare to administer Medicare. Appointed by the President and confirmed by the Senate, the members would represent health care providers, beneficiaries, and working taxpayers.

- **Functions of the Board:**

  - Certify plans and negotiates over covered benefits and premiums

  - Operate annual open enrollment process, including information distribution

  - Enforce quality and program integrity requirements (including traditional Medicare)

- **HCFA Role**: Overall program management would be transferred to the Board. HCFA would remain responsible for the traditional program only. It would be treated as any other private health plan, and would have to develop a reserve fund and rely only on capitation payments to provide services.

ALTERNATIVE TO THE MEDICARE BOARD

- **Modernized Medicare Administration:**
  - New public/private boards to (1) improve coverage policy; (2) advise on management; and (3) review and strengthen beneficiary education efforts.
  - Contracting reform to improve ability to use private sector for certain activities
- **Pros:**
  - Improves rather than replaces management; targets areas for private involvement
  - Does not create duplicate, unaccountable bureaucracy that could increase costs
- **Cons:**
  - May not go far enough Republicans and conservative Democrats
  - Already in the budget; could be perceived as dressing up existing action

COORDINATED CARE FOR DUAL ELIGIBLES

- **Medicare-Medicaid dual eligibles**: About 4 million beneficiaries are fully eligible for both programs (another 2 million receive Medicaid coverage of premiums and, in some cases, cost sharing). Despite representing only 16 percent of beneficiaries, they account for about 30 percent of Medicare and 35 percent of Medicaid costs.

- **Duplicative and uncoordinated care:** Since dual eligibles typically are sicker, older, and lower income, the problems with having different sources of coverage are more serious.

    - **Complicates clinical and management coordination:** Typically, Medicare and Medicaid rely on different providers to authorize health care service use. Medicare providers have no systematic way to know that a beneficiary is enrolled in Medicaid.

    - **Different financial incentives and Medicare "maximization":** Medicare and Medicaid differ in reimbursement and coverage policies, especially related to managed care. Also, some state have developed programs to ensure that providers bill Medicare whenever possible.

    - **Separate pools of money not being managed in ways that are best for beneficiaries and best for the program.** [add]

OPTIONS FOR COORDINATING CARE FOR DUAL ELIGIBLES

- **Identification and assessment of dual eligibles**: Medicaid would notify Medicare when it enrolls a dual eligible. Newly-enrolled dual eligibles would be sent information on their coverage and could receive a Medicare clinical assessment. This assessment, designed by geriatricians, would aid in the early detection of high risk beneficiaries who could benefit from care coordination. Can we do more?

- **Demonstration of care coordination models**: Medicare would fund a demonstration of three models to pay for care coordination: (a) a managed care option, where Medicare and Medicaid pay capitation amounts to a single plan for coordination of care; (b) a "gatekeeper" model, where a primary care provider authorizes Medicare and Medicaid services; and (c) a coordinator model, where a provider suggests but does not authorize services.

- **Pros**:
  - Improves care and allocates resources more efficiently and, in so doing, reduces cost
  - Responds to Congressional proposals to give states Medicare managed care payments – can argue that coordination does not require capitation

- **Cons**:
  - Depending on scope of our proposals, it could look modest relative to Congressional proposals
  - States would object to data requirements, focus on Medicare rather than Medicaid

II. BASE PACKAGE

(NOTE: All estimates preliminary / subject to change. 2000-2009 estimates in billions)

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE *	**-$343**

OPTIONS:

Prescription Drug Benefit	+$160
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start	
$19 Premium in 2002 (67%), Covers 50% of Costs up to $5,000	
Modernizing Traditional Medicare	-$14
Additional Provider Savings (modified BBA extenders)	-$45
Income-Related Premium ($80/100,000)	-$25
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Budget Neutral / Paid for Policies	
Medicare Buy-In, Medigap Option, Dual Eligible Coordination, etc.	
TOTAL:	**+$70**

** Does not offset costs*

ADDITIONS (Incremental costs of polices in bilions)

SAVINGS OPTIONS (Billions)	10-Yr	SPENDING OPTIONS	10-Yr
State and Employer Maintenance of Effort on Prescription Drugs	-$10-20	Balanced Budget Act Fixes	+$10-25
Income-Related Premium for Prescription Drug Benefit	-$5	Drug Benefit in 2001 (rather than 2002)	[getting]
Managed Care Competition	-$10	Drug Benefit in 2002, Catastrophic Coverage in 2006	[getting]
Additional Provider Savings	-$12	Drug Benefit in 2001, Catastrophic Coverage in 2006	[getting]
More Aggressive Income-Related Premium ($50/75,000)	-$15	Drug Benefit in 2002, Catastrophic Coverage in 2002	[getting]
$5 Home Health Copay (60 visits)	-$7		
Indexing Part B Deductible	-$5		
25% of Medicare's Surplus	-$85		
33% of Medicare's Surplus	-$115		
$0.45 Tobacco Tax (above budget)	-$41		
Other Revenues			

OPTION 1: FULLY FINANCED BY SAVINGS

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	**-$343**

OPTIONS:

Prescription Drug Benefit	***+$115-20??***
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start	
$29 Premium in 2002 (50%), Covers 50% of Costs up to $5,000	
State and employer maintenance of effort	
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Add Capped Home Health Copay	**-$7**
Modernizing Traditional Medicare	-$14
Managed Care Competition	**-$10**
Additional Provider Savings (modified BBA extenders)	-$45
Income-Related Premium ($80/100,000)	-$25
Budget Neutral / Paid for Policies (see base package)	
TOTAL:	**+$x**

OPTION 2: ADDITIONAL NON-SURPLUS FINANCING

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	**-$343**
OPTIONS:	
Prescription Drug Benefit	**+$160**
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, 2002 start $19 Premium in 2002 (67%), Covers 50% of Costs up to $5,000, ***20% after State and employer maintenance of effort; income-related premium***	
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Add Capped Home Health Copay	**-$7**
Modernizing Traditional Medicare	-$14
Managed Care Competition	**-$10**
Additional Provider Savings (**full** BBA extenders)	**-$57**
Income-Related Premium ($80/100,000)	-$25
Tobacco Tax: $0.45 on top of budget	**-$41**
TOTAL:	**+$0 BILLION**

OPTION 3: SURPLUS FINANCING

DEDICATES 15% OF SURPLUS TO STRENGTHEN MEDICARE	**-$258**
OPTIONS:	
Prescription Drug Benefit	**+$180**
Voluntary, Optional Benefit, Beneficiaries Get 10-15% Discount, ***2001 start***	
$19 Premium in 2002 (67%), Covers 50% of Costs up to $5,000, ***20% after***	
State and employer maintenance of effort; income-related premium	
Cost Sharing	
Eliminating Prevention Cost Sharing	+$3
Add Lab Coinsurance (20%)	-$4
Rationalize Nursing Home Copay	-$5
Modernizing Traditional Medicare	-$14
Managed Care Competition	**-$10**
Additional Provider Savings (modified BBA extenders)	-$45
Balanced Budget Act Fixes	**+$10**
Income-Related Premium ($80/100,000)	-$25
25 Percent of Medicare's Dedicated Surplus	**-$85**
TOTAL:	**-$5**