



MEMORANDUM

DATE: July 5, 1999

TO: Sean O'Shea, White House Office of Cabinet Affairs

FROM: Lynnette Williams, Deputy Assistant Secretary for Public Affairs *Lynnette Williams*

RE: Weekly Amplification Report

On Tuesday, June 29, **Secretary Shalala** participated in the White House event to announce the President's Medicare proposal. Secretary Shalala also participated in a press briefing at the White House to answer questions on the President's plan. In addition, the Secretary, along with Gene Sperling, John Podesta, and Secretary Rubin, participated in a roundtable to discuss the President's plan with columnists and commentators including Jules Witcover, Mara Liasson, John Harris, Robert Samuelson, Alan Murray, Marie Coco, Mark Shields, and Eleanor Clift.

AMPLIFYING THE PRESIDENT'S MEDICARE PLAN

On Sunday, June 27, **Secretary Shalala** previewed the President's Medicare plan on *"Face the Nation."*

On Tuesday, June 29, **Secretary Shalala** participated in the following amplification events to promote President Clinton's Medicare proposal:

TELEVISION:

- The Secretary was interviewed on CBS "This Morning" and CNN'S "Early Edition."

PRINT MEDIA:

- The Secretary participated in two conference call interviews. The participants on the calls included editorial writers from the *Milwaukee Sentinel Journal*, the *Columbus Dispatch*, the *Buffalo News* and *Newsday*.
- Secretary Shalala also spoke to editorial writers Terry Tang of *The New*

York Times, Peter Milius of *The Washington Post* and Graham Dower of *USA Today*.

- HHS Public Affairs contacted and sent information on the President's Medicare plan to approximately 50 dailies.

On Wednesday, June 30, **Secretary Shalala** participated in the following amplification events to promote President Clinton's Medicare proposal:

PUNDITS:

- Secretary Shalala spoke to Gloria Borger of *U.S. News/Face the Nation*, Al Hunt of *The Wall Street Journal/Capitol Gang*, Bob Schieffer of "*Face the Nation*", and George Will of *The Washington Post* and ABC's "*This Week*."

TELEVISION:

- Secretary Shalala participated in interviews via satellite with WFOR of Miami, Florida; WOI of Des Moines, Iowa; KOLO of Reno, Nevada; WEVV of Evansville, Indiana; WJW of Cleveland, Ohio; and KGTV of San Diego, California.

RADIO:

- Secretary Shalala participated in interviews with WINZ-AM of Miami, Florida; WIBC-AM of Indianapolis, Indiana; WTMJ-AM of Milwaukee, Wisconsin; WHO-AM of Des Moines, Iowa; and WJR-AM of Detroit.

On Thursday, July 1, **Secretary Shalala** participated in the following amplification events to promote President Clinton's Medicare proposal:

PUNDITS

- Secretary Shalala spoke to Jodie Allen of *U.S. News and World Report*, Fred Barnes of the *Weekly Standard*, Mort Kondracke from *Roll Call/McLaughlin*, Margaret Carlson of *Time/Capitol Gang*, E.J. Dionne of *The Washington Post* and Mary McGrory of *The Washington Post/Meet the Press*.

RADIO:

- The Secretary participated in radio interviews with WWDB-FM of Philadelphia, Pennsylvania; KCNN-AM of Grand Forks, North Dakota; WBGO-FM of Newark, New Jersey; WOR-AM and WLIB-AM (Harlem) of New York City, New York; WBZ-AM of Boston, Massachusetts; KGO-AM of San Francisco, California; KKOH-AM of Reno, Nevada; KFYY-AM of Bismarck, North Dakota; KNX-AM of Los Angeles, California; WDKX-FM of Rochester, New York; and the Associated Press Radio Network. WWL-AM of New Orleans, Louisiana also received faxed materials on the Clinton Medicare plan.

On Sunday, July 4, **Secretary Shalala** was interviewed by Tim Russert on *Meet the*

Press where she discussed the President's Medicare plan.

On Tuesday, June 29, HCFA Administrator **Nancy-Ann DeParle** participated in conference call interviews with editorial writers from the *Fort Lauderdale Sun-Sentinel*, the *Orlando Sentinel*, the *Palm Beach Post*, the *Tampa Tribune*, the *Gainesville Sun*, the *Memphis Commercial Appeal* from Tennessee, and the *Flint Journal*. In addition, HCFA Deputy Administrator **Mike Hash** spoke to the *Indianapolis Star* and the *Bangor Daily News*.

On Tuesday, June 29, **Carlos Zaraboza** of HCFA's Office of Strategic Planning taped a Spanish-language informational interview on the President's Medicare plan with Miami-based Radio Unica for its news program. The network has 58 stations in the U.S. and Puerto Rico.

On Tuesday, June 30, HHS faxed information to promote the President's Medicare plan to Kevin O'Brien of the *Cleveland Plain Dealer*, Jennifer Halperin of the *Columbus Dispatch*, Mike Douglas of the *Akron Beacon Journal*, Graham Dower of *USA Today*, Peter Milius of *The Washington Post*, Terry Tang of *The New York Times*, Rich Foster of the *Journal-Sentinel* (Milwaukee, Wisconsin), Bill Leonard of the *Des Moines Register*, and Linda Brasil of the *Capital Times* (Madison, Wisconsin).

On Wednesday, June 30, HCFA Administrator **Nancy-Ann DeParle** was interviewed on C-Span's Washington Journal to discuss the President's Medicare plan. After the interview, she also briefed health reporters on the Medicare plan.

On Wednesday, June 30, HCFA Deputy Administrator **Michael Hash** was interviewed by the American Urban Network and the Southern Urban Radio Network on the President's Medicare proposal. Both networks serve African-American audiences covering about 350 stations. The context of the interview was based on how the President's plan would benefit low-income and minority Americans. He was also interviewed by the "Larry Young Radio Show" on WOLB-AM in Baltimore.

On Wednesday, June 30, HHS provided the fact sheet on the President's Medicare plan to the National Newspaper Publishers Association for distribution to its 220 papers that serve African-American communities.

On Thursday, July 1, HHS faxed information on the President's Medicare plan to WFOR-TV in Miami, Florida; WDIV-TV of Detroit, Michigan; KABC-TV of Los Angeles California; KLAS-TV and KTNV-TV of Las Vegas, Nevada; and KMTV-TV of Madison, Wisconsin.

PROMOTING FEDERAL COMMITMENT TO MINORITY HEALTH ISSUES

On Monday, June 28, AHCPR Administrator John Eisenberg met with a health writer from the *Chicago Defender*, one of the nation's oldest black dailies, to discuss research related to reducing racial and ethnic disparities in health.

On Monday, June 28, HRSA Office of Minority Health Director M. June Horner was interviewed by Janet Dang of *Asian Week* about the new White House Initiative on Asian Americans and Pacific Islanders.

On Thursday, July 1, HHS distributed "Vida Saludable 2000," a health column that HHS provides to Spanish-language newspapers, to about 90 newspapers. The article was written by Assistant Secretary for Aging **Jeanette Takamura**. Dr. Takamura wrote about the Clinton Administration's National Family Caregiver Support Program in the context of Hispanic families caring for seniors.

Upcoming Items of Interest:

On Tuesday, July 6, **Secretary Shalala** will participate in a press event to promote the President's Medicare proposal in Las Vegas, Nevada with Senators Reid and Bryan, and Rep. Berkley. The Secretary will also be doing local radio interviews while in Las Vegas including KNUU-AM.

On Wednesday, July 7, **Secretary Shalala** will participate in a press event to promote the President's Medicare proposal in Santa Barbara, California with Rep. Lois Capps. The Secretary will also be doing local radio interviews while in California including "The Michael Jackson Show" in Los Angeles.

On the morning of Thursday, July 8, **Secretary Shalala** will participate in a press event to promote the President's Medicare proposal in St. Paul, Minnesota with Senator Wellstone, Rep. Vento, and Rep. Sabo. Before the event, the Secretary will be participating in a Medicare editorial roundtable with the *Minneapolis Star Tribune*. In the afternoon, the Secretary will participate in an health care forum in Bismarck, North Dakota to promote the Medicare plan with Senators Conrad and Dorgan, and Representative Pomeroy.

Star Tribune (Minneapolis, MN) June 28, 1999, Monday, Metro Edition

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June 28, 1999, Monday, Metro Edition

SECTION: NEWS; Pg. 1A

LENGTH: 1140 words

HEADLINE: Clinton seeks drug benefits for Medicare;
Congress, however, says plan is too ambitious, urges limits

SOURCE: News Services

DATELINE: Washington, D.C.

BODY:

At "very little" cost to taxpayers, all 39 million Americans covered by Medicare could get prescription drug benefits without bankrupting the program, administration officials said Sunday in previewing President Clinton's proposal on the issue.

But even before he announces details Tuesday, members of Congress from both parties said the plan was too ambitious, and they urged limiting the new drug coverage to the working poor.

Meanwhile, administration officials said Sunday that Clinton was completing work on a separate proposal encompassing ideas for shoring up Social Security and using larger-than-anticipated federal budget surpluses. The White House declined to provide details of the proposal, which Clinton probably will announce today.

Speaking about the Medicare prescription issue, Health and **Human Services** Secretary Donna **Shalala** said on CBS-TV's "Face the Nation": "This isn't about just adding some new lush benefit. This is critical to health care."

She said the cost of Medicare drug coverage would not "spin out of control." She didn't say how it would be financed.

Gene Sperling, chairman of the National Economic Council, said in CNN's "Late Edition" that the expanded prescription coverage would "cost very little" because of proposed savings through streamlining and strengthened competition.

Sperling said that Clinton "is going to show a bit of political guts in coming forward with such a detailed plan."

The plan depends on approval by Congress, and it's impossible to predict what Congress will do.

Administration officials said the premium for drug coverage would start at about \$20 to \$25 per month and climb gradually in subsequent years toward \$45 per month. Under the plan, the government would pay about half the cost of prescription drugs, up to a certain level to be specified by law, and beneficiaries would pay the remainder.

As of noon Sunday, an administration official said, the maximum annual benefit _ the amount payable by the government _ hadn't been decided. But like the premium, it could rise over time, the official said.

Skepticism in Congress

On Capitol Hill, there was skepticism that Clinton could save Medicare from bankruptcy and introduce a significant new benefit program at the same time.

Sen. Phil Gramm, chairman of the Senate Banking Committee, said two-thirds of Medicare recipients already have prescription coverage, either through the Medicaid program for the poor or through private Medigap policies. That leaves about 15 million beneficiaries with no coverage.

"I don't understand why we would want to drive those private programs out and substitute a government program for it," Gramm, R-Texas, said on CBS.

Sen. Orrin Hatch, R-Utah, said on NBC-TV's "Meet the Press" that it is "the working poor, the poorest of the poor not on Medicaid, who don't have it and we ought to work that out some way."

Republican leaders generally have supported the idea of providing government-subsidized drug benefits only for those near the poverty level.

The administration says that many Medigap policies are a financial burden for the elderly, averaging about \$90 per month and including a \$250 deductible.

Sen. Bob Graham, D-Fla., whose state's senior population strongly supports cheaper drug prices, said on CBS that offering prescription coverage could be accomplished by making Medicare more efficient and by cutting fraud and waste, which he said still accounts for about 10 percent of Medicare spending.

Other Democrats were less optimistic.

Sen. Joseph Lieberman, D-Conn., said the way to save Medicare from insolvency in the next decade "is not to load it up with another big costly benefit that nobody pays for, even though everybody wants it."

"We've got to do it step by step," he said on "Fox News Sunday."

Sen. Robert Torricelli, D-N.J., said expanding drug benefits is a candidate for that "one last national achievement" Clinton wants before leaving office. But the plan for universal coverage "suffers an extensive reach," he said.

Torricelli predicted prescription drug benefits will grow to only those 15 million that aren't now covered and that Medicare reform will be linked to the Republican's top priority, a package of tax cuts.

Social Security proposal

Administration officials said Clinton's new Social Security plan would include a component intended to extend the program's solvency, although not to the full 75 years that long has been the benchmark for the system's financial health. Without any changes, Social Security will run short of money to pay full retirement benefits in 2034, after the retirement of the 76 million-strong baby-boom generation.

The plan's release could signal a new willingness on the part of the White House to consider a broader bipartisan deal on taxes and spending even if Social Security's problems aren't fully dealt with. Until now, Clinton has adamantly stuck to a demand that he first made 1 years ago, that the surplus would be off limits until the retirement system's future has been assured.

Clinton's proposal is expected to specify how he would use the bigger surplus, which largely is being generated by the strong economy. New White House budget projections probably will show that the federal government could run an operating surplus next year, one year earlier than expected, meaning that it would spend less than it takes in even without including excess Social Security payroll taxes, which have erased the deficit in the past several years.

Clinton's new plan includes a revised version of a proposal that the parties have been jockeying over in Congress: a "lock box" to ensure that the excess Social Security revenues aren't spent, but used only to reduce the national debt or ensure the retirement system's long-term viability.

In his original budget proposal in January, Clinton proposed reserving 62 percent of the budget surplus over 15 years for Social Security, but in a way that would allow him to spend a portion of the Social Security surplus in the next few years. Both parties have rejected that approach, and although they differ on details, they have basically endorsed setting aside every dollar of each year's Social Security surplus.

White House officials said their new plan would respond to the congressional criticism and also would include a revised provision that would link reducing the national debt to improving Social Security's long-term financial condition. "We are very hopeful that the new presidential proposal _ the new Social Security lock box _ will be a

way of bringing together both Democrats and Republicans," Sperling said on CNN.

GRAPHIC: PHOTO

LANGUAGE: ENGLISH

LOAD-DATE: June 29, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
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AP Online, June 27, 1999

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June 27, 1999; Sunday 16:00 Eastern Time

SECTION: Washington - general news

LENGTH: 577 words

HEADLINE: Medicare Plan 'Too Ambitious'

BYLINE: JIM ABRAMS

DATELINE: WASHINGTON

BODY:

At "very little" cost to taxpayers, all 39 million Americans covered by Medicare could get prescription drug benefits without bankrupting the program, administration officials said Sunday in previewing President Clinton's reform package.

But even before he announces details Tuesday, lawmakers from both parties said the plan was too ambitious and they urged limiting the new drug coverage to the working poor.

The elderly and disabled in the Medicare program who want the prescription coverage will have to pay for it, said Donna **Shalala**, secretary of the **Department of Health and Human Services**. The poor would get help buying medicine.

"This isn't about just adding some new, lush benefit," **Shalala** said on CBS' "Face the Nation," noting that half the people in rural areas do not have drug coverage. "This is critical to health care."

Gene Sperling, chairman of the National Economic Council, said in CNN's "Late Edition" that the expanded prescription coverage would "cost very little" because of proposed savings through streamlining and strengthened competition.

The president, Sperling said, "is going to show a bit of political guts in coming forward with such a detailed plan."

But on Capitol Hill, there was skepticism Clinton could save Medicare from bankruptcy and introduce a significant new benefit program.

Sen. Phil Gramm, chairman of the Senate Banking Committee, said two-thirds of Medicare recipients already have prescription coverage, either through the Medicaid program for the poor or through private Medigap policies. That leaves about 15 million beneficiaries with no coverage.

"I don't understand why we would want to drive those private programs out and substitute a government program for it," Gramm, R-Texas, said on CBS.

It is "the working poor, the poorest of the poor not on Medicaid, who don't have it and we ought to work that out some way," Sen. Orrin Hatch, R-Utah, said on NBC's "Meet the Press."

Republican leaders generally have supported the idea of providing government-subsidized drug benefits only for those near the poverty level.

The administration argues many Medigap policies are a major financial burden for the elderly, averaging about \$90 a month and including a \$250 deductible.

Clinton's plan would require smaller premiums and might pay about half the cost of prescriptions, up to perhaps \$3,000 to \$5,000 a year.

Sen. Bob Graham, D-Fla., whose state's senior population strongly supports cheaper drug prices, said on CBS that this could be accomplished by making Medicare more efficient and by cutting fraud and waste, which he said still accounts for about 10 percent of Medicare spending.

Other Democrats were less optimistic.

Sen. Joseph Lieberman, D-Conn., said the way to save Medicare from insolvency in the next decade "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it."

"We've got to do it step by step," he said on "Fox News Sunday."

Sen. Robert Torricelli, D-N.J., said expanding drug benefits is a candidate for that "one last national achievement" Clinton wants before leaving office. But the plan for universal coverage "suffers an extensive reach," the senator said.

Torricelli predicted prescription drug benefits will grow to only those 15 million not now covered and that Medicare reform will be linked to the Republican's top priority, a package of tax cuts.

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The Atlanta Journal, June 28, 1999

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June 28, 1999, Monday, JOURNAL EDITION

SECTION: News; Pg. 1A

LENGTH: 264 words

SERIES: Final

HEADLINE: Critics say drug benefits too costly

BYLINE: Associated Press

SOURCE: Washington

BODY:

Lawmakers of both parties are questioning whether President Clinton was overreaching with a Medicare rescue plan that includes broad new prescription drug benefits.

The highlight the Medicare reform plan Clinton is announcing Tuesday will be a new program giving all 39 million Medicare recipients access to prescription drug coverage.

Currently, 15 million people in the program for the elderly and disabled have no drug coverage.

Senate Banking Committee Chairman Phil Gramm (R-Texas) said about two-thirds of those on Medicare do have prescription drug coverage, either through the Medicaid program for the poor or through private "Medigap" policies.

"Let's don't make a problem where one doesn't exist, and providing that benefit is prohibitively expensive," Gramm said on CBS' "Face the Nation."

Republicans generally favor a plan floated earlier this year that would offer government-subsidized drug benefits only for those living near the poverty level.

Health and **Human Services** Secretary Donna **Shalala** said the administration had "no intention of rolling out a benefit that's going to spin out of control."

Shalala said the new program would be voluntary and people would share the costs. "This will not be as generous as people think and that people are talking about," she said on CBS.

Sen. Joseph Lieberman (D-Conn.) said the way to save Medicare from insolvency in the next decade "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it."

"We've got to do it step by step," he said.

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The Boston Globe, June 28, 1999

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View Related Topics

June 28, 1999, Monday ,City Edition

SECTION: NATIONAL/FOREIGN; Pg. A3PHOTO

LENGTH: 1001 words

HEADLINE: Clinton aides tout Medicare plan;
Administration proposes adding drug benefit

BYLINE: By Jim Abrams, Associated Press

BODY:

WASHINGTON - Prescription drug benefits could be given to all of the 39 million Americans covered by Medicare at minimal cost to taxpayers without bankrupting the system, Clinton administration officials said yesterday.

Speaking on the Sunday television talk shows, the officials gave a preview of a program that President Clinton is expected to announce tomorrow.

However, lawmakers from both parties said Clinton's plan was too ambitious and urged limiting the drug coverage to the working poor.

Donna **Shalala**, secretary of health and **human services**, said the elderly and disabled in the Medicare program who want the prescription coverage would have to pay for it. The poor would get help buying medicine.

"This isn't about just adding some new, lush benefit," **Shalala** said on CBS's "Face the Nation," noting that half the people in rural areas do not have drug coverage. "This is critical to health care."

Gene Sperling, chairman of the National Economic Council, said on CNN's "Late Edition" that the expanded prescription coverage would cost very little because of proposed savings through streamlining and strengthened competition.

The president, Sperling said, "is going to show a bit of political guts in coming forward with such a detailed plan."

Clinton is also completing work on a proposal encompassing ideas for shoring up Social Security and using larger-than-anticipated federal budget surpluses, The New York Times reported today, citing remarks by administration officials.

The White House declined to provide details of the proposal, which Clinton is likely to unveil today, said the Times.

On Capitol Hill, there was skepticism that Clinton could save Medicare from bankruptcy and introduce a significant new benefit program.

Senator Phil Gramm, chairman of the Senate Banking Committee, said two-thirds of Medicare recipients already have prescription coverage, either through the Medicaid program for the poor or through private Medigap policies. That leaves about 15 million beneficiaries with no coverage.

"I don't understand why we would want to drive those private programs out and substitute a government program for it," Gramm, a Texas Republican, said on CBS.

The administration argues many Medigap policies are a major financial burden for the elderly, averaging about \$90 a month and including a \$250 deductible.

Clinton's plan would require smaller premiums and might pay about half the cost of prescriptions, up to perhaps

\$3,000 to \$5,000 a year.

GRAPHIC: DONNA SHALALA

"Critical to health care"

AP PHOTO/CBS

LANGUAGE: ENGLISH

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The Houston Chronicle June 28, 1999, Monday

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View Related Topics

June 28, 1999, Monday 3 STAR EDITION

SECTION: A; Pg. 3

LENGTH: 794 words

HEADLINE: Both parties skeptical about plan for new prescription drug benefits

SOURCE: Staff

BYLINE: JOHN C. HENRY, Houston Chronicle Washington Bureau

DATELINE: WASHINGTON

BODY:

WASHINGTON - Acknowledging the need to help older Americans pay for prescription drugs, Republicans and Democrats in Congress expressed reservations Sunday about President Clinton's proposal to extend the benefit to anyone qualified for Medicare.

Administration officials defended the proposal to give all Medicare recipients the option of paying a small monthly premium for prescription drugs coverage. Clinton plans to announce the package on Tuesday.

Saying the new drug benefit would cost taxpayers little, Health and **Human Services** Secretary Donna **Shalala** said the president's proposal "isn't about just adding some new, lush benefit. This is critical to health care."

Texas Sen. Phil Gramm, R-College Station, agreed that providing pharmaceutical benefits to the poorest Medicare recipients was a worthy goal, but he was skeptical about extending the benefit to all 39 million elderly or disabled Americans.

Noting that almost two-thirds of Medicare recipients have private insurance policies that pay for drugs, Gramm cautioned against a universal program. "Let's don't make a problem where one doesn't exist," Gramm said on "Face the Nation," a CBS News program. "Providing that benefit is prohibitively expensive."

Faced with overwhelming opposition from Republicans and Democrats in Congress, the administration already has decided against including in Clinton's Medicare reform plan a proposal to require wealthier recipients to pay higher premiums, either for prescription drugs or for other benefits available under Medicare.

"People will share in the cost and there will be a limit to what the government will pay for," **Shalala** said on Face the Nation. The program "will be very carefully designed . . . so it won't spin out of control."

The \$ 200 billion-a-year Medicare program currently does not provide coverage for prescription drugs, one of the fastest-rising component of health costs. To cover drug costs and other medical expenses not included in the government-financed program, many Medicare recipients buy so-called Medigap insurance from private companies.

Officials estimate it would cost the government about \$ 6 billion annually to provide prescription drug coverage to the 15 million Medicare participants who have no private insurance.

While administration officials declined to put a pricetag on Clinton's proposal before he unveils in Tuesday, Sen. Orrin Hatch, R-Utah, predicted: "It will be \$ 30 billion a year."

Acknowledging that the government "needs to do more" to help the elderly and the poor with health care, Hatch said on NBC's "Meet the Press" that not everyone should get assistance. Those most in need, are "the working poor, the poorest of the poor not on Medicaid, who don't have it," Hatch said. "And we ought to work that out some way."

Under Clinton's plan, the government would help low-income Medicare recipients - mostly the elderly and disabled - pay the premiums to become eligible for sharing in the drug coverage benefit.

The prescription drug plan is the centerpiece of Clinton's Medicare reform plan, a key part of the domestic agenda he announced during his State of the Union address in January and has sought to revive as the Kosovo conflict winds down.

Although Clinton favors requiring more affluent Medicare recipients to pay higher premiums, he backed off when congressional leaders from both parties warned that it would doom his reform effort.

"We want a plan that has a realistic chance of passing, and we became convinced that both Democrats and Republicans were too against this initially to put in our proposal," said Gene Sperling, chairman of the National Economic Council. Means-testing "would politicize (the legislation) and hurt the chances of moving forward."

Under Clinton's plan, the government would pay about half the cost of prescription drugs, up to a maximum of about \$ 3,000 a year. Once the limit is reached, the Medicare recipient would have to pay full cost. The additional premiums - estimated to range from \$ 35 to \$ 45 a month - would cost less than most private plans, officials said.

Gramm, R-College Station, said he supports offering drug coverage to low-income Medicare patients, but not to everyone in the program.

"Why would we want a universal program where two out of every three people that would get the benefit are already getting pharmaceuticals" under private insurance plans, Gramm asked.

Some Democrats were equally skeptical of Clinton's plan, saying it would do nothing to assure the solvency of Medicare.

Sen. Joseph Lieberman, D-Conn., said on "Fox News Sunday" that the way to keep Medicare from going broke "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it."

GRAPHIC: Mug: Donna **Shalala**, Health and Human Services Secretary

LANGUAGE: ENGLISH

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Agence France Presse, June 28, 1999

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June 28, 1999 22:40 GMT

SECTION: Domestic, non-Washington, general news item

LENGTH: 723 words

HEADLINE: Clinton proposes Medicare overhaul, more drug coverage

BYLINE: By Benjamin Kahn

BODY:

WASHINGTON, June 27 (AFP) - Politicians were staking out vehement positions here Sunday in advance of a plan to be put forth by President Bill Clinton to overhaul Medicare, the US public health program for the elderly and disabled.

The proposal, which would also expand prescription drug coverage and is expected to be released Tuesday by the White House, "isn't about just adding some new lush benefit," said Donna **Shalala**, the Clinton administration's secretary for health and **human services**.

"We need management reforms, competitive reforms. Those reforms are an inextricable part of what Clinton is recommending: solvency, competition, management reforms, as well as this pharmaceutical benefit," **Shalala** said.

"This is critical to healthcare," she said.

"We can't afford not to introduce prescription drug benefits into the Medicare program ... Drugs are increasingly a critical part of healthcare in this country," said the secretary, speaking on the CBS program Face The Nation.

The proposal also calls for a 700-billion-dollar cash infusion from the government, representing about 15 percent of the budget surpluses expected over the next 15 years, according to a New York Times report Sunday.

The US Medicare program provides health insurance to 39 million people, a number forecast to grow quickly as the 76 million Americans of the "Baby Boom" generation grow older, forcing the government to rethink how the program operates and how to fund it.

Conservative members of Congress rushed Sunday to condemn the Clinton proposal.

"Let's don't make a problem where one doesn't exist," said Republican Senator Phil Gramm of Texas, who chairs the healthcare subcommittee of the Senate Finance Committee.

"The president had a golden opportunity to reform Medicare ... and he didn't do it," said Gramm, also speaking on Face the Nation, but then admitted he was not yet familiar with the contents of the Clinton proposal.

Democratic Senator Joseph Lieberman of Connecticut voiced qualified support for the Clinton proposal -- "I think the president is going in the right direction" -- but warned that the way to shore up the Medicare's financial viability "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it."

"Yes, we ought to begin to cover prescription drugs. But you can't load on this benefit for every Medicare beneficjrm," Lieberman said.

Much of the Clinton plan, according to **Shalala**, is aimed at achieving substantial cost savings by steering patients to hospitals that agree to give the government deep discounts and to use competitive bidding in their purchases.

Democratic Senator Bob Graham of Florida, a supporter of the plan, sought to explain how the bid to extend drug coverage to all Medicare beneficiaries was aimed, ultimately, at controlling overall costs.

"If we have a universal plan it can be a more efficient plan, and it won't be a plan where only the people that are in

greatest need of medicaton will join the program," Graham said, speaking on Face the Nation.

Graham was referring to the bane of all insurance schemes: adverse selection.

Cited by economists as a key factor driving up US public health spending, "adverse selection" refers to the swelling of insurance costs that occurs when coverage is not universal.

As people who expect they won't need insurance exclude themselves from the system -- or "select out" -- the costs of insuring those still in the system are left to be borne by a smaller pool of premium payers. Per-person premiums for those remaining in the system thus begin to rise.

Meanwhile, when illness affects those who opted out, they find themselves faced with exhorbitant expenses in a system where rising insurance premiums have helped inflate prices.

According to Graham, also a member of the Senate Finance Committee, if drug coverage in Medicare were designed so that "those who are not in such great need won't join the program, that is what would make it prohibitively expensive."

However, Gramm, the Republican senator from Texas, said he could not grasp the advantages of universal coverage.

"The only reason you would really have a universal program is to basically try to put everybody under the same government program -- it makes no sense," Gramm said.

bok/smb

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The Commercial Appeal (Memphis, TN), June 28, 1999

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The Commercial Appeal (Memphis, TN)

June 28, 1999, MONDAY, FINAL EDITION

SECTION: NEWS, Pg. A7

LENGTH: 558 words

HEADLINE: PRESCRIPTION DRUG PROPOSAL FLAWED, LAWMAKERS SAY

BYLINE: Jim Abrams The Associated Press

DATELINE: WASHINGTON

BODY:

At "very little" cost to taxpayers, all 39 million Americans covered by Medicare could get prescription drug benefits without bankrupting the program, administration officials said Sunday in previewing President Clinton's reform package.

But even before he announces details Tuesday, lawmakers from both parties said the plan was too ambitious and they urged limiting the new drug coverage to the working poor.

The elderly and disabled in the Medicare program who want the prescription coverage will have to pay for it, said Donna **Shalala**, secretary of the **Department of Health and Human Services**. The poor would get help buying medicine.

"This isn't about just adding some new, lush benefit," **Shalala** said in a TV interview, noting that half the people in rural areas do not have drug coverage. "This is critical to health care."

Gene Sperling, chairman of the National Economic Council, said in a TV interview that the expanded prescription coverage would "cost very little" because of proposed savings through streamlining and strengthened competition.

The President, Sperling said, "is going to show a bit of political guts in coming forward with such a detailed plan."

But on Capitol Hill, there was skepticism Clinton could save Medicare from bankruptcy and introduce a significant new benefit program.

Sen. Phil Gramm, chairman of the Senate Banking Committee, said two-thirds of Medicare recipients already have prescription coverage, either through the Medicaid program for the poor or through private Medigap policies. That leaves about 15 million beneficiaries with no coverage.

"I don't understand why we would want to drive those private programs out and substitute a government program for it," Gramm (R-Texas) said.

It is "the working poor, the poorest of the poor not on Medicaid, who don't have it, and we ought to work that out some way," Sen. Orrin Hatch (R-Utah) said.

Republican leaders generally have supported the idea of providing government-subsidized drug benefits only for those near the poverty level.

The administration argues that Medigap policies are a major financial burden for the elderly, averaging about \$ 90 a month and including a \$ 250 deductible.

Clinton's plan would require smaller premiums and might pay about half the cost of prescriptions, up to perhaps \$ 3,000 to \$ 5,000 a year.

Sen. Bob Graham (D-Fla.), whose state's senior population strongly supports cheaper drug prices, said that this could be accomplished by making Medicare more efficient and by cutting fraud and waste, which he said still accounts for about 10 percent of Medicare spending.

Other Democrats were less optimistic.

Sen. Joseph Lieberman (D-Conn.) said the way to save Medicare from insolvency in the next decade "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it."

"We've got to do it step by step," he said.

Sen. Robert Torricelli (D-N.J.) said expanding drug benefits could be the "one last national achievement" Clinton wants before leaving office. But the plan for universal coverage "suffers an extensive reach," he said.

Torricelli predicted prescription drug benefits will grow to only those 15 million not now covered and that Medicare reform will be linked to the Republicans' top priority, a package of tax cuts.

LOAD-DATE: June 28, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
Mandatory date in-between june 26, 1999 : july 1, 1999
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The Des Moines Register, June 28, 1999

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The Des Moines Register

June 28, 1999, Monday

SECTION: Main News Pg.1

LENGTH: 552 words

HEADLINE: Clinton: Medicare could cover medicine

BYLINE: Jim Abrams

SOURCE: Associated Press

BODY:

By JIM ABRAMS
Associated Press

Washington, D.C. - At "very little" cost to taxpayers, all 39 million Americans covered by Medicare could get prescription drug benefits without bankrupting the program, administration officials said Sunday in previewing President Clinton's reform package.

But even before he announces details Tuesday, lawmakers from both parties said the plan was too ambitious and they urged limiting the new drug coverage to the working poor.

The elderly and disabled in the Medicare program who want the prescription coverage will have to pay for it, said Donna **Shalala**, secretary of the **Department of Health and Human Services**. The poor would get help buying medicine.

"This isn't about just adding some new, lush benefit," **Shalala** said. "This is critical to health care."

Gene Sperling, chairman of the National Economic Council, said that the expanded prescription coverage would "cost very little" because of proposed savings through streamlining and strengthened competition.

The president, Sperling said, "is going to show a bit of political guts in coming forward with such a detailed plan."

But on Capitol Hill, there was skepticism Clinton could save Medicare from bankruptcy and introduce a significant new benefit program.

Sen. Phil Gramm, R-Texas, said two-thirds of Medicare recipients have prescription coverage, either through the Medicaid program for the poor or through private Medigap policies. That leaves about 15 million beneficiaries with no coverage.

"I don't understand why we would want to drive those private programs out and substitute a government program for it," Gramm said.

It is "the working poor, the poorest of the poor not on Medicaid, who don't have it and we ought to work that out some way," Sen. Orrin Hatch, R-Utah, said.

Republican leaders generally have supported the idea of providing government-subsidized drug benefits only for those near the poverty level.

The administration argues that Medigap policies are a major financial burden for the elderly, averaging about \$ 90 a month and including a \$ 250 deductible.

Clinton's plan would require smaller premiums and might pay about half the cost of prescriptions, up to perhaps \$

3,000 to \$ 5,000 a year.

Sen. Bob Graham, D-Fla., whose state's senior population strongly supports cheaper drug prices, said that this could be accomplished by making Medicare more efficient and by cutting fraud and waste, which he said accounts for about 10 percent of Medicare spending.

Other Democrats were less optimistic.

Sen. Joseph Lieberman, D-Conn., said the way to save Medicare from insolvency in the next decade "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it.

"We've got to do it step by step," he said.

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Torricelli predicted prescription drug benefits will grow to only those 15 million not now covered and that Medicare reform will be linked to the Republican's top priority, a package of tax cuts.

Photo: Gramm
Opponent

Photo: **Shalala**
'Help poor'

LANGUAGE: English

LOAD-DATE: June 29, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
Mandatory date in-between june 26, 1999 : july 1, 1999
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St. Petersburg Times, June 28, 1999

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June 28, 1999, Monday, 0 South Pinellas Edition

SECTION: NATIONAL; Pg. 1A

LENGTH: 818 words

HEADLINE: Scale back Medicare plan, critics say

SOURCE: Compiled from Times Wires

DATELINE: WASHINGTON

BODY:

Members of both parties say giving all beneficiaries prescription drug coverage is too ambitious and expensive.

At "very little" cost to taxpayers, all 39-million Americans covered by Medicare could get prescription drug benefits without bankrupting the program, administration officials said Sunday in previewing President Clinton's reform package.

But even before he announces details Tuesday, lawmakers from both parties said the plan was too ambitious and they urged limiting the new drug coverage to the working poor.

The elderly and disabled in the Medicare program who want the prescription coverage will have to pay for it, said Donna **Shalala**, secretary of the **Department of Health and Human Services**. The poor would get help buying medicine.

"This isn't about just adding some new, lush benefit," **Shalala** said on CBS' Face the Nation, noting that half the people in rural areas do not have drug coverage. "This is critical to health care."

Gene Sperling, chairman of the National Economic Council, said on CNN's Late Edition that the expanded prescription coverage would "cost very little" because of proposed savings through streamlining and strengthened competition.

The president, Sperling said, "is going to show a bit of political guts in coming forward with such a detailed plan."

But on Capitol Hill, there was skepticism Clinton could save Medicare from bankruptcy and introduce a significant new benefit.

Sen. Phil Gramm, chairman of the Senate Banking Committee, said two-thirds of Medicare recipients already have prescription coverage, either through the Medicaid program for the poor or through private Medigap policies. That leaves about 15-million beneficiaries with no coverage.

"I don't understand why we would want to drive those private programs out and substitute a government program for it," Gramm, R-Texas, said on CBS.

It is "the working poor, the poorest of the poor not on Medicaid, who don't have it and we ought to work that out some way," Sen. Orrin Hatch, R-Utah, said on NBC's Meet the Press.

Republican leaders generally have supported the idea of providing government-subsidized drug benefits only for those near the poverty level.

The administration argues many Medigap policies are a major financial burden for the elderly, averaging about \$ 90 a month and including a \$ 250 deductible.

Clinton's plan would require smaller premiums and might pay about half the cost of prescriptions, up to perhaps \$ 3,000 to \$ 5,000 a year. After the limit is reached, the 50 percent funding would end, White House aides said.

Sen. Bob Graham, D-Fla., said on CBS that lower drug prices could be achieved by making Medicare more efficient and by cutting fraud and waste, which he said still accounts for about 10 percent of Medicare spending.

Other Democrats were less optimistic.

Sen. Joseph Lieberman, D-Conn., said the way to save Medicare from insolvency in the next decade "is not to load it up with another big costly benefit that nobody pays for even though everybody wants it."

"We've got to do it step by step," he said on Fox News Sunday.

Sen. Robert Torricelli, D-N.J., said expanding drug benefits is a candidate for that "one last national achievement" Clinton wants before leaving office. But the plan for universal coverage "suffers an extensive reach," the senator said.

Torricelli predicted prescription drug benefits will grow to only those 15-million not now covered and that Medicare reform will be linked to the Republicans' top priority, a package of tax cuts.

Medicare currently provides virtually no coverage for medications and drugs for which Medicare recipients pay, on average, about \$ 600 per year. Clinton's plan would cost seniors far less than that, **Shalala** said.

Still, "This will not be as generous as people think," **Shalala** said. "It will have a limit on how much the government will pay for, and it will be very carefully designed so it doesn't spin out of control."

She said some of the plan's funding would come from savings from other changes in Medicare and better accounting within the program. Sperling said Clinton also thinks tobacco companies "should help pay for some of the overall costs" of the plan.

He said the president would make this point Tuesday in connection with a lawsuit the government plans to file against tobacco companies to recover Medicare and Veterans Administration money spent to treat smoking-related illnesses.

"We believe the costs of Medicare are higher because of tobacco," Sperling said. He said Clinton won't call for an increase in tobacco taxes to help pay for his plan.

Medicare is in need of reform because the baby boomer population is expected to put huge pressures on the system after 2010, when the first of some 77-million boomers become eligible for coverage.

- Information from the Associated Press and Bloomberg News was used in this report.

GRAPHIC: COLOR PHOTO, (2); HHS chief Donna **Shalala**; Sen. Phil Gramm

LANGUAGE: ENGLISH

LOAD-DATE: June 29, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
Mandatory Terms: date in-between june 26, 1999 : july 1, 1999
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Date/Time: Thursday, July 1, 1999 - 1:57 PM EDT

The Record (Bergen County, NJ), June 28, 1999

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The Record (Bergen County, NJ)

View Related Topics

June 28, 1999; MONDAY; ALL EDITIONS

SECTION: NEWS; Pg. A01

LENGTH: 587 words

HEADLINE: CONGRESS WARY OVER MEDICARE DRUG PLAN ;
CLINTON AIDES CLAIM OF LOW COST IS DOUBTED

SOURCE: Wire services

BYLINE: JIM ABRAMS, The Associated Press

DATELINE: WASHINGTON

BODY:

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GRAPHIC: PHOTO (1e only) - ASSOCIATED PRESS - Health and Human Services Secretary Donna Shalala appearing Sunday on CBS "Face the Nation." She defended the administration's plan to extend drug benefits under Medicare.

LANGUAGE: English

LOAD-DATE: June 28, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
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Portland Press Herald June 28, 1999, Monday,

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Portland Press Herald

June 28, 1999, Monday, CITY EDITION

SECTION: FRONT, Pg. 1A

LENGTH: 573 words

HEADLINE: MEDICARE REFORM PLAN CRITICIZED;
LAWMAKERS SAY THE CLINTON IDEA OF EXTENDING PRESCRIPTION DRUG BENEFITS TO ALL IS TOO
AMBITIOUS.

BYLINE: JIM ABRAMS The Associated Press

DATELINE: WASHINGTON

BODY:

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GRAPHIC: PHOTO: color;

The Associated Press Health and **Human Services** Secretary Donn;

Shalala discusses Medicare on "Face the Nation."

LANGUAGE: ENGLISH

LOAD-DATE: June 29, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
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The Deseret News (Salt Lake City, UT) June 29, 1999, Tuesday

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The Deseret News (Salt Lake City, UT)

June 29, 1999, Tuesday

SECTION: WIRE; Pg. A01

LENGTH: 710 words

HEADLINE: New prescription for Medicare

BYLINE: Associated Press

BODY:

WASHINGTON -- Older or disabled Americans would pay \$24 a month if they want to take advantage of a new \$2,000-a-year prescription drug benefit that is a centerpiece of President Clinton's long-awaited proposal to bolster Medicare.

"We can't afford not to introduce prescription drug benefits into the Medicare program," Donna **Shalala**, the health and **human services** secretary, said Tuesday on "CBS This Morning." "Drugs are increasingly a critical part of health care in this country."

The proposed drug benefit, **Shalala** said, "will have a limit on how much the government will pay for, and it will be very carefully designed so it doesn't spin out of control."

The new benefit, which would cover 50 percent of prescription drug costs up to the \$2,000 annual cap, would be available as an option for those 65 and older and the disabled beginning in 2002. The monthly premium would rise gradually to \$44 and the cap to \$5,000 by 2008.

Part of that premium increase would account for inflation, the White House said, adding that the peak \$44 fee is still one-half to one-third the typical cost of private drug coverage.

Medicare recipients already are paying a \$45.50 monthly premium to cover doctor's visits.

Beneficiaries with annual incomes below \$11,000 per individual or \$17,000 per couple would pay no premium for drug coverage, while other low-income Medicare recipients would get help paying the premium.

Republicans immediately criticized the White House plan to provide drug benefits for all 39 million elderly and disabled Medicare beneficiaries as an excessive, big-government solution. Many favor more limited help for those who most need it.

Sen. Phil Gramm, R-Texas, also appearing Tuesday on "CBS This Morning," noted that two-thirds of those 65 and older already have some drug coverage -- through benefits offered by former employers, private insurance policies they purchase on their own, or HMOs that participate in Medicare.

"I can't understand why we would want to drive those private programs out and substitute a government program for it," Gramm said.

On Monday, the administration released new predictions of federal government surpluses -- \$1.1 trillion more than expected -- that Clinton said would make it easier to avert a cash shortage likely to face the health insurance program for the elderly and disabled in 2015.

The president proposed using \$794 billion of those surpluses for Medicare.

But administration officials say tough choices still had to be made in putting together the plan. Medicare beneficiaries who choose the drug benefits that Clinton will propose, for example, would have to pay new out-of-pocket fees.

"It asks people to pay a modest premium and some cost-sharing for a benefit that is far better than they'd get in the private sector," said top White House economic adviser Gene Sperling.

Other money for the drug benefit, he said, will come from changes in the way Medicare does business with health care providers -- for example, occasionally replacing complex government payment formulas with competitive bidding.

Congressional Republicans, who want to reserve some government surpluses for income tax cuts, have been skeptical about how Clinton will come up with money to add an expensive new benefit to the already cash-strapped Medicare program.

And it's unclear whether the president's plan can win the public and industry support he will need to get politically perilous Medicare changes through a Congress already nervous about the 2000 elections.

The American Association of Retired Persons, the nation's largest organization of older adults, supports the concept of a new Medicare prescription drug benefit. But senior AARP lobbyist Patricia Smith said among outstanding concerns is how much Medicare clients will be asked to pay out of pocket.

Meanwhile, drug makers are worried about how the government will decide which drugs to cover at what prices. And other health care providers, including hospitals and HMOs, worry that Medicare money to pay for drugs will be squeezed from their own budgets even as they struggle to adjust to payment cuts Congress approved two years ago to help balance the federal budget.

LANGUAGE: ENGLISH

LOAD-DATE: June 29, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
Mandatory Terms: date in-between june 26, 1999 : july 1, 1999
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Charleston Daily Mail, June 29, 1999

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Charleston Daily Mail

June 29, 1999, Tuesday

SECTION: News; Pg. P1A

LENGTH: 668 words

HEADLINE: Drug benefit would cost \$24 monthly That's how much seniors would pay for \$2,000 cap

BODY:

WASHINGTON - Older or disabled Americans would pay \$ 24 a month if they want to take advantage of a new \$ 2,000-a-year prescription drug benefit that is a centerpiece of President Clinton's long-awaited proposal to bolster Medicare.

"We can't afford not to introduce prescription drug benefits into the Medicare program," Donna **Shalala**, the health and human services secretary, said today on "CBS This Morning." "Drugs are increasingly a critical part of health care in this country."

The proposed drug benefit, **Shalala** said, "will have a limit on how much the government will pay for, and it will be very carefully designed so it doesn't spin out of control."

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The American Association of Retired Persons, the nation's largest organization of older adults, supports the concept of a new Medicare

prescription drug benefit. But senior AARP lobbyist Patricia Smith said among outstanding concerns is how much Medicare clients will be asked to pay out of pocket.

"Will Medicare beneficiaries judge this to be affordable? I think the only way we're going to find out is through the political process," said Smith.

Drug coverage accounts for about \$ 90 a month of premiums charged for most Medigap policies, which generally cover 50 percent of prescription costs after a \$ 250 deductible is reached. Annual caps on Medigap drug coverage vary up to a maximum of \$ 3,000.

LOAD-DATE: June 30, 1999

Source: News Group File, Most Recent Two Years
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International Herald Tribune, June 29, 1999

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International Herald Tribune (Neuilly-sur-Seine, France)

June 29, 1999, Tuesday

SECTION: News; Pg. 3

LENGTH: 297 words

HEADLINE: Health Chief Defends Aid For Medicine

BYLINE: By Robert Pear; New York Times Service

DATELINE: WASHINGTON

BODY:

Donna **Shalala**, the secretary of health and **human services**, has moved to head off criticism of the cost of President Bill Clinton's plan to help buy prescription drugs for older Americans, saying that the new Medicare benefits "will not be as generous as people think."

"This isn't about just adding some new lush benefit," Ms. **Shalala** said in a television interview. "This is critical to health care."

More than one-third of the 39 million Medicare beneficiaries have no insurance to cover prescription-drug costs. On Tuesday, Mr. Clinton will unveil a plan for the government to offer subsidized drug coverage to all beneficiaries.

The plan depends, in its entirety, on approval by Congress. It is impossible to predict with any certainty what Congress will do.

Administration officials said the premium for drug coverage would start in the range of \$20 to \$25 a month and then climb gradually in subsequent years toward \$45 a month. Under the plan, the government would pay about half the cost of prescription drugs, up to a certain level to be specified by law, and beneficiaries would pay the remainder.

As of noon Sunday, an administration official said, the maximum annual benefit - the amount payable by the government - had not been decided. But like the premium, it could rise over time, the official said.

Comments by Mr. Clinton and his aides suggest that the administration is open to a deal with Congress: Democrats would win Medicare coverage of prescription drugs, and Republicans would get some of the tax cuts they want.

John Podesta, the White House chief of staff, met last week with Representative Bill Archer, Republican of Texas, who is chairman of the Ways and Means Committee, where tax bills usually originate. ???

LANGUAGE: ENGLISH

LOAD-DATE: June 29, 1999

Source: News Group File, Most Recent Two Years
Terms: department of health and human services shalala
Mandatory date in-between June 26, 1999 : July 1, 1999
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The Independent (London), June 30, 1999

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June 30, 1999, Wednesday

SECTION: FOREIGN NEWS; Pg. 16

LENGTH: 432 words

HEADLINE: CLINTON WOOS PENSIONERS WITH NEW HEALTHCARE PROMISE

BYLINE: Andrew Marshall In Washington

BODY:

PRESIDENT BILL Clinton launched a plan yesterday to help pensioners to pay for prescriptions. The much-trumpeted initiative is part of a reform intended both to prop up the United States' tottering healthcare system and boost his party's electoral fortunes.

Retired people and those who will retire in the next 10 years constitute a big, important part of the electorate, with whom the new plan will be very popular. By using the budget surplus to pay for poorer Americans' health care, the President is also blocking Republican moves to use it for tax cuts for the more well-off.

Under the President's plan pensioners would initially pay an extra \$ 24 (pounds 15) a month and in exchange, the government would pick up half the cost of prescriptions up to \$ 2,000 a year. This is much below the cost of private insurance, and the government would also pay the premiums for poorer people.

Medicare, a Sixties government initiative to pay for health care for retired people, covers hospital care but not prescriptions. Expanding it is popular with most politicians, although they differ about how it should be done. There is a good case for the prescriptions plan. One-third of old people lack private insurance to cover the cost, and making medicines more readily available would help to reduce the need for hospital care.

"We can't afford not to introduce prescription-drug benefits into the Medicare programme," said Donna **Shalala**, health and **human services** secretary yesterday. But some politicians want to expand it only to poorer people, fearing more financial problems from a more general increase. Others believe the plan would undermine private healthcare schemes. "I can't understand why we would want to drive those private programmes out," said Phil Gramm, a Republican senator.

The other problem with which the President is grappling is that Medicare is going broke. When the baby-boom generation retires, millions more people will be entitled to claim hospital care under its benefits, with the number of people eligible doubling by 2002. But the number of workers paying into its funds will fall. So Mr Clinton proposes to use the accumulating federal budget surpluses over the coming decades to prop up the fund. Some \$ 800bn would be paid into Medicare in the next 15 years, most of it to pay for the expected deficit.

The new prescription benefits would be paid for with the rest of the surplus and by savings in the rest of the programme. The arithmetic looks wobbly, since the figures depend on some heroic assumptions about the economy.

LANGUAGE: ENGLISH

LOAD-DATE: June 30, 1999

Las Vegas Review-Journal (Las Vegas, NV) June 30, 1999 Wednesday,

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Las Vegas Review-Journal (Las Vegas, NV)

June 30, 1999 Wednesday, FINAL EDITION

SECTION: A; Pg. 1A

LENGTH: 1170 words

HEADLINE: Clinton unveils Medicare plan

BYLINE: Jodi Enda and David Hess

BODY:

By Jodi Enda and David Hess
Knight Ridder Newspapers

WASHINGTON _ President Clinton on Tuesday proposed a far-reaching plan to extend the life of Medicare well into the next century and to expand benefits dramatically by offering senior citizens free preventive care and an option to buy coverage for prescription drugs.

'It's the right thing to do for our parents and our grandparents,' Clinton said. '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 cost does not fall on the children and hurt their ability to raise our grandchildren.'

The president's proposal represents one of the most ambitious attempts to reform the senior citizens' health insurance program since President Johnson signed it into law in 1965. It also is Clinton's biggest foray into the world of health care reform since his mammoth plan to revamp the nation's entire medical delivery system went down in flames five years ago.

In his fourth major domestic-policy appearance since Friday, Clinton reached out to Congress to take advantage of the flush economic times and the ever-narrowing window before next year's presidential and congressional elections to pass what he deemed to be needed reforms.

Even before the president could unveil his plan, Republican leaders attacked it as too expensive and unnecessarily broad. But faced with a prescription drug proposal that is expected to generate considerable public support, the GOP dismissed nothing out of hand.

'We want to see an America in which every senior has the best possible health care, including access to affordable prescription drugs as part of an integrated health program,' Senate Majority Leader Trent Lott of Mississippi and House Speaker Dennis Hastert of Illinois said in a joint statement.

Their comments signaled the possibility that a much-anticipated budget brawl, in which Republicans will push for tax cuts while Clinton presses to pay down the national debt and shore up Social Security and Medicare, can end in a compromise that puts both parties in a positive light as they head toward elections.

The president announced Monday that he wanted to use \$ 794 billion of a larger-than-expected federal surplus to extend the life of Medicare to 2027. 'But,' he said during an address Tuesday in the White House East Room, 'securing Medicare is not enough.'

After 35 years as an essential part of the lives of 39 million senior citizens, Medicare must be modernized to reflect many of the medical breakthroughs that have taken place since its inception, Clinton said. He pointed specifically to the increased reliance on medication and preventive care to avoid surgery.

Under the president's prescription drug plan, senior citizens could choose to pay \$ 24 a month, starting in 2002, for a benefit intended to cover half their prescription drug costs. Initially, Medicare would pay up to \$ 1,000 a year for medications _ half a \$ 2,000 annual bill. Gradually, Medicare payments would increase to a maximum of \$ 2,500 in 2008, when the monthly premium would rise to \$ 44.

Administration officials said they also would allow Medicare to benefit from the same kind of bulk-buying discounts that private insurers receive, a change they predicted would reduce the price of medication some 10 percent.

'Nobody would devise a Medicare program today, if we were starting all over, without including a prescription drug benefit,' Clinton said. 'There is 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,' he said. '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 employers' health programs.'

The new prescription drug benefit would cost the federal government \$ 118 billion over 10 years, according to

administration figures.

Although a number of Congress members said the prescription plan should be available only to the most needy seniors, the White House officials rejected that proposal. Instead, theyit decided to eliminate the monthly premium to individuals who earn less than \$ 11,000 a year and couples who earn less than \$ 17,000 annually. Other low-income Medicare recipients would receive subsidies to help offset the premiums.

The American Association of Retired Persons hailed the prescription drug plan. 'That's a major step forward that could help a lot of people with substantial costs,' said lobbyist Tricia Smith said.

The plan is unlikely to survive Congress without major changes, and the prescription-drug benefit is an obvious area for compromise. House Majority Leader Dick Armey, R-Texas, said there was no need to offer the coverage to the two-thirds of senior citizens who have prescription benefits through private insurance.

'We want to focus our concern and concentrate our interests on those that do not have available coverage now,' he said. 'If you've got 31 percent of the people with the problem, you ought to put together a 31 percent solution, not necessarily a 100 percent solution.'

But Gene Sperling, Clinton's domestic policy adviser, said the prescription drug premiums offered by the administration's plan would be as much as 50 percent less than those charged by private insurers who provide so-called 'Medigap' coverage. And the AARP's Smith said Medigap coverage is both 'expensive and limited,' leaving many seniors with monthly medication bills of \$ 200 to \$ 400.

'This program was designed, in a way, with the assumption that as we get older we get poorer,' said Donna **Shalala**, secretary of Health and **Human Services**. 'But more importantly, we believe that this benefit is an integral part of good health care, that it is, in fact, modern health care to include a drug benefit. Why, then, would we limit it?'

But even some Democrats questioned the notion that coverage for medicine should be offered to everyone.

'It's almost irresistible politically,' said Sen. Bob Kerrey, D-Neb. 'But it's also costly, and I'm not sure how we can pay for it.'

Clinton also wants to stop charging seniors for preventive care, such as mammograms, screening for diabetes or routine checkups, at a cost of \$ 3 billion over 10 years.

'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,' Clinton said.

To help cover the additional costs, the White House officials proposes charging senior citizens for 20 percent of the cost of laboratory tests. It also would, for the first time, tie the Medicare deductible to inflation. The \$ 100 deductible has not increased in more than 30 years.

LANGUAGE: ENGLISH

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Daily News (New York) June 30, 1999, Wednesday

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Daily News (New York)

June 30, 1999, Wednesday

SECTION: Editorial; Pg. 35

LENGTH: 553 words

HEADLINE: CLINTON'S RX FOR SENIORS GOOD FOR THE REAL WORLD

BYLINE: BY LARS-ERIK NELSON

BODY:

WASHINGTON Times are good, Sen. Mitch McConnell (R-Ky.) observed the other day. "Everybody has two cars and a boat."

The elderly are especially well off, Robert Goldberg of the Ethics and Public

Policy Center wrote in the Wall Street Journal. "The average net worth for households in the 65-to-74 age group is \$ 331,000."

And there's no need, said Sen. Phil Gramm (R-Tex.), for providing prescription-drug insurance for seniors, except maybe the poorest. Practically everybody else including, most importantly, Phil Gramm is covered, he said.

The world can be a beautiful place for conservatives full of cars and boats

and beautiful homes and never a fear that a costly prescription drug might mean a couple of weeks on cat tuna.

In the real world, not everybody has two cars and a boat.

In the real world, averages of wealth mean very little; Bill Gates alone has

more wealth than the poorest 45% of the population put together. Averaging it all together gets you a meaningless number like the \$ 331,000 "average" net worth of retirees.

And in the real world, even those who theoretically have prescription-drug coverage can go broke trying to pay for medicine or are at risk that their employer or insurer will drop the program to cut costs.

In proposing to add prescription-drug insurance to Medicare, the Clinton administration is modestly addressing a real need of real people. The program would be voluntary and limited; \$ 24 a month would buy \$ 1,000 a year in benefits in the first year, 2002. Premiums and benefits would rise over time.

Medicine is not a frill. Blood-pressure medication can prevent strokes. Cholesterol medication can avert heart disease and keep the elderly out of hospitals provided they can afford to buy the medicine.

"This will be voluntary, universally available and managed by the private sector," Health and **Human Services** Secretary Donna **Shalala** said yesterday, wincing at memories of the "big-government" charges that sank President Clinton's initial health-care proposals.

Even those who already have prescription-drug coverage would opt for the new program, she said, because it has no deductibles and picks up 50% of the cost of the first \$ 2,000 in drug expenses. "Most people who are now in Medigap [insurance] plans will save some money," she said.

To fight off the predictable charges that this is some new form of socialized

medicine, White House chief of staff John Podesta said, "We resigned a model that is competitive and

market-oriented and that does not rely on cost controls.

With \$ 1 trillion in additional surpluses now projected in coming years, the prescription-drug program is affordable. It is projected to cost \$ 118 billion over 10 years, but that figure doesn't take into account the possible savings that result when people can afford to take the medicine that keeps them out of hospitals.

By the same logic, Clinton is proposing to eliminate all charges for preventive medicine flu shots, colorectal exams and mammograms in hopes that the relatively small additional cost will avert much bigger costs later on.

Some Republicans are already on board, but you can hear the grumbling from conservatives. They see no need to help the elderly in a world where everybody has two cars, a boat and \$ 331,000.

GRAPHIC: IGOR KOPELNITSKY

LOAD-DATE: July 01, 1999

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USA TODAY, June 30, 1999

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USA TODAY

June 30, 1999, Wednesday, FINAL EDITION

SECTION: NEWS; Pg. 14A

LENGTH: 535 words

HEADLINE: Seniors need drug benefit; taxpayers need truth about cost

BODY:

The 66% of seniors with drug coverage now get it mainly from one of three sources: former employers, **Medicare**-financed managed care plans or Medigap policies. But rising drug costs are causing employers to walk away from retiree medical benefits. Lower reimbursements are causing HMOs to rethink their coverage. And Medigap policies are ...

... counting other out-of-pocket health-care expenses, such as premiums, deductibles and co-payments.

Against all that, the Clinton administration Tuesday proposed spending \$ 118 billion over 10 years for a **Medicare** drug benefit. The plan is teeming with dubious cost estimates and questionable mechanisms. Officials expect to pay for 60% of the cost through other **Medicare** changes and savings -- a familiar Washington fantasy that ought to stop the plan till more substantive financing is arranged.

Politically, however, the time for a **Medicare** drug benefit is surely at hand. Just 10 years ago, a similar drug benefit was thoroughly savaged by the elderly and the drug industry and ultimately repealed by Congress. This time around, even the drug industry -- not to mention both Democrats and Republicans in Congress -- agree that some sort of coverage through **Medicare** is warranted.

In part, that reflects the dramatic changes in health care. As few as 15 years ago, drugs were considered a supplement to health care, not integral to it. Nowadays, drugs are viewed as ...

... by preventing hospitalizations, surgeries and complications.

Far less certain is how much the government will help and whether it will honestly address the costs, which will not be cheap.

There are lots of ways to formulate a **Medicare** drug benefit. It can be limited to catastrophic costs or restricted to the poor and near-poor. However it works out, the new entitlement must not be allowed to run riot. To that end, Clinton offers a ...

... cap
that increases in later years. That would cover almost everybody;

only 4% would spend more.

And maybe that all would work. The first priority must be to ensure the long-term financial stability of Social Security and **Medicare**. But once that's done, adding a drug benefit is exactly the right thing to do.

ORGANIZATION: MEDICARE (84%);

COMPANY: MEDICARE (84%);

SUBJECT: ; COST; DRUG; **EDITORIAL;** ELDERLY; **MEDICARE** SUPPLEMENTAL HEALTH INSURANCE (73%); MANAGED CARE ORGANIZATIONS (58%);

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The Milwaukee Journal Sentinel June 30, 1999 Wednesday

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Milwaukee Journal Sentinel

June 30, 1999 Wednesday Final

SECTION: News Pg. 10

LENGTH: 435 words

HEADLINE: Clinton's sensible plan for surplus

BYLINE: FOSTER

BODY:

President Clinton reported some extraordinary budget surplus projections this week and told Congress and the American people how he thought the new money should be spent. Generally, the president's spending priorities were the right ones, but he wasn't as cautious as he should have been about his forecasts.

The figures from Washington's number crunchers in recent months seem almost too good to be true. The government now anticipates a budget surplus of \$5.94 trillion over the next 15 years. Particularly remarkable is the forecast that next year's surplus will not depend on revenue from Social Security taxes.

On Monday, Clinton said what he has often said before, that he wants above all to use the money to shore up **Medicare** and Social Security and to pare down the national debt. These spending priorities make sense, given the serious problems facing **Medicare** and Social Security and the continuing damage inflicted on the economy by the mammoth federal debt.

Medicare, the health insurance system on which 39 million elderly Americans rely, faces a cash crunch chiefly because 76 million more Americans will reach retirement age over the next 30 years and because they will probably live longer (and run higher medical bills) than their parents did.

Using part of the projected surplus to deal with this looming problem is essential. Clinton proposed an ambitious response: a cash infusion of nearly \$800 billion over the next 15 years, a commitment that should keep the program solvent, and retirees happy and healthy, until at least 2025.

On Tuesday, Clinton gave them another gift: a plan to subsidize prescription drugs for all **Medicare** beneficiaries. Since more than one-third of these 39 million people don't have insurance to cover such drug expenses, some help is needed. But the cost of the help that Clinton recommends needs to be carefully calculated, lest the intended reform turn into a spending disaster.

In fact, the whole economic foundation of Clinton's spending plans is shakier than he's willing to admit. Revenue has been much higher than officials expected even a few months ago. Still, such projections are less trustworthy than weather forecasts, especially over long periods; in 1997, no one predicted the economic crash that hit Asian countries seemingly destined for continued economic health.

The country has reason to be proud and happy over its economic health, and it needs to use its prosperity to help the elderly and the poor; but it would be folly to make spending plans on the basis of mammoth surpluses that may not materialize.

LOAD-DATE: July 1, 1999

Newsday (New York, NY), July 1, 1999

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July 1, 1999, Thursday, ALL EDITIONS

SECTION: VIEWPOINTS; Page A42

LENGTH: 353 words

HEADLINE: EDITORIAL / UPDATING MEDICARE MEDICINE HAS CHANGED; **MEDICARE** SHOULD CHANGE WITH IT, BY INCLUDING DRUG COVERAGE.

BODY:

President Bill Clinton's plan to modernize **Medicare** and add a prescription drug benefit while extending the program's solvency is an ambitious bundle of policy changes that, with a little luck on the economic front, could accomplish all those things.

The proposed drug benefit is the big news. Under the plan, **Medicare's** 40 million beneficiaries could opt to pay a monthly premium of \$ 24 beginning in 2002 in exchange for which **Medicare** would pay half the first \$ 2,000 of drug costs. In 2008 the premium would rise to \$ 44, the benefit cap to \$ 5,000.

But the heart of Clinton's plan is its cost-saving measures. It would introduce more competition among managed-care plans offering a basic benefits package, and empower **Medicare** officials to negotiate prices with fee-for-service providers much as private insurers do now.

The plan would also extend cost-saving measures initiated in the Balanced Budget Act of 1997 that have dramatically slowed the growth of **Medicare** costs but are set to expire in 2003. Unfortunately that belt-tightening has already pushed some of New York's teaching hospitals into the red, making that component of Clinton's plan a candidate for some critical fine tuning.

Then there's the \$ 794 billion from the federal budget surplus that the plan earmarks for **Medicare** during the next 10 years. That's where luck enters the picture. The money might never materialize if the economy takes a dive.

Still, Clinton is on the right track.

Coverage for prescription drugs is an essential element in retooling **Medicare** for the future. The practice of medicine has changed in the 33 years since the program began. Drugs have assumed a much larger role in effective treatment.

And while the expense has skyrocketed, drugs are still a more cost-effective way to treat illnesses than hospitalization.

Providing prescription coverage for seniors won't be cheap. Clinton has set the 10-year price tag for his plan at \$ 118 billion. His plan provides a good starting point for Congress, which should tackle the necessary job of **Medicare** reform sooner rather than later.

LANGUAGE: English

LOAD-DATE: July 1, 1999

Sun-Sentinel (Fort Lauderdale), July 5, 1999

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July 5, 1999, Monday, Broward Metro EDITION

SECTION: EDITORIAL, Pg. 15A

LENGTH: 665 words

HEADLINE: POLITICIANS WRANGLE WHILE CLOCK TICKS ON HEALTH-CARE ILLS

BYLINE: ARTHUR E. PALAMARA

BODY:

A cardiologist friend related the story of a patient with a heart condition who had recently been stabilized after a long search for the correct medication. Shortly thereafter, his HMO refused to pay for this medicine, substituting instead a similar, but cheaper, medication, which failed to work. Despite a one-hour conversation with the HMO's medical director, it still refused to provide the better medicine. Since the retiree was unable to pay, he asked, "What can I do?" The answer for this patient is to file a complaint with Florida's Agency for Health Care Administration.

Yet it prompts the larger question, how can we as a country provide necessary and quality health care for the growing number of vibrant elderly patients? In May, the bipartisan committee charged with the responsibility of saving **Medicare** died in the stanglehold of partisan politics. Sen. John Breaux, R-La., and his committee had the responsibility to come up with a plan that would stabilize **Medicare** well into the next century.

They quit, never able to reach a consensus.

Reforming **Medicare** is a considerable challenge. Since no one is able to predict how much health care is going to cost in the future, it is very difficult to establish a plan that will meet everyone's needs.

Most of the medical miracles that are commonplace today were invented in the late 1950s and '60s. In 1965, when **Medicare** started, life expectancy was only 67 years, which meant that government was responsible for only two years of a person's life. Life expectancy now stands at about 78.

CAT scans, MRIs PET scanners, Color flow ultrasounds -- devices that we take for granted today -- were fantasies even as recently as 1970. Not only have these advances extended life, but they have increased personal expectations. People expect, and frequently receive, home health care, the latest medicines, access to specialists, second and third opinions.

What was previously regarded as care for the very rich is now available to everyone, although arguably some patients in HMOs may have to fight for it. Several years ago, Hugh Trout, speaking on behalf of the American College of Surgeons, noted that the average **Medicare** recipient received \$ 45,000 in benefits beyond that which they contributed to **Medicare**.

While these benefits are necessary, someone has to pay for them. With the median age creeping steadily upward and fewer people working and proportionately more retirees, the burden of paying for these medical miracles falls on the shoulders of fewer and fewer people. Simply put, we cannot go on the way we are. New solutions must be found.

Both Democratic and Republican members of Congress know this, yet solutions are politically unpalatable.

To their credit, Republicans advanced the idea of using the power of compound interest to help pay for Social Security and **Medicare**. Figuring that the stock market has risen from 3,500 to over 10,000 in the past five years, investing a portion of health-care funds into securities would more than double their value. This is what private pension funds have been doing all along.

Regardless of how you feel about such ideas, they are creative.

Since there is some risk to this, Democrats hammered at Republicans for risking entitlement benefits, arguing that the stock market is subject to recession and elderly and poor people could ill afford to lose even a small portion of their benefits.

Maybe, but the alternative is to raise taxes, which neither party likes to do.

President Roosevelt recognized the need in the 1930s and began Social Security. President Johnson had a similar vision in 1965 when he created **Medicare** and Medicaid. These solutions were bold and creative. Democrats appear to have lost this boldness.

With **Medicare** in trouble, and with 20 percent of this country's population having no regular access to medical care, we need to do something. The clock is ticking.

The author is a Hollywood surgeon.

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The Commercial Appeal (Memphis, TN), June 30, 1999

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June 30, 1999, WEDNESDAY, FINAL EDITION

SECTION: VIEWPOINT, Pg. A8

LENGTH: 736 words

HEADLINE: MEDICARE - HELP WITH DRUG COSTS IS WELCOME - IF IT'S PAID FOR

BODY:

EVEN AS President Clinton has warned again of the need to shore up **Medicare's** finances, he has proposed a new prescription drug benefit that by the White House's own estimate would cost the troubled program \$ 118 billion over a decade.

The plan the President offered Tuesday to reform the federal health care program for elderly and disabled Americans would make better use of the projected budget surplus than the regressive tax cuts Republican lawmakers want. It would properly emphasize preventive care. But Clinton must be careful about making promises that he - or, more accurately, his successors - may not be able to keep.

The centerpiece of the President's plan is the creation of a prescription drug option that would begin in 2002. A **Medicare** recipient ultimately could get as much as \$ 2,500 a year in federal aid to help pay for medications. To qualify, he or she would have to pay a monthly premium that would start at \$ 24 and rise to \$ 44 by 2008.

The premium would be waived for low-income beneficiaries, and there would be no deductible. Administration officials estimate that 31 million Americans would sign up for the coverage, which would pay half the cost of prescription drugs up to the \$ 2,500 limit. Critics warn that the cost of the entitlement could escalate far beyond White House projections.

The financing is a bit vague. The White House, under pressure from lawmakers of both parties, rejected a plan to pay for the voluntary drug benefit by raising premiums for upper-income **Medicare** recipients.

Instead, administration officials say they will raise more than 60 percent of the benefit's cost through savings generated by the proposed reforms. These changes are designed to make **Medicare** more competitive and efficient by applying private-sector tools in such areas as managed care, purchasing and quality improvement.

Medicare needs to be strengthened and modernized. But Tennesseans heard similar promises of big savings and cost-effectiveness when TennCare began five years ago, switching to a managed-care model from a fee-for-service system.

Those savings have not been fully realized, to say the least. The administration's **Medicare** forecasts appear to warrant a similar degree of skepticism.

The President would pay for the rest of the drug benefit by tapping the anticipated federal surplus. In all, Clinton would dedicate 15 percent of the surplus over the next 10 years - some \$ 374 million - to **Medicare**, an investment he says would ensure the solvency of the **Medicare** trust fund through at least 2027.

Budget estimates, however, are notoriously unreliable; the 15-year, \$ 5.5 trillion surplus the President projected this week is \$ 1 trillion higher than the projection just last January. Relying on today's predictions of what the economy will look like in 2015 as a basis for fixing **Medicare** and Social Security and erasing the national debt, as Clinton is doing - or financing large across-the-board tax cuts, as congressional Republicans prefer - represents a triumph of optimism over prudence.

There are other concerns. Would the Clinton plan insert Washington into decisions about medicines that are best left to patients and their doctors? Could it create a de-facto system of price controls? Would it truly provide help with drug cost where help is needed most?

Nancy-Ann Min DeParle, the former Tennessee commissioner of **human services** who now heads the federal Health Care Financing Administration, which runs **Medicare**, insists the new prescription drug entitlement would strengthen, not threaten, the program.

"Our first goal has been to ensure **Medicare's** solvency, and we've done a pretty good job of making tough decisions to do that," she told The Commercial Appeal.

"But it's not a decent health benefit if it doesn't include prescription drugs."

AS CONGRESS studies the President's **Medicare** proposals, it will want to examine alternatives as well. Premium-supported prescription drug coverage, similar to that available to federal employees, is one approach. Reasonably broadening the availability of private Medical Savings Accounts is another idea worth studying.

Medicare certainly will need a financial overhaul before the 76 million Baby Boomers start to retire early in the next century. A prescription drug benefit would represent both sound policy and popular politics - provided it is paid for honestly.

NOTES:
Editorial

GRAPHIC: photo;

Bill Clinton

LOAD-DATE: June 30, 1999

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THE INDIANAPOLIS STAR, July 2, 1999, Friday

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THE INDIANAPOLIS STAR

July 2, 1999 Friday CITY FINAL EDITION

SECTION: EDITORIAL; Pg. A17; LETTER SPOTLIGHT

LENGTH: 492 words

HEADLINE: A plan to protect, improve **Medicare**

SOURCE: JULIA VAUGHN

BODY:

The **Medicare** program, which has improved the lives of millions of elderly and disabled Americans, faces perilous times. Some politicians in Washington propose to radically change **Medicare** from a publicly administered program to a marketplace of health plans partially subsidized by the government.

The result would be a substantial increase in the proportion of the **Medicare** budget going to administration and private profit and a reduction in the funds available for health care. Most **Medicare** beneficiaries would be forced to pay for an increasing amount of their health care out-of-pocket, causing many to do without.

Rather than devise a reform plan that will reward their pals (and campaign contributors) in the insurance industry, Congress should pass legislation that is equitable for beneficiaries and can ensure the solvency of **Medicare** for the future. A three-stage proposal to protect, improve and expand **Medicare** is necessary.

First, **Medicare** must be protected fiscally by establishing a budget. By moving gradually toward a budgeted program, **Medicare** has had considerable success in reducing its rate of growth. Average annual growth dropped from 17 percent in the 1970s to 12 percent in the 1980s, to 10 percent in the years 1993-96, and to a mere 1.5 percent in 1998.

Between 1998 and 2007, expenditures are projected to increase at an annual rate considerably below private health insurance expenditure growth. If budget restraints are placed on the program, it is estimated to cost between \$ 49 and \$ 65 billion less than the current system by 2010.

Second, **Medicare** must be improved by adding prescription drug coverage and long-term care.

The third stage should be to expand a universal **Medicare** program to the entire population. This would insure the 43 million Americans without health insurance and would place a budget over all health care expenditures, thereby helping to control costs.

Expanding **Medicare** to the entire population would cushion the financial impact created by the retirement of the large baby boomer population.

Ample revenues from progressive taxes, the federal budget surplus and transfers from other government programs are available

to finance the improvement and expansion of **Medicare**. These revenues would take the place of out-of-pocket payments for health services currently made by the public, and could do so without major tax increases on the average American family.

Created by Congress in 1965 to address growing numbers of senior citizens who lost their life savings after becoming ill, **Medicare** has been a tremendous success. In order to ensure its future, the public must demand that Congress pass reforms designed to protect, improve and expand **Medicare**, not plunder it for the profit of the insurance companies.

Vaughn is health policy coordinator for Citizens Action Coalition of Indiana in Indianapolis.

LOAD-DATE: July 06, 1999

Source: The Indianapolis Star
Terms: medicare shala department of health and human services
Mandatory editorial date in-between june 30, 1999 : july 6, 1999
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THE INDIANAPOLIS STAR, July 2, 1999, Friday

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THE INDIANAPOLIS STAR

July 2, 1999 Friday CITY FINAL EDITION

SECTION: EDITORIAL; Pg. A16

LENGTH: 635 words

HEADLINE: Clinton's Medicare fix

BODY:

There are now two plans on the table for fixing **Medicare**, America's ailing health insurance plan for senior citizens, and they represent two distinct philosophies of how government should run entitlement programs.

President Clinton's plan, unveiled Tuesday, offers a significantly expanded package of benefits, including a much-needed prescription drug package. The downside is that an already expensive program will become even more expensive, and **Medicare** will continue to rely on one-size-fits-all centralized management as its primary means of controlling costs.

The Bipartisan Advisory Commission's **Medicare** plan, which Clinton rejected in March, would have transitioned the government-run program to private sector health plans. Beneficiaries would be allowed to choose from a variety of privately operated health plans, with **Medicare** paying a fixed amount toward each participant's annual premium.

It would work like the federal government's employee health plan, which provides a high level of benefits, including prescription drugs, to 3 million workers.

Clinton's plan doesn't really overhaul **Medicare's** inefficient fee-for-service system. It just patches over some of the bigger problems by piling on more benefits, more money and more controls.

Most troubling, the Clinton plan is built on a questionable foundation of highly optimistic assumptions.

For starters, it assumes the U.S. economy will not hit any major bumps in the road over the next 15 years, and that the White House's almost miraculous discovery of an additional \$ 1 trillion federal surplus will actually materialize. The discovery came just in time, as Clinton's **Medicare** plan will consume 80 percent of that new projected surplus.

Second, his plan assumes that the federal government's giant Health Care Financing Administration, which runs **Medicare**, will succeed in holding **Medicare** spending growth to no more than 4.3 percent through 2009. Given HCFA's track record, that assumption is laughable.

HCFA's solution for **Medicare's** out-of-control spending growth in the early 1990s was to impose painful price controls on hospitals and doctors and issue thousands of pages of revised billing rules.

When it became apparent that fraud, waste and abuse was eating up better than \$ 1 out of every \$ 5 spent by **Medicare**, HCFA's solution was to send out an army of auditors and FBI agents to snoop through billing records and second-guess treatment decisions by doctors.

How much money this saved is questionable. But it greatly increased red tape and reduced the quality and availability of services. Now, Clinton is suggesting that with yet more tinkering, the bureaucrats will finally get it right.

In unveiling Clinton's plan, HCFA officials adamantly denied they are contemplating price controls on prescription drugs. HCFA Deputy Administrator Michael Hash said they would control costs by contracting with pharmacy benefit managers, just as private health plans do.

"The combination of their purchasing power and their management of prescription drugs has shown over and over again in the private sector that you can contain costs without price controls," Hash said.

Perhaps. But we find it hard to believe that HCFA would not give in to the irresistible temptations of price fixing and rationing at the first sign of trouble. That's what it does best.

The best **Medicare** plan will be the one that truly solves its financial shortfalls while maximizing choice and benefits. It is especially important that choice of prescription medicines be left to doctor and patient - not to bureaucrats with their noses glued to price catalogs. Americans should look Clinton's plan over very carefully before lending it their support.

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THE INDIANAPOLIS STAR, July 2, 1999, Friday

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THE INDIANAPOLIS STAR

July 2, 1999 Friday CITY FINAL EDITION

SECTION: EDITORIAL; Pg. A17

LENGTH: 262 words

HEADLINE: Strengthening program for the long term

BODY:

Pharmaceuticals play an integral role in our health care system, and with good reason. America's pharmaceutical companies have made tremendous breakthroughs in recent years in treating cancer, osteoporosis, schizophrenia, heart disease and diabetes, just to name a few. Now, using new technologies and gene therapy, scientists at companies such as Eli Lilly are on the verge of even more exciting discoveries.

President Clinton this week announced a plan to add a prescription drug benefit to **Medicare**. There's no question that prescription medicines, which help people live longer, healthier lives, should be part of the **Medicare** program of the 21st century, but how we accomplish that is critical. We believe any proposal should:

Strengthen and improve the **Medicare** program for the long term.

Leave the choice of prescription medicines to doctor and patients.

Provide extra assistance for those seniors most in need.

Avoid price controls, direct or indirect, on drugs, which would discourage life-extending medical research.

Provide high-quality, integrated care and not manage costs by limiting choice and availability of medicines.

Provide seniors with meaningful choices among different kinds of private sector health plans.

Protect coverage choices that many seniors have and like today.

We look forward to reviewing the details of the president's plan and working with him and all members of Congress on this important national issue.

RON STOWE
Vice president
Government relations
Eli Lilly and Co.
Indianapolis

LOAD-DATE: July 06, 1999

The Idaho Statesman, June 30, 1999, Wednesday

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The Idaho Statesman

June 30, 1999, Wednesday

SECTION: Local ; Pg. 1b

LENGTH: 544 words

HEADLINE: Head Start helps migrant workers
Nampa program provides day-care for young children

BYLINE: By Liz Wyatt

SOURCE: The Idaho Statesman

DATELINE: NAMPA - When she heads to the fields each day this summer, Mary Alvarez won't have to worry about taking her littlest ones with her.

BODY:

The migrant farm worker's youngest children will have a place to go besides the hot farmland, where they likely would be supervised only by other children.

Alvarez's two youngest children are among those receiving care at La Chiquita - Nampa's Migrant Head Start. In its own full-time facility this year for the first time, La Chiquita is helping the growing number of Canyon County migrant workers who need day-care.

"The kids are very well taken care of," Alvarez said, "and parents are always welcome to come in and see what the program is all about."

Nampa has an estimated 189 children of migrant workers this year, according to Maria Salazar, Idaho's Migrant Head Start director.

It's uncertain how many migrant workers there are each year in Idaho.

"Every year, we do an assessment of the community. And when we looked last year at the population, we saw that in Canyon County, 19 percent of the community is minority and almost 18 percent is Hispanic," Salazar said. "And Hispanics are our primary service population in Migrant Head Start."

The Nampa program is one of 12 Migrant Head Starts in Idaho. Other Treasure Valley sites include Weiser and Caldwell.

The Idaho Migrant Council is working to add a 13th site, in Fremont County, for eastern Idaho's growing migrant population.

Head Start began its migrant programs in 1969. They are seasonal services designed for children of low-income migrant workers.

The programs were started separately from other Head Start programs because the population they serve moves around, U.S. **Department of Health and Human Services** spokesman Michael Kharfen said.

Migrant Head Start programs are now in 33 states and served more than 37, 000 children last year. Idaho's programs served about 700 children last year.

"This year, we are moving right along in terms of enrollment," Salazar said. "Of course, that has to do with better farming weather this year."

Services range from nutrition to education. The programs are a welcome relief to many migrant workers who work long days in the fields and cannot afford day-care for their children.

Many farm workers take their children with them to the fields, where they wait in cars or play outside. It's not uncommon for children to supervise other children.

"It's boring - real hot," said Alvarez's daughter, 8-year-old Lisa Alvarez. She used to have to go with her parents to the fields

La Chiquita opened in its new facility last week.

The program is renting space from Grace Episcopal Church. A van gives rides to families without transportation.

Children from infants up to 5-year-olds attend La Chiquita, which will stay open through October.

"Here they get love and learn," teacher's aide Cipriano Lopez said. "It helps a lot of people."

La Chiquita

A Head Start program to serve children of migrant workers is now open at 411 10th Ave. S. in Nampa.

It will be open through October. Spaces still are available. For more information, call 465-0677.

Caption: Photo by Tom Shanahan / The Idaho Statesman: Teacher Rachel Nunjaray helps Santiago Ibarra get up the slide on Tuesday. The new Head Start program in Nampa - along with other migrant Head Start sites elsewhere in Idaho - helps working migrant parents.

GRAPHIC: Photo by Tom Shanahan / The Idaho Statesman: Sharing a laugh: Head Start teacher Marna Kohlleppe-Rubio plays with student Destiny Ibarra in the outdoor play area of the new La Chiquita, Nampa's Migrant Head Start program, on Tuesday morning.;migrant workers

LOAD-DATE: July 2, 1999

Source: News Group File, Most Recent Two Years
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October 21, 1998 (12:04pm)

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I. Background

A. Diabetes--Background

1. Prevalence and costs of diabetes.

In 1997, as reported by the Department of Health and Human Services' Centers for Disease Control and Prevention, (CDC), 15.7 million people in the United States had diabetes, nearly six percent of the United States population (Morbidity and Mortality Weekly Report 4643, 1014-1018, 1997)

Center for Disease Control and Prevention). Diabetes is the seventh leading cause of death in the United States, and more than 187,000 persons died from the disease and its related complications in 1995. The American Diabetes Association estimates that \$98.2 billion was spent in 1997 on diabetes care (\$44.1 billion in costs directly attributable to diabetes and \$54.1 billion for indirect medical costs, such as work loss, disability, and premature death.) National Diabetes Fact Sheet: National estimates and general information on Diabetes in the United States. National Institutes of Health, et al., 1997. In FY 1998, we estimate the Medicare program alone would spend an estimated \$14.6 billion in treatment costs for diabetes and diabetes-related complications.

Among Americans aged 65 and older, 4 million persons (9.3 percent of this group) are estimated to have diabetes. According to the National Health and Nutrition Examination Survey (NHANES), as many as 18.7 percent of Americans over age 65 are at risk for developing diabetes. The goals in the management of diabetes are to achieve normal metabolic control and reduce the risk of micro- and macro-vascular complications. Numerous epidemiologic and interventional studies point to the necessity of maintaining good glycemic control to reduce the risk of the complications of diabetes. Despite this knowledge, diabetes remains the leading cause

of blindness, lower extremity amputations, and kidney disease requiring dialysis. Diabetes and its complications are primary or secondary factors in an estimated 9 percent of hospitalizations (Aubert, RE, et al., Diabetes-related hospitalizations and hospital utilization. In: Diabetes in America. 2nd ed. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Disease, NIH, Pub. No 95-1468-1995: 553-570). Overall, beneficiaries with diabetes are hospitalized 1.5 times more often than beneficiaries without diabetes. Ten percent of these hospitalizations are a direct result of uncontrolled diabetes, and more than half of these admissions occur in beneficiaries 65 and older (National Hospital Discharge Survey, U.S. National Center for Health Statistics, U.S. Department of Health and Human Services, 1990). In expanding the Medicare program to include outpatient diabetes self-management training services, the Congress intended to empower Medicare beneficiaries with diabetes to better manage and control their conditions. The Conference Report indicates that the conferees believed that "this provision will provide significant Medicare savings over time due to reduced hospitalizations and complications arising from diabetes." (H.R. Conf. Rep. No. 105-217, at 701 (1997)).

June 25, 1999



Health Division



Office of Management and Budget
Executive Office of the President
Washington, D.C. 20503

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		As requested_____	Copies to: HD/HFB
Subject:	HI Trust Fund Report for	Information <u>XX</u>	chrons.; Medicare exs,
	May 1999		Dick Emery, Ellen Balis,
			Jack Smalligan, Chris
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The attached charts display data from the Monthly Treasury Statement on outlays, revenue, and change-in-balance of the Hospital Insurance (HI) Trust Fund. The charts include May 1999 data which were released on Monday, June 21 in the Monthly Treasury Statement for May.

Monthly Performance in May

HI outlays (summarized in Tables 1A and 1B) were 14 percent lower than the same time last year at \$8,801 million. Revenues (summarized in Tables 2A and 2B) were 9 percent higher than the same time last year at \$9,796 million. **The combination of outlays and revenues yielded a surplus in May of \$995 million, compared to a shortfall of \$1,696 million a year ago.** Tables 3A and 3B illustrate this trend.

At the end of May 1999, the Trust Fund's balance was \$131,905 million, compared to a balance of \$115,663 million at this same time last year. Tables 4A and 4B illustrate the downward historical trend of the Trust Fund's balance.

Table 1A -- Gross HI Outlays: May 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years
(\$ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

<u>Actual Outlays</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1999	12,195	9,449	12,329	8,592	10,116	12,126	13,510	8,801					87,388
FY 1998	13,033	9,005	13,515	10,800	11,211	10,563	12,166	10,718	11,068	14,578	9,392	11,259	137,298
FY 1997	11,377	11,517	10,972	11,583	11,281	10,448	12,017	13,222	9,977	12,476	12,769	9,916	137,884
FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 99 - FY 98	(838)	444	(1,186)	(2,208)	(1,095)	1,563	1,344	(1,917)					
% Difference	-7%	4%	-11%	-19%	-10%	15%	11%	-14%					

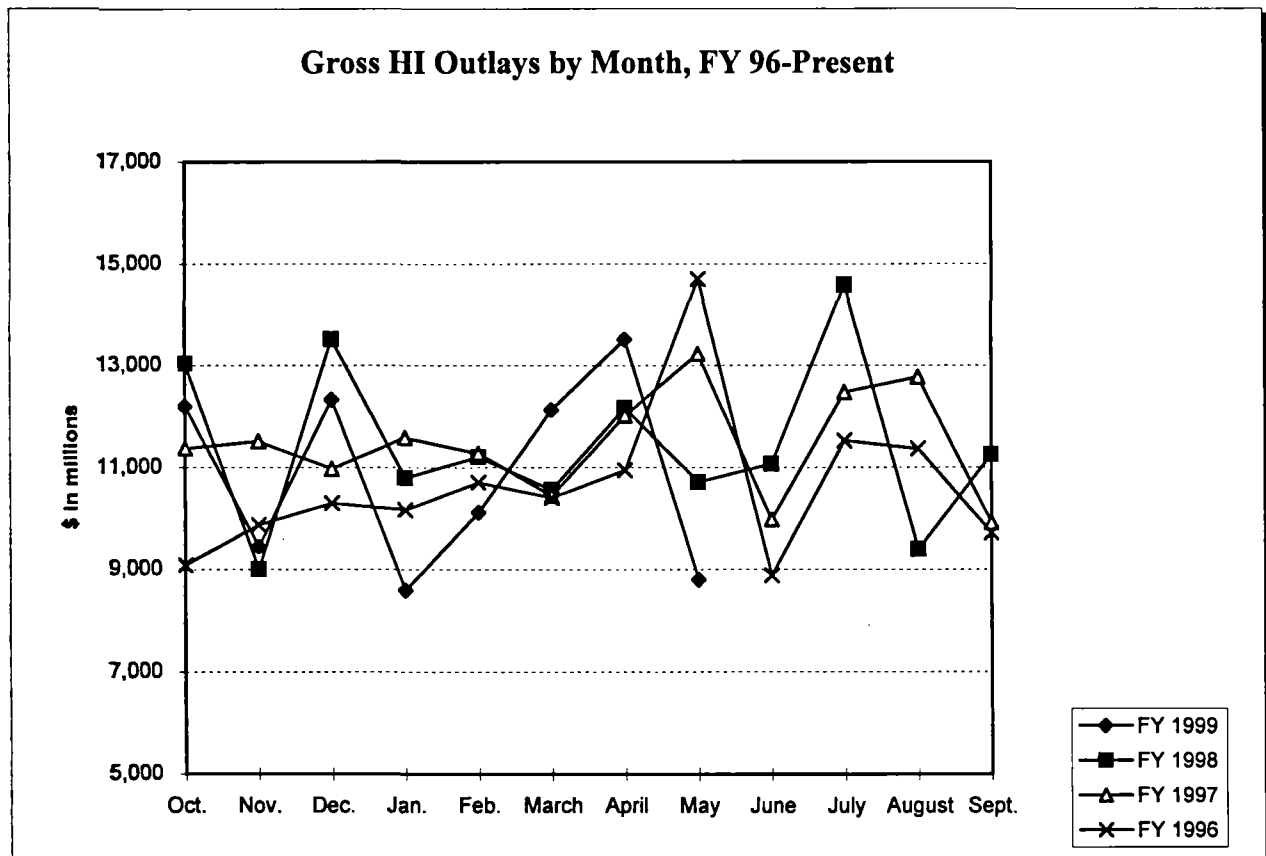


Table 1B -- Gross HI Outlays: May 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
(\$ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1999	12,195	9,449	12,329	8,592	10,116	12,126	13,510	8,801					87,388
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FY 1996	9,082	9,869	10,302	10,169	10,709	10,410	10,947	14,699	8,880	11,530	11,372	9,713	127,683
FY 99 - FY 98													
Cumulative Difference	(838)	(394)	(1,580)	(3,788)	(4,883)	(3,320)	(1,976)	(3,893)					
Cumulative % Difference	-6%	-1.8%	-4.4%	-8.2%	-8.5%	-4.9%	-2.5%	-4.3%					

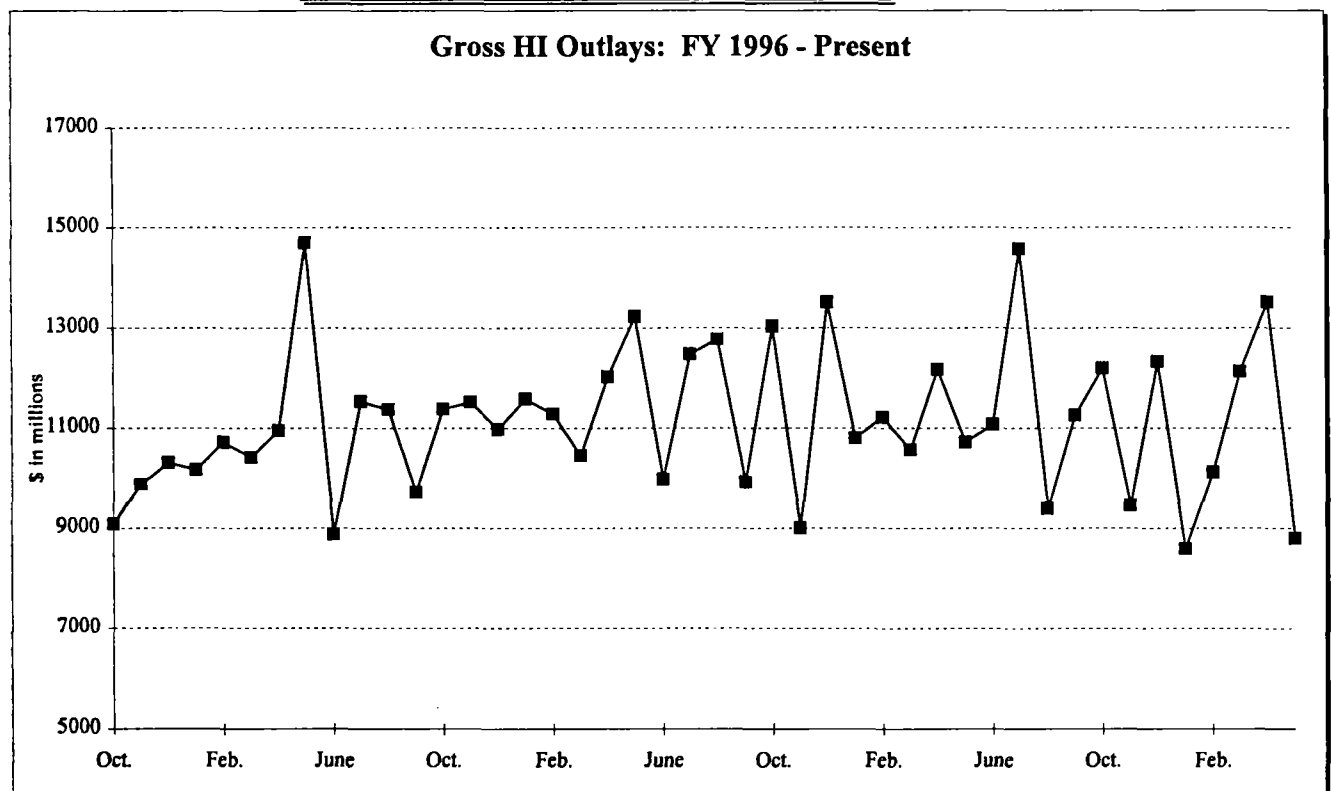


Table 2A -- HI Revenues: May 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years
(\$ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

<u>Actual Revenues</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1999	9,807	10,649	16,963	13,997	9,265	11,416	15,431	9,796					97,324
FY 1998	9,166	9,856	16,053	12,642	8,794	10,115	14,697	9,022	17,361	9,142	9,314	12,040	138,203
FY 1997	8,394	9,169	15,907	11,574	8,286	9,685	12,058	8,527	16,049	8,467	9,291	11,095	128,548
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 99 - FY 98	641	793	910	1,355	471	1,301	734	774					
% Difference	7%	8%	6%	11%	5%	13%	5%	9%					

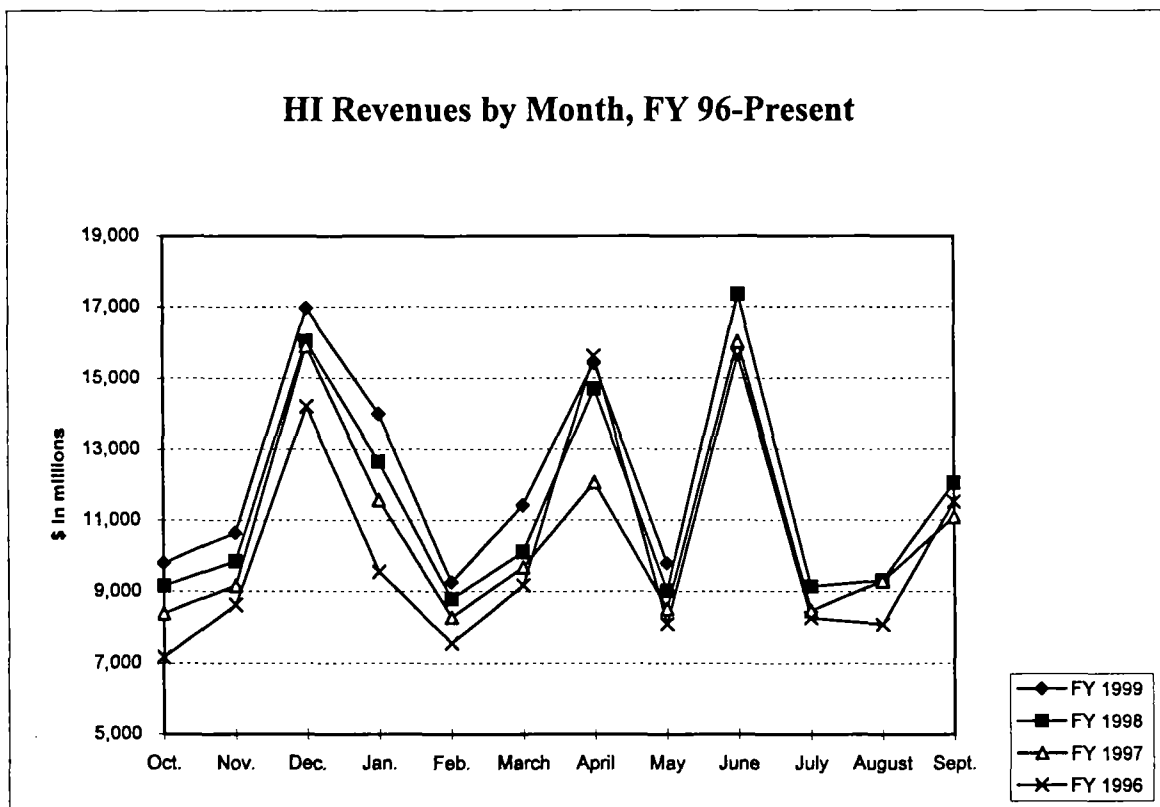


Table 2B -- HI Revenues: May 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
(\$ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1999	9,807	10,649	16,963	13,997	9,265	11,416	15,431	9,796					97,324
FY 1998	9,166	9,856	16,053	12,642	8,794	10,115	14,697	9,022	17,361	9,142	9,314	12,040	138,203
FY 1997	8,394	9,169	15,907	11,574	8,286	9,685	12,058	8,527	16,049	8,467	9,291	11,095	128,502
FY 1996	7,165	8,633	14,202	9,555	7,558	9,180	15,632	8,087	15,646	8,259	8,083	11,517	123,501
FY 99 - FY 98													
Cumulative Difference	641	1,434	2,344	3,699	4,170	5,471	6,205	6,979					
Cumulative % Difference	7%	7.5%	6.7%	7.8%	7.4%	8.2%	7.6%	7.7%					

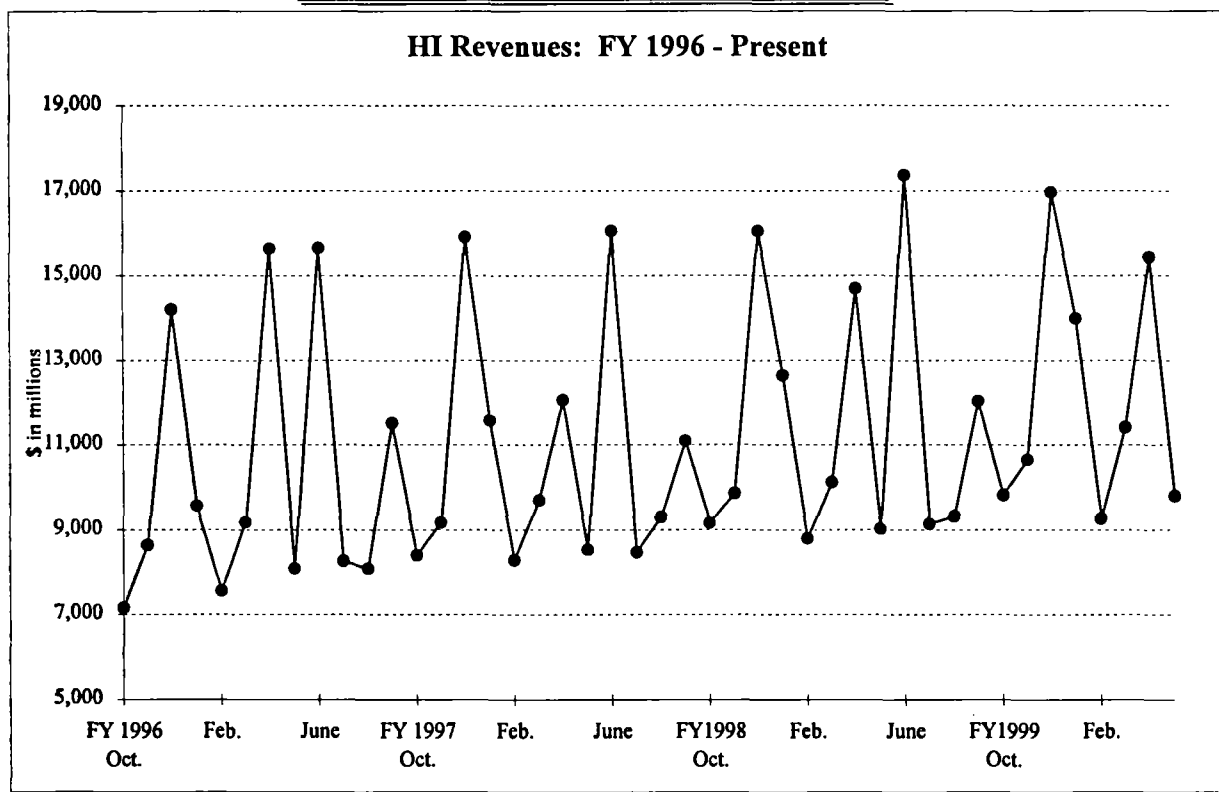


Table 3A -- Surplus (Shortfall) in HI Trust Fund: May 1999 Report
Comparison of FY 1999 Monthly Performance to Previous Years
(\$ in millions -- FY totals may not add due to rounding and monthly reconciliation process)

<u>Actual Change</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1999	(2,388)	1,200	4,634	5,405	(851)	(710)	1,921	995					9,936
FY 1998	(3,867)	851	2,538	1,842	(1,734)	(448)	2,531	(1,696)	6,293	(5,436)	(78)	781	905
FY 1997	(2,983)	(2,348)	4,935	(9)	(2,995)	(763)	41	(4,695)	6,072	(4,010)	(3,478)	1,179	(9,336)
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 99 - FY 98	1,479	349	2,096	3,563	883	(262)	(610)	2,691					
% Difference	-38%	41%	83%	193%	-51%	58%	-24%	-159%					

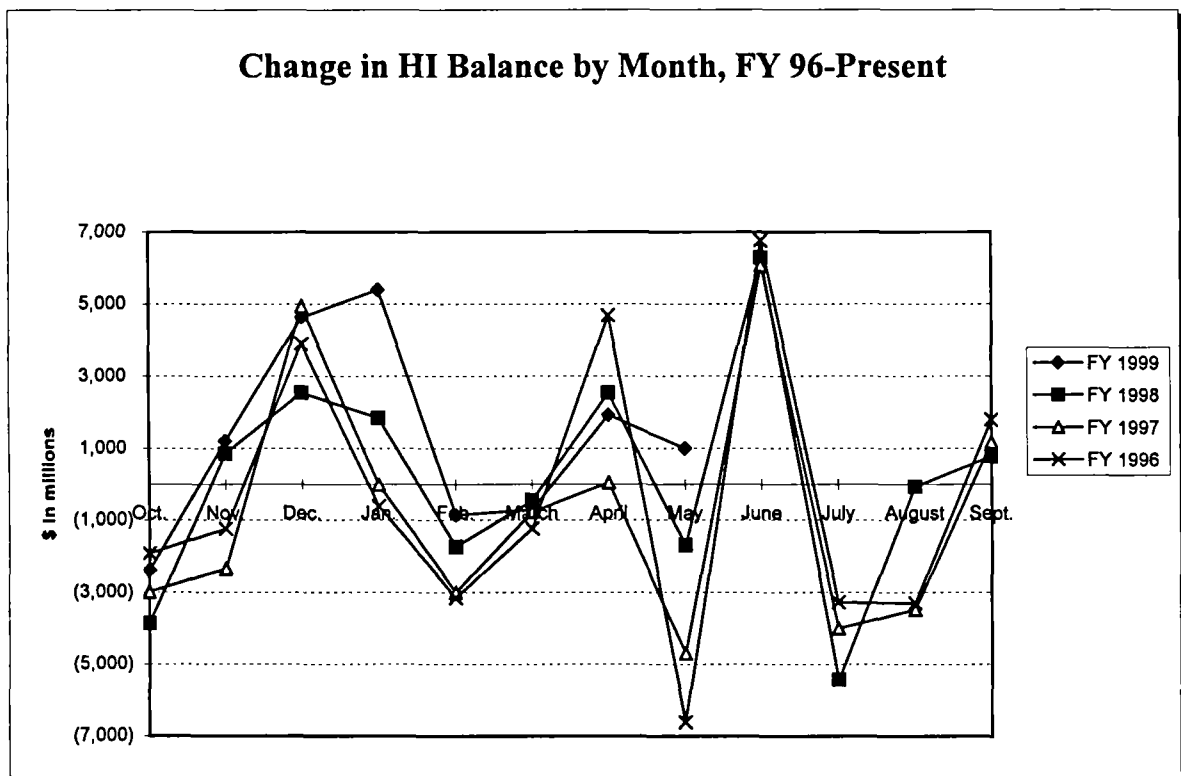


Table 3B – Surplus (Shortfall) in HI Trust Fund: May 1999 Report
Cumulative Comparison of FY 1999 Performance to Previous Years
(\$ in millions – FY totals may not add due to rounding and monthly reconciliation process)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Total</u>
FY 1999	(2,388)	1,200	4,634	5,405	(851)	(710)	1,921	995					9,936
FY 1998	(3,867)	851	2,538	1,842	(1,734)	(448)	2,531	(1,696)	6,293	(5,436)	(78)	781	905
FY 1997	(2,983)	(2,348)	4,935	(9)	(2,995)	(763)	41	(4,695)	6,072	(4,010)	(3,478)	1,179	(9,336)
FY 1996	(1,917)	(1,236)	3,900	(614)	(3,151)	(1,230)	4,685	(6,612)	6,766	(3,271)	(3,289)	1,804	(4,182)
FY 99 - FY 98													
Cumulative													
Difference	1,479	1,828	3,924	7,487	8,370	8,108	7,498	10,189					
Cumulative %													
Difference	-38%	-61%	-821%	549%	-2262%	-991%	438%	59935%					

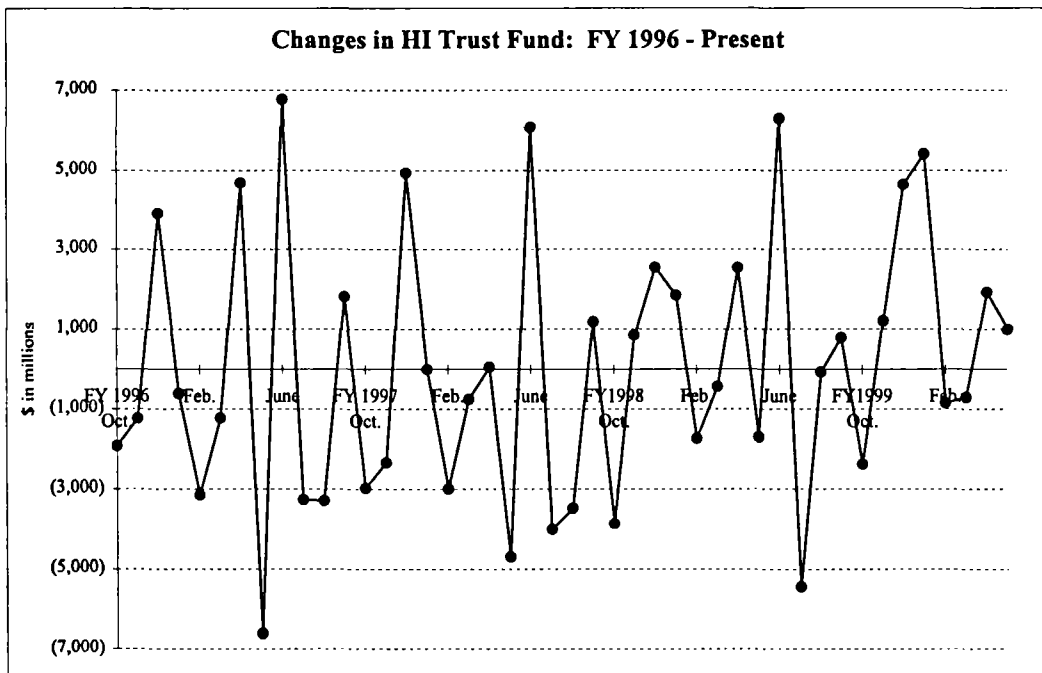


Table 4A -- HI Trust Fund Balance: May 1999 Report
Comparison of FY 1999 Monthly Balance to Previous Years
(\$ in millions)

<u>Actual Change</u>	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Average</u>
FY 1999	115,067	117,520	120,739	126,973	125,385	124,181	128,550	131,905					123,790
FY 1998	112,707	113,798	116,441	118,056	116,518	116,904	120,451	115,663	122,736	119,236	116,952	118,250	117,309
FY 1997	122,541	120,038	126,709	125,468	122,375	121,948	121,635	116,190	123,001	118,801	115,352	116,621	120,896
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610
FY 99 - FY 98	2,360	3,722	4,298	8,917	8,867	7,277	8,099	16,242					
% Difference	2%	3%	4%	8%	8%	6%	7%	14%					

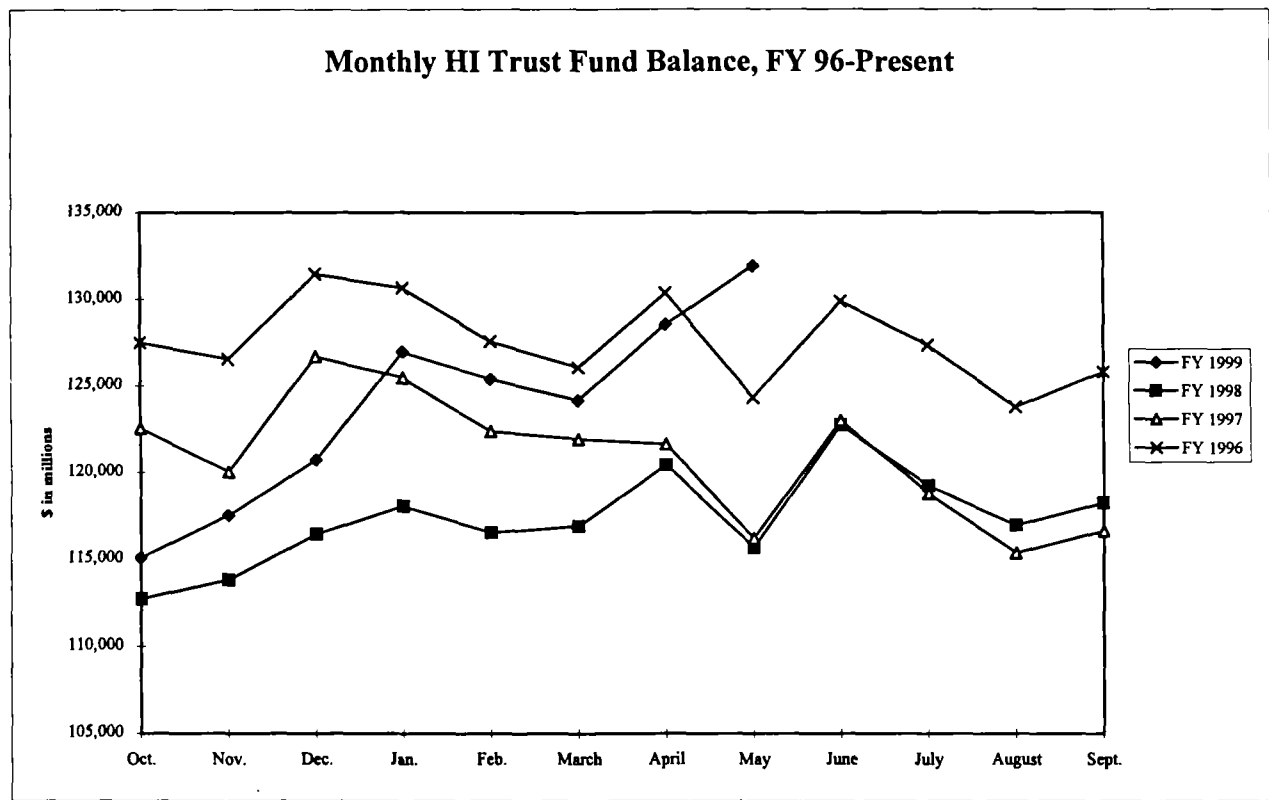
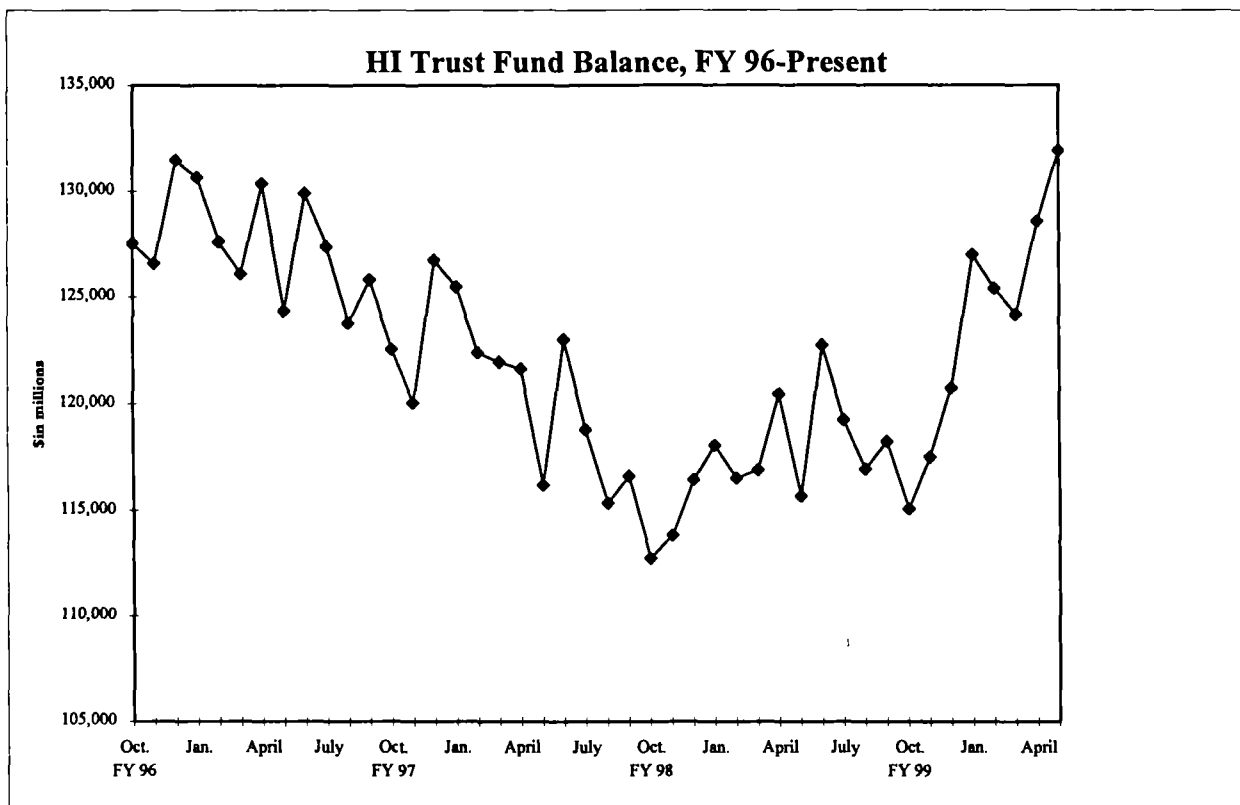


Table 4B -- HI Trust Fund Balance: May 1999 Report
Long-Term Comparison of FY 1999 Balance to Previous Years
(\$ in millions)

	<u>Oct.</u>	<u>Nov.</u>	<u>Dec.</u>	<u>Jan.</u>	<u>Feb.</u>	<u>March</u>	<u>April</u>	<u>May</u>	<u>June</u>	<u>July</u>	<u>August</u>	<u>Sept.</u>	<u>FY Average</u>
FY 1999	115,067	117,520	120,739	126,973	125,385	124,181	128,550	131,905					123,790
FY 1998	112,707	113,798	116,441	118,056	116,518	116,904	120,451	115,663	122,736	119,236	116,952	118,250	117,309
FY 1997	122,541	120,038	126,709	125,468	122,375	121,948	121,635	116,190	123,001	118,801	115,352	116,621	120,890
FY 1996	127,495	126,554	131,443	130,649	127,583	126,072	130,357	124,339	129,890	127,355	123,780	125,805	127,610



Honorable Jim McDermott
1035 Longworth Building
Washington, DC 20515

Transmittal Cover Sheet

TO John Podesta
Company White House
Fax Number 202 456 1907
Phone Number
FROM Congressman Jim McDermott
Comments Attached is the material I was talking about.

CHRIS J.
Gene S.

fyi
John

Date June 21, 1999
Time 5:58am
No. Pages Including this cover sheet 6

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OPTIONAL DIRECT MEDICARE SUPPLEMENTAL INSURANCE (DMSI)Proposal

1. Medicare beneficiaries would be given the option of "purchasing" supplemental insurance by paying a premium directly to Medicare, rather than to a Medigap insurer. Medicare would then pay their cost sharing amounts - deductible and copayments.
2. The plan would have a **\$100 deductible** that must be paid by the beneficiary and could not be insured.

Effect of Direct Medicare Supplemental Insurance (DMSI)

1. CBO has estimated (attached) that Medicare beneficiaries could reduce their monthly private Medigap premiums in the range of \$8-\$10 per month (on average).
2. With the increase in Medicare premiums needed to help pay for a prescription drug benefit, we need to find ways to offset the increases. If a prescription drug benefit would increase Medicare premiums by \$30 per month, this would help to offset that increase by \$8-\$10 for Medigap purchasers (about 1/3 of all Medicare beneficiaries).



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, DC 20515

Dan L. Crippen
Director

June 14, 1999

MEMORANDUM

To: [REDACTED]
From: [REDACTED]
Subject: Requested Estimates

As you requested, I've done some preliminary estimates of the premiums that would have to be charged to fully fund an optional supplement under Medicare to cover the basic program's cost-sharing requirements (see attached table). The three options shown are all variants of an approach that would simply cap an enrollee's cost-sharing liabilities--at either \$100, \$200, or \$500 a year. I have not yet been able to estimate an option that would replace Medicare's current cost-sharing requirements with a small copay for each physician visit or inpatient day. As we discussed, to do that kind of estimate I will have to rebuild the model to incorporate information about the number of physician visits each enrollee has during the year.

An optional supplement that capped each enrollee's cost-sharing expenses for Medicare-covered services at \$100 a year would be most closely comparable to three of the approved private medigap plans--plans D, E, and G, which cover all of Medicare's cost-sharing requirements except for the \$100 SMI deductible and have no coverage for prescription drugs. However, each of those three medigap plans also cover some services not covered by Medicare, such as balance-billing, care while traveling in foreign countries, and preventive care.

Premiums Costs for an Optional Medicare Supplement

If a cost-sharing cap of \$100 a year was offered as an option under Medicare, the average annual premium necessary to fund that benefit would be an estimated \$754 in calendar year 2000, less than the \$838 estimated average private medigap premium for comparable coverage. This estimate assumes that administrative costs for the Medicare option would be about 2 percent of total costs, while average administrative costs for private plans would be about 15 percent of costs. It also assumes that all current medigap policyholders would switch to the Medicare supplement; that employers now offering more generous supplemental coverage to retirees would enroll them for the Medicare supplement; and that Medicaid plans (which it is assumed would be required to enroll either all or none of their dual eligibles in the supplement) would take advantage of the option in those states where the premium charged for the supplement would be less than the average cost-sharing expenses Medicaid would otherwise have to pay directly. Because the premium charged

for the supplement would be substantial, it is assumed that enrollees with no supplement now would not purchase the Medicare supplement either.

An optional supplement with a higher cap on cost-sharing would have a lower premium but would expose enrollees to higher potential costs for premium and cost-sharing combined. With a \$100 cap, enrollees would pay at most \$854 to cover the supplemental premium and all of Medicare's cost-sharing requirements. With a \$200 cap, the annual premium would be \$676 in 2000, but enrollees would face potential costs up to \$876. With a \$500 cap, the annual premium would be \$534 and enrollees would face potential costs up to \$1034.

Effects on Outlays for Basic Medicare Benefits

The premiums shown were estimated so as to fully fund the benefits that would be paid by the optional supplement plan. However, introduction of a Medicare supplement would also have an effect on costs under the basic Medicare program. Costs in the basic Medicare program would fall somewhat because some of the participants moving to the optional Medicare supplement would be leaving private medigap or employment-sponsored retiree health plans that covered all of their cost-sharing liabilities under Medicare. Use of services by such enrollees would be a little lower than if they remained in plans with first-dollar coverage. For 2000, the estimates indicate that gross outlays for basic Medicare benefits would fall by about 0.5 percent under the supplement with a \$100 cap; by 1.0 percent under the supplement with a \$200 cap; and by 2.0 percent under the supplement with a \$500 cap.

Caveats

There are a number of caveats associated with the estimates discussed above. First, note that for the supplement with either a \$100 or \$200 cap the assumption that all current medigap policyholders would switch is realistic (assuming the average medigap premium is representative of premiums actually facing enrollees--discussed more below). This is because both the premium and the maximum potential expense for Medicare-covered services would be lower for these two Medicare supplement options than for the average medigap plan. However, it is less clear that all medigap policyholders would switch, as the estimates assume, if the Medicare supplement had a cap of \$500 because then the enrollee's maximum potential expense would be higher than under the average medigap plan. In particular, enrollees expecting to make relatively high use of services would tend to prefer a private medigap plan, while those with relatively low use might prefer the lower premium Medicare supplement.

A more fundamental concern is that participation in the Medicare supplement may not be accurately assessed simply by comparing the Medicare premium to the average medigap premium in the area. The estimates assume that the premium for the Medicare supplement would be uniform for all ages. (They also assume that the premium would vary geographically based on local costs--as private

premiums do. Otherwise, participation in the Medicare option would be high in high-cost areas and low or nil in low-cost areas, where it could not compete with private plans.) However, excepting plans offered through the American Association of Retired Persons, most private medigap premiums are now age-rated. Hence, the average medigap premium may not reflect the premiums actually faced by given enrollees. In particular, younger enrollees are likely to purchase private medigap plans because they would be cheaper than a Medicare supplement whose premium did not vary by age, while older enrollees would switch to the Medicare supplement once its price became competitive with private plans. Hence, the estimates shown in the table will understate the premiums required to fully fund the costs of the Medicare supplement because they assume that all current medigap policyholders would switch to the Medicare option when in reality (at least in the majority of states that do not require community rating) only the more costly older enrollees would do so.

TABLE 1 ESTIMATED AVERAGE ANNUAL PREMIUMS FOR MEDICARE SUPPLEMENTAL COVERAGE (Calendar Years)

Type of Supplemental Coverage	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
OPTIONAL SUPPLEMENT UNDER MEDICARE										
\$100 Cap on Cost-Sharing										
Liabilities Under Medicare										
Average Premium	754	804	862	925	993	1067	1146	1227	1314	1406
Maximum Expense	854	904	962	1025	1093	1167	1246	1327	1414	1508
\$200 Cap on Cost-Sharing										
Liabilities Under Medicare										
Average Premium	676	725	782	844	911	985	1063	1143	1229	1321
Maximum Expense	876	925	982	1044	1111	1185	1263	1343	1429	1521
\$500 Cap on Cost-Sharing										
Liabilities Under Medicare										
Average Premium	534	579	64	690	753	822	896	972	1054	1142
Maximum Expense	1034	1079	564	1190	1253	1322	1396	1472	1554	1642
PROTOTYPE PRIVATE MEDIGAP PLANS										
Covering All Medicare Cost-Sharing										
Average Premium	880	931	989	1053	1122	1196	1275	1356	1443	1535
Maximum Expense	880	931	989	1053	1122	1196	1275	1356	1443	1535
Covering All Medicare Cost-Sharing except \$100 SMI Deductible										
Average Premium	838	886	941	1002	1067	1139	1214	1291	1374	1461
Maximum Expense	938	986	1041	1102	1167	1239	1314	1391	1474	1561

SOURCE: Congressional Budget Office (March 1999 baseline). Estimates are preliminary.

NOTE: Estimates assume that administrative costs for the Medicare supplemental insurance would be 2 percent of total costs.

They also assume that:

- o All current medigap policyholders would switch to the Medicare supplement;
- o Employers offering more generous supplemental coverage would take advantage of the Medicare option;
- o Medicaid would be required to enroll dual eligibles in the option on an all-or-none basis, and that states would take advantage of the option in those states where the premium for the supplemental option would be less than the average cost-sharing expenses Medicaid would otherwise have to pay directly;
- o No enrollees who do not now purchase a private supplement would purchase the Medicare supplement.

Embargoed
July 10, 1999, 10:00 AM EDT

Contact: Jerry Franz
703-299-2054

American Diabetes Association Supports Efforts to Improve Medicare Coverage for People with Diabetes

Alexandria, VA (July 9, 1999) — The American Diabetes Association applauds efforts to improve upon Medicare preventive services for diabetes.

In 1997, Congress enacted key legislation to expand Medicare coverage for diabetes glucose test strips and education. By improving preventive coverage, millions of senior citizens gained access to the medical supplies they need to stay healthy and avoid complications of diabetes. The President's recent proposal (June 29, 1999) would improve upon this legislation by waiving the Part B deductible and 20 percent coinsurance rate for self-management training, and for glucose monitors and test strips.

"Good control of diabetes has been conclusively demonstrated to reduce the complications of diabetes and will reduce the costs of diabetes for the nation which now exceed \$100 billion annually," said Bruce Zimmerman, MD, President of the American Diabetes Association. "Better coverage for preventive care will provide more people with diabetes the education and training they need, and the ability to monitor their blood glucose levels," said Dr. Zimmerman.

The American Diabetes Association is the nation's leading voluntary health organization supporting diabetes research, information and advocacy. Founded in 1940, the Association has offices in every region of the country, providing services to more than 800 communities.

#

Embargoed until 10 AM
July 10, 1999

For more information, contact:
Steve Rosa
(202) 661-5712

Statement by Charles McDonald, MD, American Cancer Society Board of Directors President, on President Clinton's Medicare benefits proposal

Washington—"The American Cancer Society is very pleased with the preventive benefits section of President Clinton's Medicare reform proposal. We highly support these changes. The best way to stop cancer is to prevent it in the first place. For the cancers we don't yet know how to prevent, the next best strategy is to find it early by screening. Eliminating co-pays for older Americans for many types of cancer screening will better serve the needs of those 65 and older. For the sake of those dealing with cancer now and those who may face it in the future, we hope this very beneficial proposal will rapidly make its way through Congress and find its way back to the President's desk intact."

--ACS--



Embargoed for Release
July 10, 1999

For Information, contact: Richard N. Atkins, M.D.
Vice Chair and COO
202-463-9455

STATEMENT REGARDING PRESIDENT CLINTON'S PROPOSED CHANGES IN MEDICARE

The National Prostate Cancer Coalition

The National Prostate Cancer Coalition applauds President Clinton's proposed changes in Medicare that will eliminate the copayment for prostate cancer screening. Approximately 75% of prostate cancer cases occur in men 65 years and older. Since prostate cancer remains the most commonly diagnosed cancer in America, with almost 200,000 new cases expected in 1999 and nearly 40,000 deaths, this change will encourage men to get tested and get treated.

- 30 -



Contact: Diane Shritzler or Molly Natchipolsky
202/223-2226

EMBARGOED FOR RELEASE
Saturday, July 10 at 10:00 am EST

**NOF COMMENTS ON WHITE HOUSE INITIATIVE TO STRENGTHEN MEDICARE
Preventive Care Proposal Will Eliminate Barrier to Osteoporosis Diagnostic Testing**

Washington, DC (July 10, 1999) – President Clinton's new initiative to strengthen Medicare contains an important key to improving the health of the nation – the elimination of the 20 percent co-pay for preventative diagnostic tests. Eliminating this co-pay would make bone density tests, painless diagnostic tests for osteoporosis, more available to the population considered most at risk for the disease. Osteoporosis, a disease that gradually weakens bones and often leads to painful and debilitating fractures, is a major public health threat for 28 million Americans, 80 percent of whom are women.

Like most diseases, osteoporosis is best treated before it is advanced, especially since there is no cure. Osteoporosis is often called the "silent disease" because people cannot feel their bones weakening, and the disease can progress for years without symptoms. Bone density tests can detect who is at risk for fractures long before they have osteoporosis, and effective treatments can be initiated to prevent the disease.

"Early diagnosis is important because bone loss is progressive, and by the time fractures occur the disease is advanced and the likelihood of further hip, spine or other fractures is great," says Sandra C. Raymond, executive director of the National Osteoporosis Foundation. Hip

"Fighting Osteoporosis and Promoting Bone Health"

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fractures are not only disabling -- they are deadly. One of every five persons who has a hip fracture will not survive more than one year, and hip fractures are a major cause of nursing home admissions. Spinal fractures, another common fracture site, can cause stooped posture, chronic pain and disability. Currently, one out of two women and one in eight men over age 50 will have an osteoporosis-related fracture in their lifetime, resulting in a loss of independence and diminished quality of life.

The human toll of osteoporosis alone is devastating, however the medical costs are huge and continue to rise. This country is facing an epidemic of osteoporosis, a preventable and treatable disease. Without action, this major public health threat is expected to escalate early in the 21st century. Currently, this disease causes nearly 1.5 million fractures annually and costs this country nearly \$14 billion each year. By the year 2020, costs are estimated to rise to \$60 billion.

Osteoporosis is under-diagnosed, especially among postmenopausal women, who are developing osteoporosis without the disease being recognized or treated, yet osteoporosis is the underlying cause of at least 90 percent of all hip and spine fractures in older Caucasian women.¹ "Bone density tests are underutilized, yet they are better predictors of the risk of fracture than cholesterol is for myocardial infarction or blood pressure is for stroke," said Raymond. Only 7 percent of people with osteoporosis have been diagnosed, according to NHANES III data.²

1. Melton LJIII, et al. Fractures Attributable to Osteoporosis: Report from the National Osteoporosis Foundation. Bone Min Res, Vol. 12, No. 1, 1997.

2. MMWR, Vol. 47, p. 969-973, Nov. 20, 1998

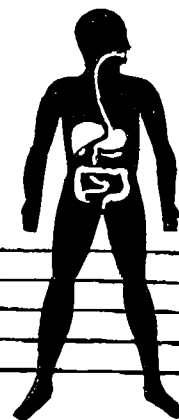
-- More --

Based on practice recommendations from the *Physician's Guide to Prevention and Treatment of Osteoporosis*, all women age 65 and older are considered at sufficient risk that they should have a bone density test, even if they have no additional risk factors for the disease. Although there are no specific age recommendations for men at this time, many men over 65 may be at risk and should ask their doctor if they need a bone density test. The President's proposal, if implemented, will improve access to this important benefit, especially for Medicare beneficiaries on a fixed income, who may defer preventive care because of cost.

With more than 250,000 members, the National Osteoporosis Foundation is the only nonprofit, voluntary health organization dedicated to reducing the widespread prevalence of osteoporosis through programs of research, education and advocacy.

###

Digestive Disease National Coalition



507 Capitol Court, N.E., Suite 200, Washington, D.C. 20002
(202) 544-7497 (202) 546-7105 - Fax

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Embargoed until Saturday, July 10, 1999 at 10:15am

THE DIGESTIVE DISEASE NATIONAL COALITION ENDORSES THE WAIVER OF PART B DEDUCTIBLE AND COINSURANCE FOR COLORECTAL CANCER SCREENING IN PRESIDENT CLINTON'S MEDICARE MODERNIZATION PLAN

The Digestive Disease National Coalition (DDNC) today endorsed President Clinton's plan to waive the Part B deductible and 20 percent coinsurance rate for preventive benefits covered under Medicare. The DDNC is particularly pleased that the president's plan would waive these cost sharing burdens for colorectal cancer screening for our nation's senior citizens.

Colorectal cancer is the third most commonly diagnosed cancer for both men and women in the United States, and the second leading cause of cancer related deaths. In 1999, 131,000 new cases will be diagnosed and 55,000 people will die from the disease. When colorectal cancer is detected and treated early, survival is greatly enhanced. However, despite the availability of proven screening tests, only 37 percent of colorectal cancers are diagnosed while the disease is still in a localized stage.

The DDNC was proud to work with the administration and the Congress to include a Medicare benefit for colorectal cancer screening in the Balanced Budget Act of 1997. Unfortunately, recent studies have shown that colorectal cancer screening and other Medicare preventive services are underutilized. The DDNC believes that many Medicare beneficiaries have not taken advantage of these new preventive services due to cost sharing burdens. By waiving the Part B deductible and 20 percent coinsurance for colorectal cancer screening, more seniors will be able to protect themselves from the country's number two cancer killer.

The Digestive Disease National Coalition is a 20 year old advocacy organization comprised of 23 patient and professional societies concerned with the many diseases of the digestive tract. The goal of the Coalition is to improve the health status of the millions of Americans who suffer from digestive disorders.

* For more information please contact Dr. William Mahood, (202) 544-7497.



7910 Woodmont Avenue, Suite 700, Bethesda, MD 20814
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CONTACT: Michael Roberts
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Embargoed until Saturday, July 10, 1999 at 10:15am

**AGA ENDORSES WAIVER OF PART B DEDUCTIBLE AND
COINSURANCE FOR COLORECTAL CANCER SCREENING IN
PRESIDENT CLINTON'S MEDICARE MODERNIZATION PLAN**

The American Gastroenterological Association (AGA) announced today that it is endorsing President Clinton's plan to waive the Part B deductible and 20 percent coinsurance rate for preventive benefits covered under Medicare. The AGA is especially pleased that the President's plan targets colorectal cancer screenings to allow a more accessible benefit for the nation's senior citizens.

Colorectal cancer is the second leading cause of cancer-related deaths in the United States. It is estimated that over 130,000 new cases will be diagnosed this year with approximately 56,000 Americans projected to die from this disease in 1999. Colorectal cancer is linked to age with over 90% of people diagnosed being over 50 years old. Early detection of pre-cancerous polyps is essential if Americans are to succeed in lowering the mortality rate of this disease.

The AGA has been at the forefront in advocating for coverage of colorectal cancer screenings. In 1997, AGA worked closely with the Congress and the White House to help enact a Medicare benefit for colorectal cancer screening as part of the Balanced Budget Act. AGA also worked closely with the First Lady's office in 1998 to bring attention to all Americans of the importance of obtaining screenings as part of the White House Summit on Colorectal Cancer.

Unfortunately, recent studies have shown that colorectal cancer screening and other Medicare preventive services are underutilized by those that need it the most. The AGA applauds the President's efforts to eliminate the economic impediments so that seniors can take advantage of greater access to screenings for this treatable disease. Strengthening

Medicare's commitment under the President's proposal is essential to substantially reducing the incidence of colorectal cancer.

The AGA is an organization of more than 10,000 physicians and scientists who specialize in the identification and treatment of digestive disorders. One of its major goals is to support the discovery of new knowledge leading to prevention, treatment and cure of digestive diseases.



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OFFICIAL PUBLICATION
THE AMERICAN JOURNAL
OF GASTROENTEROLOGY

Embargoed for Release Saturday, July 10, 1999 10:15 am

Contact: Thomas F. Fise, Executive Director
703-820-7400

ADMINISTRATION'S COMMITMENT TO ELIMINATING CO-PAYMENTS ON COLORECTAL CANCER SCREENING AND OTHER PREVENTIVE SERVICES FOR MEDICARE BENEFICIARIES WILL SAVE LIVES

Washington, DC, July 10, 1999 — Recently, the Clinton Administration announced its plans for important changes to the Medicare program, which included a provision that would eliminate the patient deductible when Medicare beneficiaries receive any of the preventive screening benefits available to seniors. President Clinton's national radio address on Saturday, July 10, will focus on these preventive screening benefits, and how important it is for Medicare beneficiaries to avail themselves of those services.

These are extremely important steps to improve public health. To the extent that Americans 50 or older focus their attention on taking advantage of colorectal cancer screening, mammography, Pap smears and other preventive benefits, countless lives can be saved and American families spared the suffering and hardship that accompany detection of these potentially lethal diseases in their later, more advanced stages.

Two years ago, a bi-partisan Congress, through passage of the Balanced Budget Amendment of 1997, scored a major victory for all Americans in approving changes to the Medicare program that included creation of a new Medicare colorectal cancer screening benefit. Colorectal cancer is America's #2 cancer killer—but the good news is that this cancer is readily treatable when detected in early or even pre-malignant stages. If all Americans received regular screening, the terrible death toll from colorectal cancer, over 55,000 Americans are projected to die this year, can be reduced by 90 percent! Hopefully, the Administration and Congress can again join forces this year to put the health of American citizens first, in adopting legislation that will include the excellent improvement to the Medicare program of eliminating the deductible on preventive benefits which the Administration has proposed.

The colorectal cancer screening benefit is newer than either the Pap smear or mammography benefit, and the data demonstrate that we still have a long way to go in breaking down the barriers that keep Americans from availing themselves of the simple, potentially live-saving tests for early detection. U.S. Department of Health and Human Services data from a recent "Healthy People 2000 Review" reveal that in 1994 about 50% of women 70 and over had

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received a Pap test within the past three years (up from just over 40% in 1987), and that utilization of mammography in this same age group had doubled from about 20% to over 40% over that same period. By contrast, only 33% of Americans 50 or over had ever received a proctosigmoidoscopy—one of the tests which Medicare now offers once every four years for detection of colorectal cancer; and a much lower proportion of Americans have ever received the most definitive of screening tests, a colonoscopy, which allows direct visual examination of the colon and often simultaneous removal of smaller cancerous or pre-cancerous lesions.

The Administration's proposal to eliminate the Medicare deductible will remove one of the financial impediments, and is an essential next step in improving all of the preventive benefits, including the new colorectal cancer benefit. The College is very hopeful that the President's highlighting of these preventive benefits in his radio address will help advance public awareness and encourage people to overcome other formidable barriers: lack of awareness of colorectal cancer or its screening options, and embarrassment or reticence about screening.

The College has undertaken an extensive program to help advance public awareness about colorectal cancer screening in the two years since the Medicare benefit was initiated—two national public service announcements, including one with major league baseball All-Star outfielder and colorectal cancer survivor Eric Davis, a massive distribution of informational brochures through doctors' offices that has reached nearly one million patients to inform them about the new Medicare colorectal cancer screening benefit, and participation in countless radio, television, and print media efforts to alert Americans that their odds of beating colorectal cancer are remarkably strong if they will take the simple step of being screened regularly. Materials on these efforts are available from the College's headquarters office.

Eliminating the barriers by having the Medicare program assume the co-payment expense that heretofore has been borne by patients, and advancing public awareness are important steps. There are other important initiatives that have, or should, merit legislative proposals and careful consideration. Legislation introduced in the U.S. Senate as S.1044 is a bi-partisan effort spearheaded by Senators Edward Kennedy and Jesse Helms which proposes an all-payor approach to assuring availability of colorectal cancer screening benefits to all insured Americans. Companion legislation, H.R. 1816, has been introduced in the House under joint sponsorship by Representatives Slaughter and Morella.

The College and several members of Congress have urged HHS Secretary Shalala to exercise the option available under the law to update the benefit by offering average risk individuals a full colonoscopy once every ten years (currently, the Medicare law offers a full colonoscopy once every two years, but only for certain high risk patients) as an alternative to the less extensive flexible sigmoidoscopy every four years. This would be largely budget neutral and help keep the Medicare benefit up-to-date with recent advances in screening recommendations from several national scientific organizations.

Finally, declining reimbursements are regrettably another impediment that must be addressed. An article in the March 16, 1999 issue of the *Annals of Internal Medicine* underscored the fact that Medicare payments to physicians for flexible sigmoidoscopy with a biopsy—a standard colorectal cancer screening test—had declined to the point that physicians are paid significantly less than the cost of the service. The College favors some type of reimbursement relief that would give the Medicare colorectal screening benefit a chance against the downward spiral of Medicare colonoscopy and flexible sigmoidoscopy fees.

The American College of Gastroenterology, on behalf of its leadership and 7000 physician members, congratulates President Clinton for asserting leadership in the critical area of preventive benefits, and for the Administration's effort in initiating one step in the essential process of removing the impediments to patients availing themselves of the screening tests that can save both lives and resources. We commend the President for his dedication to preventive health care issues broadly, and to improving access to potentially life-saving colorectal cancer screening in particular. We know that with screening and early detection, we can beat the odds against colorectal cancer, and we applaud the White House for its efforts on behalf of our nation's Medicare beneficiaries.



Crohn's & Colitis Foundation
of America, Inc.

*Serving people with Crohn's disease
and ulcerative colitis.*

Embargoed until Saturday, July 10, 1999 at 10:15am

**THE CROHN'S AND COLITIS FOUNDATION OF AMERICA ENDORSES
THE WAIVER OF PART B DEDUCTIBLE AND COINSURANCE FOR
COLORECTAL CANCER SCREENING IN PRESIDENT CLINTON'S
MEDICARE MODERNIZATION PLAN**

The Crohn's and Colitis Foundation of America (CCFA) today endorsed President Clinton's plan to waive the Part B deductible and 20 percent coinsurance rate for preventive benefits covered under Medicare. The CCFA is particularly pleased that the president's plan would waive these cost sharing burdens for colorectal cancer screening for our nation's senior citizens.

Colorectal cancer is the third most commonly diagnosed cancer for both men and women in the United States, and the second leading cause of cancer related deaths. In 1999, 131,000 new cases will be diagnosed and 55,000 people will die from the disease. When colorectal cancer is detected and treated early, survival is greatly enhanced. However, despite the availability of proven screening tests, only 37 percent of colorectal cancers are diagnosed while the disease is still in a localized stage.

The CCFA was proud to work with the administration and the Congress to include a Medicare benefit for colorectal cancer screening in the Balanced Budget Act of 1997. Unfortunately, recent studies have shown that colorectal cancer screening and other Medicare preventive services are underutilized. The CCFA believes that many Medicare beneficiaries have not taken advantage of these new preventive services due to cost sharing burdens. By waiving the Part B deductible and 20 percent coinsurance for colorectal cancer screening, more seniors will be able to protect themselves from the country's number two cancer killer.

The CCFA is a nonprofit, research-orientated organization dedicated to finding the cause of, and cure for, Crohn's disease and ulcerative colitis. Collectively known as inflammatory bowel disease (IBD), Crohn's disease and ulcerative colitis are chronic, complex gastrointestinal illnesses that represent the major cause of morbidity and mortality from intestinal disease. IBD patients are at high-risk of developing colorectal cancer.

** For more information please contact Dale P. Dirks at (202) 544-7499.*

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News from

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FOR IMMEDIATE RELEASE

June 30, 1999

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**SCHUMER ON MEDICARE PROPOSAL:
GREAT PLAN WITH ONE BIG FLAW – HURTS NY HOSPITALS**

On the day after President Clinton released his Medicare proposal, U.S. Senator Charles E. Schumer outlined how the cuts in the new plan, on top of the ones made under the 1997 Balanced Budget Act, would hurt New York's hospitals.

"Overall, I believe the president's plan is an excellent one. Any plan that can protect Social Security on into the second half of the 21st century, modernize Medicare, bring a prescription plan that recipients want and need and bring the budget deficit to zero should receive everyone's support.

Schumer also applauded Clinton's proposal to rectify the HMO "carveout." HMO's had been keeping some of the Medicare reimbursements that should have rightfully gone to teaching hospitals and to those which treat large numbers of poor patients. This provision, which has been championed by Senator Daniel Patrick Moynihan, will save New York's hospitals \$400 million over the next 5 years.

"There is, however, one major flaw: New York's hospitals are given the short shrift," said Schumer. The plan cuts funding to hospitals by \$39 billion over 10 years on top of the deep cuts in the 1997 Balanced Budget Act. New York is hit especially hard because we are one of the world's leading medical centers. Our share of the cuts will be about \$1.7 billion in the city and \$3.2 billion throughout the state."

In total, the cuts will be about \$2.8 billion for NYS hospitals and \$1.4 billion for NYC hospitals over 10 years (netting out the gain of the HMO "carveout").

Here are estimates of the effect that the President's proposal will have on some of New York State's hospitals.

- Strong Memorial in Rochester which suffered cuts of \$68.4 million from the BBA, will be cut an additional \$37.0 million under the new Medicare plan. To give you an idea of how thin profit margins are, in 1997 Strong Memorial had an operating profit of 4.0% – meaning that on their total medical operations (not including cafeteria, endowment

investment, pharmacy, etc.) they made a 4.0% profit. In 1998, after just one year of BBA cuts their profit margin dropped to a slim 2.5%.

- Beth Israel in New York which suffered cuts of \$91.6 million from the BBA, will be cut an additional \$49.3 under the new Medicare plan. Beth Israel's profit margin was -0.25% in 1997 and was a flat 0.0% in 1998.
- Long Island Jewish which suffered cuts of \$87.5 million from the BBA, will be cut an additional \$47 million under the new Medicare plan. In 1997, Long Island Jewish had an operating profit of 1.3%. In 1998, one year after the BBA, it operated at a 0.3% loss.
- University Hospital Health Science Center in Syracuse which suffered cuts of \$35.2 million from the BBA, will be cut an additional \$19.0 million under the new Medicare plan. University Hospital had an operating profit of 3.8% in 1997 and 2.5% in 1998.
- Albany Medical Center which suffered cuts of \$52.2 million from the BBA, will be cut an additional \$28.0 million under the new Medicare plan. Albany Medical's operating profit dropped from 2.3% to 0.8% between 1997 and 1998.
- Buffalo General Hospital (the entire system) which suffered cuts of \$102.4 million from the BBA, will be cut an additional \$55.2 million under the new Medicare plan. Buffalo General's operating margin dropped from -0.1% in 1997 to -1.4 percent in 1998.
- Mt. Vernon Hospital which suffered cuts of \$13.3 million from the BBA, will be cut an additional \$7.3 million under the new Medicare plan. Mt. Vernon's operating margin was -6.2% in 1997 and -4.0% in 1998.
- Sisters of Charity Hospital in Staten Island which suffered cuts of \$37 million from the BBA, will be cut an additional \$20.2 million under the new Medicare plan. Sister of Charity's operating margin was -0.9% in 1997 and -2.0% in 1998. Staten Island University Hospital which suffered cuts of \$88.8 million from the BBA, will be cut an additional \$43.4 million under the new Medicare plan. Staten Island University's operating margin was 3.3% in 1997 and 1.7% in 1998.
- St. Joseph's Hospital in Yonkers which suffered cuts of \$13.7 million from the BBA, will be cut an additional \$7.4 million under the new Medicare plan. St. Joseph's operating margin was a thin 0.3% in 1997 and a thinner 0.1% in 1998.

"I have spoken with Secretary Shalala and OMB Director Lew and am going to the White House on Thursday to impress upon Administration officials that while this Medicare proposal is a strong one, these cuts to our hospitals risk the very fabric of our health care system," said Schumer.

BCBS (PPO Benefits)

For all Screenings, benefits provided in full in conjunction with a \$12 for PPO doctor's office visit.

1. Breast Cancer Screening

Covered

High and Standard Options – Covered in full (you pay nothing)

2. PAP Smear

Covered

High and Standard Options – Covered in full (you pay nothing)

4. Colorectal Cancer Screening

(Occult Blood) – **Covered**

High and Standard Options – Covered in full (you pay nothing)

(Sigmoidoscopy) – **Coverage effective 1/1/2000**

High and Standard Options – Covered in full (you pay nothing)

4. Prostate Cancer Screening

Covered

High and Standard Options – Covered in full (you pay nothing)

5. Bone Mass Measurements

Covered , when medically necessary

High Option - After the \$150 Calendar Year Deductible, Plan pays 95%

Standard Option – After the \$200 Calendar Year Deductible, Plan pays 95%

6. Influenza and Pneumonia Vaccines

Covered

High and Standard Options – Covered in full (you pay nothing)

7. Diabetic Glucose Monitoring

Covered

In Doctor's office:

High Option – After the \$150 Calendar Year Deductible, Plan pays 95%

Standard Option – After the \$200 Calendar Year Deductible, Plan pays 95%

Supplies for Self-Monitoring (prescription drug benefit)

Preferred Retail Pharmacy - After \$50 Rx drug deductible,

Plan pays 85% (High Option)/ 80% (Standard Option)

Mail Order) -- You pay \$8 (High Option)/\$12 (Standard Option)

per prescription or refill

8. Diabetes Education

Not Covered, except for:

Local Plan Disease Management Programs

Blue Health Connection Nurse Advice Line

**When part of (expense included in) inpatient hospital confinement for
a covered condition**

Flexible Benefits

Kaiser California and Mid Atlantic

Kaiser covers all of the listed tests and procedures in conjunction with office visits at a cost of \$5.00 per visit.

To: Deborah
From: Greg

10 Leading Causes of Deaths by Age Group - 1995

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Congenital Anomalies 6,554	Congenital Anomalies 2,233	Congenital Anomalies 1,012	Congenital Anomalies 1,091	Congenital Anomalies 1,091	Congenital Anomalies 1,091	HIV 18,000	Malignant Neoplasms 44,168	Malignant Neoplasms 87,808	Heart Disease 615,428	Heart Disease 737,563
2	Short Gestation 3,933	Congenital Anomalies 695	Malignant Neoplasms 523	Malignant Neoplasms 603	Malignant Neoplasms 603	HIV 11,894	Malignant Neoplasms 17,110	Heart Disease 34,498	Heart Disease 68,440	Malignant Neoplasms 381,142	Malignant Neoplasms 638,455
3	SIDS 3,397	Malignant Neoplasms 486	Congenital Anomalies 242	Homocides 213	Suicide 2,184	Suicide 2,184	Congenital Anomalies 14,225	Congenital Anomalies 9,251	Bronchitis Emphysema Asthma 9,808	Cerebrovascular 138,782	Cerebrovascular 157,991
4	Respiratory Disease Synd. 1,454	Homocides 238	Homocides 137	Suicide 330	Malignant Neoplasms 1,842	Homocides 6,150	Heart Disease 13,693	HIV 8,179	Cerebrovascular 8,735	Bronchitis Emphysema Asthma 88,478	Bronchitis Emphysema Asthma 102,888
5	Maternal Complications 1,308	Heart Disease 251	Heart Disease 130	Congenital Anomalies 207	Heart Disease 1,039	Malignant Neoplasms 4,875	Suicide 2,097	Cerebrovascular 5,473	Diabetes 6,188	Pneumonia & Influenza 74,297	Congenital Anomalies 93,920
6	Placenta Cord Membranes 902	HIV 210	HIV 123	Heart Disease 94	HIV 629	Heart Disease 3,461	Homocides 2,143	Liver Disease 5,247	Congenital Anomalies 6,185	Diabetes 44,462	Pneumonia & Influenza 62,923
7	Perinatal Infections 788	Pneumonia & Influenza 198	Pneumonia & Influenza 73	Bronchitis Emphysema Asthma 105	Congenital Anomalies 462	Cerebrovascular 720	Liver Disease 3,705	Suicide 2,535	Liver Disease 5,388	Congenital Anomalies 25,038	Diabetes 88,254
8	Congenital Anomalies 13,055	Perinatal Period 87	Benign Neoplasms 50	HIV 68	Bronchitis Emphysema Asthma 246	Pneumonia & Influenza 622	Cerebrovascular 2,772	Diabetes 3,906	Pneumonia & Influenza 3,458	Alzheimer's Disease 20,230	HIV 43,115
9	Pneumonia & Influenza 482	Septicemia 80	Bronchitis Emphysema Asthma 38	Benign Neoplasms 55	Pneumonia & Influenza 207	Diabetes 614	Diabetes 1,844	Bronchitis Emphysema Asthma 2,756	Suicide 2,637	Nephritis 20,182	Suicide 31,334
10	Infantile Hypoxia 475	Cerebrovascular 57	Anemia 31	Pneumonia & Influenza 56	Cerebrovascular 172	Liver Disease 604	Pneumonia & Influenza 1,480	Pneumonia & Influenza 2,078	HIV 2,320	Septicemia 16,899	Liver Disease 25,222

Subtotal: 26,151 4,756 2,979 3,822 30,297 48,679 84,184 120,267 204,730 1,428,967 1,872,026
 * Other Deaths: +442,664

TOTAL # DEATHS

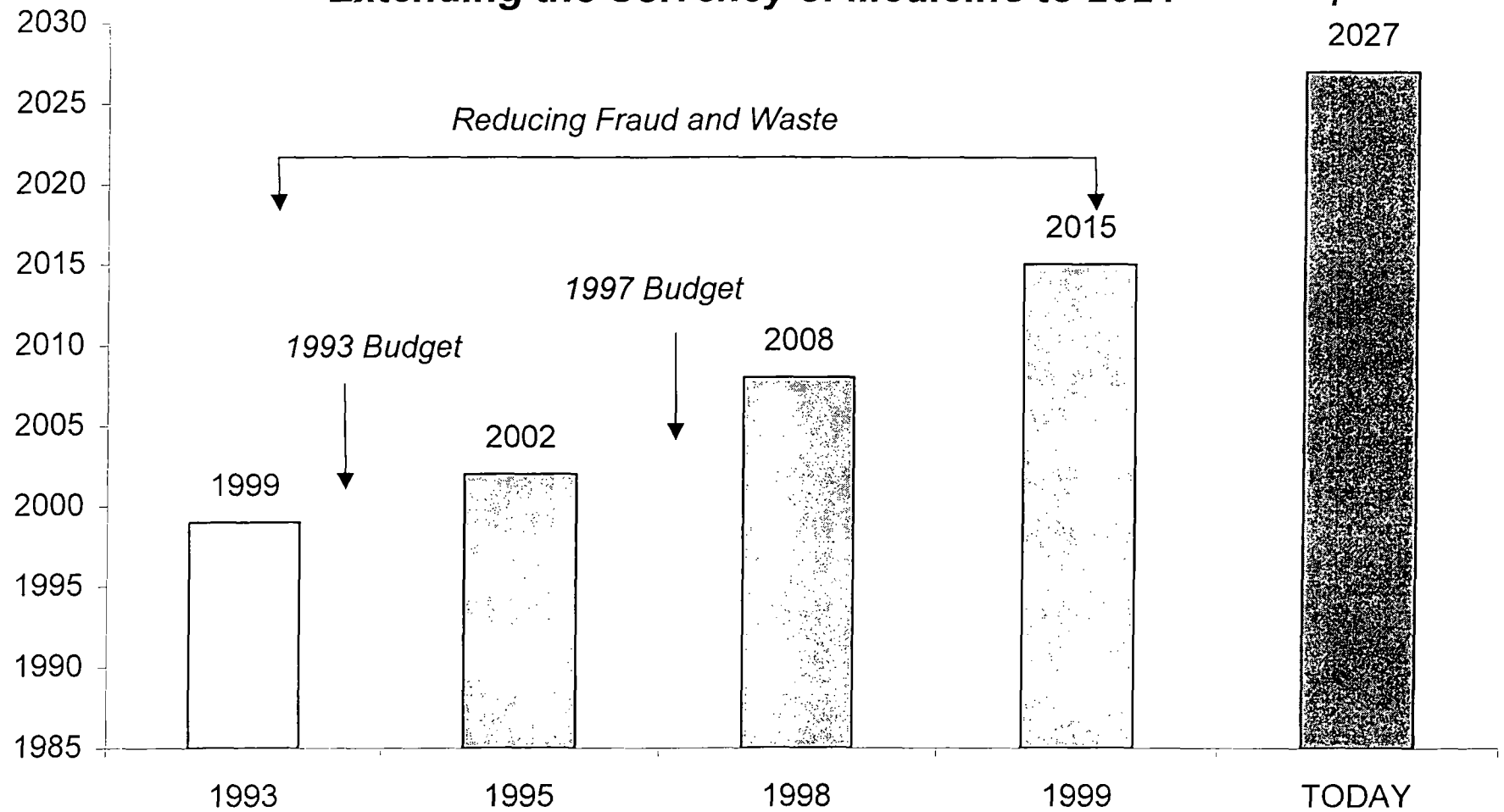
% of TOTAL DEATHS: .87% .21% .13% .17% 1.71% 2.19% 3.6% 5.2% 8.8% 61.7% 80.9%

2,314,690

Modernizing and Strengthening MEDICARE

Extending the Solvency of Medicare to 2027

*President's
Reform
Proposal
2027*



We met w/DWL

this week
about
Medicare $\frac{1}{2}$

The Face of Medicare is a Woman You Know ⁻⁸⁷⁷ ₋₂₆

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1999 Mother's Day Report ⁻²⁶

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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.

2 - 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 different 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).

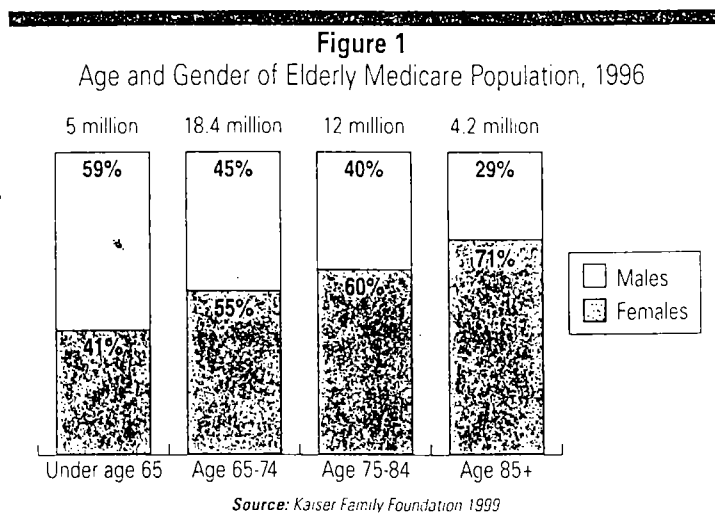
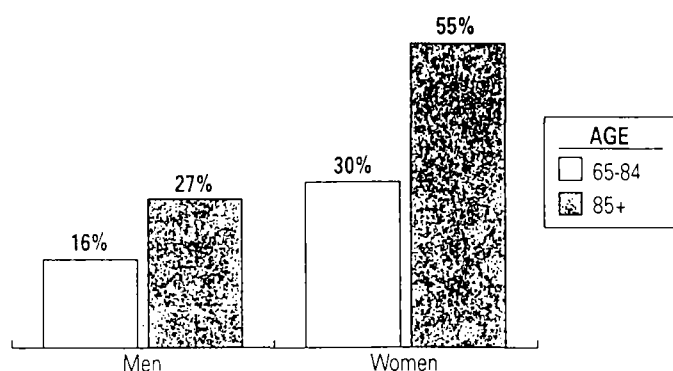


Figure 2

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).

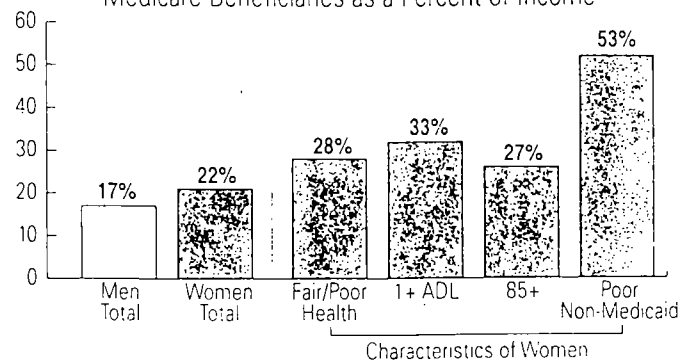
Because women have lower incomes and greater health care needs, the proportion of their income spent on out-of-

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

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

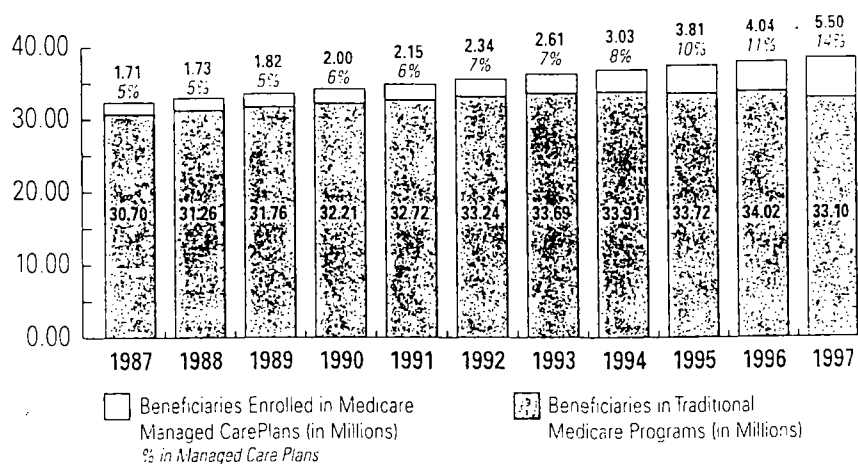
costs for covered health care services.

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

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 (Mar 1995), 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).

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

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.

basic Medicare benefit package.

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 health 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).

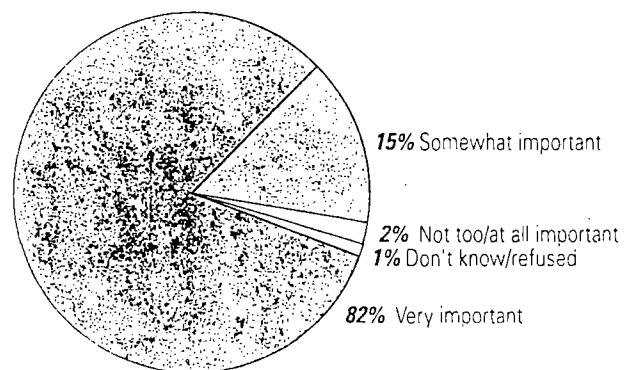
OWL supports proposals that would improve Medicare's benefit package, enhance financial protections for low-income women, improve protections in managed care, expand access to Medicare coverage, and address fiscal problems to preserve Medicare for the next generation.

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

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*

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 for 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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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 606 11th Street, NW, Suite 700, Washington, D.C. 20001 or call 1/800/825-3695 or 202/783-6686.

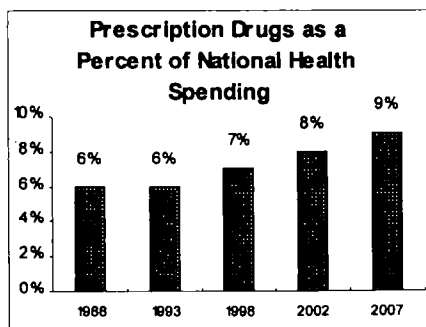
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BACKGROUND ON A PRESCRIPTION DRUG BENEFIT

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

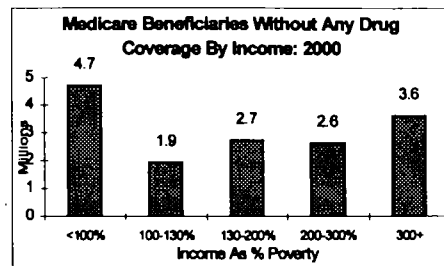
- **Increasing reliance on drugs.** Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulants with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.
- **Elderly and people with disabilities rely more on prescription drugs.** Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.
- **Rising share of national health spending.** The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 years, spending on prescription drugs has risen as a percent of total spending by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.



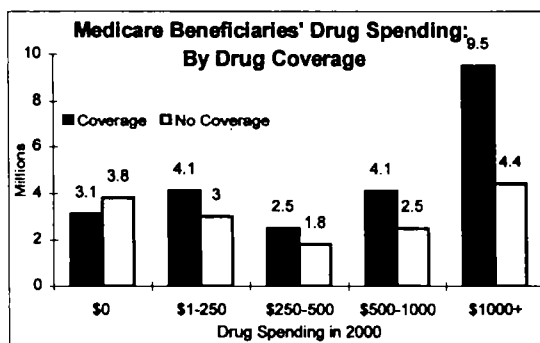
- **Drugs may reduce need for and cost of other services.** Some studies have found that elderly, ill Medicare beneficiaries whose Medicaid drug coverage is limited are twice as likely to enter nursing homes. The increased cost of institutionalization exceeds the savings from reduced drug utilization by 20 fold. And, stroke patients treated promptly with drugs to thin clots have lower health care costs. Despite this evidence, there is no consensus on the nature and amount of any savings from drug coverage since experts are uncertain about potential new costs due to increases in utilization and possible extension of lives. However, they do agree that such coverage would have positive effects on beneficiaries' health and quality of life.

BENEFICIARIES WITHOUT DRUG COVERAGE: CHARACTERISTICS AND CONSEQUENCES

- About 16 million beneficiaries (40%) are projected to have no drug coverage in 2000.** Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about \$17,000 for a single, \$23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



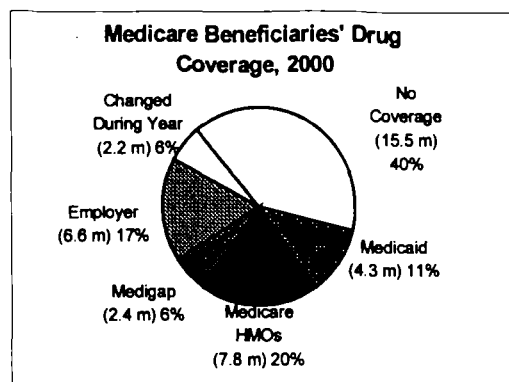
- Many beneficiaries need drugs but do not use them because they are uninsured.** Most research has found that lack of coverage reduces needed drug utilization. One study found that elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodilators) when their Medicaid drug coverage was limited. And while some do not receive the drugs they need, nearly half of all beneficiaries without any insurance coverage for prescription drugs have annual out-of-pocket spending of \$500 or more.



- Elderly without coverage pay higher prices.** Because they do not benefit from drug purchasing programs, Medicare beneficiaries without drug coverage pay prices that can be 15 to 30 percent higher than large HMOs, employers and the Veterans' Administration. A recent General Accounting Office study found that pharmaceutical benefit managers in the Federal Employees' Health Benefits Plan reduced costs by 20 to 27 percent.
- Larger financial burden.** Elderly with private insurance for drugs have about half the financial burden (out-of-pocket drug spending as a percent of income) as those without drug coverage. The financial burden of drug costs for rural elderly is on average 35 percent higher than urban elderly since they are less likely to have insurance covering drugs. Women have, on average, out-of-pocket costs as a percent of income that are 20 percent higher than men, primarily because many are widowed and have lower income. About 1 million beneficiaries without drug coverage have annual out-of-pocket expenses that exceed \$3,000 - which more than 20 percent of income for at least half of these beneficiaries.
- Difficult to help only beneficiaries without drug coverage.** While ideally public policy would target only those beneficiaries who are uninsured, this is impossible given their diversity, along with their rising numbers, as Medigap and retiree coverage erode.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES

- **Private supplemental drug coverage is low and declining:** Only 23 percent of Medicare beneficiaries are expected to have private employer-based or Medigap insurance for drug coverage in 2000 according to the Medicare actuary -- down significantly from 1995. Both sources of coverage have been declining as the cost of coverage rises. Therefore, they cannot be relied upon to provide coverage in the future.



- **Retiree health insurance:** Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent. The Medicare actuaries project that, by 2000, only 17 percent of beneficiaries will have retiree drug coverage.
- **Medigap:** Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in some of its plans. Its drug benefit has a \$250 deductible, 50 percent coinsurance, and a cap on benefits spending of \$1,250 or \$3,000. Medigap premiums are expensive and virtually always underwritten, meaning that premiums are based on the person's health. Beneficiaries can be denied coverage if they do not enroll immediately when they are age 65. The premium for a plan with drug coverage is about \$1,100 more than a plan without drug coverage (\$2,073 v \$913 in 1998). Medigap premiums have been rising at double-digit inflation, and coverage has been declining. About 6 percent of beneficiaries are expected to have Medigap drug coverage in 2000.
- **Public coverage exceeds private coverage:** More beneficiaries are projected to have public (30%) than private (23%) drug coverage -- suggesting that the potential for "crowding out" private spending are exaggerated.
 - **Medicare managed care:** Over 90 percent of beneficiaries in Medicare HMOs have some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, 42 percent of beneficiaries had coverage limited to \$1,000 or less. Rising costs and lower Medicare payments could reduce benefits in the future.
 - **Medicaid:** Only about 4.3 million Medicare beneficiaries who are fully eligible for Medicaid (e.g., who receive Supplemental Security Income (SSI) or are medically needy) receive prescription drug coverage. This represents less than half of Medicare beneficiaries below poverty since Medicaid eligibility is typically only up to 75 percent of poverty. Moreover, even those beneficiaries who are eligible have low participation rates; only about 55 percent of beneficiaries eligible for SSI participate.