MEDICARE:

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

July, 1999

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

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I. OVERVIEW
IMPORTANCE OF MEDICARE

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

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

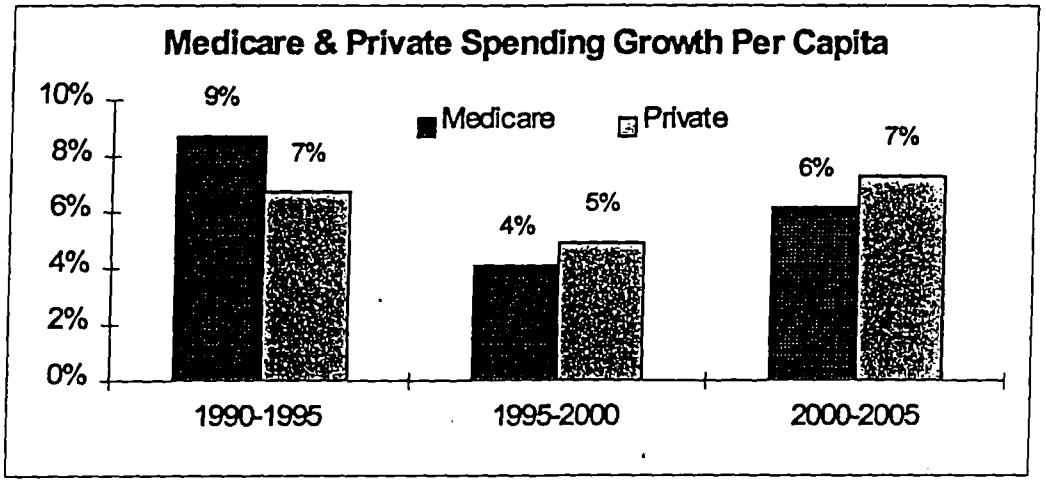
- **Improves life expectancy, access to care and reduces poverty:** Since 1965:
  - Life expectancy of people who reach age 65 has increased by 20 percent (79 to 82 years)
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

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

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

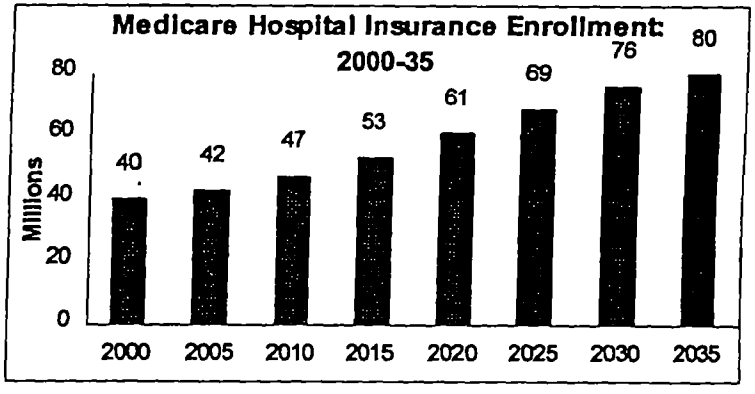
- The slow Medicare spending growth is expected to continue through 2002 – when many policies in the Balanced Budget Act (BBA) of 1997 expire and cost growth goes up.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

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

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



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

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

ADDITIONAL CHALLENGES FACING MEDICARE: LACK OF PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

OUTDATED AND INEFFICIENT PAYMENT SYSTEMS

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

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

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

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

    - Hard for beneficiaries to comparison shop on benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Competitive Defined Benefit Proposal

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

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

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

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

Example: Competitive Defined Benefit Proposal

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

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

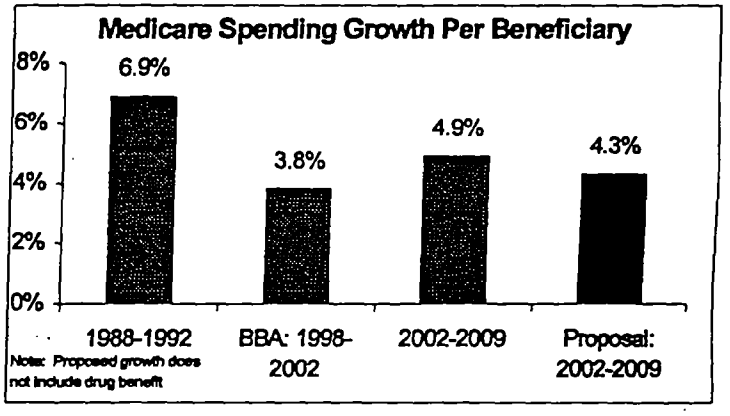
- **Smoothing out the Balanced Budget Act of 1997 reductions.** Some evidence suggests that some BBA policies may have unintended effects. To address this, this plan includes:

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

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

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

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



Improving Medicare Management

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

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

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

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

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

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

MODERNIZING MEDICARE BENEFITS
Prescription Drug Benefit

- **New Medicare prescription drug benefit.** The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002.

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

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

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

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

Improving Preventive Benefits and Eliminating Cost Sharing

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

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

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

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

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

Rationalizing Cost Sharing and Medigap

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

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

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

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

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

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

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

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

Medicare Buy-In for Certain People Ages 55-65

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

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

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

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

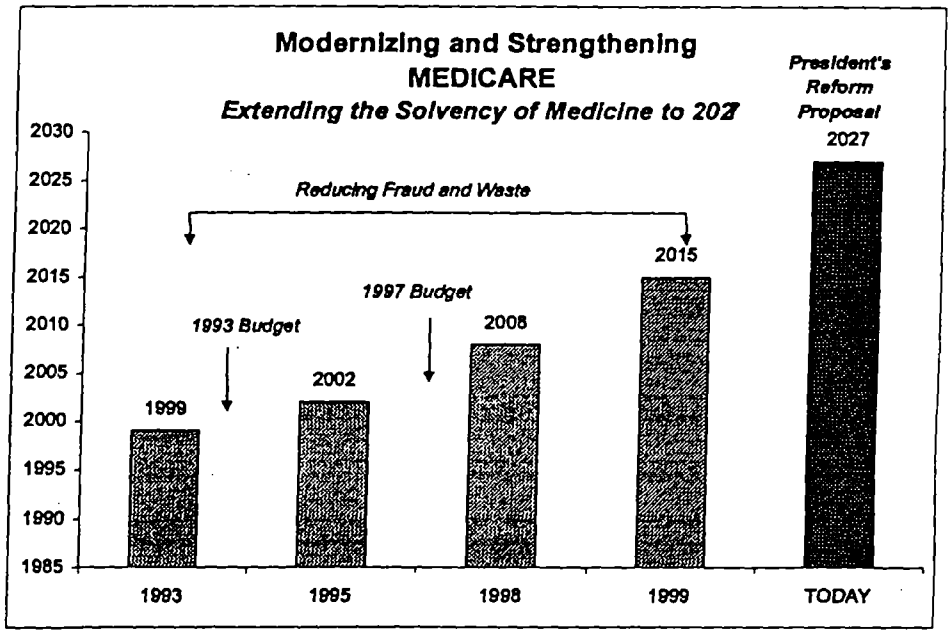
- All three proposals are designed to be paid for by the people who benefit. People ages 62 to 64 who buy into Medicare will, over time, repay the amount that Medicare "loans" them when they are buying in. Displaced workers will pay a premium that takes into account participants' costs. And, the COBRA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

III. STRENGTHENING MEDICARE'S FINANCING FOR THE 21st CENTURY

Surplus for Medicare Solvency

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

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



Financing for the Prescription Drug Benefit

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

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

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

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

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

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release June 29, 1999

REMARKS OF THE PRESIDENT ON STRENGTHENING MEDICARE

The East Room

3:23 P.M. EDT

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

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

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

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

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

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

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

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

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

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

This renewal is basically the consequence of the hard work of tens of millions of our fellow citizens. It is also, however, clearly the result of new ideas and good decisions made here in this city -- beginning with the fiscal discipline pursued since 1993, the reduction in the size of government and controlling spending while dramatically increasing investments in education, health care, biomedical research, the environment and other critical areas. The vast budget deficits have been transformed into growing budget surpluses. And America is better prepared for the new century.

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

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

But securing Medicare is not enough. To modernize Medicare, my plan will also create a much better match between the benefits of modern science and the benefits offered by

Medicare. It will provide for more preventive care and help our seniors afford prescription drugs. The plan is credible, sensible and fiscally responsible. It will secure the health of Medicare while improving the health of our seniors. And we can achieve it.

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

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

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

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

The original Medicare law was written at a time when patients' lives were more often saved by scalpels than by pharmaceuticals. Many of the drugs we now routinely use to treat heart disease, cancer, arthritis, did not even exist in 1965. Yet Medicare still does not cover prescription drugs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

END 3:44 P.M. EDT

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

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

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

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

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

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

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

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

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

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

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

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

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

PRESIDENT'S PLAN TO MODERNIZE & STRENGTHEN MEDICARE

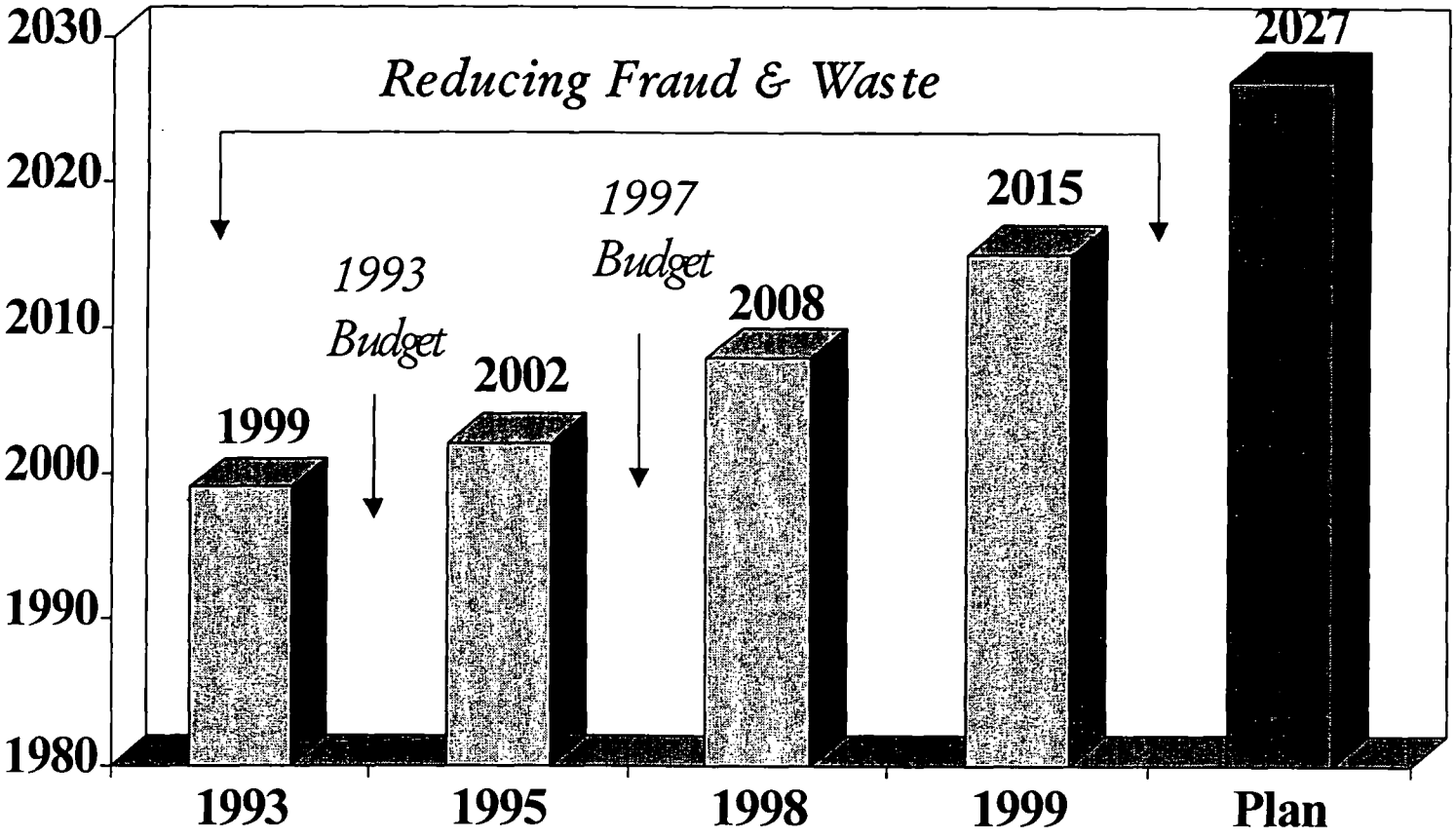
July 16, 1999

President's Plan To Modernize and Strengthen Medicare

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

Modernizing and Strengthening MEDICARE

Extending The Solvency Of Medicare To 2027



President's Proposal For Medicare Prescription Drug Coverage

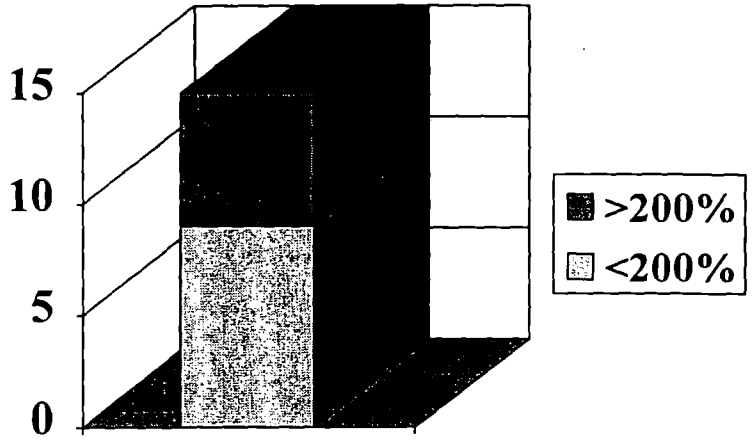
- **Meaningful coverage.** Beginning in 2002, beneficiaries have the option to enroll in Part D:
  - No deductible -- coverage with first prescription
  - 50% copay with access to discounted prices
  - Benefit limited after $5,000 in costs (phased-in)

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

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

All Types of Beneficiaries Lack Coverage For Prescription Drugs

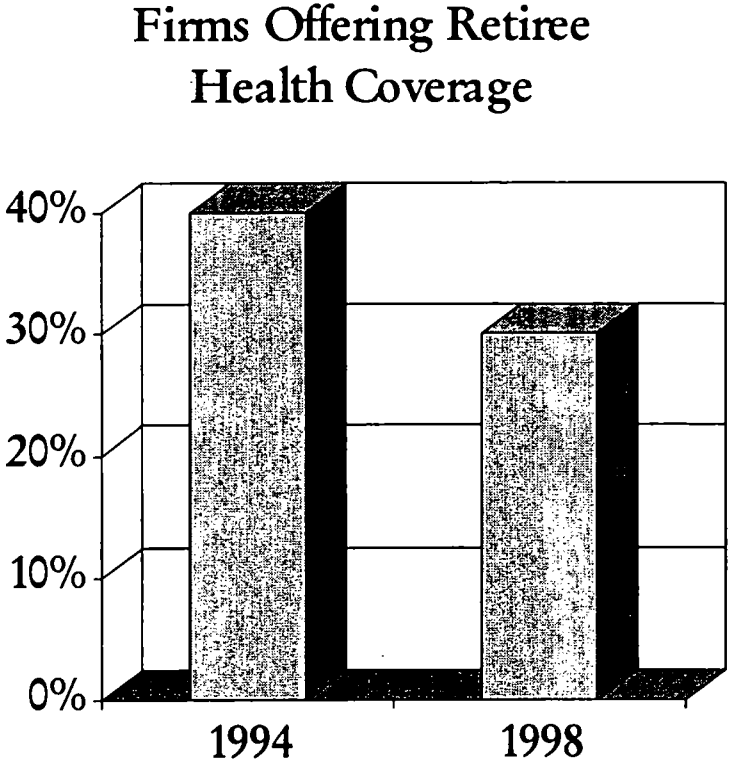
Over 40% of Beneficiaries Without Drug Coverage Have Income Above 200% of Poverty (Millions of People)



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

- **Disproportionately affects rural beneficiaries.** About half of rural beneficiaries have no coverage
- **Older beneficiaries are less likely to have coverage.** Over 40 percent of beneficiaries older than 85 pay for their prescription drug costs out-of-pocket, compared to about one-third of beneficiaries ages 65-69

Prescription Drug Coverage: Private Sources Declining



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

Making Medicare Managed Care More Competitive

Current System

- No price competition
- Plans compete by offering hard-to-compare benefits
- Over 1 in 4 beneficiaries do not have access to managed care -- or the extra benefits they offer

Competitive Defined Benefit

- Plans paid based on price and quality
- Plans compete by lowering premium & cost sharing
- Explicitly pays for drugs in managed care as well as traditional Medicare

Smoothing Out Balanced Budget Act Policies In The Short Run

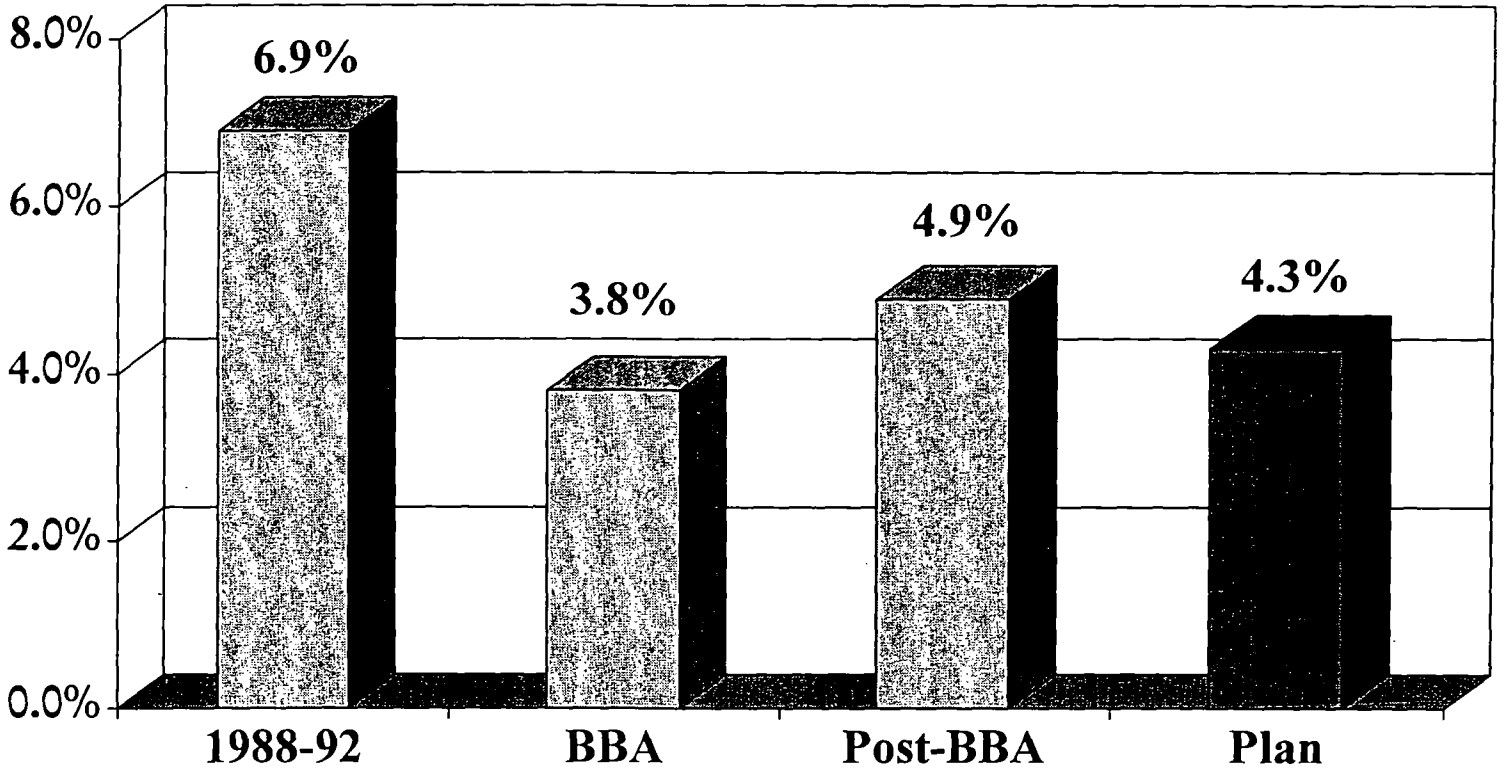
- **Immediate Administrative Actions**, that moderate the impact on hospitals, academic health centers and home health agencies

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

- **$7.5 Billion Quality Assurance Fund**

Keeping Medicare's Growth In Check

Spending Growth Per Beneficiary



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

MEDICARE:

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

July, 1999

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

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. President's Plan for Modernizing and Strengthening Medicare

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

I. OVERVIEW
IMPORTANCE OF MEDICARE

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

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

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

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

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

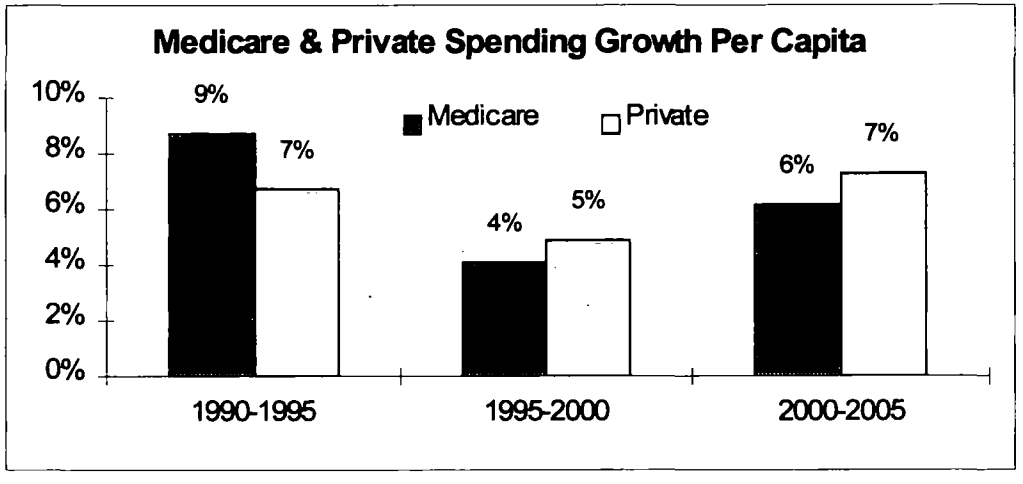
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

MEDICARE'S FINANCIAL STATUS HAS IMPROVED

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

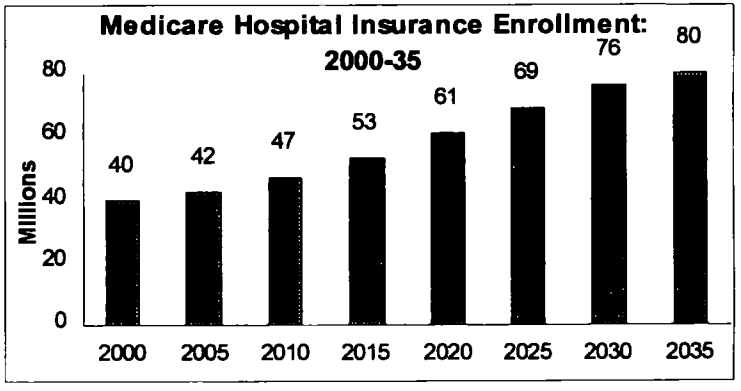
- In response, the President advocated for Medicare reforms in 1993 and 1997, and instituted an unprecedented crack-down on fraud and abuse. These actions, in combination with a strong economy, constrained cost growth and extended the life of the trust fund until 2015.

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



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

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



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

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

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

ADDITIONAL CHALLENGES FACING MEDICARE: LACK OF PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

OUTDATED AND INEFFICIENT PAYMENT SYSTEMS

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

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

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

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

    - Hard for beneficiaries to comparison shop on benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Competitive Defined Benefit Proposal

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

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

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

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

Example: Competitive Defined Benefit Proposal

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

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

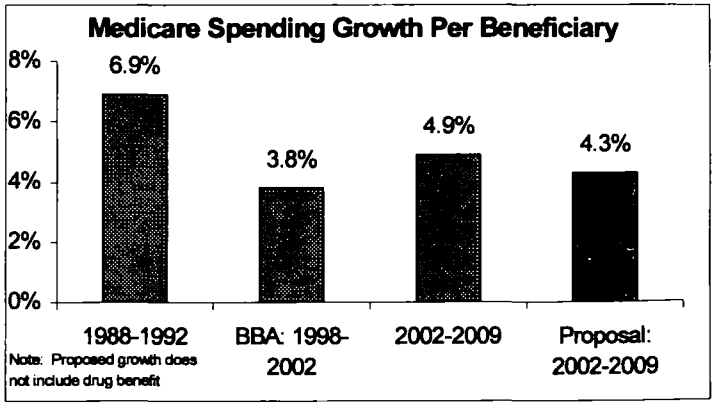
- **Smoothing out the Balanced Budget Act of 1997 reductions.** Some evidence suggests that some BBA policies may have unintended effects. To address this, this plan includes:

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

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

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

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



Improving Medicare Management

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

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

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

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

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

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

MODERNIZING MEDICARE BENEFITS
Prescription Drug Benefit

- **New Medicare prescription drug benefit.** The President's plan includes a new, voluntary Medicare drug benefit. Called Medicare Part D, it would offer all beneficiaries, for the first time, access to affordable, high-quality prescription drug coverage beginning in 2002.

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

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

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

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

Improving Preventive Benefits and Eliminating Cost Sharing

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

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

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

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

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

Rationalizing Cost Sharing and Medigap

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

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

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

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

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

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

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

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

Medicare Buy-In for Certain People Ages 55-65

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

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

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

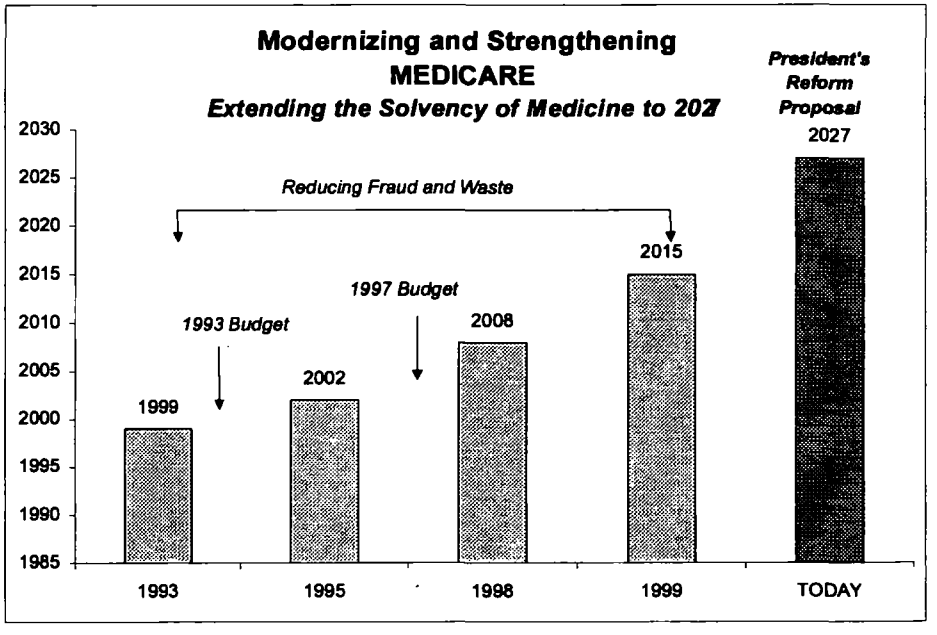
  - Retirees over age 55 who had been promised health care in their retirement years would be provided access to "COBRA" continuation coverage if their old firm reneged on their commitment.

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

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

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

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



Financing for the Prescription Drug Benefit

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

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

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

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

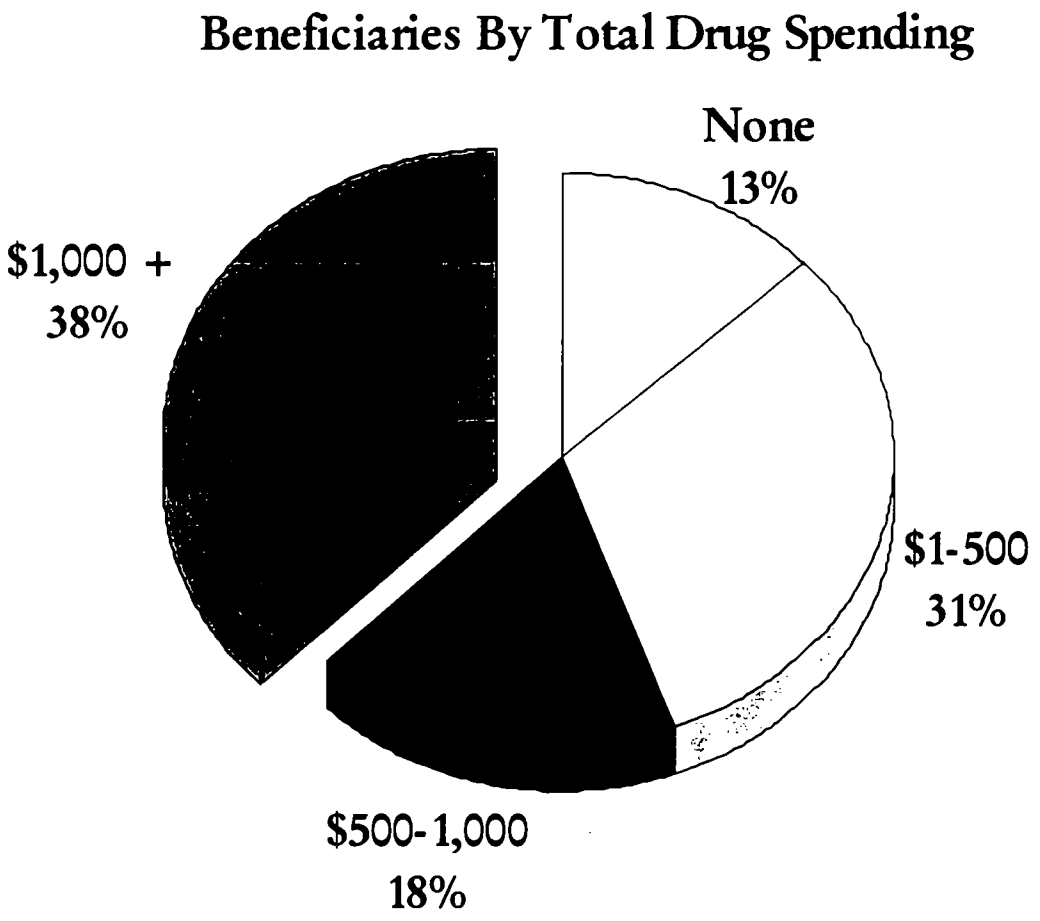
- **Medicare baseline has dropped, in part because of administrative actions.** Policy experts advising the Congress (MedPAC, CBO, and Medicare Trustees) have credited our success in combating fraud, waste, and abuse as a major reason for the $241 billion, 10-year drop in Medicare spending from 1998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

DISTURBING TRUTHS AND DANGEROUS TRENDS:

The Facts About Medicare Beneficiaries and Prescription Drug Coverage

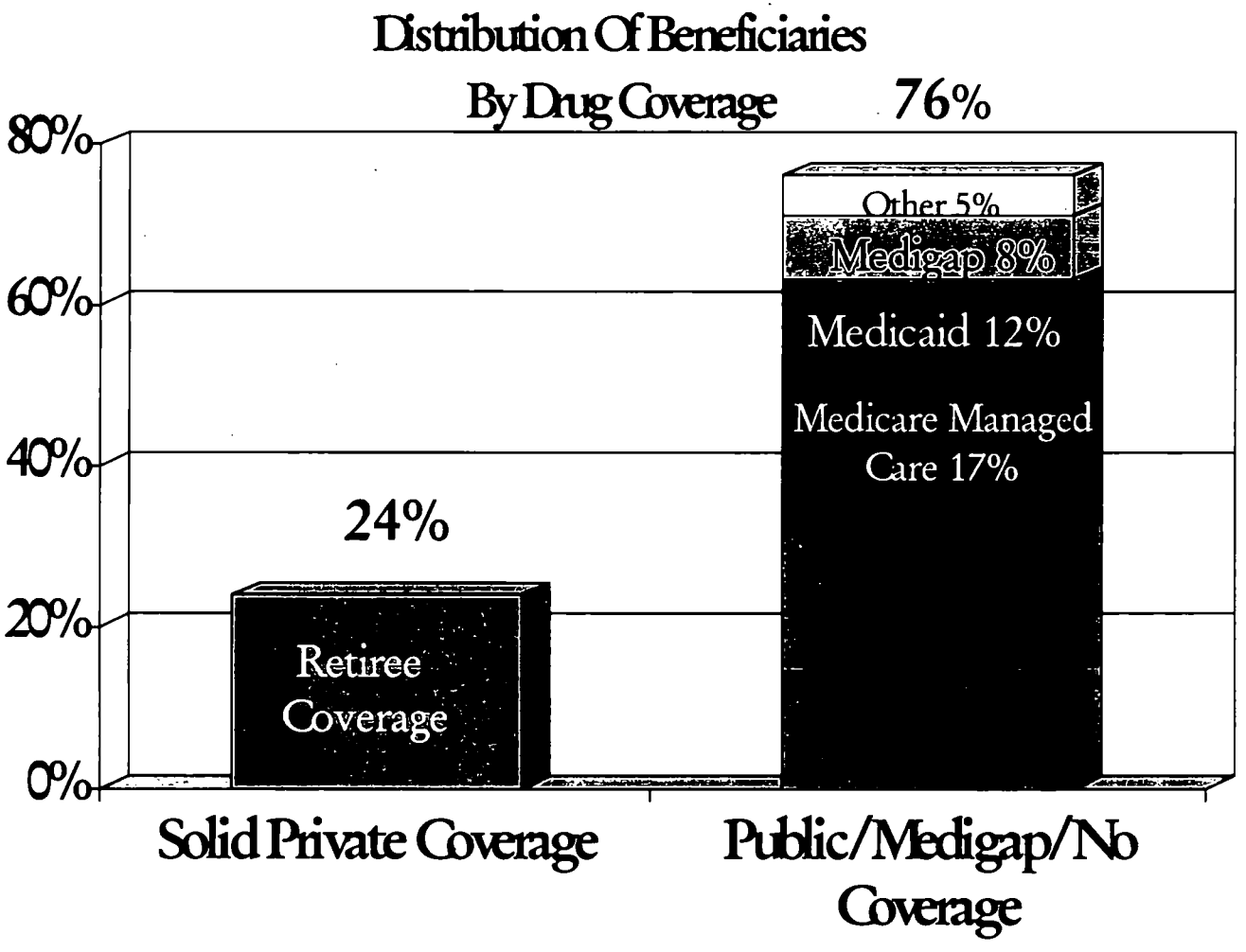
July, 1999

Medicare Beneficiaries Need Prescription Drugs



SOURCE: Actuarial Research Corporation for HHS, 2000

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



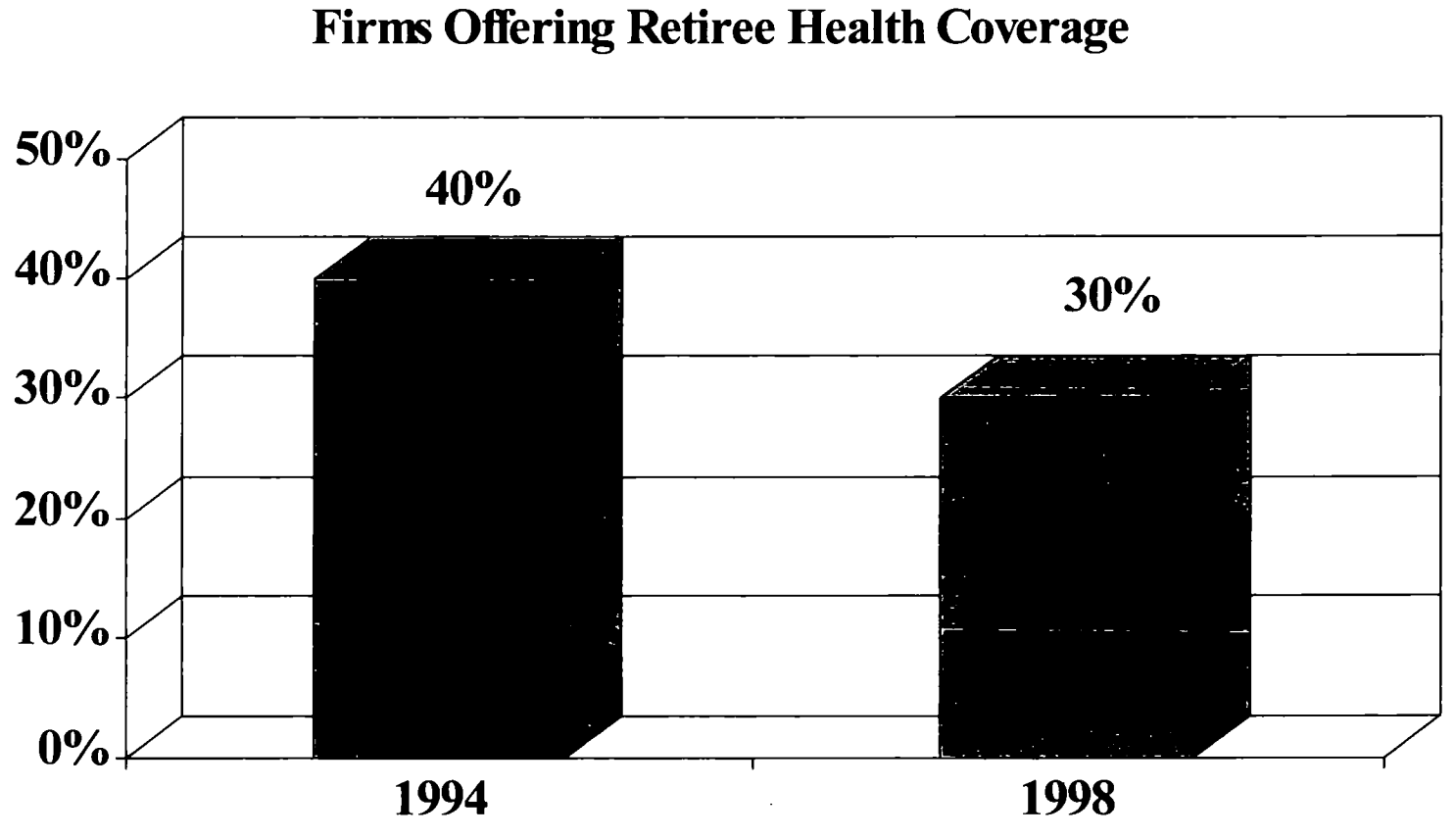
SOURCE: Actuarial Research Corporation for HHS, point-in-time, 2000

PRIVATE DRUG COVERAGE:

Unstable and Declining

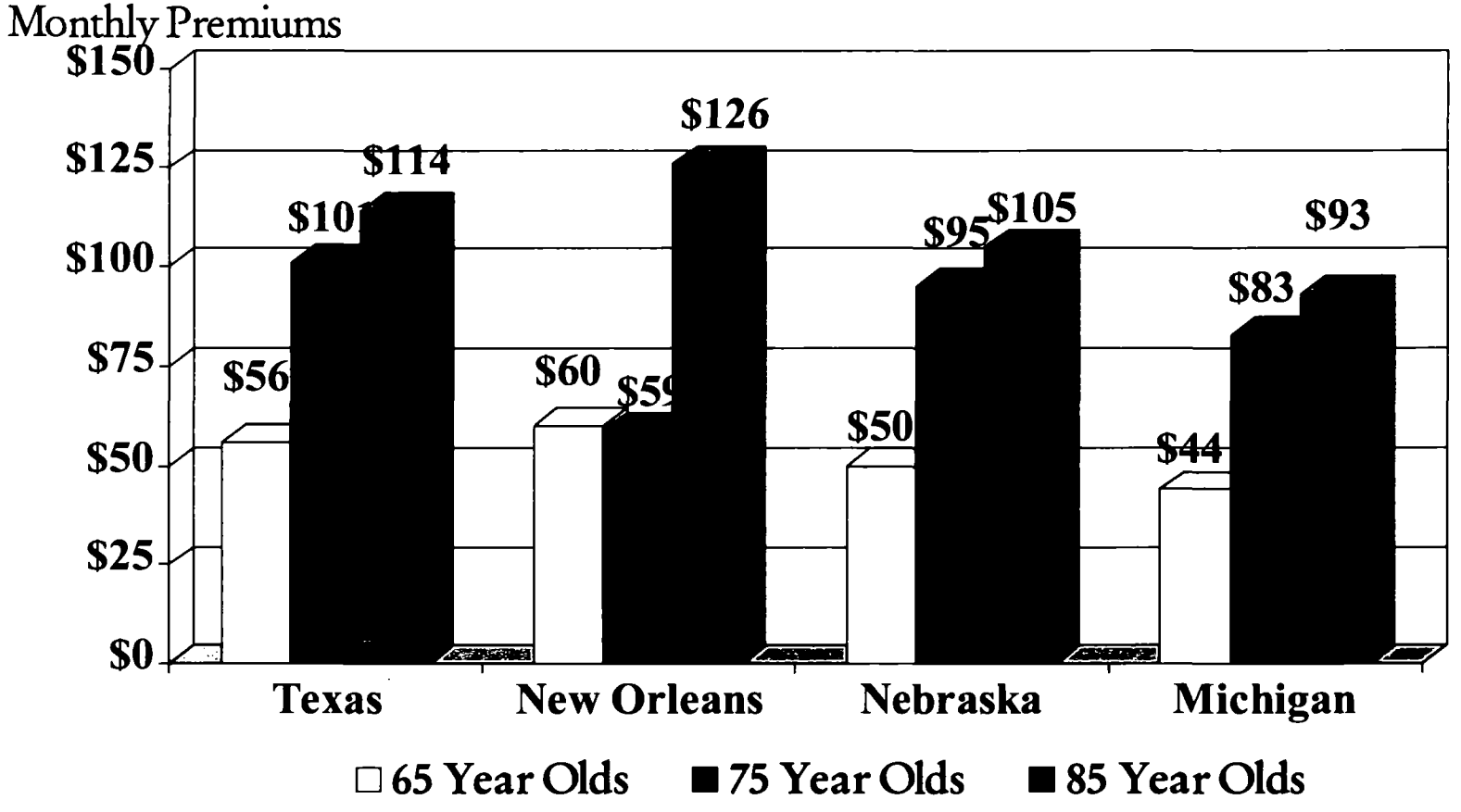
Retiree Health Coverage Is Declining

25% Fewer Firms Are Offering Retiree Health Benefits



SOURCE: Foster-Higgins, 1998

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

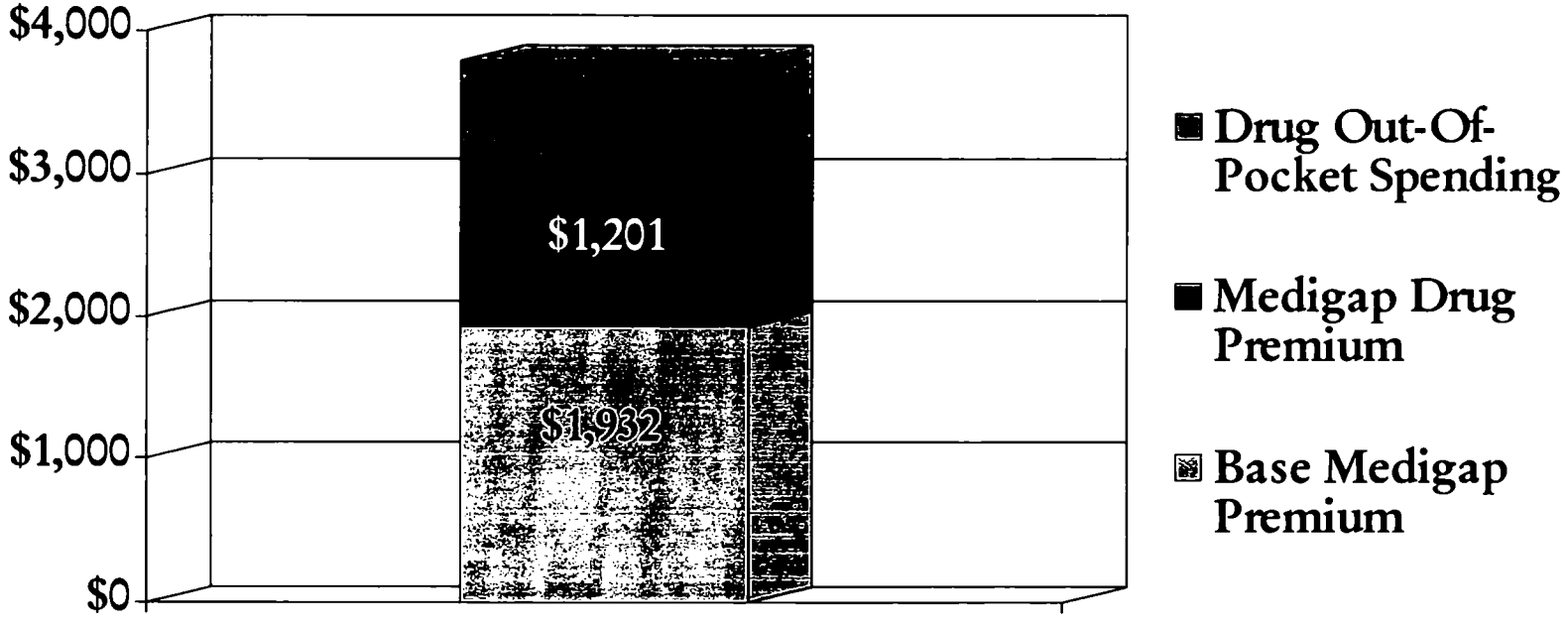


Sample Premiums for 1999. Difference between Plans I ($1,250 benefit limit) and Plan F which is similar but has no drug coverage. These premiums will be higher in 2002, when the President's proposed drug benefit will cost $24 per month.

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

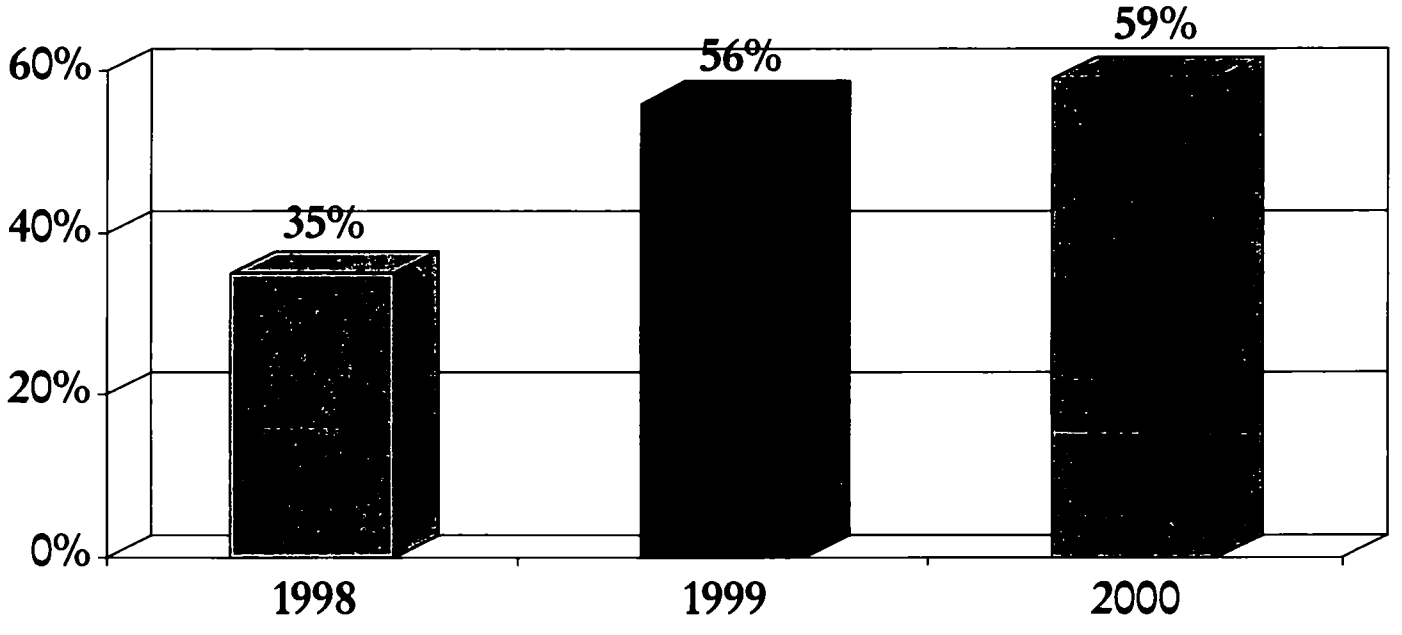


SOURCE: Actuarial Research Corporation for HHS. Premium from Texas for a 75 year old: base is $161 per month; drug addition is $101 per month

PUBLIC COVERAGE FOR PRESCRIPTION DRUGS

Value of Medicare Managed Care Drug Benefits Is Declining

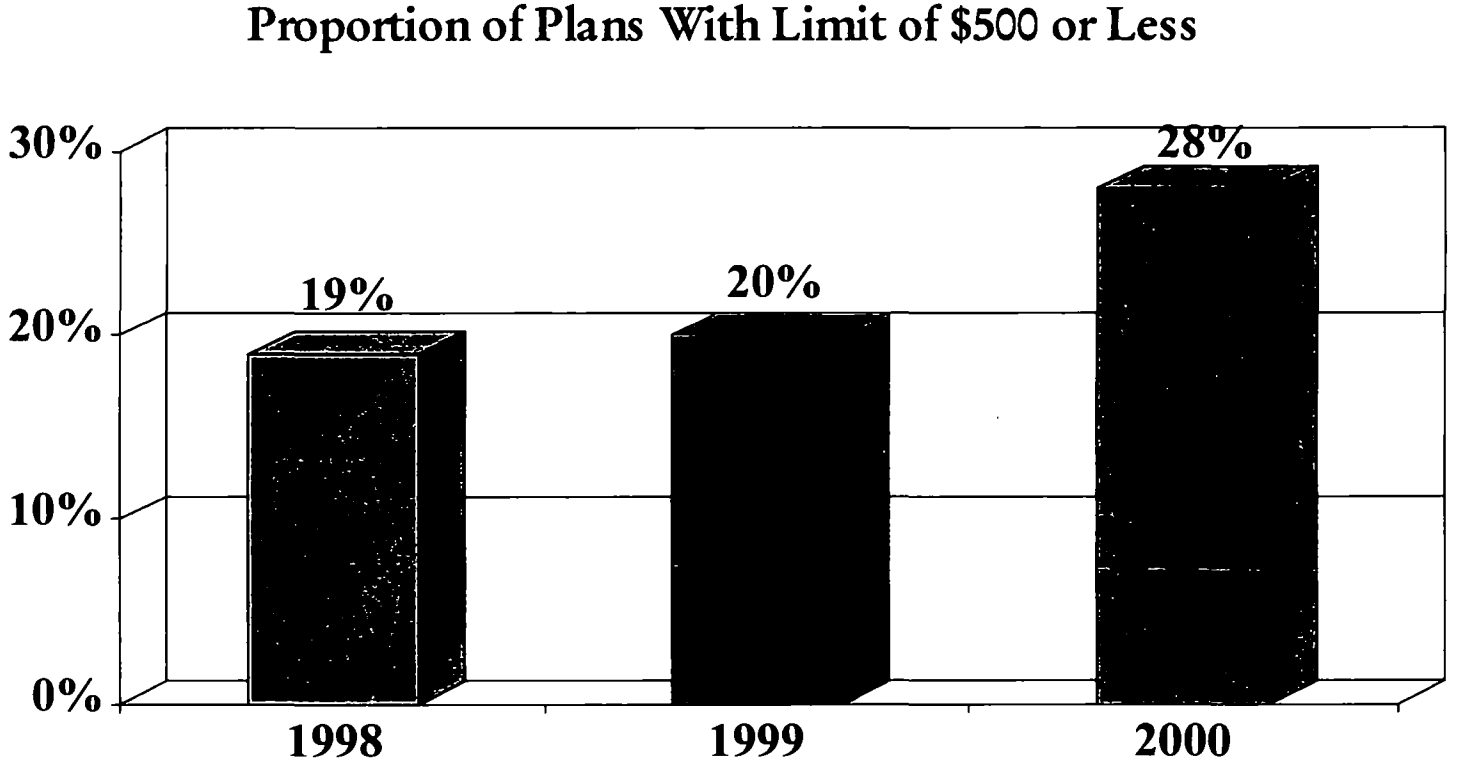
Nearly Three-Fifths Of Plans Will Cap Benefit Payments Below $1,000 In 2000



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%

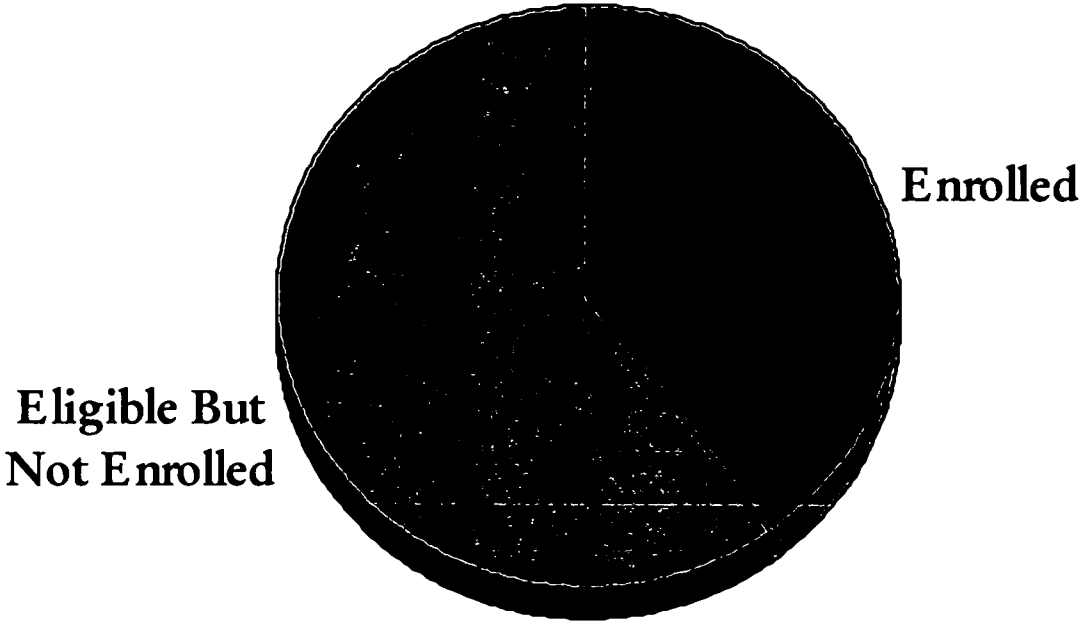


Source: HHS analysis of plan submissions for 2000; preliminary. This includes plans with unlimited generics and limited brand name drug spending

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)

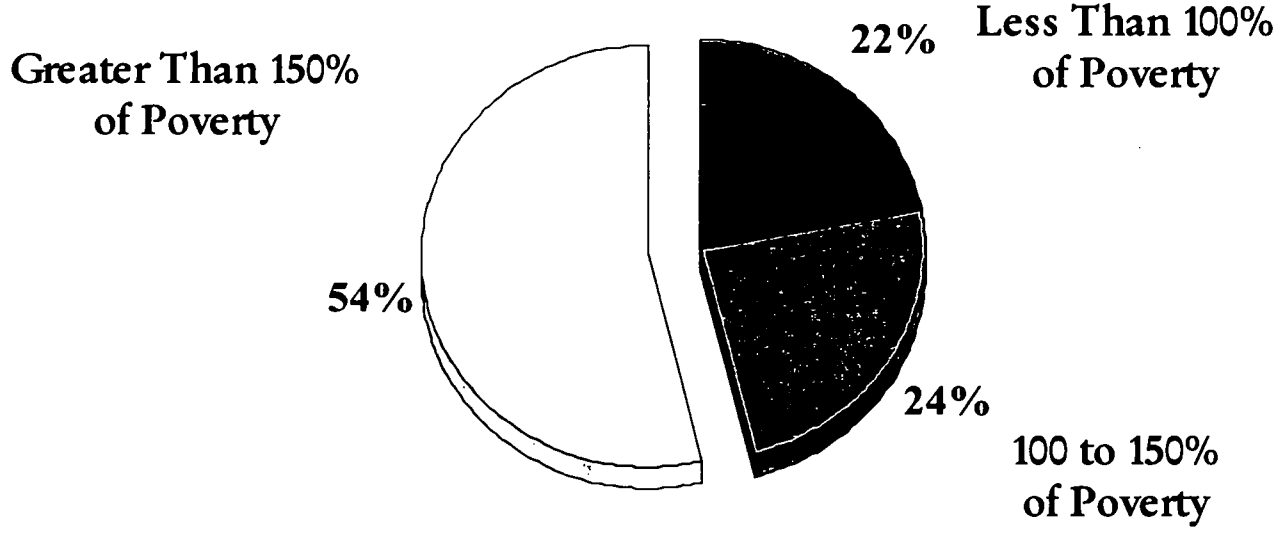
MILLIONS OF BENEFICIARIES HAVE NO DRUG COVERAGE

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

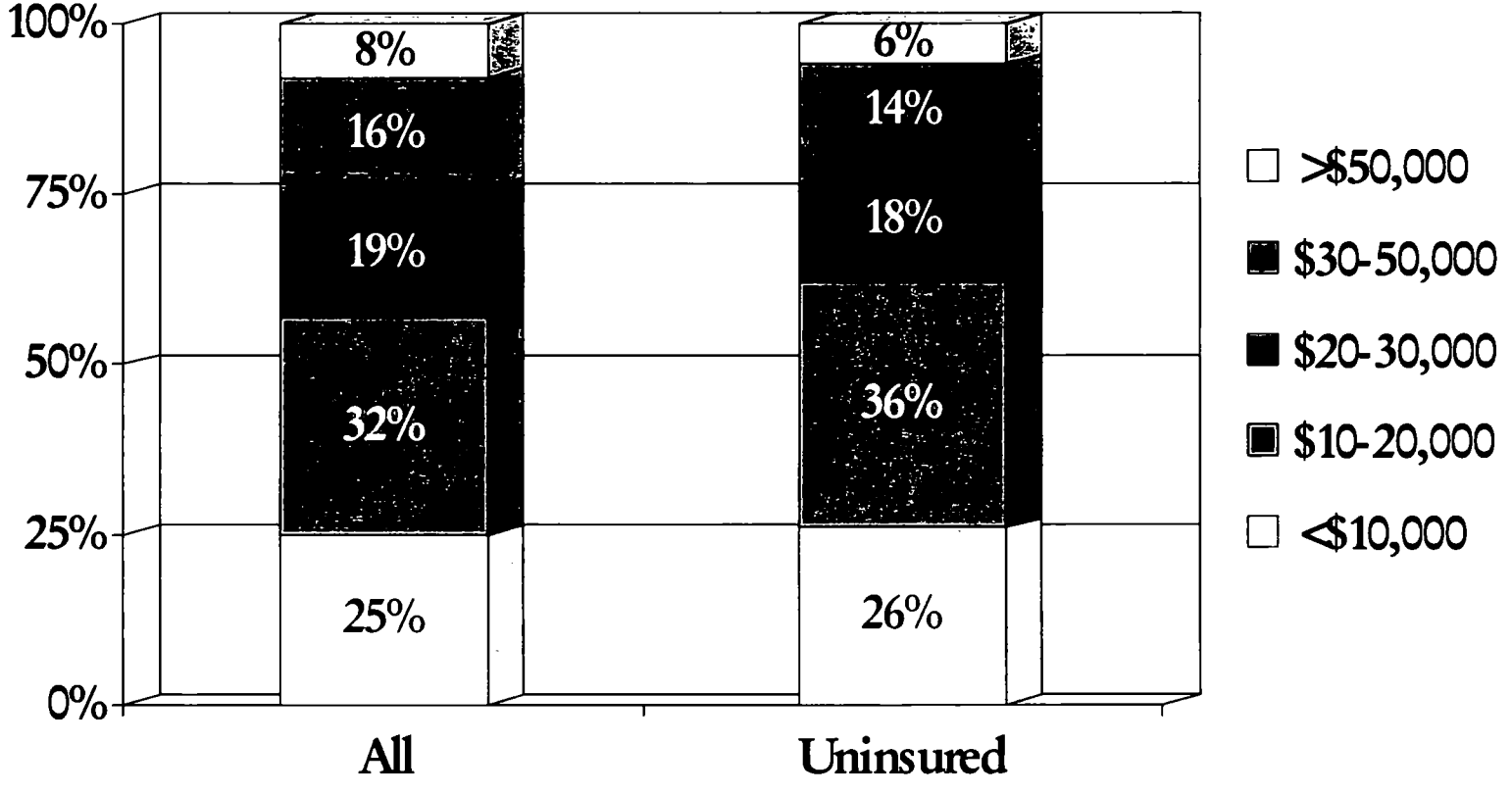
Income of Beneficiaries Without Drug Coverage (As A Percent Of Poverty)



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.

THE HENRY J. KAISER FAMILY FOUNDATION

THE MEDICARE PROGRAM

THE KAISER MEDICARE POLICY PROJECT

Women and Medicare

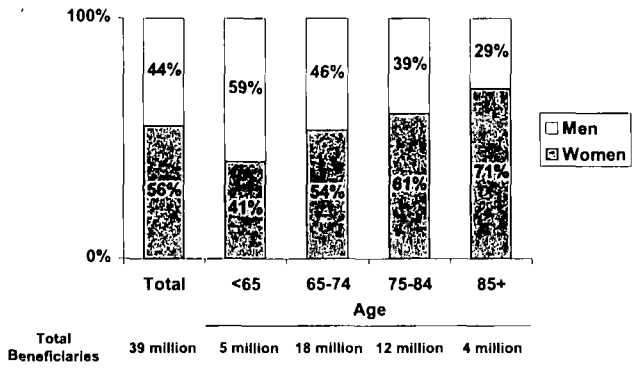
May 1999

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

Figure 1

Over half of all Medicare beneficiaries are women

Seven of 10 beneficiaries 85+ are women



SOURCE: Medicare Current Beneficiary Survey, 1996

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

Health and Long-Term Care Needs

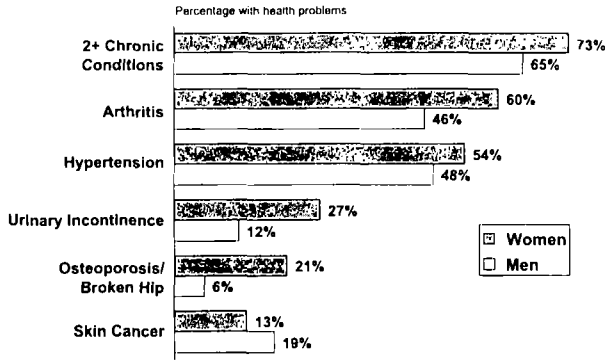
Given their longer life spans, women are likelier than men to live with multiple chronic conditions and certain health problems (Figure 2). A greater share report having often disabling conditions like arthritis, hypertension, urinary incontinence, and osteoporosis.

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

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

Figure 2

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



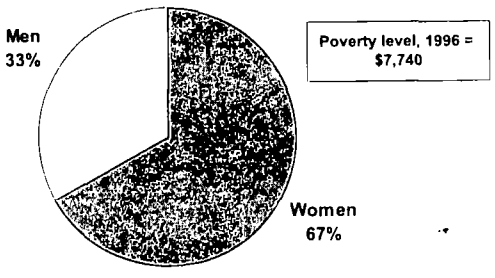
Note: Minimal differences (<4%) between genders were reported for heart disease, diabetes, pulmonary disease, strokes, and mental disorders.
SOURCE: Medicare Current Beneficiary Survey, 1996.

Poverty

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

Figure 3

Seven of 10 Medicare beneficiaries with incomes below poverty are women



Total = 5 million poor beneficiaries

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

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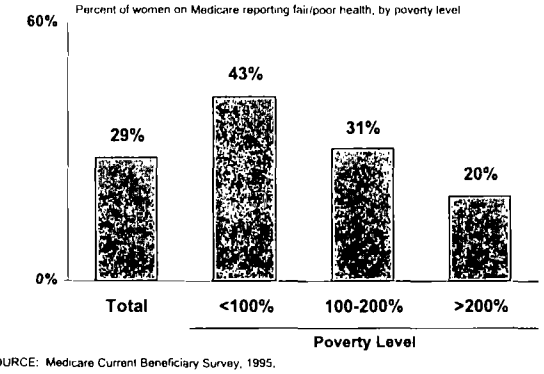
Compounding the financial difficulties of living in poverty, women with low incomes are, on average, in worse health than those who are better off. Of all poor female Medicare beneficiaries, 43 percent report being in fair or poor health, compared to 20 percent of women with incomes above 200 percent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

Figure 4

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



SOURCE: Medicare Current Beneficiary Survey, 1995.

Insurance Coverage

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

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

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

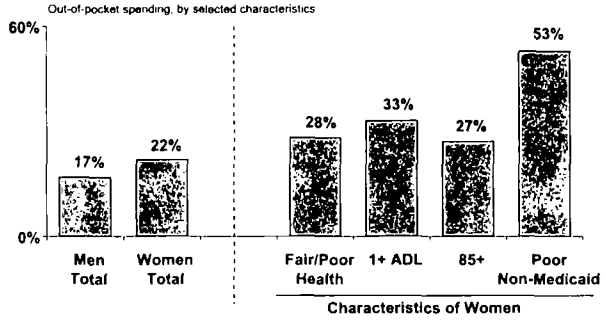
Out-of-Pocket Spending

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

Figure 5

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

The most vulnerable pay significantly more



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

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

Issues for Women

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

OWL PRESS RELEASE

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FOR IMMEDIATE RELEASE
June 29, 1999

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

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

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

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

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

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

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

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

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

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

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

1. Strengthening the Trust Fund.

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

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

2. Modernizing Medicare.

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

New prescription coverage.

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

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

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

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

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

New coverage for preventive screening.

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

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

3. Cost-Sharing Provisions.

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

Competitive defined benefit for managed care.

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

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

Early buy-in.

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

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

*****

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

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

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

OWL
THE VOICE OF MIDLIFE AND OLDER WOMEN

MEMORANDUM

July 19, 1999

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

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

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

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

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

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

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The Face of Medicare is a Woman You Know

OWL 1999 Mother's Day Report

A Message from Betty Lee Ongley

President, OWL

Happy Mother's Day!

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

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

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

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

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

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

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

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

Highlights

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

- President Lyndon Johnson, 1965

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

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

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

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

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

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

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

Introduction

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

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

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

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

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

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

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

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

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

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

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

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

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

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

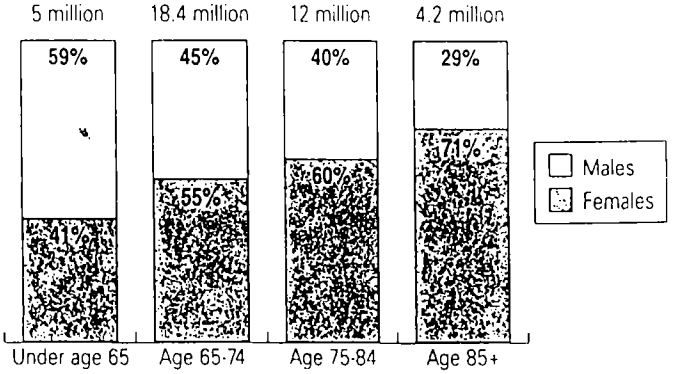
Women, Health, and Income

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

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

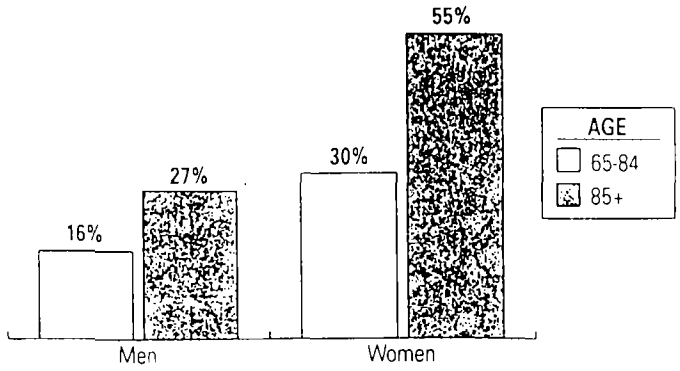
Most women marry older men. Because men do not live as long as women, older women are three times more likely to be widowed than men and four out of five women age 85 or older are widowed (Rice and Michel 1998). The older the woman, the more likely she is to be living alone. More than one in three (35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

Figure 1
Age and Gender of Elderly Medicare Population, 1996



Source: Kaiser Family Foundation 1999

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



Source: Medicare Current Beneficiary Survey, 1996

Chronic Illness and Long-term Care

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

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

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

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

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

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

Women, Poverty, and Access to Health Care

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

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

The Medicare Program

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

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

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

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

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

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

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

Gaps in Medicare

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

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

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

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

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

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

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

Out-of-pocket Spending

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

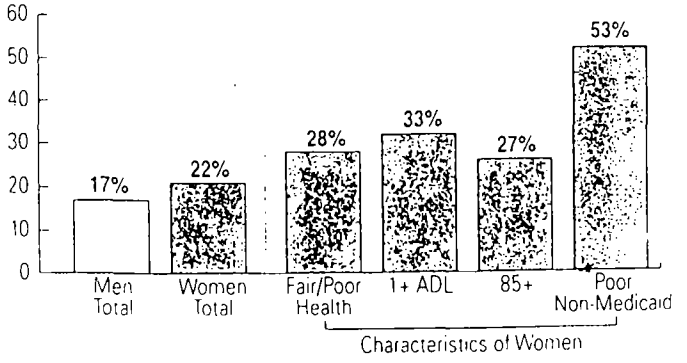
However, Medicare-related costs for individuals have risen quite dramatically over the last three decades. In fact, older Americans today are spending a higher proportion of their incomes for health care than they were prior to the enactment of the Medicare program—and today they spend three times the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

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

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

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

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



Source: Gibson & Brangan 1998

Supplemental Health Coverage

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

Medigap

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

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

Retiree Health Coverage

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

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

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

Medicaid

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

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

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

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

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

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

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

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

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

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

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

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

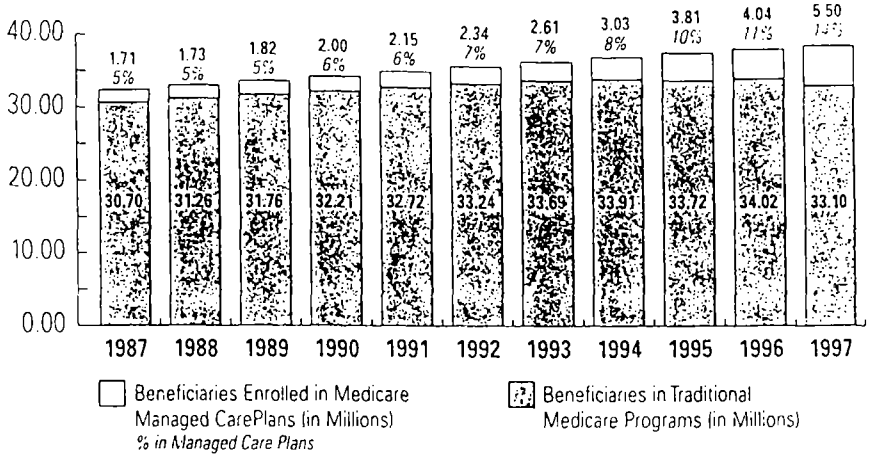
Medicaid is today the largest payer of long-term care services, comprising nearly one-half of all national health payments for nursing home care. Medicaid primarily pays for nursing home services and, to a limited extent, for home—community-based—care services. As discussed above, however, Medicaid only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

families cannot afford to bear these costs.

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

Medicare and Managed Care

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



Source: 1987-94 and 1996 data from Health Care Financing Administration, Profiles of Medicare 30th Anniversary (May 1966), 95 1995 data from Health Care Financing Administration, Office of Prepaid Health Care Operations and Oversight, 1997 data from Health Care Financing Administration "Managed Care in Medicaid and Medicare Fact Sheet" (represents enrollment as of August 1997)

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

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

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

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

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

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

Implications for Women

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

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

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

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

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

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

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

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

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

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

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

Medicare+Choice

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

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

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

Medicare+Choice Options

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

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

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

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

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

Source: The Henry J Kaiser Family Foundation 1999

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

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

Making Wise Decisions About a Medicare Plan

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

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

Medicare Reform Proposals

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

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

National Bipartisan Commission on the Future of Medicare

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

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

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

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

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

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

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

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

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

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

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

Federal Initiatives

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

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

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

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

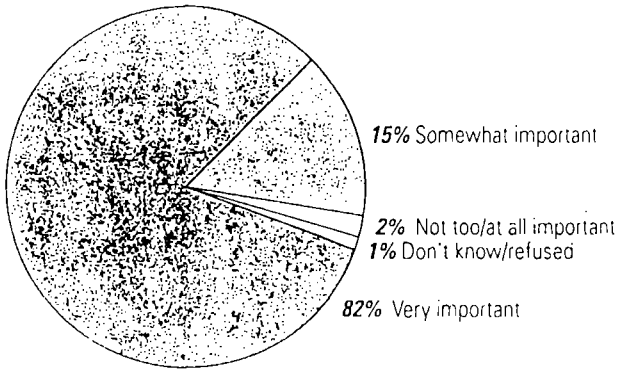
Recommendations and Conclusions

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

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

Figure 6

Most Women Say it's Very Important to Preserve Medicare



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

Improve Medicare benefit package

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

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

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

Improve financial protections

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

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

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

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

Improve protections for individuals in managed care

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

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

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

Expand access to Medicare coverage

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

Address fiscal problems to preserve Medicare

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

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

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

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

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

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

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

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

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

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

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

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fyi Medicare NR - invitees for tomorrow's event. Thanks KO

Women and Medicare Briefing
July 26, 1999
Invite List

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Dr. Lorraine Cole	National Medical Association—Exec. Dir.	202-347-1895	LM 7/23 LM 7/26
Angela Vincent	National Medical Association—Senior Health Policy Analyst	202-347-1895	Attending
Millicent Gorham	National Black Nurses Association—Executive Director	301-589-3200	Attending
Ruth Perot	Summit Health Institute for Research and Education, Inc.—Executive Director	301-567-2410	LM 7/23 LM 7/26
Dr. Celia Judith Maxwell	Howard University, Director Women's Health Institute	202-865-4810	Attending
Dr. Bil Spriggs	National Urban League Washington Bureau Director	202-898-1604	LM 7/23 Out of Town
Suzanne Marie Bergeon,	National Urban League Washington Bureau Senior Legislative Policy Analyst	202-898-1604	Attending
Sam Simmons	National Caucus and Center on Black Aged—President	202-637-8400	NO
Hilary Johnson Shelton	NAACP Washington Bureau Director	202-638-2269	Attending
Carolyn McCrea	NAACP Washington Bureau Legislative Director	202-638-2269	Attending

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Sullivan Robinson	The Congress of Nat'l Black Churches, Ex. Dir.	202-371-1091	Attending
Cassandra Arviette Sparrow	The Congress of National Black Churches Director, National Health Program	202-371-1091	Attending
Dr. Yvonne Scruggs Leftwich	Black Leadership Forum, Executive Director	202-789-3506	Attending
Dr. Jane E. Smith	NCNW—President and CEO	202-737-0120	Attending
Dr. Karin Lynette Stanford	National Rainbow/PUSH Coalition	202-333-5270	Attending
Sharon Levine	National Women's Law Center	202-588-5180	Attending
Mimi Major	Heidepriem & Major	202-822-8060	Attending
Sandi Smith	Wider Opportunities for Women	202-638-3143	Attending
Joanne Hustead	National Partnership for Women and Familes	202-986-2600	Attending
Nancy Zirkin	AAUW	202-785-7793	Attending

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Gabrielle Smith	General Federation of Women's Clubs	202-347-3168	Attending
Maxine Scarbro	General Federation of Women's Clubs	202-347-3168	Attending
Patricia Hendel	National Association of Commissions for Women	860-442-1054	NO
Tova Litwak	Hadassah	202-363-4600	LM 7/23 LM 7/26
Sarita Bhalotra	Brandeis University National Center on Women and Aging	781-736-3866	NO
Phyllis Mutschler	Brandeis University National Center on Women and Aging	781-736-3866	NO
Shannon Stewart	Bass and Howes	202-530-2900	Attending
Christine Brunswick	National Breast Cancer Coalition, Vice President	202-973-0583	NO (someone else from NBCC will attend-Marlene McCarthy)
Fran Visco	National Breast Cancer Coalition, Vice President	202-973-0583	NO
Marcy J. Nielson-McPherson	AFL-CIO, Legislative Affairs	202-637-5233	Attending

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Marilyn Park	AFL-CIO, Health Care Policy	202-637-5233	LM 7/23 LM 7/26
Eleanor Smeal	Feminist Majority	703-522-2214	LM 7/23 Someone from Fem. Majority will call back to attend….. (7/26)
Jennifer Jackman	Feminist Majority	703-522-2214	LM 7/23 LM 7/26
Karen Nussbaum	AFL-CIO Working Women Dept.	637-5064	NO
Gail Shaffer	Business and Professional Women, USA	293-1100 ext. 111	Attending
Prema Mathai-Davis	YMCA of the USA	212-273-7800	LM 7/23 Talked to assistant 7/26
Jane Gruenebaum	League of Women Voters	429-1965	Attending
Sammie Moshenberg	National Council of Jewish Women	296-2588	Attending
Leena Frescas Dobbs	Wider Opportunities for Women	638-3143	NO
Cindy Pearson	National Women's Health Network, Program Director	347-1140	LM 7/23 LM 7/26

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Christine Hansen	Center for Policy Alternatives	387-6030 ext. 206	NO (no subs available)
Anne Mosle	Center for Policy Alternatives	387-6030 ext. 127	NO
Elisa Sanchez	MANA	833-0060	NO (LM for Miryam Granthom 7/26)
Cindy Hounsell		393-5452	NO (Patricia Humphlett instead)
Patricia Humphlett	Power Center Coordinator for WISR	393-5452	Attending (instead of Cindy Hounsell)
Gloria Johnson		785-7261	NO
Joan Entacher	National Women's Law Center	588-5180	Attending
Susan Liss	National Women's Law Center	588-5180	LM 7/23 LM 7/26
Martha Romans	Jacobs Institue for Women's Health Director	863-4990	LM 7/23 LM 7/26
Christine Cook	MALDEF	293-2828	Attending

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Kery Wilkie	National Puerto Rican Coalition	223-3915	Attending
Yolanda Rios	National Puerto Rican Coalition	223-3915	Attending
Hilda Crespo	Hispanic Working Group on Healthcare	835-3600 ext. 114	NO (Katherine Aguilar instead)
Elena Rios	Hispanic-Serving Health Professional Schools Hispanic Medical Association	265-4297	LM 7/23 LM 7/26
Kay Bengston	Evangelical Lutheran Church in America	783-7507 ext. 212	NO
Mary Cooper	National Council of Churches	544-2350	Attending
Ann K. Delorey	Church Women United	544-8747	Attending
Nancy Widso	US Catholic Conference, Domestic Policy Office	541-3187	NO (Patricia King instead)
Sharon Daly	Catholic Charities USA	703-549-1390 ext. 139	LM 7/23 LM 7/26
Heidi Hartmann	Institute for Women's Policy Research	202-785-5100	Out of Town (possible Sub)
Jennifer Tucker	Center for Women Policy Studies	202-872-1770	NO

NAME	ORGANIZATION	PHONE NUMBER	STATUS
Nancy Zirkin	AAUW	785-7793	Attending
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Nancy Duff Campbell		588-5180	NO
Jan Erickson	NOW	331-0066	Attending
Anna Rappaport		312-902-7518	NO