Withdrawal/Redaction Sheet
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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. fax	re: phone number (partial) (3 pages)	07/27/1999	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20147

FOLDER TITLE:
Medicare Reform Event [Folder 1]

2012-0463-S
rc700

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
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Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
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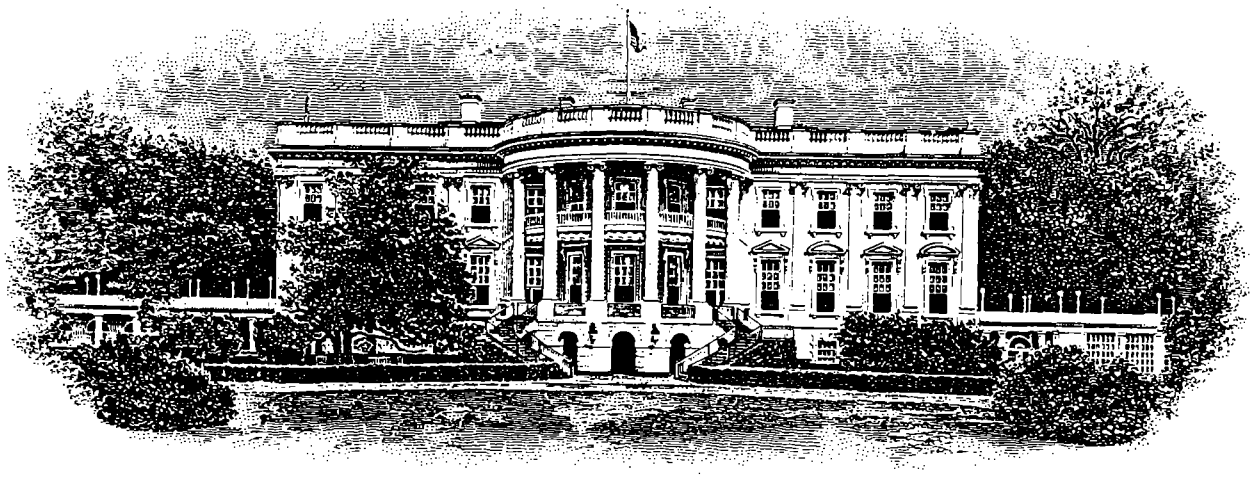
REFORM

The White House



Th report
Short walkthru
29th

Breaux transcript

THE WHITE HOUSE

WASHINGTON

July 26, 1999

MEDICARE AND WOMEN EVENT

DATE:	July 27, 1999
LOCATION:	Presidential Hall
BRIEFING TIME:	9:35am – 9:55am
EVENT TIME:	10:00am – 10:50am
FROM:	Bruce Reed, Gene Sperling, Mary Beth Cahill, Chris Jennings

I. PURPOSE

To join the Older Women's League (OWL) in releasing a report entitled *"Medicare: Why Women Care,"* which includes a new analysis documenting why strengthening and modernizing Medicare is particularly important to women of all ages.

II. BACKGROUND

Today, in your remarks you will:

UNVEIL A NEW REPORT BY THE OLDER WOMEN'S LEAGUE. Nearly 60 percent of Medicare beneficiaries are women and this proportion rises with age – over 4 in 5 people over age 100 are women. Moreover, older women tend to have more chronic illness and lower incomes, making Medicare even more important as a health and financial safety net. Since it was created in 1965, Medicare has contributed to lengthening older women's lives by 20 percent and reducing their poverty rate dramatically. Yet, the 21st century brings with it challenges that will affect all beneficiaries.

Key findings of the report include:

- **In the next 30 years, the number of Medicare beneficiaries will double – most of them will be women.** In 2035 alone, there will be nearly 40 million elderly women and fewer than 34 million older men. This large enrollment increase is a major factor in the projected exhaustion date of the Medicare trust fund by 2015 and in the need for more revenue to avoid devastating cuts to the program.

- **Total prescription drug spending for women on Medicare averages $1,200 – nearly 20 percent more than that of men.** Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about $12,750 for a single, $17,000 for a couple), despite older women's lower average income.

- **Medicare's preventive benefits are underused by older women.** Financial and information barriers prevent older women from using critical preventive services. In recent years, just 1 in 7 women have taken advantage of Medicare-covered mammograms.

Other key findings include:

MEDICARE, A SOURCE OF FINANCIAL AND HEALTH CARE SECURITY FOR OLDER WOMEN, IS AT RISK.

- **Most elderly Americans covered by Medicare are women.** Twenty out of the 34 million elderly Americans covered by Medicare are women, who comprise nearly 3 out of 5 older Americans. The proportion of the elderly who are women rises with age; about 71 percent of people age 85 or older are women. Eighty-three percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years.

- **New revenue is necessary to ensure that the Medicare trust fund is solvent when women in the baby boom generation retire.** Since most women turning 65 today are expected to live through 2018, the projected insolvency of the Medicare Trust Fund will occur within their lifetime.

- **Women have greater health care needs and lower income.** Older women are more likely to need Medicare's health care services. About 73 percent have two or more chronic illnesses compared to 65 percent of men. Women's incomes are lower than men's incomes, and they must stretch fewer financial resources over longer lives. Seven out of 10 Medicare beneficiaries living below poverty are women. The increased likelihood that women will live alone in their later years places them at increased risk of poverty.

WOMEN FACE GREATER COST BURDENS – AND BARRIERS TO HEALTH CARE – BECAUSE OF MEDICARE BENEFIT LIMITATIONS. As important as Medicare coverage is to women, its benefits are outdated.

- **Higher out-of-pocket health spending.** The combination of greater health problems and lower income results in women on Medicare spending 22 percent of their income on health care compared to 17 percent for men. Lower income women spend an even greater share of their limited incomes on health care – 53 percent for the poorest.

- **Total prescription drug spending averages $1,200 for women on Medicare – 20 percent more than that of men.** Older women tend to have more chronic illnesses that require medication to manage.

- **For most women, existing coverage is unstable, unaffordable and declining.** Medigap routinely increase premiums with age – at age 85, premium for a Medigap plan with drug coverage up to $1,250 costs from $300 to $400 per month -- $3,600 to $4,800 per year. This discriminates against women, who comprise nearly three-fourths of people in this age group. It also charges more at a time where income has declined.

- **About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs.** Despite their lower average income, fully half of these women without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people of all age groups.

- **Out-of-pocket payments for preventive services also constitute a barrier to health.** In recent years, just one in seven women without supplemental insurance used Medicare-covered mammograms. One study found that in 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

EMPHASIZE GREATER PROBLEMS FACING RURAL BENEFICIARIES IN ACCESSING PRESCRIPTION DRUG COVERAGE. In an event later today, the Vice President will release new facts on the challenges facing rural beneficiaries. Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries. This reflects the lower access to Medicare managed care and retiree health coverage for these beneficiaries. The Vice President will also release information documenting that lack of access to prescription drug coverage occurs throughout the income spectrum – 45 percent of rural beneficiaries with income above $50,000 lack prescription drug coverage compared to 25 percent of all beneficiaries.

HIGHLIGHT THE IMPORTANCE OF INVESTING IN THE FUTURE OF THE MEDICARE PROGRAM. Today, you, the First Lady and the Vice President will underscore the fact that there will not be a debate about how to strengthen Medicare or how to provide a prescription drug benefit if all of the surplus is invested in a large tax cut. You will state your strong belief that the Congress and the American public face an important decision: to invest in a stronger Medicare program for our mothers and grandmothers or give away the entire surplus on a risky and irresponsible tax scheme.

I. PARTICIPANTS

Briefing Participants:
Secretary Donna Shalala
Bruce Reed
Gene Sperling
Mary Beth Cahill
Chris Jennings
Jeanne Lambrew
June Shih

Event Participants:
The First Lady
Secretary Donna Shalala
Judy Cato

Judy Cato, 60, receives health insurance through her employer, but is worried about the stability of her coverage especially as she reaches retirement age. In addition to worrying about the health care needs of both herself and her husband, Judy is the primary caregiver to her 80 year-old mother who has lived with her family for three years. Her mother's prescription drug costs are approximately $300 monthly, and without the daily needs assistance Judy provides she would not be able to make it alone. Joan is employed as a site manager for Council House, a housing facility for low-income seniors. She has one daughter and one grandson.

II. PRESS PLAN

Open Press.

III. SEQUENCE OF EVENTS

- **YOU** and the First Lady will be announced, accompanied by Sec. Shalala and Judy Cato, onto the stage.
- Secretary Shalala will make remarks and introduce the First Lady.
- The First Lady will make remarks and introduce Judy Cato.
- Judy Cato will make remarks and introduce **YOU**.
- **YOU** will make remarks, work a ropeline, and depart.

VI. REMARKS

To be provided by speechwriting.

June Shih 07/26/99 08:58:36 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: women and medicare final

Draft 7/26/99
Shih

PRESIDENT WILLIAM J. CLINTON
REMARKS ON WOMEN AND MEDICARE
THE WHITE HOUSE
JULY 27, 1999

Good morning. Today, after listening to Judith speak about her mother and her family, I am reminded that the aging of America is a challenge that we are truly blessed and lucky to have. It is what I like to call a high-class problem. Americans are living longer. And America is richer for it. Older Americans are leading more active lives and making important contributions to our communities well into retirement. Our children are enjoying the love and wise counsel of their grandparents long into adulthood. I know I would have loved to have my mother still with me in my retirement years.

On the eve of the 21st Century, the health and vitality of America's seniors is in no small part due to Medicare. Everyone here knows the difference Medicare has made in the lives of older Americans and their families. For 34 years, Medicare has protected the health of our seniors, enriched the lives of the disabled, and eased the financial burden on families as they cared for their loved ones. For millions of American women, Medicare has been the lifeline to a dignified retirement. As the report released today by the Older Women's League so convincingly tells us, a strong and modern Medicare system is vital to the health and future of America's women -- to our grandmothers, mothers, wives, sisters and daughters.

First, a strong and modern Medicare system is critical to women because, very simply, the majority of Medicare beneficiaries -- twenty of the 34 million Americans currently enrolled --are women. [*point to chart*]This is so because the majority of Americans 65 and older -- three out of every five -- are women. But what's more, as we grow older, so does the proportion of women. Nearly three-fourths of all Americans who reach the age of 85 are women. And 4 out of 5 centenarians -- Americans lucky enough to witness the breadth of an entire century -- are women.

Second, without Medicare, the doors to hospitals and doctors' offices, to basic medical treatment and good health would be closed to millions of older women. Throughout their

lives, women's incomes have always lagged behind those of men - a gap underscored in retirement through smaller pensions and Social Security checks. Even as they must make ends meet on smaller incomes, women must meet greater health care needs than men. Nearly three-fourths of older women have two or more chronic illnesses compared to just 65 percent of older men. For these women, Medicare has truly meant the difference between a healthy retirement and one clouded by untreated illness and poverty.

But as we know, the clock is ticking on this critical institution's ability to serve America's women and families into the next century. With our people living longer than ever, and the retirement of the Baby Boom generation rapidly approaching, the Medicare Trust Fund will become insolvent by 2015. At the same time, Medicare's benefits - which have not changed significantly since 1965 -- have failed to keep pace with the rapidly changing world of modern medicine.

There are some who say that strengthening Medicare is a challenge that we can still afford to put off toward later years. To them I say, look at Judith Cato and her mother. Like millions of women in the same situation, affording prescription drugs is a very immediate challenge. The typical 65-year old woman retiring this year can expect to see the ripe old age of 84. That's 19 more years of retirement. But if we do not act soon, the Medicare Trust Fund will expire in 16 years.

We must act now. Over the past six and a half years, we have managed to transform a sick deficit economy into an economy that is the picture of fiscal health. In 1993, the budget deficit was projected to be a $290 billion. Today, we have an unprecedented surplus of $99 billion. We've balanced the budget, cut unnecessary spending, expanded our investments in education and training. As a result, we have the longest peacetime expansion in history, with 19 million new jobs and the lowest minority unemployment rates ever recorded.

We cannot afford to miss this unprecedented opportunity to strengthen and modernize Medicare for the 21st Century. My plan would secure Medicare by dedicating over $370 billion of our budget surplus over the next 10 years to extending the life of the Trust Fund to the year 2027. We will keep Medicare costs low even as we improve quality by introducing the most effective private sector innovations into the program. And we will promote competition by giving seniors the chance to choose between lower-cost Medicare managed plans and the traditional program.

Strengthening Medicare is important, but so is modernizing its benefits. Over the past thirty years, a medical revolution has transformed health care with prescription drugs that have supplanted some surgeries, lengthened and improved the quality of life. As the OWL study shows, women have borne the greatest cost of this pharmaceutical revolution. According to this chart, women spend $1,200 a year on prescription drugs, almost 20 percent more than men. As many of you know, my plan will help seniors afford the prescription drugs that have become essential to modern medicine.

I am committed to providing an optional prescription drug benefit to all Medicare

beneficiaries. Affording prescription drugs is a challenge not just for poor women, but for middle income women as well. Half of all middle class women - those who make at least $12,700 a year, or with their husbands make $17,000 -- have no prescription drug coverage at all. [show chart]. Women who have tried to buy extra drug coverage through private Medigap policies have had to cope with escalating premiums as they grow older. Anyone who says that America's seniors must bear these burdens in retirement is simply out of touch and out of date.

Finally, my plan will also eliminate the last barrier between seniors and preventive screenings-- tests for breast cancer, colon cancer, prostate cancer, diabetes, and osteoporosis -- that can help save their lives. For too many seniors on fixed incomes - especially low-income women -- the cost of a modest copayment is simply prohibitive. Last year, just one in seven women took advantage of the mammograms covered by Medicare. To encourage more people to take advantage of this benefit, my plan will waive the deductible and all co-payments.

I call on Congress to move forward on this plan - and seize the historic opportunity we have to ensure that Medicare truly serves our mothers, grandmothers, sisters, wives and all Americans well into the 21st Century. By dedicating the surplus first to Social Security and Medicare, we can strengthen these programs without walking away from our vital commitments to education, to law enforcement, to biomedical research, to national defense, to the environment. Under my plan, we could actually free America from its debt for the first time since 1835 - and still have funds left over for a substantial tax cut - one targeted toward retirement savings, long term care, and child care.

Regrettably, there are some in Congress who have voted to squander this historic opportunity to prepare for the aging of America. Last week, the House of Representatives passed an irresponsible tax bill that would spend our surplus without devoting a dime toward boosting the solvency of Medicare. What's more, the Republican tax cuts won't go into full effect until the year 2010, draining the most resources just as the baby boomers begin retiring, Medicare nears insolvency, and Social Security begins to feel new strains. This week, the Senate will consider a similar bill. These bills are skewed toward the special interests. They do not protect our national interests. They are unacceptable.

I have made it very clear that I will not accept any bill that undermines our ability to save Social Security and strengthen Medicare. I ask the Senate and the House to work with me to honor this fundamental obligation to the future. We must make certain there are enough resources for Medicare, for Social Security, and for education, for law enforcement and the environment before we embark on a tax scheme that could squeeze out vital priorities in years to come. First things first.

The aging of America is an important challenge for our nation. It tests our commitment to our parents who deserve high quality health care after a lifetime of hard work. It tests our commitment to our children who should not be burdened with the cost of bailing out Medicare just as they are raising their own families. It tests our foresight -- our ability to recognize and fulfill our duties and obligations to the future. It is a test I am confident we, the American people, can pass.

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To Deborah → 456-5557

President Clinton ... Mrs. Clinton . . . Executive Director Briceland-Betts . . .Dr. Altman . . . Mrs. Cato.

It's a priviledege to be able to join with you today in the release of this important report.

As I was preparing for today's program, I recalled that, over a century ago, Charles Warner wrote, "goodness comes out of people who bask in the sun."

But, I have to tell you, judging from what we saw last week on Capitol Hill, I'm guessing he never spent a summer in Washington.

Earlier this month, the President offered Congress a carefully crafted proposal to strengthen Medicare's finances while modernizing its benefits.

As the President pointed out, under our plan -- for the first time ever -- Medicare would provide the prescription drug benefit Medicare beneficiaries need, but at a price America can afford.

It would make Medicare more efficient, more competitive and provide the financial strength it needs to meet the challenges of the 21st century.

But, today, I must tell you that the cause of a stronger, more modern Medicare system is in jeopardy.

It's not because Americans don't want it -- and it's not because we don't need it.

It's because the tax cut passed by the House is so large it will eliminate any chance that we could ever have it.

And the Republican tax cut wouldn't just undermine Medicare -- it would mean cuts in the Meals on Wheels program that provides older Americans with the food they need.

It would mean cuts in the Head Start program that readies their grandchildren for school.

In short, it would mean cuts in vital services families of all ages need and depend on.

In fact, their plan is so far reaching it could derail the economic expansion itself.

That would hurt everyone -- but it would hurt older women most of all.

Older women are the Americans who have the most at stake in this debate -- and older women are the Americans who have the most to lose.

That's why I'm particularly proud to introduce someone who has long distinguished herself as one of our nation's leading voices on behalf of the needs of America's women -- young and old.

It's my priviledge to introduce a woman who understands that America cannot move forward if it leaves anyone behind -- the First Lady of the United States, Hillary Rodham Clinton.

REMARKS BY JUDITH CATO

Thank you, Mrs. Clinton for your remarks – and thank you so much for caring.

Good morning, Mr. President, Secretary Shalala, and other distinguished guests.

I am here today to share my story with you so that you will understand how important the Medicare program is to my health, and the health of my family.

My husband and I are five years away from qualifying for the Medicare program. Right now I have health insurance through my employer with a pretty good prescription drug benefit, and I'm thankful for it, because both my husband and I use a lot of prescription medications. I take five different medications daily for high blood pressure and other conditions. But when I retire, we're not going to have prescription drug coverage – my employer doesn't cover it. So I'm worried about what I'll do when we turn 65 and our prescription drug coverage disappears. We could join a Medigap plan – but the cost of Medigap insurance seems to go up every day, and not all of those plans offer prescription drugs. We could join an HMO – but I like the security of seeing the same doctor that's taken care of us for the past 30 years, and I've heard that they're cutting back on the drug benefits they offer anyway. I'm worried that we'll end up paying for these medications on our own, and I just don't think that we can afford it.

As it is, we've had a tough time saving for our retirement now that we've begun to help out my mother with her health care costs. I see what my mother has gone through trying to afford the cost of her health care, and although it's difficult for her to take help from us – she's a proud person – there's no way that she would have been able to make it

without us. She's on Medicare and has a Medigap plan, but it doesn't cover prescription drugs. If it offered a good, affordable prescription drug benefit, she might still be able to afford to live on her own. She spends almost $4,000 a year – almost half her income – on the 10 different medications she takes daily to treat diabetes, glaucoma, and heart failure. We knew that she was having a tough time making ends meet when she told us that she was going to stop taking some of her medications so that she could afford to come see her grandchildren. That really scared me, and it's one of the reasons I asked her to come live with us.

Frankly, there is no such thing as an empty nest these days. My daughter hadn't even moved out of the house before my mother moved in. Mr. President, I don't want my daughter to have to worry about me the way I worry about my mother. I'm 60 now, and when I'm my mother's age, I want to know that Medicare will be there for me when I need help. But I'm told that the program will be bankrupt before I turn 80. We've worked and saved all our lives and tried to do the right thing – and it's frightening to think that the Medicare program may not be able to help me pay for the health care services I need the most. I know – and I think that most seniors would agree – I would be happy to pay a modest premium and a limited copayment to ensure that I can access the prescription drugs I need to stay healthy as I get older.

But I'm hearing that this might not even be a possibility because some in Congress want to use up the entire surplus for a tax cut. Mr. President, I know a tax cut sounds good, but I also know that we've got to take care of the obligations we know we have now. There's going to be a lot of us retiring soon, and we need to make sure that we don't place a great burden on our children just as they're trying to put their children through school. I hope that we can put politics aside and put people first and do the right thing by Medicare for all generations of Americans. It's my

honor and privilege to introduce the man that I think can help us do just that – William Jefferson Clinton, the President of the United States.

THE CLINTON-GORE ADMINISTRATION HIGHLIGHTS THE IMPORTANCE OF THEIR PLAN TO STRENGTHEN AND MODERNIZE MEDICARE TO WOMEN
July 27, 1999

Today, at the White House, President Clinton and First Lady Hillary Rodham Clinton joined the Older Women's League (OWL) in releasing a report entitled *"Medicare: Why Women Care,"* which includes a new analysis documenting why strengthening and modernizing Medicare is particularly important to women of all ages. The President and the First Lady also underscored the importance of taking advantage of the historic opportunity to dedicate a significant portion of the surplus to secure the life of the Medicare trust fund for a quarter century. In releasing this report, OWL stated its strong support for the President's vision of dedicating the surplus to strengthen Medicare, adding a prescription drug benefit, and improving preventive services.

The Vice President later joined the Democratic leadership and released a new analysis on the greater challenges that beneficiaries in rural America face in accessing prescription drug coverage. He pointed out that, although representing fewer than one-fourth of the Medicare population, beneficiaries living in rural areas account for over one in three of all beneficiaries lacking prescription drug coverage. Today, the Clinton-Gore Administration:

UNVEILED A NEW REPORT BY THE OLDER WOMEN'S LEAGUE. Nearly 60 percent of Medicare beneficiaries are women and this proportion rises with age – over 4 in 5 people over age 100 are women. Moreover, older women tend to have more chronic illness and lower incomes, making Medicare even more important as a health and financial safety net. · Since it was created in 1965, Medicare has contributed to lengthening older women's lives by 20 percent and reducing their poverty rate dramatically. Yet, the 21st century brings with it challenges that will affect all beneficiaries.

Key findings of the report include:

- **In the next 30 years, the number of Medicare beneficiaries will double – most of them will be women.** In 2035 alone, there will be nearly 40 million elderly women and fewer than 34 million older men. This large enrollment increase is a major factor in the projected exhaustion date of the Medicare trust fund by 2015 and in the need for more revenue to avoid devastating cuts to the program.

- **Total prescription drug spending for women on Medicare averages $1,200 – nearly 20 percent more than that of men**. Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about $12,750 for a single, $17,000 for a couple), despite older women's lower average income.

- **Medicare's preventive benefits are underused by older women**. Financial and information barriers prevent older women from using critical preventive services. In recent years, just 1 in 7 women have taken advantage of Medicare-covered mammograms.

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MEDICARE, A SOURCE OF FINANCIAL AND HEALTH CARE SECURITY FOR OLDER WOMEN, IS AT RISK.

- **Most elderly Americans covered by Medicare are women.** Twenty out of the 34 million elderly Americans covered by Medicare are women, who comprise nearly 3 out of 5 older Americans. The proportion of the elderly who are women rises with age; about 71 percent of people age 85 or older are women. Eighty-three percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years.

- **New revenue is necessary to ensure that the Medicare trust fund is solvent when women in the baby boom generation retire.** Since most women turning 65 today are expected to live through 2018, the projected insolvency of the Medicare Trust Fund will occur within their lifetime.

- **Women have greater health care needs and lower income.** Older women are more likely to need Medicare's health care services. About 73 percent have two or more chronic illnesses compared to 65 percent of men. Women's incomes are lower than men's incomes, and they must stretch fewer financial resources over longer lives. Seven out of 10 Medicare beneficiaries living below poverty are women. The increased likelihood that women will live alone in their later years places them at increased risk of poverty.

WOMEN FACE GREATER COST BURDENS – AND BARRIERS TO HEALTH CARE – BECAUSE OF MEDICARE BENEFIT LIMITATIONS. As important as Medicare coverage is to women, its benefits are outdated.

- **Higher out-of-pocket health spending.** The combination of greater health problems and lower income results in women on Medicare spending 22 percent of their income on health care compared to 17 percent for men. Lower income women spend an even greater share of their limited incomes on health care – 53 percent for the poorest.

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- **About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs.** Despite their lower average income, fully half of these women without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people of all age groups.

- **Out-of-pocket payments for preventive services also constitute a barrier to health.** In recent years, just one in seven women without supplemental insurance used Medicare-covered mammograms. One study found that in 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

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OWL REPORT (BEING FORMATTED FOR PRINTING)

Medicare: Why Women Care
Executive Summary

Medicare must be strengthened and improved to survive the challenges of the 21st century. Medicare is especially important to women, who are the majority of Medicare beneficiaries.

Medicare is expected to be bankrupt in 2015. Meanwhile the elderly population is expected to double over the next 30 years.

Medicare also faces the challenge of continuing to meet the needs of an aging population with a benefit package that is essentially the same as it was when the program was established in 1965.

These challenges have particular ramifications for women, who are the majority of Americans covered by Medicare.

This report documents why a strong and modernized Medicare program is particularly important to women.

- **Medicare, which is a source of financial as well as health care security for older women, is at risk.**

✓ Threats to Medicare's future. Medicare faces new and daunting challenges in the 21st century. The number of people enrolled in Medicare will double by 2035. In 2035 alone, there will be nearly 40 million elderly women and 34 million older men. This large enrollment increase is a major factor in the projected exhaustion date of the Medicare trust fund.

✓ Most women in the baby boom generation cannot count on Medicare. Given the average life expectancy for older women--an additional 19 years beyond retirement at age 65--no woman turning age 65 today can count on Medicare being there for her life span. She is expected to live through 2018, while the Medicare Trust Fund is expected to expire in 2015.

✓ 20 out of the 34 million elderly Americans covered by Medicare are women. Women comprise nearly three out of five older Americans and the proportion of the elderly who are women rises with age. About 71 percent of people age 85 or older are women. And, 83 percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years.

✓ Medicare's value to women is increased by their greater health care needs and lower income. Older women are more likely to need Medicare's health care services. About 73 percent have two or more chronic illnesses compared to 65 percent of men. Women's

incomes are lower than men's incomes, and they must stretch fewer financial resources over longer lives. Seven out of 10 Medicare beneficiaries living below poverty are women. The increased likelihood that women will live alone in their later years places them at increased risk of poverty.

✓ Older women will be no better off financially in the next century than they are today. Today, 12 percent of older women live in poverty. In 2020 the poverty rate for older women will be the same.

- **Women face greater cost burdens--and barriers to health care--because of Medicare benefit limitations.** As important as Medicare coverage is to women, its benefits are outdated.

✓ Higher out-of-pocket health spending. The combination of multiple health problems and lower income results in women on Medicare paying 22 percent of their income on health care compared to 17 percent for men. Lower income women pay an even greater share of their limited incomes for health care - 53 percent for the poorest.

✓ Lack of coverage for prescription drugs is a particular hardship for women. Total prescription drug spending for women on Medicare is nearly 20 percent more than that of men ($1,200 in 2000 compared to $1,000 for men).

✓ For most women, existing supplemental coverage for prescription drugs is unaffordable and on the decline. Medigap policies routinely increase premiums with age--at age 85, the premium for a Medigap plan with drug coverage up to $1,250 costs from $300 to $400 per month -- $3,600 to $4,800 per year. This disproportionately affects women, who comprise nearly three-fourths of people in this age group. Medigap premiums go up as her income goes down.

✓ About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs. Despite their lower average income, fully half of these women without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people at all income levels.

✓ Cost-sharing requirements for preventive services also constitute a barrier to health. In the first two years that Medicare covered mammography, just 14 percent of women without supplemental insurance to help with copayments had a mammogram. One study found that in 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

Medicare: Why Women Care

Medicare provides a health and financial safety net for 34 million elderly Americans, regardless of health history, health status, employment status or income. Twenty million of them are women (OWL, 1999).

Medicare is a women's issue.

Since 1965, Medicare has embodied the nation's commitment to its mothers and grandmothers, so that, in the words of President Lyndon Johnson, "no longer will illness crush and destroy savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years." Medicare has contributed towards lengthening women's lives. A woman turning age 65 today can expect to live until age 84--nearly 20 percent longer than in 1960, before Medicare was created (HCFA, 1998). It also has helped reduce poverty among the elderly by two-thirds (U.S. Census Bureau, 1998).

Women comprise nearly three out of five older Americans, and the proportion of the elderly who are women rises with age. About 71 percent of people age 85 or older are women (U.S. Census Bureau, 1996). And, 83 percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years (U.S. Census Bureau, 1999).

Women need Medicare.

Women's longer lives, lower incomes in retirement, and heightened patterns of chronic illness make protection against the high cost of health care that Medicare provides especially critical for women. This is increasingly so as the baby boom generation ages. By 2035, the Medicare population is expected to surge from 39 to 80 million (Board of Trustees, 1999). In 2035 alone, there will be less than 34 million older men and nearly 40 million elderly women (U.S. Census Bureau, 1996).

If Medicare does not work for women, then, frankly, it does not work for the majority of Medicare beneficiaries. If it is not affordable for women, it cannot protect the elderly against the high cost of health care. If Medicare-covered services do not reflect changing medical practice, then the program will become increasingly irrelevant for all.

Medicare: Why Women Care, an addendum to OWL's 1999 Mother's Day report, *The Face of Medicare is a Woman You Know,* was written by Kathryn Stern Ceja and edited by Deborah Briceland-Betts. To find out more about the women mentioned in this addendum, or women in your community with compelling stories to tell, please contact Deborah Briceland-Betts, Executive Director, OWL, at (202) 783-6686 or (800) 863-1539.

Medicare must be strengthened and preserved for the millions of Americans who are retired or looking forward to retirement and adjusted to better respond to women--the majority of its beneficiaries--and their health needs.

This report documents why a strong and modernized Medicare program is particularly important to women.

I. Without Change, Medicare Will Not Be There For Women Retiring Today.

First and foremost, America needs to renew its commitment to its mothers and grandmothers by assuring Medicare's solvency. For more than 35 years, Medicare has provided millions of older women with health care coverage they would not otherwise have had--strengthening and preserving Medicare for future beneficiaries is by far the most urgent requirement for older women. Medicare that works for women means a program that is financially secure well into the next century--well beyond the current financial projections until 2015 (Board of Trustees, 1999).

"For most of my life I just never thought about health insurance, says Betty, age 70. "Through either my workplace or my husband's, our family had great coverage."

Betty says she was always healthy and didn't have much occasion to use health insurance. Then, at age 62, she developed heart problems. Her late husband's company covered her heart surgery for an artificial heart valve, through COBRA. But COBRA expired after 36 months, and at 64, Betty was not yet eligible for Medicare. Betty shopped for an affordable policy and discovered she was not going to get one--she was considered "uninsurable."

Legally her husband's company had to offer a policy continuation, but the price was astronomical, says Betty. Her premium increased from $132 a month to $1600 a month; from $1584 annually to $19,548 annually. "And," she says," the coverage offered was puny."

But she took it. There was nothing else available. Betty says, "I emptied my savings and purchased the paltry plan. I kept driving my 10-yer old car and I did not help my grandchildren with college."

Medicare covers Betty now. "I LOVED celebrating my 65th birthday and receiving Medicare in 1995. I try not to think of my vanished savings account...I'm really glad my old car is running...and thank heavens, so am I!"

Most women in the baby boom generation cannot count on Medicare. Given today's average life expectancy for older women--an additional 19 years beyond retirement at age 65--no woman turning age 65 today can count on Medicare being there for her life span. Medicare solvency would have to be extended to 2028 to be viable through the retirement of the entire baby boom generation. Even then, the last of the baby boom generation will live through nearly 2050 (U.S.

Census Bureau, 1996).

And, just as they do today, a disproportionate number of older women will be living on low incomes, very likely alone, and most likely suffering from at least one chronic illness (and probably more). The size and urgency of this problem must be addressed now.

Medicare is not just a health program; it is also an income security program that provides women with relief from the economic burden of illness.

Clarabelle rents a federally-subsidized apartment in an elderly housing complex. She is 80 years old and her sole source of income is a $750 monthly Social Security check.

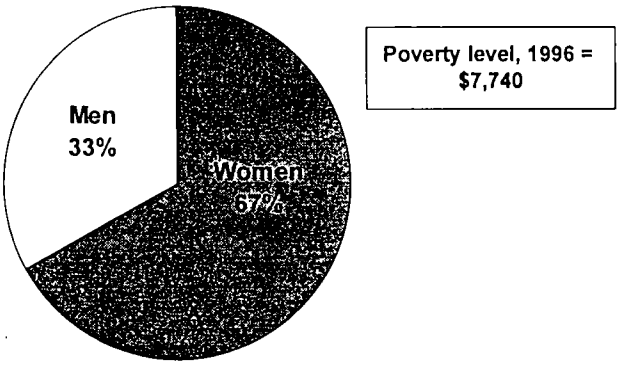
Clarabelle says that Medicare has come through for her. Over the years, Medicare has covered the cost of surgery for a pinched nerve, for cancer of the throat, and for thyroid surgery. She has broken her hip twice. Like many elderly women, Clarabelle has more than one chronic condition, including high blood pressure and asthma. In addition, she is currently suffering from a kidney infection and bronchitis. Clarabelle reports that she spends between $230 and $240 on medication every month.

Clarabelle's other expenses include a life insurance policy, her rent (which she says went down this year from $172 a month to $167), and $10 a month for the cost of her late husband's funeral. "That leaves me $200 to goof off on," Clarabelle says, including groceries. "But I don't eat but one thing a day," she adds.

Seven in ten of low-income Medicare beneficiaries are women. Seventeen percent of female beneficiaries have incomes below the federal poverty level--less than $8,000--compared to 11 percent of men. Half have incomes below about $16,000 compared to 39 percent of men (See exhibit 1).

Exhibit 1

Seven of 10 Medicare beneficiaries with incomes below poverty are women



Total = 5 million beneficiaries with incomes below poverty

SOURCE: The Henry J Kaiser Family Foundation, *The Faces of Medicare*, July 1999. Analysis of the Current Population Survey of non-institutionalized population, 1997.

Why are elderly women so much more likely to be poor than elderly men are? In part, lower lifetime earnings translate into lower retirement income.

- Women today still earn only 76 cents for every man's dollar (BLS, 1999).
- Three out of four women age 65 and over do not have any pension income; of those who do, their median benefit was just over half that of men (OWL, 1998).
- Women's work patterns--lower wages, fewer hours, and more interruptions from paid work for caregiving--will continue to place them at a disadvantage (OWL, 1998).

And, as women get older, increasingly, they live alone. Poverty rates are highest among women living alone, approximately 20 percent, compared to a poverty rate of 5 percent for married women (Estes and Michel, 1999).

According to a 1999 study by the Gerontological Society of America, 69 percent of unmarried women ages 51-61 were in the three lowest deciles for total net wealth compared to one quarter of married women.

"Widowhood," says this report, "is a risk factor for poverty." Eighty percent of all widows in poverty become poor only after their husbands die (OWL, 1997). Higher benefits expected for the increasing numbers of older women who will have their own work in the labor market need to be balanced with future lower benefits for a large and growing number of divorced and never-married women. The upward trend in divorce (it has tripled since 1970), and precipitous rise in the number of unmarried women (from 18.6 percent in 1970 to 32.1 percent in 1997), for women in the baby boom generation, will have a negative effect on prospective income in

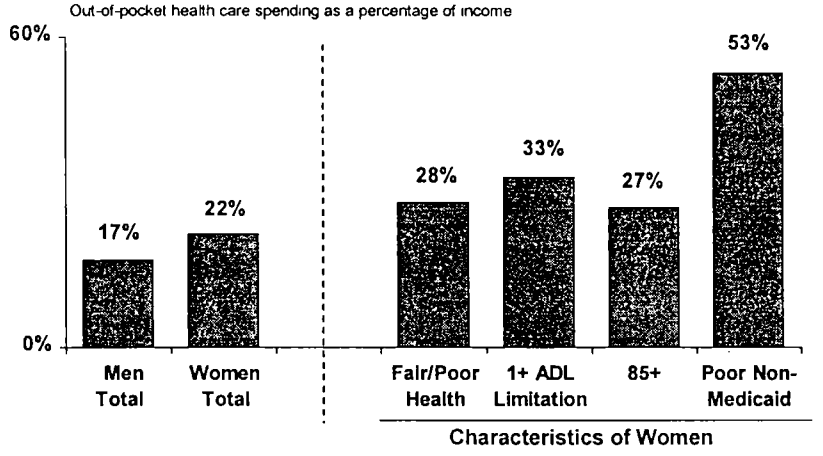
retirement (Estes and Michel, 1999).

"Poverty and insecurity will be as much a problem of older women in 2020 as in 1991 or 1999," conclude the report's authors.

Elderly women today spend a larger percentage of limited income on health care than men the same age (See exhibit 2).

Exhibit 2

Women on Medicare have significant out-of-pocket health care costs



Note: Excludes beneficiaries enrolled in Medicare HMOs, the under-65 and disabled, and those in long-term care facilities. ADL= Activity of daily living, such as eating or bathing.
SOURCE: AARP Public Policy Institute analysis of the Medicare Benefits Simulation Model, 1998

On average, Medicare-eligible women spend a greater share of income on health than men do (22 percent versus 17 percent). But the most vulnerable women spend a greater percentage of income:

- Women over age 85 spend 27 percent of income;
- Women with chronic illness spend one-third of income;
- Poor women who are not covered by Medicaid spend over half (53 percent) of their incomes on health (AARP, 1998).

And their situation may only get worse. Costs of services not covered by Medicare are rising faster than services Medicare covers. The Urban Institute projects Medicare beneficiaries out-of-pocket expenditures will rise by as much as 94 percent between 1998 and 2025--from $2,508 to $4,855 (Moon, 1999).

II. Modernize Benefits to Better Reflect Current Medical Practice.

One of the most essential services in modern medical practice is access to prescription drugs, yet Medicare beneficiaries must find supplemental coverage for this or pay for it out of their own pockets.

Clusta, 77, titles her story "Call Me a Juggler." Widowed 15 years, she lives alone. Social Security is her sole source of income, though she also holds a small life insurance policy for her burial. Her Medicare Part A hospital coverage is supplemented by Blue Cross/Blue Shield, (which increases its premium every year, she says). Medicaid pays her Medicare Part B premium as part of the Specified Low-Income Beneficiary (SLMB) program.

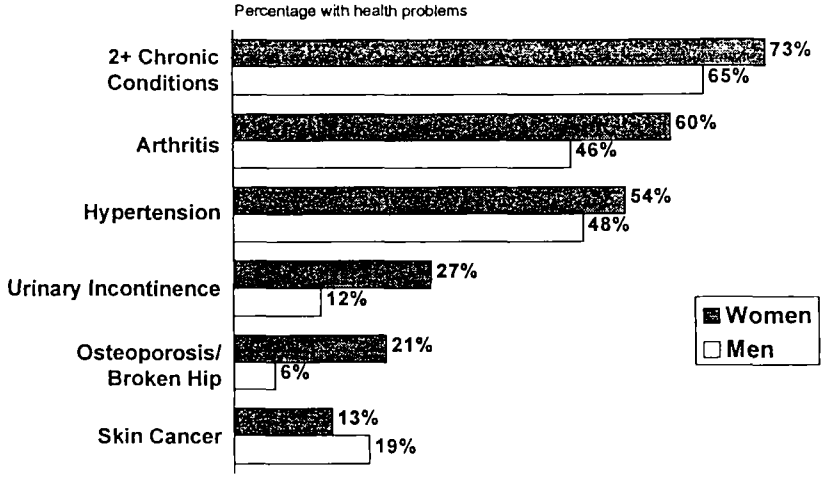
"Medicare has been a lifesaver for me," says Clusta. "But it is not enough." She spends as much as $3000 a year on her health, most of which goes for medicine. Clusta reports that she takes 15 different medications, some twice a day. Recently Hospice has begun paying for a portion of them.

Clusta lives in subsidized housing. "I have to save every penny so I can take care of my health," says Clusta. "I look around me and see many other people who also need care," she adds.

Prescription drugs are especially important in managing chronic illness, which increases with age. Nine out of ten women aged 65 and over report one or more chronic conditions and 73 percent have two or more conditions. In 1996, 60 percent of older women reported arthritis, 54 percent had hypertension and 21 percent had osteoporosis or a broken hip (see exhibit 3).

Exhibit 3

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



Note. Minimal differences (<4%) between genders were reported for heart disease, diabetes, pulmonary disease, strokes, and mental disorders.
SOURCE: The Henry J. Kaiser Family Foundation, *The Faces of Medicare*, July 1999 Analysis of the Medicare Current Beneficiary Survey, 1996.

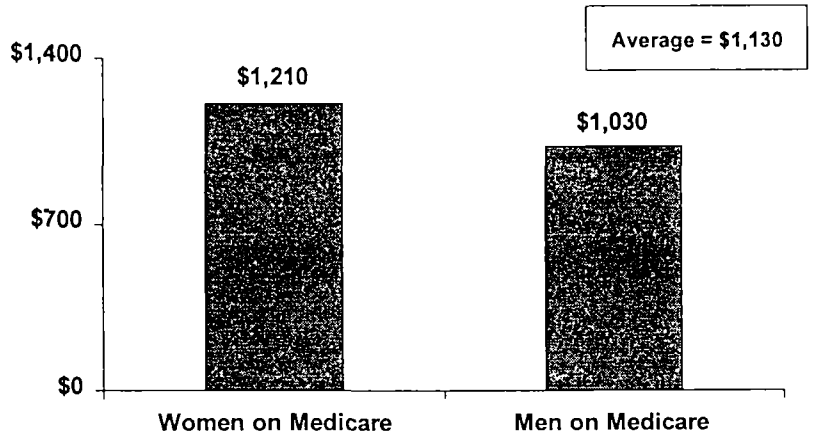
In 1999, drug prices are expected to rise between 14 and 18 percent, compared to 5.3 percent for all other spending on health (Gluck, 1999). Though only 12 percent of Americans, the elderly account for one third of all spending on prescription drugs--and women spend more than men (National Economic Council/Domestic Policy Council, 1999).

➢ Total prescription drug spending for women on Medicare is projected to be nearly 20

percent more than that of men ($1,200 in 2000 compared to $1,000 for men). (See exhibit 4).

Exhibit 4

Total drug spending is projected to be higher for women than men on Medicare in 2000



SOURCE: Actuarial Research Corporation, July 1999.

Meanwhile, two important sources of prescription drug coverage, employer-based retiree health plans and HMO participation in Medicare, are declining. Medigap premiums are also rising and the oldest are most vulnerable to insurance rating practices that increase premiums with age. At age 85, a premium for a Medigap plan with drug coverage up to $1,250 costs from $300 to $400 a month--$3,600-$4,800 a year. As such, Medigap premiums are the highest at the very point when women on on Medicare far outnumber men, and when they can least afford it. If Medicare does not opt to cover prescription medications, out-of-pocket health care spending for women who are covered by Medicare will go up (ASPE, HHS, 1999).

At least 13 million Medicare beneficiaries have no drug coverage at all (National Economic Council/Domestic Policy Council, 1999). About 7.3 million of these Medicare beneficiaries without coverage are women. Despite their lower average income, fully half of women on Medicare without drug coverage have incomes above 150 percent of poverty, underscoring the importance of drug coverage for people of all incomes (Actuarial Research Corporation, 1999).

Rhoda, age 70, and her late husband both suffered from chronic disease. "I am a breast cancer survivor...so far. Also, I have fibromalagia, osteoarthritis, and Graves Disease." Her husband, Paul, lived with "the multiple effects of a heart attack, 25 years of diabetes, and physical and optical problems after a stroke."

"Medicare was there for us when Paul had his stroke. It was there to pay for my mastectomy.

Without it, our medical bills would have destroyed us financially and emotionally." But, says Rhoda, Medicare did not help them with the ongoing chronic health bills that ate away at their fixed income.

"Medicare works. We do not need to scrap it," says Rhoda. "Medicare needs to be there to pay those bills when a medical crisis occurs." But Medicare also needs to "provide the kind of preventive care and treatment of chronic disease that can keep those crises from happening--- including things like prescription drugs and adult day care."

Medicare beneficiaries are required to cover a portion of the cost of preventive screenings such as mammograms or Pap smears, although full coverage could both prevent and help manage illness before it reaches the acute stage and save money for Medicare. The Centers for Disease Control estimates that making screening services available to all women could prevent approximately 15 percent to 30 percent of all deaths from breast cancer and "virtually all deaths" from cervical cancer (CDC, 1999).

Low income is correlated with a lower likelihood of using preventive services (Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries, 1998). The cost of services has been shown to be a barrier. Only about half of women covered by Medicare had mammograms the previous year. In the first two years that Medicare covered mammography, just 14 percent of women without supplemental insurance took advantage of the screening (CDC, 1999).

Studies have reported similar findings for Pap smears, which screen for cervical cancer. Doctors recommend, and Medicare covers, a Pap smear once every three years. In 1993, one study found that only 37 percent of Medicare beneficiaries without supplemental insurance had this test, compared with 59 percent of women covered by Medicare and private supplemental insurance (National Center for Health Statistics, 1997).

Catherine, a few short years from Medicare eligibility, provides an example of what can happen even if a woman does everything right.

Catherine exhausted her savings caring for her late husband who was stricken with Alzheimer's Disease. She left her job to care for her husband, and to meet his health care expenses, she was forced to spend their savings, their IRAs, to take her annuity in a lump sum, and refinance their home. Finally her resources ran out and she was forced to return to work. Soon after he died, she was diagnosed with breast cancer.

Catherine maintained a full time schedule even though she was ill, in order to keep her health care coverage and meet the considerable out-of-pocket expenses of a cancer diagnosis. "Retirement is not in my future--I'll probably work for the rest of my life," says Catherine. Catherine's story illustrates how interconnected family health care issues are for women. Her role as her husband's caregiver and then her own health forced her to spend all she had carefully saved for retirement.

"All of my savings are gone," says Catherine. "The last bit of retirement security I have is

Medicare. I need a Medicare program I can depend on with defined benefits I can count on."

The practice of medicine is no longer the same today as it was in 1965 when Medicare was established. But Medicare is every bit as important to women retiring today, and those who will retire in the next century, as it was when President Johnson signed the program into law.

Modern medicine is changing its focus to the management of illness. But Medicare has not followed suit. That fact will not change as national demographics and economics compel us to turn our attention to an onslaught of retired Americans--mostly women--in the coming century.

Medicare must change its focus.

One of the greatest challenges facing Medicare and our nation as a whole is preparing for the demographic changes of the 21st century. The facts are undeniable--Medicare needs to be strengthened if it is to provide older women with high quality health care. Women in the future will need the health and financial support that Medicare provides, just as they do today.

To meet the needs of the majority of retired Americans, Medicare must respond to their mounting out-of-pocket expenses. It must better manage chronic care through prescription coverage and prevention, and must emphasize prevention to save money and lives.

If Medicare works for women, it works, not only for the majority of beneficiaries, but for all beneficiaries--women and men. Medicare must be protected and modernized not only for this generation of retired Americans, but sustained in the coming century for future generations as well.

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Jeanne Lambrew
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Record Type: Record

To: Melissa G. Green/OPD/EOP@EOP, Patrick M. Dorton/OPD/EOP@EOP, Devorah R. Adler/OPD/EOP@EOP

cc:
Subject: AP story on medicare

Clinton Urges Women to Nix Tax Cut

By Alice Ann Love
Associated Press Writer
Monday, July 26, 1999; 7:39 p.m. EDT

WASHINGTON (AP) -- The Clinton administration is planning an appeal to women in its effort to rally opposition to the big tax cut Republicans are trying to push through Congress, saying women could be hurt more than men if government surpluses aren't available to bolster Medicare.

``Congress and the American public face an important decision: to invest in a stronger Medicare program for our mothers and grandmothers or give away the entire surplus on a risky and irresponsible tax scheme,'' says an administration document describing the message President Clinton and first lady Hillary Rodham Clinton hope to get across at a White House event scheduled for Tuesday.

At the event, the Clintons plan to highlight a study by a nonprofit group showing that women rely more than men do on Medicare -- the nation's health insurance program for the elderly and disabled -- mainly because women on average live longer and have lower incomes.

The study also found that elderly women spend an average of 20 percent more on prescription drugs than men -- something Medicare doesn't cover, although the administration says it should.

Vice President Al Gore, a contender for the 2000 Democratic presidential nomination, is expected to tout the statistics about women and Medicare at a separate rally against GOP tax cuts with Democratic leaders on Capitol Hill Tuesday.

The Democrats are also expected to single out Americans living in rural areas in their pitch. Gore plans to take along administration figures showing that nearly half of senior citizens in rural areas lack health insurance covering prescription drugs, compared to about a third of all retirees nationally.

The administration has proposed, and congressional Democrats are backing, new universal Medicare coverage for prescription drugs -- at a 10-year cost of $118 billion to taxpayers.

To pay for the new benefit and buttress Medicare against the coming wave of baby boom retirements, Clinton wants to use $794 billion of the federal budget surpluses projected over the next 15 years.

Republican leaders also have endorsed the idea of a Medicare overhaul and new drug benefits. But they are trying to earmark much of the future surplus for a tax cut costing $792 billion over 10 years.

Clinton has promised to veto the GOP tax cut, which passed the House last week and is scheduled for consideration on the Senate floor this week, ensuring that the two parties will have to work out a compromise later this year.

But in the meantime, the two political parties are competing to exploit debate over the surplus as a symbol of their different visions for the country leading up to the 2000 elections.

Women are expected to play a pivotal role in those elections, and Gore wants to inherit the support Clinton has enjoyed among them. Clinton's focus on family issues helped him win the women's vote 55 percent to 37 percent in 1996.

The study showing women's disproportionate reliance on Medicare was conducted by the Older Women's League.

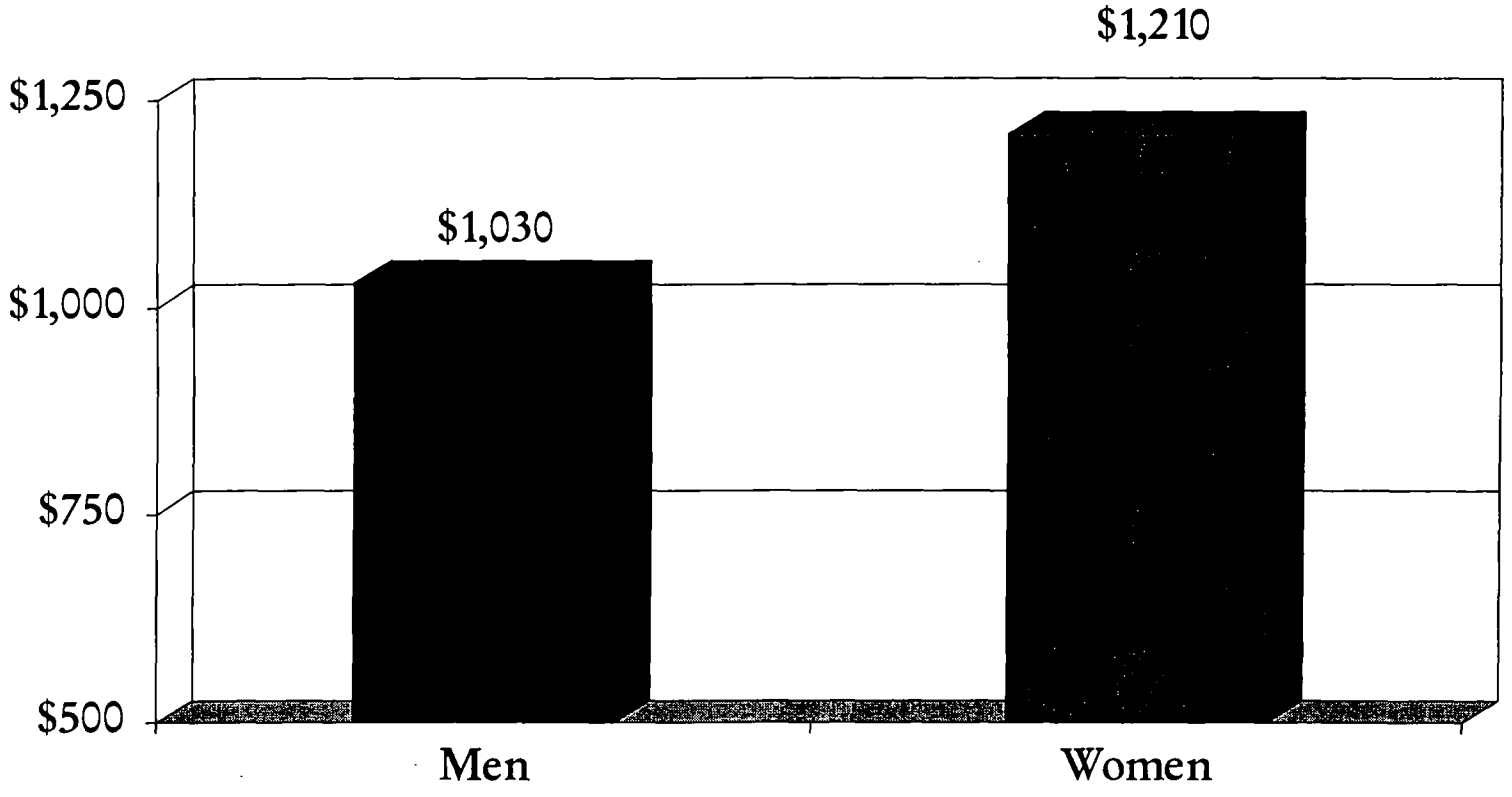
``Medicare is a women's health plan,'' said OWL's executive director, Deborah Briceland-Betts.

Three out of five Medicare beneficiaries are women. Among the oldest participants in the program, the study found, women comprise an even greater share: 71 percent of those over age 85, and 83 percent of those over age 100.

Women also have a greater financial need for help paying medical bills in old age. Seven in 10 of the nation's retirees living in poverty are women. And women, who are also more likely to have chronic illnesses, spend 22 percent of their old-age incomes on health care, compared with 17 percent for men.

On prescription drugs alone, the study estimates, elderly women will spend an average $1,200 on in the year 2000, compared with $1,000 for men.

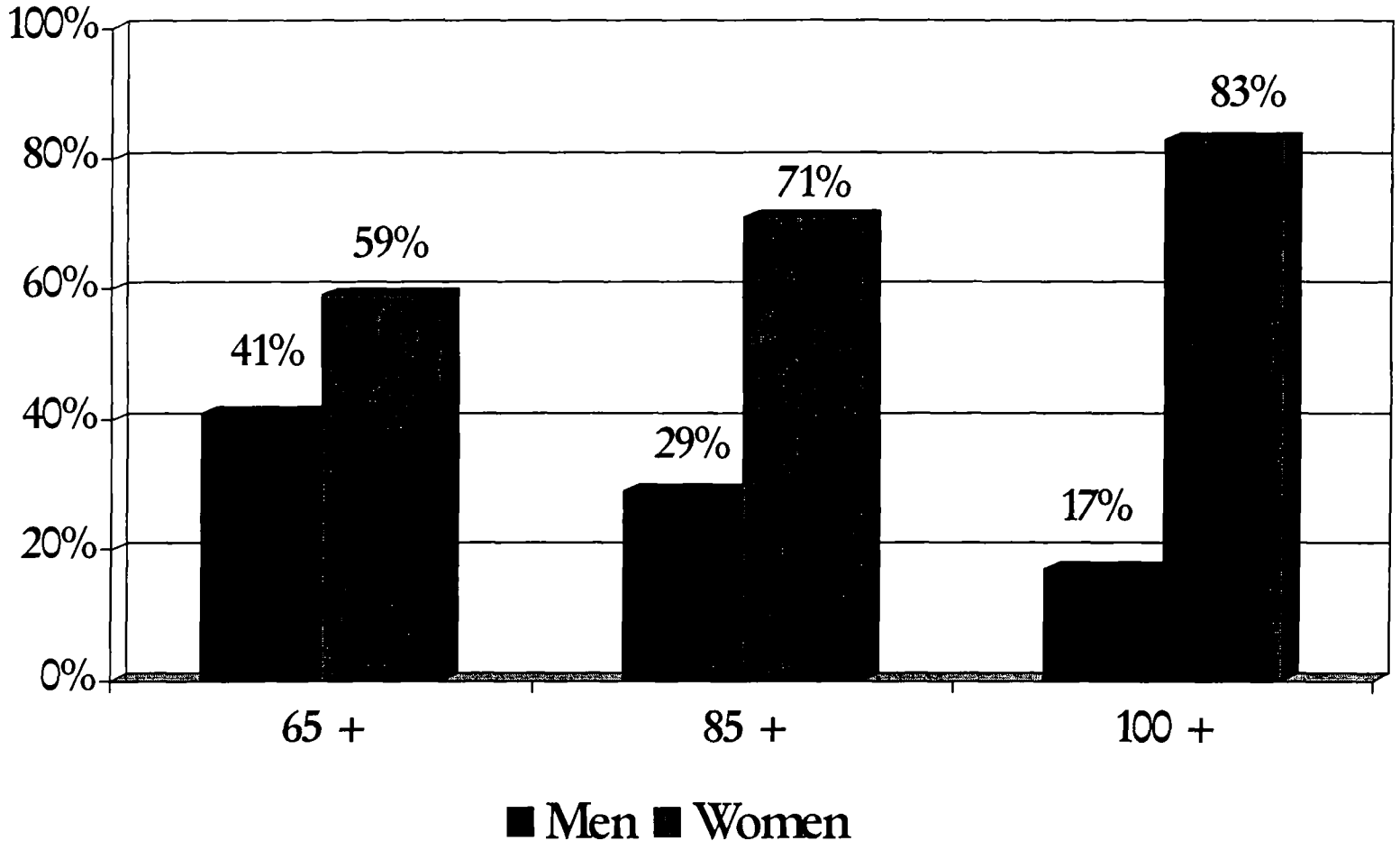
Total Prescription Drug Spending For Women On Medicare Is $1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

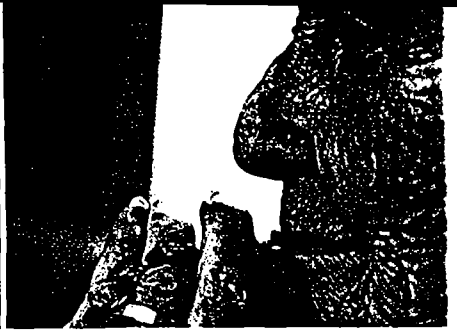
Source: Actuarial Research Corporation. As cited in OWL Report

Most Medicare Beneficiaries Are Women



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

Nearly 7 in 10 Medicare beneficiaries with incomes below the poverty level are women.



As a partner program to Social Security, Medicare provides a health and financial safety net for virtually all older Americans and for many with disabilities who are under 65. Though Medicare covers both women and men, more than half of the nearly 40 million beneficiaries are women.

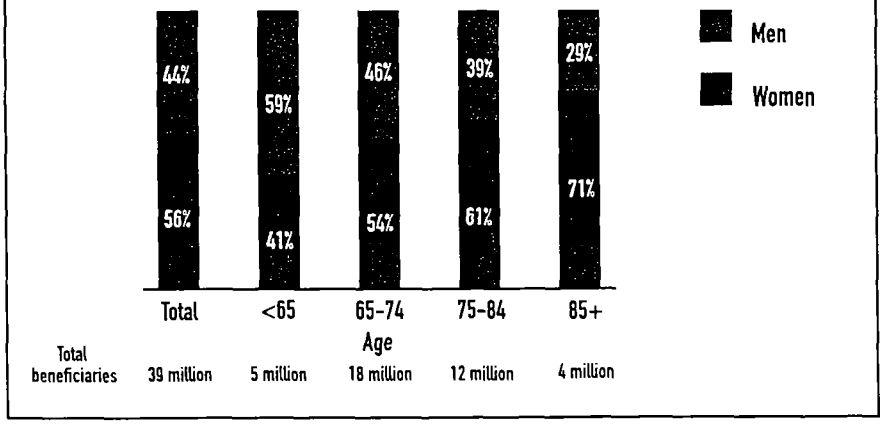
Women's life expectancy at birth, on average, is 79—seven years longer than men's. They, therefore, rely on Medicare for more years than men, and are disproportionately represented among beneficiaries 85 and older (Figure 1). Compared with men, older women are three times likelier to be widowed and far more apt to live alone. Among women 85 and older, four out of five are widowed; more than 43 percent live alone.

Health and Long-Term Care Needs

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

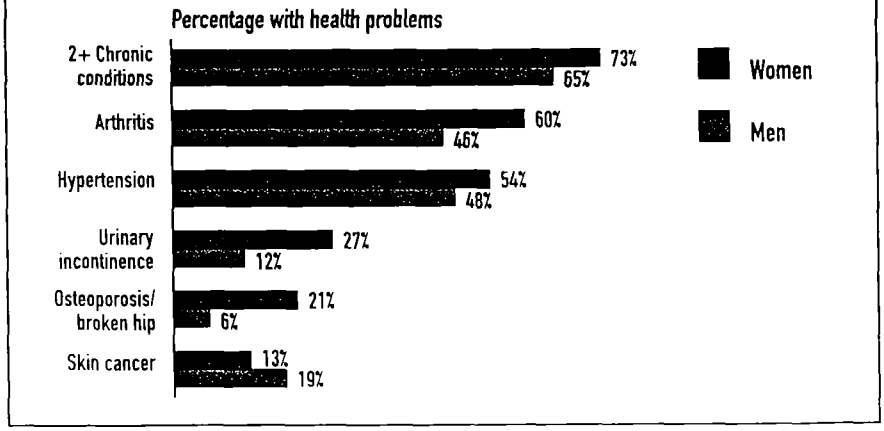
Also compared with men, women are more likely to have functional impairments and long-term care needs. Of the 6 million beneficiaries with functional limitations—measured as needing assistance with one or more activities of daily living (ADL) such as eating or bathing—two-thirds (65 percent) are women. One-third (34 percent) of women 65 to 74 report functional limitations, as do 82 percent of women 85 and older.

Figure 1 More than half of all Medicare beneficiaries are women



SOURCE. Urban Institute analysis of the Medicare Current Beneficiary Survey, 1996.

Figure 2 Women on Medicare are likelier than men to have many health problems



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

THE HENRY J. KAISER FAMILY FOUNDATION
Additional copies of The Faces of Medicare (#1481) and individual copies of Medicare and Women (#1481d) are available by calling the Kaiser Family Foundation's publication request line at 1-800-656-4533, or by visiting our website at www.kff.org

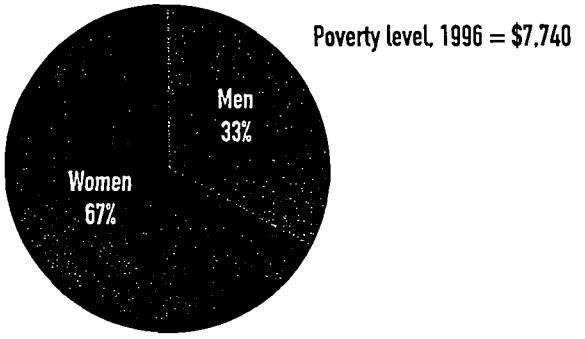
Given their disproportionately low incomes and their greater long-term care needs, women on Medicare are more likely than men to rely on Medicaid.

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

Poverty

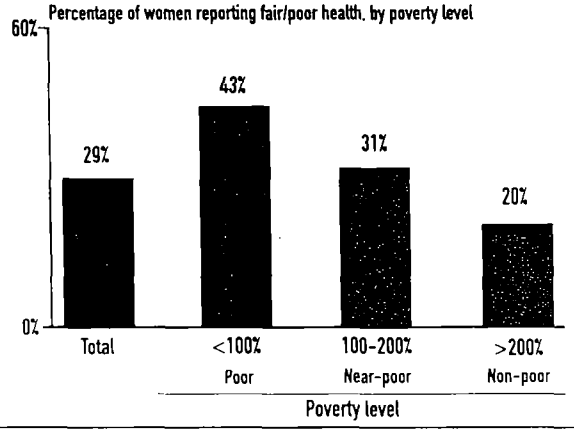
Women are especially hard-hit by changes in policies and programs that affect poor Medicare beneficiaries. Not only do they have higher poverty rates than their male counterparts—nearly 7 in 10 with incomes below poverty are women—but disparities increase with age (Figure 3). Of all female beneficiaries, 17 percent have incomes below the federal poverty level ($7,740 for an individual in 1996), compared with 11 percent of men. Half have incomes below twice the poverty level ($15,480 for an individual), compared with 39 percent of men. Nearly two-thirds (62 percent) of all women 85 and older have incomes below twice the poverty rate, compared with 53 percent of all men in this age group.

Figure 3 Seven of 10 Medicare beneficiaries with incomes below poverty are women



SOURCE: Urban Institute analysis of the Current Population Survey of noninstitutionalized population, 1997

Figure 4 Poor women on Medicare have higher rates of health problems than those with higher incomes



SOURCE: Urban Institute analysis of Medicare Current Beneficiary Survey, 1995

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

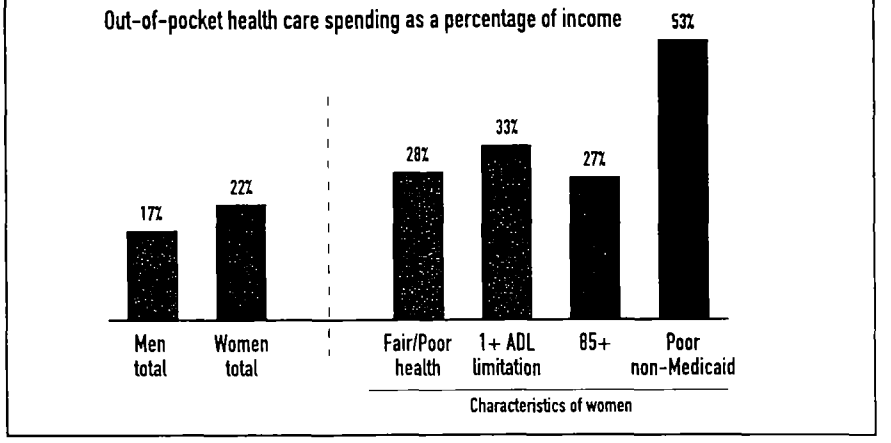
Insurance Coverage

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

beneficiaries (9 percent for both men and women in 1995) are enrolling in Medicare HMOs for supplemental benefits.

Given their disproportionately low incomes and their greater long-term care needs, female Medicare beneficiaries are more likely than males to rely on Medicaid, the federal/state health program that provides health and long-term care coverage for the poor. Nearly 17 percent of women rely on Medicaid to fill in Medicare's gaps, compared with 11 percent of men. Despite Medicaid's protections for the very poor, nearly 10 million female Medicare beneficiaries with incomes below twice the poverty level are not on Medicaid. This group is especially vulnerable to financial burdens in the event of a serious, high-cost illness.

Figure 5 Women on Medicare have significant out-of-pocket health care costs



NOTE: Excludes beneficiaries enrolled in Medicare HMO's, the under-65 disabled, and those in long-term care facilities. ADL = activity of daily living, such as eating or bathing.
SOURCE: AARP Public Policy Institute analysis using the Medicare Benefits Simulation Model, 1998.

Out-of-Pocket Spending

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

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

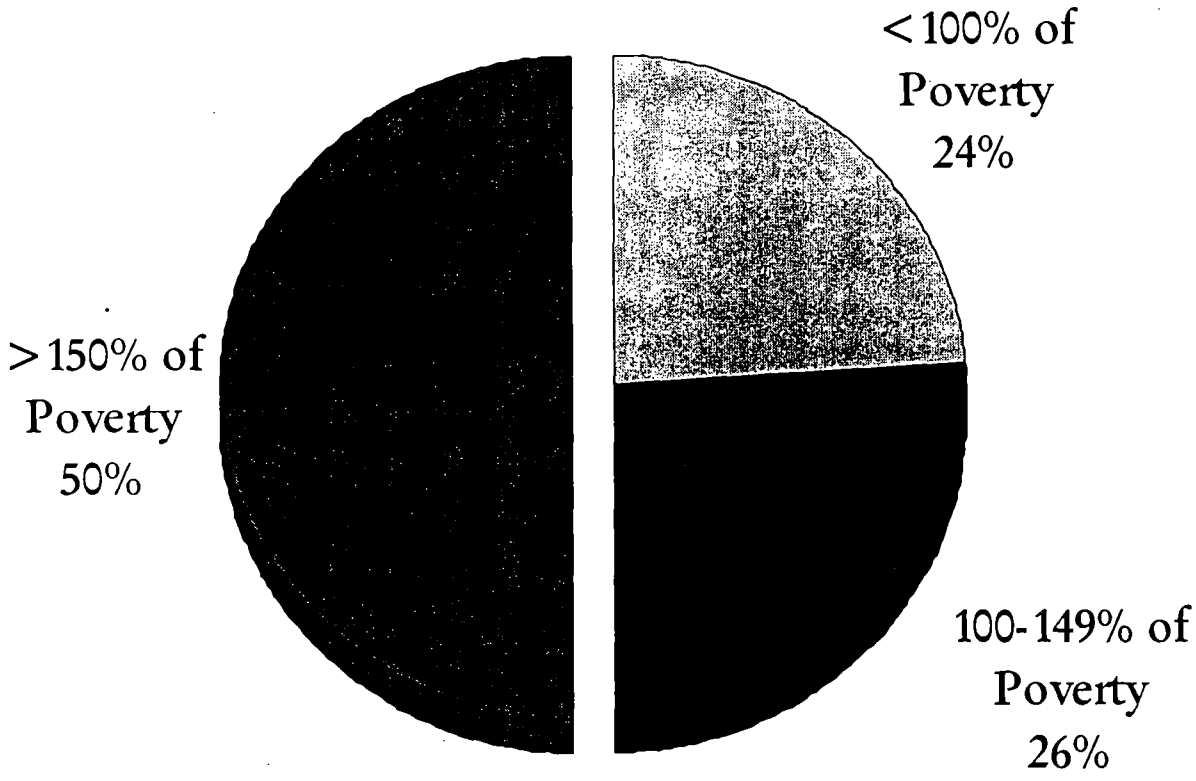
Issues for Women

Women are major stakeholders in the debate over Medicare's future. Given their higher rates of poverty, multiple chronic conditions, and long-term care needs, adequate health insurance is especially important as women grow older. Policies that improve financial protections for the poor and near-poor would provide relief for all low-income beneficiaries, the majority of whom are women. Likewise, policies that expand access to outpatient prescription drugs and long-term care would help fill coverage gaps that drive up out-of-pocket spending for women. Conversely, policies that erode coverage or that shift costs to beneficiaries could adversely affect women, especially those with low incomes.

Understanding the full implications of proposed reforms for aging women will be an essential component of efforts to preserve and protect Medicare for future generations.

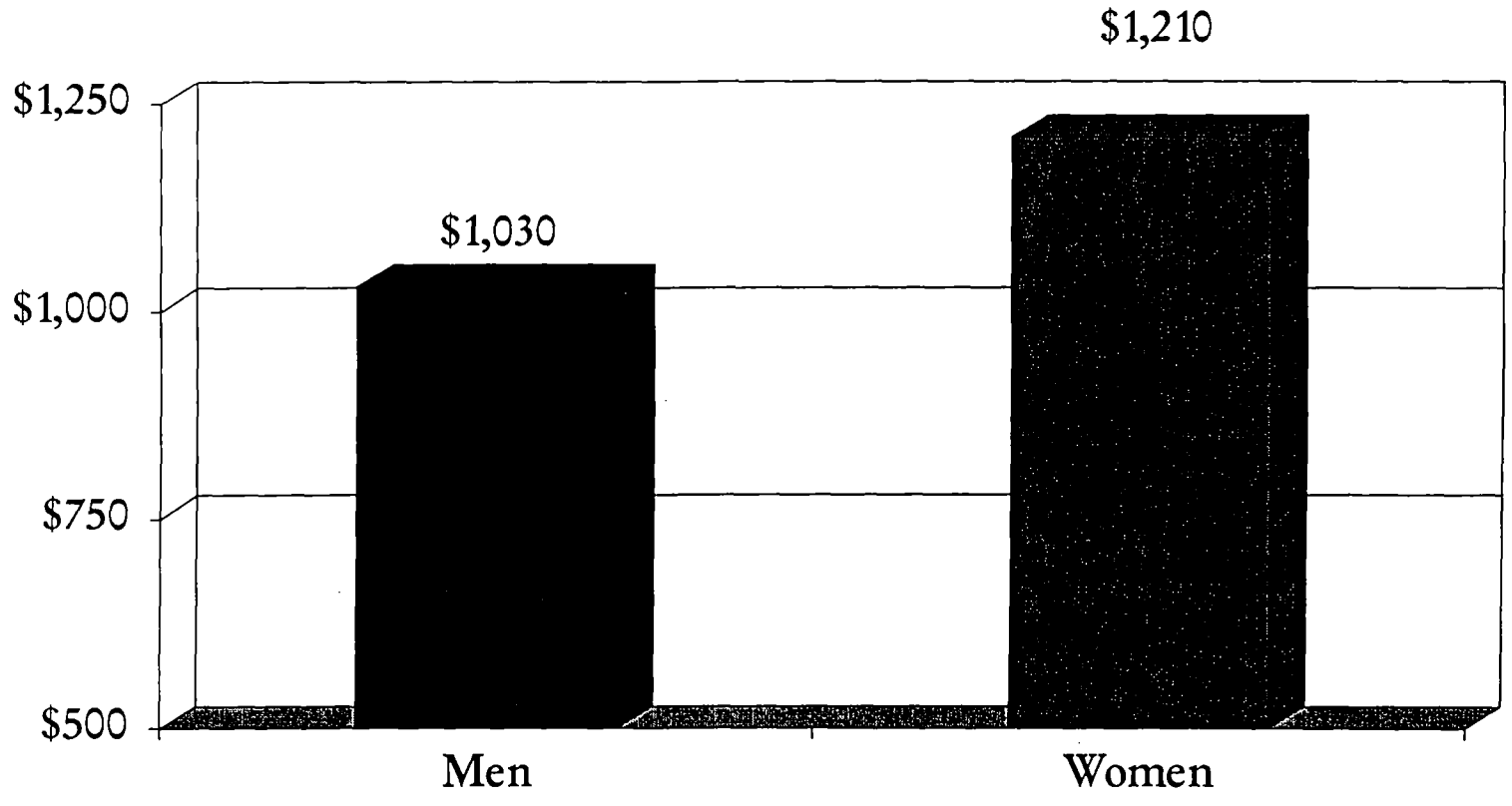
The Kaiser Family Foundation gratefully acknowledges the significant contributions of Dorothy Rice and Martha Michel of the Institute for Health and Aging, University of California, San Francisco, and Marilyn Moon of the Urban Institute to the development of this fact sheet.

Half Of Women on Medicare Without Drug Coverage Are Middle Income



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

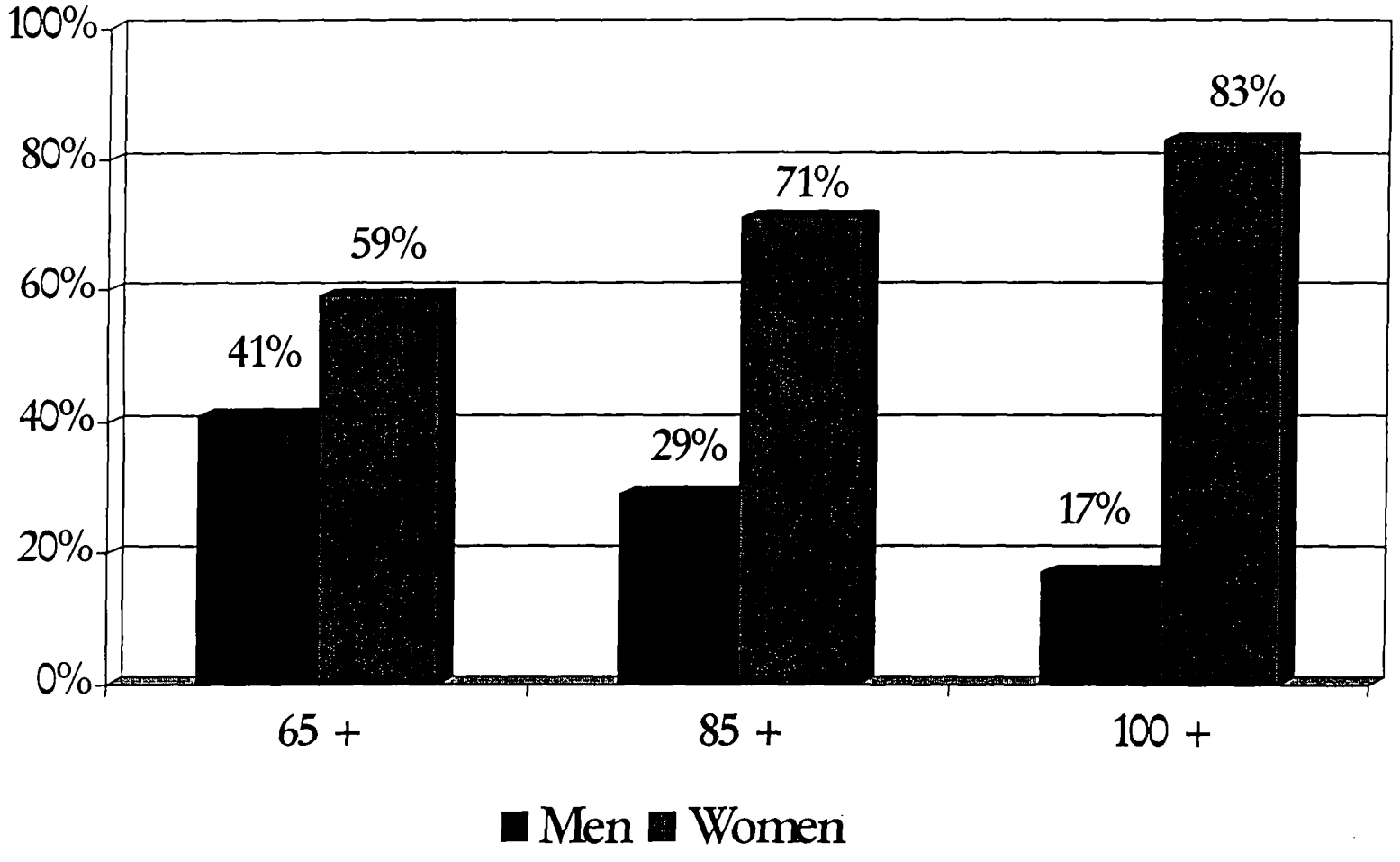
Total Prescription Drug Spending For Women On Medicare Is $1,200: Nearly 20% More Than Men



Average Total Drug Spending, 2000

Source: Actuarial Research Corporation. As cited in OWL Report

Most Medicare Beneficiaries Are Women



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

THE CLINTON-GORE ADMINISTRATION HIGHLIGHTS THE IMPORTANCE OF THEIR PLAN TO STRENGTHEN AND MODERNIZE MEDICARE TO WOMEN

July 27, 1999

Today, at the White House, President Clinton and First Lady Hillary Rodham Clinton joined the Older Women's League (OWL) in releasing a report entitled *"Medicare: Why Women Care,"* which includes a new analysis documenting why strengthening and modernizing Medicare is particularly important to women of all ages. The President and the First Lady also underscored the importance of taking advantage of the historic opportunity to dedicate a significant portion of the surplus to secure the life of the Medicare trust fund for a quarter century. In releasing this report, OWL stated its strong support for the President's vision of dedicating the surplus to strengthen Medicare, adding a prescription drug benefit, and improving preventive services.

The Vice President later joined the Democratic leadership and released a new analysis on the greater challenges that beneficiaries in rural America face in accessing prescription drug coverage. He pointed out that, although representing fewer than one-fourth of the Medicare population, beneficiaries living in rural areas account for over one in three of all beneficiaries lacking prescription drug coverage. Today, the Clinton-Gore Administration:

UNVEILED A NEW REPORT BY THE OLDER WOMEN'S LEAGUE. Nearly 60 percent of Medicare beneficiaries are women and this proportion rises with age – over 4 in 5 people over age 100 are women. Moreover, older women tend to have more chronic illness and lower incomes, making Medicare even more important as a health and financial safety net. Since it was created in 1965, Medicare has contributed to lengthening older women's lives by 20 percent and reducing their poverty rate dramatically. Yet, the 21st century brings with it challenges that will affect all beneficiaries.

Key findings of the report include:

- **In the next 30 years, the number of Medicare beneficiaries will double – most of them will be women.** In 2035 alone, there will be nearly 40 million elderly women and fewer than 34 million older men. This large enrollment increase is a major factor in the projected exhaustion date of the Medicare trust fund by 2015 and in the need for more revenue to avoid devastating cuts to the program.

- **Total prescription drug spending for women on Medicare averages $1,200 – nearly 20 percent more than that of men**. Moreover, like all beneficiaries, about three-fourths of women have coverage that is inadequate, unstable, and declining. Of those women without drug coverage, fully 50 percent have income above 150 percent of poverty (about $12,750 for a single, $17,000 for a couple), despite older women's lower average income.

- **Medicare's preventive benefits are underused by older women**. Financial and information barriers prevent older women from using critical preventive services. In recent years, just 1 in 7 women have taken advantage of Medicare-covered mammograms.

Other key findings include:

MEDICARE, A SOURCE OF FINANCIAL AND HEALTH CARE SECURITY FOR OLDER WOMEN, IS AT RISK.

- **Most elderly Americans covered by Medicare are women.** Twenty out of the 34 million elderly Americans covered by Medicare are women, who comprise nearly 3 out of 5 older Americans. The proportion of the elderly who are women rises with age; about 71 percent of people age 85 or older are women. Eighty-three percent of centenarians are women; in fact, the number of women age 100 or older will double in the next 10 years.

- **New revenue is necessary to ensure that the Medicare trust fund is solvent when women in the baby boom generation retire.** Since most women turning 65 today are expected to live through 2018, the projected insolvency of the Medicare Trust Fund will occur within their lifetime.

- **Women have greater health care needs and lower income.** Older women are more likely to need Medicare's health care services. About 73 percent have two or more chronic illnesses compared to 65 percent of men. Women's incomes are lower than men's incomes, and they must stretch fewer financial resources over longer lives. Seven out of 10 Medicare beneficiaries living below poverty are women. The increased likelihood that women will live alone in their later years places them at increased risk of poverty.

WOMEN FACE GREATER COST BURDENS – AND BARRIERS TO HEALTH CARE – BECAUSE OF MEDICARE BENEFIT LIMITATIONS. As important as Medicare coverage is to women, its benefits are outdated.

- **Higher out-of-pocket health spending.** The combination of greater health problems and lower income results in women on Medicare spending 22 percent of their income on health care compared to 17 percent for men. Lower income women spend an even greater share of their limited incomes on health care – 53 percent for the poorest.

- **Total prescription drug spending averages $1,200 for women on Medicare – 20 percent more than that of men.** Older women tend to have more chronic illnesses that require medication to manage.

- **For most women, existing coverage is unstable, unaffordable and declining.** Medigap routinely increase premiums with age – at age 85, premium for a Medigap plan with drug coverage up to $1,250 costs from $300 to $400 per month -- $3,600 to $4,800 per year. This discriminates against women, who comprise nearly three-fourths of people in this age group. It also charges more at a time where income has declined.

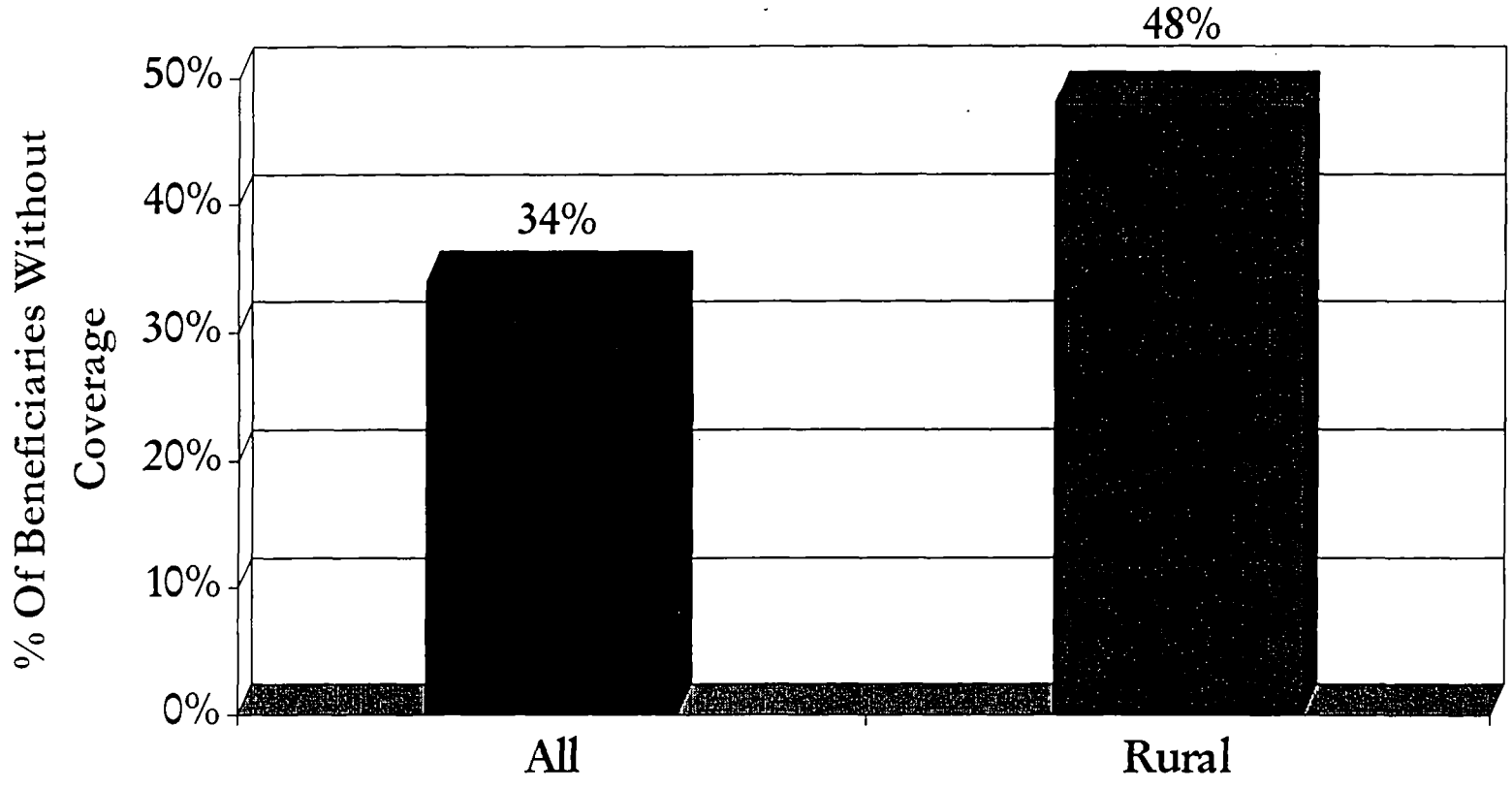
- **About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs.** Despite their lower average income, fully half of these women without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people of all age groups.

- **Out-of-pocket payments for preventive services also constitute a barrier to health.** In recent years, just one in seven women without supplemental insurance used Medicare-covered mammograms. One study found that in 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

EMPHASIZED GREATER PROBLEMS FACING RURAL BENEFICIARIES IN ACCESSING PRESCRIPTION DRUG COVERAGE. The Vice President also released new facts on the challenges facing rural beneficiaries. Although one in four of all Medicare beneficiaries live in rural areas, over one in three (34 percent) of those lacking drug coverage live in rural America. In fact, nearly half of all rural beneficiaries lack drug coverage compared to 34 percent of all beneficiaries. This reflects the lower access to Medicare managed care and retiree health coverage for these beneficiaries. The Vice President also released information documenting that lack of access to prescription drug coverage occurs throughout the income spectrum – 45 percent of rural beneficiaries with income above $50,000 lack prescription drug coverage compared to 25 percent of all beneficiaries.

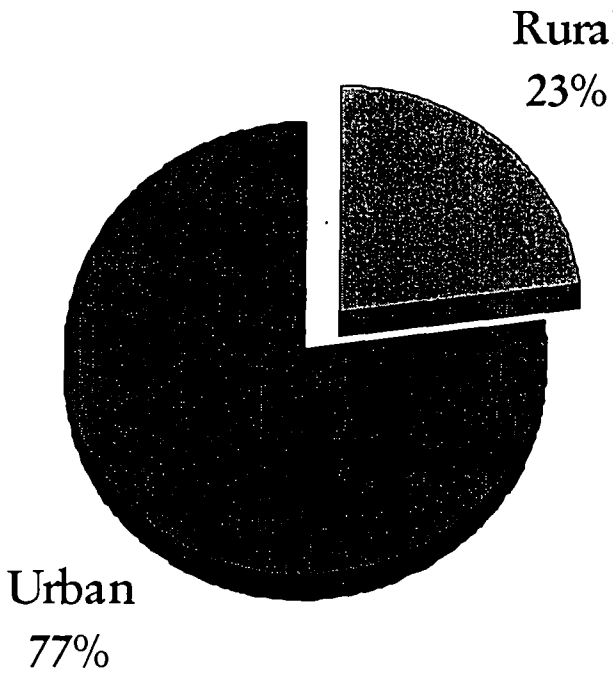
HIGHLIGHTED THE IMPORTANCE OF INVESTING IN THE FUTURE OF THE MEDICARE PROGRAM. Today, the President, First Lady and Vice President underscored the fact that there will not be a debate about how to strengthen Medicare or how to provide a prescription drug benefit if all of the surplus is invested in a large tax cut. They stated their strong belief that the Congress and the American public face an important decision: to invest in a stronger Medicare program for our mothers and grandmothers or give away the entire surplus on a risky and irresponsible tax scheme.

More Rural Medicare Beneficiaries Lack Prescription Drug Coverage

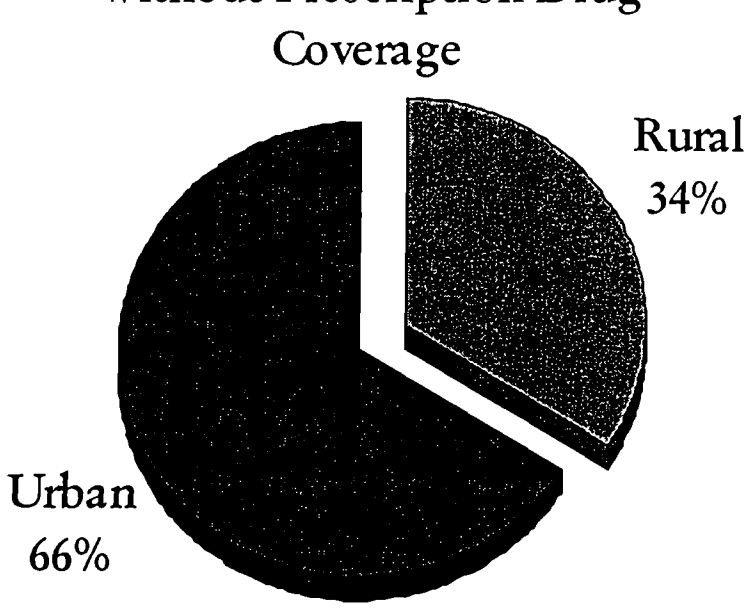


One In Three Beneficiaries Without Prescription Drug Coverage Lives In Rural America

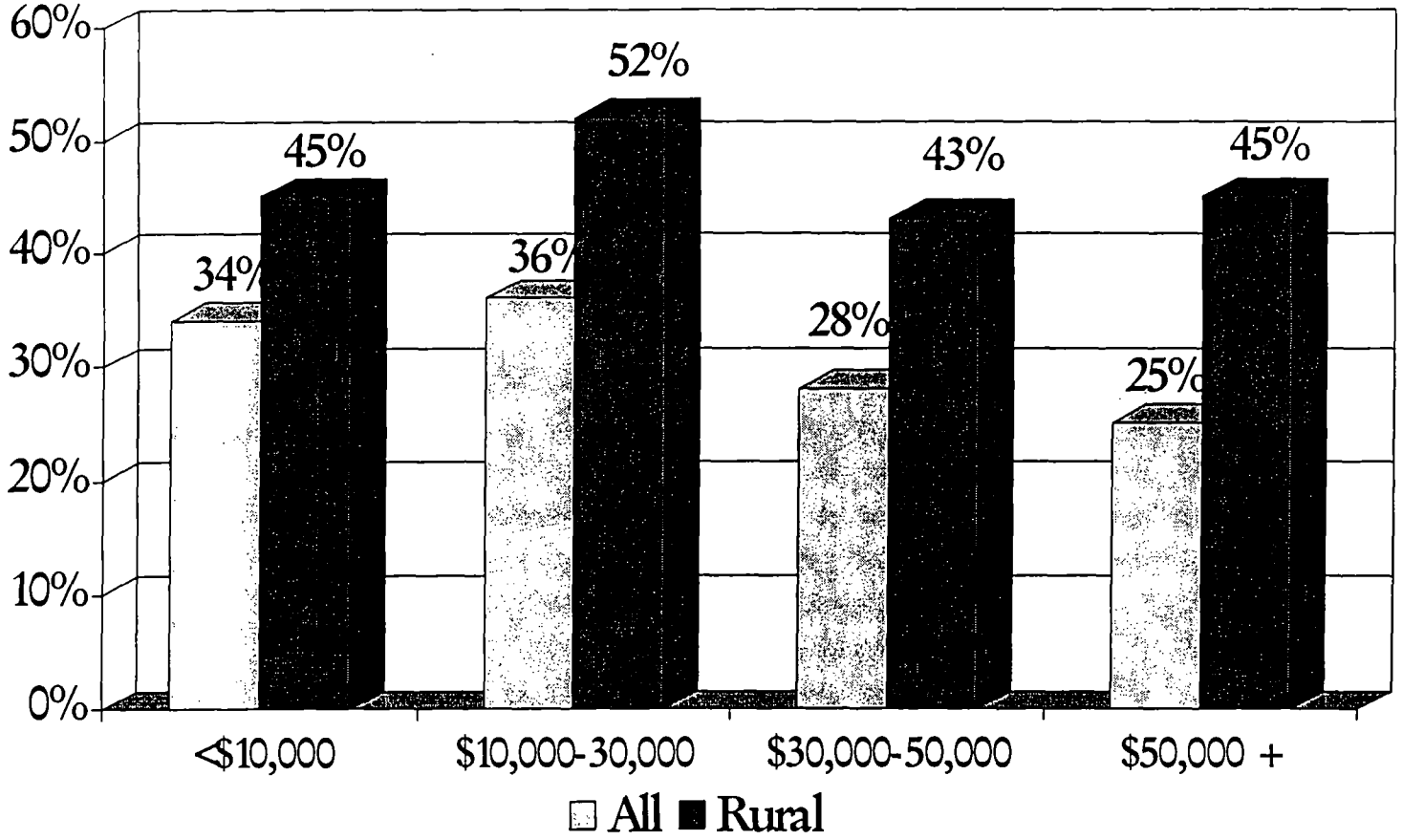
All Medicare Beneficiaries



Medicare Beneficiaries Without Prescription Drug Coverage



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



FIRST LADY HILLARY RODHAM CLINTON
WOMEN'S MEDICARE EVENT
THE WHITE HOUSE
JULY 27, 1999

DRAFT

Thank you, Secretary Shalala. Good morning, and welcome to the White House. I want to thank all of you for being here – as we come together to talk about some of the most urgent challenges our nation faces today.

I want to acknowledge the many people here today who have done so much over the years to help us meet our obligations to each other, and to the next generation: members of the Older Women's League, the Henry Kaiser Family Foundation, and **who else should be mentioned here?**

We've all come here this morning because our nation is engaged in a critical debate about America's future. We're living in a time of great prosperity – and of almost unparalleled opportunities for progress for all Americans. And we should all take pride in what we have been able to accomplish together over the past six and a half years. But the question before us now is how do we take advantage of this historic opportunity to take on some of the tough challenges that lie ahead? How do we strengthen -- rather than weaken -- our fundamental commitments not only to our parents and grand parents – but to future generations as well?

One of the most critical challenges facing America today – and an issue that touches all of us – is the urgent need to protect and preserve Medicare. Unless we act now – current projections say the Medicare Trust Fund will be insolvent in 2015. While this is a critical concern for all Americans, we're here today to spotlight those who have the greatest stake in a strong and healthy Medicare program: America's women.

Because women simply live longer than men, we are more likely to suffer from multiple and chronic illnesses, and have greater long term needs. Four out of five of America's elderly women are widowed – and almost half live out their days alone. And not surprisingly, elderly women are much more likely to be poor. Among women 85 and older, nearly seven in 10 Medicare beneficiaries living in poverty are women.

For all of these reasons, women rely on Medicare more than men – and are more vulnerable to changes in its policies. Over the past six years – and as recently as a few weeks ago – I've spoken to women around the country about their concerns. Women living alone, who worry about who's going to care for them when they can no longer live independently. Women with limited incomes, who are struggling to pay for their prescription drugs, or who don't think they can afford to go to regular check ups or screening tests for osteoporosis or breast cancer.

There's a woman from Virginia here today whose mother came to live with her after her father died. As her mother became increasingly frail, Mary stopped working -- to devote full time to her mother's care. Like so many elderly women today, her mother

order
3 of 3 meal

AARP

suffered from multiple health problems. And while she had a Medicare and Medigap policy – it didn't cover prescription drugs. Because her mother's sole source of income was a monthly $800 Social Security check – Mary and her family paid $4500 a year – in out of pocket expenses to cover her prescription drugs. An amount that would have depleted half of her mother's yearly income. Mary's mother passed away last November. But her valiant efforts to care for her – often under very difficult conditions – are a vivid reminder of why we must act now to protect and preserve Medicare.

It is up to all of us to make sure that Medicare remains strong not only for our own parents and grandparents – but for those in this generation who have been their caretakers -- as we begin to age, or become disabled.

Because if we don't invest in our nation's priorities – and dedicate the necessary funds to save and modernize Medicare – then women like Mary and her mother will be at even greater risk than they are today. If we don't save and modernize Medicare – then women will continue to struggle to pay for outpatient prescription drugs. And that problem will only get worse -- as medical advances increasingly rely on drug treatments that even today are often beyond the means of most ordinary citizens. If we don't save and modernize Medicare – then women will continue to skip the regular screenings and check ups that would enhance their quality of life -- and reduce long-term costs for Medicare.

And perhaps most importantly, if we don't take advantage of this time of prosperity that we have worked so hard to achieve – then we will look back at our generation as having missed a unique opportunity to make responsible decisions – and instead have run the risk of becoming the burden to our own children that we never wanted to be.

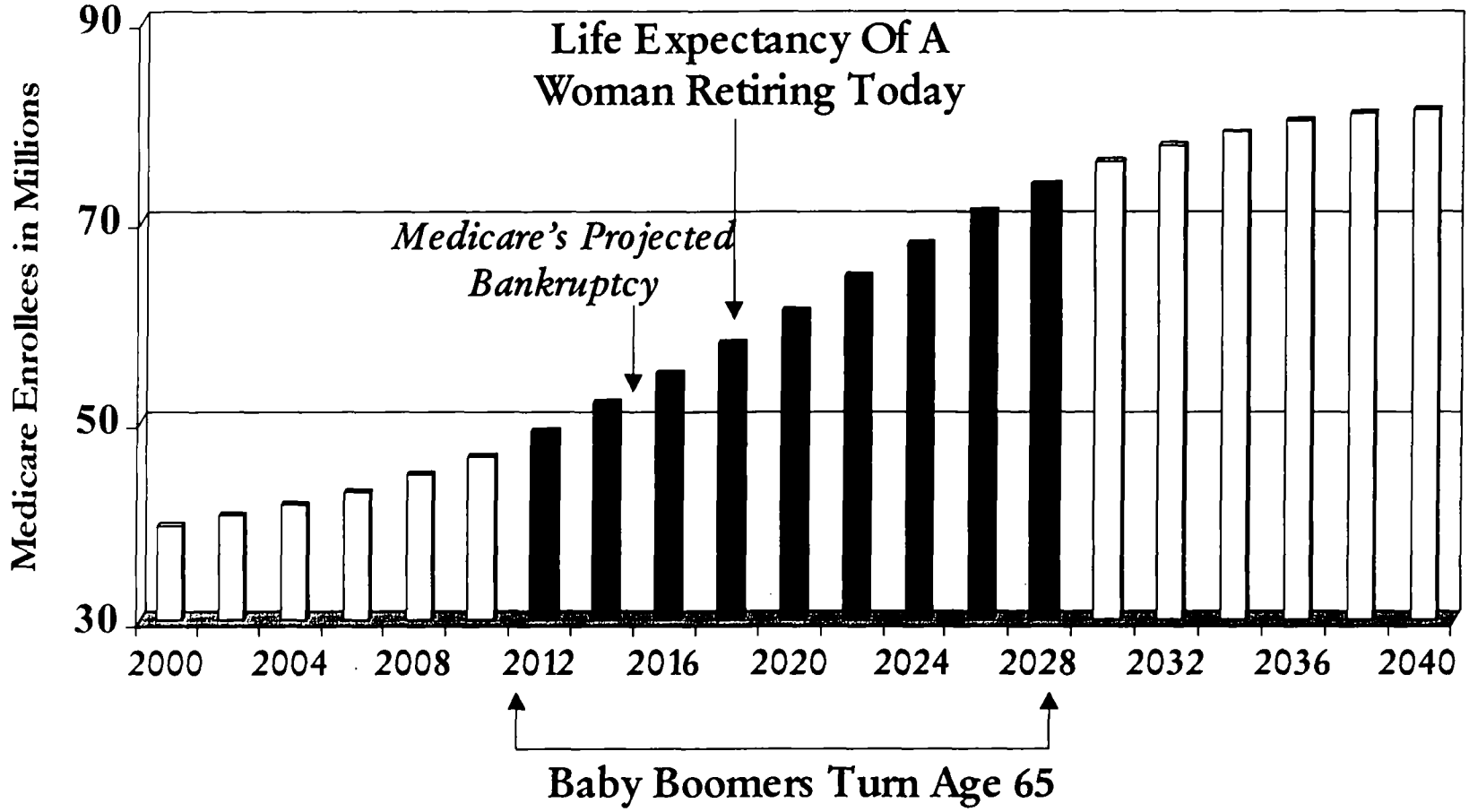
That's why I believe that to meet these critical challenges, we must take a responsible and balanced approach to tax cuts. Only then will we be able to meet our obligations to America's elderly and disabled, and extend the life of the Trust Fund for the next quarter century. Only then will we be able to modernize the benefit package to include prescription drugs and preventive care; and support our teaching hospitals that are so critical to providing health care to America's poor and elderly. And only then will we be able to sustain and expand the investments we are now making – in our schools, in our environment, in our cities -- that are all so vital to our nation's future prosperity.

As we continue to debate these critical issues in the halls of Congress – and around our kitchen tables – let's never forget the human dimension of what we stand for, and what we care about, and who we're seeking to protect.

I want to introduce someone who knows first hand what's at stake for women in this debate over the future of Medicare. She also represents the millions of women who would benefit if we act now to strengthen and modernize Medicare. It is my pleasure to introduce to you Joan Cato.

Not Being Released

A Woman Retiring Today Cannot Count On Medicare -- Let Alone The Baby Boom Generation



Source: OWL Report

Medicare Event

Location
Tuesday July 27, 1999, 11:30 am
SC-5, United States Capitol

Briefing prepared by Sarah Bianchi
Phone: (202) 456-5585

EVENT

This event is a press conference with Representative Gephardt, Senator Daschle and other Democrats on the Capitol Hill to urge the Republican leadership to reconsider using the entire surplus for risky tax cuts rather than investing in Medicare. Earlier in the morning the President and the First Lady are participating in an event at the White House also advocating dedicating a portion of the surplus for Medicare and underscoring the importance of Medicare for women.

LOGISTICS

- Following your meeting with the Congressional Hispanic Caucus you go to SC-5;
- Senator Daschle opens the press conference and introduces Representative Gephardt;
- Representative Gephardt speaks and introduces you;
- You speak.

YOUR ROLE and CONTRIBUTION

This event provides an opportunity for you to:

(1) Underscore your views in the tax debate this week by urging Republicans who want to spend the entire surplus on tax cuts to reconsider these risky proposals that undermine prosperity and do not dedicate one dime to the Medicare program;

(2) Highlight the importance of the Administration's proposal to extend the life of the Medicare Trust Fund and the need for a long overdue Medicare prescription drug benefit, and unveil new statistics that underscore the particular importance of this in rural America; and

(3) Join Democrats in a united call for avoiding risky tax cuts and dedicating some of the surplus to Medicare. Earlier in the morning the President and First Lady are also participating in an event at the White House that highlights the importance of Medicare to women. You can also amplify this message that is similar to an event you did on Medicare and older women with the Older Women's League earlier this spring.

ATTACHMENTS

- Background on policy and message;
- Background on Medicare and rural beneficiaries;
- Highlights of the facts on Medicare and women unveiled earlier at the White House.
- General Q&A *(provided by your press office)*

BACKGROUND OF GENERAL MEDICARE POLICY AND MESSAGE

Today you are:

Underscoring that the Clinton/Gore Plan Strengthens Medicare for a Quarter Century and Provides a Long Overdue Critical Prescription Drug Benefit. You are highlighting that the Administration's proposal would:

- **Extend Medicare solvency until 2027.** The Administration's proposal dedicates $374 billion to Medicare most of which helps extend the life of the Medicare Trust Fund and makes Medicare more efficient and competitive.

- **Reduce the public debt.** By locking away most of the surplus dedicated to Medicare, the Administration's proposal buys down the debt which helps boost national savings, leading to lower interest rates and a higher standard of living. Under the Administration's framework, the public debt will be eliminated by 2015.

- **Provide a much-needed prescription drug benefit.** Seventy-five percent of Medicare beneficiaries have unstable or inadequate prescription drug coverage. The Administration is proposing a new prescription drug option that is available for all Medicare beneficiaries.

- **Eliminate the deductible and all copayments on all preventive benefits covered by Medicare,** including benefits to prevent and detect osteoporosis, all cancer screenings, and diabetes.

Highlighting that the Republican Plan Makes No Commitment to Medicare. The Republican proposals invest nearly the entire surplus in tax cuts and do not invest at all in Medicare. Instead they support proposals that undermine the Medicare program. They:

- **Raise traditional Medicare premiums** through a new premium support proposal which mostly produces savings by raising premiums for traditional Medicare.

- **Do not dedicate one dime of the surplus to strengthen Medicare.** Independent analysts agree that the retirement of the baby boomers will require additional revenues to adequately finance the Medicare program for the next generation. Without this investment, Medicare would have to grow at a rate at 60 percent below the per capita growth rate projected for the private sector.

- **Reduce provider payments excessively and have no relief for providers in need today.** The Republican proposals extend most of the Balanced Budget Act (BBA) policies that save by reducing provider payments. They also do not include any financing to ease providers who have been excessively cut by the BBA that need some immediate relief.

- **Raise age eligibility to 67,** which would increase the number of uninsured Americans.

- **Impose new copayments for home care and nursing homes** that cause higher out-of-pocket costs for some of the most vulnerable Medicare beneficiaries.

MEDICARE BENEFICIARIES IN RURAL AMERICA HAVE A GREATER NEED FOR A PRESCRIPTION DRUG BENEFIT. You are also unveiling new facts that underscore the need for the Administration's proposed prescription drug benefit for Medicare beneficiaries in rural America.

Nearly One in Four Medicare Beneficiaries Live in Rural America. Of the forty million Medicare beneficiaries, over nine million live in rural America.

One in Three Medicare Beneficiaries Without Prescription Drug Coverage Live in Rural America.

- **There are thirteen million Medicare beneficiaries without prescription drug coverage.**

- **One-third – approximately 4.5 million -- of these Medicare beneficiaries live in rural America.**

Rural Beneficiaries Are More Likely to Lack Medicare Prescription Drug Coverage.

- **Nearly fifty percent of rural Medicare beneficiaries lack prescription drug coverage.** Thirty-four percent of all Medicare beneficiaries lack coverage.

Rural Beneficiaries are Less Likely to Have Prescription Drug Coverage Across All Income Groups.

- **Forty-five percent of Medicare beneficiaries with incomes above $50,000 lack prescription drug coverage** whereas only 25 percent of Medicare beneficiaries across the country in this same income category lack prescription drug coverage.

- **Forty-three percent of Medicare beneficiaries with incomes between $30,000 and $50,000 lack prescription drug coverage** whereas only 28 percent of all Medicare beneficiaries in this same income category across the country lack coverage.

- **Fifty-two percent of Medicare beneficiaries with incomes between $10,000 and $30,000 lack prescription drug coverage** whereas only 36 percent of all Medicare beneficiaries in this same income category lack coverage.

- **Forty-five percent of beneficiaries with incomes below $10,000 lack prescription drug coverage** whereas 34 percent of all Medicare beneficiaries in this same income category lack coverage.

These Trends Are Explained By Insufficient Medicare Managed Care, Retiree Health Plans, and Medigap Plans in Rural Areas.

- Many Medicare Managed Care plans, which often offer prescription drug coverage, are not available rural areas and beneficiaries only have access to traditional Medicare, which does not cover prescription drugs. In fact, nearly three out of four Medicare beneficiaries in rural areas do not have access to Medicare managed care plans at all.

- Rural Medicare beneficiaries are less to likely have jobs that offer retiree health plans that often offer prescription drug coverage (since such coverage is typically associated with large firms).

Millions More Rural Americans Have Insufficient Drug Coverage.

- Medigap plans are often the only option for supplemental coverage in rural areas. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the Administration. Moreover, unlike the Administration's proposal, premiums for Medigap plan substantially increase with age due to "age rating."

HIGHLIGHTS OF STATS ON MEDICARE AND WOMEN THAT THE PRESIDENT AND FIRST LADY RELEASED EARLIER TODAY

Earlier today at a White House event, the President and the First Lady joined the Older Women's League (OWL) in releasing a new report entitled *"Medicare: Why Women Care,"* which documents the need to strengthen and modernize Medicare and describes the importance of Medicare to women. This report, that is similar to the one you unveiled with OWL in May, has key findings including:

MEDICARE, A SOURCE OF FINANCIAL AND HEALTH CARE SECURITY FOR OLDER WOMEN, IS AT RISK.

- **Most elderly Americans covered by Medicare are women.** Twenty out of the 34 million elderly Americans covered by Medicare are women, who comprise nearly 3 out of 5 older Americans.

- **Women in the baby boom generation will not be able to count on Medicare.** Most women turning 65 today are expected to live through 2018, while the Medicare Trust Fund is expected to expire in 2015. Medicare solvency would have to be extended to 2028 to be viable through the retirement of the entire baby boom generation.

- **Women have greater health care needs and lower incomes.** About 73 percent of older women have two or more chronic illnesses compared to 65 percent of men. Women also have lower incomes than men, and seven out of 10 Medicare beneficiaries living below poverty are women.

WOMEN FACE GREATER COST BURDENS – AND BARRIERS TO HEALTH CARE – BECAUSE OF MEDICARE BENEFIT LIMITATIONS. As important as Medicare coverage is to women, its benefits are outdated.

- **Higher out-of-pocket health spending.** Women on Medicare pay 22 percent of their income on health care compared to 17 percent for men. Lower income women pay an even greater share of their limited incomes – 53 percent for the poorest.

- **About 7.3 million women on Medicare have no coverage to help pay for their prescription drug costs.** Half of these women without drug coverage have income above 150 percent of poverty, underscoring the importance of drug coverage for people of all age groups.

- **Out-of-pocket payments for preventive services also constitute a barrier to health.** In the first two years that Medicare covered mammography, just 14 percent of women without supplemental insurance had this screening. In 1993, only 37 percent of Medicare beneficiaries without supplemental insurance had Pap smears, compared with 59 percent of women who had supplemental insurance.

STATEMENT BY VICE PRESIDENT AL GORE
IMPORTANCE OF MEDICARE TO RURAL AMERICA
Tuesday, July 27, 1999

Thank you, Dick – for leading the fight in the House to protect and strengthen Medicare, year after year. And I want to thank Tom Daschle for his remarkable leadership in the Senate; there is no greater champion of rural America.

As we all know, last week the House passed a risky, unaffordable tax scheme that would drain away America's hard-won budget surplus – and make it virtually impossible to strengthen Medicare for the future.

While we are fighting for measures that would secure Medicare for a quarter of a century and help seniors pay for the prescription drugs they need, the Republican tax scheme would ensure that not a single penny goes into Medicare. It's an approach you might call "miser-care."

The Republicans are even proposing to raise premiums for Medicare, raise the eligibility age, and impose new costs for home care and nursing home care.

Earlier today, President Clinton and the First Lady released a new analysis, showing that both Medicare and prescription drugs are of crucial importance to America's women.

Now I want to share the results of a compelling new analysis that shows why Medicare and prescription drugs are especially important for America's rural communities.

First of all, nearly one quarter of all people on Medicare live in rural America. And they have disproportionate need for prescription drug coverage. Yet nearly half of all rural Americans on Medicare lack prescription drug coverage – as opposed to about one-third of all Medicare recipients. And this is not just a problem for the rural poor: in our rural communities, the lack of drug coverage extends across all lines of income.

We have a chance to meet this critical need – to ensure that Medicare stays strong for the farm families that depend on it. And to finally make affordable prescription drugs available throughout our rural areas.

But some in Congress are willing to squander this chance -- for a handful of supply-side silver. I believe the overall stakes are even greater.

In the past six and a half years, through hard work and sacrifice, the American people have turned our economy around, and pulled this nation out of a deep economic ditch.

Instead of a $290 billion deficit, we have a $99 billion surplus. Instead of high unemployment and a deep recession, we have 19 million new jobs. Instead of scrambling to keep our economy afloat, we now have the security and prosperity to meet our greatest challenges for the future:

Saving Social Security before it goes broke. Strengthening Medicare and enabling seniors to buy the prescription drugs they need. Preparing our children for the jobs of the future. And getting the United States completely out of debt for the first time since 1835.

We can do all of this, and still have tax cuts for hard-working families: targeted tax cuts to help with long-term care and child care, and to rebuild and modernize our schools.

But not if we allow the Republican leadership to take us back to the trickle-down tragedies of the past – the retro-nomic policies that brought us exploding deficits, and economic decline.

The Republican tax scheme would blow a $3 trillion dollar hole in our budget over the next two decades – making today's sound economy and strong surplus look like a budgetary swiss cheese.

At the same time, it would jeopardize the future of Social Security, it would not put a single penny into saving Medicare, it would require deep cuts in education and medical research – and it would leave our nation mired in the debt we ran up in the 1980's and early 90's.

We don't need a debate on the merits of the Republican plan; we've already tried it. And it failed our families the first time. Nostalgia for the Republican tax schemes of the past is like nostalgia for the days before anesthesia.

The American people have come too far, and worked too hard, too put our prosperity on a reckless Republican chopping block.

If the Republican leadership insists on passing its plan, President Clinton will strike it down with the veto. And I will personally lead the fight to protect our prosperity, and save Social Security and Medicare for the future. Thank you.

REMARKS BY JUDITH CATO

Thank you, Mrs. Clinton for your remarks – and thank you so much for caring.

Good morning, Mr. President, Secretary Shalala, and other distinguished guests.

I am here today to share my story with you so that you will understand how important the Medicare program is to my health, and the health of my family.

My husband and I are five years away from qualifying for the Medicare program. Right now I have health insurance through my employer with a pretty good prescription drug benefit, and I'm thankful for it, because both my husband and I use a lot of prescription medications. I take five different medications daily for high blood pressure and other conditions. But when I retire, we're not going to have prescription drug coverage – my employer doesn't cover it. So I'm worried about what I'll do when we turn 65 and our prescription drug coverage disappears. We could join a Medigap plan – but the cost of Medigap insurance seems to go up every day, and not all of those plans offer prescription drugs. We could join an HMO – but I like the security of seeing the same doctor that's taken care of us for the past 30 years, and I've heard that they're cutting back on the drug benefits they offer anyway. I'm worried that we'll end up paying for these medications on our own, and I just don't think that we can afford it.

As it is, we've had a tough time saving for our retirement now that we've begun to help out my mother with her health care costs. I see what my mother has gone through trying to afford the cost of her health care, and although it's difficult for her to take help from us – she's a proud person – there's no way that she would have been able to make it

without us. She's on Medicare and has a Medigap plan, but it doesn't cover prescription drugs. If it offered a good, affordable prescription drug benefit, she might still be able to afford to live on her own. She spends almost $4,000 a year – almost half her income – on the 10 different medications she takes daily to treat diabetes, glaucoma, and heart failure. We knew that she was having a tough time making ends meet when she told us that she was going to stop taking some of her medications so that she could afford to come see her grandchildren. That really scared me, and it's one of the reasons I asked her to come live with us.

Frankly, there is no such thing as an empty nest these days. My daughter hadn't even moved out of the house before my mother moved in. Mr. President, I don't want my daughter to have to worry about me the way I worry about my mother. I'm 60 now, and when I'm my mother's age, I want to know that Medicare will be there for me when I need help. But I'm told that the program will be bankrupt before I turn 80. We've worked and saved all our lives and tried to do the right thing – and it's frightening to think that the Medicare program may not be able to help me pay for the health care services I need the most. I know – and I think that most seniors would agree – I would be happy to pay a modest premium and a limited copayment to ensure that I can access the prescription drugs I need to stay healthy as I get older.

But I'm hearing that this might not even be a possibility because some in Congress want to use up the entire surplus for a tax cut. Mr. President, I know a tax cut sounds good, but I also know that we've got to take care of the obligations we know we have now. There's going to be a lot of us retiring soon, and we need to make sure that we don't place a great burden on our children just as they're trying to put their children through school. I hope that we can put politics aside and put people first and do the right thing by Medicare for all generations of Americans. It's my

honor and privilege to introduce the man that I think can help us do just that – William Jefferson Clinton, the President of the United States.

THE WHITE HOUSE

Office of the Vice President

For Immediate Release
July 27, 1999

Contact:
202/456-7035

Vice President Gore Joins Democrats on Capitol Hill to Urge Republicans to Reconsider Using Entire Surplus for Tax Cuts Rather Than Investing in Medicare

Highlights New Statistics about the Importance of Prescription Drugs for Medicare Beneficiaries in Rural America

Today, Vice President Gore joined Senator Daschle, Representative Gephardt, and other Democrats on the Capitol Hill to urge the Congressional Republican Leadership to reconsider their proposal to use the entire surplus for a risky tax cut without dedicating one dollar to extending the life of the Medicare Trust Fund. The Vice President underscored the unique historical opportunity that the nation has to secure Medicare for a quarter of a century and to provide Medicare beneficiaries which a much-needed long-overdue prescription drug benefit. The Vice President also unveiled new facts that highlight the critical impact the Administration's Medicare proposal has for Medicare beneficiaries in rural areas. Earlier in the morning, the President and the First Lady released a new analysis underscoring the importance of Medicare for women.

"As a nation, we face a fundamental choice of how best to move forward into the 21st Century," said Vice President Gore. "We can pass dangerous tax cuts that imperil our prosperity or we can strengthen Medicare, pay off our debt, and pass responsible tax cuts that advance prosperity and protect families." Today, the Vice President:

Unveiled New Facts That Underscore the Need for the Administration's Proposed Prescription Drug Benefit for Medicare Beneficiaries in Rural America. Nearly one in four Medicare beneficiaries live in rural America. These Medicare beneficiaries tend to be older and sicker and have a disproportionate need for prescription drug coverage.

- **One in three Medicare beneficiaries without prescription drug coverage lives in rural America.** While nearly one in four Medicare beneficiaries live in rural America, one-third of those beneficiaries without prescription drug coverage live in rural America.

- **Nearly half (48 percent) of all Medicare beneficiaries in rural areas lack prescription drug coverage,** whereas only thirty-four percent of all Medicare beneficiaries lack prescription drug coverage.

- **Rural Medicare beneficiaries across all incomes are less likely to have prescription drug coverage.**
  - -- Forty-five percent of Medicare beneficiaries in rural America with incomes above $50,000 lack prescription drug coverage compared to 25 percent of all Medicare beneficiaries.
  - -- Forty-three percent of Medicare beneficiaries in rural America with incomes between $30,000 and $50,000 lack prescription drug coverage compared to 28 percent of beneficiaries.
  - -- Fifty-two percent of Medicare beneficiaries in rural America with incomes between $10,000 and $30,000 lack prescription drug coverage compared to 36 percent of all Medicare beneficiaries.
  - -- Forty-five percent of beneficiaries in rural America with incomes below $10,000 lack prescription drug coverage whereas 34 percent of all Medicare beneficiaries in this same income category lack coverage.

The Clinton/Gore Plan Strengthens Medicare for a Quarter Century and Provides a Long Overdue Critical Prescription Drug Benefit. The Administration's proposal would:

- **Extend Medicare solvency until 2027.** The Administration's proposal dedicates $374 billion to Medicare most of which helps extend the life of the Medicare Trust Fund and makes Medicare more efficient and competitive.

- **Reduce the public debt.** By locking away most of the surplus dedicated to Medicare, the Administration's proposal buys down the debt which helps boost national savings, leading to lower interest rates and a higher standard of living. Under the Administration's framework, the public debt will be eliminated by 2015.

- **Provide a much-needed prescription drug benefit.** Seventy-five percent of Medicare beneficiaries have unstable or inadequate prescription drug coverage. The Administration is proposing a new prescription drug option that is available for all Medicare beneficiaries.

- **Eliminate the deductible and all copayments on all preventive benefits covered by Medicare,** including benefits to prevent and detect osteoporosis, all cancer screenings, and diabetes.

The Republican Plan Makes No Commitment to Medicare. The Republican proposals invest nearly all of the surplus in tax cuts and invest nothing in Medicare. The Republicans also support Medicare reforms that would undermine the program. These proposals:

- **Raise traditional Medicare premiums** through a new premium support proposal which mostly produces savings by raising premiums for traditional Medicare.

- **Do not dedicate one dime of the surplus to strengthen Medicare.** Independent analysts agree that the retirement of the baby boomers will require additional revenues to adequately finance the Medicare program for the next generation. Without this investment, Medicare would have to grow at a rate at 60 percent below the per capita growth rate projected for the private sector.

- **Reduce provider payments excessively and include no relief for providers in need today.** The Republican proposals extend most of the Balanced Budget Act (BBA) policies that save by reducing provider payments. They also do not include any financing to ease providers who have been excessively cut by the BBA that need some immediate relief.

- **Do not provide for a meaningful prescription drug benefit.**

- **Raise age eligibility to 67** which would increase the number of uninsured Americans;

- **Impose new copayments for home care and nursing homes** that cause higher out-of-pocket costs for some of the most vulnerable Medicare beneficiaries. This is particularly important for rural beneficiaries who are sicker and poorer and more likely to need home health services.

MEDICARE BENEFICIARIES IN RURAL AMERICA HAVE A GREATER NEED FOR A MEDICARE PRESCRIPTION DRUG BENEFIT

Nearly One in Four Medicare Beneficiaries Live in Rural America. Of the forty million Medicare beneficiaries, over nine million live in rural America.

One in Three Beneficiaries Without Prescription Drug Coverage Live in Rural America.

- **There are thirteen million Medicare beneficiaries without prescription drug coverage.**

- **One-third -- approximately 4.5 million -- of these Medicare beneficiaries live in rural America.**

Rural Beneficiaries Are More Likely to Lack Medicare Prescription Drug Coverage.

- **Nearly fifty percent of rural Medicare beneficiaries lack prescription drug coverage,** whereas only thirty-four percent of all Medicare beneficiaries lack coverage.

Rural Beneficiaries are Less Likely to Have Prescription Drug Coverage Across All Income Groups.

- **Forty-five percent of Medicare beneficiaries in rural America with incomes above $50,000 lack prescription drug coverage** whereas only 25 percent of all Medicare beneficiaries across the nation in this same income category lack prescription drug coverage.

- **Forty-three percent of Medicare beneficiaries in rural America with incomes between $30,000 and $50,000 lack prescription drug coverage** whereas only 28 percent of Medicare beneficiaries across the country in this same income category lack prescription drug coverage.

- **Fifty-two percent of Medicare beneficiaries in rural America with incomes between $10,000 and $30,000 lack prescription drug coverage** whereas only 36 percent of all Medicare beneficiaries nationwide in this same income category lack prescription drug coverage.

- **Forty-five percent of beneficiaries in rural America with incomes below $10,000 lack prescription drug coverage** whereas 34 percent of all Medicare beneficiaries in this same income category lack coverage.

These Trends Are Explained By Insufficient Medicare Managed Care, Retiree Health Plans, and Medigap Plans in Rural Areas.

- Many Medicare Managed Care plans, which often offer prescription drug coverage, are not available rural areas and beneficiaries only have access to traditional Medicare, which does not cover prescription drugs. In fact, nearly three out of four Medicare beneficiaries in rural areas do not have access to managed care plans at all.

- Rural Medicare beneficiaries are less to likely have jobs that offer retiree health plans that often offer prescription drug coverage (since such coverage is typically associated with large firms).

Millions More Rural Americans Have Insufficient Drug Coverage.

- Medigap plans are often the only option for supplemental coverage in rural areas. Medigap premiums vary widely throughout the nation but are consistently two to three times higher than the Medicare premium proposed by the Administration. Moreover, unlike the Administration's proposal, premiums for Medigap plan substantially increase with age due to "age rating."

RURAL BENEFICIARIES:
ISSUES WITH THE BREAUX-THOMAS MEDICARE PROPOSAL

Challenges Facing Rural Beneficiaries Today. About 9 million, or one in four, Medicare beneficiaries live in rural America.

- **Fewer doctors**. Only slightly more than 10 percent of physicians practice in rural areas, and some rural beneficiaries have to travel great distances for health care.

- **Fewer health plan options and extra benefits**. This year, 85 percent of all rural counties with three-fourths of rural beneficiaries have no Medicare+Choice plans available to them. As such, these rural beneficiaries do not get the extra benefits (e.g., prescription drugs, lower cost sharing, preventive benefits) that managed care offers to beneficiaries in areas where Medicare payment rates are higher.

- **Greater health problems.** About 43 percent of rural beneficiaries 75 years old or older report fair to poor health, compared to 30 percent of beneficiaries in metropolitan areas.

- **Lower income**. Rural beneficiaries are more likely to be poor (13 percent versus 10 percent of urban elderly).

- **Less coverage for prescription drugs.** The proportion of rural Medicare beneficiaries with no insurance coverage for prescription drugs is about twice as high as that for urban residents. This is because rural beneficiaries have both less access to employer-based retiree coverage (since such coverage is typically associated with large firms) and Medicare managed care plans that typically offer drug coverage. As a result, the proportion of income spent on drugs is about 35 percent higher for rural than urban beneficiaries.

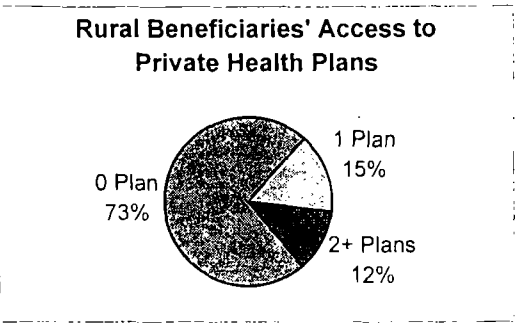
Effects of the Breaux-Thomas Proposal on Rural Beneficiaries. The Breaux-Thomas proposal would probably not help -- and could hurt -- rural beneficiaries.

- **Dilemma: Greater choice or higher premiums**. The Breaux-Thomas "premium support" proposal would limit the government contribution to all Medicare plans -- including the traditional Medicare fee-for-service program. Beneficiaries choosing low-cost plans would pay less and those choosing high-cost plans pay more. However, since the Medicare actuary estimates that traditional Medicare would be a high-cost plan, its premiums would be 18 to 30 percent more than current law (10 to 20 percent with increased efficiency) nationwide.

  To help rural beneficiaries, the proposal would charge beneficiaries with no access to private plans the current premium for traditional Medicare since they have no lower cost options. However, this proposal puts beneficiaries in a difficult situation.

  - **Different premiums depending on location**. Within a state -- and even from town to town -- rural beneficiaries would pay different premiums for the same, traditional Medicare, depending on whether they have access to a private health plan option.

- **Millions of rural beneficiaries would not be protected against higher premiums.** Over 25 percent of rural beneficiaries have access to a Medicare managed care plan, and thus would pay higher premiums for traditional Medicare. Over half of those beneficiaries with access to private plans have only one option. (see attached state table). Even if this single plan has limited capacity or does not include the beneficiary's physician or hospital, all beneficiaries in its area would either have to pay the higher premium for traditional Medicare or enroll in managed care.

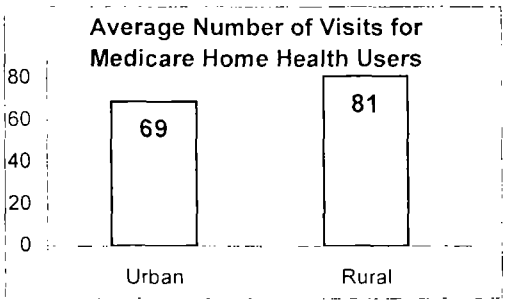


- **Premium protection ends if even one managed care plan enters a rural county.** The Breaux-Thomas plan would subsidize private plans that enter low-cost areas, increasing the likelihood that at least one plan option would be available. If one plan enters the area, the traditional Medicare premium would increase abruptly.

- **More likely to lose coverage as a result of raising Medicare's age eligibility**. Today, workers in rural America tend to have more physically demanding jobs and typically retire earlier: 36 percent of rural people ages 60 to 64 were retired, compared to 32 percent of urban people in the same age bracket. However, rural residents have less access to employer-based health insurance (60 v 68 percent of rural v urban 55 to 65 year olds have employer insurance) -- especially retiree health insurance. As such, rural beneficiaries are at greater risk of becoming uninsured if Medicare's age eligibility were raised.

- **Less able to purchase unsubsidized drug coverage**. The Breaux-Thomas plan would expand Medicaid coverage for beneficiaries with income up to 135 percent of poverty (about $11,000 for a single beneficiary, $15,000 for a couple). It would also provide access to -- but not premium assistance for -- Medigap and a new traditional Medicare drug option. However, since rural elderly disproportionately have lower income, it could be more difficult for them to afford premiums that could be as high as $1,000 annually.

- **More likely to have high home health care use -- and to suffer from an unlimited home health copay.** The Breaux-Thomas proposal would add an unlimited 10 percent home health copay. This is slightly higher than the $5 home health copay and does not contain the cap on beneficiary payments that were in the Senate 1997 proposal. Rural beneficiaries are more likely than urban home health users to have more home health visits. Rural beneficiaries who use home health services average 81 visits per year, relative to an average of 69 visits for urban beneficiaries. The proportion of rural beneficiaries whose home health visits are greater than 100 is about 20 percent higher than that of urban beneficiaries. Combined with their lower average income and access to supplemental insurance coverage, this copay could pose a significant financial burden for some rural beneficiaries.



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Goals for Reform:**

  - Make Medicare More Competitive and Efficient

  - Modernize Medicare's Benefits

  - Strengthen Medicare's Financing for the 21st Century

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

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

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

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

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

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

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

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

AT your convenience, can you

make 50 copies

of this?

Thanks.

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

National Economic Council
Domestic Policy Council

July 22, 1999

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

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

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

- **Prescription drug coverage is good medicine.**

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

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

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

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

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

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

- **Private trends: Decline in coverage and affordability.**

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

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

- **Public drug coverage trends: managed care benefits reduced.**

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

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

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

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

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

IMPORTANCE OF PRESCRIPTION DRUGS TO MEDICARE BENEFICIARIES

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

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

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

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

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

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

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

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

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

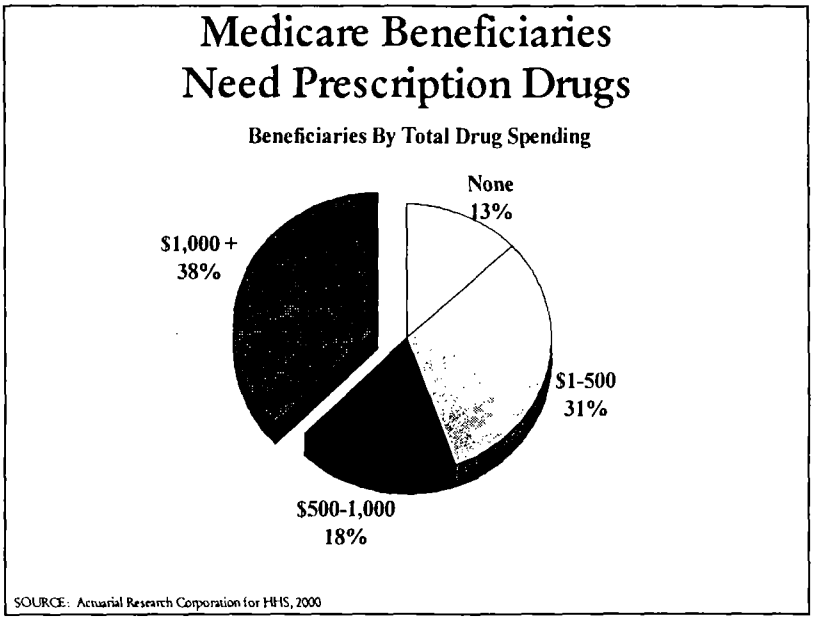
  - Decreased use of needed medications. Elderly and disabled Medicaid beneficiaries experienced significant declines in the use of essential medicines (e.g., insulin, lithium, cardiovascular agents, bronchodialators) when their Medicaid drug coverage was limited.[10] Many elderly must choose between prescriptions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

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

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

PRESCRIPTION DRUG SPENDING BY MEDICARE BENEFICIARIES

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



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

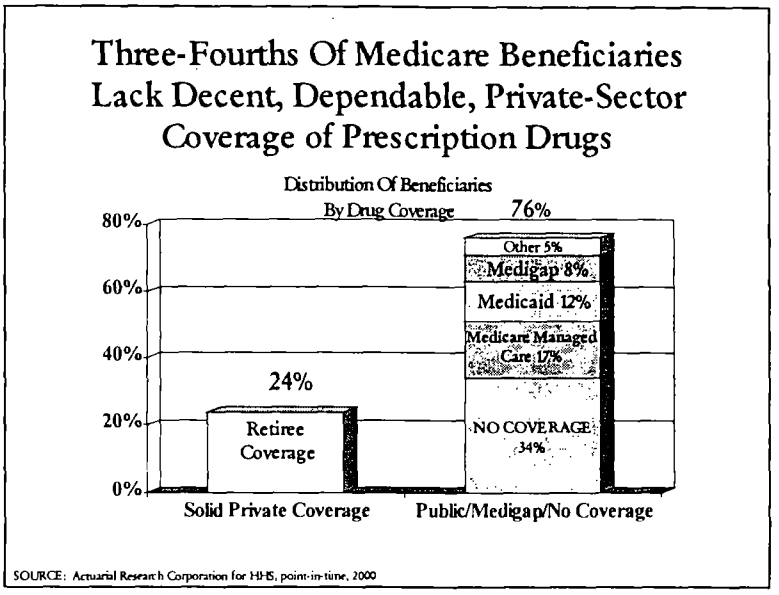
- **The average total drug costs for Medicare beneficiaries is estimated to approach $1,100 in 2000.** Over 85 percent of Medicare beneficiaries will spend money on prescription drugs, and more than half will spend more than $500.

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

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

COVERAGE FOR PRESCRIPTION DRUGS FOR MEDICARE BENEFICIARIES

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



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

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

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

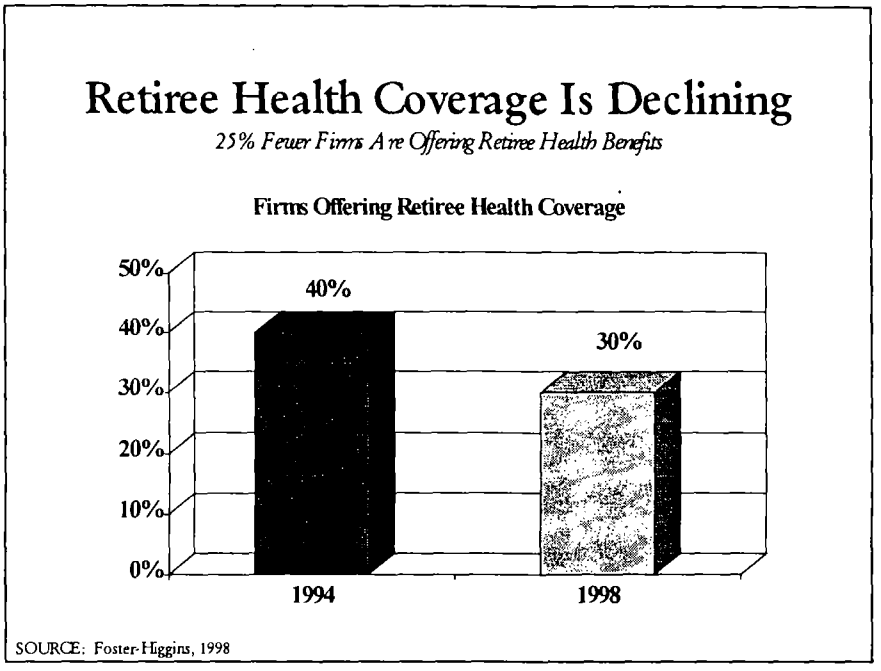
  - Medicare managed care. About 17 percent of beneficiaries have coverage through Medicare managed care. Given the projected leveling off of managed care enrollment and actual declines in the scope of managed care drug benefits, this source of coverage is unstable.

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

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

RETIREE HEALTH COVERAGE

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



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

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

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

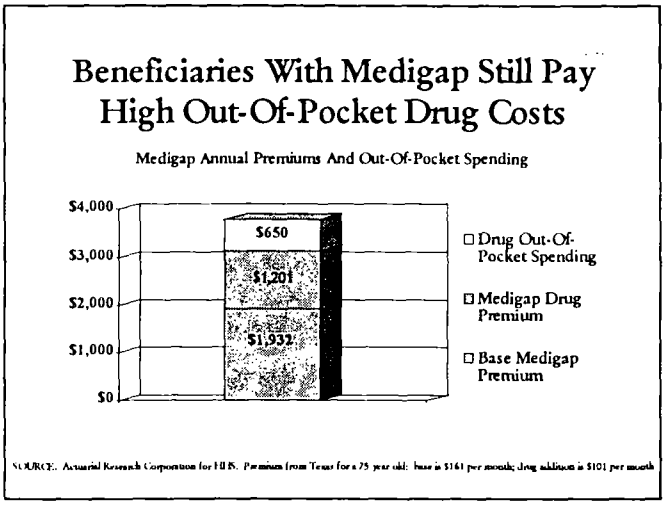
- **Firms are increasingly moving their retirees to Medicare managed care.** To help constrain costs, a number of employers are providing incentives for their retirees to join managed care. The number of large employers offering Medicare managed care plans rose from 7 percent in 1993 to 38 percent in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

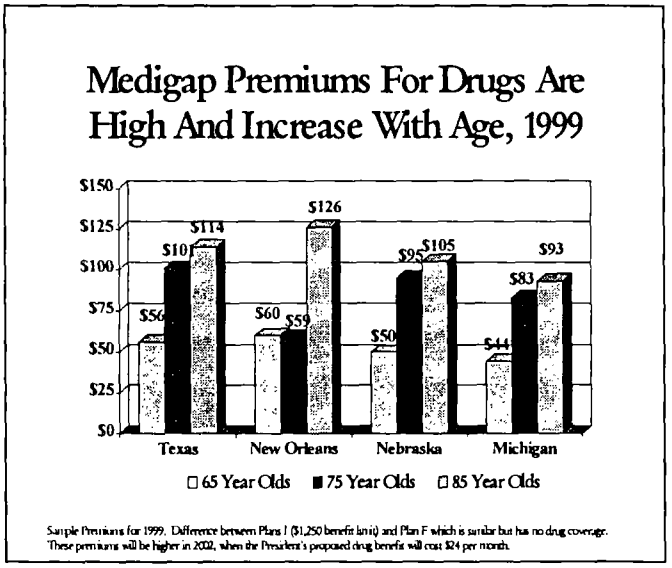
MEDIGAP PRESCRIPTION DRUG COVERAGE

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

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

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





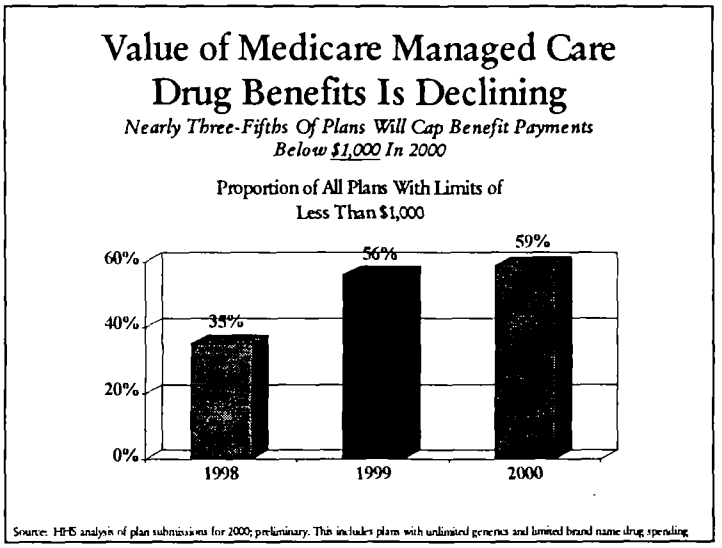
Inefficient. Because it is sold to individuals, Medigap does not offer beneficiaries the kind of premiums that result from group purchasing. This also adds to the administrative costs per policy, which are typically two to three times more than that of group coverage.

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

MEDICARE MANAGED CARE

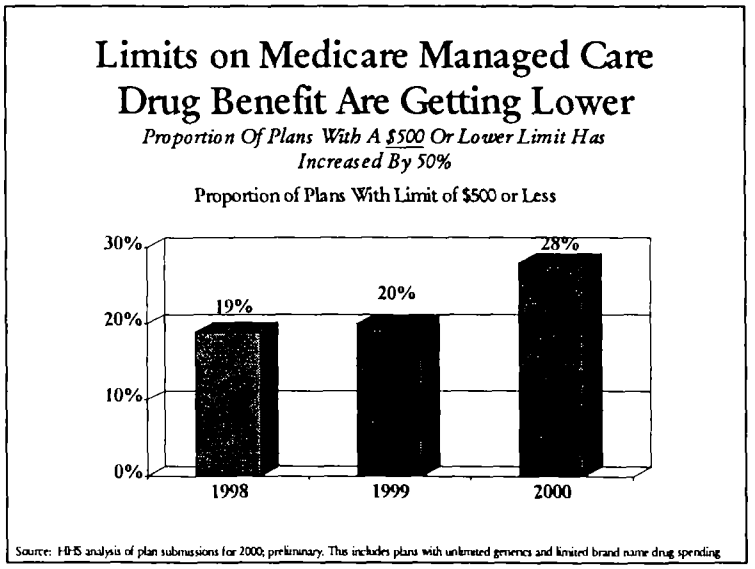
- **The number of beneficiaries with drug coverage through Medicare managed care has risen to 17 percent.** Most Medicare managed care plans offer prescription drugs. Drug coverage is one of the major attractions for beneficiaries to enroll in these plans.

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



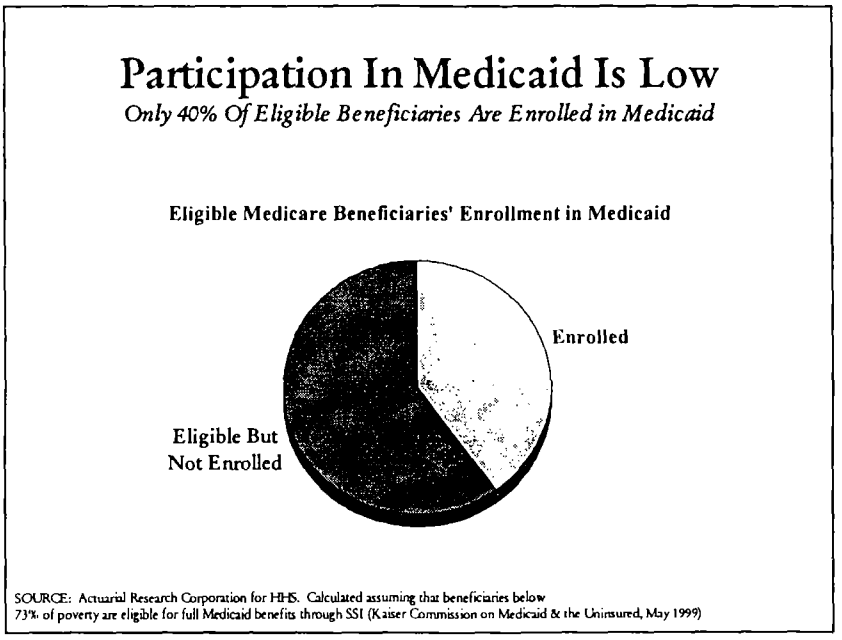
- **The value of Medicare managed care drug benefits is declining.** Nearly three-fifths of plans are reporting that they will cap prescription drug benefits below $1,000 in the year 2000. The proportion of plans with $500 or lower benefit caps will increase by over 50 percent between 1998 and 2000.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

- **Plans dropping out of Medicare limit access to drugs.** Nearly 50,000 Medicare beneficiaries will lose access to Medicare managed care next year as plans withdraw from particular areas or Medicare altogether.



MEDICAID

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



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

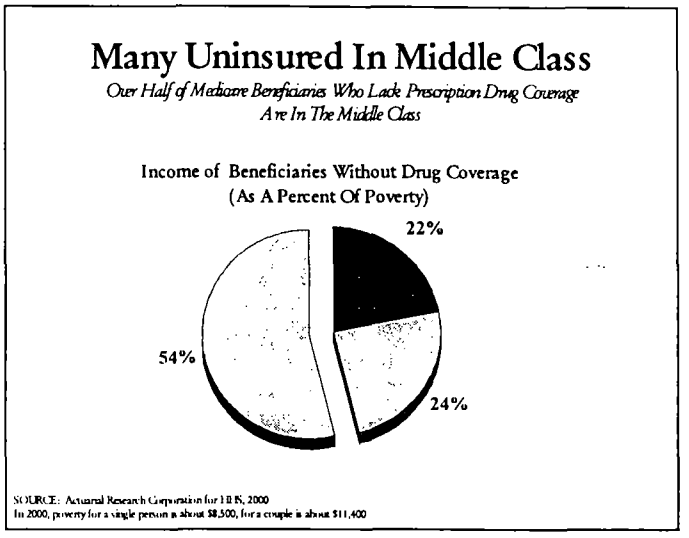
  - Lack of information, ineffective outreach and welfare stigma contributes to these low participation levels.

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

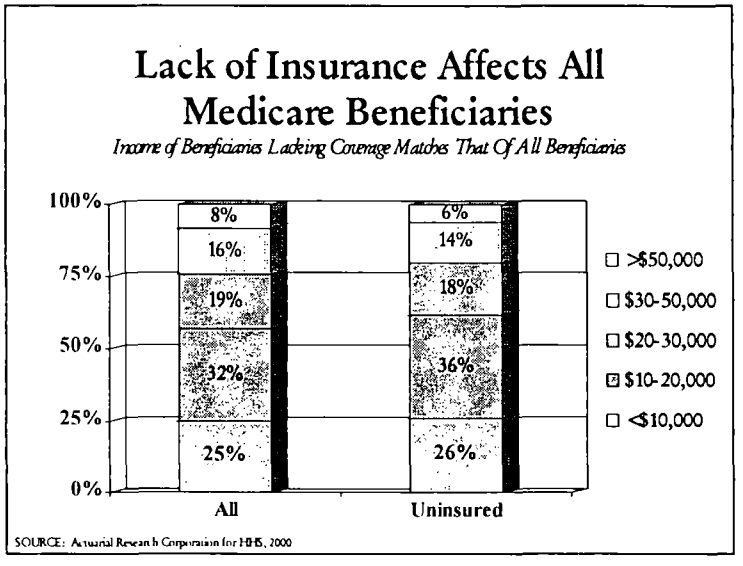
BENEFICIARIES LACKING DRUG COVERAGE

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

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



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



PRESIDENT'S PROPOSED PRESCRIPTION DRUG BENEFIT

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

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

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

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

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

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

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

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

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

APPENDIX: METHODOLOGY & ENDNOTES

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

Endnotes.

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

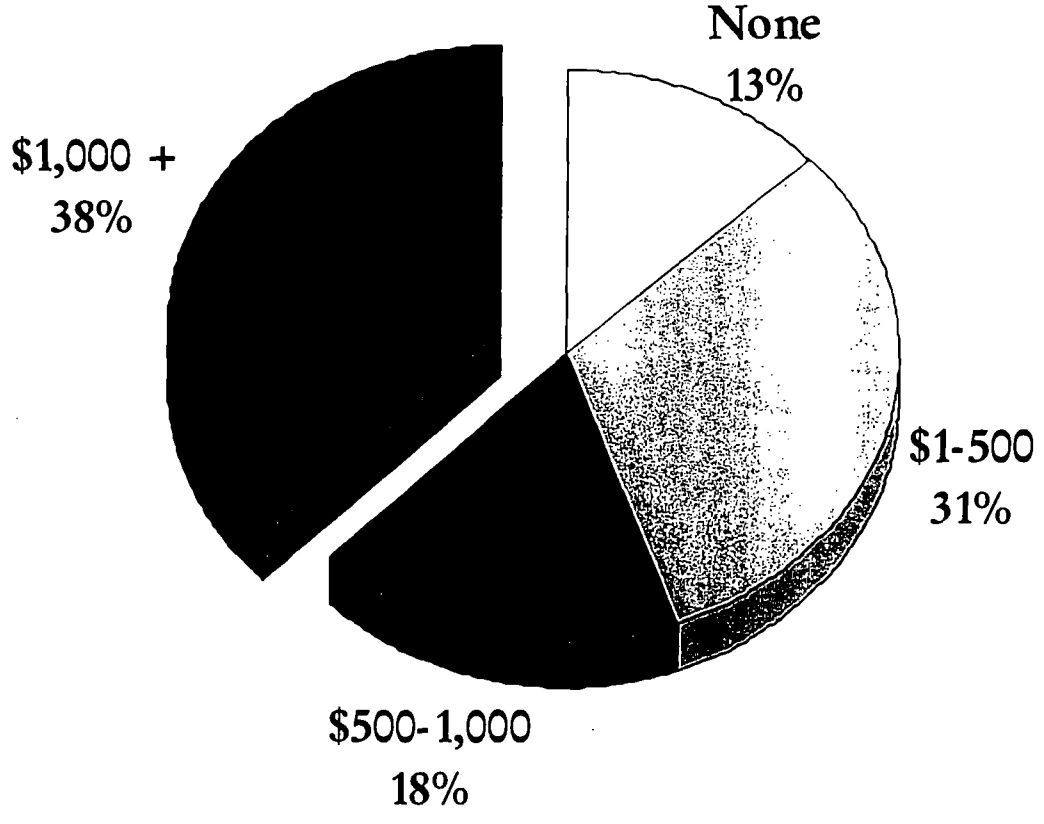
DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

July, 1999

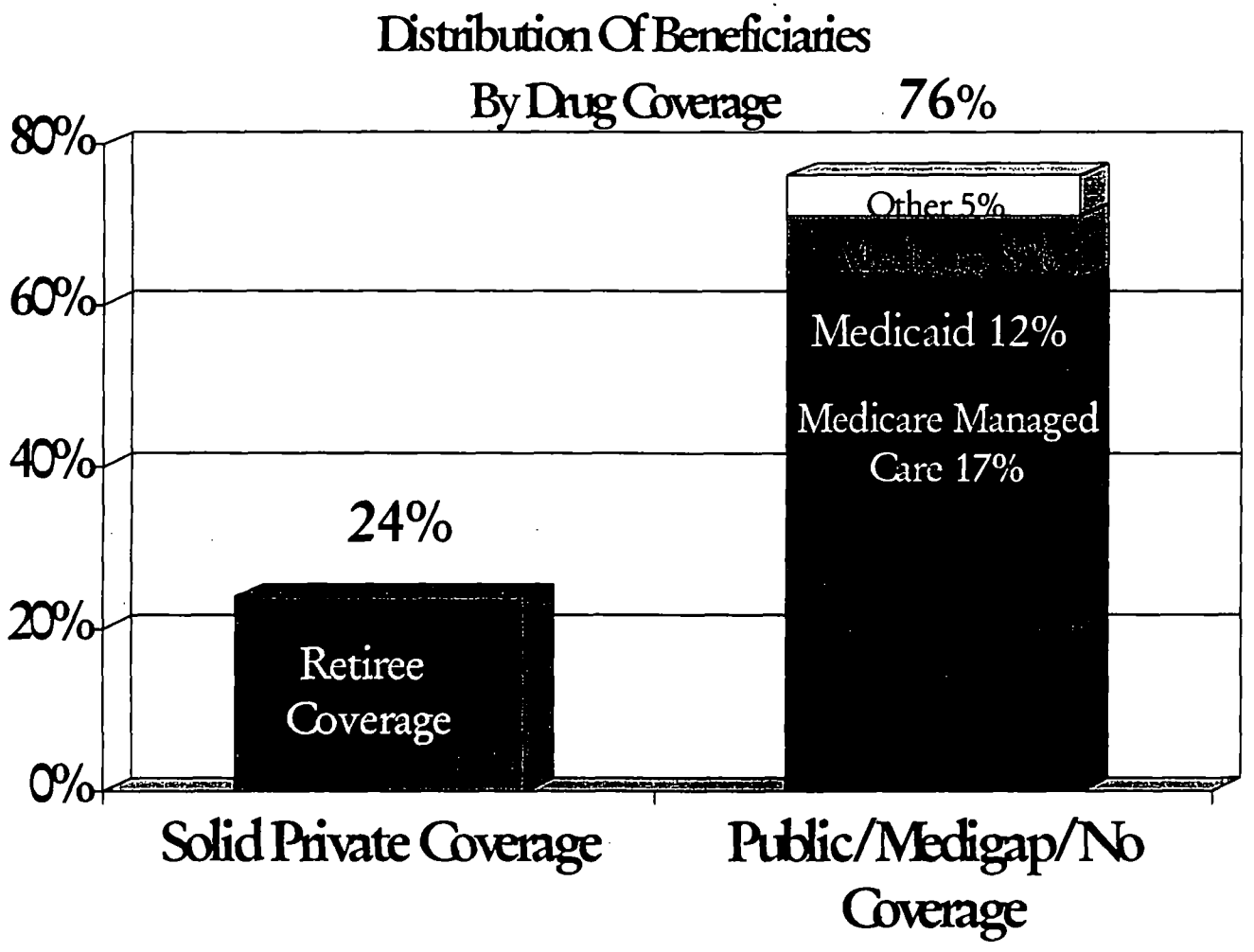
Medicare Beneficiaries Need Prescription Drugs

Beneficiaries By Total Drug Spending



SOURCE: Actuarial Research Corporation for HHS, 2000

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



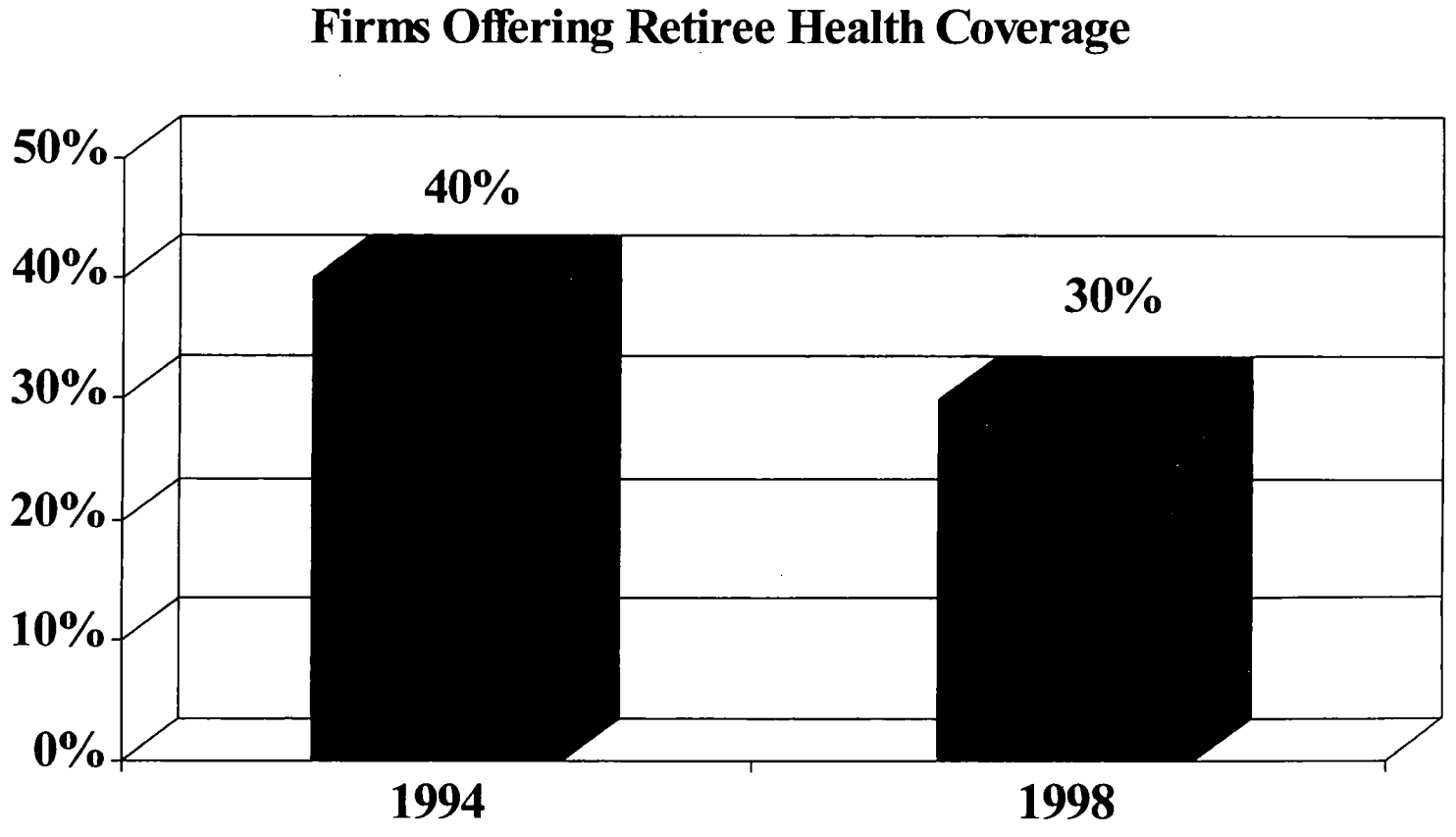
SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

PRIVATE DRUG COVERAGE:

Unstable and Declining

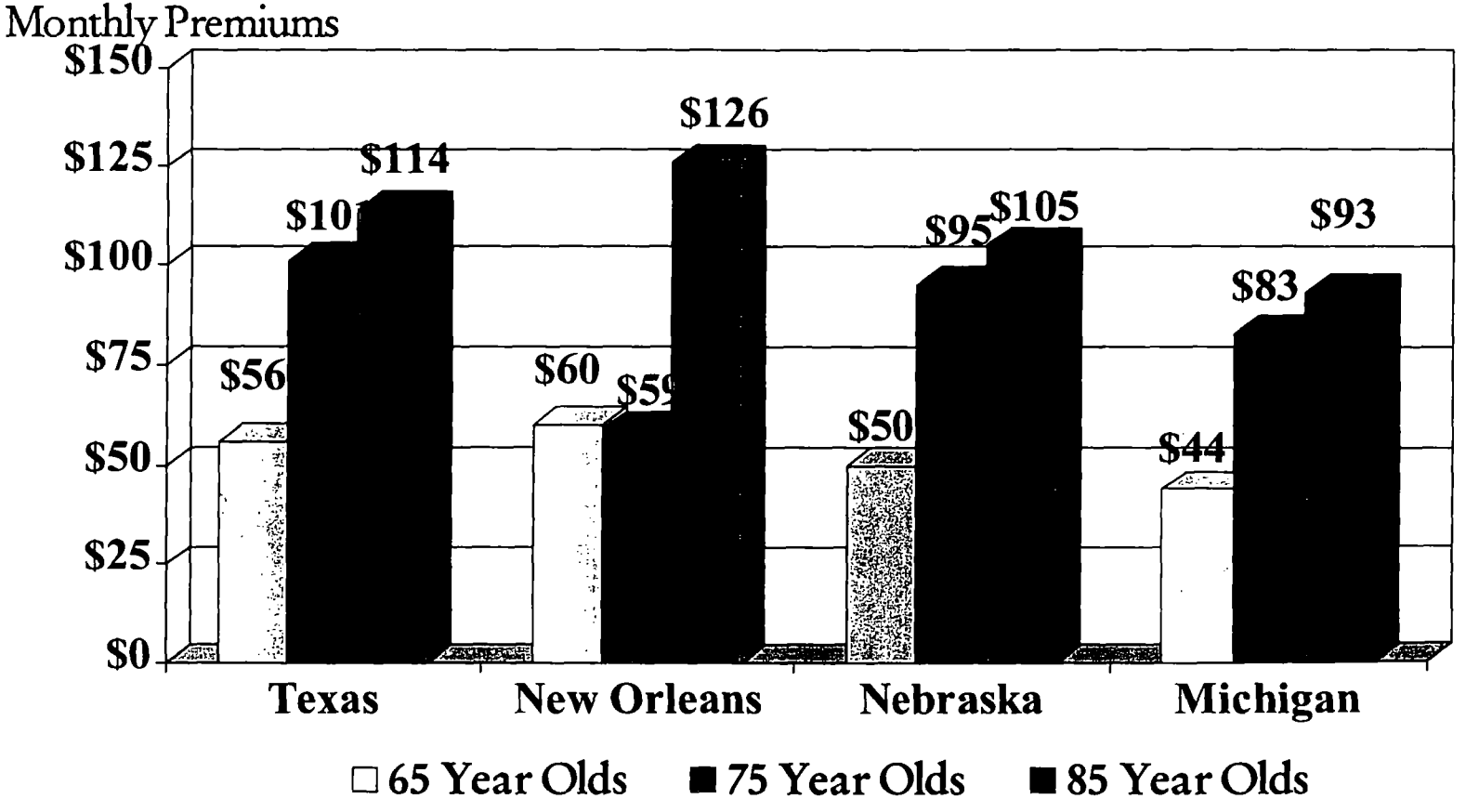
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

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

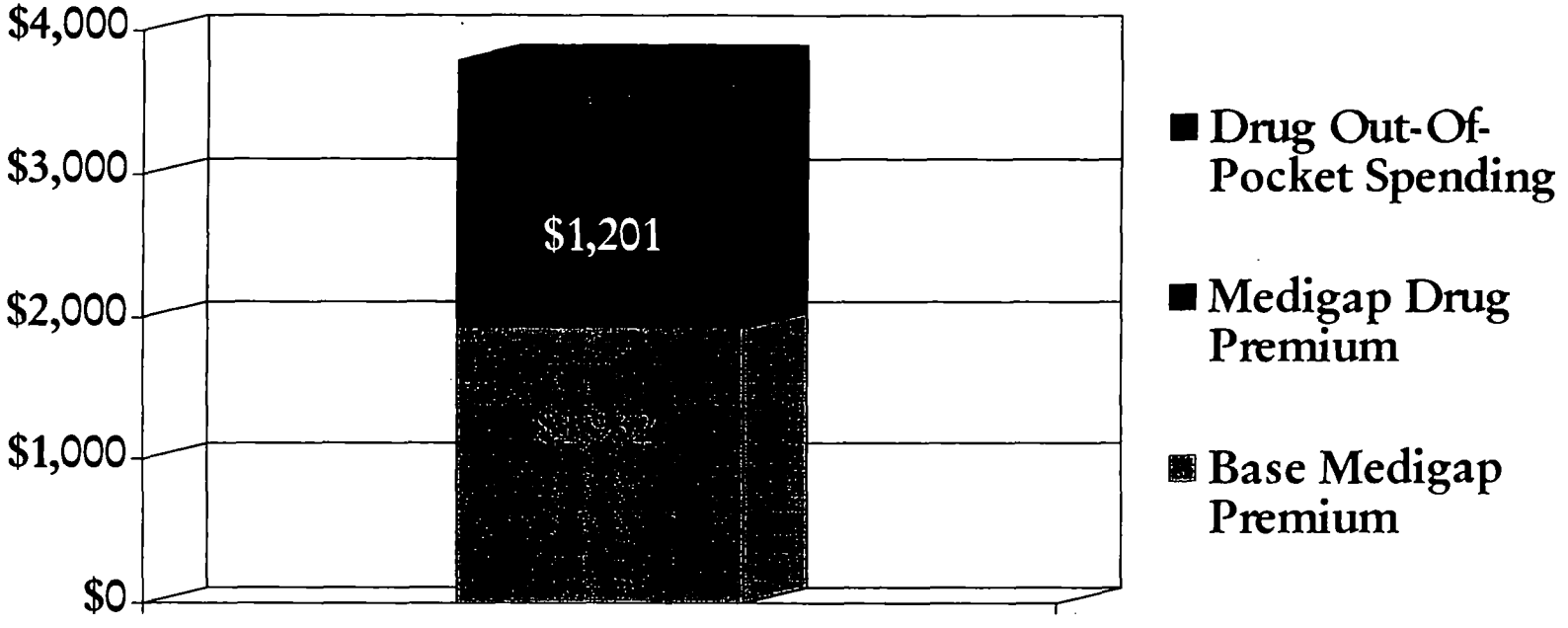


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

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

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

Medigap Annual Premiums And Out-Of-Pocket Spending



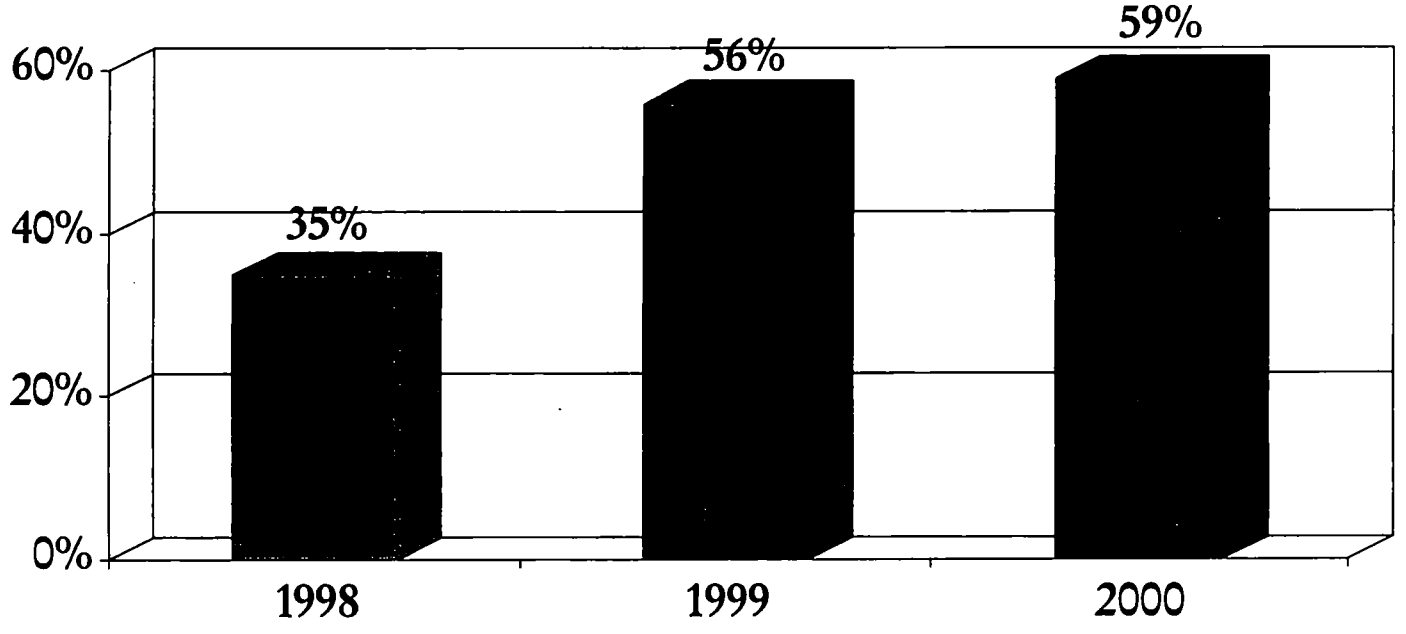
SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is $161 per month; drug addition is $101 per month

PUBLIC COVERAGE FOR PRESCRIPTION DRUGS

Value of Medicare Managed Care Drug Benefits Is Declining

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

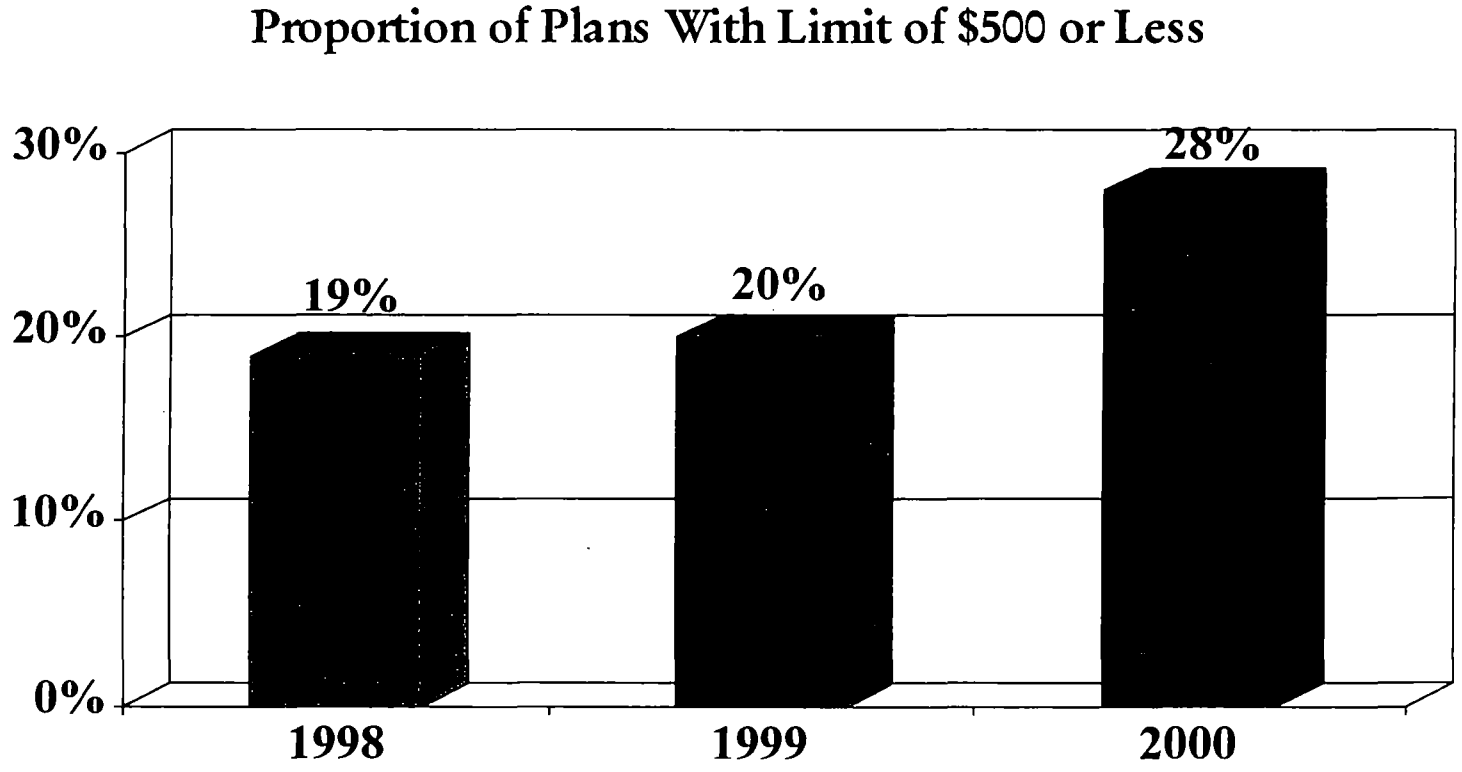
Proportion of All Plans With Limits of Less Than $1,000



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

Limits on Medicare Managed Care Drug Benefit Are Getting Lower

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

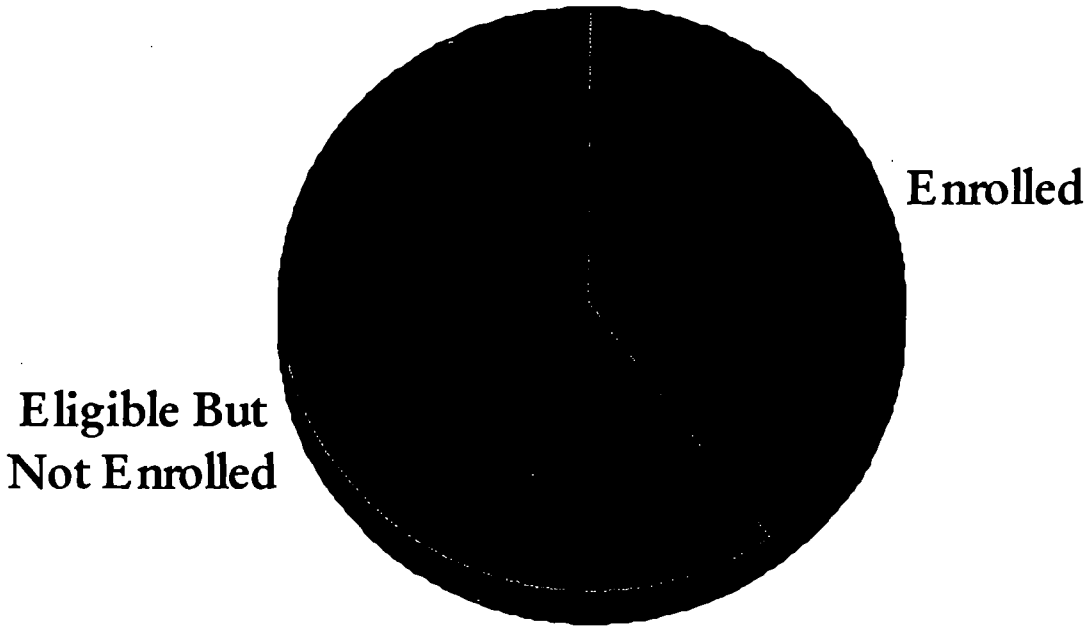


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

Participation In Medicaid Is Low

Only 40% Of Eligible Beneficiaries Are Enrolled in Medicaid

Eligible Medicare Beneficiaries' Enrollment in Medicaid



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

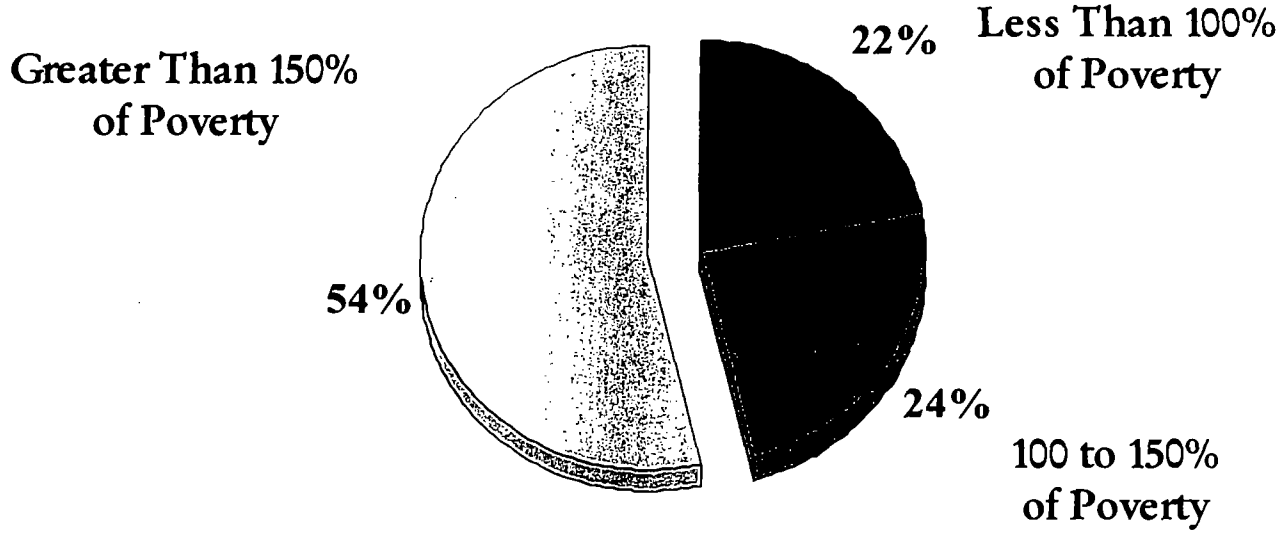
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

At Least 13 Million Medicare Beneficiaries Lack Prescription Drug Coverage

Many Uninsured In Middle Class

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

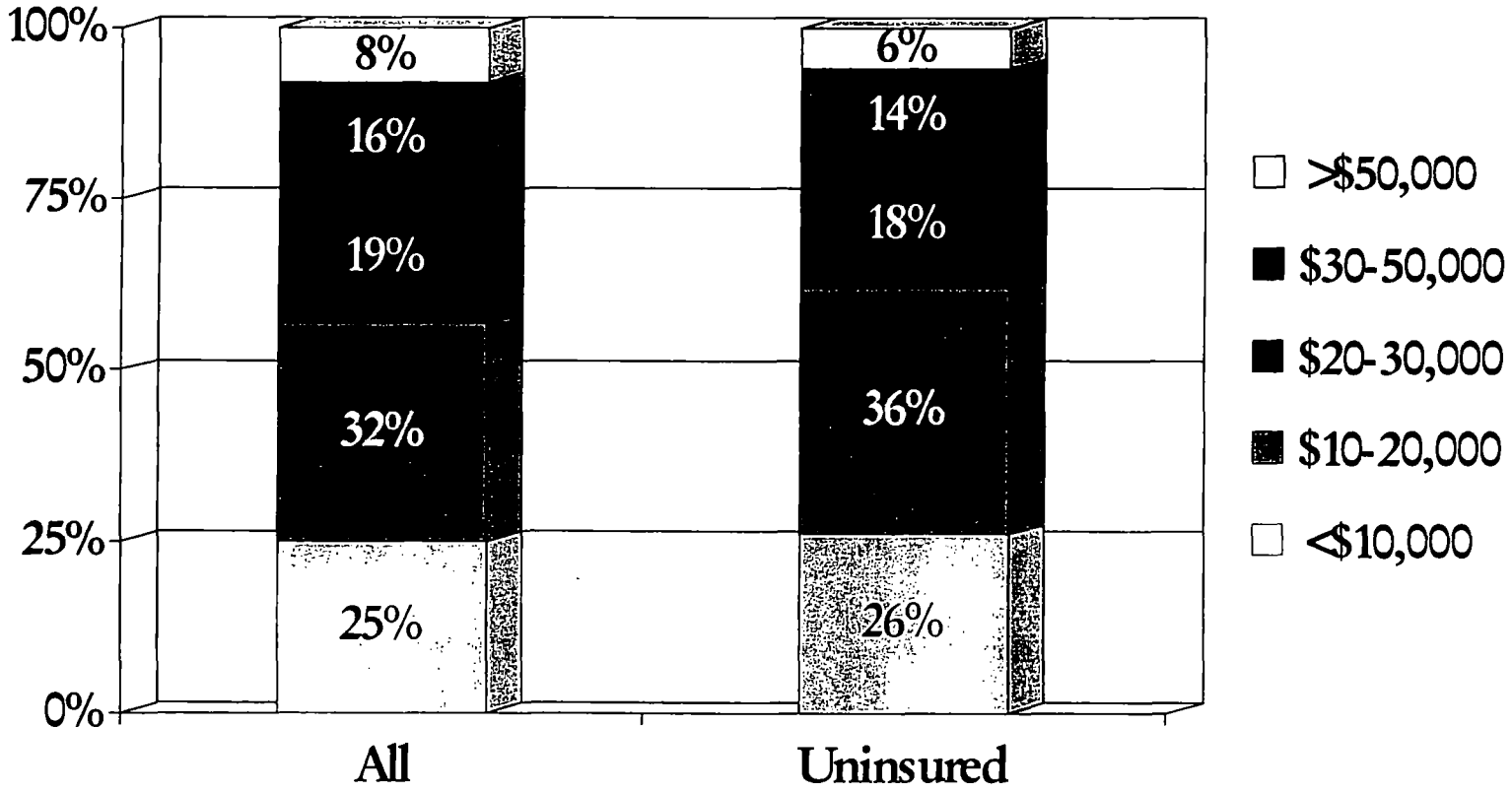
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



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

Lack of Insurance Affects All Medicare Beneficiaries

Income of Beneficiaries Lacking Coverage Matches That Of All Beneficiaries



SOURCE: Actuarial Research Corporation for HHS, 2000

Methodology

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Goals for Reform**:

  - Make Medicare More Competitive and Efficient

  - Modernize Medicare's Benefits

  - Strengthen Medicare's Financing for the 21st Century

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

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

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

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

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

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

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

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