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PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

FOR THE 21st CENTURY

National Economic Council / Domestic Policy Council

The White House

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE

TAB 1.

OVERVIEW: BUDGET PRIORITIES

BUDGET PRIORITIES:

Protect And Build On Our Prosperity? Or Threaten The Health Of Our Economy?

- We have the best economy in the world today. But remember, just six and a half years ago, the budget deficit was $290 billion and rising. Wages were stagnant, economic inequality was growing, social conditions were worsening.

  In the 12 years before President Clinton took office, unemployment averaged more than 7 percent. It's almost difficult to remember what it was like. No one really thought we could turn it around, let alone bring unemployment to a 29-year low, or turn decades of deficits, during which time the debt of our country was quadrupled in only 12 years, into a surplus of $99 billion. The keys to our prosperity have been fiscal responsibility and key investments in the American people.

- President Clinton has a responsible budget plan that *builds* on our prosperity, by putting *first things first.* The President's plan uses the surplus to strengthen Social Security and Medicare, including modernizing Medicare with a long-overdue prescription drug benefit. It provides targeted tax cutsfor childcare, long-term care and the President's USA Accounts proposal which helps middle-income Americans save for retirement. It provides for military readiness and strengthens our investment in domestic priorities like education, lawenforcement and the environment

  And, the President's plan continues down the path of fiscal responsibility – and would eliminate the national debt by 2015.

- Republicans would spend nearly the entire surplus on a risky tax cut scheme that would *threaten* the continued health of our economy. Their plan does nothing to strengthen Social Security. Nothing to strengthen and modernize Medicare. Nothing about providing prescription drug coverage for Medicare beneficiaries.

  Fifty economists, including six Nobel laureates, signed a statement on July 21st which said: *"[C]ommitting to a large tax cut would create significant risks to the budget and the economy."* And on July 22nd, Federal Reserve Chairman Alan Greenspan said: *"I would prefer to hold off on significant further tax cuts."*

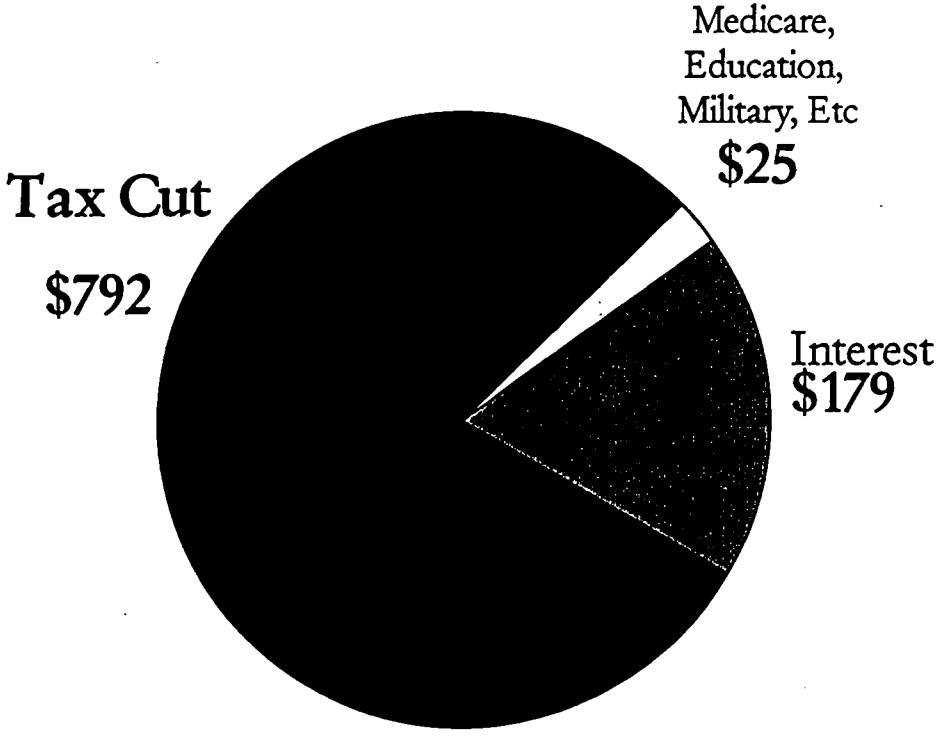
- Republican plans would lead to deep, across the boardcuts in domestic priorities. In order to pay for their risky tax cut and fund our military at the same level as the President, Republicans would have to cut *more than $700 billion* from domestic spending. In 2009, that would mean roughly a 50% cut in domestic programs across the board.

TAB 2.

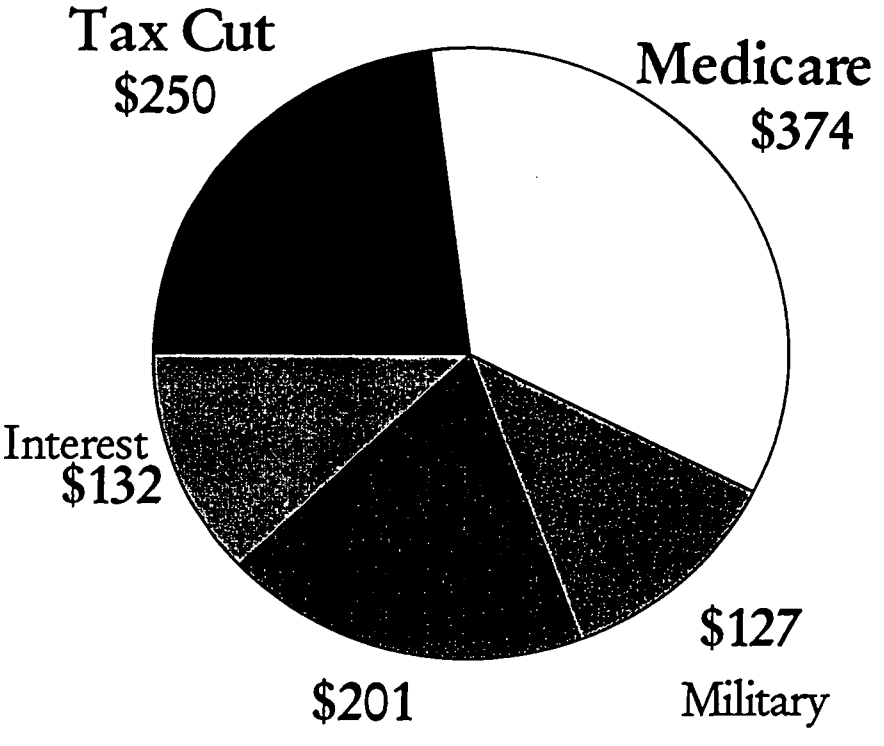
COMPARISON OF PRESIDENT'S AND REPUBLICANS' PRIORITIES

Plans For The On-Budget Surplus
(Dollars in Billions)

Republican Plan



President's Plan



FY 2000-2009; Republicans Use CBO, President Uses OMB Estimates

Impact of Republican Tax Plan

- Fails to extend Social Security Solvency
- Fails to dedicate surplus to Medicare to extend solvency for even one day
- Fails to fund adequately military readiness, education, environment, health, & other priorities

- **More than $700 billion cut** in domestic spending -- 50% in 2009. This means:
- Cutting services to 425,000 of 835,000 children in Head Start
- Reducing spending on bio-medical research by $9.8 billion
- Lowering NASA's budget to its 1984 level

Programmatic Impacts in FY 2009 of Republican Tax Cut
Assuming Defense is Equal to the President's Request

Education and Training

- A cut of this magnitude would force **Head Start** to cut services to **425,000** of the 835,000 children who would otherwise be served in FY 2009.

- About **306,000** summer **jobs and training opportunities** for low-income youth could be eliminated from the 577,700 that would otherwise be provided in FY 2009.

- **Title I, Education for the Disadvantaged** could be slashed, cutting more than **7.4** million children (from the total 14.6 million assumed in the baseline) in high poverty communities from key educational services necessary to improve their future prospects.

- The **Reading Excellence** program, which would otherwise help 1.2 million children learn to read by the 3rd grade, could serve **622,000** fewer students.

Environment and Health

- In FY 1999, the **VA Medical Care** budget projects providing treatment for 3,468,000 veteran patients, a figure that would drop by **1,622,00** should a cut of this magnitude take place.

- Funding for the **Health Resources and Services Administration** would be cut by **$2.5** billion from the current services baseline, resulting in the loss of health services for roughly **15** million women, children, uninsured people, and people living with AIDS from the total 30 million recipients assumed in the baseline.

- Funding for the **National Institutes of Health** would be cut by **$9.8** billion from the current services baseline, resulting in approximately **15,000** fewer biomedical research grants being funded from the total 31,000 assumed in the baseline. At this level, NIH might not be able to fund any new research grants, and support for research grants begun in previous years would have to be reduced.

- **Stopping Toxic Waste Cleanup** -- EPA's Superfund program would be cut by nearly **$1 billion,** eliminating funding for all new Federally-led cleanups due to begin in 2009. Major reductions would also be needed in emergency response actions, ongoing Superfund cleanups, negotiation and oversight of private party-led cleanups, cost recoveries, EPA's brownfields program, and support for other federal agencies and states. Over a thousand employees could lose their jobs, and Superfund contractors would be out of work.

Crime, Housing, and Other Priorities

- Cuts to the **Immigration and Naturalization Service** could result in a reduction of approximately **6,993** Border Patrol agents (from the total 8,947 assumed in the baseline). Cuts to the **FBI** could result in a reduction of approximately **7,187 FBI agents** (from the total 10,687 assumed in the baseline).

- Cuts of this magnitude to **HUD**'s housing rental subsidy could result in the termination of rent subsidies to approximately **1.5** million HUD subsidized low-income tenants in FY 2009.

- Cuts of this magnitude would reduce **NASA**'s funding to the lowest level since **FY 1984.** With this level of funding, NASA could support either a human spaceflight program or a science program relying on robotic missions, but not both.

- The **National Park Service** operating budget would be cut by **almost a billion dollars** below the FY 2009 baseline. Park rangers and other staff would have to be reduced through hiring freezes and RIFs. Seasonal workers could not be hired, resulting in widespread cutbacks in visitor services, seasonal programs, and hours of operations, as well as closures at many of the 378 park units serving almost 300 million visitors annually.

Source: Office of Management and Budget

TAB 3.

PRESIDENT'S MEDICARE PLAN

STRENGTHENING MEDICARE FOR THE 21st CENTURY

President Clinton has proposed to strengthen Medicare by making it more competitive and efficient; modernizing its benefits; and improving its financing. This plan would both offer a long-overdue prescription drug benefit to Medicare beneficiaries and use a portion of the surplus to secure the life of the Medicare Trust Fund for at least the next 25 years. It would also add structural reforms that constrain cost growth by making Medicare fee-for-service and managed care compete more effectively. Lastly, the plan would smooth out and moderate Balanced Budget Act provider payment changes that are excessive. *The New York Times* editorial board described the proposal as "well-considered" and said it would "constitute the most substantial change to Medicare since its creation in 1965."

MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT. In recent years, the President and Congress have worked together to extend the life of the Medicare trust fund from 1999 to 2015. Building on this success, this plan:

- Gives Medicare new private purchasing and quality improvement tools to improve care and constrain costs;
- Injects true price competition between traditional Medicare and managed care plans, making it easier for beneficiaries to make informed choices and saving money over time for both beneficiaries and the program;
- Reduces average annual Medicare spending growth, ensuring that program growth does not significantly increase after most of the Medicare provisions of the Balanced Budget Act expire in 2003; and
- Takes administrative and legislative action, including a $7.5 billion quality assurance fund, to smooth out provisions in the Balanced Budget Act which may be affecting Medicare beneficiaries' access to quality care.

MODERNIZING MEDICARE'S BENEFITS. The current Medicare benefits package does not include all the services needed to treat health problems facing the elderly and people with disabilities. To address this, the President's plan:

- Establishes a new prescription drug benefit that is affordable and available to all Medicare beneficiaries. All beneficiaries would have the option to purchase this benefit that provides for privately-negotiated price discount and covers 50 percent of the costs from the first prescription for spending up to $5,000 when fully implemented. Premiums for this coverage would begin at $24 in 2002 and phase in to $44 per month in 2008;
- Eliminates copayments and deductibles for all preventive services covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, and mammographies;
- Rationalizes cost-sharing requirements to help pay for the prescription drug and preventive benefits by adding a 20 percent copayment for clinical laboratory services and indexing the Part B deductible for inflation;
- Reforms Medigap policies by working to add a new lower-cost option with low copayments and provide Medicare beneficiaries easier access to and a better understanding of Medigap policies; and
- Includes the President's Medicare Buy-In proposal which provides an affordable coverage option for vulnerable Americans between the ages of 55 and 65.

STRENGTHENING MEDICARE'S FINANCING FOR THE 21ST CENTURY. Medicare enrollment will double from almost 40 million today to 80 million by 2035, creating a need to strengthen Medicare financing. To address this, the plan dedicates part of the budget surplus to secure the life of the Medicare trust fund for the next quarter century.

- It is impossible to reduce provider payments enough to extend the life of the Medicare trust fund for any significant length of time. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person.
- Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster, helping to eliminate public debt by 2015. This would make America debt-free for the first time in the 160 years

June 30, 1999

The New York Times

Founded in 1851

ADOLPH S. OCHS, *Publisher 1896-1935*
ARTHUR HAYS SULZBERGER, *Publisher 1935-1961*
ORVIL E. DRYFOOS, *Publisher 1961-1963*
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Improving Medicare

President Clinton's Medicare reform plan, if approved by Congress, would constitute the most substantial change to Medicare since its creation in 1965. Although no reform can instantly improve quality and increase cost-efficiency in the enormous program, Mr. Clinton has delivered a well-considered proposal that can shore up Medicare without heedlessly expanding costs or creating chaos for 39 million beneficiaries.

The plan takes a prudent, incremental approach in adding benefits and changing Medicare's structure. The proposal is premised on putting $794 billion into Medicare over the next 15 years from the projected $5.5 trillion Federal surplus. But any plan that does not greatly cut benefits or reduce eligibility through income tests or other means would need to put more money into Medicare in the next two decades as baby boomers reach retirement and technology makes it possible for more people to live longer. The Clinton plan would extend the solvency of the Medicare trust fund to 2027.

The Administration would spend $118 billion over 10 years to provide limited prescription drug coverage. That step is long overdue. A third of Medicare recipients have no drug coverage, even though drugs have become crucial to managing chronic illnesses and can help keep patients out of the hospital. The proposed voluntary program, beginning in 2002, would charge Medicare enrollees $24 a month. The Government would pay half the cost of prescription drugs for those who enroll, with a maximum Government payment of $1,000 a year. The monthly premium would gradually increase to $44 in 2008, with the maximum benefit cap rising to $2,500. Low-income people would receive help paying the monthly premiums and co-payments.

The drug plan, which would increase Medicare costs by about 5 percent in 2009, would not create an open-ended benefit. But it would enable Medicare to get volume discounts from drug companies, as large purchasers typically do, and to pass those discounts on to the elderly. The plan may also help staunch the decline in employer-paid retiree health benefits by covering some of the drug costs.

The Administration's package would also make it more attractive for beneficiaries to join managed care plans, a shift that is essential to future cost containment. Health plans bidding for Medicare patients would have to offer the same benefits as fee-for-service Medicare. If a plan could provide the same coverage for less money, enrollees would benefit directly from those savings, most likely through discounts off the current $45.50 monthly Medicare premium. That incentive could help pull more people into lower-cost plans. The proposal would increase competition and efficiency in the fee-for-service sector by enabling qualified, cost-efficient doctors to attract Medicare patients by offering patients lower cost-sharing than traditional Medicare, where patients usually pay 20 percent of the costs and the Government pays 80 percent.

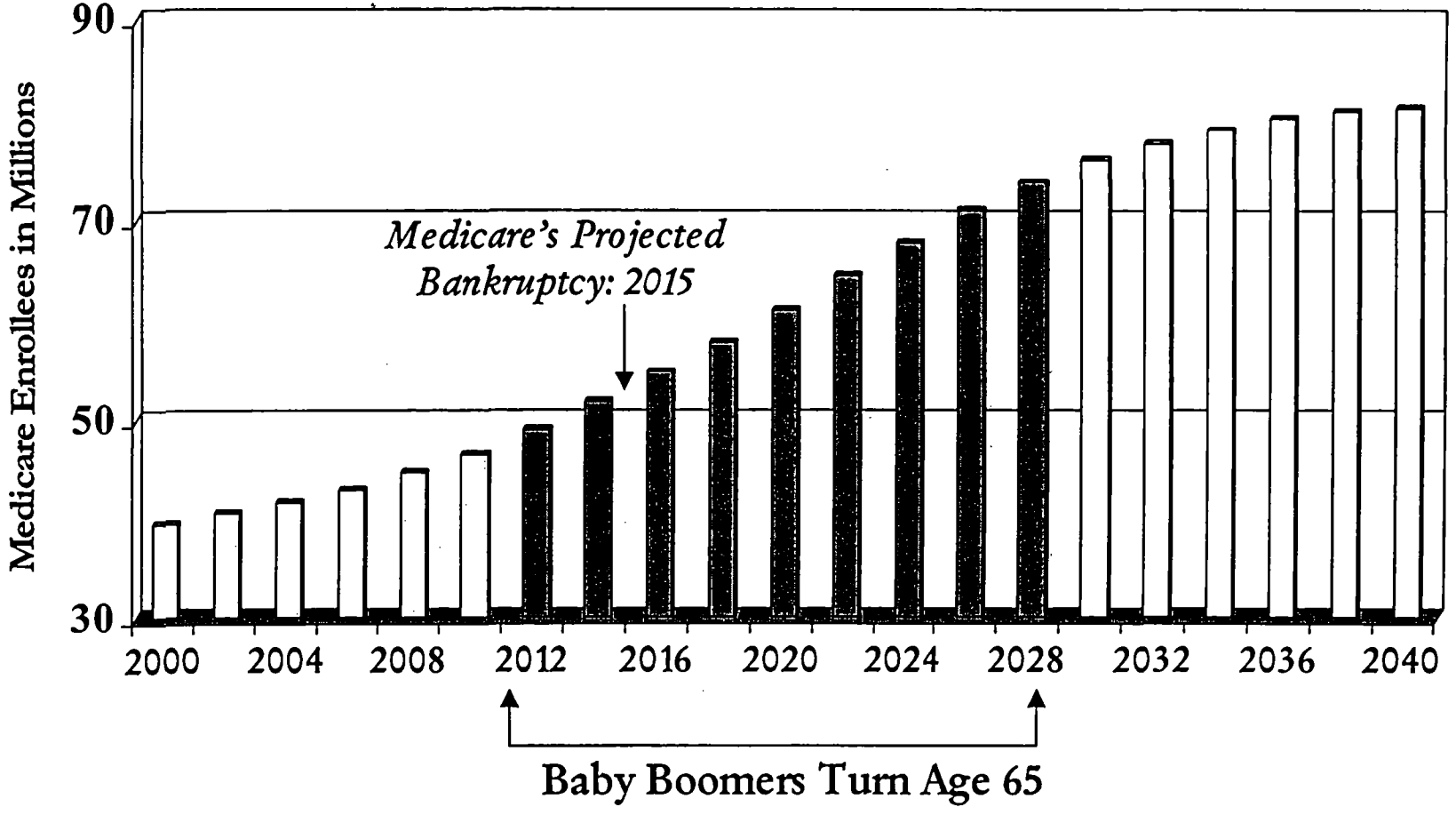
Reforming Medicare requires modernizing the benefits and improving cost controls. The Clinton proposal, made feasible by the surplus, offers some sensible ways to achieve those goals while keeping Medicare a broad-based social insurance program.

PRESIDENT'S PLAN TO MODERNIZE & STRENGTHEN MEDICARE

Plan To Modernize and Strengthen Medicare

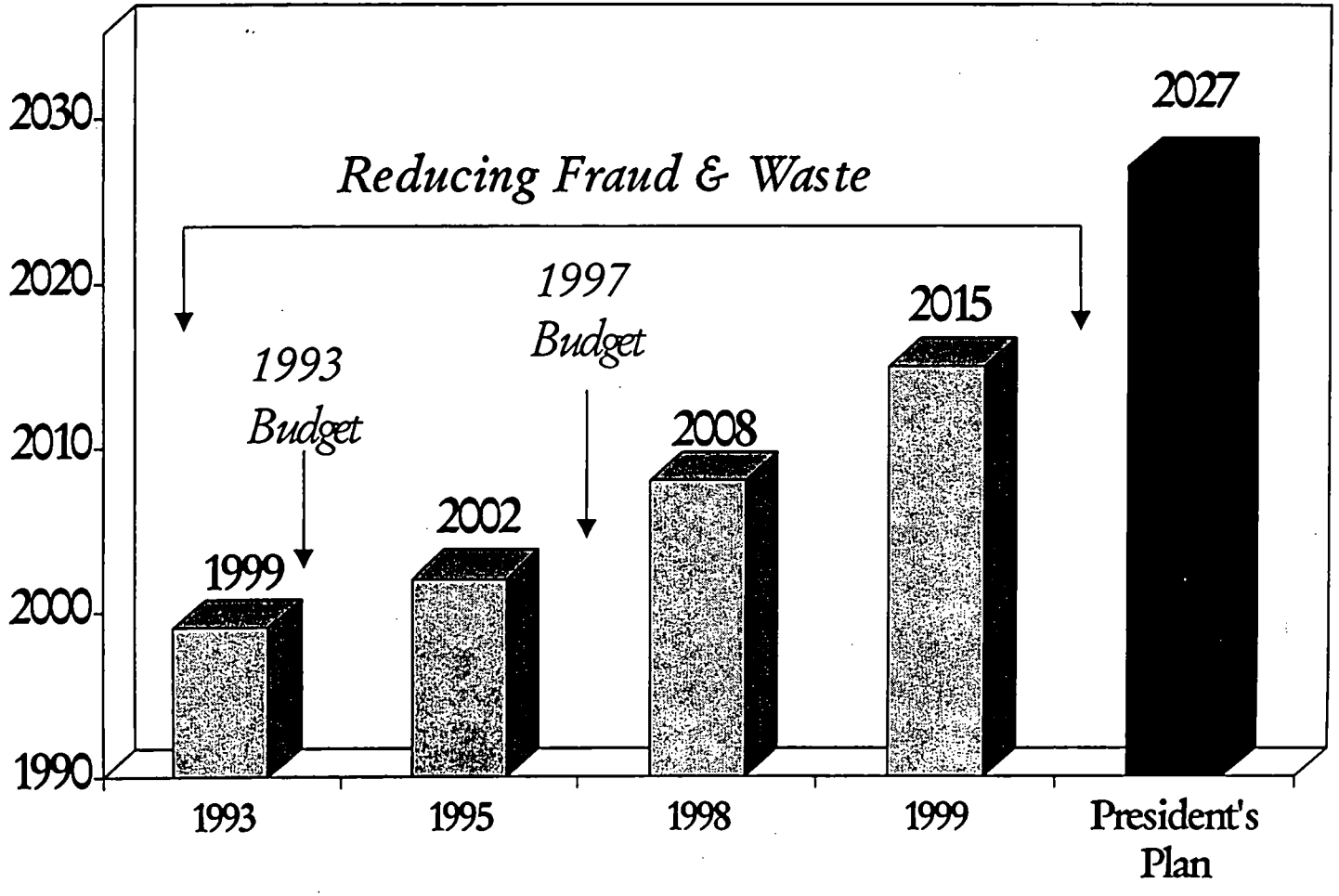
- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Financing for the 21st Century By Dedicating Part of the Surplus to Medicare

Medicare Enrollment Will Double As The Baby Boom Generation Retires



Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



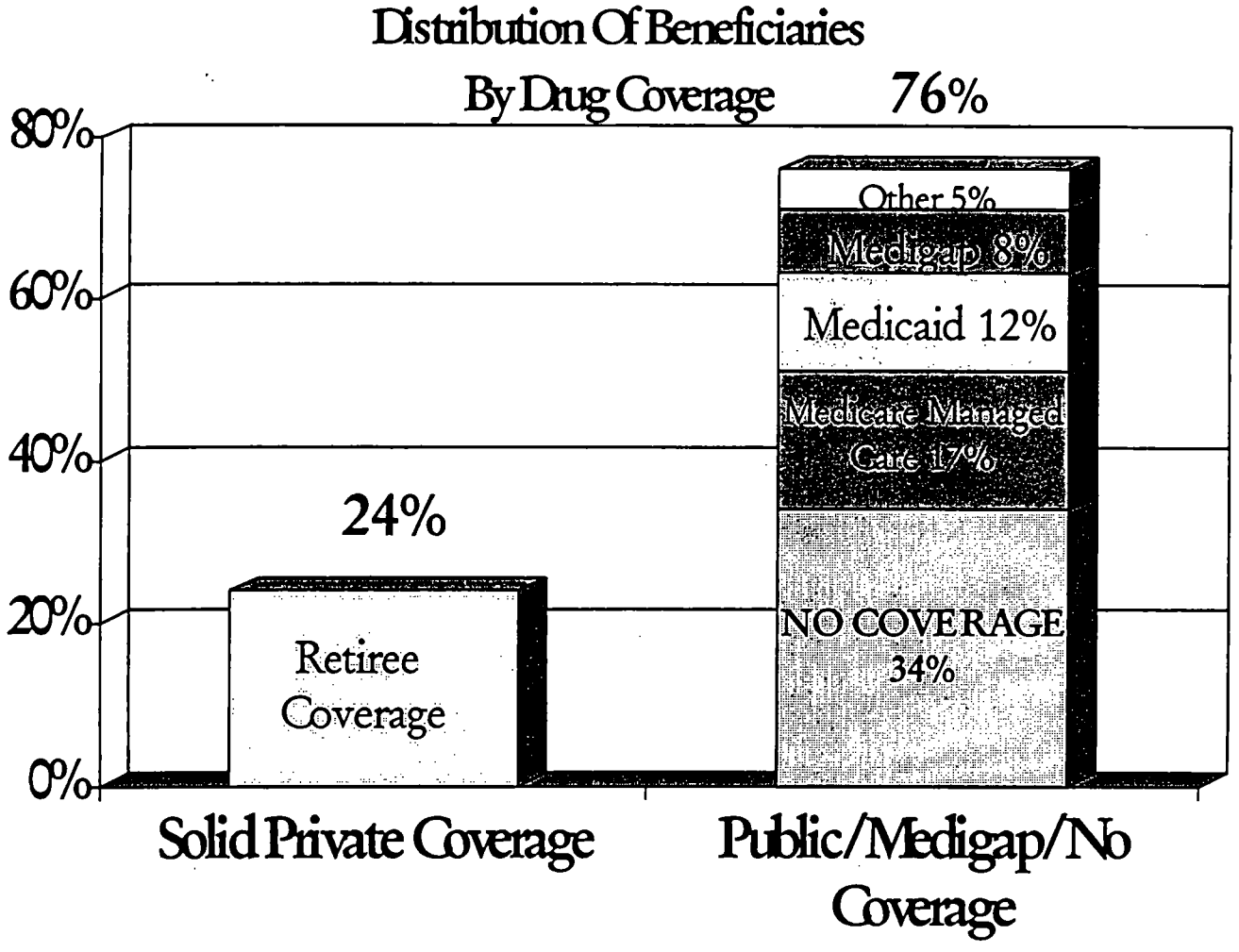
President's Proposal For Medicare Prescription Drug Coverage

- **Meaningful coverage:** Beginning in 2002, beneficiaries have the option to enroll in Part D:
  - No deductible -- coverage with first prescription
  - 50 percent copay with access to discounted prices
  - Benefit limited after $5,000 in costs (phased-in in 2008)

- **Affordable premiums:** $24/month, rising to $44/month when fully phased in. Includes low-income protections

- **Private management,** and incentives for retaining retiree health coverage

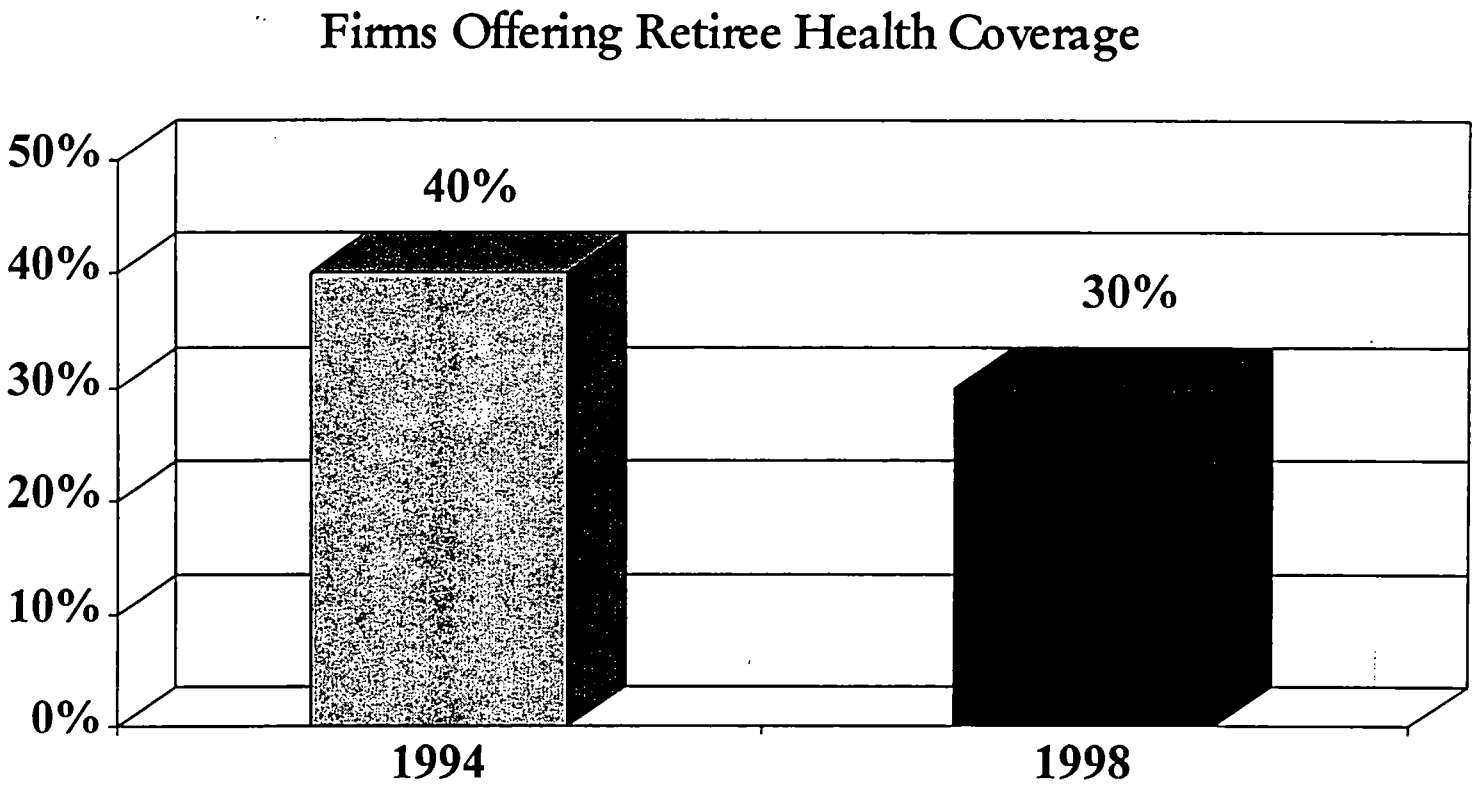
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

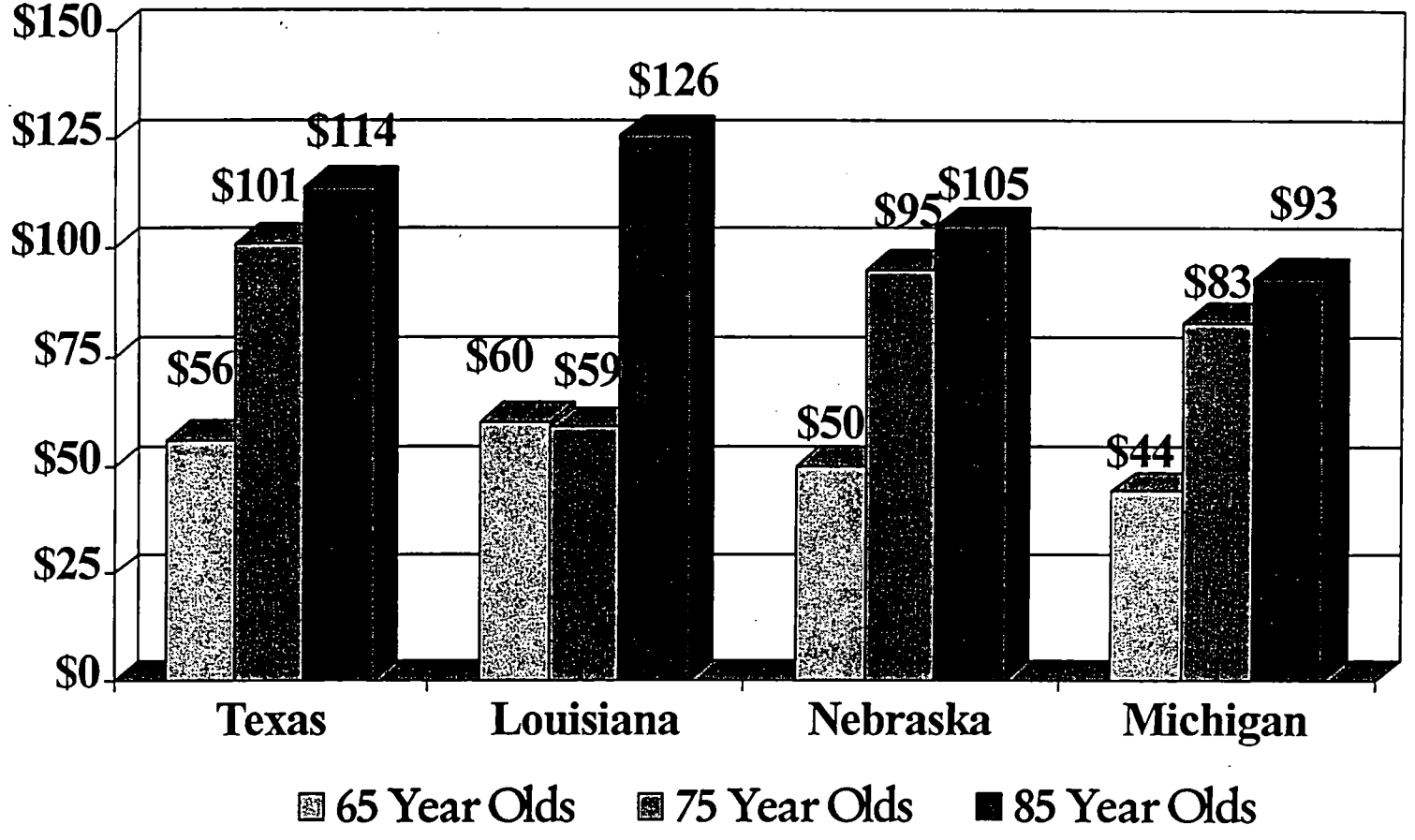
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

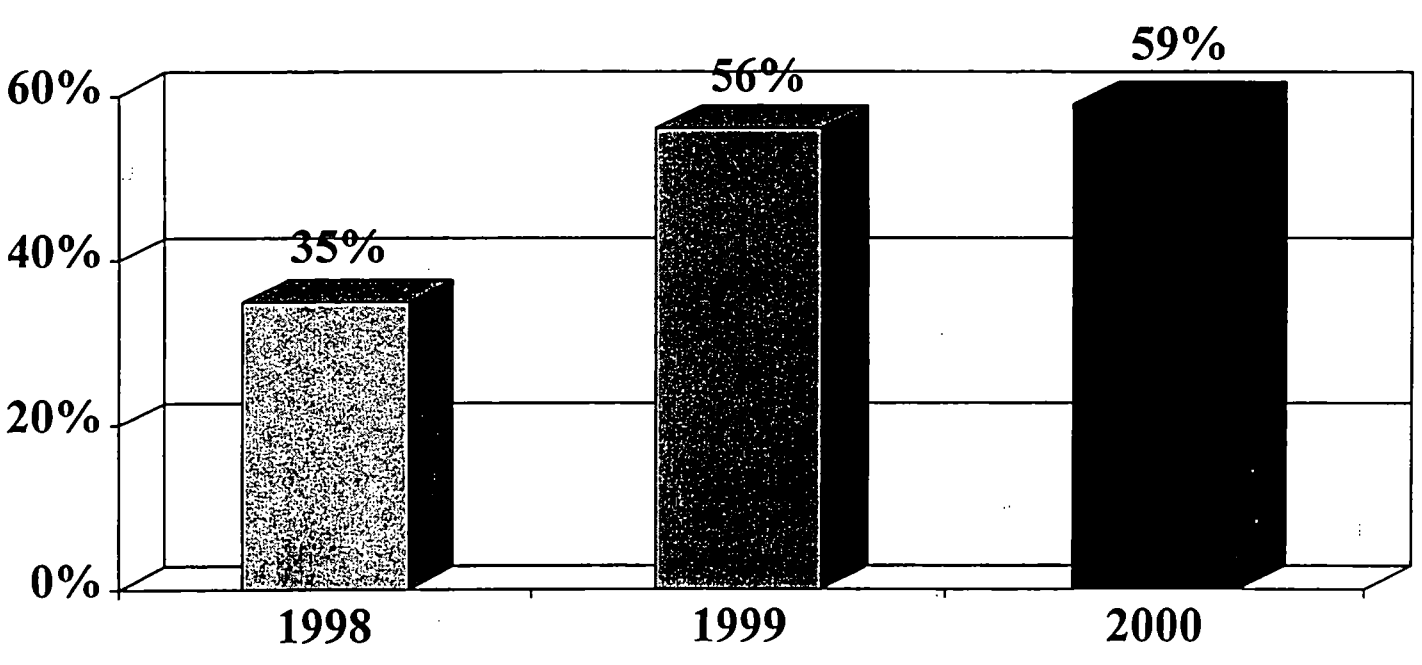
Premiums for Medigap, Which Only Covers 8% of Beneficiaries, Are High And Increase With Age



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

Value of Medicare Managed Care Drug Benefits Is Declining

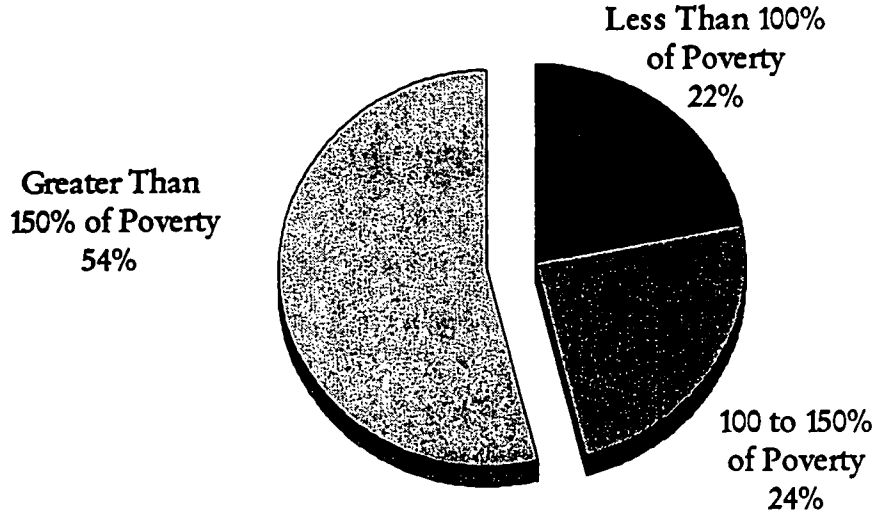
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Many Middle-Class Beneficiaries Lack Coverage For Prescription Drugs

Income of Beneficiaries Without Drug Coverage
(As A Percent Of Poverty)



Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

Disproportionately Affects:

- **Rural beneficiaries,** since nearly half have no coverage
- **Older women,** for whom total prescription drug spending averages $1,200 -- 20% more than men's

SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, 150% of poverty for a single person is about $12,750, for a couple is about $17,000

Making Medicare Managed Care More Competitive

Current System	Competitive Defined Benefit
• No price competition	• Plans paid based on price and quality
• Plans compete by offering hard-to-compare benefits	• Plans compete by lowering premium & cost sharing for clearly defined benefits
• Over 1 in 4 beneficiaries do not have access to managed care -- or the extra benefits they offer	• Explicitly pays for drugs in managed care as well as traditional Medicare

Smoothing Out Balanced Budget Act Policies In The Short Run

- **Immediate Administrative Actions**, that moderate the impact on hospitals, academic health centers and home health agencies

- **Targeting Disproportionate Share Hospital Payments Directly to Hospitals**

- **$7.5 Billion Quality Assurance Fund**

TAB 4.

PRESCRIPTION DRUG BENEFIT

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

National Economic Council
Domestic Policy Council

July 22, 1999

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

Table of Contents

OVERVIEW

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

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

- Prescription drug coverage is good medicine.

  - Part of modern medicine. Prescription drugs serve as complements to medical procedures, such as anti-coagulants, used with heart valve replacement surgery; substitutes for surgery, such as lipid lowering drugs that reduce the need for bypass surgery; and new treatments where there previously were none, such as medications used to manage Parkinson's disease. In addition, as our understanding of genetics grows, the possibility for breakthrough pharmaceutical and biotechnology will increase exponentially.

  - Medicare beneficiaries are particularly reliant on prescription drugs. Not only do the elderly and people with disabilities have more problems with their health, but these problems tend to include conditions that respond to drug therapy. Not surprisingly, about 85 percent of beneficiaries fill at least one prescription a year for such conditions as osteoporosis, hypertension, myocardial infarction (heart attacks), diabetes, and depression.

  - The lack of drug coverage has led to inappropriate use of medications which can result in increased costs and unnecessary institutionalization. Recent research has determined that being uninsured leads to significant declines in the use of necessary medications. The consequence of inappropriate and underutilization of prescription drugs has also been found to double the likelihood that low-income beneficiaries entering nursing homes. One study concluded that drug-related hospitalization accounted for 6.4 percent of all admissions of the over 65 population and estimated that over three-fourths of these admissions could have been avoided with proper use of necessary medications.

- About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drug coverage.

  - Only one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage.

- Over three-fourths of beneficiaries lack decent, dependable. At least one-third of Medicare beneficiaries have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries. About 17 percent have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable. Drug coverage in managed care can only be assured if it becomes part of Medicare's basic benefits and is explicitly paid for in managed care rates. The remaining 17 percent are covered through Medicaid, Veterans' Affairs and other public programs.

- Private trends: Decline in coverage and affordability.

  - The proportion of firms offering retiree health coverage has declined by 25 percent in the last four years. Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage. The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

  - Medigap premiums for drugs are high and increase with age. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the President. Moreover, unlike the President's proposal, premiums substantially increase with age as virtually every Medigap plan "age rates" the cost of the premium. This means that just as beneficiaries need prescription drug coverage most and are the least likely to be able to afford it, this drug coverage is being priced out of reach. This cost burden will particularly affect women, who make up 73 percent of people over age 85.

- Public drug coverage trends: managed care benefits reduced.

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

  - Participation by Medicaid eligible populations remains low. Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent. This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries. Inadequate outreach and welfare stigma contributes to these low participation levels and raise serious questions about the feasibility and advisability of using the Medicaid program to provide needed coverage for a population at higher income levels.

- **Millions of beneficiaries have no drug coverage.**

  - At least 13 million Medicare beneficiaries have absolutely no prescription drug coverage. The number of the uninsured is not concentrated among the low income. In fact, the income distribution of uninsured Medicare beneficiaries is almost exactly the same for beneficiaries at all income levels.

  - More than half of Medicare beneficiaries without drug coverage are middle class. Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This clearly indicates that any prescription drug coverage policy that limits coverage to below 150 percent of poverty, as some in Congress suggest, will leave the vast majority of the Medicare population unprotected.

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

- **Part of modern medicine.** Prescription drugs serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other medical procedures (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV and Parkinson's). Some of the major advances in public health – the near eradication of polio and measles and the decline in infectious diseases – are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

- **Greatest need for prescription drugs.** The elderly and people with disabilities are particularly reliant on prescription drugs. Not only do they experience greater health problems, but these problems tend to include conditions that respond to drug therapy. As a result, about 85 percent of beneficiaries fill at least one prescription a year. Some examples of common conditions include:

  - Osteoporosis: Over 1 in 5 older women have osteoporosis and about 15 percent have suffered a fracture as a result.[1] It is a leading risk factor for hip fractures, which affects 225,000 people over the age of 50. Estrogen replacement can reduce the risk of osteoporosis as well as that of cardiovascular disease. One commonly used drug costs $20 per month, $240 per year.

  - Hypertension: About 60 percent of people over age 65 have hypertension.[2] African Americans are more likely to have hypertension. For a person over age 55, hypertension increases the risk of a heart attack or other heart problem over 10 years by 10 percent.[3] Hypertension roughly doubles the risk of cardiovascular disease and is the leading factor for stroke. According to one study, treatment results in a one-third reduction in the probability of stroke and a one-quarter reduction in the probability of a heart attack.[4] ACE inhibitors which typically cost $40 per month, $480 per year are commonly prescribed to control hypertension, and are frequently used in combination with diuretics and /or beta-blockers.

  - Myocardial Infarction (Heart Attack): Heart disease is the leading cause of death for persons 65 and over. About 1.5 million Americans each year have heart attacks, which are fatal in about 30 percent of patients. Since people who survive heart attacks are much more likely to have subsequent attacks, disease management including drugs can significantly improve health and longevity. For example, a study of the use of a lipid lowering drug by people who had an acuate myocardial infarction found a 42 percent reduction in coronary mortality after 5 years of follow-up.[5] A common lipid reduction drug costs about $85 per month, $1,020 per year. A beta-blocker costs about $30 per month, $360 per year, and can reduce long-term mortality by 25 percent.[6]

  - Adult-Onset Diabetes: About 1 in 10 elderly have Type I or II diabetes.[7] Diabetes can lead to blindness, kidney disease and nerve damage. Glucose (blood sugar)

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

- Depression: An estimated 1 in 10 to 1 in 20 community-based elderly experience depression.[8] Depression can lead to institutionalization and other health problems. From 60 to 75 percent of patients respond to drug therapy.[9] New therapies can cost from $130 to $290 per month or $1,560 to $3,480 per year.

- **Many beneficiaries need drugs but do not use them as prescribed because they do not have well managed, affordable drug insurance.** Most research has found that drug coverage influences use of needed drugs:

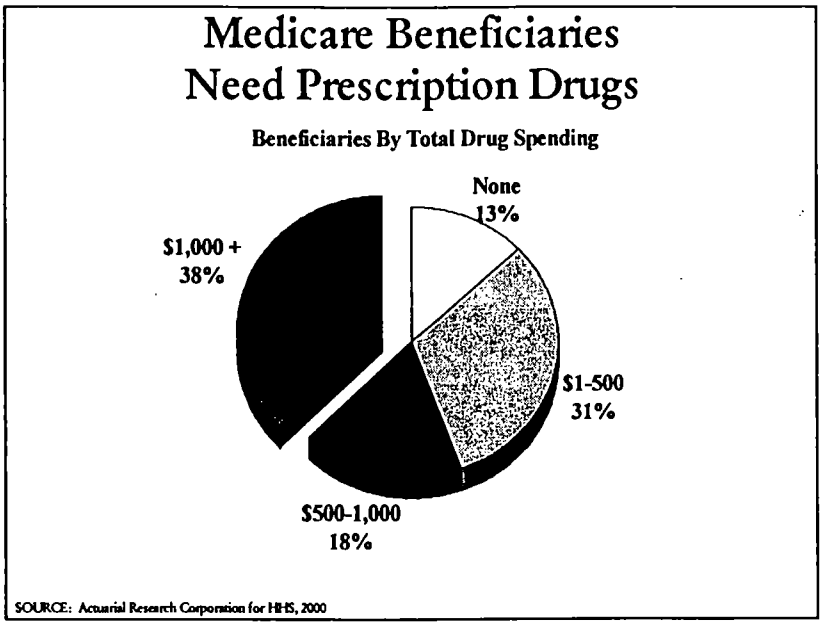
  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.[10] Many elderly must choose between prescriptions and other basic household needs.[11]

  - Increased nursing home use. Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes.[12]

  - Less protection against drug complications. Even though the elderly and disabled take more prescription drugs and have more complex medical problems, Medicare beneficiaries without coverage do not benefit from drug management. This could lead to adverse drug reactions, inappropriate use of drugs, or discontinuation of needed drugs. One study which classified the geriatric admissions to a community hospital found that drug-related hospitalization accounted for 6.4 percent of all admissions among the over 65 population. The study estimated that 76 percent of these admissions were avoidable.[13]

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

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



- **Over one-third (38%) of Medicare beneficiaries will spend more than $1,000 on prescription drugs.** Less than 5 percent will spend more than $5,000.

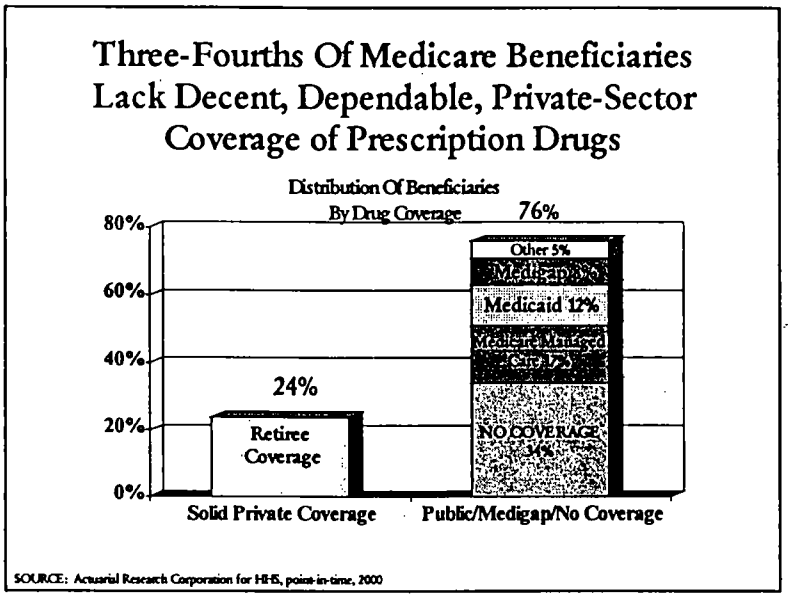
- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than $500.

- **Spending is higher for women.** Because of their greater likelihood of living longer and having chronic illness, women on Medicare spend nearly 20 percent more on prescription drugs than men.

- **Out-of-pocket spending is also high.** In 2000, Medicare beneficiaries are estimated to spend about $525 on prescription drugs out-of-pocket. This spending is linked to insurance coverage – it is much higher for those with no coverage ($800) and people with Medigap ($650) than those with retiree coverage ($400).

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

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



- **Only one-fourth of Medicare beneficiaries have retiree drug coverage.** Employers provide health insurance for most Americans under the age of 65, but pay for supplemental coverage for only a fraction of their elderly retirees. When available, this coverage tends to have reasonable cost sharing and affordable premiums.

- **About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage of prescription drugs.** These beneficiaries include those with:

  - Medigap. About 8 percent of beneficiaries purchase Medigap with drug coverage – but this coverage is frequently expensive, inaccessible and inadequate for many Medicare beneficiaries.

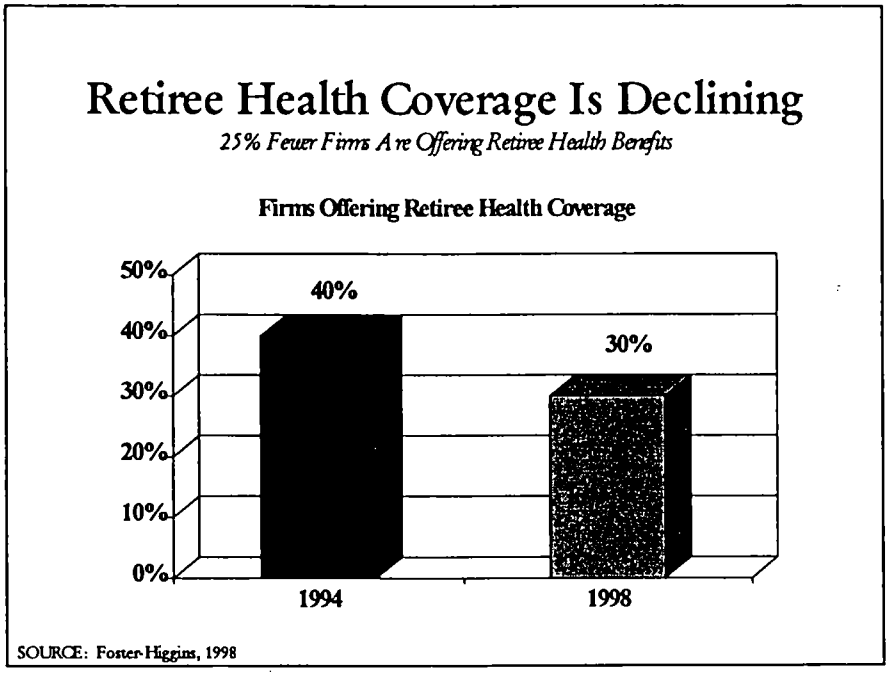
  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

  - Medicaid and other public programs. Medicaid covers about 12 percent of beneficiaries and programs like the Veterans' Administration cover another 5 percent of beneficiaries. Eligibility for these programs is very restrictive.

  - No coverage at all. 34 percent of Medicare beneficiaries has no drug coverage.

RETIREE HEALTH COVERAGE

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



- Firms offering retiree health coverage have declined by 25 percent in the last four years.[14] Retiree health coverage is declining substantially because many firms previously providing it are opting to drop their coverage.

  - The decline was more pronounced among the largest employers (greater than 5,000 employees), over a third of whom dropped coverage in this period.

- Most serious effect will occur when the baby boom generation retires. Although there are employers who are dropping health coverage for current retirees, most are restricting coverage for future retirees. This means that the access problems that are emerging now could be more severe in the future.

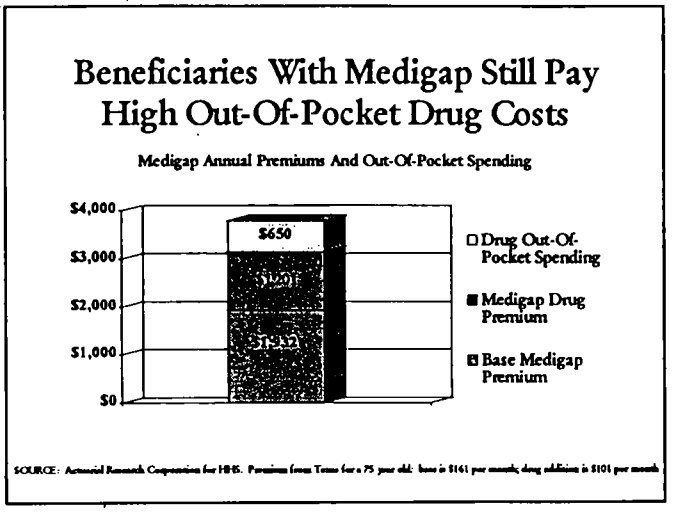
- Firms are increasingly moving their retirees to Medicare managed care. To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in 1996.[15]

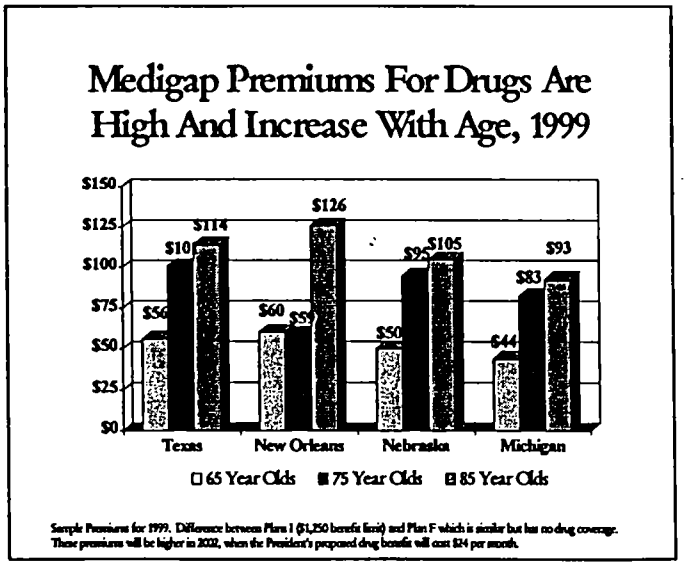
MEDIGAP PRESCRIPTION DRUG COVERAGE

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

- Medigap is expensive, inefficient, and often uses higher prices to discriminate against the oldest beneficiaries.

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





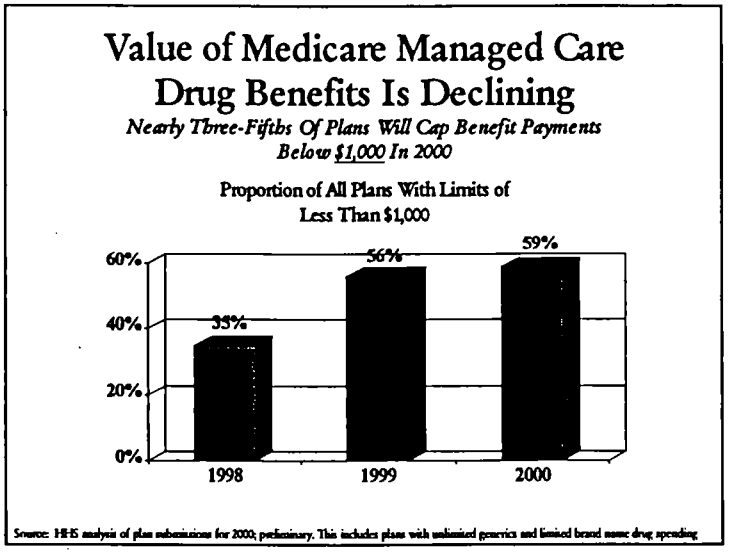
Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

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

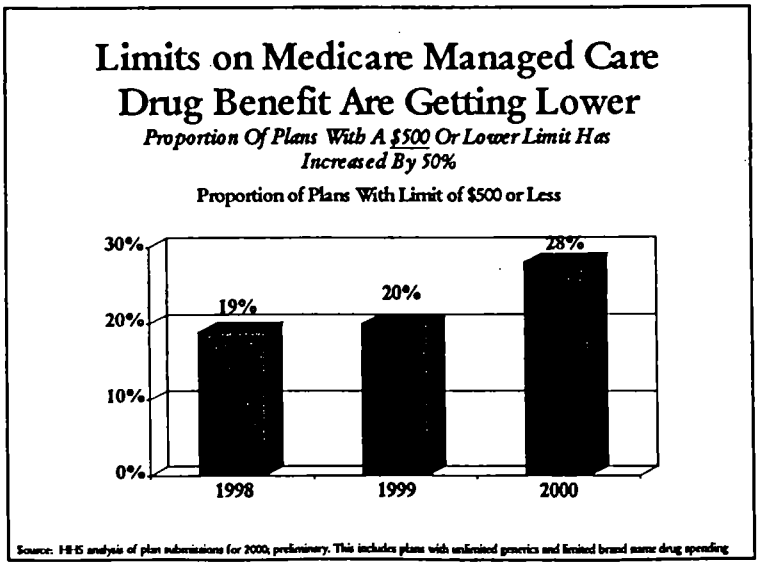
MEDICARE MANAGED CARE

- **The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent.** Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.

- **Drug coverage under Medicare+Choice is unstable.** Managed care plans are not required to offer a drug benefit, but can do so with any excess Medicare payments or by charging a premium. This results in wide variation across areas, since payments vary by area, and over time.



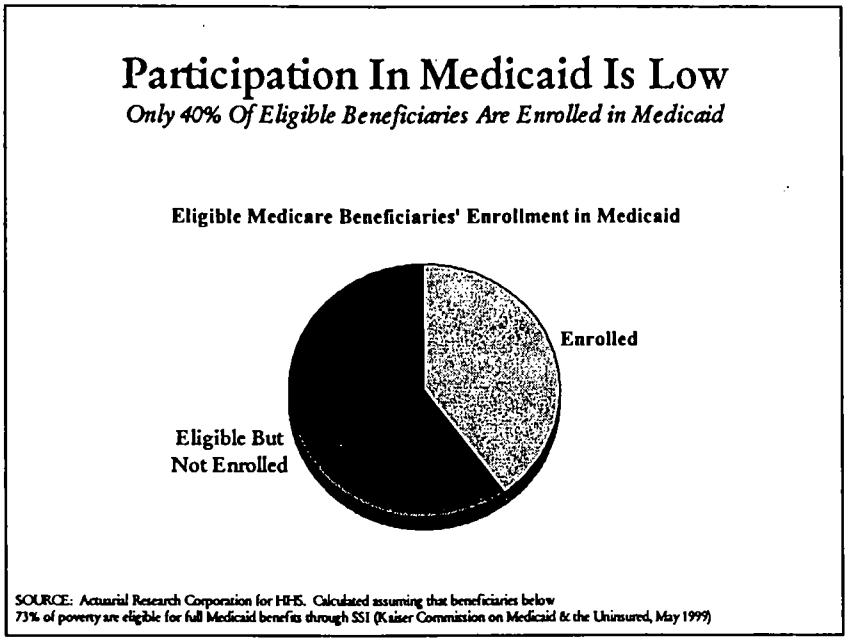
- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.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



- **Plans dropping out of Medicare limit access to drugs.** Nearly 80,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.

MEDICAID

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



- **Participation by Medicaid eligible populations remains low.** Millions of Medicare beneficiaries under 75 percent of poverty (about $6,000 for a single, $8,500 for a couple) are eligible for Medicaid prescription drug coverage, but the participation rate is only about 40 percent.

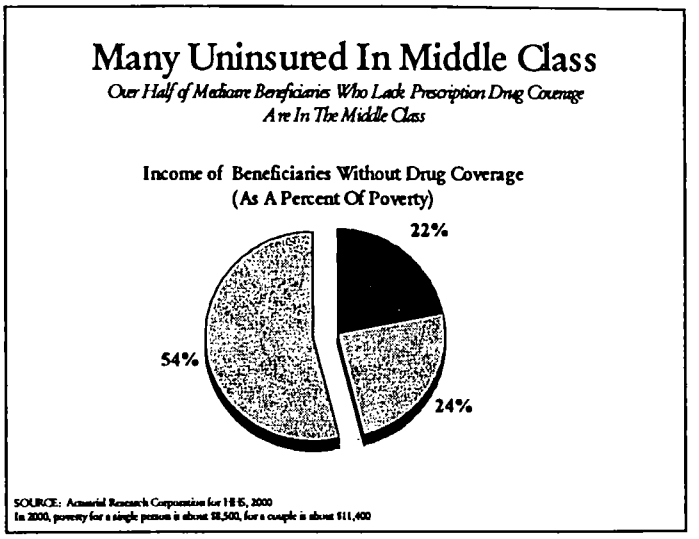
  - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.

  - This contrasts with an almost 100 percent participation rate in Medicare Part B for beneficiaries.

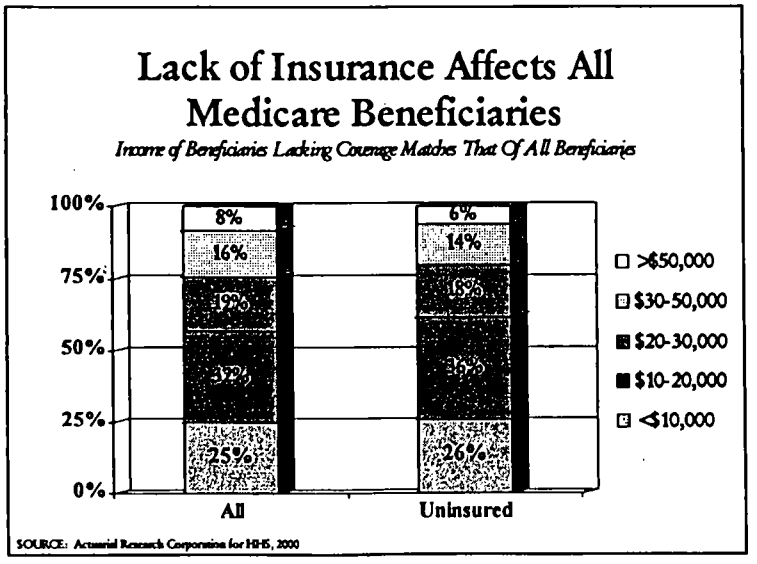
BENEFICIARIES LACKING DRUG COVERAGE

- **At least 13 million or 34 percent of Medicare beneficiaries have no insurance coverage for prescription drugs.** These beneficiaries pay retail prices for prescription drugs, which can often be significantly more expensive than what large firms or public programs pay for the same drugs.

- **More than half of Medicare beneficiaries without drug coverage are middle class.** Over 50 percent of Medicare beneficiaries without drug coverage have incomes in excess of 150 percent – an annual income of approximately $17,000 for couples. This indicates that targeting a drug benefit only to the low-income cannot address even half of the problem.



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



PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

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

- **Meaningful coverage.** Beginning in 2002, beneficiaries would have the option of participating in the new Medicare Part D program. It would have:

  - No deductible – coverage begins with the first prescription filled and

  - 50 percent coinsurance, with access to discounts negotiated by private pharmacy managers after the limit is reached.

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

- **Affordable premiums.** Beneficiaries who opt for Part D would a pay separate premium for Medicare Part D – an estimated $24 per month in 2002, and $44 per month in 2008 when fully implemented. This premium represents 50 percent of program costs. Enrollment would be optional and, after an initial open enrollment for all beneficiaries in 2001, would occur when a beneficiary becomes eligible for the program or when they transition out of employer-based coverage. Premiums would generally be deducted from Social Security checks.

  - **Low-income protections.** Beneficiaries with income up to 150 percent of poverty ($17,000 for a couple) would pay no Part D premium. Those with income below 135 percent of poverty ($15,000 for couples) would pay no premiums or cost sharing. This assistance would be administered through Medicaid, with the Federal government assuming all of the premium and cost sharing costs for beneficiaries with incomes above poverty.

- **Private management.** Beneficiaries in managed care plans would continue to receive their benefit through their plan. For enrollees in the traditional program, Medicare would contract with numerous private pharmacy benefit managers (PBMs) or similar entities. Medicare would use competitive bidding to award contracts for drug management. The private managers would use the latest, effective cost containment tools, drug utilization review programs, and meet quality and consumer access standards. No price controls would be imposed.

- **Incentives to develop and retain retiree coverage.** Employers that choose to offer or continue retiree drug coverage would be provided a financial incentive to do so.

APPENDIX: METHODOLOGY & ENDNOTES

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

Endnotes.

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[11] Families USA, 1994.

[12] Soumerai SB; Ross-Degnan D; Avorn J; McLaughlin TJ; Choodnovskiy I. (1991). Effects of Medicaid drug-payment limits on admissions to hospitals and nursing homes. *The New England Journal of Medicine,* 325: 1072-1077.

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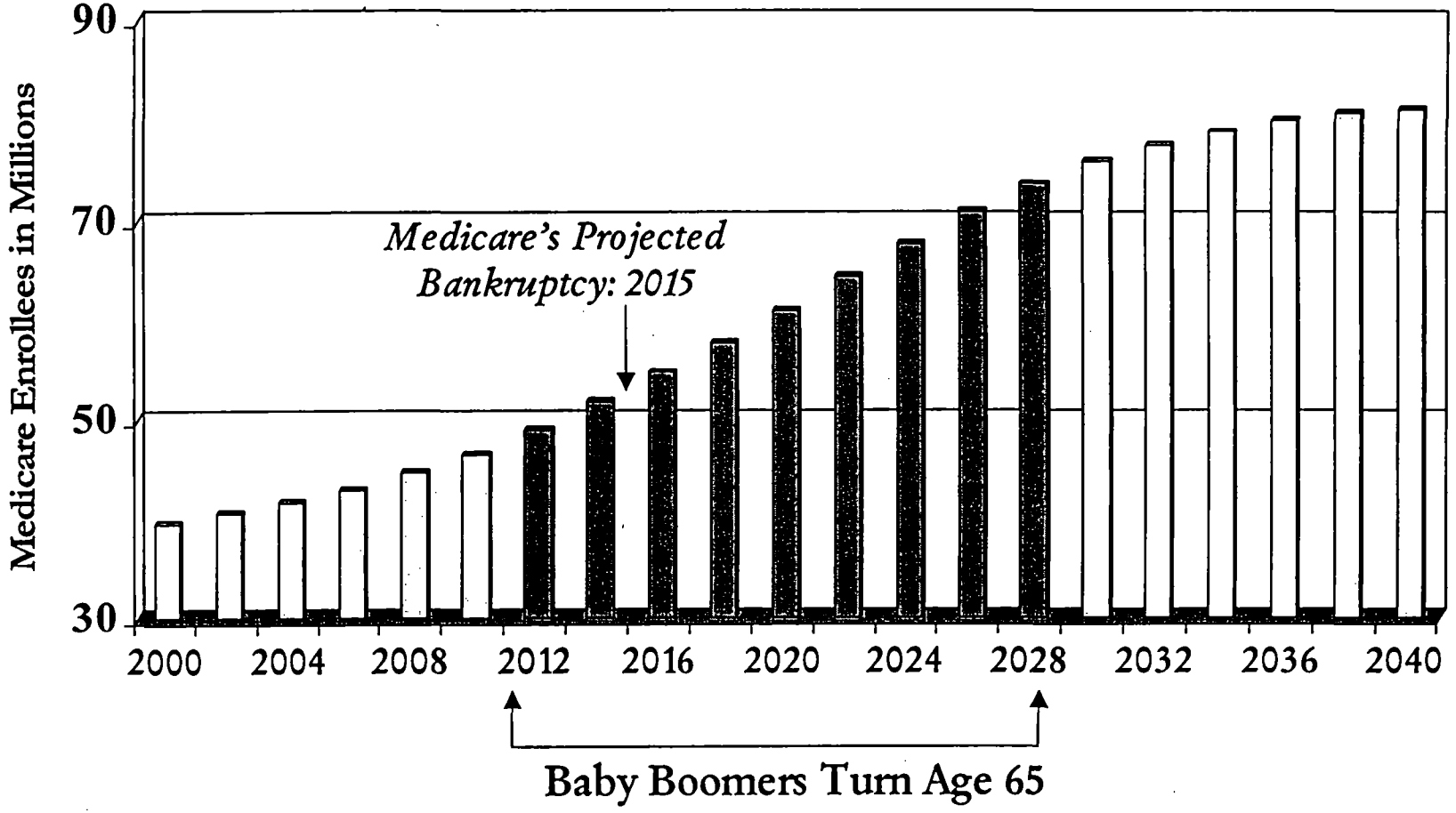
[14] Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1998.

[15] Foster Higgins, National Survey of Employer-Sponsored Health Plans, 1996. As reported in Hewitt Associates. (1997). Retiree Health Trends and Implications of Possible Medicare Reforms. Washington, DC: The Kaiser Medicaid Project.

TAB 5.

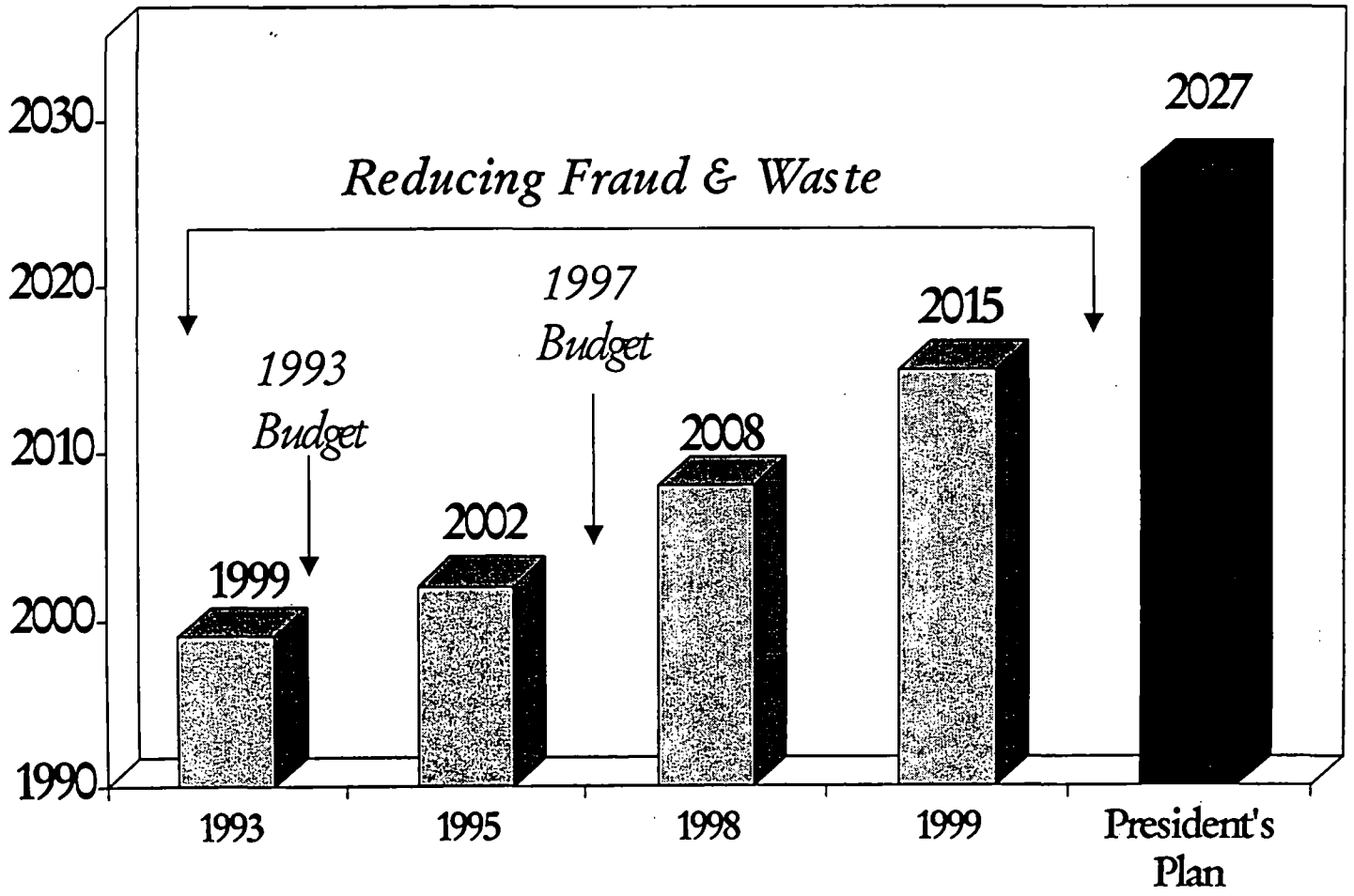
CHARTS

Medicare Enrollment Will Double As The Baby Boom Generation Retires

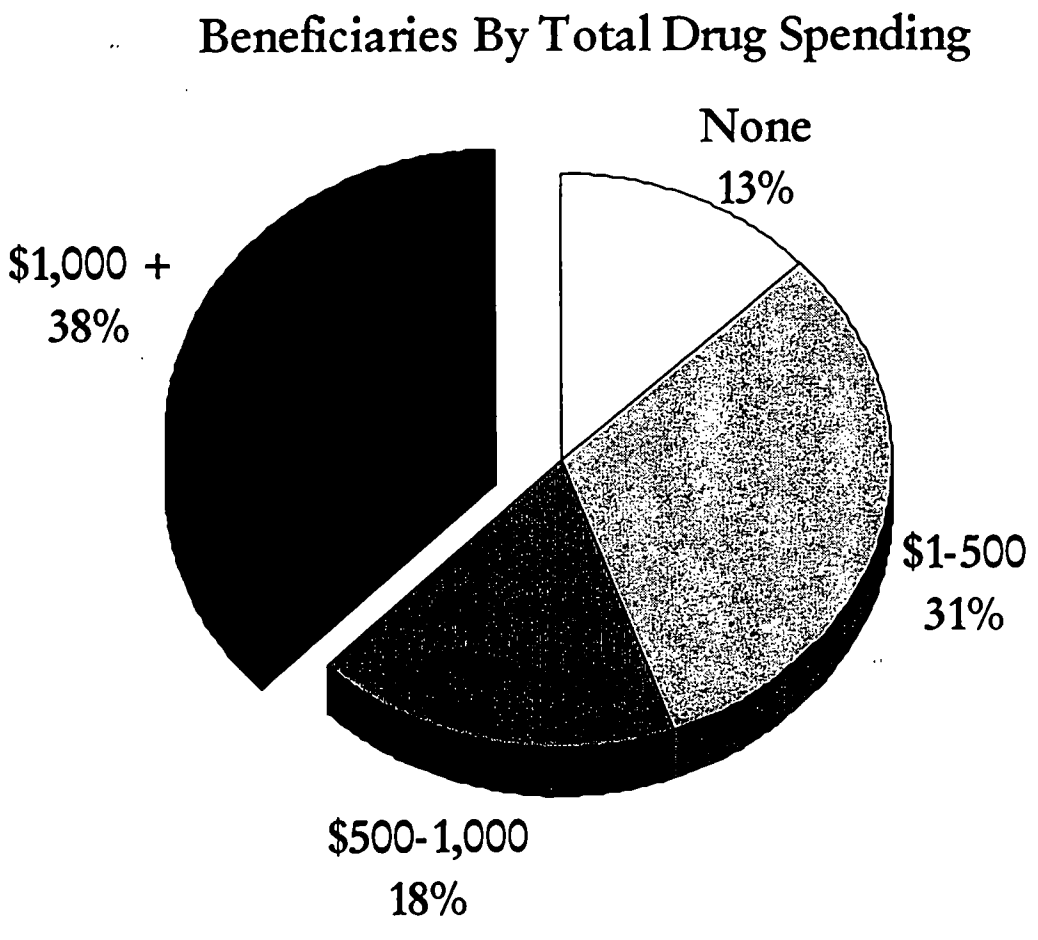


Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027

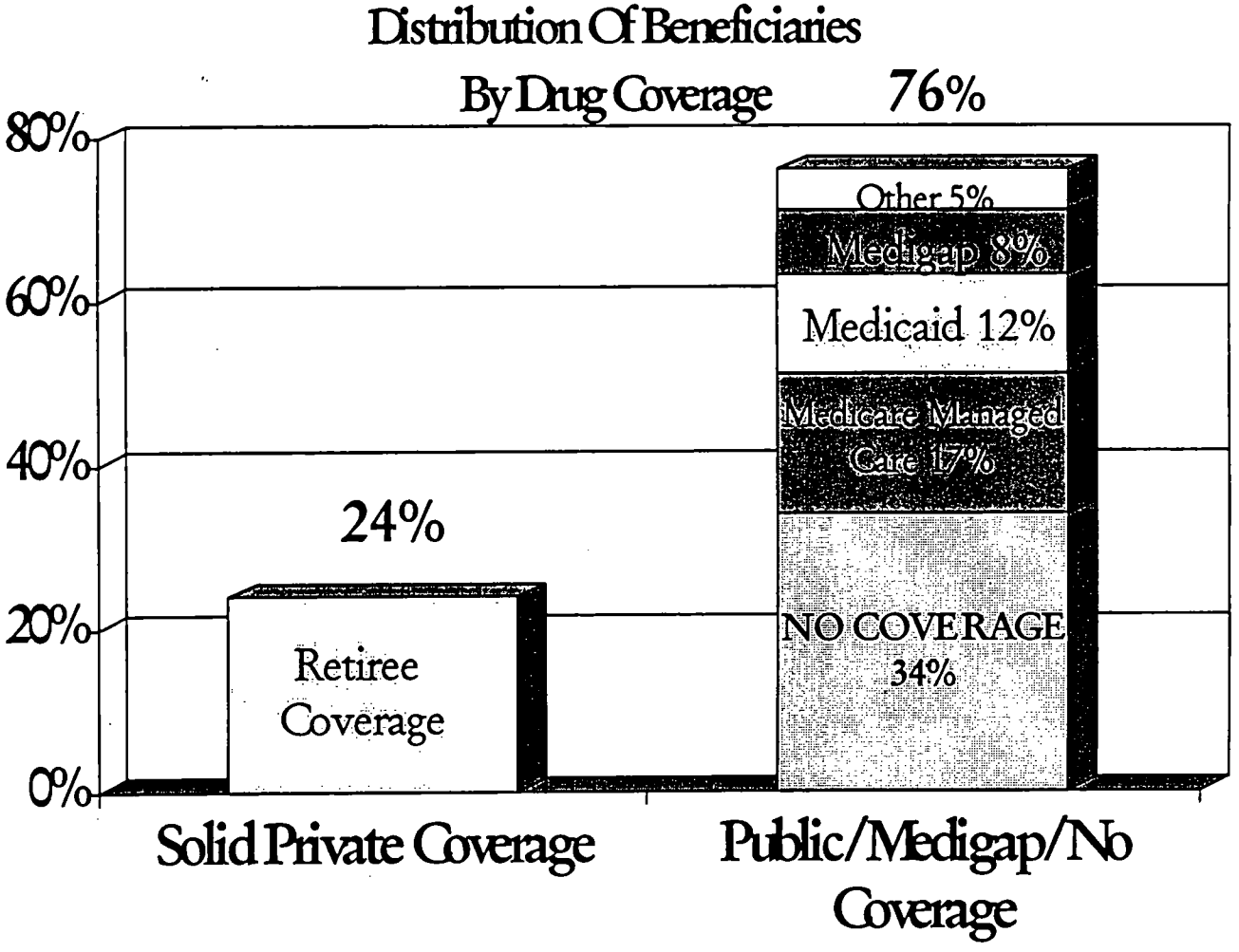


Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

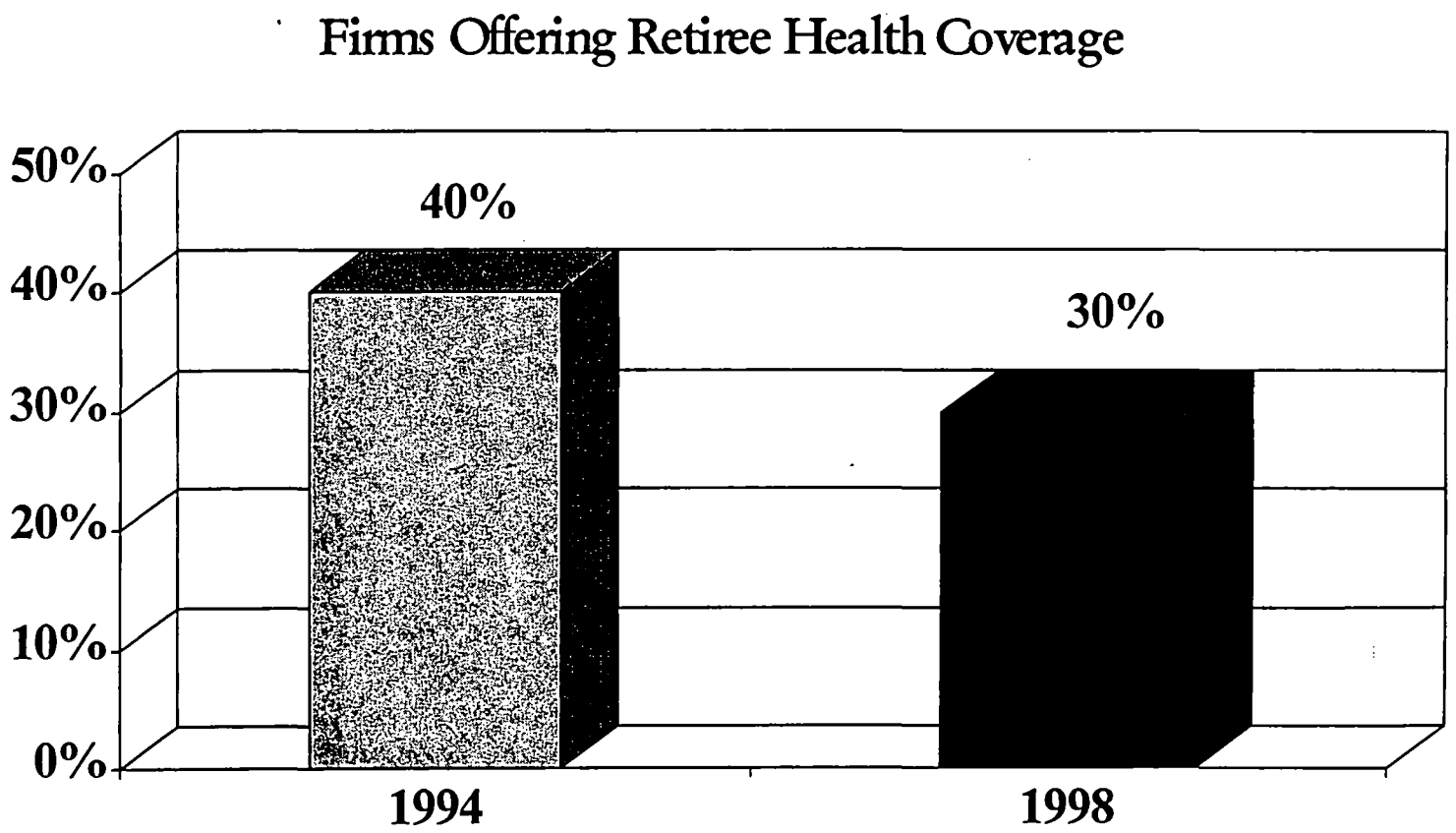
Three Out Of Four Beneficiaries Do Not Have Solid Private Drug Coverage



SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

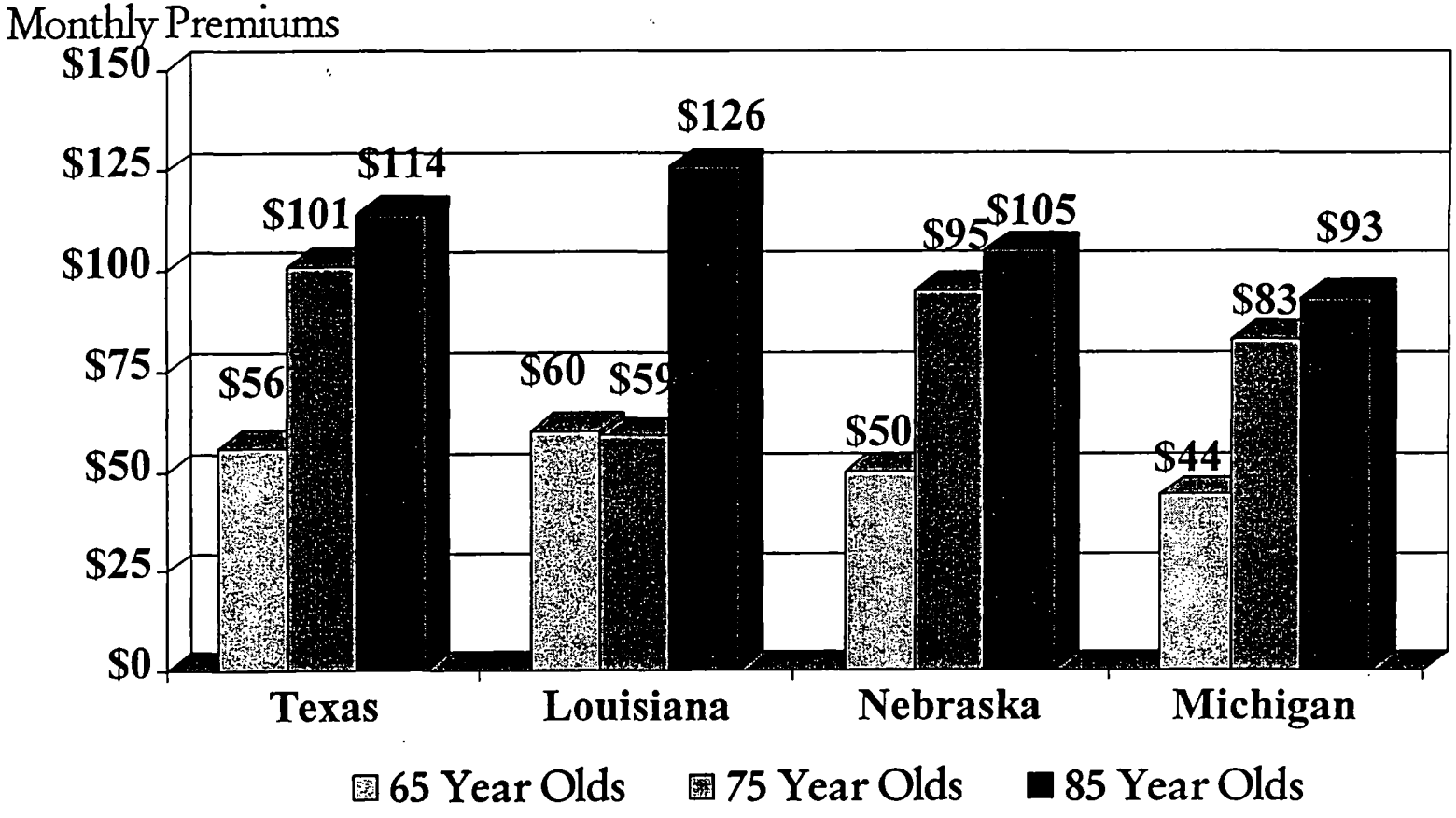
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

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

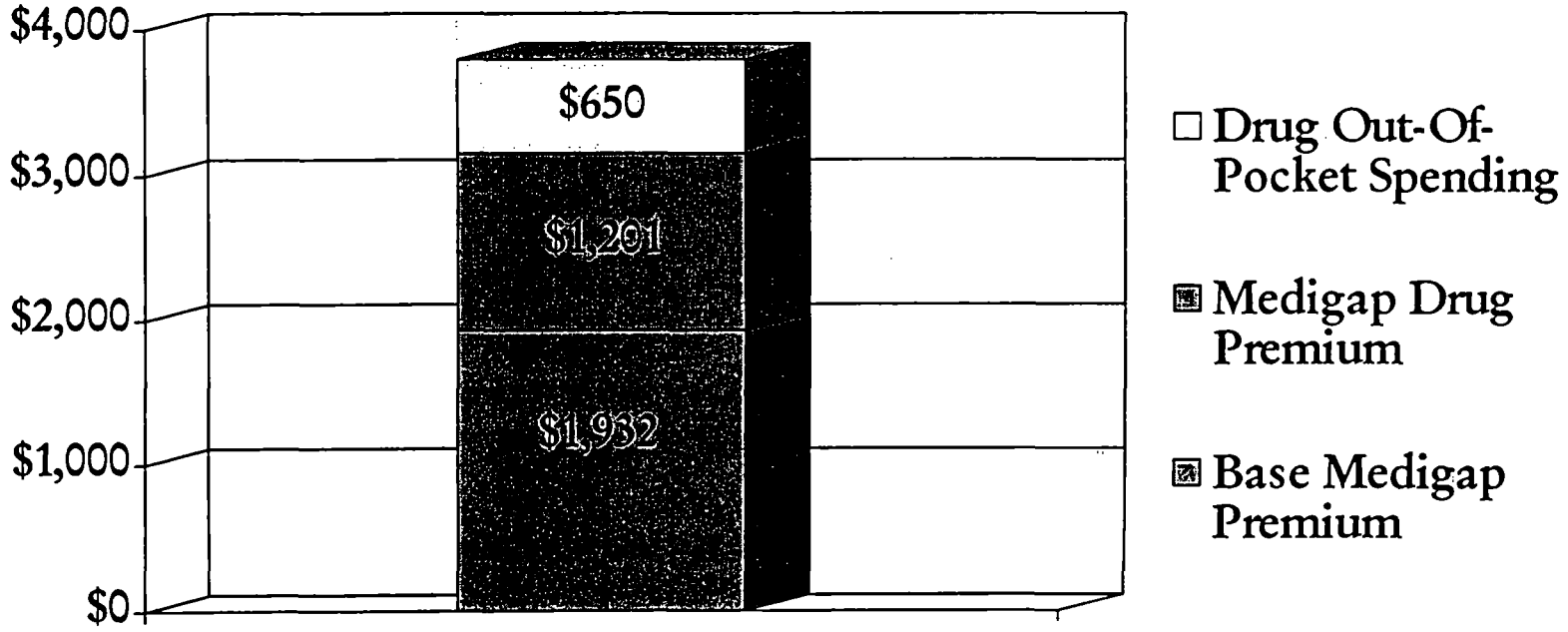


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

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

On Top Of The Premium For The Base Medigap, Beneficiaries Pay An Extra Premium For Drugs Plus Out-Of-Pocket Spending for Drugs

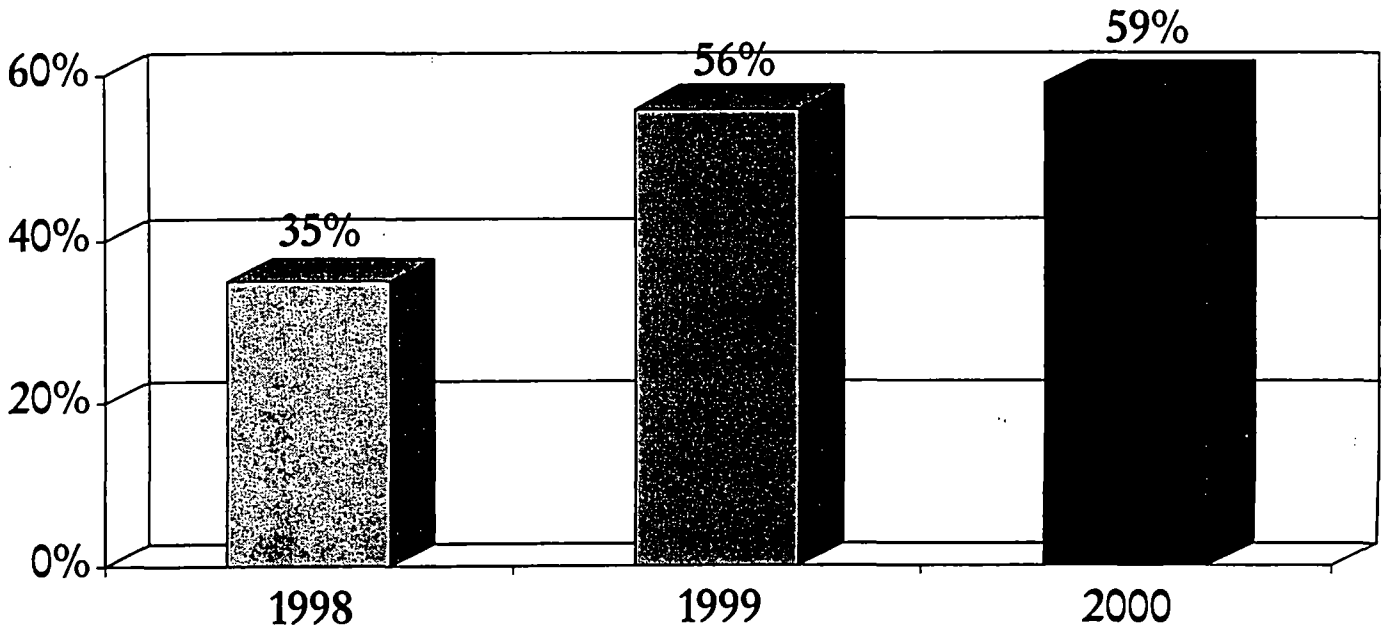
Medigap Annual Premiums And Out-Of-Pocket Spending



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

Value of Medicare Managed Care Drug Benefits Is Declining

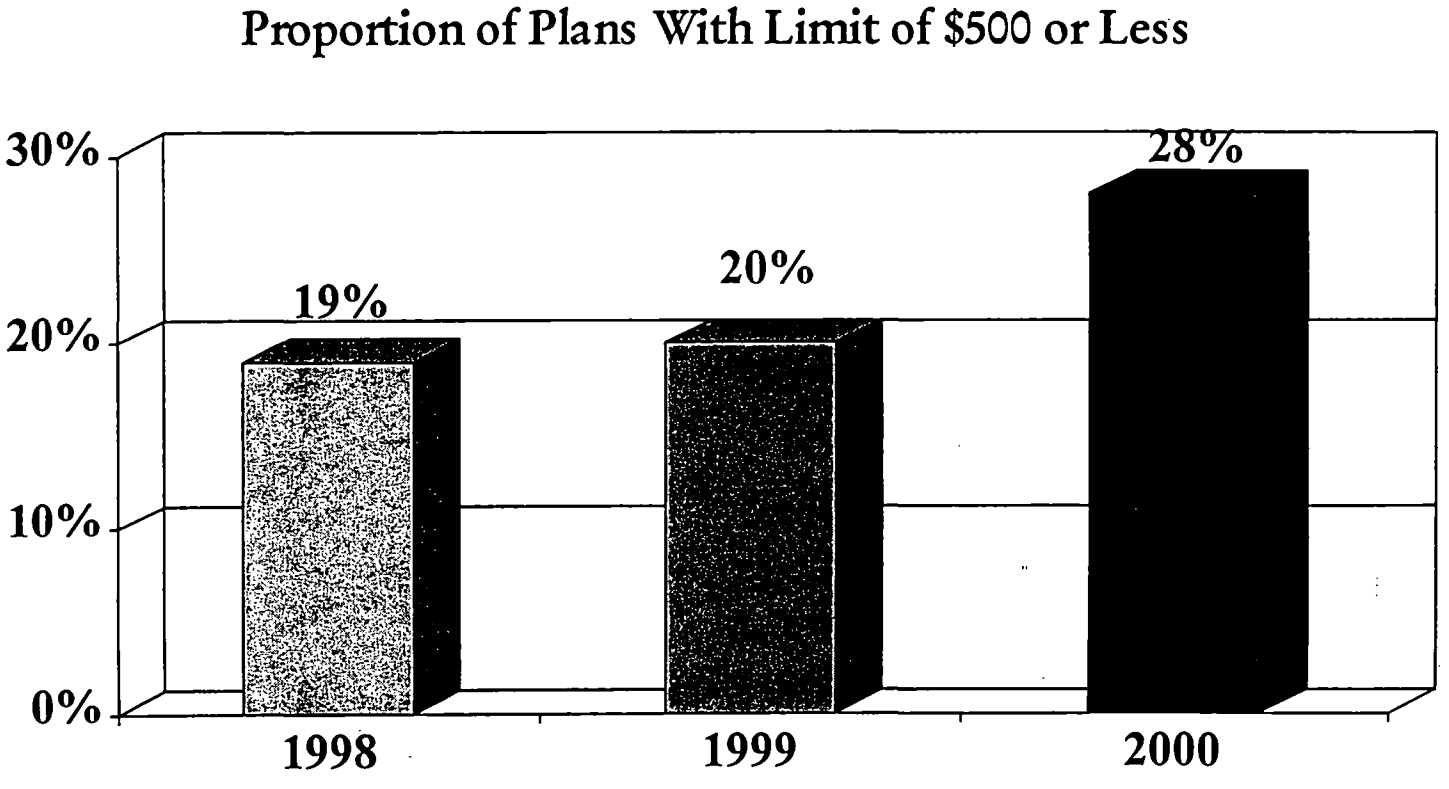
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

Proportion Of Plans With A $500 Or Lower Limit Has Increased By 50%

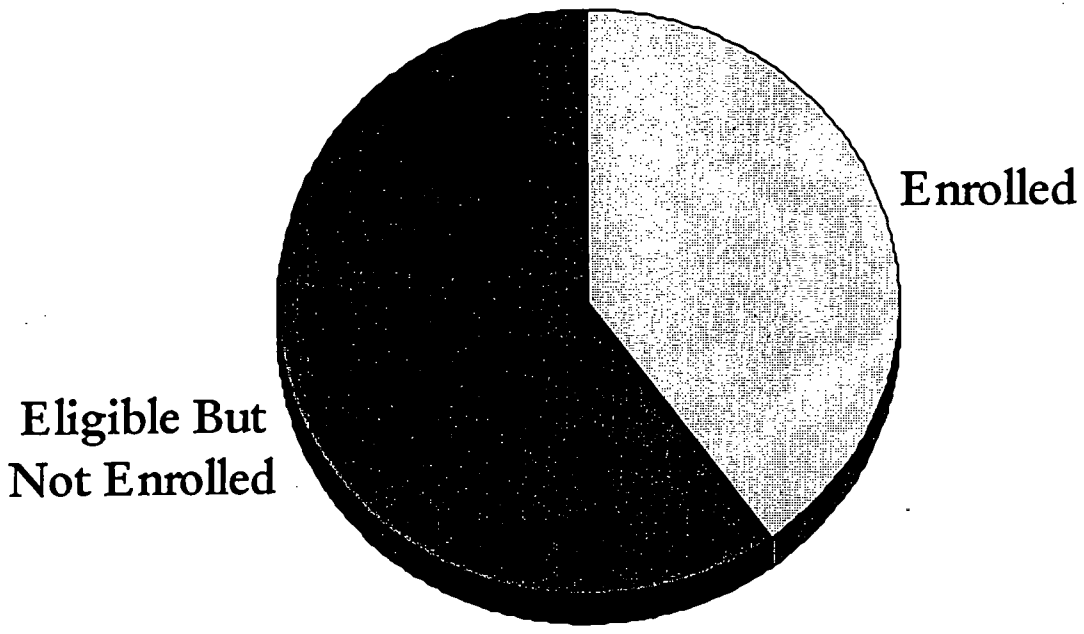


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



SOURCE: Actuarial Research Corporation for HHS. Calculated assuming that beneficiaries below 73% of poverty are eligible for full Medicaid benefits through SSI (Kaiser Commission on Medicaid & the Uninsured, May 1999)

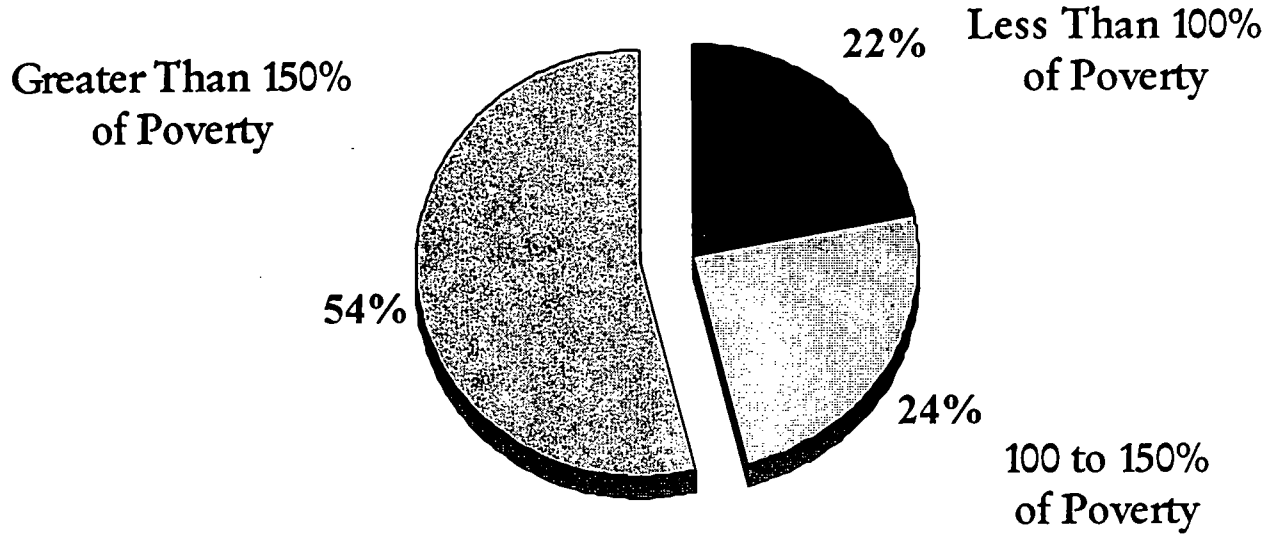
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

Over Half of Medicare Beneficiaries Who Lack Prescription Drug Coverage Are In The Middle Class

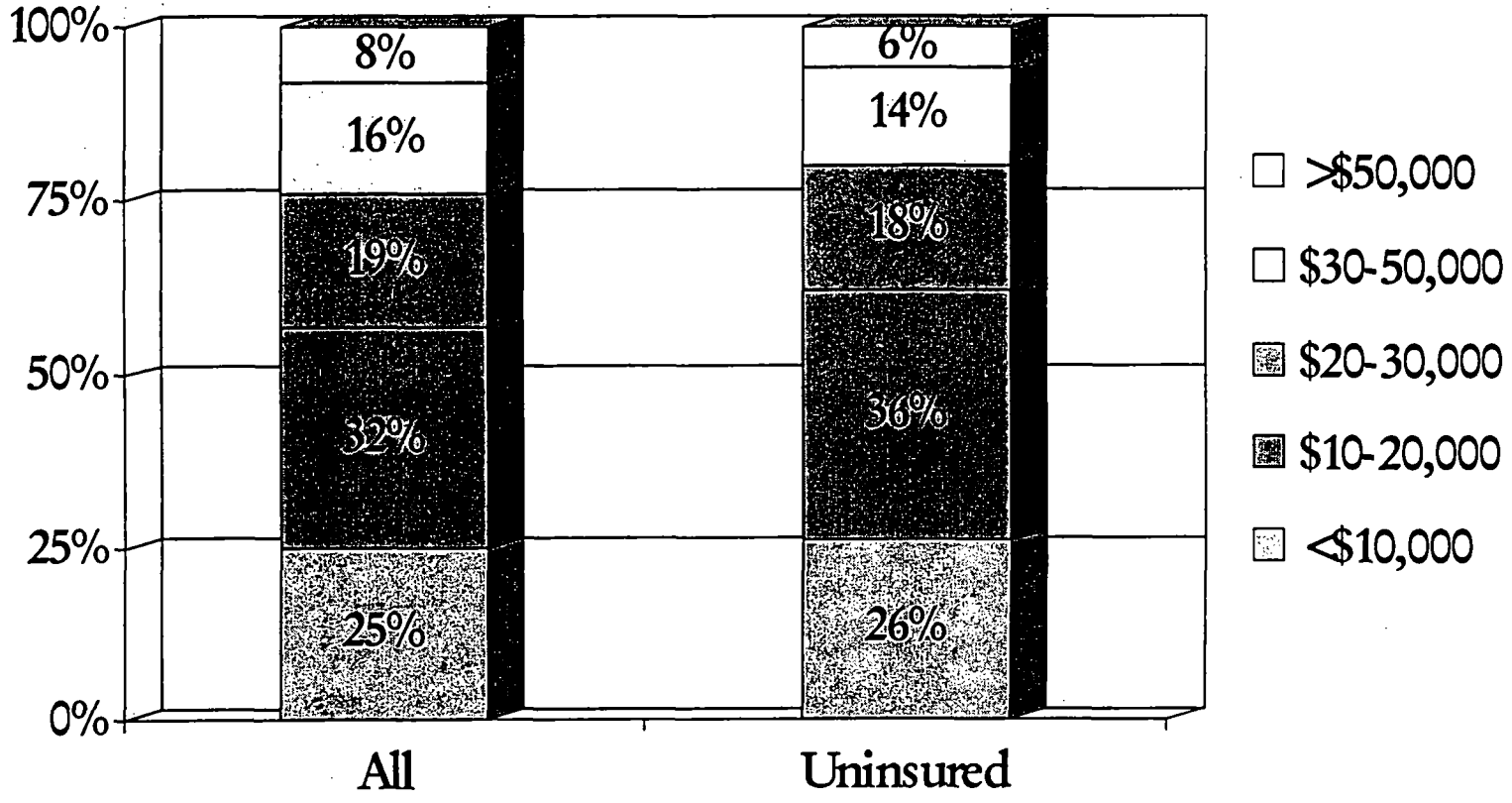
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



SOURCE: Actuarial Research Corporation for HHS, 2000
In 2000, poverty for a single person is about $8,500, for a couple is about $11,400

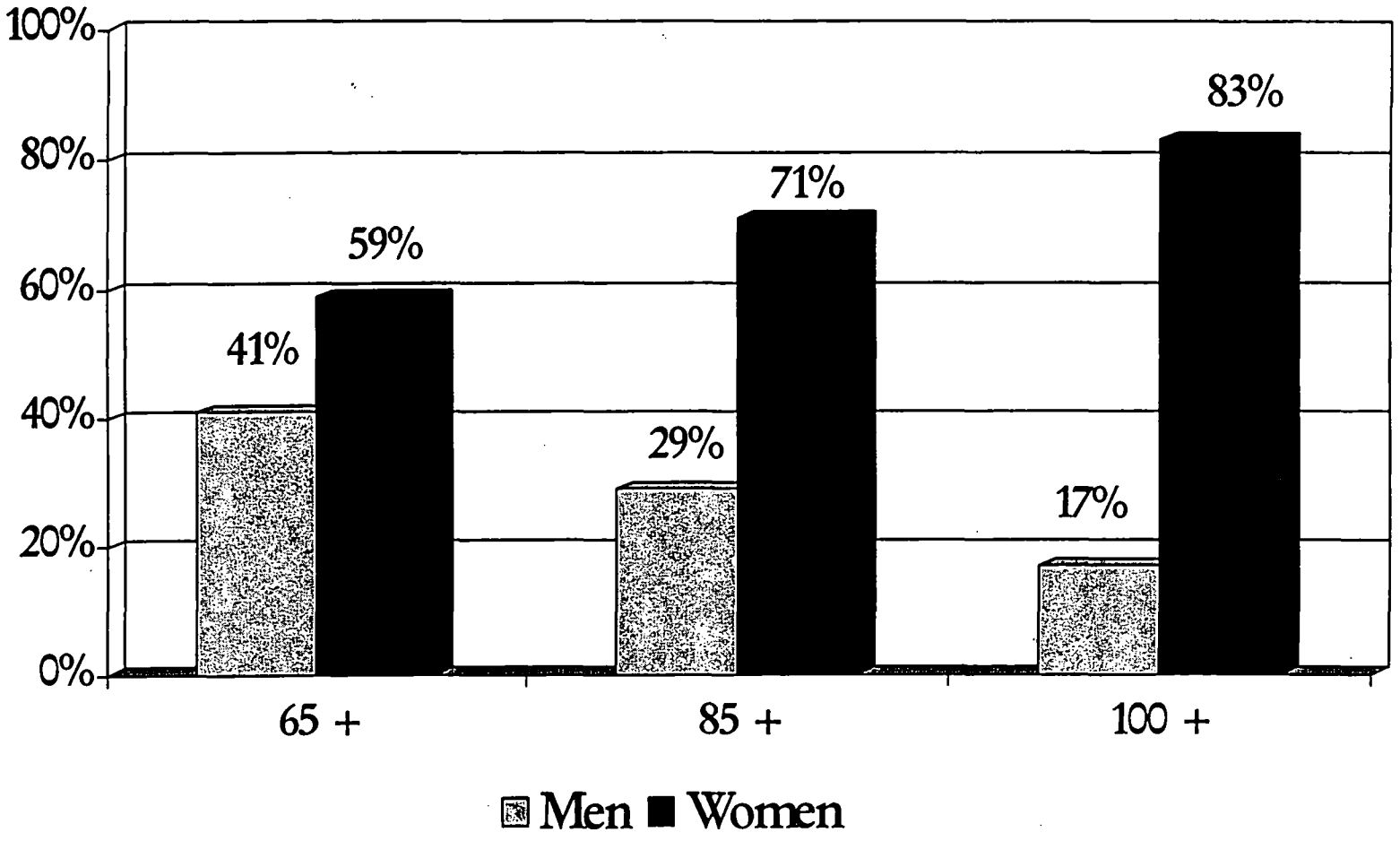
Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



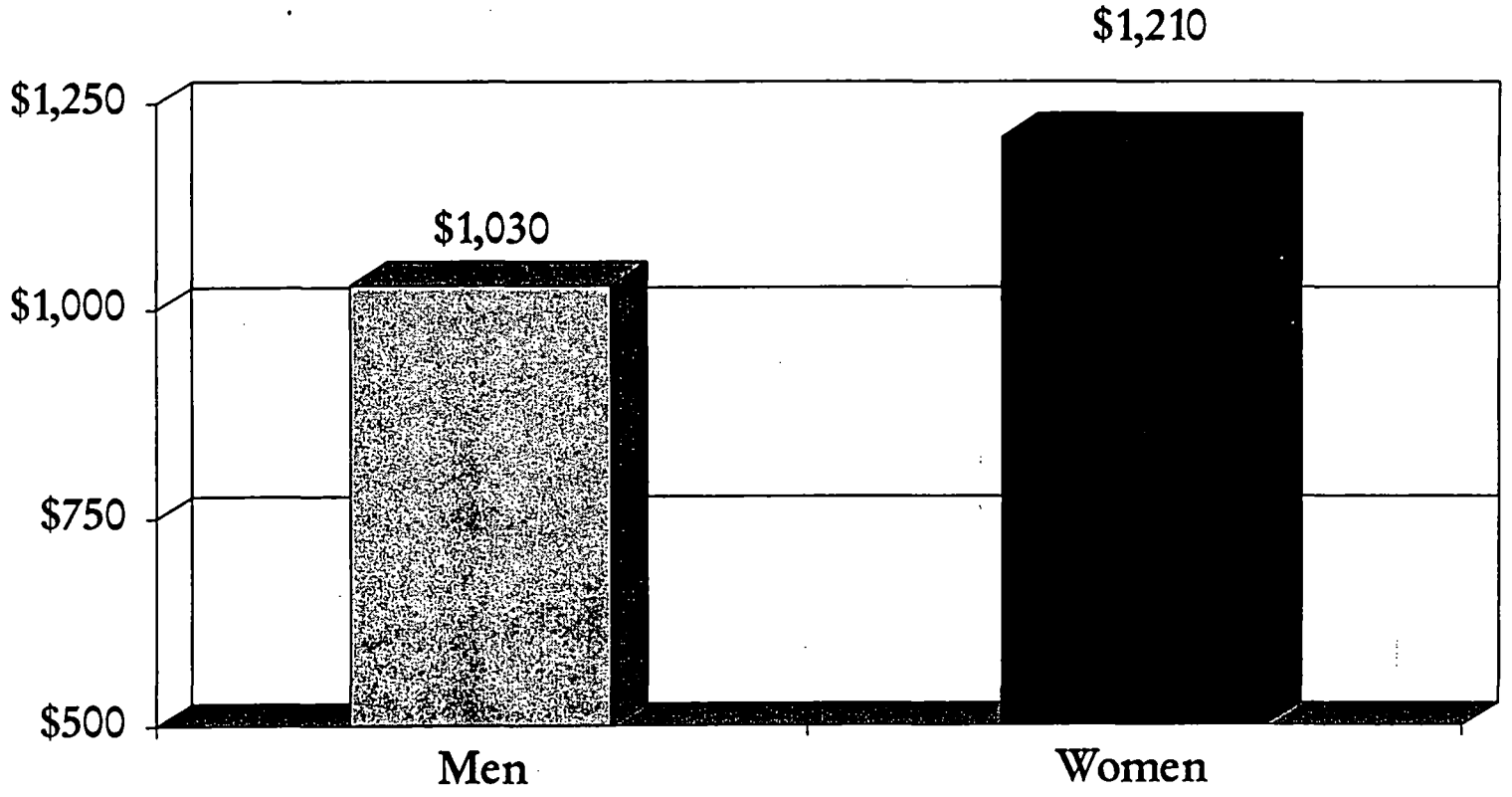
SOURCE: Actuarial Research Corporation for HHS, 2000

Most Medicare Beneficiaries Are Women



Source: U.S. Census Bureau projections for 2000. As cited in OWL Report

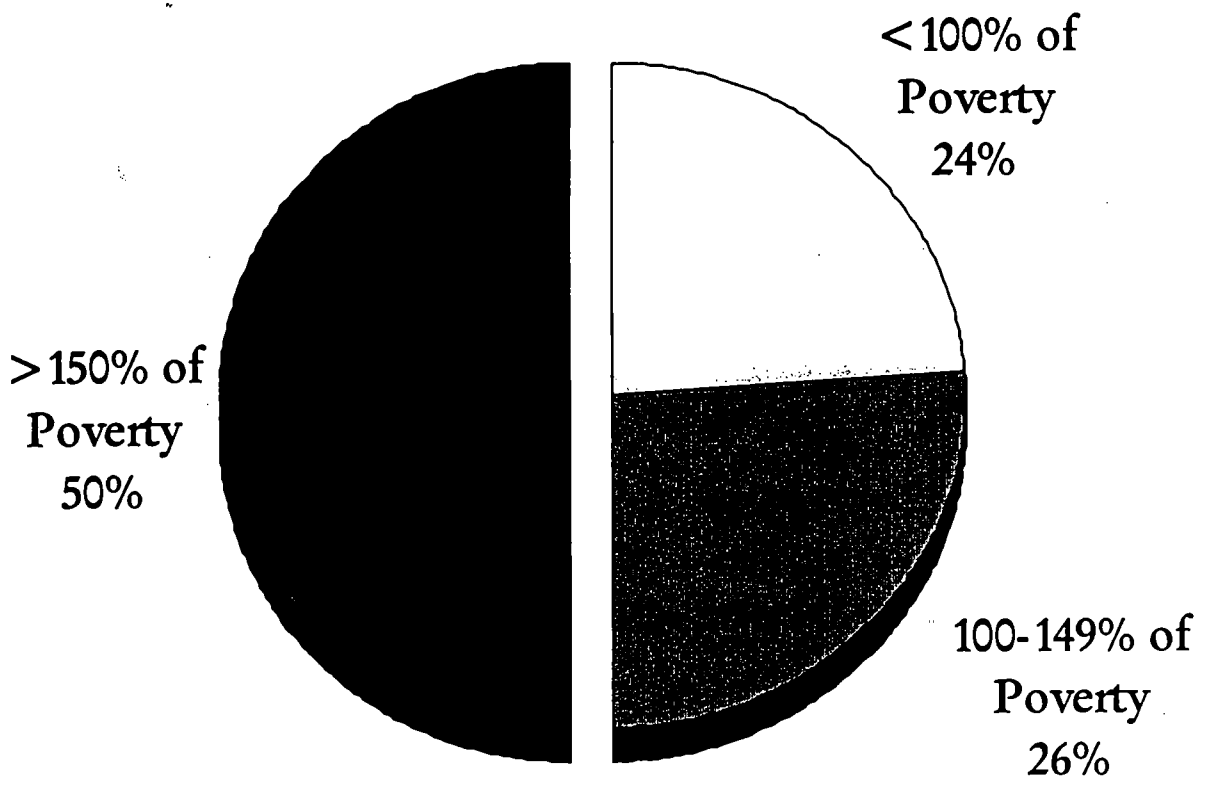
Total Prescription Drug Spending For Women On Medicare Is $1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

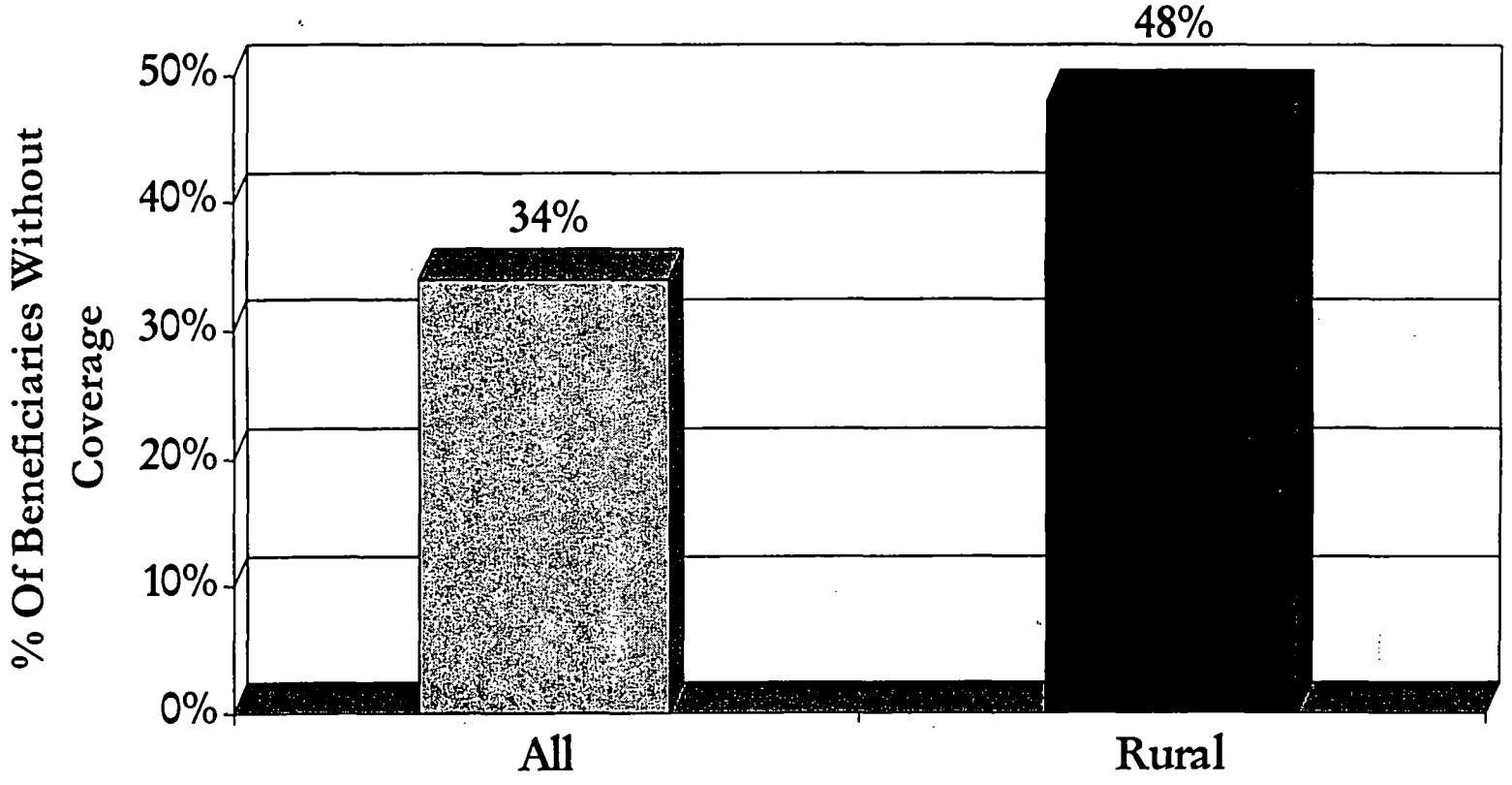
Source: Actuarial Research Corporation. As cited in OWL Report

Half Of Women on Medicare Without Drug Coverage Are Middle Income



Source: Actuarial Research Corporation. As cited in OWL Report
150% of poverty is about $12,750 for a single, $17,000 for a couple in 2000

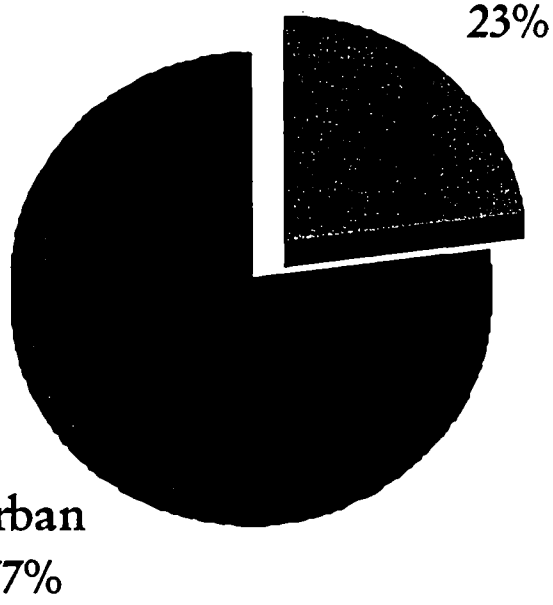
More Rural Medicare Beneficiaries Lack Prescription Drug Coverage



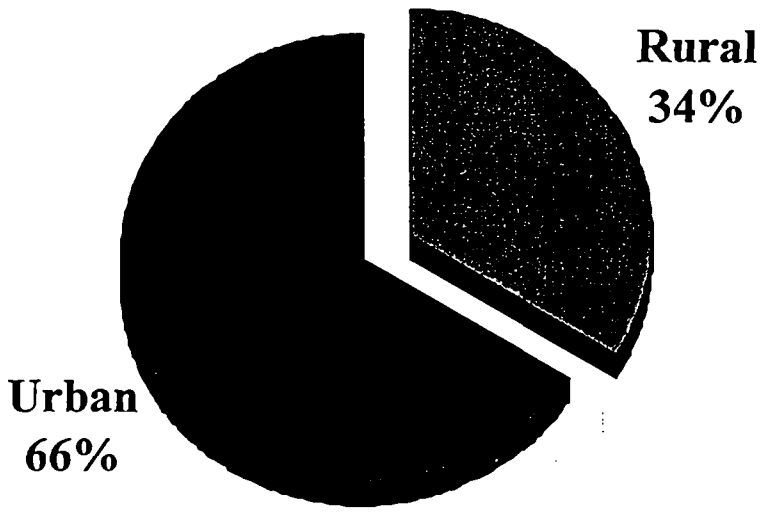
SOURCE: Actuarial Research Corporation for HHS, 2000

One In Three Beneficiaries Without Prescription Drug Coverage Lives In Rural America

All Medicare Beneficiaries

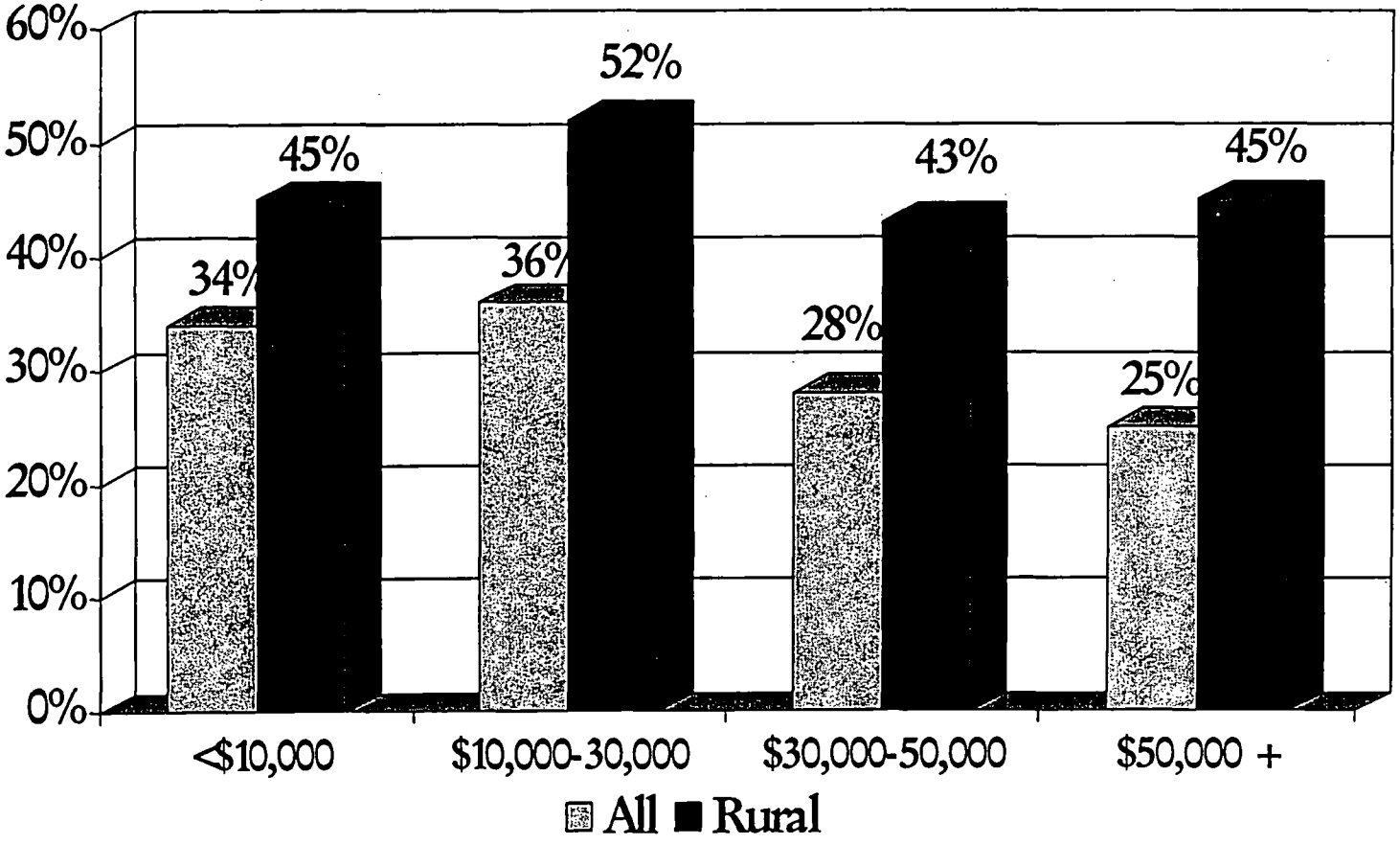


Medicare Beneficiaries Without Prescription Drug Coverage



SOURCE: Actuarial Research Corporation for HHS, 2000

Rural Beneficiaries Are Less Likely To Have Prescription Drug Coverage Across All Income Groups



SOURCE: Actuarial Research Corporation for HHS, 2000

TAB 6.

BREAUX-THOMAS MEDICARE REFORM PLAN

ISSUES WITH BREAUX-THOMAS MEDICARE REFORM PLAN

In recent weeks, the Republican Leadership has claimed it does have a Medicare plan -- the Breaux-Thomas Medicare reform plan. Under the leadership of Senator Breaux, the Bipartisan Commission on the Future of Medicare made significant contributions towards the Medicare reform debate. However, the final plan did not receive the necessary votes to formally report its recommendations and has several major flaws that need to be addressed, including:

- **No dedication of surplus to strengthen Medicare**: All experts agree that the doubling of Medicare beneficiaries in the next 30 years cannot be accommodated through spending reductions alone. Such cuts would be too deep to be absorbed by providers without sacrificing quality of care for beneficiaries. Waiting to address Medicare's financing makes the problem much harder to solve and shifts more of the burden to our nation's children.

- **"Premium support" proposal increases premiums for traditional Medicare, effectively financially coercing beneficiaries into managed care**: The Breaux-Thomas "premium support" proposal caps the government contribution to private plans and traditional Medicare based on the national average. Since traditional Medicare will be above an average that includes managed care plans, its premium will rise nationwide – 10 to 30 percent according to the independent Medicare actuary. This would have the effect of coercing beneficiaries into managed care. Despite this, a significant amount of the savings achieved by this proposal come from raising premiums for the beneficiaries who remain in traditional Medicare.

- **Inadequate prescription drug benefit:** The Breaux-Thomas proposal limits drug coverage to beneficiaries with incomes below 135 percent of poverty (about $11,500 a year for a single, $15,400 for a couple). This helps only a fraction of beneficiaries without drug coverage; over half of beneficiaries without any drug coverage would not qualify. For example, a widow with $19,000 in income would not qualify for assistance for coverage. Nor would millions more beneficiaries who have expensive and/or extremely poor coverage.

- **Raises the age eligibility to 67 for Medicare, increasing the number of uninsured**: The most rapidly growing group of the uninsured is aged 55 to 65. Raising the Medicare eligibility age without a policy alternative would exacerbate the problem of the uninsured.

- **Includes an unlimited home health and nursing home copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits – without any limits. The more than 1 million beneficiaries who need more than 60 visits per year – who tend to be older, sicker and widows – could pay more than $300. In addition, beneficiaries would pay about $60 per day for the first 20 days of nursing home care which, for those without supplemental coverage, could be a real burden.

- **Calls for continuation of Balanced Budget Act cuts for hospital, nursing home, and other providers:** Breaux-Thomas proposes to extend virtually every cut included in BBA.

- **Provides no immediate relief from BBA cuts:** Unlike the President's plan, Breaux-Thomas provides for no immediate moderation of the payment reductions in the BBA.

TAB 7.

TOP-TIER QUESTIONS AND ANSWERS ABOUT MEDICARE REFORM

TOP-TIER MEDICARE QUESTIONS AND ANSWERS

PRESCRIPTION DRUG BENEFIT

Q1: How do you respond to critics that charge that a new Medicare drug benefit available to all beneficiaries is not necessary because "two-thirds" of the population already have coverage?

A: **Those who use the argument that "two-thirds" of beneficiaries do not need a Medicare drug option are out of touch and out of date.** The two-thirds number -- inaccurately used by opponents of prescription drug coverage -- does not reflect current facts or trends in coverage of the elderly and disabled of this nation. All one has to do is go to any senior center around the nation to get a sense of the magnitude of this problem.

About 75 percent of Medicare beneficiaries lack decent, dependable, private-sector coverage. Less than one-fourth of Medicare beneficiaries have retiree drug coverage, which is the only meaningful form of private coverage. About one-third of Medicare beneficiaries – at least 13 million beneficiaries – have no drug coverage at all. Another 8 percent purchase Medigap with drug coverage – but this coverage is expensive and inadequate. About 17 percent have it through Medicare managed care, but plans are severely limiting coverage. The remaining beneficiaries are covered through Medicaid and other public programs.

The limited private coverage that exists is declining and becoming more unaffordable. The number of firms offering retiree health coverage has declined by a staggering 25 percent in just the last four years. Premiums for Medigap prescription drug coverage are extremely expensive and increase with age. The most frequently purchased Medigap policy is typically priced at two to three times the President's option, has a $250 deductible, and limits plan payments to $1,250. Medigap premiums usually increase dramatically with age, just when beneficiaries need the coverage the most and are least likely to have the income to afford it. This is a particular problem for women who make up over 70 percent of those over age 85.

Public coverage is decreasing in value and becoming more unreliable. Nearly three-fifths of all Medicare managed care plans are reporting that they will cap their drug benefits below $1,000 in 2000. In fact, the proportion of plans with $500 or lower benefit caps will increase by 50 percent between 1998 and 2000. Medicaid coverage is meaningful, but is available only for those with the lowest incomes (generally less than about $6,200 for a single elderly person). And, because of "welfare" stigma and other reasons, this program only enrolls 40 percent of the low-income elderly who are eligible.

The President's proposed drug benefit offers all beneficiaries another option. Beneficiaries can choose to take it, choose to keep their current coverage, or choose to remain uncovered. The same critics opposing this proposal are usually the advocates of more health care choices. This benefit is simply a new option.

Q2: How do you respond to opponents' arguments that the proposal represents another step toward socialized medicine and a government takeover?

A: **The proposed drug benefit is purely voluntary. Beneficiaries can choose to take it, to keep their current coverage, or to remain uncovered.** No one can credibly argue this is a government take-over; it is simply another choice for beneficiaries. Since 75 percent of beneficiaries lack reliable, affordable, decent private sector coverage, this option is clearly needed.

Prescription drug coverage is essential to a modern Medicare program. No one designing the Medicare program today would exclude prescription drug coverage. It is as central to health care as hospital care was in 1965. The President's proposal simply provides an option to access this critically necessary benefit.

Those who oppose the President's proposal are making the exact same arguments that opponents of Medicare's creation did over 34 years ago. It is striking how similar the arguments against the new prescription drug option are to the arguments that many Republicans used against the passage of Medicare in the first place. Clearly, Medicare has not led to "socialized medicine."

Q3: Why not just target the benefit to the low-income beneficiaries who really need it?

A: **Over 50 percent of beneficiaries without prescription drug coverage are middle class.** Those who argue we should design a benefit for just the lower income ignore the fact that such an approach would leave out millions of beneficiaries in desperate need of help. Fully 54 percent of all beneficiaries without coverage have incomes over 150 percent of poverty -- over $17,000 a year for couples. And this number does not include the millions of middle-class seniors and Americans with disabilities who have excessively expensive, inadequate and declining drug coverage.

The President's proposal provides special assistance to low-income beneficiaries. Beneficiaries with income below 150 percent of poverty would not pay premiums, and those with income below 135 percent of poverty would not pay coinsurance for prescription drugs.

Ironically, some of the same Republicans who suggest that any drug benefit should be targeted to the poor just supported the House Ways and Means Committee tax deduction provision that provides the greatest assistance to wealthier beneficiaries. Despite their rhetoric of concern about the poor, the House Republicans just passed a bill that allows seniors to take a tax deduction for Medigap premiums. This helps higher income beneficiaries like Ross Perot, but would leave out millions of beneficiaries since over 55 percent of seniors have no tax liability and would be ineligible for this tax break. Indeed, while Republicans feel that the middle class should be denied help on drug coverage, its House plan would give 4 times more in tax relief to the top 1 percent (families making over $340,000) than to the entire bottom 60 percent of taxpayers.

Q4: Why should the Medicare program subsidize a drug benefit for people like Ross Perot?

A: This argument is nothing but a red herring used by those who are opposed to a prescription drug option for the millions of middle-class seniors who need it. People making this argument are seeking to cut off prescription drug assistance at only $12,750 for a single, $17,000 for a couple – leaving the millions in the middle class with no coverage or weak coverage out in the cold. This is the real issue: a debate between those who want to provide an option to all beneficiaries so that middle-class seniors have access to affordable prescription drug coverage and those who believe that seniors making over $17,000 are like Ross Perot and don't need any help.

Moreover, many beneficiaries who are sick -- regardless of income -- cannot access affordable insurance. Premiums in the private Medigap market increase with age and, except when beneficiaries initially turn age 65, are usually medically underwritten. As such, seriously ill patients without coverage today cannot get coverage at virtually any price. In the absence of a new Medicare prescription drug benefit option, we are sentencing too many seniors who have worked hard and played by the rules to a Medigap market that will not provide the coverage that they need.

Q5: How will beneficiaries who already have very good retiree health coverage be affected by this new proposal?

A: Since the new Medicare drug benefit is optional, the less than one-fourth of Medicare beneficiaries who are fortunate enough to have good retiree health coverage can -- and likely will -- keep their current coverage. The prescription drug benefit is simply another choice, but it is an important alternative to even those beneficiaries with retiree coverage. This is because, over the last 4 years, the numbers of firms offering retiree health coverage has declined by 25 percent. Under the President's plan, if a beneficiary chooses to stay in his or her current plan and the firm subsequently drops the coverage, he or she will have the ability to opt for the Medicare option.

Most importantly, the plan provides new financial incentives to firms to keep and increase their commitment to private retiree health coverage. The plan provides firms that are offering prescription drug benefits, which are at least as good as the Medicare option, an estimated $11 billion over 10 years in assistance if they continue or start to offer private health coverage. This policy is designed to slow down the trend of firms dropping their retiree health coverage and to provide incentives for employers not now offering to do so.

Q6: Will this new prescription drug benefit cover Viagra?

A: In general, the private sector contractors who will manage the Medicare drug benefit will be required to cover prescriptions that are determined to be medically necessary, including Viagra. However, as is the case in the Medicaid program and with other private insurers, the private contractors who manage the Medicare benefit could require doctors to get prior authorization before prescribing drugs for which there are documented abuses.

Q7: How do you reconcile a brand new entitlement with the need to constrain the growth of the Medicare program?

A: The prescription drug benefit is not a stand-alone initiative; it is part of a broader reform package that modernizes Medicare, makes it more competitive and efficient, and dedicates part of the surplus to Medicare to keep it solvent until 2027. It is simply not credible to suggest that the Medicare program can be modernized without adding the option for prescription drug coverage. Prescription drugs today are as important as hospital care was when Medicare was created. Having said this, the drug benefit is designed in a way that is affordable to both the program and the beneficiaries it serves.

Q8: Does the prescription drug benefit impose an unfunded mandate on states?

A: The prescription drug benefit both relieves states from their current coverage of very low-income elderly and asks states to share in paying for the premiums and cost sharing for poor elderly, as they do for Medicare Part B premiums and cost sharing. All states currently provide prescription drug coverage to Medicare beneficiaries who also qualify for Medicaid (known as "dual eligibles"). Some states cover prescription drugs for all poor elderly. Since Medicare will take over primary responsibility for drug coverage, the states will receive a windfall that will be used to pay for the prescription drug benefits' premiums and copayments for all poor beneficiaries. The Federal government would pay 100 percent of the cost of drug premiums and copayments for those beneficiaries with income between 100 and 150 percent of poverty.

Q9: Will a prescription drug benefit eventually lead to some form of price control?

A: No. The prescription drug benefit will be administered by contracting with private sector benefit managers just like virtually all private health insurers and employers do. There are no price controls. Pharmacy benefit managers (PBMs) and other entities have developed and successfully employed innovative management tools to offer affordable, high quality, prescription drug coverage. Recognizing that drug therapy holds great promise, the plan does not include price controls that would discourage research and development.

IMPORTANCE OF DEDICATING PART OF THE SURPLUS TO MEDICARE

Q10: Why don't you use structural changes rather than dedicating surplus to extend the life of Medicare?

A: Both structural reforms and new financing are needed to significantly extend the life of Medicare. We need to make Medicare a more competitive and efficient program – but all experts agree that it is impossible to rely only on provider payment reductions to extend the life of the Medicare trust fund for any significant length of time, given the doubling of Medicare enrollment that will occur as the baby boom generation retires. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person. Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. Providers are already concerned that the BBA cuts were excessive, making it highly unlikely that significant additional savings could be achieved.

Dedicating over $300 billion to Medicare solvency has the additional effect of buying down the debt faster – it contributes to eliminating public debt entirely by 2015. This would make America debt-free for the first time in the last 160 years.

UNCERTAINTY OF PROJECTED SURPLUS, SAVINGS, AND DRUG COSTS

Q11: What happens if the surplus doesn't materialize?

A: The uncertainty of projections is exactly why the most responsible approach to allocating the surplus is dedicating most of it to meet our existing obligations in Social Security and Medicare. If the surplus turns out to be less than our forecast projects, it will translate into a less significant extension of the trust fund. In contrast, if the surplus is fully spent on a tax cut, the consequence of misestimates means deficits and new taxes.

Q12: How do you respond to the Congressional Budget Office (CBO) testimony that concluded that the Administration underestimated the cost of the prescription drug benefit and overstated the plan's savings?

A: The Administration's economic team and the HCFA Actuary did a thorough and careful analysis in developing a cost estimate for the President's plan. The Medicare Actuary is the same independent and respected career expert who has been cited repeatedly by Republicans in the past for his estimates on the Medicare Trust Fund. The Clinton Administration's health and economic forecasts have been consistently more conservative than actual experience.

PROVIDER REIMBURSEMENT

Q13: How can you propose additional provider savings without restoring some of the excessive savings of the BBA?

A: We are certainly not ignoring the concerns that have been raised by providers in the wake of the implementation of the BBA. At the President's direction, HHS will implement administrative actions that would relieve unnecessary burdens that could undermine the ability of providers to deliver quality services. In addition, the proposal explicitly provides for a $7.5 billion quality assurance fund to help smooth out problems that Congress and the Administration decide, based on objective evidence, have resulted in harm to beneficiaries. Although the reform proposal includes proposals to constrain out-year spending, they are much more moderate than those included in the BBA and those recommended by the Republicans on the Medicare Commission. They do not include any hospital outpatient department savings, disproportionate share hospital payment reductions, nursing home savings, and new home health care provider savings.

Q14: How do you know that $7.5 billion is the right amount for correcting the overreach of the BBA? How should this fund be allocated?

A: The $7.5 billion set aside was designed to be responsive to legitimate provider concerns without opening the door to unsubstantiated complaints. It is based on a serious analysis of a range of provider concerns, but there is no one specific package of provider modifications that is linked to this amount. While there have been a number of concerns raised, we believe it is premature to assign any specific policy or funding amount to any one provider group. We need additional evidence to make informed decisions, and we look forward to working with the Administration in a collaborative and constructive manner.

STRUCTURAL REFORM

Q15: What do you say to those who say that this is about politics not substance?

A: The President's plan represents a serious proposal to strengthening and modernizing both Social Security and Medicare. The surplus provides a golden opportunity for members of both sides of the aisle to contribute to the development of important reforms essential to these important programs. It serves no one's interest – Democrats or Republicans – to ignore challenges facing the program.

Q16: Does this proposal qualify as real, structural reform of Medicare?

A: The proposal represents a bold initiative to strengthen and modernize the Medicare program and prepare it for the challenges of the 21st century. Its inclusion of traditional fee for service reforms, true competition between managed care plans, and savings from providers and beneficiaries alike, a new drug benefit, the elimination of all copayments and deductibles for all preventive services, and an explicit dedication of 15 percent of the surplus to extend the life of the trust fund can be defined as nothing short of comprehensive reform. This has been validated by experts such as Robert Reischauer, former director of the Congressional Budget Office, who says that the President's proposal will "restructure Medicare at its root." (New York Times, July 1, 1999).

Q17: Does your plan suggest that Medicare can be fixed without beneficiaries have to bear any burden?

A: The Medicare reform plan asks all affected parties to contribute to the solution. Both beneficiaries and providers will help offset the costs of the drug benefit through a new clinical lab copayments, indexing the Part B deductible to inflation, and outyear provider savings. The additional costs are financed through savings in the surplus that have been largely achieved through our aggressive efforts to curb waste, fraud and abuse in the program.

Q18: What is the problem with Senator Breaux and Congressman Thomas' proposal?

A: Although the plan outlined by Senator Breaux and Congressman Thomas in March has made an important contribution to the Medicare debate, it has serious flaws that must be addressed, including:

- No dedication of the surplus to strengthen Medicare, passing on the inevitable financing crisis to our children;
- Higher premiums for traditional Medicare in its so-called premium support program, which has the effect of implicitly, financially coercing beneficiaries into managed care;
- A totally inadequate, means-tested prescription drug benefit. More than half of beneficiaries without drug coverage today would not be eligible;
- Raising the age eligibility which would increase the uninsured;
- An unlimited home health and nursing home copay;
- Continuation of the Balanced Budget Act cuts without relief in the early years.

PRESIDENT CLINTON URGES CONGRESS TO RECONSIDER LARGE TAX CUT AND ADDRESS THE CHALLENGES FACING MEDICARE

July 13, 1999

Speaking to the Communications' Workers of America, the President urged the Congressional Republican Leadership to reconsider their proposal to use the entire surplus for a tax cut without dedicating one dollar to extending the life of the Medicare Trust Fund. He emphasized the unique historical opportunity that the nation has to secure Medicare's financial stability for a quarter of a century and to provide for a long-overdue prescription drug benefit. He also outlined the consequences of Republican plan by highlighting how difficult it would be to strengthen Medicare without the use of the surplus, how it would have a negative effect on the national debt, and its severe underfunding of priorities like military readiness and education.

✓ **MEDICARE FACES UNPRECEDENTED FINANCING CHALLENGES**. The next century will double Medicare's enrollment, from 40 to 80 million by 2035.

- **Medicare Is Insolvent Nearly Two Decades Before Social Security**. Not only does Medicare face the same demographic tidal wave of baby boom generation retirees as Social Security, but it has to adapt to health innovations and challenges of an aging society. Without change, Medicare will run out of funding in 2015 – 19 years before Social Security's projected insolvency.

- **Medicare's Need For New Financing Is Inevitable**. The current financing structure for Medicare was not – and cannot – accommodate a doubling of Medicare's enrollment.

- **Insolvency May Come Sooner Than 2015**. At least half dozen times in the last 25 years, the prognosis for Medicare worsened from one year to the next. Given this uncertainty, securing financing now that extends the life of Medicare by another decade can protect against unexpected shortfalls.

✓ **PRESIDENT'S PLAN DEDICATES $374 BILLION OVER 10 YEARS TO STRENGTHEN MEDICARE.** The President's commitment to Medicare would lengthen the solvency of Medicare until 2027.

- **Surplus Helps Secure Medicare For The Next Quarter Century**. About $328 billion would contribute to solvency, building on the Medicare reforms in the President's plan.

- **Only A Fraction Of The Surplus Dedicated To The Prescription Drug Benefit**. The amount from the surplus that explicitly finances the prescription drug benefit is about $45 billion over 10 years – less than one-eight the amount dedicated to Medicare, one-twentieth the on-budget surplus, and less than the amount that the President dedicated to expanding children's health insurance coverage in 1997 ($48 billion over 10 years).

✓ **REDUCES PUBLIC DEBT.** By locking away most of the surplus dedicated to Medicare:

- **The Medicare Surplus Dedication Contributes To The President's Framework That Eliminates Public Debt by 2015.** Without locking away the Medicare amount in its Trust Fund, less public debt would be bought down. Buying down debt also helps boost national savings which leads to lower interest rates, a larger capital stock, a more productive workforce, a higher standard of living, and an enhanced ability to finance current Medicare obligations.

✓ **NO REASONABLE WAY TO GET SAME IMPROVEMENT WITHOUT SURPLUS.** The President is deeply committed to addressing Medicare financing challenges now – not passing the problems along to our children and grandchildren. Without additional financing:

- **Growth Rate Per Beneficiary Would Have To Be Held Below General Inflation – Resulting In A Real Cut In Medicare**. Medicare Part A spending growth per beneficiary would have to be limited to less than 3 percent per beneficiary in every year to get to 2027 without the surplus dedication. This rate is about 60 percent below projected private health insurance spending per person (7.3 percent). Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode. These projections help explain why virtually every independent health analyst agrees that Medicare cannot be significantly strengthened without adding outside financial support such as the surplus.

✓ **NO OTHER PLAN ACHIEVES PRESIDENT'S GOALS.**

- **No Commitment From The Republican Leadership To Medicare.** There has not been a single Republican Leadership proposal this year that dedicates any funding from the surplus for Medicare, proposes specific, responsible reforms to make Medicare more competitive or efficient, or adds a meaningful prescription drug benefit to Medicare.

- **Breaux-Thomas Proposal Would Not Get Close To 2027.** According to their own estimates, the Breaux-Thomas proposal would produce programmatic savings of only about $66 billion over 10 years ($127 billion without the Medicaid low-income drug benefit). As such, its Part A programmatic savings would total $50 to 60 billion. This small effect on the Trust Fund occurs despite including problematic proposals like:

  - ***Premium Support*** which mostly saves by raising premiums for traditional Medicare;

  - ***Raising Age Eligibility To 67*** where savings may come at the cost reducing coverage;

  - ***Larger Provider Payment Reductions*** which extend most of the BBA policies or find other, equivalent savings;

  - ***Home Care And Nursing Home Copays.***

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Lots of Medicare remks

THE WHITE HOUSE

Office of the Press Secretary
(Lansing, Michigan)

For Immediate Release July 22, 1999

REMARKS BY THE PRESIDENT
IN CONVERSATION ON MEDICARE

Lansing Community College
Lansing, Michigan

11:45 A.M. EDT

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

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

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

I would like to thank our sponsors today, the National Committee to Preserve Social Security and Medicare -- the President, Martha McSteen; the Executive Vice President, Max Richtman, are here. I thank the National Council of Senior Citizens and their Executive Director, Steve Protulis, who

is here. The Older Women's League National Board President, Betty Lee Ongley; Judith Lee of the Older Women's League; John DeGostino (phonetic) of the Michigan State Council of Senior Citizens.

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

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

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

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

But it occurred to me if I had come here in '92 and I said, I want you to support me because if you do we've got a $290 billion deficit today, but I'll be back here in six years and we'll talk about what to do with the surplus -- (applause) -- now, I think it's fair to say that if I had said that people would have said, he seems like a nice young man, but he's terribly out of touch -- (laughter) -- he doesn't have any idea what he's talking about. This guy is too far gone to have this job. But that's what we're doing here.

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

President Kennedy was in office. So I think that's very important. And the tax relief which has been given in the last six years in focused on families and education.

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

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

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

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

Children being born today, when you take into account all of the things that can happen -- illness, accident, crime, everything -- have a life expectancy of 77 from birth now. We expect to unlock the genetic code with the Human Genome Project in the next three to four years, and it then will become normal for a young mother taking a baby home from the hospital to have a genetic map of that baby's body which will be a predictor of that baby's future health. It will be troubling in some ways. It will say, well, this young baby girl has a strong predisposition to breast cancer. But it will enable you to get treatment, to follow a diet, to do other things which will minimize those risks; will say, this young boy is highly likely to have heart disease at an earlier-than-normal time, but it will enable us to prepare our children from birth to avert those problems. So this is a very important thing.

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

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

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

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

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

I believe the wise thing to do is to take care of the 21st century challenge of the aging of America, to do it in a way that does not require us to walk away from the education of our children; and under my plan, because we would save most of the surplus, the side benefit we'd get is that in 15 years we could actually take the United States of America out of debt for the first time since 1835. (Applause.)

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

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

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

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

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

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

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

proposal to save Social Security, to keep investing in education,

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

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

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

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

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

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

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

that we allow people between the ages of 55 and 65 who aren't working anymore or don't have health insurance on the job and don't have retiree health insurance to buy into Medicare in a way that doesn't compromise the stability of the program. I think

that is terribly important. That's a huge problem in our country today and a growing one. People who are out of the work force or working for very small businesses without employer-sponsored care, who can't get any health insurance because of their age or their previous health condition.

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

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

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

Now, there are those who say, well, this is good, but I've got a good retiree health plan with prescription drugs, and if you offer this my employer will drop it and it's better than this deal. Well, I want you to know that one of the things we've done in here is put substantial subsidies in here to employers who offer drug benefits to their retirees. So I think it is less likely that they will drop the benefits, not more -- because they're going to get a real incentive to keep the employer-based retiree programs. The second thing I want to say, again, is this is an entirely voluntary program.

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

getting worse.

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

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

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

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

Securing and modernizing Medicare I believe is the right thing to do for our seniors, but I also think it's the right thing to do for all the young people here. And for the next generation, the young parents in their 30s and 40s. Why? First, because it guarantees we can get out of debt by 2015 -- I explained why that's a good idea.

Second, because if we do this and we stabilize Social

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

Now, I've already explained that that's what our budget does. Today the Congress is voting, the House of Representatives is voting on the Republican tax plan which basically would spend virtually the entire non-Social Security surplus on a tax

cut. And it would cost a huge amount of money, not just in this 10 years, but it triples in cost in the next 10 years, it explodes.

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

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

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

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

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

So what I hope to do today is to answer your questions and hear your stories, and let's explore whether or not we really

need to do these things for Medicare, and whether or not they really will help not only the seniors, but the non-seniors in the country. And if you disagree, you ought to say that, too. But my concern now is for what America will be like in 10 years, or 20 years, or 30 years.

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

Thank you very much. (Applause.)

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

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

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

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

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

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

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

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

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

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

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

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

lower cost -- and they make money doing it because they recover all the cost of developing new drugs from Americans. And then the Europeans put actual price controls on them and they sell anyway.

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

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

MR. WITT: That's exactly what I'm getting at, Mr. President, because my sister-in-law is a nurse and they go to Texas every year and they go across the border and buy the same prescriptions at a fraction of the cost of what we're paying here in Michigan. And I read in the paper where they can do the same thing in Canada. So what I'm getting at is I think that the government should start purchasing these prescription drugs, many of them, and make them available to seniors, the same way they are in the hospitals, at a fraction of the cost that we as seniors are paying. We're subsidizing a lot of other things out of our meager retirement income.

THE PRESIDENT: You are subsidizing the pharmaceuticals made in America, sold in virtually every other country in the world, because they're made here and you're paying higher prices for them than people in other places.

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

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

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

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

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

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

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

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

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

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

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

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

So I think anything we can do to make people healthier and keep them out of the hospital and keep them out of more extensive and expensive care is a plus. So thank you very much. (Applause.)

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

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

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THE PRESIDENT: First, let me say that we have made dramatic increase in medical research one of the priorities for

the last two years for the millennium. We're trying to double funding for the National Cancer Institute and eventually double funding for all the National Institutes of Health.

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

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

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

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THE PRESIDENT: Let me say -- I think we're mostly talking about this prescription drug issue today. But don't forget, as important as it is, the most important thing that we're doing is securing Medicare for 27 years. We've got to get -- the basic program has to be secure, because that would literally, as many people as are terrifically burdened by this prescription drug benefit, if anything happens to the solvency of Medicare, or we have to adopt some draconian changes that raise the cost of the program so much that it's as out of reach as the drugs are now for people, the consequences would be disastrous. So let's not forget we have two things to do. We've got to stabilize and modernize and secure the Medicare program itself for the next 27 years as well as add this drug benefit.

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

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

THE PRESIDENT: I think tell the Congress that the country's doing well now and that, yes, you would like to have a

tax cut, but you will settle for a smaller one rather than a bigger one if the money goes to save Medicare and Social Security and keep up our investment in the education of our children and pay the debt off. I think that's a simple message. (Applause.)

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

I mean, I hope you're my friends, but that's -- and I think what you have to say is that the country has become prosperous by looking to the future, by getting the deficit down, by getting our house in order, by getting this budget balanced, by investing in our people. And now, we have these big challenges.

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

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

MS. ALDRIDGE: And when you tell your lawmakers, write

them a letter, send them an e-mail.

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

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

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

Well, I don't think they will necessarily lose. Once they go back to what this gentleman said over here about it, and let's put what he said and what you said together. The profit margins may go down some on heavily-used drugs where we have the power to bargain per drug; but the volume will surely go up. That's the point you're trying to make.

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

the past is any experience of every other change, the increased volume of medicine going to seniors who need it will more than offset the slightly reduced profit margins from having more reasonable prices.

Thank you very much.

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

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

THE PRESIDENT: But she's not designated disabled?

MR. GRAHAM: I beg your pardon?

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

MR. GRAHAM: Correct.

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

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

MR. GRAHAM: Well, I know a lot of people that are in the same situation. Although I have supplemental insurance, there's no guarantee that that supplemental insurance will continue. Because in our retirement, that's a part of it, but there's nothing in writing that says we're going to get it forever.

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

I think if we can get it out that far, the whole way health care is delivered will change so dramatically that the

people who come along after me and the Congress and in the White House will have opportunities to structure this in a different way that will be even more satisfying to the people as well as being better for their health.

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

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

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

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

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

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

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DR. SHAHNI: -- I can tell you, Mr. President, the list is very long of these patients who are out there suffering because they cannot afford these medications. Drug costs in this nation are skyrocketing. They are having dire

consequences on the health care system. We do need to do something. We strongly support your health care plan.

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

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

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

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

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

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

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

the pharmacists, Heather was making the same point -- there are lots of people like this.

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

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

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

I thank you very much, sir.

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

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

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

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

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

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

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

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

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

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

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

Thank you and God bless you. (Applause.)

END 1:00 P.M. EDT

Message Sent To:_____