THE HENRY J. KAISER FAMILY FOUNDATION

THE MEDICARE PROGRAM

THE KAISER MEDICARE POLICY PROJECT

Women and Medicare

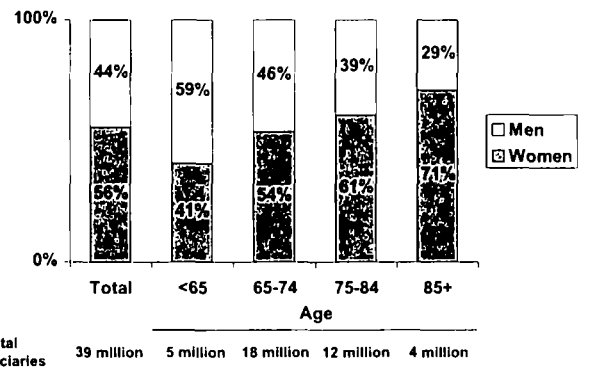
May 1999

As a partner program to Social Security, Medicare provides a health and financial safety net for virtually all older Americans and for many with disabilities who are under 65. Medicare covers both women and men, yet more than half of the nearly 40 million people covered by the program are women. Seven of ten beneficiaries 85 and older are women (Figure 1).

Figure 1

Over half of all Medicare beneficiaries are women

Seven of 10 beneficiaries 85+ are women



SOURCE: Medicare Current Beneficiary Survey, 1996.

Women's life expectancy, on average, is 79 — seven years longer than men's. At 65, their life expectancy is more than three years longer. Compared with men, older women are three times likelier to be widowed, and far more apt to live alone. Among women 85 and older, four out of five are widowed, and more than 43 percent live alone.

Health and Long-Term Care Needs

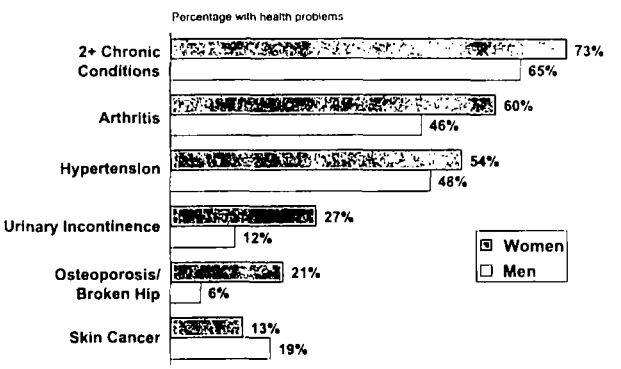
Given their longer life spans, women are likelier than men to live with multiple chronic conditions and certain health problems (Figure 2). A greater share report having often disabling conditions like arthritis, hypertension, urinary incontinence, and osteoporosis.

Also compared with men, women are more likely to have functional impairments and long-term care needs. Of the six million beneficiaries with functional limitations — measured as needing assistance with one or more activities of daily living (ADL) like eating or bathing — two-thirds (65 percent) are women. One-third (34 percent) of women 65 to 74 report functional limitations. Among those 85 and older, 82 percent do.

As for long-term care, women are more likely than men to use long-term care services: two-thirds of all Medicare beneficiaries who receive home health services and three quarters of all nursing home residents are female. Policies that affect users of these services have a disproportionate impact on women.

Figure 2

Women on Medicare are likelier than men to have many health problems



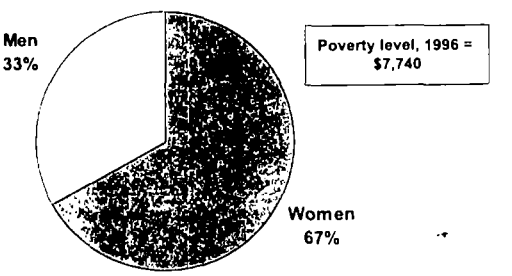
Note: Minimal differences (<4%) between genders were reported for heart disease, diabetes, pulmonary disease, strokes, and mental disorders.
SOURCE: Medicare Current Beneficiary Survey, 1996

Poverty

Women are especially hard-hit by changes in policies and programs that affect poor Medicare beneficiaries. Not only do they have higher poverty rates than their male counterparts — nearly seven in 10 with incomes below poverty are women — but disparities increase with age (Figure 3). Of all female beneficiaries, 16 percent have incomes below the federal poverty level ($7,740 for an individual in 1996), compared to 11 percent of men. Half have incomes below twice the poverty level ($15,480 for an individual), compared to 39 percent of men. And among those 85 and older, nearly two-thirds (62 percent) of all women have incomes below twice the poverty rate, compared to 53 percent of all men.

Figure 3

Seven of 10 Medicare beneficiaries with incomes below poverty are women



Total = 5 million poor beneficiaries

SOURCE: Current Population Survey of non-institutionalized population, 1997.

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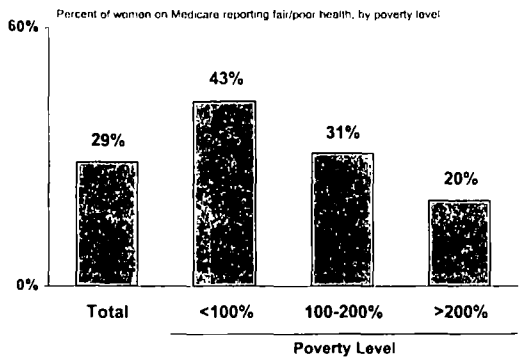
Compounding the financial difficulties of living in poverty, women with low incomes are, on average, in worse health than those who are better off. Of all poor female Medicare beneficiaries, 43 percent report being in fair or poor health, compared to 20 percent of women with incomes above 200 percent of poverty (Figure 4).

Figure 4

Poor women on Medicare have greater health needs than those with higher incomes



SOURCE: Medicare Current Beneficiary Survey, 1995.

Insurance Coverage

While Medicare provides coverage for basic acute care services, it has high cost-sharing requirements and does not cover outpatient prescription drugs. Consequently, most beneficiaries have public or private supplemental insurance to fill in the gaps in Medicare's benefit package. Like their male counterparts, 60 percent of all female beneficiaries have private supplemental insurance. In 1995, 33 percent had employer-sponsored retiree health benefits (versus 36 percent of men) and 27 percent had individually purchased Medigap policies (versus 23 percent of men). A growing share of beneficiaries (9 percent for both men and women in 1995) are enrolling in Medicare HMOs for supplemental benefits.

Given their disproportionately low incomes and their greater long-term care needs, female Medicare beneficiaries are more likely than men to rely on Medicaid, the federal/state health program that provides health and long-term care coverage for the poor. Nearly 17 percent of women rely on Medicaid to fill in Medicare's gaps, compared with 11 percent of men.

Despite Medicaid's protections, nearly 10 million female Medicare beneficiaries with incomes below twice the poverty level are not on Medicaid. This group is especially vulnerable to financial burdens in the event of a serious, high-cost illness.

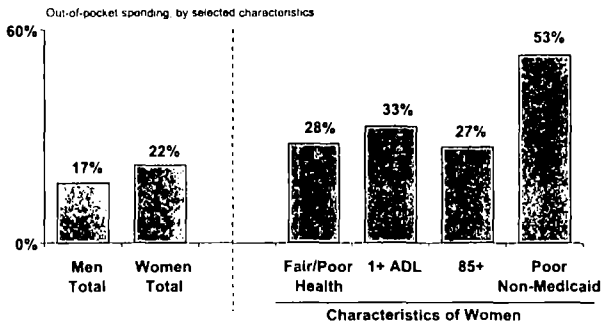
Out-of-Pocket Spending

Because Medicare provides basic rather than comprehensive coverage, many beneficiaries face high-out-of-pocket health care expenses. Women, on average, devote a greater share of their income to health care than men do. In 1998, 22 percent of their incomes went toward medical care, compared with 17 percent for men (Figure 5). These figures mask the fact that the most vulnerable spent a significantly larger share of their incomes for health care: Women 85 and older spent 27 percent of their incomes, on average, for health, while those with ADL impairments spent a third of their income. But the burden was highest for poor women without Medicaid, whose health care spending consumed over half of their income.

Figure 5

Women on Medicare spend a greater share of their incomes on health care than men

The most vulnerable pay significantly more



Note: Excludes beneficiaries enrolled in Medicare HMOs, beneficiaries under-65 and disabled, and beneficiaries in long-term care facilities. ADL= activities of daily living limitation, such as eating or bathing.
SOURCE: AARP Public Policy Institute, 1998

That traditional Medicare does not cover outpatient prescription drugs exposes many beneficiaries to high out-of-pocket costs. Most women on Medicare — 17 million — use prescription drugs regularly. More than a quarter (29 percent) spend over $50 a month for this purpose, according to the Kaiser/Commonwealth 1997 Survey of Medicare beneficiaries.

Issues for Women

Women are major stakeholders in the debate over Medicare's future. Given their higher rates of poverty, multiple chronic conditions, and long-term care needs, adequate health insurance is especially important as they grow older. Policies that improve financial protections for the poor and near-poor would improve the lot of all low-income beneficiaries, the majority of whom are women. Likewise, policies that extend Medicare coverage to outpatient prescription drugs and long-term care would help fill coverage gaps that drive up out-of-pocket spending for women. Conversely, policies that erode coverage or that shift costs to beneficiaries will adversely affect women, especially those with low incomes. Understanding the full implications of proposed reforms for aging women will be essential to the success of any effort to preserve and protect Medicare for future generations.

OWL PRESS RELEASE

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FOR IMMEDIATE RELEASE
June 29, 1999

WOMEN BENEFIT FROM CLINTON PROPOSAL TO STRENGTHEN MEDICARE AND NEW DRUG COVERAGE

OWL today praised President Clinton's plan to strengthen and modernize Medicare, as "real help to millions of Medicare beneficiaries--most of whom are women."

"Nothing makes better sense in good economic times than to support the generation who sacrificed so much for us," said OWL Executive Director Deborah Briceland-Betts. Because nearly six in ten Medicare beneficiaries are women, the President's plan has a disproportionate impact on women. "You know these women," said Briceland-Betts. "They are our mothers and our grandmothers."

Shoring up Medicare with the surplus, adding a Medicare prescription drug benefit, helping low-income beneficiaries and eliminating cost-sharing for preventive care "directly addresses gaps in Medicare coverage that cause particular problems for women," said Briceland-Betts. She noted that--

- Women are the majority of low-income elderly Americans. Women age 65 and over are twice as likely as men the same age to have annual incomes under $10,000.
- Nearly eight out of ten women on Medicare use prescription drugs regularly. Lack of prescription drug coverage represents a significant out-of-pocket cost for elderly women.
- Chronic conditions are sources of significant and increasing disability for older women, in contrast to men, who are more likely to suffer one acute, fatal episode. Picking up the cost to help identify and treat diabetes, osteoporosis, arthritis, breast cancer and a host of other disabling diseases could greatly enhance women's quality of life, as well as reduce long-term costs for Medicare.

Briceland-Betts cautioned, however, that while the President's plan is an excellent start, it does have some rough edges. "We are concerned that plan's efforts to control costs in the short run may create a precedent to alter the fundamental social insurance principle on which the program was founded. OWL will be working to smooth these rough edges as the proposal makes its way through Congress."

OWL is the only national grassroots membership organization to work on issues unique to women as they age. OWL has 75 chapters and over 15,000 members nationwide.

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Women and Medicare:
President Clinton's Plan to Strengthen and Modernize Medicare
OWL--July, 1999

On June 29, 1999, President Clinton announced a new plan to prepare Medicare "for the health, demographic, and financing challenges it faces in the 21st Century." The President's proposal has three parts, which would:

(1) Strengthen Medicare's financing;
(2) Modernize Medicare's benefits by responding to medical practice today; and,
(3) Introduce market constraints to "make Medicare more competitive and efficient."

Because women are the majority of Medicare beneficiaries, outnumbering men 3 to 2 at age 65 and making up 71 percent of beneficiaries age 85 and over, President Clinton's plan, like any Medicare reform plan, will have a disproportionate impact on women. The following is an analysis of the key components of the President's 21st Century Medicare Plan, from the perspective of the 20 million older women who are Medicare beneficiaries.

1. Strengthening the Trust Fund.

The President's plan would extend the life of the Trust Fund to 2027, by dedicating 15 percent of the projected budget surplus to Medicare. The proposal also uses two percent of the surplus to help finance the new Part D drug benefit.

Strengthening and preserving Medicare for future beneficiaries is by far the most important impact of the President's plan on older women. The number of Medicare beneficiaries is expected to more than triple by 2030. And, just as they do today, a disproportionate number of older women will be living on low incomes, very likely alone, and most likely suffering from at least one chronic illness (and probably more). For more than 35 years, Medicare has provided millions of older women with health care coverage they would not otherwise have had. This provision maintains that commitment.

2. Modernizing Medicare.

This provision contains two proposals which directly address two of the most significant gaps in Medicare for women: prescription drug coverage and preventive screening. Even while Medicare cuts back on coverage for acute care, it still treats prescriptions and preventive services much as it did in 1965, when acute care was the norm and illness almost always resulted in hospitalization.

New prescription coverage.

Today, prevention is central to the practice of medicine and when illness cannot be prevented, it is managed by medication. Access to prescription drugs is a women's issue.

Women account for 62.5 percent of all prescriptions, according to independent pharmacy benefit manager Express Scripts. More than 40 percent of prescriptions are written to women age 40 and over.

When fully phased in, the President's plan would pay for half of prescription drug costs up to a limit of $5000, with no deductible. Medicare recipients would pay a monthly premium, estimated at $44 when the program is fully operational, but would buy drugs at a discount even if their costs exceed the $5000 limit. According to the White House, over 90 percent of Medicare recipients would never reach this cap. All costs would be covered for low-income Medicare beneficiaries.

Almost eight out of ten women on Medicare use prescription drugs regularly, and most pay for medication themselves. As many as 15 million older Americans have no prescription drug coverage, according to the White House. Because older women are more likely to have low incomes (women 65 and over are twice as likely as men the same age to have annual incomes under $10,000), and more likely to be chronically ill (nine in ten women age 65 and over report one or more chronic conditions; once they pass age 85, the figure rises to 97 percent). Help with the cost of medication is especially urgent for women.

Even those who have coverage are seeing it move out of reach as the price of Medigap coverage rises, as HMOs opt out of the Medicare program, and as retiree health coverage declines.

New coverage for preventive screening.

The President proposes to eliminate all copayments and deductibles for preventive services covered by Medicare. This is an especially critical provision for women, for whom chronic conditions are the source of significant and increasing disability (in contrast to men, who are more likely to suffer one acute, fatal episode).

The White House notes that in 1995-96, "only one in four women in their sixties were tested as often as recommended for breast cancer...only 14 percent of eligible women without supplemental insurance received a mammogram" in the first two years that service was covered under Medicare. Not only would this provision improve quality of life for countless older women, it would save lives and money when Medicare is *not* called upon to pay for a hip fracture, for breast or colon cancer, or a hospitalization brought on by diabetes identified too late.

3. Cost-Sharing Provisions.

The President's plan contains two beneficiary cost-sharing proposals in particular which should be carefully examined for their impact on low-income elderly women. These are:

Competitive defined benefit for managed care.

This provision establishes a core mix of Medicare benefits for Medicare managed care plans. It also would give Medicare beneficiaries the option of choosing a plan with a lower or no Part B premium if they choose a low-cost HMO, and allow beneficiaries to pay out-of-pocket for a richer mix of benefits. The proposal explicitly includes prescription drug coverage in the core managed care benefit package, which is essential from a woman's perspective.

However, women have the greatest health needs and the fewest financial resources and, frankly, need a richer mix of benefits and specialists. We hope that provision does not set a precedent which moves Medicare away from the social insurance model which has provided the same level of care to beneficiaries regardless of income, to a market-driven program in which wealthier beneficiaries receive better care.

Early buy-in.

The President proposes to extend health care coverage through a Medicare buy-in, to displaced workers beginning at 55 and early retirees beginning at age 62, and offers COBRA coverage for retirees whose companies dropped retiree health insurance. Though women in this group urgently need this access to care, a $300 monthly premium for the buy-in is out of reach for most uninsured, low-income women.

In addition, an monthly payment will be assessed beginning when a beneficiary of the buy-in becomes eligible for Medicare. Because women live an average of six years longer than men, and because the premium is a "lifetime premium," it has an unintended gender bias.

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Women are the majority of Medicare beneficiaries. Their incomes are lower and their health care costs are higher. Women's out-of-pocket health spending is as much as five percent higher than men's; poor older women can spend more than half of their incomes on health.

The President's plan is a strong first effort to strengthen Medicare and improve services to beneficiaries. The plan does have provisions--the HMO market-driven proposal and the early buy-in plan--which require further examination for their impact on the most vulnerable women in Medicare. However, fortifying the Medicare trust fund, adding help for the cost of prescription drugs, helping low-income beneficiaries and providing direct incentives for preventive care, represent important and overdue advances in Medicare for the millions women who depend on it.

This analysis was prepared by OWL for the National Council of Women's Organizations. For further information, contact Deborah Briceland Betts, OWL Executive Director at 202/783-6686.

OWL
THE VOICE OF MIDLIFE AND OLDER WOMEN

MEMORANDUM

July 19, 1999

TO: The National Council of Women's Organizations
FROM: Deborah Briceland-Betts
Executive Director, OWL
SUBJ: White House Meeting

I am writing in reference to this afternoon's Medicare meeting at the White House and the opportunity that I believe it presents to the women's community.

Medicare long has been a key issue for OWL. We are wrapping up our 1999 Mother's Day campaign, *The Face of Medicare is a Woman You Know*, and I hope you received our Mother's Day report of the same name. The report describes why Medicare is a women's program--at every age, we are the majority of beneficiaries--why it is so important to protect and preserve Medicare for women's health the decades to come, and how we must do it if we are to be effective for the women we know.

But just as with Social Security, Medicare is becoming an issue for all women as the Baby Boom ages and we women increasingly find ourselves in the majority. We are delighted that the White House has chosen to take such a high profile on Medicare and that its policy people have chosen to frame the issue from a woman's perspective.

We are looking forward to getting together to talk about how we can make the Medicare reform debate real for the millions of women who are current Medicare beneficiaries, and for the millions more women who will become eligible for Medicare in the next century. We at OWL hope that you will feel free to use us as a resource as this debate heats up and you become more involved. Call us for statistics, for fact sheets, for the experiences of real people, and of course, for copies of the Mother's Day report.

I have attached an analysis we prepared of the President's Medicare proposal, and a press release we issued the day the proposal was released. I hope that this will be of help as we begin to put our heads together on Medicare, and I look forward to your creativity and input.

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The Face of Medicare is a Woman You Know

OWL 1999 Mother's Day Report

A Message from Betty Lee Ongley

President, OWL

Happy Mother's Day!

Each year, OWL marks Mother's Day with a report highlighting an issue of critical importance to America's midlife and older women. *The Face of Medicare is a Woman You Know* ranks as one of our most significant and timely efforts. It goes directly to the heart of the critical national debate now taking place about the future of Medicare and delineates the issues unique to women that must be addressed if the program is to be strengthened effectively for the future.

The report is based on the findings of a series of three forums held by OWL, with the support of the Henry J. Kaiser Family Foundation, on Women and the Future of Medicare. At the forums in San Francisco, Atlanta and Chicago, some of the country's top experts helped to pinpoint the benefits and barriers in a program that has literally provided a lifeline for America's older women for nearly 35 years.

The report vividly shows that the face of Medicare is a women's face. We are almost six in ten of those receiving benefits from the program at age 65, and more than seven in ten by the time we reach 85. Two times more of us are poor than men, and 20 percent of the most vulnerable—widows, divorced and never married—are poor. Medicare has made it possible for us to have access to the health care we increasingly need as we age and that we otherwise would not be able to afford.

As we age, we develop more—and more complex—chronic conditions. We are more likely to become disabled and to require long-term care. Without Medicare, we would not have access to necessary treatments and important new preventive benefits. There are, however, significant gaps in coverage that can, even with Medicare, make our health care costs close to unaffordable. Prescription drug costs, specialized treatments and high-tech medicine are often not covered by Medicare, low income programs, or the supplemental Medigap insurance policies we buy, and we spend an average 22 percent of our already meager incomes on out-of-pocket expenses.

Increasingly, the report shows, we are being urged to look to Medicare managed care as a way to expand our access to health care while lowering its costs. Managed care has been beneficial for older women in many ways. Increasingly, however, as plans seek to reduce their costs, we are being asked to sacrifice quality for efficiency. Access to many services is being limited, new high cost pharmaceuticals and treatments are often not covered, and when doctors leave plans, continuity of care may be disrupted. We have learned, according to the report, that the result is poorer health outcomes.

The Medicare+Choice managed care options that were included in the 1997 Balanced Budget Act, and new proposals being considered by policymakers, must be carefully assessed to make certain they meet our needs for affordable, high quality care.

Today's Medicare must be strengthened for future generations of women. As we look to reform our major social programs, we must remember that Medicare and Social Security fit hand in glove to protect women as they age, and they must continue to do so. We need the continuing guarantee of a program with defined benefits, a program that maintains and enhances our ability to access affordable high quality health care services.

OWL believes that policymakers must assess the impact on women of any changes they propose for Medicare. They must first look at our health care needs, and what they cost, and then how best to design a framework that is inclusive as well as efficient. As our report clearly shows, if Medicare works for women, it will be a program that will work for everyone—today and in the future.

Highlights

...with the passage of this Act, the threat of financial doom is lifted from senior citizens and also from the sons and daughters who might otherwise be burdened with the responsibility for their parents' care. [Medicare] will take its place beside Social Security and together they will form the twin pillars of protection upon which all our people can safely build their lives.

President Lyndon Johnson, 1965

Medicare, the nation's health insurance program for older women and men, is not typically thought of as a "woman's program." But it should be. Almost six in ten individuals receiving Medicare are women and more than seven in ten over the age of 85 are women. Over time, the proportion of Medicare beneficiaries who are women will only increase. More and more, the face of Medicare is a woman's face.

Women have a significant stake in the Medicare program. Women live longer than men—and are more likely to suffer from chronic health conditions, to require more medical care, and to need assistance with activities of daily living. With women's poverty rates twice that of men, health care costs take a bigger bite out of women's limited incomes. Women are Medicare's most vulnerable population.

This OWL Mother's Day Report, *The Face of Medicare is a Woman You Know,* shines a spotlight on Medicare as a women's issue. It shows that while Medicare provides crucial health care for older women, the gaps in the program and the limitations of supplemental insurance leave women vulnerable to high out-of-pocket costs. These gaps, such as long-term care coverage, affect women disproportionately. Moreover, the shift of individuals on Medicare to managed care in recent years has had mixed consequences for women, lowering their health care costs and increasing access to services in some cases—but creating new problems with access and quality in others.

The report cautions women to pay close attention to changes that have already taken place in the Medicare program and to proposals for reforming it further. Some of the reform proposals on the table would increase barriers to health care for women, and make health care costlier as well. Women have a stake in preserving and strengthening the Medicare program to ensure that they and future generations will have access to quality, affordable health care.

- In all age groups over age 65, women outnumber men in the Medicare program. By age 85, women outnumber men in the Medicare program by two to one.
- Women rely on Medicare for more years than men do because they live longer. Women's average life expectancy is 79 years—compared to 73 years for men.
- The longer a woman lives, the more likely she is to suffer from prolonged chronic illness. Nine in ten women age 65 and over report one or more chronic conditions and almost three out of four have two or more chronic conditions.
- Chronic conditions are sources of significant and increasing disability as well as mortality for older women. The older a woman, the more likely she is to need assistance with activities of daily living such as eating, walking, and bathing.
- With more chronic and disabling conditions and a greater likelihood of living alone, women are more likely than men to have long-term care needs and to use long-term care services. In 1996, 1.5 million elderly women resided in a long-term care facility and women made up three out of four of the residents in these facilities.
- At every age, women are at greater risk of poverty than men—but the disparities are particularly pronounced in old age. Women age 65 and over are twice as likely

as older men in this age group to be poor, with incomes less than $10,000.

- There are a number of gaps in the Medicare program—most notably the absence of coverage for prescription drugs and long-term care, as well as the lack of stop-loss protection—that result in higher out-of-pocket health care costs for low- and moderate-income women.
- Poor elderly women often face financial barriers to health care. The Kaiser/Commonwealth 1997 Survey of Medicare beneficiaries found that more than one in four women experienced difficulty getting needed health care or paying their medical bills.
- Older women on Medicare have substantial out-of-pocket costs. Estimates for 1998 showed that women spent, on average, $2,613 for health care—or 22 percent of their incomes. Men spent, on average, $2,385 or 17 percent of their incomes on out-of-pocket health care costs.
- The older and poorer the woman, the higher her out-of-pocket costs. Estimates indicate that in 1998, women age 85 and over spent 27 percent of their incomes on health care. However, women living below the poverty level spent 34 percent of their incomes on health care.
- Many older women rely on private insurance or Medicaid to supplement their Medicare coverage. Seventy-eight percent have some type of private supplemental insurance coverage.
- Seventeen percent of older women have Medicaid coverage to supplement their Medicare coverage. However, 22 percent of poor older women have no coverage other than Medicare.
- In recent years, the managed care industry has moved aggressively to enroll those on Medicare in managed care plans. Today, women represent the majority of Medicare recipients enrolled in managed care, reflecting their share of general medicare population: 2.9 million women (about eight percent of the Medicare population) and 2.2 million men (about six percent), were enrolled in managed care plans in 1997.
- Women enrolled in Medicare managed care plans have increased access to preventive and screening services such as mammography, clinical breast exams, Pap smears, bone scans, and blood pressure screening. Additionally, most managed care plans offer some coverage for prescription drugs.
- Research suggests that managed care plans are more effective than fee-for-service plans at coordinating health services—and at identifying and treating certain diseases at earlier stages. These features are particularly important for older women who require many complex services from difference sources.
- Research has also identified potential concerns for women enrolled in managed care plans including poorer health outcomes, disruption of patient-provider relationships, and, in some instances, difficulties gaining access to specialists and high-cost prescription drugs.
- The Balanced Budget Act of 1997 created Medicare+Choice which expands the range of private managed care plans that may contract with Medicare to provide health care to older Americans. As these new types of plans become available, women will need to assess their options and choose a plan that most closely meets their individual requirements.
- In 1997, Congress established the National Bipartisan Commission on the Future of Medicare to recommend proposals to reform Medicare. Women need to understand how these changes could affect their coverage, their costs and access to care. Several of the proposals now under consideration could have adverse consequences for women, such as raising the eligibility age for Medicare and increasing cost-sharing for home health services. More broadly, the commission considered a new system of "premium supports"—a that would provide a set amount of money which seniors and people with disabilities of proposed changes for women—our mothers and grandmothers—is essential for the success of any effort to preserve and protect Medicare.

Introduction

In their later years, both women and men rely on Medicare—the nation's health care program for 39 million aged and disabled persons. Like Social Security, Medicare is a social insurance program. It provides health care protection to all people with disabilities and the aged regardless of income or health history.

As the majority of those on Medicare, women have a particular stake in preserving and strengthening the program. They live longer than men—and are a disproportionate share of persons who are over age 85. Women are more likely to be widowed, to live alone, and to live in nursing homes.

Women are also more likely than men to suffer from multiple chronic illnesses—and they are more likely to experience difficulties with activities of daily living. In addition, women are heavy users of health and long-term care services. Because their incomes are lower than men's, out-of-pocket spending for health care by elderly women takes a bigger bite out of their available incomes.

For almost thirty-five years, Medicare has provided millions of older women with access to health care they would not otherwise have had. However, there are a number of gaps in the Medicare program—most notably the absence of coverage for prescription drugs and long-term care as well as the lack of stop-loss protection—which make the program costly for low- and moderate-income women.

The Medicare program has undergone significant changes in recent years. Out-of-pocket health spending has increased as a result of the increased costs of sophisticated treatments and prescription drugs not covered by Medicare, as well as Congressionally-mandated increases in payments for premiums, deductibles, and copayments. Increasing numbers of individuals on Medicare are turning to managed care plans to help pay for uncovered services and lower out-of-pocket costs.

In recent years, Medicare has come under scrutiny because of the rapidly growing Medicare population—program rolls are projected to swell to 76 million by the year 2030—and the rising costs of services provided under the program. Medicare spending now represents 12 percent of the federal budget and spending is projected to grow in the future. Moreover, the expected drop in the number of workers per beneficiary means that there will be proportionately fewer people to contribute payroll taxes to support those on Medicare in the future. The Medicare Trust Fund is currently projected to be depleted by 2015.

A variety of changes were made in recent years to reform the Medicare program and to help slow the growth in Medicare spending by expanding the role of private plans and encouraging managed care enrollment through the Medicare+Choice program. Women should monitor these changes and be aware of what they mean for their ability to get—and pay for—health care.

...women outnumber men in the Medicare program. Almost six in ten of those on Medicare are women, and more than seven in ten age 85 and older are women.

Other changes made by the Balanced Budget Act of 1997 will have a disparate impact on women. The most important of those changes imposes a prospective payment system on home health and skilled nursing care. The payment formula for these services sets levels which provide disincentives for providers to serve patients requiring more intense care, primarily women.

In addition to the significant changes in law already enacted, Congress is considering further changes to preserve the program for the baby boom generation.

Some new proposals would build on Medicare's existing structure. However, other initiatives call for a restructuring

of the program. Because older women are more likely than older men to have low incomes, multiple chronic conditions, and high out-of-pocket costs, they could be disproportionately affected by changes in the program—especially those that shift costs onto beneficiaries. Women need to assess any reform proposals to ensure that their financial, health, and long-term care needs will be met in the future.

This OWL Mother's Day Report, *The Face of Medicare is a Woman You Know*, focuses attention on Medicare as a women's issue. Part One presents an overview of the health and income status of women on Medicare. Part Two explains how the Medicare program works and describes the gaps and limitations of the program—and the resulting out-of-pocket costs for women. In Part Three, the report assesses how well the various types of supplemental health coverage—Medigap, retiree health insurance, and Medicaid—are working for women.

In the final section of the report, the implications of Medicare managed care for women are considered. Finally, the report describes recent proposals for Medicare reform and concludes by making recommendations for policy changes which would strengthen the Medicare program for today's older women and men, as well as for future generations.

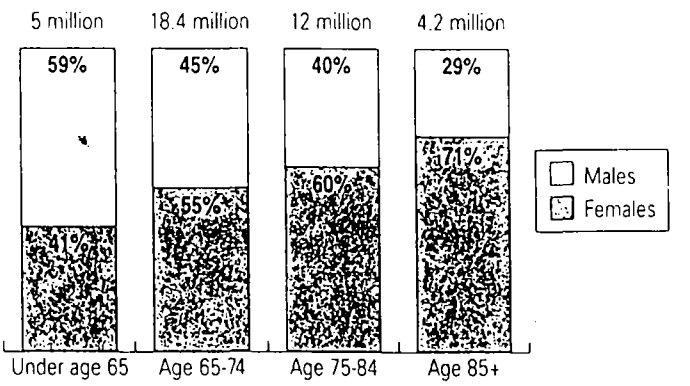
Women, Health, and Income

Today, there are 20 million older women on Medicare. Another two million women are covered by Medicare because they receive Social Security disability benefits At all age groups over age 65, women outnumber men in the Medicare program. Almost six in ten (58 percent) of those on Medicare are women and more than seven in ten (71 percent) age 85 and older are women(see Figure 1). By age 85, women outnumber men in the Medicare program by more than two to one (Rice and Michel 1998).

Women rely on Medicare for more years than men do because they live longer—an average of six years longer. Women's average life expectancy is 79 years—compared to 73 years for men. If a woman lives to age 65, she can expect to live until the age of 84—about 3.3 more years than a man will (Rice and Michel 1998).

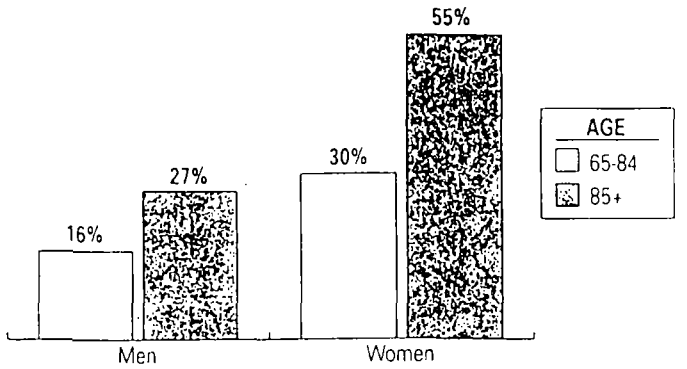
Most women marry older men. Because men do not live as long as women, older women are three times more likely to be widowed than men and four out of five women age 85 or older are widowed (Rice and Michel 1998). The older the woman, the more likely she is to be living alone. More than one in three (35 percent) older women live alone—compared with 14 percent of older men. And more than half (53 percent) of women age 85 and older live alone, whereas only one in four men do (Gibson and Brangan 1998).

Figure 1
Age and Gender of Elderly Medicare Population, 1996



Source: Kaiser Family Foundation 1999

Figure 2
Medicare Beneficiaries with Incomes Under $10,000, 1996



Source: Medicare Current Beneficiary Survey, 1996

Chronic Illness and Long-term Care

The longer a woman lives, the more likely she is to suffer from prolonged chronic illness. Nine in ten women age 65 and over report one or more chronic conditions and almost three out of four have two or more chronic conditions. Among women age 85 and over, 97 percent have one or more chronic conditions and 47.5% women in this age group suffer from Alzheimer's disease (Rice and Michel 1998). (Evans et al. 1990)

Chronic illnesses are sources of significant and increasing disability, as well as mortality, for older women. The older a woman, the more likely she is to need assistance with activities of daily living such as eating, walking, and bathing. One in three women age 65 to 74 report functional limitations and more than eight in ten women age 85 and over report being limited in their functioning (Rice and Michel 1998).

Most older persons with long-term care needs are women (Neuman 1998). Long-term care includes a broad array of in-home, community, and institutional services for people who need assistance carrying out everyday tasks because of a chronic condition.

Many elderly women who require help with everyday activities rely on family and friends. In fact, three out of four elderly disabled persons rely exclusively on informal unpaid caregivers—most of whom are older women themselves: three out of four informal caregivers are women and their average age is 57. One out of four caregivers is between the ages of 65 and 74—and one in ten is age 75 and over (Rice and Michel 1998).

Millions of elderly women rely on paid help for long-term care assistance at some point in their lives as well. In 1996, 1.5 million elderly women resided in a long-term care facility—a skilled nursing home, retirement home, or institution for the mentally retarded—and they made up three out of four of the residents in these facilities. In addition, women comprised two out of three (67 percent) of home health care users and over half (55 percent) of hospice patients in 1996 (Rice and Michel 1998).

Older women are twice as likely as older men to be poor... among those 85 and older, more than half of women... had incomes of less than $10,000.

Women, Poverty, and Access to Health Care

At every age, women are at greater risk of poverty than men are—but in old age, the disparities are particularly pronounced(see Figure 2). Older women are twice as likely as older men to be poor. In 1996, women between the ages of 65 and 85 were nearly twice as likely (30 percent) as older men (16 percent) in this age group to have incomes under 125 percent of the poverty line (less than $10,000 annually). The older the woman, the more likely she is to be poor: among those on Medicare age 85 and older, more than half of women compared to one in four men had incomes less than $10,000 in 1996 (Rice and Michel 1998).

Poor elderly women often face financial barriers to health care. The Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries found that more than one in four women (26 percent) experienced difficulty getting needed health care or had problems paying their medical bills. This survey also reported that low incomes were correlated with a lower likelihood of using preventive services: poor and near-poor women were about 20 percent less likely to have had mammograms than were women with incomes more than twice the poverty level (Schoen et al. 1998).

The Medicare Program

Before Medicare was enacted in 1965, half of our nation's older citizens were uninsured—and just one serious illness away from financial ruin. Today, nearly all Americans age 65 and over are insured under Medicare. Medicare provides health insurance for one in seven Americans.

Like Social Security, Medicare is a "social insurance" program. It offers health care protection to all eligible elderly and disabled people—regardless of income or health history. Individuals contribute to Medicare while they are working so that they and their spouses will be provided with health insurance upon retirement.

Medicare consists of two parts which together provide health care coverage for basic medical services. Part A—hospital insurance—primarily covers hospital inpatient care. It does not cover most long-term care, although it does pay for some skilled nursing facility benefits and home health benefits following a hospital or nursing stay as well as hospice care. Medicare Part B—Supplemental Medical Insurance—covers physician services, outpatient hospital services, home health visits not covered under Part A, and other services such as laboratory procedures and medical visits.

Before Medicare was enacted in 1965, half of our nation's older citizens were uninsured—and just one serious illness away from financial ruin.

With the passage of the Balanced Budget Act of 1997, a range of preventive services necessary for women are now covered by Part B of Medicare, including mammography, Pap smears, bone mass density screening for osteoporosis, and diabetes testing.

As long as they are eligible for Social Security, citizens age 65 and older are automatically entitled to benefits under Part A without paying a premium. For Medicare Part B, individuals pay a monthly premium ($45.50 in 1999) which is deducted from their Social Security checks.

The most glaring gap in Medicare is in the area of long-term care...a serious problem for women, who make up the majority of those who need long-term care assistance.

Gaps in Medicare

For more than three decades, Medicare has provided millions of older women and men, and since 1972, people with disabilities, with access to health care they would not otherwise have had. However, there are a number of gaps in the Medicare program which make the program costly for low- and moderate- income women. Cost sharing and deductibles can be high, and there is no cap on what an individual must pay towards the costs of treatment. Because of these gaps Medicare is less generous in coverage than health plans typically offered by large employers (Hewitt Associates LLC 1997).

Traditional Medicare does not cover prescription drugs unless they are used in a hospital or other health care institution. Almost eight out of ten women on Medicare use prescription drugs regularly and most pay for these medications out-of-pocket (Schoen et al. 1998). Nor does the program cover the costs of vision, hearing, and dental care.

The most glaring gap in Medicare for women is the absence of long-term care coverage. Many of those on Medicare are surprised to learn that Medicare covers only a small proportion of long-term care services and is limited to coverage of skilled nursing care, usually following an acute health care crisis. This is a serious problem for women, who make up the majority of those who need long-term care assistance.

Figure 3
Average Percent of Income Medicare Beneficiaries are Spending Out-of-Pocket for Health Costs 1998, by Gender

	Dollars	% of Income
Women	$2,613	22%
Men	$2,385	17%

Source: Projections from Medicare Benefits Simulation Model, 1998, Gibson and Brangan 1998.

Another problem with Medicare is it does not include stop-loss protection, which caps the maximum amount that individuals are required to pay for covered services. Private insurance offered by large companies generally includes stop-loss protection. This is not the case with Medicare, leaving those with serious medical problems vulnerable to catastrophic expenses. Many women and families often are left with significant out-of-pocket costs in the event of catastrophic illness due to this gap in Medicare.

Out-of-pocket Spending

Many individuals on Medicare have high out-of-pocket costs due to the financial requirements of the Medicare program. Those on Medicare are responsible for the cost of Part B premiums, deductibles and cost sharing, outpatient prescription drugs, and long-term care. To help cover these costs, most women (78 percent) receiving Medicare also have some form of supplemental insurance, which can provide coverage to meet some of these needs. Only the most costly plans provide coverage for services such as prescription drugs.

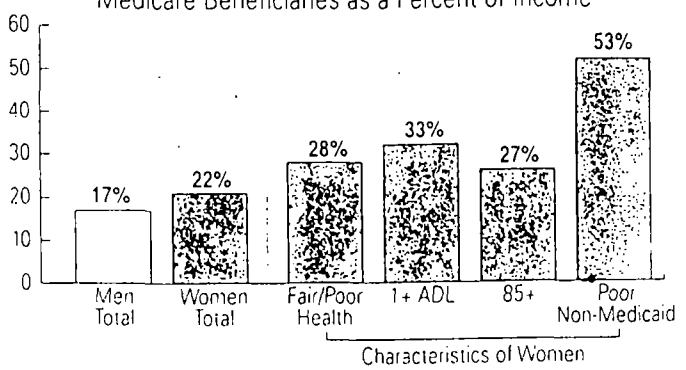
However, Medicare-related costs for individuals have risen quite dramatically over the last three decades. In fact, older Americans today are spending a higher proportion of their incomes for health care than they were prior to the enactment of the Medicare program—and today they spend three times the share of household income that younger families spend on health care (Families USA Foundation 1992).

Because women have lower incomes and greater health care needs, the proportion of their income spent on out-of-pocket costs is higher than their male counterparts. AARP projected that in 1998 women spent, on average, $2,613 on out-of-pocket costs for health care—or 22 percent of their incomes—compared to the $2,385 (17 percent of income) spent by men (See Figure 3). These figures exclude the costs of home care and nursing home care (Gibson and Brangan 1998).

The older and poorer the woman, the higher her out-of-pocket health care costs: women age 85 and over spent 27 percent of their income for health care in 1998. Women living below the poverty level spent a third of their incomes on out-of-pocket health care in 1998 and elderly women with one or more limitations with activities of daily living also spent a third of their incomes on out-of-pocket health care in 1998 (see Figure 4). Poor older women without Medicaid coverage were the most vulnerable group spending more than half (53 percent) of their incomes on out-of-pocket health care (Gibson and Brangan, 1998).

Older women's health care spending will continue to grow substantially over time. For example, changes in the Balanced Budget Act of 1997 are projected to increase Medicare premiums from $45.50 per month ($546.00 a year) in 1999 to $105.70 per month ($1268.40 a year) in 2008. Although Medicare premiums were expected to rise over time, this is $552 a year more than the increase projected prior to passage of the Balanced Budget Act of 1997 (Congressional Budget Office 1998). The increased costs of Medicare premiums will place an even greater burden on low- and moderate-income women in the future.

Figure 4
Out-of-Pocket Spending on Health Care by Medicare Beneficiaries as a Percent of Income



Source: Gibson & Brangan 1998

Supplemental Health Coverage

Seventy-eight percent of women on Medicare have some form of supplemental health insurance—either private insurance through a former employer, an individual Medigap policy, or Medicaid. These supplemental insurance plans pay for the deductibles and coinsurance costs faced by Medicare enrollees and some offer coverage for outpatient prescription drugs. However, these private and public plans have limitations as well.

Medigap

Slightly more women (27 percent) than men (23 percent) have individually-purchased Medicare supplemental insurance policies, known as Medigap coverage. Medigap policies help older women by helping to defray Medicare's cost-sharing requirements, and in some cases, paying for some prescriptions (Kaiser Family Foundation, forthcoming).

In recent years, premiums for Medigap policies have increased dramatically, especially for policies that cover some prescription drugs. If premiums continue to rise, these policies may be priced out of reach for many older women.

Retiree Health Coverage

Many people on Medicare have traditionally relied on employer-sponsored retiree health benefits that "wrap around" Medicare coverage. Women are somewhat less likely (33 percent) than men (36 percent) to have retiree health coverage (Kaiser Family Foundation 1999).

Retiree health coverage is an important source of coverage for the women who have it. However, this type of coverage has been eroding in recent years and health benefits for future retirees are uncertain. A declining proportion of large employers offered health benefits to retirees in 1996 (87 percent) compared to 1991 (92 percent). In addition, the scope of covered benefits in many retiree health plans has been reduced (Hewitt Associates LLC 1997).

Moreover, large employers who do provide retiree health benefits are shifting a larger share of the costs to retirees. Between 1966 and 1991, the proportion of large employers requiring post-65 retirees to pay premiums increased from 72 to 88 percent. And during this time period, an increasing share of large employers increased deductibles, raised retiree contributions for dependent coverage, and moved retirees into managed care plans (Hewitt Associates LLC 1997).

Medicaid

Lower income individuals are much less likely than their higher income counterparts to have Medigap or retiree health coverage. For approximately six million low-income Medicare beneficiaries, Medicaid is the primary source of supplemental health coverage (Kaiser Family Foundation 1997). More older women (17 percent) receive assistance from Medicaid than do older men (11 percent) (Kaiser Family Foundation 1999).

Medicaid differs from Medicare in a number of ways. Medicare is an entirely federal program that provides a standardized package of health services to the aged and certain disabled individuals. Eligibility is *not* based on income or resources. Medicaid is a combined federal-state program. Although general program requirements for Medicaid are dictated by federal law, Medicaid is operated and administered by the states. Eligibility for Medicaid is based on income and resources below specified ceilings that differ greatly from state to state.

While 78 percent of women have some type of private supplemental coverage, 22 percent have no coverage except for Medicare. Forty-six percent of older women below the

poverty line are not enrolled in Medicaid (Gibson and Brangan 1998).

Depending on the state in which they reside, and their income level, low income Medicare recipients can be either fully Medicaid eligible, or receive partial Medicaid coverage through other programs. For those fully eligible for Medicaid, the program will pay their Medicare coinsurance and deductibles, as well as for services covered by Medicaid but not Medicare, such as prescription drugs.

For the elderly and disabled poor who do not receive full Medicaid benefits, they may have partial Medicaid coverage to cover some of Medicare out-of-pocket costs. The most important of these programs are the Qualified Medicare Beneficiary Program (QMB) and the Specified Low-Income Medicare Beneficiary Program (SLMB).

Individuals on Medicare with incomes below the poverty level and limited assets (less than $4,000 per person) are eligible for the QMB program which pays Medicare's premiums, deductibles, and in some instances, cost-sharing. Individuals with incomes between 100 and 120 percent of poverty and limited assets are eligible to have Medicaid pay their Part B premiums only (SLMB).

For Medicare beneficiaries who are not low income, but have exceptionally high medical bills, a majority of the states have "medically needy" programs through which these individuals may become eligible for Medicaid benefits, including outpatient prescriptions.

The QMB and SLMB programs offer crucial protection to low-income women and men. Unfortunately, almost a decade after the enactment of the program, about half those eligible for this protection are not receiving these critical benefits (Moon, Kuntz, and Pounder 1996; Families USA Foundation 1998).

A major reason for the low participation has been lack of knowledge about the programs—on the part of both beneficiaries and social service workers. Although individuals must visit a Social Security office to enroll in Medicare, they are not allowed to apply for low-income benefits at that office. Instead, they must make a separate trip to a welfare office. Senior citizens report how difficult it is to find someone in welfare offices or Social Security offices who knows about the special programs for low-income individuals (General Accounting Office 1994; Nemore 1997; Families USA Foundation 1993).

A recent White House initiative has focused attention on efforts to enhance the enrollment of the low-income elderly in the QMB and SLMB programs. Mailings and other public education programs have been undertaken by the Health Care Financing Administration to inform those already receiving Medicare that these programs exist. Additionally, two demonstration projects are underway by the Social Security Administration, one through which the Social Security Administration office will set up appointments for eligible Medicare recipients with state Medicaid offices, and another through which Social Security will directly enroll qualified individuals in the programs.

Medicaid fills the long-term care gap left by Medicare. However, in order to qualify for Medicaid coverage of long-term care, individuals must first exhaust most of their assets and annual family incomes—or at least "spend down" these resources to a very low level and leading to premature institutionalization. Essentially, Medicaid offers long term care protection after catastrophe has occurred (Moon 1996).

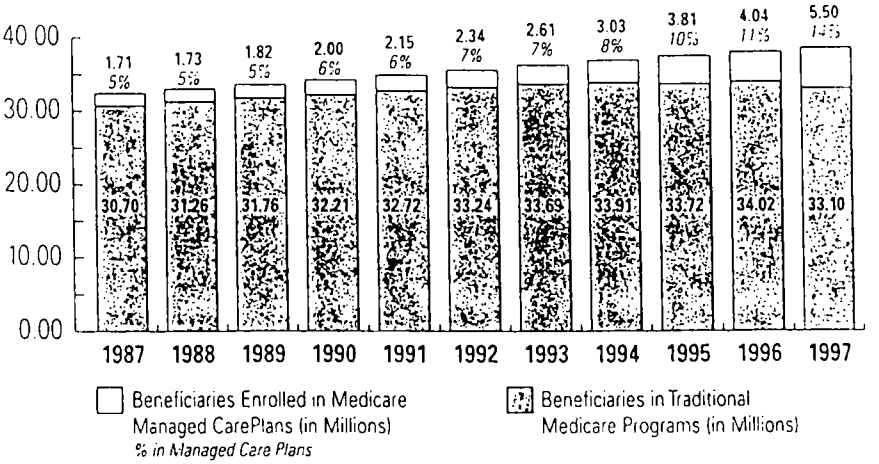
Medicaid is today the largest payer of long-term care services, comprising nearly one-half of all national health payments for nursing home care. Medicaid primarily pays for nursing home services and, to a limited extent, for home—community-based—care services. As discussed above, however, Medicaid only covers long-term care for those who are poor or who have spent much of their income and assets on health and long-term care. In essence, the Medicaid program has become the long-term care insurance program of last resort for many of those on Medicare—largely because the costs of long-term care are out of reach for so many individuals. The annual cost of a nursing home stay ranges from $30,000 to more than $60,000 in high cost areas (Moon 1996). Most women and

families cannot afford to bear these costs.

Private long-term care insurance is not an option for most women. The average annual premiums for a five-year policy for an individual age 65 to 69 were over $2,500 in 1998 and over $8,000 per year for a 75-year-old person (Long Term Care Campaign 1998). The women most in need of long-term care are also very likely to have low incomes. These women are unlikely to have assets on which they can draw to pay for private, long-term care insurance.

Medicare and Managed Care

Figure 5
Medicare Managed Care and Traditional Enrollment, 1987-1997



Source: 1987-94 and 1996 data from Health Care Financing Administration, Profiles of Medicare, 30th Anniversary (May 1996). 95 1995 data from Health Care Financing Administration, Office of Prepaid Health Care Operations and Oversight, 1997 data from Health Care Financing Administration, "Managed Care in Medicaid and Medicare Fact Sheet" (represents enrollment as of August 1997).

The Medicare program is facing the challenge of continuing to guarantee access to health care and economic security to elderly and disabled citizens while bringing costs under control (Davis 1996). Many policymakers see moving individuals into managed care plans as part of the solution.

In recent years, the managed care industry has moved aggressively to enroll individuals in Medicare managed care plans—a development that has important implications for older women (OWL 1997). In 1997, 5.5 million individuals were enrolled in Medicare managed care plans. Between 1987 and 1997, enrollment in Medicare managed care plans almost tripled from five percent to 14 percent of the Medicare population.

Defining managed care is becoming an increasingly complex process. From its origins in health maintenance organizations (HMOs), managed care now includes many hybrid forms. At the broadest level, managed care organizations encompass a wide array of organizational structures which restrict enrollees' choice of physicians and certain expensive treatments but charge lower out-of-pocket costs for covered health care services.

Under managed care, physicians, hospitals, and other providers agree to the rules, guidelines, and payment levels set forth by the managed care plans in exchange for access to plan enrollees. A primary care doctor often serves as a "gatekeeper" in the managed care plan, controlling access to specialists and procedures (Schoen 1995).

Managed care contains built-in incentives to underuse services, particularly specialty care. A capitated fee system creates incentives for gatekeepers to limit specialty care and

expensive treatments. A common practice in managed care plans, capitation pays physicians and hospitals a fixed amount per person enrolled in the physician practice or physician-hospital mini-network.

Implications for Women

Women represent the majority of Medicare managed care enrollees, most of whom are enrolled in Medicare health maintenance organizations, a reflection of their overall participation in the Medicare program. As of March 1997, approximately 2.9 million women and 2.2 million men were enrolled in Medicare managed care plans (HCFA 1997).

Managed care has produced mixed results for older women. On the plus side, women enrolled in Medicare HMOs have, on average, lower cost-sharing and increased benefits. Access to preventive and screening services (recently added to traditional Medicare benefits)—including mammography, clinical breast exams, Pap smears, bone scans, and blood pressure screening—is crucial to ensuring women's health as they age. Importantly, most HMOs provide coverage for prescription drugs, hearing, vision and dental services. By providing these important health services to women, often with minimal cost-sharing requirements and low additional premiums, managed care has improved access to certain health services for many women (Wyn, Brown, and Yu 1996).

With its emphasis on prevention and screening, managed care has the potential to identify and treat diseases at early stages. One study showed that HMOs diagnosed certain diseases—colon cancer, cervical cancer, and melanoma—at an earlier stage than fee-for-service plans (Riley, Tudor, and Chiang 1994). A second study just released by the Health Care Financing Administration reported that women enrolled in Medicare HMO plans were diagnosed at an earlier stage of breast cancer than were women in Medicare fee-for-service plans (Boodman 1999).

One of the promises of managed care is improved coordination of services. This feature is particularly important to older women with chronic conditions and those who require many, complex services from different sources. In fact, the evidence suggests that managed care does coordinate care better than fee-for-service plans. A 1994 study of primary care found that coordination of care was highest among HMO patients (Meyer, Wilow-Carroll, and Regenstein 1996).

At the same time, Medicare managed care has given rise to a variety of concerns. Payment of a capitated fee for each enrollee can encourage providers to deliver fewer or less-expensive services. This is a serious problem for older women, especially those with disabilities, many of whom have complex health conditions that require care from a number of specialists (Meyer, Wilow-Carroll, and Regenstein 1996).

There is evidence of poorer health outcomes for chronically ill older people participating in managed care—an issue of particular concern to older women who often have one or more chronic conditions.

There is evidence of poorer health outcomes for chronically ill older people participating in managed care—an issue of particular concern to older women who often have one or more chronic conditions. A recent study which tracked Medicare beneficiaries over a four-year period found that declines in physical health were more common among those in HMOs (54 percent) than among those individuals in fee-for-service plans (28 percent) (Ware et al. 1996).

Another study showed that stroke patients enrolled in Medicare managed care were more likely to be discharged to a skilled nursing facility than to a rehabilitation hospital than those in traditional Medicare. The authors suggest that care in a rehabilitation hospital, which is more expensive than a skilled nursing facility, can improve the health outcomes of stroke patients (Retchin et al 1997).

Additionally, continuity of care may be disrupted in Medicare managed care plans when physicians leave plans or when plans leave Medicare. Older women often have long-term relationships with providers who are familiar

with their medical and family histories. If women are required to switch to a new provider in a managed care network, the benefits derived from having a physician knowledgeable about the patient's health condition can be lost (Meyer, Wilow-Carroll, and Regenstein 1996).

A study of Medicare beneficiaries by the Inspector General's Office of the US Department of Health and Human Services found substantial dissatisfaction among individuals enrolled in managed care plans. Problems included a lack of awareness about their appeal rights, delays in getting medical appointments, and difficulties getting referrals to specialists. Many of those who had disenrolled from managed care plans reported a decline in their health status while enrolled in managed care plans (Department of Health and Human Services 1995).

Medicare+Choice

The Balanced Budget Act of 1997 created Medicare+Choice, a Part C of Medicare, which broadens the range of private health plans that may contract with Medicare to provide care. The goal of Medicare+Choice is to increase participation in HMOs and other private plans. Under the new program, the range of plan options that will be available will expand to include preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and on an experimental basis, medical savings accounts (MSAs) together with a high-deductible insurance plan (see box).

To date, the Health Care Financing Administration has received only a few applications from managed care plans and insurance companies interested in offering new Medicare+Choice options. However, older women need to pay close attention to developments in this area. A key issue for women requiring care for chronic conditions is whether the plan will remain affordable, and provide necessary services without limitations.

Individuals who enroll in Medicare+Choice plans will continue to pay their Part B premium, but a private plan will deliver all Medicare-covered benefits. For the most part, Medicare+Choice plans are required to provide the basic Medicare benefit package.

Medicare+Choice Options

HMO: Individuals enrolled in an HMO obtain services from a designated network of doctors, hospitals, and other health care providers usually with little or no out-of-pocket payments.

PPO: Individuals obtain services from a network of health care providers established by a health plan. Unlike an HMO, individuals can choose to go to providers who are not in the plan's network and the plan will pay a portion of the costs.

PSO: PSO's are similar to HMOs except they are set up by a group of doctors and hospitals who assume the financial risk of providing comprehensive services to Medicare enrollees

Private Fee-for-Service: A private indemnity health insurance policy which does not limit individuals to using a network of providers. Under this type of plan, there is no limit on the monthly premium that individuals may be charged for basic Medicare benefits.

MSA: With this option, offered on a demonstration basis, individuals select a high deductible catastrophic plan. Medicare pays the monthly premium for this plan and makes a deposit into a tax-free medical savings account for the individual, who then may draw from their MSA to meet any health care expenses.

Source: *The Henry J. Kaiser Family Foundation 1999.*

Through the year 2002, individuals who opt for the new Medicare+Choice program will continue to be able to enroll in a plan, switch plans, or disenroll from a plan at any time during the year. After that time, certain restrictions will go into effect. Beginning in 2003, those in Medicare+Choice plans will generally not be allowed to switch plans until the next annual enrollment period (Kaiser Family Foundation 1999).

Important questions remain about whether managed care will be able to deliver quality health services to elderly and disabled Americans while achieving financial savings. It is crucial that women educate themselves about how to protect themselves in this rapidly shifting health care environment.

Making Wise Decisions About a Medicare Plan

Before enrolling in a Medicare plan, whether traditional fee-for-service or a managed care option, women need specific information about whether a particular plan offers a choice of doctors, easy access to specialists without unexpected bills, coverage when away from home, prescription drug coverage—and whether the plan is affordable and can be coordinated with Medicaid. Women should ask the following questions before selecting a Medicare plan:

1. **Does this option offer a choice of any doctor?**
   The traditional Medicare program offers Medicare allows choice of any doctor, whereas managed care plans typically limit that choice. Increasingly, managed care plans allow enrollees to see doctors outside the plan's network at extra cost to the enrollee. Before enrolling in a managed care plan, a woman should find out whether her current physician is a member of the plan—how limited her choices will be—and how much it will cost to see doctors outside the plan's network.
2. **Does the option provide easy access to specialists, without additional charges?**
   Traditional Medicare does not limit access to specialty care whereas most managed care plans require a referral from a primary care provider before a specialist can be seen. Women need to learn the managed care plan's procedures for referring patients to specialty care. They also should find out if the plan's network includes the specialists they may need to see and whether those specialists are physically accessible.
3. **Does the option provide coverage away from home?**
   Traditional Medicare covers health care anywhere in the United States, whereas many managed care plans require prior authorization before health care can be received from providers outside the plan's network or geographic area. Women need to ask what the plan's rules are for getting emergency care when away from home.
4. **Does the option cover prescription drugs?**
   Traditional Medicare does not cover outpatient prescription drugs, whereas many managed care plans do. However, many managed care plans only cover those prescription drugs included on the plan's list. Women need to find out whether the pharmaceuticals they currently use are on the plan's formulary, and what would happen if they needed a drug outside the plan's list.
5. **Is the option affordable for someone on a fixed budget?**
   Women with traditional Medicare can incur significant costs from premiums, deductibles, and the costs of uncovered services such as prescription drugs. Combining original Medicare with a Medigap policy can help defray these costs. Typically managed care plans are less expensive than original Medicare—and provide some additional benefits—although the costs of these plans is rising.
6. **Will the option work with Medicaid?**
   Medicaid covers some of the Medicare out-of-pocket costs incurred by many low-income women. If a woman receives Medicaid, she should make sure that switching to a managed care plan will not jeopardize her eligibility. She should also make sure that Medicaid will continue to cover her copayments.

Medicare Reform Proposals

The rapidly growing Medicare population—program rolls are projected to swell to 76 million by the year 2030—and the cost of providing services, have raised concerns about how to provide and pay for health care in the years ahead. A broad array of proposals has been made to reform Medicare in recent years.

Some of the proposals would retain Medicare's basic framework, but make changes to reduce government spending and individuals' contributions to the program. Other proposals call for a more radical restructuring of Medicare, replacing the social insurance features of the program with a system of premium supports. And still other proposals would enhance individuals' protections and access to heath care under Medicare.

National Bipartisan Commission on the Future of Medicare

In 1997, Congress established the National Bipartisan Commission on the Future of Medicare to recommend proposals for strengthening and improving the Medicare program. While this 17-member panel of lawmakers, policy experts, and citizens failed to achieve consensus on any recommendation, several parts of the plan presented to the Commission by the two Chairmen, Sen. John Breaux (D-LA) and Rep. Bill Thomas (R-CA), are now under consideration by the Congress, and could have adverse consequences for women.

Restructuring the Program into Premium Supports. The centerpiece of the Breaux-Thomas proposal would fundamentally restructure Medicare, replacing the social insurance nature of the program with a "premium support" model. Under this system, Medicare would provide a fixed amount of money that would be applied by the elderly and disabled toward the cost of health coverage. Individuals would have a choice of private plans which would offer at least a basic level of benefits. Regardless of the health plan selected, or the cost of premiums for the plan, the government would pay a specific amount for each enrollee, based on the cost of the average plan.

Transforming the Medicare system into a "premium support" consistency program would jeopardize the guaranteed Medicare benefits women have come to rely on. As a social insurance program, Medicare is a program of clearly defined benefits. In the "premium support" model, as described by Sen. Breaux and Rep. Thomas, a range of plans would be offered with higher-cost plans providing a broader range of benefits. While wealthier individuals would probably be able to afford the higher premiums associated with better plans, those with modest means, primarily women, would have strong financial incentives to enroll in low-cost plans with limited benefits.

...a premium support program would jeopardize the guaranteed Medicare benefits women have come to rely on...

People are spending a rising share of their income on health. With "premium supports," individuals could face even higher out-of-pocket spending (Moon 1999). This is because premium supports would undermine the ability of Medicare to pool risk. With any proposal that suggests using multiple risk pools, there is the danger that plans, in order to save money, would avoid the sickest patients. While this problem can be addressed by making higher payments to plans that enroll sicker individuals, any

experts agree that it continues to be difficult to accurately calculate and adjust such payments to plans (risk adjustment). Women, with their lower incomes and chronic health problems, would be at greater risk than men for much higher out-of-pocket costs for the difference between Medicare's payment and the plan's cost.

Raising Eligibility Age for Medicare. The Breaux-Thomas plan proposes to raise the eligibility age for Medicare to conform with that of the Social Security program. The age for full Social Security benefits will gradually rise in the next century, until it reaches age 67 in the year 2027 for people born in 1960 or after. Increasing the age for Medicare eligibility from 65 to 67 would have a disproportionately negative impact on women—large numbers of whom would be left without any insurance coverage at all until age 67.

In 1996, three out of five uninsured persons between the ages of 62 and 65 were women. The high cost of premiums in the individual market is the most common reason these women are uninsured (Smolka, Brangan, and Figueiredo 1998). Raising the Medicare eligibility age would leave many more women without insurance coverage. Some have proposed that these individuals be given the option of "buying in" to the Medicare program by paying the full costs of the Medicare premiums themselves. However, their lower incomes would prevent many women from paying the full premium price of $5,041 a year (McDevitt 1998).

Provide limited coverage for prescription drugs. Another proposal being explored would provide some coverage for prescription drugs. The Breaux-Thomas plan includes paying for the medicine of all elderly persons with incomes up to 135 percent of poverty. The proposal also would require health plans to make available a "high option" plan which would offer coverage above Medicare's standard benefit package, and include coverage for outpatient prescription drugs. Any effort to extend prescription drug coverage is a step in the right direction, but the consequences for women, who have significant out-of-pocket spending for prescriptions, are uncertain.

Those with low incomes could benefit from the initiative, but outcome for those choosing the "high option" plan is less certain. If healthier individuals are the majority of those utilizing this option, the costs of prescription drugs could decline. However if only the sickest individuals enroll, the cost of coverage for prescription drugs could increase.

Others have proposed to provide prescription drug coverage to the Medicare population without limiting it to the very poorest. Such proposals would clearly benefit a large share of women on Medicare who have incomes above 135 percent of poverty and are without other insurance that covers their prescription expenses.

Federal Initiatives

A number of proposals have been introduced by the Administration and lawmakers in both chambers covering some of the issues discussed in this report.

In his fiscal year 2000 budget, President Clinton included several initiatives that affect Medicare and the health of older Americans:

- A proposal to apply 15 percent of the projected federal surplus to the Medicare Trust Fund in order to extend its solvency to 2025.
- A package of programs, including respite care, counseling and information initiatives, as well as a $1000 tax credit, to provide some federal assistance for the enormous financial and personal burdens long-term care places on those requiring assistance as well as on their caregivers.
- A Medicare early buy-in plan that would enable individuals between the ages of 62 and 65 to receive Medicare coverage by paying the full premium for the program, including an add-on to Part B premiums after retirement.
- A managed care bill of rights that would provide a package of consumer protections to private health care plans similar to that covering all federal health care programs since 1998.

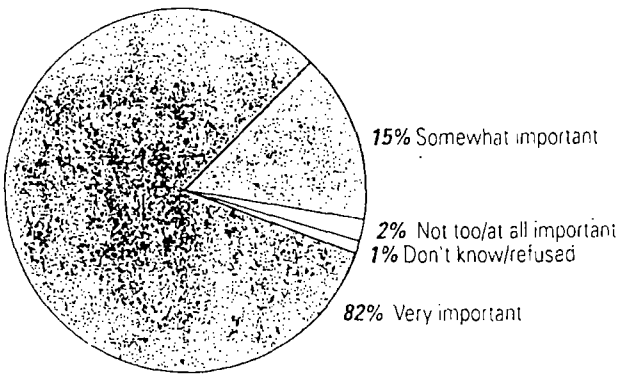
In addition, legislators have introduced a number of bills that would enhance Medicare to cover prescription drugs, add low-income protections to the early Medicare buy-in, and extend protections to those enrolling in Medicare+Choice plans.

Recommendations and Conclusions

The debate over how to strengthen Medicare will continue well into the 21st century as the baby boom moves into retirement and Medicare costs continue to rise. Older women have a stake in preserving and enhancing the Medicare program to ensure that they and future generations will have access to quality, affordable health care. In fact, 82 percent of women of all ages say it is very important to preserve Medicare (Kaiser Family Foundation/Harvard School of Public Health 1998; see Figure 6).

OWL supports proposals that would improve Medicare's benefit package, enhance financial protections for low-income women, improve protections in managed care, expand access to Medicare coverage, and address fiscal problems to preserve Medicare for the next generation.

Figure 6
Most Women Say it's Very Important to Preserve Medicare



Source: Kaiser Family Foundation/Harvard School of Public Health National Survey on Medicare, October 20, 1998

Improve Medicare benefit package

Medicare's benefit package could be improved in several ways that would benefit women: the addition of coverage for prescription drugs; the expansion of Medicare to include long-term care; and the introduction of stop-loss protection.

Prescription drugs are a crucial component of chronic care management for older women today. Seventy-eight percent of all women receiving Medicare use prescription drugs regularly. Because Medicare does not cover them (except when used in a hospital or other health care institution), women's out-of-pocket costs for prescription drugs are substantial. Guaranteeing full coverage of prescription drugs for all those on Medicare would make a significant contribution to making the program a more comprehensive health insurance plan for women.

Increasing **long-term care coverage** in the Medicare program would fill the most glaring gap in the program. Women's long life expectancy and high incidence of chronic illness increase their probability of needing long-term care assistance. The current patchwork system of private insurance and Medicaid is far from adequate. Enhancing Medicare coverage for services such as home and community-based care and respite care could provide women and families with greater peace of mind in old age.

Improve financial protections

Improving access to the Medicare low-income protections (QMB and SLMB) would greatly benefit low-income women. Because women are overrepresented among the elderly poor, QMB and SLMB programs are of particular importance to them. However, many women who qualify

for these benefits still do not receive them—either because they are unaware of the program or because they are reluctant to go to welfare offices to apply. An important option for reform would be to enable individuals to apply directly through the Medicare or Social Security programs for low-income benefits.

The lack of **stop-loss protection**—a cap on the maximum amount individuals must pay for covered health care—exposes older women with serious health problems to the risk of catastrophic medical expenses. This is particularly a problem for women who are not covered by retiree health insurance, Medigap, or Medicaid. The addition of stop-loss protection to Medicare would help defray the high costs of health care for millions of women.

Guaranteeing full coverage of prescription drugs...would make a significant contribution to making the program a more comprehensive and affordable health insurance plan for women.

Improve protections for individuals in managed care

As a result of federal law, those in Medicare managed care now enjoy greater statutory protections than those available in private managed care plans. For example, the law permits women in Medicare managed care plans to self-refer to a women's health specialist for routine and preventive women's health care services. However, the Health Care Financing Administration needs to enforce these protections to ensure that individuals in managed care plans get the protections to which they are entitled. The laws protecting Medicare managed care enrollees could be further strengthened.

Further, as consumer choices in health care continue to proliferate, in order to enhance consumer education and protect the vulnerable from misleading information about their health care choices, the Health Care Financing Administration should undertake, and strictly enforce, initiatives to ensure that enrollees receive unbiased, objective, and standardized information about what a particular plan covers, and options they may pursue if dissatisfactions arise.

Additionally, it is particularly important for women that whatever safeguards are adopted are designed to protect those who are chronically ill. One important example of a proposal that would benefit chronically ill women is one that would allow the use of specialists as primary care physicians, without requiring referral from a "gatekeeper" each time care is needed. Another example would be support to the number of counseling programs available to those requiring assistance with their health care choices or plans.

Expand access to Medicare coverage

Women make up the majority of uninsured persons between the ages of 62 and 65. Expanding Medicare coverage to people in this younger group would provide insurance protection to women who are at risk of significant health care costs. Bringing early retirees into the Medicare program would have other advantages as well, including broadening the base of support for the program. Low-income subsidies are necessary if such a program is to be accessible to most women.

Address fiscal problems to preserve Medicare

All those on Medicare—women as well as men—have a stake in ensuring that the Medicare program is fiscally sound, both for themselves and for future generations.

Many experts agree that the fiscal challenges facing Medicare are due to the rise in the number of people who will be covered by Medicare, rather than a failure of the program to control the growth in per capital spending. While Medicare faces real fiscal problems, it is not necessary or desirable to radically restructure the program. Such a "crisis" response would, in fact, succeed only in eroding the benefits and protections Medicare currently affords to older Americans. (Feder and Moon 1999) Applying some of the budget surplus to the Medicare program would make it possible to extend the program well into the 21st century—providing new revenues to cover a generation of retiring baby boomers. This would provide time for careful consid-

eration of reforms that would strengthen Medicare without harming women or other vulnerable groups.

It is also important to explore strategies for controlling costs within Medicare. In the past, policymakers have effectively contained Medicare costs by restraining the growth of payments to doctors, hospitals, and other health care providers. Since its inception, Medicare has, on average, controlled costs as well as private insurance, limiting increases in payments to physicians and hospitals, and by paying for inpatient care on a prospective basis (under which Medicare pays providers a predetermined amount per unit of service). The Balanced Budget Act of 1997 further restrained payments to providers and plans. Medicare must carefully build on its successes and expand its efforts to control costs without reducing or eliminating needed services. Efforts to streamline program administration and eliminate fraud and abuse should be enhanced.

As our nation's leaders debate the future directions which Medicare might take, it is imperative that the impact of different options for change on women be given careful consideration. Millions of women depend upon Medicare today—and millions more will depend upon the program in the future. More often than not, the face of Medicare is a woman's face. And that woman is likely to have limited income and significant health care needs.

Reducing Medicare benefits, exposing the vulnerable to added financial cost, and restricting access to quality health services could "fix" Medicare's fiscal problems while creating new problems for the most vulnerable...

Medicare was enacted almost 35 years ago to provide our nation's elderly with access to high quality, affordable health care. The demands on the program have grown over time. Longer lives, the aging of the baby boom generation, and the rising costs of medical technology and specialized care will continue to place considerable strain on the Medicare program in the years ahead.

Yes, changes are needed to preserve and strengthen Medicare for future generations. But the way to shore up the Medicare program for the 21st century is not by taking away the protections it offers today. Reducing Medicare benefits, exposing the vulnerable to added financial costs, and restricting access to quality health services could "fix" Medicare's fiscal problems while creating new and more serious problems for the most vulnerable elderly and Americans with disabilities.

Any changes made to Medicare must not threaten women's ability to get the health care they need. As one of our nation's most vulnerable groups of citizens, women present policy-makers with an opportunity to make sure that reforms do not backfire. When considering options for reform, lawmakers must ask themselves: how will these reforms affect women? If they benefit women, then they will benefit the majority of Americans. A sound Medicare program for women is a sound program for all.

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Copies of this report are available from OWL, 666 11th Street, NW, Suite 700, Washington, D.C. 20001.

OWL

OWL is a national membership organization that strives to improve the status and quality of life for midlife and older women.

OWL's 15,000 volunteer members conduct public education campaigns through its 75 chapters nationwide. Membership in OWL is $25 annually. For additional information, contact OWL at 666 11th Street, NW, Suite 700, Washington, D.C. 20001 or call 1/800/825-3695 or 202/783-6686.

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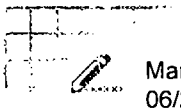

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THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 29, 1999

REMARKS OF THE PRESIDENT
ON STRENGTHENING MEDICARE

The East Room

3:23 P.M. EDT

THE PRESIDENT: Thank you very much, and good afternoon. I would like to welcome all of you to the White House. I appreciate the presence here of Secretary Shalala, Secretary Rubin, Deputy Secretary Summers, Social Security Commissioner Apfel, OPM Director Janice Lachance. I thank all the people on the White House staff who are here who worked so hard on this proposal, including our OMB Director, Jack Lew; and Gene Sperling, Bruce Reed, Chris Jennings, and of course, John Podesta.

I welcome the leaders of groups representing seniors, the disability community and the health care industry. I would especially like to welcome the very large delegation of members of Congress who are here today. Four of them were here at the inception of Medicare -- Senator Kennedy, Congressman Dingell, Congresswoman Mink, and Congressman Conyers. This must be a particularly happy day for them.

I thank the Senators who are here -- Senator Daschle, Senator Roth, Senator Kennedy, Senator Conrad, Senator Baucus, Senator Dorgan, Senator Rockefeller, and Senator Breaux.

I thank the members of the House here. There are a large number of Democrats here and I think virtually all the members of the leadership -- Mr. Gephardt, Mr. Bonior, Congresswoman DeLauro, Mr. Frost, Congressman Rangel, Congressman Lewis. I would like to thank the Republican House members who have come -- Mr. McCrery, Mr. Whitfield and Mr. Thomas, especially.

When Senator Breaux and Congressman Thomas issued their commission report, I said that I would do my best to build on it; that I had some concerns about it, but that I thought that there were elements in it which deserved support and serious consideration. Their presence here today indicates that we can all raise concerns about each other's ideas without raising our voices; and that if we're really committed to putting our people first, we can reach across party lines and other lines to work together.

And I am very grateful for their presence here and for the presence of all the members of Congress here from both parties. It augers well for this announcement today and for the welfare of our republic. (Applause.)

In just a few days we will celebrate the last 4th of July of the 20th century -- 223 of them. Our government, our country was created based on the ideal that we are all created equal, that we should work together to do those things that we cannot do on our own, and that we would have a permanent mission to form a more perfect union.

The people who got us started understood that each generation of Americans would be called upon to fortify and renew our nation's most fundamental commitments -- to always look to the future. I believe our generation has begun to meet that sacred duty, for, at the dawn of a new century, America is clearly a nation in renewal.

Our economy is the strongest in decades, perhaps in our history. Our nation is the world's leading force for freedom and human rights, for peace and security -- with our Armed Forces showing once again in Kosovo their skill, their strength, and their courage. Our social fabric, so recently strained, is on the mend, with declining rates of welfare, crime, teen pregnancy and drug abuse, and 90 percent of our children immunized against serious childhood diseases for the first time in our history.

Our cities, once in decline, are again vibrant with economic and cultural life. Even our rutted and congested interstate highways, thanks to the commitments of this Congress, are being radically repaired and expanded all across America -- I must say, probably to the exasperation of some of our summer travelers.

This renewal is basically the consequence of the hard work of tens of millions of our fellow citizens. It is also, however, clearly the result of new ideas and good decisions

made here in this city -- beginning with the fiscal discipline pursued since 1993, the reduction in the size of government and controlling spending while dramatically increasing investments in education, health care, biomedical research, the environment and other critical areas. The vast budget deficits have been transformed into growing budget surpluses. And America is better prepared for the new century.

But we have to use this same approach of fiscal discipline plus greater investment to deal with the great challenge that we and all other advanced societies face, the aging of our nation, and, in particular, to deal with the challenge of Medicare, to strengthen and renew it.

Today, I ask you here so that I could announce the details of our plan to secure and modernize Medicare for the 21st century. My plan will use competition and the best private sector practices to secure Medicare in order to control costs and improve quality. And it will devote a significant portion of the budget surplus to keep Medicare solvent.

But securing Medicare is not enough. To modernize Medicare, my plan will also create a much better match between the benefits of modern science and the benefits offered by Medicare. It will provide for more preventive care and help our seniors afford prescription drugs. The plan is credible, sensible and fiscally responsible. It will secure the health of Medicare while improving the health of our seniors. And we can achieve it.

The stakes are high. In the 34 years since it was created, Medicare has eased the suffering and extended the lives of tens of millions of older and disabled Americans. It has given young families the peace of mind of knowing they will not have to mortgage their homes or their children's futures to pay for the health care of their parents and grandparents. It has become so much a part of America it is almost impossible to imagine American life without it. Yet, life without Medicare is what we actually could get unless we act soon to strengthen this vital program.

With Americans living longer, the number of Medicare beneficiaries is growing faster -- much faster -- than the number of workers paying into the system. By the year 2015, the Medicare trust fund will be insolvent -- just as the baby boom generation begins to retire and enter the system, and eventually doubling the number of Americans who are over 65.

I've often said that this is a high-class problem. It is the result of something wonderful -- the fact that we Americans are living a lot longer. All Americans are living longer, in no small measure because of better health care, much of it received through the Medicare program.

President Johnson said when he signed the Medicare bill in 1965, "The benefits of this law are as varied and broad as the marvels of modern medicine itself." Yet modern medicine has changed tremendously since 1965, while Medicare has not fully kept pace.

The original Medicare law was written at a time when patients' lives were more

often saved by scalpels than by pharmaceuticals. Many of the drugs we now routinely use to treat heart disease, cancer, arthritis, did not even exist in 1965. Yet Medicare still does not cover prescription drugs.

Many of the procedures we now have to detect diseases early, or prevent them from occurring in the first place, did not exist in 1965. Yet Medicare has not fully adapted itself to these new procedures.

Many of the systems and organizations that the private sector uses to deliver services, contain costs, and improve quality -- such as preferred provider organizations and pharmacy benefit managers did not exist in 1965. Yet, under current law, Medicare cannot make the best use of these private sector innovations.

Over the last six and a half years we have taken important steps to improve Medicare. When I took office, Medicare was scheduled to go broke this year. But we took tough actions to contain costs, first in '93, and then with a bipartisan balanced budget agreement in 1997. We have fought hard against waste, fraud and abuse in the system, saving tens of billions of dollars.

These measures have helped to extend the life of the trust fund to 2015. But with the elderly population set to double in three decades, with the pace of medical science quickening, we must do more to fully secure and modernize Medicare for the 21st century.

The plan I release today secures the fiscal health of Medicare, first, by providing what every objective expert has said Medicare must have if it is to survive -- more resources to shore up its solvency. As I promised in the State of the Union address, the plan devotes 15 ~~percent~~ of the federal budget, over 15 years, to Medicare -- federal budget surplus. That is the right way to use this portion of the surplus.

There are a thousand ways to spend the surplus, all of them arguable attractive, but none more important than first guaranteeing our existing obligation to secure quality health care for our seniors. First things, first. (Applause.)

In addition to these new resources, we must use the ~~most modern and innovative~~ means to keep Medicare spending in line while rigorously maintaining -- indeed, improving -- quality. So the second part of the plan will bring to the traditional Medicare program the best practices from the private sector. For instance, doctors who do a superior job of caring for heart patients with complex medical conditions will be able to offer patients lower co-payments, thus attracting more patients, improving more lives, saving their patients, and the system money.

Third, the plan will use the forces of competition to keep costs in line, by empowering seniors with more and better choices. Seniors can ~~choose to save money by~~ choosing lower-cost Medicare managed care plans under our plan, without being forced out of the traditional Medicare program by larger than normal premium increases.

And we will make it easier for seniors to shop for coverage based on price and quality, because all private plans that choose to participate in Medicare will have to offer the same core benefits. Consumers shouldn't be forced to compare apples and oranges when shopping for their family's health care.

Fourth, we will take action to make sure that Medicare costs do not shoot up after 2003, when most of the cost containment measures put in place in 1997 are set to expire. And to make sure that health care quality does not suffer, my plan includes, among other things, a quality assurance fund, to be used if cost containment measures threaten to erode quality. And given the debates we're having now on the consequences of the decisions we made in 1997, I think that is a very important thing to put in this plan. (Applause.)

These steps will secure Medicare for a generation. But we should also modernize benefits as well. Over the years, as I said earlier, Medicare has advanced -- medical care has advanced in ways that Medicare has not. We have a duty to see that Medicare offers seniors the best, and the wisest, health care available.

One such rapidly advancing area of treatment is preventive screening for cancer, diabetes, osteoporosis, and other conditions -- screenings which, if done in time, can save lives, improve the quality of life, and cut health care costs.
Therefore, my plan will eliminate the deductible in all co-payments for all preventive care under Medicare. (Applause.)

It makes no sense for Medicare to put up roadblocks to these screenings and then turn around and pick up the hospital bills that screenings might have avoided. No senior should ever have to hesitate -- as many do today -- to get the preventive care they need.

To help cover the cost of these and other crucial benefits and strengthen the Medicare Part B program, we will ask beneficiaries to pay a small part of the cost of other lab tests that are prone to overuse, and we will index the Part B deductible to inflation.

Nobody would devise a Medicare program today, if we were starting all over, without ~~including~~ a prescription drug benefit. (Applause.) There's ~~a good reason for this.~~ We ~~all know that these prescription~~ drugs both save lives and improve the quality of life. Yet, Medicare currently lacks a drug benefit. That is a major problem for millions and millions of seniors -- and not just those with low incomes. Of the 15 million Medicare beneficiaries who lack prescription drug benefits today, nearly half are middle class Americans. And with prescription drug prices rising, fewer and fewer retirees are getting drug coverage through their former employer's health programs.

My plan will offer an affordable prescription drug benefit to all Medicare recipients, with additional help to those with lower incomes, paid for largely through the cost savings I have outlined. It will cover half of all prescription drug costs, up to $5,000 a year, when fully phased in, with no deductible -- all for a modest premium that will be less than half

the price of the average private Medigap policy.

It's simple: If you choose to pay a modest premium, Medicare will pay half of your drug prescription costs, up to $5,000. (Applause.) This is a drug benefit our seniors can afford at a price America can afford.

Seniors and the disabled will save even more on their prescription drugs under my plan because Medicare's private contractors will get volume discounts that they could never get on their own. By relying on private sector managers, I believe that my plan will help Medicare beneficiaries and ensure that America continues to have the most innovative research and development oriented pharmaceutical industry in the world. (Applause.)

With the steps I have outlined today, we can make a real difference in our people's lives. And I believe the good fortune we now enjoy obliges us to do so. In a nation bursting with prosperity, no senior should have to choose between buying food and buying medicine. But we know that happens. (Applause.) I'll never forget the first time I ever met two seniors on Medicare who looked at me and told me that they were choosing, every day, between food and medicine. That was almost seven years ago, but it still happens today.

At a time of soaring surpluses, no senior should wind up in the hospital for skimping on their medication to save money. But that also happens today, in 1999. At a moment of such tremendous promise for America, no middle-aged couple should have to worry that Medicare will not be there when they retire, that a lifetime's worth of investment and savings could be swallowed up by medical bills. If we want a secure life for our people, we must commit ourselves, as a country, to secure and modernize Medicare, and to do it now.

In the months before the election season begins, we can put partisanship aside and make this a season of progress. With our economy strong, our people confident, our budget in surplus, I say again, we have not just the opportunity, but a solemn responsibility, to fortify and renew Medicare for the 21st century.

It's the right thing to do for our parents and our grandparents. It's the right thing to do for the children of this country. It is the right thing to do so that, when we need it, the burden of our health care costs does not fall on the children, and hurt their ability to raise our grandchildren.

Like every generation of Americans before us, our generation has begun to fulfill our historic obligation to strengthen our fundamental commitments, and keep America a nation of permanent renewal. Just a few days before our last Independence Day of this century, let us commit again to do that with Medicare.

Thank you, and God bless you. (Applause.)

END 3:44 P.M. EDT

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

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

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

- **Gives traditional Medicare new private sector purchasing and quality improvement tools.** The President's proposal would make the traditional fee-for-service program more competitive through the use of market-oriented purchasing and quality improvement tools to improve care and constrain costs. It would provide new or broader authority for competitive pricing within the existing Medicare program, incentives for beneficiaries to use physicians who provide high quality care at reasonable costs, coordinating care for beneficiaries with chronic illnesses, and other best-practice private sector purchasing mechanisms. Savings: $25 billion over the next 10 years.

- **Extends competition to Medicare managed care plans by establishing a "Competitive Defined Benefit" while maintaining a viable traditional program.** The Competitive Defined Benefit (CDB) proposal would, for the first time, inject true price competition among managed care plans into Medicare. Plans would be paid for covering Medicare's defined benefits, including the new drug benefit, and would compete over cost and quality. Price competition would make it easier for beneficiaries to make informed choices about their plan options and would, over time, save money for both beneficiaries and the program. The CDB would do so by reducing beneficiaries' premium by 75 cents of every dollar of savings that result from choosing plans that cost less than traditional Medicare. Beneficiaries opting to stay in the traditional fee-for-service program would be able to do so without an increase in premiums. Savings: $8 billion over the next 10 years, starting in 2003.

- **Constrains out-year program growth, but more moderately than the Balanced Budget Act (BBA) of 1997.** To ensure that program growth does not significantly increase after most of the Medicare provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates, but are more modest than those included in the BBA. These proposals along with the modernization of traditional Medicare would reduce average annual Medicare spending growth from an estimated 4.9 percent to 4.3 percent per beneficiary between 2002 and 2009. Savings: $39 billion over next 10 years (including interactions and premium offsets).

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

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

- **Establishes a new voluntary Medicare "Part D" prescription drug benefit that is affordable and available to all beneficiaries.** The historic outpatient prescription drug benefit would:

  - Have no deductible and pay for half of the beneficiary's drug costs from the first prescription filled each year up to $5,000 in spending ($2,500 in Medicare payments) when fully phased-in by 2008.

  - Ensure beneficiaries a price discount similar to that offered by many employer-sponsored plans for each prescription purchased – even after the $5,000 limit is reached.

  - Cost about $24 per month beginning in 2002 (when the coverage is capped at $2,000 in spending) and $44 per month when fully phased-in by 2008. (This is one-half to one-third of the typical cost of private Medigap premiums.)

  - Ensure that beneficiaries with incomes below 135 percent of poverty ($11,000/$15,000 single/couples) would not pay premiums or cost sharing for Medicare drug coverage. Those with incomes between 135 and 150 percent of poverty would receive premium assistance as well. The Federal government would assume all of the costs of this benefit for those above poverty.

  - Provide financial incentives for employers to develop and retain their retiree health coverage if it provides a prescription drug benefit to retirees that was at least equivalent to the new Medicare outpatient drug benefit. This approach would save money for the program because the subsidy given would be generous enough for employers to maintain coverage yet lower than the Medicare subsidies for traditional participants.

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

- **Eliminates all cost sharing for all preventive benefits in Medicare and institutes a major health promotion education campaign.** This proposal would cost $3 billion over 10 years and would:

  - Eliminate existing copayments and the deductible for preventive service covered by Medicare, including colorectal cancer screening, bone mass measurements, pelvic exams, prostate cancer screening, diabetes self management benefits, and mammographies.

  - Initiate a three-year demonstration project to provide smoking cessation services to Medicare beneficiaries.

  - Launch a new, nationwide health promotion education campaign targeted to all Americans over the age of 50.

- **Rationalizes cost sharing.** To help pay for the new prescription drug and preventive benefits, the President's plan would save $11 billion over 10 years by rationalizing the current cost sharing requirements for Medicare by:

  - Adding a 20 percent copayment for clinical laboratory services. The modest lab copayment would help prevent overuse, and reduce fraud.

  - Indexing the Part B deductible for inflation. The Part B deductible index would guard against the program assuming a growing amount of Part B costs because, over time, inflation decreases the amount of the deductible in real terms. Compared to average annual Part B per capita costs, the deductible has fallen from 28 percent in 1967 to about 3 percent in 2000.

- **Reforms Medigap.** The President's plan would reform private insurance policies that supplement Medicare (Medigap) by: (1) working with the National Association of Insurance Commissioners to add a new lower-cost option with low copayments and to revise existing plans to conform with the President's proposals to strengthen Medicare; (2) directing the Secretary of HHS to determine the feasibility and advisability of reforms to improve supplemental cost sharing in Medicare, including a Medigap-like plan offered by the traditional Medicare program; (3) providing easier access to Medigap if a beneficiary is in an HMO that withdraws from Medicare; and (4) expanding the initial six month open enrollment period in Medigap to include individuals with disabilities and end stage renal disease (ESRD).

- **Includes the President's Medicare Buy-In proposal.** The plan includes the President's proposal to offer American between the ages of 62-65 without access to employer-based insurance the choice to buy into the Medicare program for approximately $300 per month if they agree to pay a small additional monthly payment once they become eligible for traditional Medicare at age 65. Displaced workers between 55-62 who had involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400). And retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment. The $1.4 billion cost over 5 years is offset in the President's FY 2000 budget.

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

- **Extends the life of the Trust Fund until at least 2027.** Dedicating 15 percent of the surplus ($794 billion over 15 years) to Medicare not only contributes toward extending the estimated financial health of the Trust Fund through 2027, but it will also lessen the need for future excessive cuts and radical restructuring that would be inevitable in the absence of these resources.

- **Responsibly finances the new prescription drug benefit through savings and a modest amount from the surplus.** The new drug benefit would cost about $118 billion over 10 years. Its budgetary impact would be fully offset by:

  - Savings from competition and efficiency. About 60 percent of the $118 billion Federal cost of the new Medicare prescription drug benefit would be offset through these savings.

  - Dedicating a small fraction of the surplus. About $45.5 billion of the surplus allocated to Medicare would be used to help finance the benefit. To put this amount in context, it is:

  - Less than one eighth of the amount of the surplus dedicated for Medicare (2 percent of the entire surplus); and

  - Less than the reduction in the Medicare baseline spending between January and June, 1999.

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

PRESIDENT'S PLAN TO STRENGTHEN AND MODERNIZE MEDICARE FOR THE 21st CENTURY

- **Goals for Reform:**

  - Make Medicare More Competitive and Efficient

  - Modernize Medicare's Benefits

  - Strengthen Medicare's Financing for the 21st Century

- **Reduces Medicare spending for current services by $72 billion over 10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition. As a result of these policies, Medicare growth per beneficiary from 2003 to 2009 would slow from 4.9 percent to 4.3 percent.

- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years. This cost is only about 5 percent of total Medicare spending in 2009 (net of premiums).

  - Over 60 percent of the costs are offset by the proposal's savings.

  - The remaining $45.5 billion would come from the Medicare allocation of the surplus. This amount is one-eighth of the $374 billion over 10 years dedicated to Medicare, and less than 2 percent of the overall surplus.

- **Extends the life of the Medicare Trust Fund to at least 2027.** The President's plan would dedicate 15 percent of the surplus to strengthen Medicare. This amount, when combined with the offset for the drug benefit and Part A savings, would extend the estimated life of the Medicare Trust Fund for a quarter century from now, through at least 2027.

PRESIDENT'S PROPOSAL
(Dollars in Billions, Trustees' Baseline)

	00-04	00-09
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	*-5*	*-64.5*
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	*+27*	*+110*
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	*-22*	*-45.5*
Surplus Allocation	*-50*	*-374*

*Includes $5.7 billion in interactions/premium offset
** Does not count toward package

PRESIDENT'S PLAN TO MODERNIZE & STRENGTHEN MEDICARE

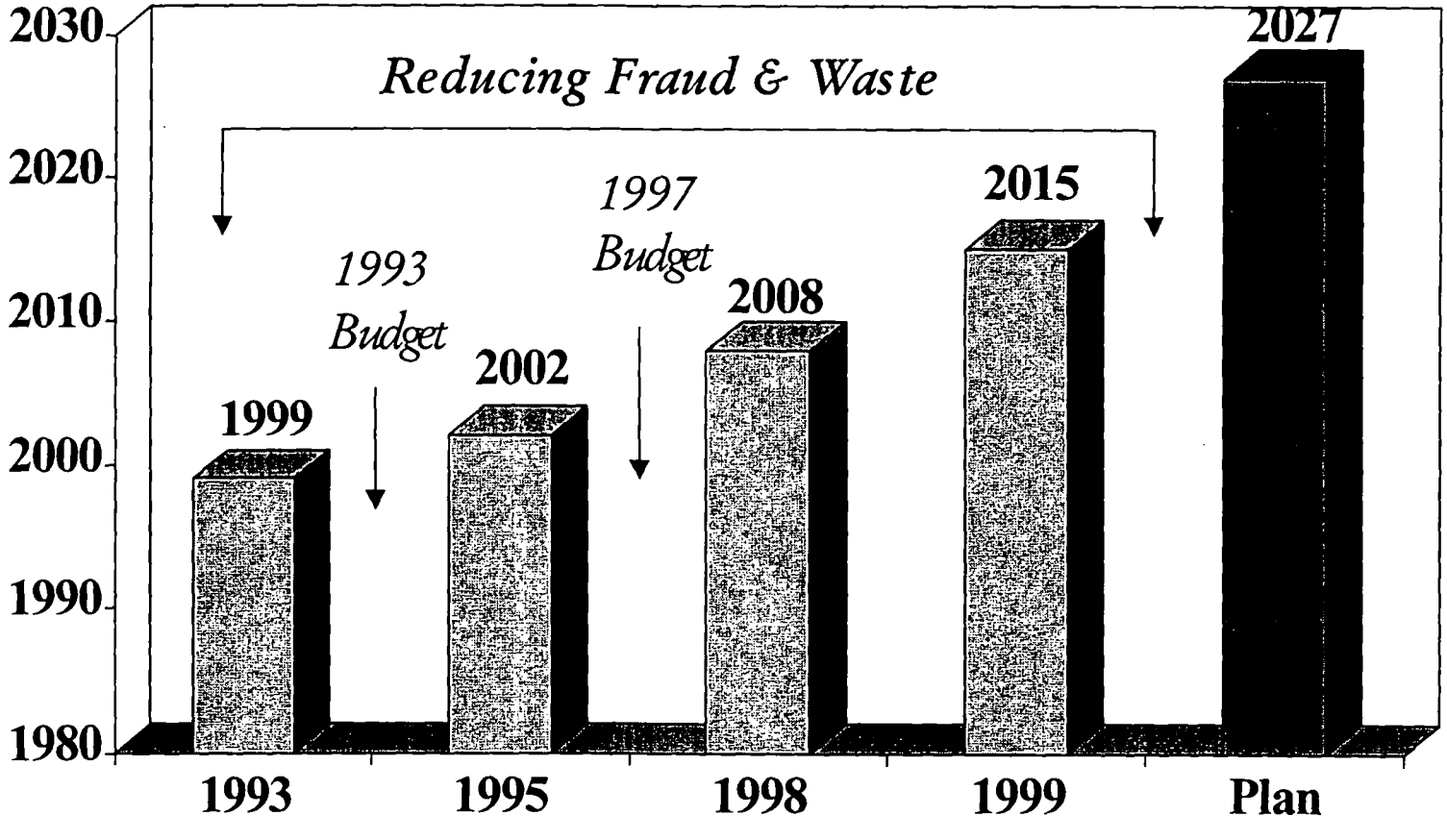
July 16, 1999

President's Plan To Modernize and Strengthen Medicare

- Make Medicare More Competitive & Efficient
- Modernize Medicare Benefits, Including a Long-Overdue Prescription Drug Benefit
- Strengthening Medicare's Financing for the 21st Century

Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



President's Proposal For Medicare Prescription Drug Coverage

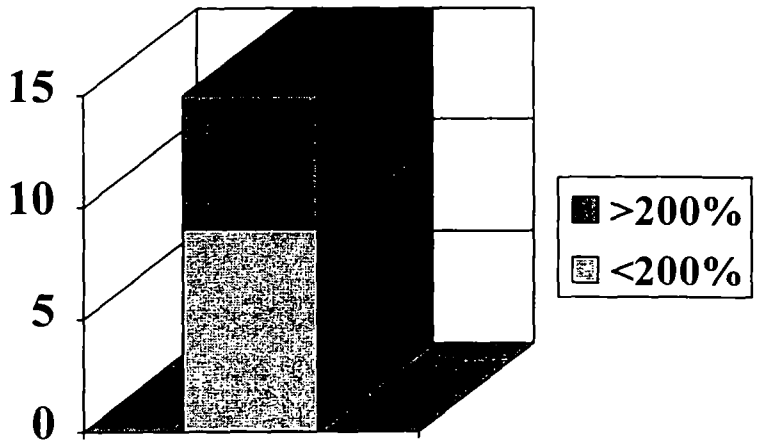
- **Meaningful coverage.** Beginning in 2002, beneficiaries have the option to enroll in Part D:
  - No deductible -- coverage with first prescription
  - 50% copay with access to discounted prices
  - Benefit limited after $5,000 in costs (phased-in)

- **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

All Types of Beneficiaries Lack Coverage For Prescription Drugs

Over 40% of Beneficiaries Without Drug Coverage Have Income Above 200% of Poverty (Millions of People)



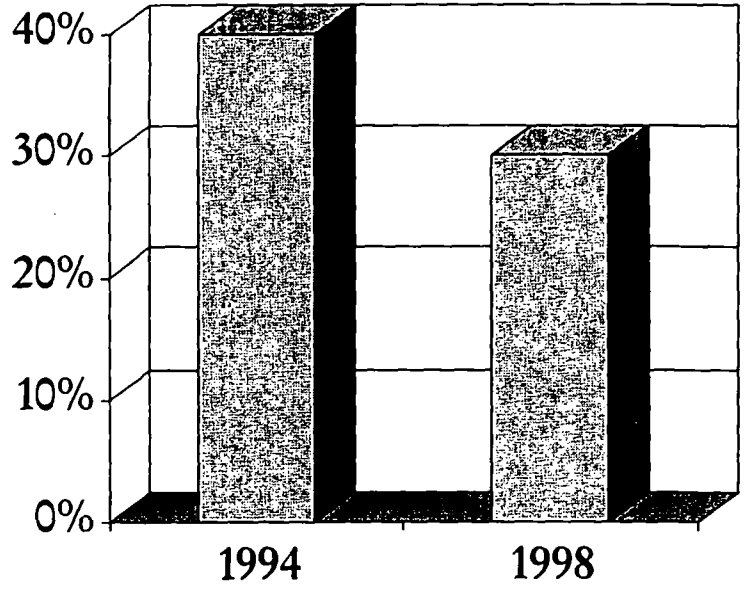
200% of Poverty = $16,000 for singles, $22,000 for couples

- **Disproportionately affects rural beneficiaries.** About half of rural beneficiaries have no coverage

- **Older beneficiaries are less likely to have coverage.** Over 40 percent of beneficiaries older than 85 pay for their prescription drug costs out-of-pocket, compared to about one-third of beneficiaries ages 65-69

Prescription Drug Coverage: Private Sources Declining

Firms Offering Retiree Health Coverage



- **Individual Medigap coverage is becoming even more rare -- and expensive.** Premiums for drug coverage through Medigap can be $90 per month -- and twice as high for older beneficiaries. Only about one in 20 beneficiaries have drug coverage through Medigap.

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
• 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

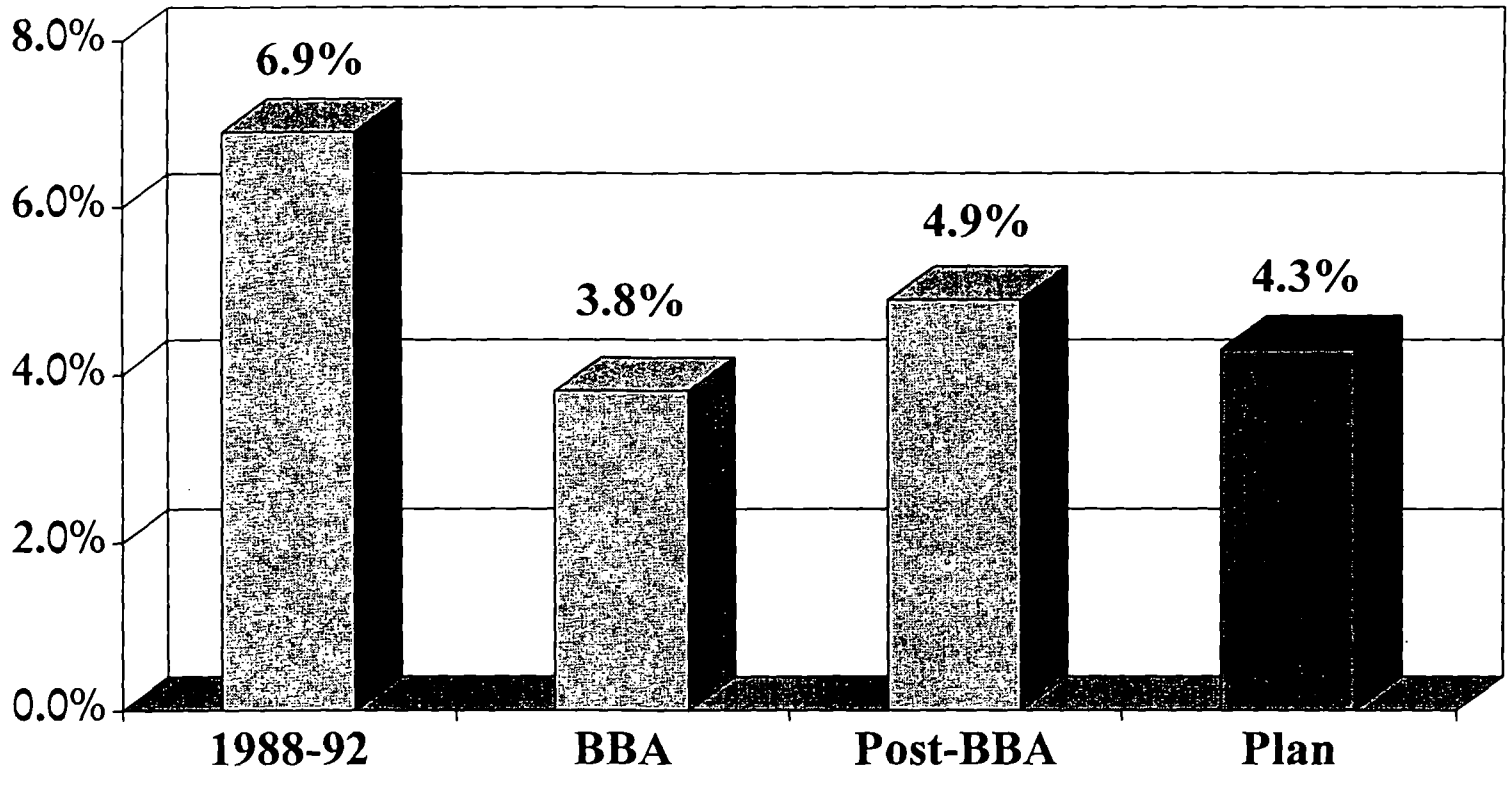
- **Immediate Administrative Actions**, that moderate the impact on hospitals, academic health centers and home health agencies

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

- **$7.5 Billion Quality Assurance Fund**

Keeping Medicare's Growth In Check

Spending Growth Per Beneficiary



BBA is for 1998-2002; Post-BBA is for 2002-2009; Plan is for 2002-2009 under the President's plan

MEDICARE:

THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

July, 1999

THE PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. President's Plan for Modernizing and Strengthening Medicare

- Making Medicare More Competitive and Efficient
- Modernizing Medicare's Benefits, Including Adding a Prescription Drug Benefit
- Strengthening Medicare's Financing for the 21st Century

I. OVERVIEW
IMPORTANCE OF MEDICARE

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

- **Helps those who would otherwise be uninsured:** Before Medicare, almost half (44 percent) of the elderly were uninsured and millions more had substandard coverage. Given the recent rapid rise of the uninsured ages 55 to 65 who are even healthier than seniors, this problem would have been worse today.

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

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

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

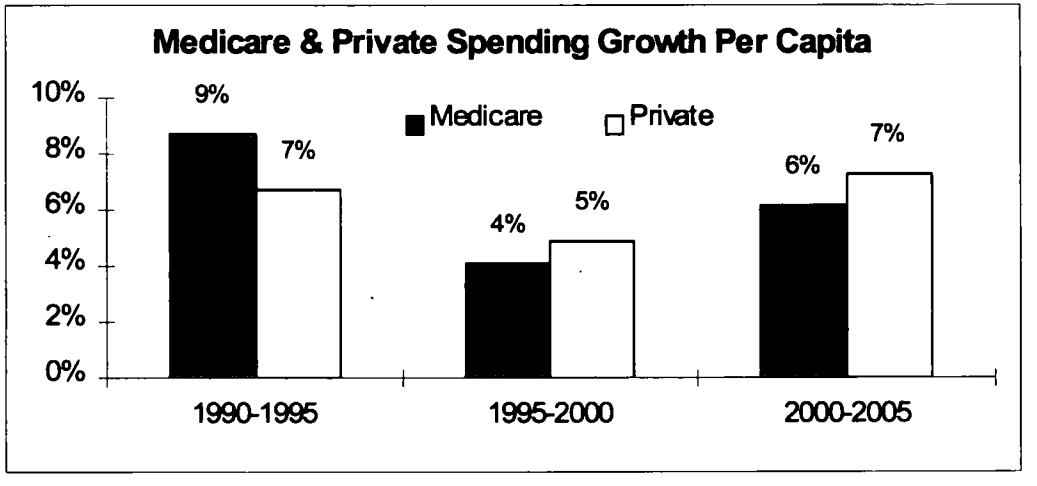
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. When President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999.

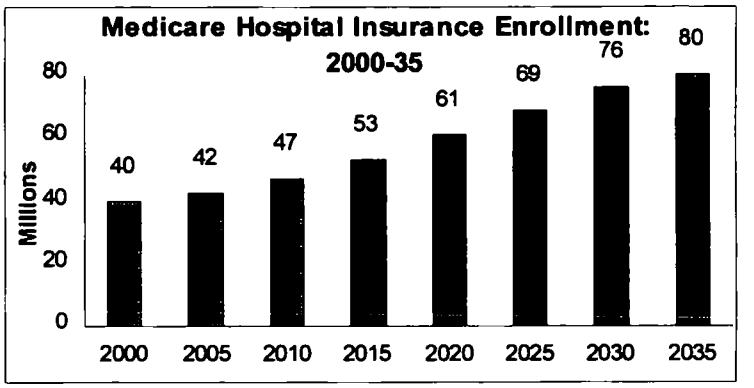
- In response, the President advocated for Medicare reforms in 1993 and 1997, and instituted an unprecedented crack-down on fraud and abuse. These actions, in combination with a strong economy, constrained cost growth and extended the life of the trust fund until 2015.

- The slow Medicare spending growth is expected to continue through 2002 – when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

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



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

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

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

ADDITIONAL CHALLENGES FACING MEDICARE: LACK OF PRESCRIPTION DRUG COVERAGE

- **Millions have no coverage for prescription drugs.** Prescription drugs have become central to modern medicine, yet nearly 15 million Medicare beneficiaries have no coverage.
  - About 40 percent of beneficiaries without drug coverage (about 6 million) have income above 200 percent of poverty (about $16,000 for a single, $22,000 for a couple).

- **Current prescription drug coverage is unstable and declining rapidly.**
  - Employer-sponsored retiree health insurance is declining. The number of firms offering retiree health insurance coverage dropped by 20 percent between 1993 and 1998.

  - Medigap, the individually purchased supplemental policies, has grown very expensive and less common. Medigap premiums have been rising rapidly, are often set so to increase with age, and typically cost at least twice as much as the premium as the President's plan.

  - Medicare managed care plans frequently cover drugs, but 11 million beneficiaries do not have access to any managed care plans. Drug coverage is typically limited (e.g., $1,000 cap), and many plans are dropping or severely limiting coverage.

- **Drug coverage today resembles hospital coverage before Medicare.** Before 1965, 56% of the elderly had insurance, but this coverage was expensive, inadequate and unreliable. Medicare would not have been created if this coverage was considered adequate.

OUTDATED AND INEFFICIENT PAYMENT SYSTEMS

- **Insufficient flexibility in traditional Medicare to adopt best private sector practices to reduce costs and increase quality.** Medicare is governed by statutory constraints that limit its ability to adopt innovative payment and management strategies.

- **Medicare pays managed care plans a flat rate, set by a complex statutory formula, that has nothing to do with plan prices.**

  ° Overpaid. A June 1999 report from the General Accounting Office found that the Balanced Budget Act has not eliminated managed care plan overpayments. For example, managed care plans in Los Angeles can provide the traditional Medicare benefits package for 79 percent of what they are currently paid.

  ° No price competition – only competition on providing extra benefits. Managed care plans offer extra benefits with the overpayment – they cannot compete on price.

    - Hard for beneficiaries to comparison shop on benefits

    - Easy to attract healthy or avoid sick beneficiaries by custom-designing benefits

    - Unfairly subsidizes benefits in high-cost / high-payment areas: 75 percent of rural beneficiaries do not even have the option of joining managed care.

II. PRESIDENT'S PLAN TO MODERNIZE AND STRENGTHEN MEDICARE FOR THE 21st CENTURY

- **Goals for Reform:**
  - Make Medicare More Competitive and Efficient
  - Modernize Medicare's Benefits
  - Strengthen Medicare's Financing for the 21st Century

- **Reduces Medicare spending by $72 billion /10 years.** About half of these savings come from innovative proposals to adopt successful private sector tools and competition.

- **Adds an optional prescription drug benefit.** This benefit would cost $118 billion over 10 years, fully financed by the offsets in the proposal.

- **Extends the life of the Medicare trust fund for a quarter of a century, to at least 2027.** This will significantly reduce the need for excessive reductions in Medicare spending when its costs explode as the baby boom generation retires.

PRESIDENT'S PROPOSAL
(Dollars in Billions, Trustees' Baseline)

	00-04	00-09
COMPETITION & EFFICIENCY		
Medicare Modernization	-5	-25
Competition	-0	-8
Provider Savings	-4	-39*
Provider Set-Aside	+4	+7.5
Total	***-5***	***-64.5***
MODERNIZING BENEFITS		
Prescription Drug Benefit	+29	+118
Cost Sharing Changes	-2	-8
Total	***+27***	***+110***
DEDICATING FINANCING		
Contribution to Solvency	-28	-328.5**
Surplus for Drug Benefit	***-22***	***-45.5***
Surplus Allocation	*-50*	*-374*

* Includes $5.7 billion in interactions/premium offset
** Does not count toward package

I. MAKING MEDICARE MORE EFFICIENT
Private Sector Purchasing & Quality Improvement Tools for Traditional Medicare

- **Allowing Traditional Medicare to Adopt Best Private Practices.** This proposal would build on the President's commitment to give traditional Medicare the ability to adopt payment and quality improvement tools that are frequently used in the private sector.

  - Promoting the use of high-quality, cost-effective providers. Give beneficiaries a financial incentive (e.g., lower cost sharing) to choose selected providers (like a PPO); pay facilities that meet quality and cost standards a single price (Centers of Excellence).

  - Primary care case management and disease management. Structure payments to promote coordination of services for certain diseases or beneficiaries who have high health costs to reduce hospitalizations.

  - Coordinating care for dual eligibles. The 17 percent of beneficiaries who are Medicare-Medicaid dual eligibles account for 28 percent of spending. Provide information to help coordinate benefits; test models in traditional Medicare to coordinate services.

  - Using competitive pricing, selective contracting, negotiated discounts. These market-oriented practices will make Medicare a stronger negotiator and more efficient manager.

Competitive Defined Benefit Proposal

- **Competitive defined benefit proposal.** This proposal would pay managed care plans based on competitive prices, not on fixed rates. If a plan's price is higher than 96 percent of traditional program costs, the beneficiary would pay a higher premium. If it is less, the beneficiary would pay a premium that is lower than the Part B premium.

- **Saves through competition, not rate reductions.** Unlike the current system, Medicare would save money when beneficiaries choose lower cost plans. For each dollar saved, beneficiaries would receive 75 cents, the government 25 cents.

- **Price competition promotes informed beneficiary choice.** By having plans compete over a defined benefit, beneficiaries can make "apples-to-apples" comparisons over price and quality. This eliminates the problem of plans designing benefits to attract healthy enrollees.

- **Plan payments more rational.** Rather than receiving a rate based on a complicated formula, managed care plans would get paid what they bid, although the higher the price, the higher the beneficiary premium. The government payment includes the costs of prescription drugs, risk adjustment and full geographic adjustment in high-cost areas.

Example: Competitive Defined Benefit Proposal

Option	Plan Price (monthly)	Split of Plan Payments	
		Beneficiary	*Government*
Low-Price Plan	$433.33	$0.00 0%	$433.33 100%
Medium-Price Plan	$490.00	$42.50 9%	$447.50 91%
Price Equals 96% Of Traditional Costs	$500.00	$50.00 10%	$450.00 90%
High-Price Plan	$520.00	$70.00 13%	$450.00 87%

Smoothing Out Balanced Budget Act Policies: Short- and Long-Term

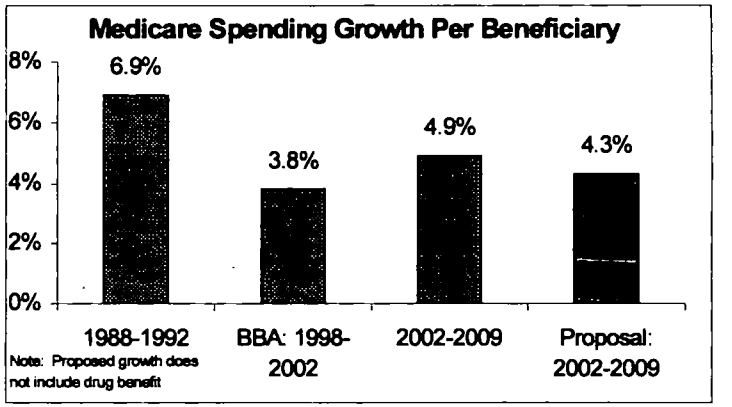
- **Smoothing out the Balanced Budget Act of 1997 reductions.** Some evidence suggests that some BBA policies may have unintended effects. To address this, this plan includes:

  - Administrative actions. The plan includes immediate administrative actions to moderate the impact of the BBA on hospitals, academic health centers, and home health agencies.

  - Better targeting disproportionate share hospital payments. These payments would be removed from managed care payments and paid directly to qualifying hospitals.

  - $7.5 billion quality assurance fund. This fund would be used to modify BBA provisions that have been determined by the Administration, Congress, and health experts to be severely undermining providers' ability to delivery high-quality, affordable health care.

- **Constraining out-year program growth, but more moderately than BBA 1997.** To moderate program growth after most of the provisions of the BBA expire in 2003, the proposal includes out-year policies that protect against a return to excessive growth rates. They are more modest than those included in the BBA 1997 and would result in a growth rate that is 15% higher than it would have been had BBA rates continued.



Improving Medicare Management

- **Modernizing Medicare management.** The President's plan includes a major modernization reform of the management of Medicare. It would:

  - **Increase accountability through public/private advisory boards.** These include:

    - Management Advisory Council. Panel of public and private sector management experts to identify and recommend best management practices for Medicare.

    - Medicare Coverage Advisory Committee. Experts in medicine and science, consumer and industry representatives would provide advise on coverage policy.

    - Citizens' Advisory Panel on Medicare Education. Experts in consumer education and health policy and health care providers would monitor and evaluate Medicare's consumer education initiatives.

- **Increasing personnel flexibility.** Medicare has taken strides in hiring experts from the private sector to manage its programs. It has contracted with an outside evaluator to determine how best it can prepare its staff for the challenges of the next century.

MODERNIZING MEDICARE BENEFITS
Prescription Drug Benefit

- **New Medicare prescription drug benefit.** The President's plan includes 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.

  - Meaningful coverage. Medicare would cover half of drug costs from the first prescription up to $5,000 in spending per year ($2,500 in Medicare payments). The spending limit would be phased in from 2002 to 2008 and, in subsequent years, adjusted for inflation. Beneficiaries would have access to discounts negotiated by private managers.

  - Affordable premiums. Beneficiaries would pay separate premium for Medicare Part D -- an estimated $24 per month in 2002, and $44 per month in 2008, when fully implemented. Cost sharing protections for low-income beneficiaries would be expanded (no premiums below 150% of poverty; no cost sharing below 135% of poverty).

  - Private management. Beneficiaries in managed care would be covered through their plan. For the rest, Medicare would contract out with numerous private pharmacy benefit managers or similar entities to manage the benefit. No price controls would be used.

  - Medicare support for retiree coverage. Medicare would pay a reduced premium subsidy for beneficiaries who receive coverage through their employers' health plan.

Improving Preventive Benefits and Eliminating Cost Sharing

- **Promoting prevention for Medicare beneficiaries.** This proposal would take a number of steps to make preventive services more affordable, as well as to raise awareness of services

  - Eliminating all existing preventive services cost sharing. The deductible would be waived for hepatitis B vaccinations, colorectal cancer screening, bone mass measurements, prostate cancer and diabetes self-management benefits. Coinsurance would be waived for screening mammography, pelvic exams, hepatitis B vaccinations, colorectal screening, bone mass measurements, prostate cancer screening and diabetes self-management benefits. For the rest of the preventive services covered by Medicare, cost sharing is already waived. Cost: $3 billion over 10 years.

  - Smoking cessation demonstration. A three-year demonstration project would evaluate the cost-effectiveness of smoking cessation services for Medicare beneficiaries.

  - Education campaign. A new, nationwide campaign would be launched to encourage use of preventive services and promote healthy behaviors for all Americans over age 50.

  - U.S. Preventive Services Task Force study. This impartial panel of experts would evaluate preventive services that are appropriate for the elderly, providing guidance for future Medicare improvments.

Rationalizing Cost Sharing and Medigap

- **Rationalizing Medicare cost sharing.** The plan would change Medicare cost sharing by:

  - Adding a 20 percent clinical laboratory coinsurance. Having beneficiaries contribute towards their lab services would make cost-sharing requirements under Part B more uniform. It also could cut down on fraud and help reduce over-use.

  - Indexing the Part B deductible to inflation. Medicare's Part B deductible of $100 would be indexed annually to inflation so its value does not decline over time.

- **Reforming Medigap.** The plan would update the private insurance policies called Medigap:

  - Adding a new plan option, with nominal cost sharing. This would better track the coverage for the nonelderly, and could reduce premium costs for Medigap.

  - Updating existing plan options. In light of the new prescription drug policy and other changes proposed in the plan, all of the Medigap plan options would be updated.

  - Reporting to Congress on policy alternatives to Medigap, since access problems are rising.

  - Improving access to Medigap for beneficiaries whose private plans withdraw from Medicare.

Medicare Buy-In for Certain People Ages 55-65

- **Important insurance option for those nearing Medicare eligibility.** The plan includes the President's proposal to expand health options for people ages 55 to 65. Its costs are offset in the context of the FY 2000 President's Budget submission.

  - People ages 62 to 65 without access to employer-sponsored insurance would have the choice to buy into the Medicare program for approximately $300 a month if they agreed to pay a small risk adjustment payment once they become eligible for Medicare at age 65.

  - Displaced workers between 55-62 who involuntarily lost their jobs and insurance could buy in at a slightly higher premium (approximately $400).

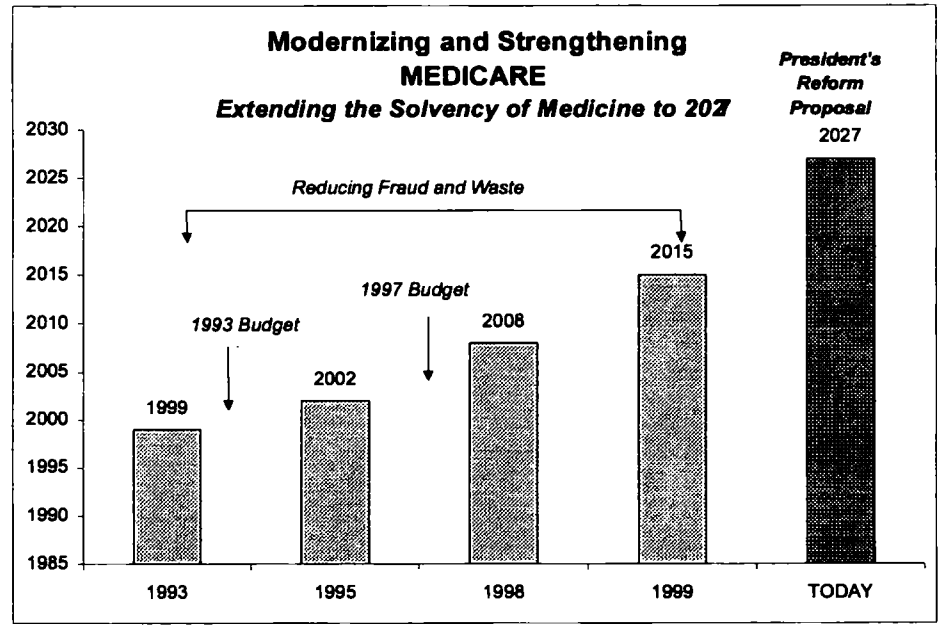
  - Retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.

- All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA buy-in policy has no Federal budget impact whatsoever. The initiative should help 300,000 to 400,000 people.

III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY
Surplus for Medicare Solvency

- **The President has renewed the commitment he made in the State of the Union Address to dedicate 15 percent of the surplus to Medicare.** Over the 15-year window covered by the President's Framework, $794 billion would be dedicated to strengthening Medicare and extending its solvency. This amount is more than the $686 billion from the budget since the surplus has increased.

- **Extends the trust fund to 2027.** The combined effect of this reform package would extend the life of the Hospital Insurance trust fund to at least 2027 – 12 years longer than its current projected expiration in 2015.



Financing for the Prescription Drug Benefit

- **Prescription drug benefit designed to be fiscally responsible.** To ensure that it does not result in unsustainable spending growth in the out-years, this proposal's drug benefit's limit is indexed to general inflation. Thus, Medicare offsets are able to keep pace with its growth.

- **Medicare savings are the primary source of funding for the new prescription drug benefit.** About 60 percent of the costs of the prescription drug benefit would come from reducing Medicare cost growth, improving its efficiency, and beneficiary contributions.

- **Small fraction of the surplus used as financing.** The remaining $45 billion would be financed by using a fraction of the 15 percent of the surplus dedicated to Medicare. To put this amount in context, it is:

  - Less than one-eighth of the amount for Medicare -- 2 percent of the entire surplus.
  - Less than one-fifth of the drop in Medicare baseline from 1998 to 1999.

- **Medicare baseline has dropped, in part because of administrative actions.** Policy experts advising the Congress (MedPAC, CBO, and Medicare Trustees) have credited our success in combating fraud, waste, and abuse as a major reason for the $241 billion, 10-year drop in Medicare spending from 1998 to 1999. Reinvesting savings that can be reasonably attributed to our anti-fraud and waste activities in a new prescription drug benefit is completely consistent with our precedent of using savings for programmatic improvements.

PRESIDENT'S PRESCRIPTION DRUG BENEFIT FOR MEDICARE
How It Would Work

The President has proposed giving Medicare beneficiaries the option of purchasing affordable, meaningful prescription drug coverage through Medicare. Medicare would cover half of the beneficiary's drug costs, from the first prescription filled each year up to $5,000 in spending (fully phased-in by 2008). This benefit would have no deductible and would cost about $24 per month beginning in 2002 and $44 per month when fully phased-in.

This is how the new option would work for a Medicare beneficiary:

1. GIVES THE OPTION TO JOIN MEDICARE "PART D" (DRUG BENEFIT PROGRAM). When they become eligible for Medicare, beneficiaries would be given information on the Medicare prescription drug benefit and the option to join. This same option would be presented to all beneficiaries in the first year that the program is running.

    - **If interested, sign up for Part D**. This would be done in the same way that beneficiaries sign up for Medicare today – as part of the initial enrollment package.

    - **If not interested – for whatever reason – beneficiaries don't have to sign up**. Those wanting to keep private retiree health coverage could. No premiums would be collected from these beneficiaries Special financial incentives would be given to employers to retain coverage and to reduce the trend of employers dropping coverage. If in the future an employer drops retiree coverage, the beneficiaries would have the Part D option.

2. DECIDE WHETHER TO JOIN TRADITIONAL MEDICARE OR MANAGED CARE. As they do today, beneficiaries would be given information and make the choice about how they want their care delivered.

    - **If staying in traditional Medicare**, Part D premium treated like Part B premium – the national premium amount would be deducted from their Social Security check.

    - **If joining managed care**, the Part D premium may be lower or nothing. Under the President's Competitive Defined Benefit proposal, managed care plans could reduce or eliminate premiums and/or copayments in order to be competitive. Since managed care plans would be explicitly subsidized for drug coverage for the first time, most probably would offer more affordable – and more generous coverage than today.

3. USE OF THE BENEFIT. Part D enrollees in managed care would get their drug benefit in the same way that they do today – through their managed care plan. Those in traditional Medicare would get a card from their local private benefit manager. This card:

    - Secures a discount every time it is used – even when the benefit limit is reached;

    - Pays for half of every drug prescription until total costs exceed the limit ($2,000 in 2002, $5,000 in 2008); and

    - Tracks and monitors drug use, to assure that the right mix and right amount of medications are used.

Noa A. Meyer 07/22/99 03:18:58 PM

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To: Christine N. Macy/WHO/EOP@EOP

cc:
Subject: remarks at Medicare conversation

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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.)

* * * * *

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.)