

Medicaid

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April 14, 1997

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The Honorable William J. Clinton  
The White House  
Washington, DC 20500

Dear Mr. President:

As budget discussions continue to move forward, we wanted to reiterate our concerns regarding the role of Medicaid in a deficit reduction package. No single decision made in the context of balancing the budget will be of greater importance to states than the treatment of the Medicaid program. For that reason, we believe that it is critical that the concerns we raise on behalf of the National Governors' Association be addressed successfully as negotiations continue. Our most vital concerns relate to the level of Medicaid savings targeted in a deficit reduction package, the per capita cap, and the disproportionate share hospital (DSH) program.

As set forth in NGA testimony before the Senate Finance Committee and the House Commerce Committee on March 11, the Governors strongly believe that the overall level of Medicaid savings included in any deficit reduction package should reflect the contribution the program already has made to deficit reduction. Despite limited flexibility in the program, Governors have been able to significantly restrain Medicaid spending in recent years. In recognition of this success, the Congressional Budget Office lowered its baseline projections of future growth in Medicaid spending by almost \$86 billion in February.

This \$86 billion makes a significant contribution to deficit reduction. Accordingly, any additional Medicaid savings included in a balanced budget package should be kept to a minimum. Governors believe that with the additional program flexibility we outlined in our testimony, another \$8 billion in Medicaid savings can be produced between now and 2002. Attached you will find a detailed description of our savings recommendations. Actual state experiences in implementation could well yield levels of savings beyond our conservative estimate.

In order to ensure that recipients retain access to high quality health care, Governors believe overall levels of additional Medicaid savings should be kept at \$8 billion. Furthermore, the method adopted for achieving Medicaid savings is of primary importance to Governors. We adamantly oppose a cap on federal Medicaid spending in any form. Unilateral caps in federal Medicaid spending will result in cost shifts to states, enabling the federal government to balance its budget at the expense of the states.

Under a cap, once the federal spending obligation is fulfilled, states would become solely responsible for meeting uncontrollable program cost increases, stemming from things such as new drug treatments, lawsuits, and disasters. In confronting this cost shift, states would be presented with several bad alternatives. States would have to choose between cutting back on payment rates to providers, eliminating optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

Rather than make the tough choices on budget priorities, the federal government is putting states in the position of having to make an impossible decision. No option would be painless. If states chose to address shortfalls by significantly cutting provider reimbursement rates, those who needed health care the most could find it difficult to access care. Medicaid options could not be easily eliminated, because they make up an important core of the program. More than two-thirds of Medicaid spending goes toward the elderly and people with disabilities. So-called optional eligibility categories include the frail elderly in nursing homes and pregnant women and children. The largest optional benefit in many states is coverage for critical prescription drug services. In the end, states could find that they have no choice but to raise taxes or cut other important spending priorities, such as education.

The federal government will spend almost \$7 billion on the Medicaid prescription drug benefit in 1998. Shifting costs to states through a per capita cap in order to achieve \$7 billion in savings essentially forces states to confront choices such as discontinuing a vitally important benefit that is currently provided to 24 million Americans.

The Medicaid proposals that have been set forth so far have included significant cuts in the DSH program in addition to the federal savings that would be realized through a per capita cap. Governors believe that \$8 billion in additional savings on top of the \$86 billion already produced is a reasonable savings target for Medicaid. Accordingly, we would oppose the high levels of DSH savings included in the budget proposals on the table. It is also important that DSH not be considered a potential source of savings isolated from the rest of Medicaid; DSH funds are an important part of statewide systems of health care access for the uninsured. All Medicaid savings proposals will be evaluated on the basis of their impact on the program as a whole.

Furthermore, DSH funds must continue to be distributed through states and not directly to providers. This will ensure that DSH dollars are used in ways that complement other federal and state sources of health care funding. Maintaining the state role in the distribution of DSH will ensure effective coordination with the state's overall health infrastructure.

Governors place the highest priority on the successful resolution of the concerns we have raised. We would welcome the opportunity to work with you as Medicaid issues are addressed in the context of developing a balanced budget package, and we would be happy to provide you with any additional information you may require. Because states administer the program and provide on average 43 percent of its funding, Governors must be involved in any budget negotiations related to the future of Medicaid.

Sincerely,

Bob Miller

George V. Voinovich

Laura Chiles

Michael O. Lewitt

Tommy J. Thompson

John Miller

John Eyles

Edward T. Schaper

Jim Edgar

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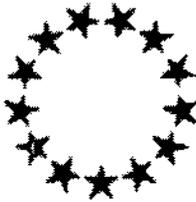
Long Charles

E. Benjamin

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Max Ruzick



**Cost Saving Strategies as Alternatives  
to Any Medicaid Cap  
March 1997**

**Background.** In the late 1980s and early 1990s, Medicaid spending was increasing at average annual rates in excess of 20 percent. These growth rates were unsustainable. Medicaid costs were making it difficult to support other important state priorities. To address financial pressures and to develop a more quality-oriented system, Governors began to transform state Medicaid systems from their historical role as claims processors and bill payers to more sophisticated value purchasers of quality health care services.

This transformation is producing results. Governors have been able to significantly restrain spending despite limited flexibility in the program. Medicaid spending has grown at an average rate of less than 4 percent over the last two years. In February 1997, the Congressional Budget Office lowered its baseline projections of future growth in Medicaid spending by almost \$86 billion, reflecting the successes states have achieved in controlling costs. This \$86 billion makes a significant contribution toward efforts to balance the federal budget, and follows a similar CBO revision in December 1995 that yielded \$31 billion in Medicaid savings.

Last year, Congress initially considered Medicaid reform proposals producing \$185 billion in Medicaid savings over seven years. By the end of the debate, Congress supported a package including Medicaid savings of \$85 billion. Throughout last year's reform discussions, the President supported a reform package that would have achieved \$54 billion in Medicaid savings.

With the savings already produced and recognized by CBO, Medicaid's contribution of \$86 billion toward deficit reduction this year is well within the parameters of last year's debate. In fact, when you combine the two baseline recalculations made by CBO within the last 18 months, Medicaid savings have already contributed \$117 billion in deficit reduction, exceeding the targets of both Congress and the Administration at the end of last year's Medicaid debate.

**Recommended Funding Level.** Given this contribution, Governors believe that additional Medicaid savings included in any deficit reduction package developed by Congress and the Administration should be kept to a minimum. With state program transformations reflected in the new CBO baseline, there is less room in the program from which to squeeze additional savings without having a detrimental effect on the number of people served by the program or the range of benefits they receive.

However, Governors do believe that limited Medicaid savings on top of the \$86 billion already achieved are possible. The same pursuit of administrative simplification, innovation and good management that produced the extraordinary low Medicaid growth rates of recent years will continue to restrain unnecessary program spending.

We believe that with the additional flexibility outlined below, states can produce \$8 billion in scorable Medicaid savings between now and 2002. As has been the case in the past, although the scorable savings may be in the range of \$8 billion, our ability to actually achieve savings could exceed CBO's expectations with this enhanced flexibility. Governors would not support a savings target and policy changes based purely on the budgetary process. Instead, the flexibility provided through programmatic reforms should determine the level of savings targeted.

**Recommended Savings Strategy.** Governors adamantly oppose a cap on federal Medicaid spending in any form. It seems to us particularly unnecessary to experiment with a fundamental transformation of a program on which the federal government will spend half a trillion dollars over the next five years in order to achieve the \$8 billion in additional savings Governors consider reasonable.

Unilateral caps in federal Medicaid spending will result in cost shifts to states. The federal budget must not be balanced at the expense of states. Under a cap, once the federal spending obligation is fulfilled, states would have to choose between cutting back on payment rates, optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

Governors believe that there are better ways to achieve Medicaid savings in the range of an additional \$8 billion by 2002. The Medicaid Task Force of the National Governors' Association has developed an alternative strategy to realize these savings. Governors would welcome the opportunity to work with Congress and the Administration to explore a number of options which when combined would produce significant budgetary savings.

The following reform possibilities provide Congress and the Administration with concrete alternatives to program caps. Federal legislative or administrative action would be necessary for the changes set forth below to be implemented. The specific barriers that currently prohibit state implementation are identified in boldface following each description.

#### Managed care reforms

1. **Managed care.** Repeal of the waiver requirement for mandatory managed care will facilitate further development of the Medicaid managed care market. As the Medicaid markets mature, competition between managed care entities will enable states to negotiate even more favorable rates. -- 1902(a)(23)

Savings attributable to managed care should be calculated using three separate assumptions. First, that managed care enrollment is mandatory. Second, that mandatory enrollment would be triggered if voluntary enrollment does not reach a targeted level. Third, that managed care enrollment is voluntary.

States have already achieved significant savings through Medicaid managed care. For example, Michigan will save \$120 million in Medicaid costs through managed care in 1998, about 2.5% of the state's total program budget. Missouri's managed care program will have saved \$50 million through 1997 compared to fee for service costs

Managed care does not simply produce a one time savings bonus for states. Between 1990 and 1996, Wisconsin has saved more than \$100 million as a result of managed care. Through competitive bidding, Florida's newest round of managed care contracts include capitation rates between 87 and 92 percent of fee for service rates. Previous contracts included rates at 95% of fee for service.

With the development of models to accommodate special population needs, Medicaid managed care will increasingly penetrate the more complicated and costly segments of the caseload - the elderly and disabled.

2. *Managed care for the dually eligible.* The dually eligible population, which currently numbers 6 million, would be enrolled in managed care, creating a more streamlined, cost-effective system of health care delivery for those elderly and disabled individuals who receive a complete, but uncoordinated, package of benefits from both Medicaid and Medicare. Managed care will produce savings for both programs, while creating a more user-friendly health care experience for recipients. -- 1902 (a)(23) and 1802

As above, savings attributable to enrolling the dually eligible in managed care should be calculated using three separate assumptions. First, that managed care enrollment is mandatory. Second, that mandatory enrollment would be triggered if voluntary enrollment does not reach a targeted level. Third, that managed care enrollment is voluntary.

Utah has conducted a voluntary managed care program for the dually eligible, operating within existing federal limitations, and has seen a reduction in costs for services of approximately 10 percent for the population enrolled in managed care. Minnesota's managed care program for the dually eligible has produced a 5 percent reduction compared to fee for service costs.

3. *Provider selectivity.* To clarify that there is no de facto entitlement for providers to participate in the Medicaid program in the fee for service environment, HCFA should support states in their efforts to contract with a limited number of facilities so they can negotiate better rates. For example, Medicaid recipients could be directed to two out of four hospitals in a city for services, or to a particular source to have prescriptions filled. Texas and Washington each have achieved 2 percent savings in their hospital reimbursement rates through selective contracting. -- 1902(u)(23)

#### Reimbursement reforms

4. *Reimbursement rates for QMBs and the dually eligible.* Recent judicial interpretations have begun to force states to reimburse providers at Medicare rates for services provided to these populations. Medicaid rates, which are on average significantly lower than Medicare rates, should be sufficient to discharge state obligations until the federal government assumes full responsibility for the cost-sharing obligations associated with QMBs and until a more integrated system is developed to serve the dually eligible. Michigan estimates that permitting the state to limit reimbursement rates to Medicaid levels for these populations would save \$85 million per year in Michigan alone. Florida had to include \$87 million in its 1997-1998 budget following a suit requiring the state to use Medicare rather than Medicaid reimbursement rates. Alabama has seen its costs increase approximately \$50 million per year following its loss in the defining case on this issue, *Haynes Ambulance Service, Inc., et al. v. State of Alabama, et al.* -- For definition of Medicare cost sharing, see 1905(p)(3)

5. *Boren repeal.* States and HCFA agree that reimbursement rates for institutional care will be significantly moderated when the Boren amendment is repealed. The American Public Welfare Association has developed a model projecting federal savings through Boren repeal ranging from a conservative estimate of \$6 billion to as much as \$8 billion over four years in nursing facility costs and additional savings ranging between \$4 billion and \$10 billion in hospital costs. -- 1902(a)(13)(A)

6. *Cost based reimbursement.* Policies that require states to reimburse providers such as federally qualified health clinics at rates that do not reflect states' positions as dominant purchasers in the health care market place should be repealed. Wisconsin will save \$5 million annually through the repeal of FQHC provider protections.

Similarly, Boren-like language that has exposed states to lawsuits driving up rates for services including outpatient and home health care should be repealed. California's recent loss of a case on outpatient care rates will cost the state hundreds of millions per year. Ohio currently faces a cost-based reimbursement lawsuit for home health services that could cost the state between \$100 and \$130 million, essentially doubling home health reimbursement rates. -- 1902(a)(30)(A) and 1902 (a)(13)(E)

#### Other reforms

7. *Cost sharing.* Significant Medicaid savings could be realized through a number of cost sharing models. For example, if every Medicaid recipient were responsible for a sliding scale premium that averages \$5 monthly, over \$2 billion in Medicaid savings would be generated annually, contributing significantly to efforts to avoid any cap in spending. An even more fundamental reexamination of family cost-sharing obligations for children with disabilities living at home or institutions would yield additional savings. Oregon has implemented a sliding scale premium for new enrollees in the Oregon Health Plan, with premiums ranging from \$6 to \$28 per month. Between December 1995 and January 1997, Oregon has collected over \$7 million in premiums from its expanded eligibility group of approximately 75,000 households. -- 1916

8. *EPSDT.* Governors, Congress and the Administration should work together to assess the difference in cost between EPSDT and an actuarially based package of benefits comparable to those offered by Medicaid's package of mandatory and optional benefits. -- 1905(r), especially 1905(r)(5)

9. *Fraud and abuse.* Aggressive new state-based strategies to prevent Medicaid fraud should be expanded nationwide as needed. For example, a Florida fraud reduction initiative that includes a provision requiring durable medical equipment suppliers to purchase surety bonds has produced savings between one and two percent of the state's total Medicaid budget. Florida's non-partisan budget scoring entity predicts additional savings due to fraud reduction of \$81 million in 1998 and \$111 million in 1999. There is an administrative concern regarding whether states have adequate authority to proceed without additional clarification from HCFA.

THE WHITE HOUSE

WASHINGTON

May 22, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

cc: Bruce Reed, Gene Sperling

This memo is in response to your conversation with Gene on Saturday and our conversation Sunday regarding Judy Havemann's story in *The Washington Post* on Medicare premiums. As we discussed, Havemann's story suggested that the original Medicare premium estimates were too low and that the actual increase will be twice as high previously projected (about a dollar a month).

Our response (below) has been very well received both with the aging advocacy community and with our base Democrats. Perhaps because of our success in obtaining a positive response from the aging advocacy community, Minority Leader chose not to mention the increases in Medicare premiums in his initial critique of the balanced budget agreement.

Understanding that we should not take anything for granted, Gene has suggested we get the aging advocates (AARP, etc.) to go on record by asking for written statements of support for Medicare provisions. To entice these groups to do this, we are considering designing a White House event or meeting, perhaps with the Vice President, as early as next week. It is our intention to ensure that these groups formally support the Medicare premiums, savings, and structural reforms, that we are assuming in the current budget agreement. We anticipate that they may be willing to go on record on the provisions they support to give themselves the opportunity to highlight additional provisions that they will not accept but fear that Republicans may try and include in the final agreement.

The following is our response to the criticisms raised in Judy Havemann's story on Saturday:

**While original preliminary CBO projections may have been slightly off, we still estimate that the Part B premium will be only about \$1 more in 1998 than under current law. In subsequent years within the 5-year Budget Agreement, the annual increase should be no more than about \$2 more per month. As a result, by 2002, we project the premium being approximately \$8 more than it otherwise would have been without the home health reallocation.**

Regardless of the final projection, the Part B premium will be almost \$20 per month less than it would have been if it was set at the same 31.5 percent level that the President vetoed. The monthly premium under the 1997 Budget Agreement will be about \$69 in 2002. If the policy were a 31.5 percent premium instead of 25 percent, the premium would be about \$87. In 2002 alone, this would equate to about \$215 a year more for a single beneficiary, \$430 for a couple.

**Low-income beneficiary protections are expanded.** Unlike the 1995 Budget Agreement that the President vetoed, which eroded current-law low-income protections, the 1997 Balanced Budget Agreement invests \$1.5 billion to expand premium assistance to low-income beneficiaries. We believe this commitment will help many of the estimated 2.5 million Medicare beneficiaries who have incomes between 125 and 150 percent of poverty-- just above the current eligibility level for Medicare premium protection.

**Savings from the new premium are offset by investments in beneficiary improvements.** The \$9 billion in savings that comes from gradually including home health in the 25 percent premium is virtually identical to the amount of money dedicated to the investment in new benefits. Specifically, the 1997 Balanced Budget Agreement invests \$3-4 billion in new preventive benefits (which will, for example, detect breast and colon cancer, and cover the management of diabetes), \$4 billion to limit excessive hospital outpatient coinsurance to beneficiaries, and \$1.5 billion in premium protections for low-income Medicare beneficiaries. (This contrasts with the vetoed 1995 balanced budget agreement, which reinvested virtually none of its much greater beneficiary savings for benefit enhancements.)

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

February 10, 1997

TO: Interested Parties

FROM: Chris Jennings  
Nancy-Ann Min

SUBJECT: Validation for Home Health Transfer

Attached please find an op-ed piece from today's *Washington Post* that validates our policy to shift most home health expenditures from Part A of Medicare to Part B. The author, Marilyn Moon, is not only a fellow at the Urban Institute, but is also a Trustee of the Medicare trust fund. Following are some excerpts from the article:

- ◇ "Shifting home health from Part A of Medicare to Part B does not reduce overall spending. It is nonetheless needed to help delay the exhaustion of Medicare's Part A trust fund, buying enough time to consider what long-term changes make sense for the Medicare program. No combination of reasonable options for slowing the growth in spending on the program will achieve the full amount of short-run savings needed to extend the life of the Part A trust fund for more than a year or two. The home-health shift--or some equivalent policy change--is necessary to supplement other changes."
- ◇ "Indeed, if the only allowable solutions to the trust-fund problem that Medicare faces are cuts in spending, then we are in danger of having the cure of 'saving' the trust fund kill the patient."
- ◇ "Rather, shifting the home-health benefit--in conjunction with other changes designed to achieve a reasonable level of savings--can buy time for an orderly consideration of longer-range solutions to Medicare's problems."

Marilyn Moon

# No Medicare 'Gimmick'

In anticipating likely proposals for the Medicare program from the Clinton administration, it has become fashionable for budget experts, lawmakers and *The Post* to refer to the idea of shifting Medicare's home-health-care benefit from one part of the program to another as merely a "gimmick" because it does not help to balance the federal budget [editorial, Jan. 12]. But that misses the point.

Shifting home health from Part A of Medicare to Part B does not reduce overall spending. It is nonetheless needed to help delay the exhaustion of Medicare's Part A trust fund, buying enough

## Taking Exception

time to consider what long-term changes make sense for the Medicare program. No combination of reasonable options for slowing the growth in spending on the program will achieve the full amount of short-run savings needed to extend the life of the Part A trust fund for more than a year or two. The home-health shift—or some equivalent policy change—is necessary to supplement other changes.

Medicare's Part A trust fund pays for hospital and related care for persons age 65 and over and those with disabilities. It is financed mainly by payroll taxes. In 1996 spending on Part A grew faster than the revenues coming into the trust fund. Like a family that spends more than it earns, Medicare is dipping into its savings in order to keep paying the hospital and other bills of its beneficiaries.

If left unchecked, the trust fund for Medicare will be exhausted by 2001. And by the end of 2003, the gap is projected to be more than \$200 billion.

Efforts to address this gap need to begin immediately, but aggressive attempts to solve the problem *only* through cutting payments to hospitals and other providers of care or reducing benefits would do real harm to the Medicare program. These changes would have to go well beyond slowing the rate of growth of spending. To close the gap in fiscal year 1998, Medicare Part A spending would have to fall by about 13 percent from its projected 1998 level—a feat that none of the usual set of cost savings proposals could achieve.

In addition, a major restructuring of Medicare may not be the answer if it merely shifts the problem onto beneficiaries. Changes are underway in the overall delivery of health services and private insurance arrangements for younger families, much to the discomfort of many. Even healthy people are having difficulty in adjusting to

the world of managed care, and the rules seem to be changing constantly. More time is needed to assess the changing marketplace before locking in changes for Medicare. Further, if incremental reforms begin to slow Medicare growth to more reasonable levels, less restructuring might be needed over time.

What, then, does make sense? First, efforts should begin immediately to make sensible changes in the Medicare program under both Parts A and B. Examples of changes in the traditional program—proposed by both Republicans and Democrats—include moving the system used to pay home-health benefits away from paying for reported costs to establishing fixed prices, and reducing the level of payments for hospital care to levels in line with the discounts being negotiated by private insurers. Improving the managed-care option by reforming how Medicare establishes premiums while encouraging further enrollment also makes sense. These reforms will help extend the life of the trust fund and balance the federal budget. But these changes take time to become fully effective.

Thus, it is also necessary to look for other adjustments *in addition to* cost-savings options to close the gap between spending and revenues and to extend the life of the Part A trust fund. Shifting home-health from Part A to Part B would have an immediate impact on narrowing the gap.

In addition, since Part A largely covers institutional care, home-health fits in more appropriately with physician and other services provided in the community that are associated with Part B. Originally, home-health services were offered under both parts of the Medicare program, so moving some or all of this service to Part B would not be unprecedented.

Why has such a seemingly minor issue become a sticking point about proposals to change Medicare? It is because such a proposal betrays the claim that "saving" Medicare can be done *only* by cutting spending on the program. Opponents to the shift point out that it does not help balance the federal budget. But that is not why it is being proposed. Indeed, if the only allowable solutions to the trust-fund problem that Medicare faces are cuts in spending, then we are in danger of having the cure of "saving" the trust fund kill the patient. But it is equally important not to oversell the issue; the shift does not contribute to overall savings for Medicare. Rather, shifting the home-health benefit—in conjunction with other changes designed to achieve a reasonable level of savings—can buy time for an orderly consideration of longer-range solutions to Medicare's problems.

*The writer is a senior fellow at the Urban Institute.*

# The Washington Post

MONDAY, FEBRUARY 10, 1997

Medicare

## MEDICARE TRUST FUND SOLVENCY PROBLEM

**Unlike the Republicans, This Is Not a Problem Democrats Just Discovered.** The President, his Administration and the Democrats have been concerned about Medicare trust fund from the beginning. OBRA 1993 and economic improvements resulting from this legislation have strengthened the trust fund and pushed out the insolvency date by three years. Furthermore, in the context of broader reforms, the Administration's proposal would have extended the life of the trust fund another 5 years. **The Republicans rejected each and every initiative that would have strengthened the Medicare Trust Fund.**

**The Medicare Trust Fund is a Long-Term Problem that Needs to be Addressed.** Of course with the aging of our population, there is a long-term solvency problem for the Medicare trust fund. This is nothing new, but it needs to be addressed. It needs to be addressed thoughtfully, outside the budgetary process, and independent of partisan politics.

**In Contrast to the Democrats, the Republicans Have Just Discovered this Issue.** In the last two years, all the Republicans have done has been to oppose our efforts to improve the Trust Fund. As a matter of fact, the only proposal they have put forth (their tax cut for the highest income seniors -- the top 13 percent) actually exacerbates the problem.

**The Republicans are Using the Trust Fund as a Smoke Screen for Cuts.** Let's be clear: Their proposals have nothing to do with the long-term solvency issue; they do not address the underlying problems of an aging population. The Republicans want to use the Medicare program as a bank for their tax cuts for the wealthy and to fulfill their campaign promises.

**When they Finally Put Forth a Detailed Budget and Commit to Dealing with Medicare in the Context of Serious Health Care Reform, the President Stands Ready to Work Toward a Real Solution:** Currently, the issue of Medicare is only being addressed by Republicans as they face a political crisis to find funds to pay for large tax cuts for the well-off and fulfill their campaign budget promises. When Republicans finally put forth a budget that is detailed and makes clear they are not slashing Medicare to pay for tax cuts, the President stands ready to work with Republicans to address the real problems facing the Trust Fund and the American people in the health care system.

## REPUBLICAN MEDICARE CUTS

Republicans are considering proposals that would cut Medicare funding by between \$250 billion and \$305 billion between now and 2002. Slashing Medicare at this level translates into 20% to 25% cuts in 2002 alone for this program serving our most vulnerable Americans — the elderly and disabled.

**COERCION INSTEAD OF CHOICE:** Managed care simply cannot produce anywhere near the magnitude of Federal savings being suggested by the Republicans without turning Medicare into a fixed voucher program. That would put Medicare's 36 million beneficiaries, many of whom have pre-existing conditions, into the private insurance market to shop for what they can get. With a fixed and limited voucher, beneficiaries would have to pay far more to stay in the current Medicare program if large savings are to be realized. That's not choice, that is financial coercion.

**ADDING TO ALREADY HIGH COSTS FOR SENIORS:** Today, despite their Medicare benefits, health care consumes major amounts of older Americans' income. According to the Urban Institute, the typical Medicare beneficiaries already dedicate a staggering 21% (or \$2,500) of their incomes to pay for out-of-pocket health care expenditures.

**\$3,100-\$3,700 Out-of-Pocket Payments:** If the Republican cuts (\$250 billion to \$305 over seven years) are evenly distributed between health care providers and beneficiaries, the cuts would add an additional \$815 to \$980 in out-of-pocket burdens to Medicare beneficiaries in 2002. Over the seven year period, the typical beneficiary would pay between \$3,100 to \$3,700 more.

**Reduce Half of Social Security COLA:** The Republicans say they aren't cutting Social Security, but these Medicare cuts are a back-door way of doing just that. By 2002, the typical Medicare beneficiary would see 40 to 50 percent of his or her cost-of-living adjustment eaten up by the increases in Medicare cost sharing and premiums. In fact, about 2 million Medicare beneficiaries will have all or more than all of their COLAs consumed by the Republican beneficiary cost increases.

**\$40-\$50 Billion in Cost-Shifting:** Assuming the other half of the Republicans' cuts go to providers, hospitals, physicians and other providers would be targeted with between a \$125 billion to \$150 billion cut over seven years. In 2002 alone, a \$33 billion cut in providers would be needed. Even if only one-third of Medicare provider cuts overall are shifted onto other payers (an assumption consistent with a 1993 CBO analysis), businesses and families would be forced to pay a hidden tax of \$40 billion to \$50 billion in increased premiums and health care costs between now and 2002.

**Rural and Inner City Hospitals At Risk:** Cuts of this magnitude, combined with the growing uncompensated care burden (which would be further exacerbated by Medicaid cuts and increases in the number of uninsured), would place rural and inner-city providers in jeopardy because they have limited or no ability to shift costs to other payers. As a result, quality and access to needed health care would be threatened.

## THE REALITY OF MEDICARE GROWTH

- Despite the current rhetoric, Medicare expenditure growth is comparable to the growth in private health insurance.
  - Under Administration estimates, Medicare spending per person is projected to grow over the next five years at about the same rate as private health insurance spending. Under CBO estimates, Medicare spending per person is projected to grow only about one percentage point faster than private health insurance.
  - So, unless Medicare can control costs substantially better than the private sector, beneficiaries and providers would be forced to shoulder the burden of the huge cuts being proposed by Republicans.

## MAJOR BURDEN ON RURAL AMERICA

- Reducing Medicare payments would disproportionately harm rural hospitals.
  - Nearly 10 million Medicare beneficiaries (25% of the total) live in rural America where there is often only a single hospital in their county. These rural hospitals tend to be small and serve large numbers of Medicare patients.
  - Significant cuts in Medicare revenues has great potential to cause a good number of these hospitals, which already are in financial distress, to close or to turn to local taxpayers to increase what are already substantial local subsidies.
  - Rural residents are more likely than urban residents to be uninsured, so offsetting the effects of Medicare cuts by shifting costs to private payers is more difficult for small rural hospitals.
  - Rural hospitals are often the largest employer in their communities; closing these hospitals will result in job loss and physicians leaving these communities.

## UNDERMINES URBAN SAFETY NET

- Large reductions in Medicare payments would have a devastating impact on a significant number of urban safety-net hospitals. These hospitals already are bearing a disproportionate share of the nation's growing burden of uncompensated care. **On average, Medicare accounted for a bigger share of net operating revenues for these hospitals than did private insurance payers.**

## REPUBLICAN MEDICAID CUTS

Republicans are considering cutting federal Medicaid funding by \$160 to more than \$190 billion between 1996 and 2002. The Republicans claim that they are not cutting the program, but simply reducing the rate of growth. Yet, these technical number disputes avoid the real question: who will be hurt, who will lose coverage and who will lose benefits if \$160 to \$190 billion are cut from a program that provides critical health care services. It also ignores the fact that 3 to 4 percent of program growth is for the increasing number of people being covered, without which millions more Americans would be uninsured.

- **HEAVY BURDEN TO FAMILIES FACING LONGTERM CARE:** While most people think that Medicaid helps only low-income mothers and children, about two-thirds of Medicaid funds are spent on services for elderly and disabled Americans. Without Medicaid, working families with a parent or spouse who need long-term care would face nursing home bills that average \$38,000 a year.
- **MANAGED CARE SAVINGS NOT NEARLY SUFFICIENT:** Savings from managed care cannot produce anywhere near the magnitude of cuts proposed by the Republicans. Two-thirds of Medicaid funds are spent on the elderly and disabled, and there is little to no evidence that putting them in managed care can produce savings. And because the baseline projections already assume that a growing number of mothers and children on Medicaid will be in managed care plans, there are little additional savings left in the remaining one-third of the program.
- **FLEXIBILITY CAN'T MASK DEEP CUTS:** Republicans defend these cuts by saying that what they are doing is giving added flexibility to states through block grants. Issues of flexibility can't mask the inevitable fact that states are being asked to absorb enormous federal cuts --- forcing them to cut spending for education, law enforcement or other priorities -- and that's unrealistic.

**LIKELY IMPACTS:** So let's look at what these cuts really mean. Even accounting for some managed care savings, they mean deep cuts in eligibility, benefits and payments to doctors, hospitals, nursing homes and other health care providers. If the Republicans were to cut \$160 to \$190 billion between 1996 and 2002 and those cuts were divided evenly between eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, that would mean -- in the year 2002 alone -- that:

- **5 TO 7 MILLION KIDS WOULD LOSE COVERAGE;** and
- **800,000 TO 1 MILLION ELDERLY AND DISABLED BENEFICIARIES WOULD LOSE COVERAGE;** and
- **TENS OF MILLION LOSE BENEFITS:** All preventive and diagnostic screening services for children, home health care and hospice services would be eliminated -- as well as dental care if the \$190 billion were cut; and
- **OVER TEN BILLION REDUCED TO HEALTH CARE PROVIDERS:** Already low payments to health care providers would be reduced by \$10.7 to \$12.8 billion.

**MEDICARE/MEDICAID CUTS:  
BUSINESS, PROVIDER AND ADVOCACY GROUPS' RESPONSES**

**The National Association of Manufacturers says:**

*"Across the board reductions in [Medicare and Medicaid] should be avoided, since they are likely to exacerbate cost-shifting to the private sector." (February 11, 1995)*

**Eastman Kodak says:**

*"My message to you as you wrestle with the growing costs of the Medicare program is that greater use of managed care and aggressive purchasing of care on the part of the government are more appropriate solutions than massive across-the-board cuts in payments to providers, which result in cost shifting or an invisible tax on companies providing coverage to employees in the private sector." (March 21, 1995)*

**American Hospital Association says:**

*"One of every four hospitals in the United States is in 'serious trouble,' and with deep reductions in Medicare growth will be forced to cut services or close its doors." (April 13, 1995)*

*"The wrong way [to reform Medicare] is to do business as usual, letting short-sighted political pressures squeeze Medicare spending and weaken a program that needs to remain strong for our nation's seniors." (February 6, 1995)*

*"Sixty-four percent of the electorate believes that if you ran for office saying that you would not cut social security, and if Congress votes this year to cut Medicare then that Member of Congress has broken their campaign promise." (April 1995 Polling Data Report)*

**American Association of Retired Persons says:**

*"Medicare was hardly discussed in the last election; and there was certainly no mandate from the electorate to change the system." (March 28, 1995)*

*Medicare cuts "would mean that over the next 5 years older Americans would pay at least \$2000 more out of pocket than they would pay under current law. And over the next seven years they would pay \$3489 more out of pocket." (March 6, 1995)*

*"...[T]he total number of Medicaid beneficiaries in need who would lose long-term care services...could reach 1.75 million in the year 2000." (March 6, 1995)*

**The National Council of Senior Citizens says:**

*"The facts do not warrant a panic approach or a fundamental recasting of Medicare. The trust fund is not about to go belly-up; a seven-year window does not merit a panic button."*

*"The levels of the cuts in Medicare contemplated by the Senate and House Budget Committees will not just devastate the finances of millions of older citizens, but more importantly, they will devastate the hopes for a secure and healthy old age for all Americans." (April 1995)*

**Older Women's League says:**

*"We receive hundreds of letters from women who are already forced to choose between paying for food and rent and buying much needed medicine that is not covered by their Medicare. Substantial cuts in Medicare will literally take food out of the mouths of these older women." (January 10, 1995)*

**Children's Defense Fund says:**

*"States could make these cuts in several ways: by raising taxes substantially; by excluding groups of children from programs or putting them on waiting lists; by reducing benefits or the quality of services; or by making low-income families pick up more costs through co-payments and fees. Regardless of which method is chosen, the overall effect would be large." (April 19, 1995)*

**Catholic Health Association says:**

*"Budget cuts of such magnitude [in Medicare and Medicaid] would attack the very fiber of these programs and, in fact, decimate them. Consequently, the Catholic Health Association believes that Congress should put aside consideration of tax cuts for now and refocus the debate on how best to solve the deficit problem." (March 2, 1995)*

April 27, 1995

**MEMORANDUM**


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**To:** Kevin Kelly  
Senator Mikulski's office

**From:** Jean Heame, CBO

**Subject:** Medicaid baseline information

**CC:** Murray Ross  
Robin Rudowitz

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The following CBO estimates from our March projection may be helpful in evaluating SWAP alternatives. The projections do not represent a cost estimate of your plan. Let me know if there is anything else you might find useful.

(All outlays are for federal fiscal years in billions of dollars.)

Projection year	1997	1998	1999	2000	2001	2002
Medicaid spending on children and non aged/disabled adults	58.6	64.6	71.6	79.0	87.5	96.6
Federal share for children and non-aged/disabled adults	33.4	36.8	40.8	45.1	49.9	55.1
Federal share for elderly and disabled	67.2	75.4	83.6	92.4	101.9	111.7
Federal share for DSH payments	9.4	9.8	10.3	10.5	10.8	11.0

I have a preliminary staff estimate through the year 2000 of extending the transition benefit. This can give you an idea of the costs involved for that benefit.

<i>Federal and state share of extending the transition benefit (in billions of dollars)</i>	1997	1998	1999	2000
	.6	.6	1.3	1.5

A fundamental problem you may want to think about with respect to including Medicaid in SWAP proposals is that under current law Medicaid is essentially a state administered program. States must meet general federal guidelines but underneath those guidelines they have a great deal of flexibility in setting eligibility rules and benefits packages. If the federal government were to pick up a large piece of the Medicaid program AND administer that piece of the program, it would seem logical that benefits and eligibility rules would need to be standardized. On the other hand, if the federal government were to allow the states to continue administering the program while the federal government pays for all of the benefits, states would have a strong incentive to extend both eligibility and benefits. If your proposal ends up including a capitated payment with a growth ceiling - as in the CBO Reducing the Deficit book, you may not have quite as much of a problem to deal with.

Another consideration - what to do with disproportionate share payments. States report their share of DSH payments to be about 42% of total DSH payments. You can figure out how much that would be by multiplying the above payments by .42/ .58 or .72.

If you have any questions you can give either Robin Rudowitz or myself a call at x62820.

## Medicaid/Child Care Swap

Green Book, Page 800: (FY92)

# of AFDC children receiving Medicaid.....	15.1 million
# of AFDC adults receiving Medicaid.....	6.9 million

Green Book, Page 802 (FY92)

\$ for Medicaid Expenditures for AFDC kids	14.49 million
\$ for Medicaid Expenditures for AFDC adults	12.185 million

Green Book, Page 804 (FY92)

% Share of Medicaid:

AFDC kids	16%
AFDC adults	13.4%

### Questions:

Assume: 2 year transition of Medicaid and extension of current law (expiring in '98)

- 1) Pick up adult share only?
- 2) Pick up kids share only?
- 3) Pick up \$ after current law (ie: for extension only feds will pick up tab?)
- 4) Other suggestions:

Medicare

**REPUBLICANS BREAK CONTRACT:  
MEDICARE CUTS FOR SENIORS AND TAX HIRES FOR WORKING FAMILIES  
TO PAY FOR TAX CUTS FOR THE WEALTHY**

Republicans have repeatedly promised that they could provide a huge tax cut targeted at the wealthy, balance the budget by 2002--and not hurt the elderly or raise taxes on working families. Their budgets show that these were false promises. Republicans have broken their contract with historically severe cuts in Medicare and tax hikes for working families in order to finance their tax break for the wealthy.

**REPUBLICANS ARE MAKING THE LARGEST MEDICARE CUT IN HISTORY TO PAY FOR THEIR TAX CUT AND CAMPAIGN PROMISES.** On April 28, Speaker Gingrich said that Medicare would not be a part of the Republican budget cuts. He could not have been more wrong. Medicare takes the largest single cut in the Republican budget. By their accounting, nearly 25 cents out of every dollar that Republicans cut is from Medicare. The cut is three times larger than the largest previous Medicare cut in history.

**THEIR MEDICARE CUT IS ABOUT PAYING FOR TAX CUTS AND HITTING ARBITRARY DEFICIT TARGETS--NOT ABOUT THE ECONOMY OR HEALTH CARE REFORM.** The proposed Medicare cuts of \$250 billion to \$300 billion are needed to make room for most--but not all--of a \$345 billion tax cut that provides a tax break of over \$20,000 for the wealthiest 1 percent. Speaker Gingrich and Majority Leader Dole have rejected the White House's call to renounce tax breaks for the wealthy; instead, Speaker Gingrich calls the Contract tax cuts his "crown jewel," while Senate Majority Leader Dole and Senator Gramm have insisted they will make room for the tax cut. However the tax cuts are officially paid for, the fact remains that the entire Medicare cut would be totally unnecessary if Republicans did not need to pay for their tax cuts.

**WHEN IT COMES TO HEALTH CARE, REPUBLICANS SINGLE OUT SENIORS FOR PAIN: CUTTING GROWTH PER PERSON IN THEIR MEDICARE BELOW GROWTH IN PRIVATE HEALTH CARE.** Republicans claim that they are just slowing the "exploding" rate of growth in Medicare. In fact, the cost per person in Medicare is about the same as the private sector, even though Medicare deals with a population more prone to have health problems. The Republican approach ignores health care costs generally, and simply cuts the average growth rate for a Medicare recipient far below that for other Americans not on Medicare. *Medicare was designed to provide health insurance for senior citizens, not get turned into a second-class citizen program in order to meet arbitrary campaign promises.*

**BY 2002, REPUBLICAN CUTS WOULD INCREASE OUT-OF-POCKET COSTS BY ABOUT \$900 A YEAR AND DEVASTATE RURAL HOSPITALS.** If cuts are distributed evenly between providers and beneficiaries, they represent about a \$900 increase in out-of-pocket costs per beneficiary per year. That is equivalent to eliminating 40%-50% of the Social Security cost-of-living allowances for each Medicare beneficiary between now and 2002. As reimbursement rates decline, many rural hospitals that rely on Medicare would have to close down.

**REPUBLICAN MEDICAID CUTS WOULD DRASTICALLY RAISE LONG-TERM CARE COSTS FOR WORKING FAMILIES.** If the Republican cuts were divided evenly among eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, they would force states to cut off coverage for 5 to 7 million children and 800,000 to 1 million elderly and disabled Americans. The House and Senate budgets include a \$160 billion cut in Medicaid. They would limit growth to 4% per year--even though Medicaid's beneficiary growth alone is nearly that high. As a result, millions of Americans will be cut off while the costs of long-term care drastically increase. Two-thirds of Medicaid funds are spent on services for elderly and disabled Americans; without Medicaid, working families with a parent or spouse who needs long-term care would face nursing home bills averaging \$38,000 per year.

**REPUBLICAN MANAGED CARE PROPOSALS WILL NOT LEAD TO SIGNIFICANT SAVINGS UNLESS THEY CUT BENEFITS AND COERCE SENIORS.** There is no evidence that simply shifting to managed care can achieve significant savings among the populations that Medicare and Medicaid overwhelmingly serve--the elderly and disabled. Republican voucher proposals would overspend on younger, healthier seniors, while achieving limited savings only by dramatically raising costs, cutting benefits, and limiting choice for the seniors who need Medicare and Medicaid most.

**WHILE CUTTING TAXES FOR THE WEALTHY, REPUBLICANS ALSO RAISE TAXES FOR 12 MILLION LOW-INCOME WORKERS AND THEIR FAMILIES BY SLASHING THE EARNED INCOME TAX CREDIT.** The EITC helps families move from welfare to work and makes work pay for hard-working, lower-income Americans, providing a tax cut averaging nearly \$1,400 per year for over 21 million workers and their families earning up to \$28,500. Senate Republicans have proposed a major cut in the EITC that will raise taxes by an average of \$235 for 12 million of these workers and their families. Thus, 12 million low-income working families will pay \$235 more under the Republican budget, while the top 1% will pay \$20,000 less under the Contract's tax cuts.

MEMORANDUM

~~Call State~~  
~~by State~~  
Medicare

To: Distribution  
From: Chris Jennings  
Date: May 12, 1995  
Re: Medicare State by State Information

Attached, for your information, are the back-up tables for the Medicare portion of the state by state analysis being released today. You will find two pages of information: the first is a beneficiary breakout by state, and the second is the state by state analysis of the Kasich proposal.

As you will note, the analysis provides both aggregate dollar loss breakouts, as well as per beneficiary impact breakout for both 2002, and the total seven year period.

I hope you find the information useful. If you have any questions, please call me at 6-5560.

Projected Medicare Beneficiaries by State

	1995	2002
US	37,631,000	41,299,000
Alabama	641,971	703,082
Alaska	33,784	49,773
Arizona	598,737	743,525
Arkansas	422,580	450,365
California	3,638,311	4,034,936
Colorado	423,478	514,095
Connecticut	503,906	533,943
Delaware	100,545	115,722
District of Columbia	76,730	76,330
Florida	2,615,604	2,951,880
Georgia	832,454	953,079
Hawaii	150,818	184,336
Idaho	149,769	171,120
Illinois	1,625,786	1,690,497
Indiana	827,174	890,461
Iowa	476,142	484,783
Kansas	383,997	397,890
Kentucky	585,580	636,855
Louisiana	582,491	634,122
Maine	202,149	221,565
Maryland	604,202	677,465
Massachusetts	837,292	996,344
Michigan	1,354,523	1,461,749
Minnesota	632,457	671,394
Mississippi	395,768	421,671
Missouri	834,228	876,653
Montana	129,141	141,557
Nebraska	249,529	256,357
Nevada	194,035	295,417
New Hampshire	156,237	178,655
New Jersey	1,174,802	1,244,404
New Mexico	212,160	257,452
New York	2,645,176	2,718,120
North Carolina	1,028,054	1,202,188
North Dakota	103,477	106,274
Ohio	1,673,948	1,800,336
Oklahoma	487,058	519,526
Oregon	470,268	524,031
Pennsylvania	2,083,051	2,187,666
Rhode Island	168,503	175,375
South Carolina	508,854	593,614
South Dakota	117,061	122,172
Tennessee	769,041	853,930
Texas	2,090,359	2,419,444
Utah	168,349	228,000
Vermont	82,989	91,752
Virginia	818,458	936,837
Washington	687,136	771,781
West Virginia	330,115	348,402
Wisconsin	763,230	804,207
Wyoming	60,570	72,355
Puerto Rico	476,704	527,920
All Other Areas	330,201	357,073

NOTES: Based on historical state share of Medicare enrollees, trended forward with growth in the states' share of enrollees.  
 \* Totals may not add due to rounding

Effects of the Katch Medicare Proposal By State  
Losses by State Under the Proposal  
(Fiscal years)

	Aggregate Dollars (millions)		Per Capita Effect (\$/benef.)	
	2002	1996-2002	2002	1996-2002
US	84,900	279,200	1,028	3,447
Alabama	1,986	6,146	1,412	4,450
Alaska	50	171	502	1,669
Arizona	1,491	4,799	1,002	3,389
Arkansas	627	2,185	696	2,435
California	11,830	37,780	1,456	4,783
Colorado	1,147	3,579	1,116	3,630
Connecticut	1,247	4,103	1,167	3,885
Delaware	281	899	1,215	4,002
District of Columbia	1,431	4,001	NA	NA
Florida	9,314	29,258	1,578	5,082
Georgia	2,077	6,754	1,090	3,649
Hawaii	432	1,311	1,173	3,710
Idaho	149	532	436	1,603
Illinois	2,652	8,301	784	2,770
Indiana	1,569	5,253	861	2,894
Iowa	495	1,786	510	1,845
Kansas	834	2,741	1,048	3,454
Kentucky	968	3,318	760	2,652
Louisiana	1,590	5,235	1,254	4,201
Maine	231	825	621	1,900
Maryland	1,069	3,752	787	2,843
Massachusetts	3,072	9,828	1,542	4,989
Michigan	2,165	7,717	737	2,657
Minnesota	1,512	4,725	1,126	3,557
Mississippi	674	2,297	799	2,758
Missouri	1,531	5,219	873	3,004
Montana	157	551	553	1,986
Nebraska	338	1,156	659	2,266
Nevada	638	1,946	1,080	3,620
New Hampshire	292	955	816	2,755
New Jersey	2,320	7,945	932	3,229
New Mexico	249	866	484	1,761
New York	6,359	18,539	986	3,423
North Carolina	2,165	6,998	900	3,012
North Dakota	159	651	750	2,604
Ohio	2,584	8,083	718	2,662
Oklahoma	757	2,625	729	2,560
Oregon	1,010	3,213	863	3,135
Pennsylvania	4,526	15,479	1,034	3,670
Rhode Island	482	1,611	1,375	4,336
South Carolina	1,103	3,495	929	3,043
South Dakota	153	530	625	2,185
Tennessee	2,378	7,537	1,393	4,509
Texas	6,428	17,668	1,122	3,767
Utah	331	1,086	727	2,511
Vermont	105	365	673	2,034
Virginia	1,052	3,711	651	2,044
Washington	978	3,377	633	2,246
West Virginia	471	1,626	676	2,362
Wisconsin	914	3,254	569	2,044
Wyoming	49	182	337	1,313
Puerto Rico	457	1,488	433	1,440
All Other Areas	3	14	4	20

Variation in the costs per beneficiary across states reflects factors such as: (1) practice pattern differences, (2) cost differences; (3) differences in health status and the number of very old persons in a state; and (4) differences in the supply of health care providers.

NOTES: Assumes that increases in beneficiary out-of-pocket costs (e.g., premiums and coinsurance) are equal to 50% of the total cuts. Based on historical state share of Medicare outlays & enrollment, trended forward with growth in the states' share of outlays & enrollment. Estimates based on Medicare outlays by location of service delivery. Thus, certain state estimates may be affected by part-year residency and state border crossing to obtain care (e.g., Florida & Minnesota). State border crossing makes the District of Columbia estimates unreliable. Technical reestimates of the aggregate savings may result in a 7-year total of \$282 billion.



*HC -  
Medicare  
Fraud*

February 21, 1997

NOTE TO: Bruce Reed  
Rahm Emanuel  
Chris Jennings  
Nancy Ann Min  
Janet Murguia  
Emily Bromberg  
Barbara Wooley  
Elena Kagen

Per our conversation yesterday, please find attached a summary description of the fraud and abuse proposals that could be included in an Administration initiative next month. Preliminary discussions with HCFA indicate that we could have legislative language ready by March 13.

Richard J. Tarplin

Attachment:

cc: Melissa Skolfield

## ANTI-FRAUD and ABUSE LEGISLATIVE PROPOSALS

### Proposals that OMB has Approved of for Inclusion in a "Spring" Anti-Fraud Bill:

#### Program Integrity

- o **Social Security Numbers** - Under this proposal the Secretary would have the authority to require providers and suppliers to disclose their Social Security Numbers (SSNs). The SSA would be required to verify the validity of the SSNs.

Rationale: With the knowledge of a national, unique personal identifier, this proposal would provide an important tool to improve our ability to deny entry into Medicare to fraudulent and unscrupulous providers and suppliers.

- o **Provider Enrollment Process** - This proposal would authorize the Secretary to assess an application fee for all Medicare providers at times of enrollment or reenrollment. Under the new enrollment process, a corrective action plan would need to be instituted and any overpayment recouped before a provider would be given another billing number. Additionally, HCFA would have the authority to revoke a provider number if it is determined that the provider is engaged in fraud or abuse.

Rationale: One of the most effective and efficient measures to combat Medicare fraud and abuse is the verification of provider enrollment applications to ensure that only legitimate health care providers are able to bill Medicare. Current law authorizes the Secretary to collect application fees from physicians. However, certain other provider types (e.g. DME suppliers) require a more comprehensive review and, as such, require incremental funding to satisfy enrollment requirements.

- o **Enrollment Waiting Period After Denial** - This proposal would specify that if an application has been denied, there would be a six-month waiting period before the provider could reapply.

Rationale: Instituting a six month waiting period would allow sufficient time for the applicant to meet the conditions of participation. Further a six month moratorium would prevent denied applicants the ability to inundate HCFA with applications that are not significantly different from the application that was denied.

#### Hospice

- o **Prevent Duplicative Payments for Hospice Services** - This proposal would clarify that a hospice can receive payment from either Medicare or Medicaid for dually eligible beneficiaries, but not both.

Rationale: Under current law, when dual eligibles who are nursing home residents elect the Medicare hospice benefit, Medicaid continues to pay at least 95% of the full nursing home rate (which includes both room and board and to some extent, medical and social services) and Medicare pays the hospice per diem (which covers the provision of all hospice benefits, including medical nursing, home health aide, and social services). The nursing home would be expected to provide the palliative care.

- o **Benefit Period Modifications and Limitation on Total Available Hospice Days** - This proposal would replace the current third and fourth hospice benefit periods with a finite number of thirty and/or sixty-day periods (after the two 90-day periods).

Rationale: The hospice benefit is intended for beneficiaries with terminal illnesses. However, there have been instances where beneficiaries have been under the hospice benefit, for example, for more than two-years. This proposal would limit the hospice benefit by allowing a beneficiary to be able to use only 360 days of hospice care in their lifetime.

- o **Limitation of Liability and Beneficiary Protection** - This proposal would clarify that if a hospice submitted a claim for a beneficiary that they had reason to believe was terminally ill we would pay the claim upon appeal. In this instance, neither the hospice nor the beneficiary would be liable for the services.

Rationale: Under current law the beneficiary is unprotected and a hospice may seek full payment from the beneficiary for denied claims for hospice care furnished to the beneficiary.

- o **Hospice Payment at Location of Service** - This proposal would link payment for hospice services to the zip code of the site where the service was furnished.

Rationale: This proposal would ensure that payments reflect the prevailing costs in the areas where services are furnished, not the higher cost urban areas where agencies tend to locate their parent offices.

TOP PRIORITY

Q's & A's

## WHAT IS YOUR POSITION ON A MEDICARE COMMISSION?

### QUESTION:

There's nothing in your budget about the long-term solvency of the Medicare program. Do you still support creating a commission?

### ANSWER:

- Let me speak as a Medicare trustee first, and as a Cabinet Secretary second.
- As a trustee we have said in each of the last four years that we need to first address the short-term financing problems of the Medicare program so that we have enough time to confront the long-range problems created by the retirement of the Baby Boom generation. The President has endorsed that approach and has laid out a series of savings that will extend the trust fund for a decade.
- As HHS Secretary I would say that it is important to have bipartisan support for both the short-term and long-term fixes. I think we are much closer together on both issues this year. I would like to see the Congress deal quickly with the short-term package and then we can sit down and talk about creating a commission or some other panel to help us deal with the long-term problems.
- The bottom line is that we will all have to deal with these issues. No commission is going to shield us from the hard choices that have to be made. That is why the President has stepped forward to meet the Congress halfway on the short-term issues. And that is why we will all need to be at the table when we deal with the long-term issues.

## WHAT'S MAGIC ABOUT TEN YEARS?

### QUESTION:

What's magic about 10 years for the Trust Fund?

### ANSWER:

- ▶ The President has proposed Medicare savings sufficient to extend the life of the Hospital Insurance Trust Fund for the next ten years to ensure that there is sufficient time for Congress and the Administration to address the issue of long-term solvency.
- ▶ The Medicare savings included in the Republican budget last year extended HI Trust Fund solvency for more than ten years.
- ▶ There is nothing magic about ten years. The President does feel, however, that it is important to extend the trust fund for about this length of time in order to develop the broad consensus necessary for a long-term solution.

## COMPARING THE PRESIDENT'S 1997 & 1998 BUDGET PROPOSALS

### QUESTION:

How does this year's Medicare budget proposal differ from last year's? If you are serious about balancing the budget and protecting the solvency of the Medicare Part A Trust Fund, why do you have essentially the same proposals as last year -- which were no different from savings proposals we've seen for the past several years?

### ANSWER:

- Many of the proposals in this year's budget are repeated from last year and, yes, are similar to proposals we have seen over the years. However, these are all solid proposals that exhibit fiscal prudence as we manage this large program.
- We have added a few legislative items. These changes were made to reflect passage of the Health Insurance Portability Protection Act (HIPPA), as well as additional research into the needs of our beneficiaries and providers.
- The major changes include:
  - ▶ Correcting HIPPA by eliminating advisory opinions and replacing them with interpreted rulings for anti-kickback statutes, repealing the exemptions to anti-kickback statutes for certain managed care plans, and reinstating reasonable diligence standard for providers facing civil monetary penalties.
  - ▶ Limiting beneficiary out-of-pocket expenditures for outpatient services.
  - ▶ Lowering the Medicare reimbursement rate for managed care from 95 percent to 90 percent of the AAPCC; and
  - ▶ Eliminating the proposed interim Prospective payment system (PPS) for Skilled Nursing Facilities, and replacing it with a full PPS implementation in 1998.
  - ▶ We have advanced the respite benefit from 2002 to 1998.
  - ▶ A new beneficiary centered purchasing initiative will give us new tools to better manage Medicare and adopt private sector initiatives.

## CBO VS. OMB BASELINE

### QUESTION:

Will the President use the OMB or CBO baseline to score his Medicare proposals?

### ANSWER:

- Our plan saves \$138 billion in Medicare over six years, about half-way between the CBO's \$116 billion scoring of our plan last year and the Republican's last offer of \$158 billion as scored by CBO.
- We recognize that due to differences in technical and economic assumptions, CBO's scoring of our Medicare package and of the individual proposals will differ from Administration scoring. We want to work with Congress to adopt a common set of economic assumptions and spending projections to use in fashioning a bipartisan balanced budget.
- We expect that will be doable in light of the similarity between CBO and the Administration baselines. To that end, we will work with Congress to develop a package of Medicare proposals that achieves a savings level agreeable to all sides.

## HOW PRESIDENT'S MEDICARE SAVINGS COMPARE TO REPUBLICAN PLAN

### QUESTION:

The six-year savings in your plan sounds very similar to the six year savings in the Republican's 1996 budget. Why was it so bad last year, but okay this year? Doesn't this really prove that the President was demagoguing on Medicare?

### ANSWER:

- Last year, the Republicans took a huge step in the right direction when they modified their extreme \$270 billion Medicare plan and offered a less severe \$158 billion plan.
- While the size of proposed Medicare savings is important, how those savings are achieved is equally, if not more, important. Despite the smaller gap between our current Medicare savings and the Republican's last offer, the President's FY 1998 budget retains some key differences with the Republican's plan last year:
  - ▶ The President's plan protects beneficiaries from increased liability, not only by limiting increases in Part B premiums, but also by lowering outpatient coinsurance rates, maintaining balanced billing protections, excluding Medical Savings Accounts, and establishing community rating for Medigap plans.
  - ▶ Our plan places a smaller burden on hospitals, with \$33 billion in savings over 6 years compared to \$74 billion in the Republican's last offer. Our hospital savings are small enough to ensure that beneficiaries will still have access to care, particularly in rural areas.
  - ▶ We propose a richer package of preventive benefits that will improve the health and quality of life of our beneficiaries and save Medicare money in the long-run.
  - ▶ Our plan will make Medicare a more prudent purchaser of services -- just like a private insurance company -- through innovative approaches such as expanding centers of excellence, competitive bidding, and flexible purchasing authority.
  - ▶ We are continuing to crack down on fraud and abuse in Medicare by building on progress we made together in HIPPA.
- Having said this, we in the Administration would like to focus on what we have in common, not how we differ. We share the goal of extending the solvency of the Part A trust fund and finding prudent savings in Medicare that can contribute to a balanced budget. Our goal is to work in a bipartisan fashion to achieve these two important goals this year.

## WHAT ABOUT PROPAC RECOMMENDATION TO FREEZE HOSPITAL PAYMENTS?

### QUESTION:

Why do you recommend an update for hospital payments when ProPAC recommends a freeze?

### ANSWER:

- ProPAC recently recommended that hospital payments be frozen for a year at FY96 levels. They based this recommendation on the fact that Medicare costs per case have actually been decreasing in real terms over the past few years while payments have increased.
- Our budget was developed before ProPAC's recommendation was announced, and we think our proposal is sound and reasonable. In the context of our other budget provisions, many of which will reduce hospital payments in other ways, we did not think that freezing hospital payments was appropriate, and we did not need to do that to achieve necessary savings and extend the trust fund for ten years.
- We are continuing to analyze ProPAC's work and we think they can contribute greatly to the dialogue on Medicare reforms this year.

## DID YOU IGNORE THE REPUBLICAN GME PROPOSAL?

### QUESTION:

Why did you ignore the Republican's proposal? Isn't there anything you liked about it?

### ANSWER:

- We did not ignore the Republican proposal at all. We are very supportive of efforts to broaden the base of funding for teaching hospitals beyond Medicare funding. However, we focused our GME Reform proposals on the Medicare program.
- As a matter of fact, the Republican approach embodied many of the same principles as our approach, that is:
  - to provide a stable source of funding for graduate medical education,
  - to cap the growth in the number of residents,
  - to provide specific teaching payments for services provided to managed care enrollees.
- However, we did have some concerns about the way the Republican GME Trust Fund was structured in last year's Balanced Budget Act, and about how a GME trust fund would operate in general. Our primary concerns were:
  - 1) that the funding of the General Funds was distributed basically in block grant style, with little or no connection between the level of current teaching activities or services and the level of funding;
  - 2) the distribution mechanism for the Managed Care Trust Fund, while related to a level of services, had no linkage between the cost of teaching services expended by a hospital and the level of payment;
  - 3) the lack of clarity on how the national cap on the number of residents was supposed to be enforced;
  - 4) the source and amount of money in the trust funds.
- As you can see, our GME proposal this year is very similar to our approach last year. It is a group of incremental proposals designed to cap the growth in the number of residency slots, encourage more training in primary care and in non-hospital settings, and equalize funding for Medicare FFS beneficiaries and managed care enrollees.
- Departmental staff would be happy to discuss ideas about GME trust funds with your staff at any time.

## WON'T YOUR MEDICARE MANAGED CARE REFORMS HURT BENEFICIARIES?

### QUESTION:

Senator Wyden and others have said you are taking too big a bite out of managed care payments. Won't these policies result in fewer benefits, higher premiums, and fewer people in managed care? Won't managed care plans take away the extra benefits and raise the premiums they charge beneficiaries?

### ANSWER:

- ▶ There is very clear evidence that Medicare is overpaying for managed care services. Because of "favorable selection," Medicare lost about \$1 billion in the last year alone.
- ▶ The President's plan:
  - Establishes interim limits on payments beginning in 1998:
  - Removes payments to teaching hospitals and DSH hospitals so that those funds go to the facilities directly; and
  - Reduces the formula from 95 to 90% beginning in 2000.
- ▶ We don't believe beneficiaries will lose benefits or be charged higher premiums for several reasons:
  - Managed care plans must remain competitive and to do so they must offer additional benefits or reduced premiums;
- ▶ We are also proposing changes that will enhance managed care as an option. They include:
  - Open Enrollment
  - New Choices: PPOs and PSOs
  - Medigap Reforms: No pre-existing condition exclusions
  - Our payment floor will make managed care more attractive in markets where payments are too low today.

## QUALITY IN MANAGED CARE

### QUESTION:

What is HHS doing to improve quality in managed care?

### ANSWER:

- Since their inception, the Medicare and Medicaid programs have acted to ensure access to high quality health care for their beneficiaries. The Clinton Administration is taking new steps to assure that the growing portion of Americans who are covered by managed health care plans receive the care they deserve.
- Specific recent actions include:
  - ▶ Banning "gag" clauses in managed care contracts with physicians that limit what can be discussed with patient about medically necessary services;
  - ▶ Limiting financial incentives that put physicians' income at "substantial risk," so that incentives to control costs do not curtail needed care;
  - ▶ Requiring Medicare plans to report state-of-the-art measurement of their performance;
  - ▶ Requiring surveys of member satisfaction with services provided by managed care plans, and assessment of the results of care;
- Additional initiatives underway include:
  - ▶ Strengthening rights of beneficiaries to appeal managed care plan decisions to deny specific treatments;
  - ▶ Providing side-by-side comparisons of costs, benefits, and other key features in managed care plans available to Medicare beneficiaries; and
  - ▶ Establishing national marketing guidelines that detail what information managed care plans need to cover in marketing materials sent to Medicare beneficiaries.

## IS HOME HEALTH PROPOSAL A GIMMICK?

### QUESTION:

Isn't the President's proposal to transfer home health from Part A to Part B a gimmick?

### ANSWER:

- There's been a great deal of confusion about these proposals. Let me walk you through our thinking on this issue.
- It is very clear that we have a problem with the cost of home health care. This is one of the fastest growing areas of the Medicare budget, with a projected annual growth of 10.6 percent between 1997 and 2002.
- With respect to our proposal, it is important first to understand that the home health reallocation is not a part of the \$100/138 billion in savings the President seeks in Medicare. However, it does contribute substantially to extending the solvency of the Part A trust fund.
- Second, it is also important to remember that our proposal is designed to return to the original intent of the home health policy that existed prior to 1980 -- to provide post-acute care services under Part A for beneficiaries who have been hospitalized. That also makes this benefit consist with the post-hospital SNF benefit, which covers 100 days following a 3-day hospitalization.
- Finally, this reallocation is only one part of a comprehensive home health care package designed to reform the payment system and reduce fraud and abuse. For example:
  - We reduce spending on home health by \$15 billion over five years and \$20 billion over six years.
  - We close loopholes that have allowed home health agencies to defraud the Medicare program.
  - And we modernize the payment system by moving to a prospective payment system in 2000.

## EXPLAIN HOME HEALTH TRANSFER

### QUESTION:

Can you explain your home health benefit transfer proposal?

### ANSWER:

- This proposal is not part of the \$100 billion in 5-year Medicare savings. It is budget neutral.
- We propose to restore the home health benefit under Part A to a limited "post-hospital" benefit and return other home health services to Part B:
  - Under this proposal, the first 100 visits following a three-day hospital stay would be paid under Part A, with all subsequent visits paid under Part B.
  - For beneficiaries who do not have a prior hospital stay, all home health visits would be paid under Part B.
- This is consistent with the original division of services under Parts A and B of Medicare.
- It also is consistent with the post hospital SNF benefit, which covers 100 days following a 3-day hospitalization.
- This is a mainstream proposal that has enjoyed bipartisan support. House Republicans voted to move home health visits beyond a certain limit to Part B on two separate occasions during the last budget debate. In addition, the so-called Blue Dog coalition has proposed to return extended home health visits to Part B.
- Beneficiaries would continue to not pay coinsurance or deductibles when using any home health services. In addition, the Part B premium will not be increased to reflect increased home health costs.
- Finally, this proposal is part of a broader home health reform plan that will reduce the deficit by \$15 billion over 5 years by limiting current home health payments and then creating a new prospective payment system for home health. It also curbs payment loopholes and other fraud and abuse in the home health benefit.

### KEY INFORMATION

This proposal is consistent with the original intent of Medicare Part A:

- ▶ Part A was originally designed to pay for short-term, post-acute care services.
  - ▶ OBRA 80 removed the 3-day hospital stay requirement and 100-visit limits, which caused utilization to explode and turned home health into an unlimited chronic care benefit.
- **Redefining home health recognizes the changing nature of the benefit:**
    - ▶ More and more beneficiaries have come to accept and prefer home care to institutional care. As a result, the home health benefit has really become two benefits: one for post-acute care needs and one for chronic care needs.
    - ▶ Financing post-acute home visits from Part A and chronic care visits from Part B recognizes the transformation of the home health benefit, and makes it consistent with the original structure of the Medicare program.
- **Our home health proposal protects the HI trust fund:**
    - ▶ Since the OBRA 80 change, Part A finances about 99 percent of all home health care, regardless of whether the visit is post-acute or long-term. Part A can no longer financially support the explosive growth in long-term home health care.

**SAVINGS -- in millions**

	FY 1998	FY 1998 - 2002
Part A	-\$14,410	-\$81,960
Part B	\$14,410	\$81,960
Medicare Effect	\$0	\$0

**ADDITIONAL INFORMATION:**

- ▶ Under this proposal, fiscal intermediaries (FIs) would continue to process home health claims and determine which visits are paid under Part A versus Part B. In the first year, HCFA would provide guidance on to FIs on how to make these determinations. After the first year, when settled cost reports are available, FIs will make these determinations themselves.

## TRUST FUND EFFECT WITHOUT HOME HEALTH SHIFT

### QUESTION:

How far into the future would your plan extend the Trust Fund if the Home Health Transfer proposal was not included?

### ANSWER:

- It would extend solvency for a year and a half. That would move us into late 2002 from the current estimate of early 2001. As you can see, removing that proposal has a severe impact on our ability to extend the trust fund for ten years. While some may call the proposal a gimmick, I would make two points in that regard:
  - ▶ We view this as a sound proposal, based on the notion that those visits that are not closely connected to a hospital stay, more naturally belong in Part B;
  - ▶ Second, by moving this portion of home health to Part B, where it rightly belongs, we can meet our goal of trust fund solvency, without resorting to extreme cuts to either providers or beneficiaries. To extend the life of the trust fund until 2007 without this policy, much deeper cuts in payments to hospitals, managed care plans and nursing homes would be required.

### KEY INFORMATION:

- The reason that the home health shift proposal appears to have such a disproportionate effect on trust fund solvency is twofold:
  - ▶ It takes a significant level of savings to begin to move back the insolvency date. Once that level has been achieved, then additional savings will have a more noticeable effect. In other words, after you get over that initial hump, you get more bang for the buck.
  - ▶ While the total five-year savings from the Part A provider savings proposals is comparable to the five-year savings for the home health shift, the savings streams are different. The provider savings proposals grow significantly over the budget window, from \$5 billion in FY 1998 to \$25 billion in FY 2002. The Home Health Shift grows from \$12 billion to \$15 billion over the same period. The Home Health Shift starts at a higher level of savings, which is important because the earlier you address the trust fund imbalance, the more effective a given level of savings will be.

## CBO LETTER TO ARCHER ON HI TRUST FUND

### QUESTION:

CBO has sent me this letter (attached) laying out 3 illustrative scenarios for preserving a positive end-of-year balance in the HI trust fund through 2007. The 5-year Medicare cuts illustrated under these scenarios range from \$72 billion to \$100 billion. None of these involve a home health transfer. In light of this analysis, shouldn't you drop the home health transfer gimmick and concentrate on real policies to preserve the Part A trust fund?

### ANSWER:

- ▶ The CBO analysis proves perfectly our point that without our home health proposal, extremely severe Medicare spending cuts would be required to extend the Part A trust fund into 2007.
- ▶ Don't be distracted by the "3 scenarios" -- they are all quite similar. The main difference is the degree to which cuts are back loaded.
  - Scenario 1 shows \$103 billion in 5-year cuts and \$458 billion in 10 year cuts.
  - Scenario 2 shows \$88 billion in 5-year cuts and \$468 billion in 10 year cuts.
  - Scenario 3 shows \$72 billion in 5-year cuts and \$475 billion in 10 year cuts.
- ▶ Under any of these scenarios, the Part A cuts required to maintain a positive Trust Fund balance into 2007 are **almost twice as deep** as the budget cuts we propose.
- ▶ Our Part A savings, leaving aside the home health transfer, are only \$245 billion over 10 year vs. \$460-475 billion. [note, with the home health transfer, our Part A savings are \$448 billion over 10 years]
- ▶ Put another way, in the 10th year, under any of the CBO scenarios, Part A spending would have to be cut more than 33% below baseline. We propose a cut of 14% below baseline in the 10th year.
- ▶ Once again, our home health policy is not a gimmick. We propose real reforms to rein in the cost of this benefit. But we also insist on moving out of Part A that part of the benefit that belongs in Part B.

PART A PROVIDER CUTS

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
CBO Baseline	146.7	159.1	174.5	182.4	199.5	215.1	232.2	256.9	272.5	287.1
CUTS IN CBO PLAN	0	0	11	23	37	51	67	86	96	102
% cut	0.0%	0.0%	6.3%	12.6%	18.5%	23.7%	28.9%	33.5%	35.2%	35.5%

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
OMB Baseline	147.2	159.2	171.7	185.2	199.3	214	229.4	245.3	261.9	280.3
CUTS IN 1998 PB	5	10	17	21	25	28	30	33	36	40
% cut	3.4%	6.3%	9.9%	11.3%	12.5%	13.1%	13.1%	13.5%	13.7%	14.3%

1998-2002 1998-2007  
71 473

1998-2002 1998-2007  
78 245



CONGRESSIONAL BUDGET OFFICE  
 U.S. CONGRESS  
 WASHINGTON, D.C. 20515

June E. O'Neill  
 Director

January 29, 1997

Honorable Bill Archer  
 Chairman  
 Committee on Ways and Means  
 U.S. House of Representatives  
 Washington, D.C. 20515

Post-it Fax Note	7671	Date	# of pages
To	RICK FOSTER	From	MURRAY ROSS
Co./Dept	OACT	Co.	CBO
Phone	410-780-6374	Fax	202-225-1938
Fax	410-780-1095	Fax	202-226-2963

Dear Mr. Chairman:

CBO has received numerous requests from Members and Committees asking, "How large are the policy changes needed to preserve the Hospital Insurance (HI) trust fund?" The answer to this question depends on the desired level of trust fund balances, the time period over which the policy changes are measured, and the specific policies proposed. As a result, the question has no unique answer.

The attached memorandum describes three scenarios that could preserve a positive end-of-year balance in the HI trust fund through 2007. These scenarios are only illustrative; they are not based on specific policies. Instead, the scenarios are intended to illustrate the magnitude of the required reductions. Estimating the effect of any given proposal on the HI trust fund would require an assessment of the underlying policies.

We hope that you will find this information useful. Please contact me if we can be of further assistance. The CBO staff contact is Tom Bradley.

Sincerely,

*June E. O'Neill*  
 June E. O'Neill

Enclosure

cc: Honorable Charles B. Rangel  
 Ranking Minority Member

Identical letter sent to Honorable William V. Roth, Jr.

ILLUSTRATIVE CALCULATIONS OF  
POLICY CHANGES REQUIRED  
TO EXTEND THE LIFE OF THE  
MEDICARE HOSPITAL INSURANCE TRUST FUND

In fiscal years 1995 and 1996, outlays from the Medicare Hospital Insurance (HI) Trust Fund exceeded income, resulting in a decline in the trust fund's balance. This balance stood at \$125 billion at the end of 1996. The Congressional Budget Office (CBO) projects that, under current law, HI outlays will continue to outpace income, and the trust fund will be exhausted in 2001.

CBO projects that HI outlays will exceed payroll taxes and other receipts by \$10 billion in 1997 and by growing amounts thereafter. By 2007, outlays will exceed receipts by \$130 billion, and the trust fund will have a negative balance of \$556 billion. Cumulative noninterest outlays, from the depletion of the trust fund in 2001 through 2007, are expected to exceed noninterest receipts by nearly \$500 billion. In addition, the projections include interest costs incurred after the trust fund is depleted (see Table 1).

Avoiding depletion of the HI trust fund during the coming decade will require a substantial slowing in the growth of outlays, a large rise in payroll taxes or other receipts, or a combination of lower-than-projected outlays and higher receipts. CBO has received a number of requests for the minimum change in outlays or revenues required to preserve a positive balance in the HI trust fund.

This memorandum presents three scenarios that preserve a positive trust fund balance through 2007 by making a constant percentage-point reduction in the annual rate of growth of outlays until the gap between outlays and receipts is closed:

- Under scenario 1, the rate of growth of outlays is reduced by 4.3 percentage points in each year beginning in 1998 (from 7.7 percent a year in the baseline over the 1998-2007 period to 3.4 percent);
- Under scenario 2, the reduction is delayed until 1999, and the rate of growth of outlays is reduced by 5.3 percentage points;
- Under scenario 3, the reduction is delayed until 2000, and the rate of growth of outlays is reduced by 7.0 percentage points.

In comparison, a similar result could be achieved by increasing the HI payroll tax rate from 2.9 percent for employers and employees, combined, to about 3.8 percent starting in 1998. The figure shows the status of the Hospital Insurance Trust Fund under the CBO baseline and the three alternative scenarios. The data underlying the figure are presented in Table 2.

These scenarios demonstrate several important points:

- Over \$450 billion in cumulative policy changes are needed over the next 10 years to keep the HI trust fund from being exhausted before the end of 2007. The reduction in noninterest outlays over the 1998-2007 period is \$458 billion in scenario 1, \$468 billion in scenario 2, and \$475 billion in scenario 3.
- The amount of savings needed over the next 5 years depends on the specific policies under consideration. Over the 1998-2002 period, the reduction in noninterest outlays is \$103 billion in scenario 1, \$88 billion in scenario 2, and \$72 billion in scenario 3.
- The smaller are the reductions in years 1-5, the larger must be the reductions in years 6-10.
- All three scenarios involve a substantial reduction in the rate of growth of HI outlays over the 1998-2007 period. Under scenario 1, the average annual rate of growth of outlays would be reduced by more than half (from 7.7 percent in the baseline to 3.4 percent). In scenarios 2 and 3, outlays would grow at an average rate of only 2.6 percent.

**Table 1: Medicare Hospital Insurance Trust Fund, CBO January 1997 Baseline  
by fiscal year, dollar amounts in billions**

FISCAL YEAR	Cumulative Amount											Average % Rate of GIC FY99-07 FY	
	1999	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006		2007
Balance, Beginning of Year	130	125	116	99	73	36	-4	-59	-125	-207	-310	-428	
Outlays	126	137	149	161	177	184	202	217	235	259	276	290	2,149
Interest Receipts	10	10	8	7	6	2	-1	-5	-9	-15	-21	-29	-57
Noninterest Receipts	111	116	122	129	136	142	148	158	163	171	180	186	1,533
Surplus (Receipts - Outlays)	-4	-10	-18	-25	-39	-41	-54	-67	-91	-103	-117	-130	-672
Balance, End of Year	126	116	98	73	36	-4	-59	-126	-207	-310	-428	-550	
Trust Fund Ratio <sup>1/</sup>	103%	91%	76%	61%	41%	20%	-2%	-27%	-64%	-60%	-113%	-147%	6.0%
Percentage Change in Outlays	9.1%	8.5%	9.1%	8.4%	9.8%	4.6%	8.3%	7.8%	7.9%	10.6%	6.1%	6.3%	

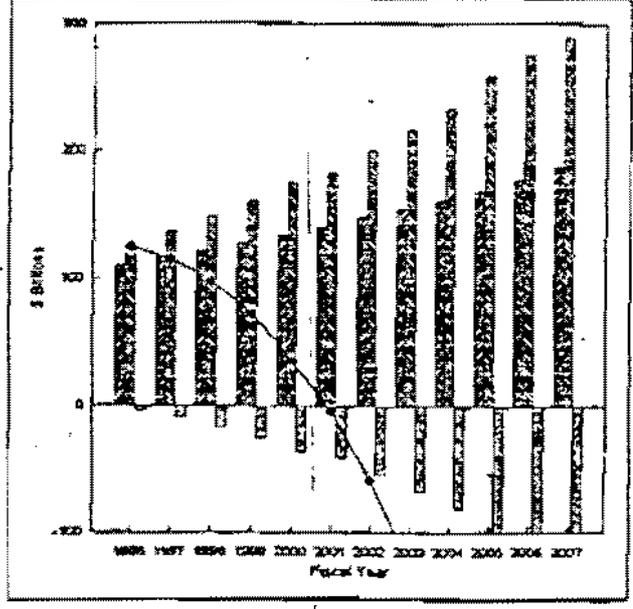
Memorandum:

Number of Capitation Payments /2 11 12 12 12 12 12 12 12 12 13 13 13 12 11

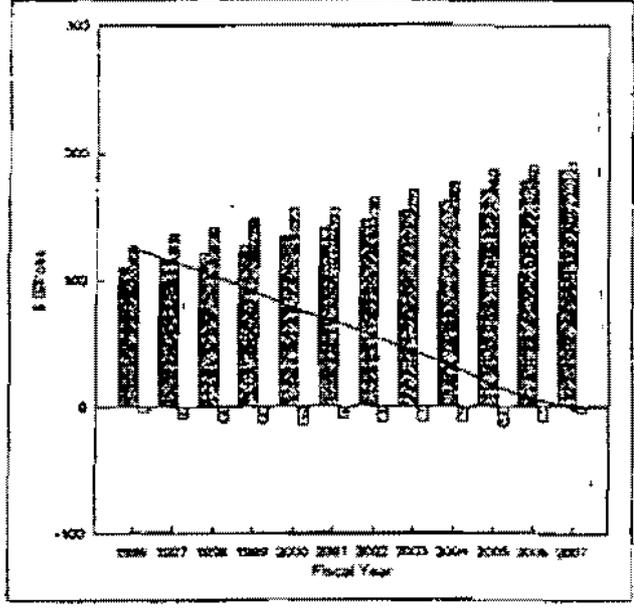
- 1/ The trust fund ratio is the beginning-of-year trust fund balance expressed as a percentage of outlays during the year.
- 2/ HMO capitation payments for the month of October are accelerated into the preceding fiscal year when October 1st falls on a weekend.

OUTLAY GROWTH RATES TO MAINTAIN A POSITIVE TRUST FUND BALANCE THROUGH FY 2007, WITH IMPLEMENTATION BEGINNING IN 1998 OR SUBSEQUENT YEARS

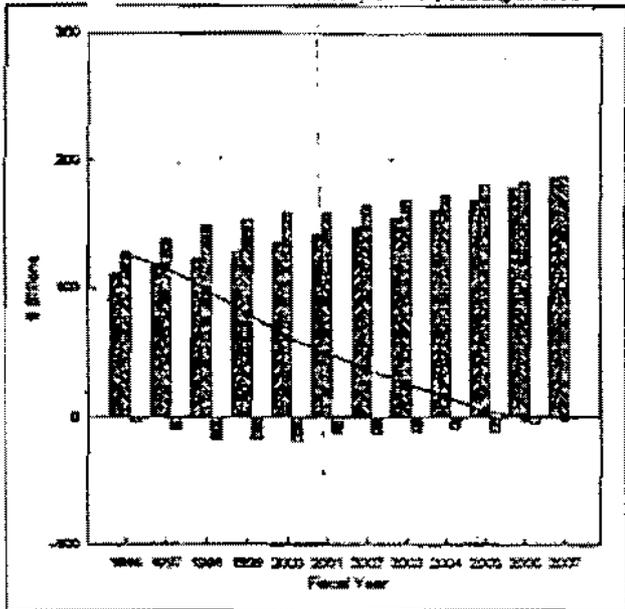
CBO Baseline



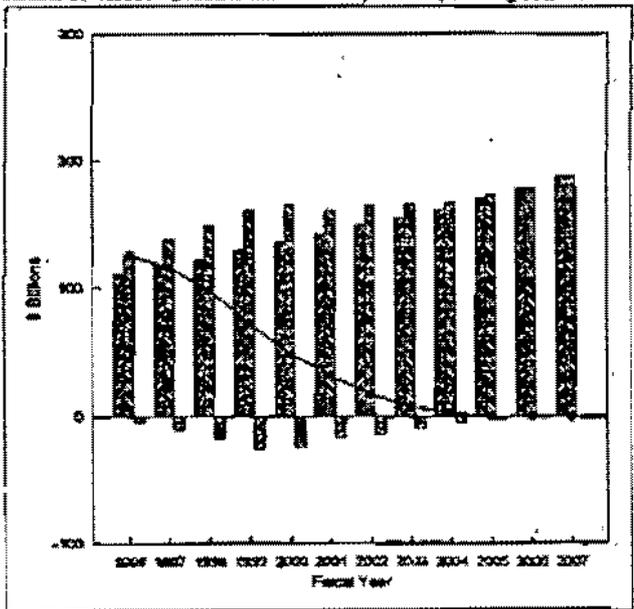
Scenario 1: Reduce Baseline Rate of Outlay Growth, Starting in 1998



Scenario 2: Reduce Baseline Rate of Outlay Growth, Starting in 1999



Scenario 3: Reduce Baseline Rate of Outlay Growth, Starting in 2000



Noninterest Receipts    
  Outlays    
  Surplus    
  End of Year Balance

**TABLE 2: Scenarios to Maintain a Positive Trust Fund Balance Through Fiscal Year 2007 With Slower Outlay Growth Beginning in 1998 or Subsequent Years**

by fiscal year, dollar amounts in billions

	Scenario 1: Reduce Rate of Outlay Growth Beginning in 1998										Cumulative Change in Outlays FY98-02 FY98-02 FY98-02 FY98-02 FY98-02	Average Annual Rate of Growth FY98-02 FY98-02
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005		
Percentage Point Reduction from Baseline Rate of Outlay Growth	0.0%	0.0%	-4.3%	-4.3%	-4.3%	-4.3%	-4.3%	-4.3%	-4.3%	-4.3%	-4.3%	-4.3%
Change from Baseline Outlays	0	0	-8	-12	-23	-29	-37	-47	-58	-71	-84	-95
Outlays	125	137	143	149	157	157	155	171	177	169	191	194
Interest Receipts	10	10	9	8	7	6	6	4	3	2	1	0
Noninterest Receipts	111	116	122	128	135	141	146	155	162	170	179	189
Surplus (Receipts - Outlays)	-4	-10	-12	-14	-10	-10	-12	-11	-12	-16	-12	-6
Balance, End of Year	125	118	104	82	63	48	35	28	35	17	5	0
Trust Fund Ratio	103%	81%	81%	70%	59%	48%	33%	29%	29%	10%	6%	3%
Scenario 2: Reduce Rate of Outlay Growth Beginning in 1999												
Percentage Point Reduction from Baseline Rate of Outlay Growth	0.0%	0.0%	0.0%	-5.3%	-5.3%	-5.3%	-5.3%	-5.3%	-5.3%	-5.3%	-5.3%	-5.3%
Change from Baseline Outlays	0	0	0	-8	-17	-29	-37	-48	-61	-77	-91	-102
Outlays	125	137	149	153	150	158	155	169	173	162	184	189
Interest Receipts	10	10	9	7	6	6	4	3	2	1	0	0
Noninterest Receipts	111	116	122	128	135	141	148	155	162	170	179	189
Surplus (Receipts - Outlays)	-4	-10	-15	-17	-19	-12	-13	-11	-9	-11	-5	-0
Balance, End of Year	125	118	98	81	62	50	37	26	18	8	0	0
Trust Fund Ratio	103%	91%	76%	64%	51%	39%	30%	22%	16%	8%	3%	0%
Scenario 3: Reduce Rate of Outlay Growth Beginning in 2000												
Percentage Point Reduction from Baseline Rate of Outlay Growth	0.0%	0.0%	0.0%	0.0%	-7.0%	-7.0%	-7.0%	-7.0%	-7.0%	-7.0%	-7.0%	-7.0%
Change from Baseline Outlays	0	0	0	0	-11	-23	-37	-61	-87	-96	-95	-102
Outlays	125	137	149	161	165	161	165	169	167	173	179	189
Interest Receipts	10	10	9	7	6	4	2	1	1	0	0	0
Noninterest Receipts	111	116	122	129	135	141	148	155	162	170	179	189
Surplus (Receipts - Outlays)	-4	-10	-18	-26	-25	-18	-14	-10	-5	-3	-0	-0
Balance, End of Year	125	118	98	73	49	32	16	6	3	0	0	0
Trust Fund Ratio	103%	91%	76%	61%	44%	30%	18%	11%	6%	2%	0%	0%

\* The trust fund ratio is the beginning-of-year trust fund balance expressed as a percentage of outlays during the year.

## HOW DOES YOUR HOME HEALTH PROPOSAL REFLECT PRE-1980 POLICY?

### QUESTION:

Why do you say that the home health transfer restores pre-1980 policy? Part B expenses used to be included in the Part B premium, but you are recommending these expenses be excluded from the Part B premium.

### ANSWER:

- Our proposal to reallocate some of the home health financing to Part B restores the *post-acute care nature of Part A* and, in this way, is consistent with the original Medicare law.
- Part A insurance (financed by the HI Trust Fund) was designed to cover hospitalizations and short-term, recuperative, post-acute care in the home or in other facilities.
- This is reflected in the division of home health services that existed prior to the OBRA 1980 reforms.
- Until OBRA 1980, the Part A portion of the home health benefit was limited to only 100 visits per year, and could only be provided after a hospital stay of 3 days or more. The Part B portion financed an additional 100 home health visits after the Part A benefit was exhausted.
- Under our proposal, the first 100 visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B.
- It is true that the Administration does not propose to allow an increase in the Part B premium due to an reallocation of home health expenditures.
- The Administration is committed to reforming Medicare without increasing beneficiaries' out-of-pocket costs.
- The Administration is concerned about the impact that higher beneficiary out-of-pocket expenses would have on poorer Medicare beneficiaries. Currently, Medicare beneficiaries spend an average of \$2,605 on out-of-pocket health expenditures; this accounts for 18% of family income for Medicare beneficiaries. Poorer beneficiaries spend a greater proportion of their incomes.

## IMPOSING PREMIUM ON PART B HOME HEALTH

### QUESTION:

Why aren't you going to charge a premium or coinsurance for home health spending that is transferred to Part B?

### ANSWER:

- The cornerstone of the President's Medicare plan is our commitment to protecting beneficiaries from unnecessary increases in their out-of-pocket health expenses.
- Contrary to popular opinion, most Medicare beneficiaries have modest incomes. About 75 percent of beneficiaries have annual incomes of \$25,000 or less, and nearly 12 percent have incomes below the federal poverty level.
  - Elderly Americans already spend about 18 percent of their income on out-of-pocket health care costs -- more than two-and-one-half times what the non-elderly pay.
- Imposing coinsurance or premiums on home health services financed under Part B would substantially lower the standard of living for the majority of Medicare beneficiaries. It would be especially devastating for our lowest-income beneficiaries, who tend to rely heavily on home health services.

### KEY INFORMATION:

- 1992 HCFA data show that beneficiaries with 3 or more limitations in Activities of Daily Living (ADLs) have a higher number of home health visits during the year. As these beneficiaries tend to be more frail and have less income, they would be most vulnerable to additional out-of-pocket costs for home health.
  - ▶ The average number of visits for all users was 55, whereas the number of visits for beneficiaries with 3 or more ADLs was 98; in addition, a greater percentage of beneficiaries with 3 or more ADLs use 100 or more visits in a year compared to all home health users.

## INCREASE IN HOME HEALTH TRANSFER SAVINGS

### QUESTION:

Why is the amount of money moved by your home health transfer higher than last year?

### ANSWER:

- Our policy has not changed. However, scoring of this policy has been updated.
- Since last year, our actuaries have obtained better data on who uses home health care and for how long. With this new data, the actuaries have developed a more reliable estimate of how much home health care will be financed in Part B under our reform proposal.
  - ▶ Last year, the actuaries used 1993 Medicare beneficiary survey data -- which includes only a sample of the Medicare population -- as the basis for its home health reform estimate.
  - ▶ This year, the actuaries used 1994 and 1995 claims data -- which includes the entire population -- as the basis for its home health reform estimate.
  - ▶ This new data shows that compared to what we estimated last year, a greater percentage of beneficiaries use more than 100 visits in a given year. Since our proposal would finance these visits under Part B, this new data increased our estimate of its effect on Part A.

### KEY INFORMATION:

- Another factor affecting the estimated amount of home health financed in Part B is percentage of beneficiaries using more than 100 visits per year. The following table shows that between 1991 and 1994, the percentage of beneficiaries using 100 or more visits in a given year grew from 13 percent to 20 percent.

Visits Used	1991	1992	1994
1-50	74.2%	68.4%	64.4%
51-100	12.8%	13.7%	14.8%
101-150	5.0%	7.1%	6.9%
151-200	4.1%	4.4%	4.2%
200+	3.9%	6.4%	9.7%

## WHY IS 25% PREMIUM AN EXTENSION OF CURRENT LAW?

### QUESTION:

Last year Republicans proposed extending the then-current law Part B premium, set at 31.5% of program costs, and you criticized that as a beneficiary cut. Now you propose extending the current-law 25% premium rule and it's not a cut. Why is that?

### ANSWER:

- In 1984, the Part B premium was established at 25 percent of Part B program costs. Since that time, this policy has been maintained through extensions in various budget bills.
- Up until 1990, the law required the premium to be set at a level to cover 25 percent of program costs. HCFA's actuaries then determined that dollar amount.
- In OBRA 90, Congress wrote into law dollar amounts based on CBO's projections of 25 percent premiums for 1991-1995.
- Part B program growth during that period was slower than expected. As a result, the premium for 1995 actually represented 31.5% of program costs.
- Extending the 31.5 percent policy -- the result of an estimating error -- into the future would have imposed a financial burden on beneficiaries. This is why that policy would have been a cut.
- Fortunately, that did not happen, and the Part B premium in 1996 and 1997 returned to levels that reflect 25 percent of program costs.
- We think this is a reasonable share for beneficiaries to pay and now propose to make the policy permanent.

## INCOME-RELATED PART B PREMIUM

### QUESTION:

Why isn't there a means-tested Part B premium? In the past, the President supported a means-tested premium, yet there isn't one in the FY 1997 budget. Why not?

### ANSWER:

- The President is committed to protecting beneficiaries from unnecessary increased out-of-pocket costs. The proposal to permanently extend the Part B premium to cover 25 percent of costs would continue the premium policy for the last decade. Congress began the 25 percent premium in TEFRA, though it has varied somewhat since then.
- Three years ago, the Administration supported a means-tested Part B Premium in the context of overall health care reform. In that plan, the President proposed to expand Medicare benefits, including providing coverage for prescription drugs and long term care. The income-related increase in the Part B premium would have helped to offset the additional benefits.
- Although we are not proposing one this year, the President has indicated his willingness to discuss this issue in the context of bipartisan discussions on a balanced budget.

## WHY AREN'T THERE MORE INCENTIVES FOR BENEFICIARIES TO BE COST CONSCIOUS?

### QUESTION:

Senator Lott has said your budget doesn't ask enough of beneficiaries. Why don't you ask seniors to pay more?

### ANSWER:

- First it's important to remember that our senior citizens are not, by and large, a wealthy group. Three-quarters of beneficiaries earn less than \$25,000 a year; elderly women on Medicare have an average annual income of less than \$13,000. Plus, we know that seniors spend an average of 21% of their income on health care costs (compared with 8% for those under 65).
- Second, we do ask beneficiaries to contribute. By keeping the Part B premium at 25% of costs we produce \$10 billion in savings over 5 years and \$17.7 billion over 6 years.
- The President has said he is willing to discuss an income-related premium for upper-income beneficiaries. But we must be careful not to create an incentive for those seniors to drop out of Part B.

## WHAT IS THE STATUS OF THE QUALITY COMMISSION?

### QUESTION:

What is the status of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry? I thought he was going to make appointments by the November elections.

### ANSWER:

- I am a co-chair of the Commission, along with the Secretary of Labor. We are working with the White House to finalize decisions about the members of the Commission. We have appreciated especially the recommendations from the Congress.
- I expect there will be an announcement on the Commission's appointment in the near future.

## WHY ARE YOU OPPOSED TO ADVISORY OPINIONS?

### QUESTION:

How can you propose repeal of the recently-enacted advisory opinion requirement when your department STILL, after all these years, has not published regulations on the so-called Stark II legislation prohibiting so-call physician self-referrals?

### ANSWER:

- The Advisory opinion requirements addresses, among other issues, the applicability of the anti-kickback law which is an intent-based provision.
- Under HIPPA, individuals can submit specific requests to HHS as to whether certain business arrangements may or may not be considered to violate the anti-kickback laws. Because it is difficult, if not impossible, to determine intent based on such a request, we believe that the HIPPA provision is impractical. Our responses to requests will not be satisfactory to the sender since we will be unable to address the intent of the requester.
- As to the Stark II provisions, the development of these regulations has been a difficult task for HCFA. The development of the regulation has been completed and it is now in clearance within the Administration. We would anticipate its publication by late spring.
- There are a number of reasons for the delay. Unfortunately, there was no expertise in the agency in regard to the intricate financial arrangements that are the subject of the regulation. Staff had to develop this expertise through consultations with professional organizations and legal experts.
- The process was further complicated by the fact that the health care marketplace was rapidly evolving while the regulation was being developed. Given the potential for a flawed regulation to cause unnecessary disruption in the health care sector, we thought caution was warranted.
- That being said, we have tried as the regulation was being developed to address questions from the industry in regard to our interpretation of areas of the law that are not straightforward. For example -- questions were raised about whether screening mammography services were included under the definition of designated health services as a radiological service. We have informed interested parties that given the statutory limits on the use of screening mammography services, we did not consider that the referral for these services poses a risk of abuse. Similarly, we have informed physicians that the provision of use of lithotritor services to treat kidney stones does not pose a risk of abuse.

## TOTAL MEDICAID SAVINGS

### QUESTION:

What are the total savings in Medicaid and how does the President's Medicaid legislative package achieve its savings?

### ANSWER:

- ▶ The President's plan saves approximately \$9 billion net of new investments over five years.
- ▶ Total savings are about \$22 billion over five years.
- ▶ Roughly two-thirds of the savings comes from a reduction in Disproportionate Share Hospitals (DSH) payments and roughly one-third from the per capita cap.
- ▶ In addition, the President's plan invests \$13 billion in improvements to Medicaid, including health initiatives to expand coverage for children, changes to last year's welfare reform law, and new policies to help people with disabilities return to work.

## MEDICAID GROWTH RATES

### QUESTION:

Last year you criticized the Republicans for constraining the aggregate growth rate in Medicaid to 5 percent per year. Now you are proposing approximately 6.5 percent growth. Isn't that hypocritical on the part of the Administration?

### ANSWER:

- ▶ When the Republican block grant proposed a 5 percent growth rate, predictions of future growth in Medicaid were higher than they are now.
- ▶ We are proposing a growth rate for Medicaid that we think is realistic in view of the growth in private sector health costs, the reduced growth rate in Medicaid itself over the last year, and our and CBO's projections of the Medicaid baseline over the next decade. With the decline of the Medicaid baseline, we can maintain services with lower growth.
- ▶ The goal of the per capita cap policy is twofold:
  - First, we can constrain Medicaid to an appropriate growth rate.
  - Second and more important, the per capita cap policy imposes fiscal discipline in Medicaid. If costs increase more dramatically in the future, we will have a policy that automatically protects States that want or need to expand the number of eligibles, but at the same time keeps costs down.

## GROWTH INDEX FOR THE PER CAPITA SPENDING LIMIT

### QUESTION:

How much does the per capita cap save and what is the per capita growth index?

### ANSWER:

- ▶ The President's Medicaid budget proposes net savings of \$9 billion over the 5 year budget period -- this is less than 2 percent below the baseline spending projected for this period.
  - ▶ This will include savings of \$22 billion from a combination of the per capita cap proposal and a reduction to disproportionate share hospital (DSH) payments -- roughly one-third from the per capita cap and two-thirds from DSH. The Budget proposes \$13 billion in new spending in Medicaid primarily for children and to restore reductions to legal immigrants that were included last year's welfare reform bill.
- ▶ In the policy we proposed last year, the per capita cap growth index was based on the nominal GDP - index of the change in the gross domestic product. We are currently examining the index and will be refining our proposal in close consultation with the Congress.

## DOES THE PER CAPITA CAP LOCK IN INEQUITIES?

**QUESTION:** Does per capita cap lock in inequities?

**ANSWER:**

- ▶ It is not the goal of the per capita cap to address the differences that have evolved over time among States in per capita spending. The goal of the per capita cap is to ensure that Medicaid has "fiscal discipline" by limiting per capita growth in the states's program to reasonable rates.
- ▶ Having said this, the per capita cap creates an incentive for greater efficiency. The per capita cap growth rates are applied equally to all states.
  - Those states that are -- or become -- more efficient than average will be better able to keep spending growth under this limit. They will be "rewarded" by having more resources to spend.
  - By contrast, those states that are less efficient will have to work harder than they do now to keep spending growth within the limits.
- ▶ The per capita cap does not address variation in base year spending due to decisions states have made historically about the overall generosity of their Medicaid programs. For example, some states have decided to cover many optional benefits, while others cover very few.
  - For 3 decades, low spending states have declined to adopt more expansive Medicaid programs, even in the face of unlimited federal matching funds at matching rates as high as 80 percent.
  - It is possible these low spending States, now faced with a per capita cap, will decide to dramatically expand their Medicaid programs and the share of the State budget they devote to Medicaid; but we don't think this is very likely.

(Continued on the following page)

## DSH CUTS - IMPACT ON STATES

### QUESTION:

What is the President's policy on disproportionate share hospital (DSH) payments and what impact will it have on States? How are DSH payments retargeted? How much savings will be achieved through a reduction in DSH payments?

### ANSWER:

- ▶ The DSH policy proposed in the President's FY 1998 Budget is in accordance with demonstrated Congressional intent to maintain control over DSH expenditures.
  - The policy will include a redefinition of Disproportionate Share Hospitals to more closely target those hospitals providing the majority of uncompensated care, and will provide for reallocation of DSH funding to safety net providers that offer outpatient care.
  - States will have some discretion to target a portion of their DSH funds to those providers and facilities most in need.
  - All States will experience cuts in DSH funding.
- ▶ The President's Medicaid savings plan is made up of \$22 billion in Medicaid savings, of which roughly 2/3 is DSH savings and 1/3 is savings from the per capita cap policy. With other legislative proposals, final savings derived from the Administration's Medicaid package will net \$9 billion.

## MEDICAID FOR IMMIGRANTS

### QUESTION:

The Welfare Reform bill just enacted by Congress and signed by the President eliminated Medicaid coverage for newly arriving immigrants. Why are you proposing to allow States to cover disabled immigrants and children under Medicaid?

### ANSWER:

- ▶ When he signed the welfare reform bill, the President expressed his grave reservations about provisions of the bill that had nothing to do with the central goal of moving people from welfare to work. In particular, he opposed limitations on benefits for legal immigrants and promised to develop legislation to address those concerns.
- ▶ The benefits restored in the President's budget are targetted toward those who cannot work. Disabled legal immigrants and legal immigrant children are the most vulnerable of this population and are least able to manage without critical SSI and Medicaid benefits.
- ▶ While it may be fair to expect immigrants to enter the country prepared to take care of their own basic needs, medical care is different. It is impossible to predict or plan in advance to pay for medical care that an immigrant may need as a result of unexpected illness or injury after he or she has entered the country.
- ▶ Our budget proposals assist the most vulnerable groups of immigrants for whom lack of access to medical care may produce long-term negative consequences.

## OUTREACH TO MEDICAID ELIGIBLE CHILDREN

### QUESTION:

How do you propose to pick up the 3 million kids who are not enrolled in Medicaid? Isn't this going to be a burden on the states? Exactly how many of the three million children will be enrolled?

### ANSWER:

- We plan to work very closely with the States as we move forward to fulfill the promise of Medicaid for children who are eligible. This effort cannot succeed without State support and we will rely extensively on State expertise and best practices regarding outreach efforts to Medicaid beneficiaries.
- We want to minimize the burden on the states by building upon current activities.
- Working with States, public and private entities, provider communities, foundations, etc. we intend to initiate a campaign to determine and eliminate barriers to enrollment for the 3 million eligible children currently not participating in Medicaid.
- We intend to build upon existing partnerships with other Federal programs such as Headstart, WIC, Department of Education programs, etc. to ensure families with eligible children are aware of Medicaid.
- We hope to enroll as many children as we can. Our current estimate is 1.6 million.

## DOES THE CAP PROPOSAL GIVE STATES ADEQUATE FLEXIBILITY?

### QUESTION:

You propose a per capita cap on states but deny them much of the program flexibility they are seeking.

Why do you insist that the Governors come to you "hat in hand" to request this flexibility through waiver? Shouldn't a per capita cap be paired with broader State flexibility to enable States to do what is necessary to live within the spending limits?

### ANSWER:

- ▶ The President's budget seeks to grant maximum flexibility to States to run the federal-State Medicaid program within the context of a national guarantee of health care and basic national minimum standards for eligibility and benefits.
- ▶ We believe that the President's proposals for Medicaid reform go a long way in responding to the interests of the States. In particular, the President's plan addresses the top concerns of the Governors:
  - Repeal of the Boren Amendment regulating provider payments;
  - Ending the burdensome waiver process for managed care and home- and community-based waivers;
  - Eligibility simplification and expansions without waivers; and
  - Elimination of many unnecessary and duplicative administrative requirements.
- ▶ Furthermore, we believe strongly in the importance of maintaining a national standard for eligibility and benefits. The eligibility groups for which the Medicaid program requires mandatory coverage are among the most vulnerable, and the mandatory services make up a core benefit package.

## WHY NOT REPEAL REQUIREMENTS YOU WAIVE UNDER 1115

### QUESTION:

The Administration has waived many provisions of Medicaid law to enable States to pursue the demonstration projects that you hail so loudly. However, you are unwilling to repeal or revise these provisions of the law for other States. Isn't this inconsistent? Why should States have to come to you to ask for permission to reform their Medicaid programs?

### ANSWER:

The Medicaid statute imposes minimum requirements for State Medicaid programs. HCFA has tried to provide maximum flexibility to States under title XIX. However, specific repeal of provisions of certain requirements can only be done under section 1115 authority. HCFA has prepared legislation to address many of the major areas in which States request waivers. For instance:

- ▶ Managed care--Proposed legislation addresses eliminating the 75/25 enrollment composition requirements (but retaining the Federal oversight of quality) and making 1915(b) freedom-of-choice waivers a State Plan option. These changes will make it easier for States to implement managed care without waivers.
- ▶ Expansions--Proposed legislation contains provisions under a per capita cap to enable States to enroll individuals up to 150 percent of the FPL.
- ▶ FQHCs--Legislation proposes to phase-out cost-based reimbursement. Instead, targeted funding would be established to provide continued viability of these safety net providers. Access standards would be maintained.

**NEW INITIATIVES FOR THE MIDDLE CLASS  
AT THE EXPENSE OF THE POOR?**

**QUESTION:**

Why did you decide to use Medicaid savings to finance your initiatives for uninsured children and unemployed workers?

**ANSWER:**

- ▶ We did not.
- ▶ Medicaid savings are used only to finance Medicaid investments, including restored coverage for legal immigrants who are disabled or children, and twelve month continuous eligibility for children.

## HEALTHY WORKING FAMILIES - COMPARED TO LAST YEAR

### QUESTION:

How does this proposal to assist workers between jobs differ from your proposal in last year's budget?

### ANSWER:

- ▶ The program is very similar to last year's proposal.
  - It will give grants to states to extend subsidies to workers who lose their jobs and health benefits.
  - Workers will be eligible for a full subsidy if their income is at or below 100 percent of poverty. The subsidy will be phased out at 240 percent of poverty.
  - States will have flexibility in determining how to use funds to assure access to a health insurance product.
- ▶ We have made a few changes:
  - We have changed a few provisions to assure the portability rights established in the Health Insurance Portability and Accountability Act are protected.
  - The structure of the program has been changed to assure cost containment. It is now a 4-year, capped demonstration program with a limited loan fund to account for growth in demand within states.
  - The eligibility, coverage, and administration provisions in the proposal are essentially the same as those included in last year's proposal.

## GRANTS VS. TAX SUBSIDIES

### QUESTION:

Senators Daschle, Kennedy and others have introduced multibillion tax credit and grant programs to provide insurance to uninsured children. Isn't the Administration's approach an implicit rejection of these costly new federal entitlements proposed by Democrats in Congress?

### ANSWER:

- No, we believe our proposals are consistent with the goals of those in Congress who have introduced legislation to expand insurance coverage for children.
- Nearly 10 million children --one in seven--are uninsured in America today. That number has increased as employers have been reducing dependent coverage. Our goal must be to significantly reduce the number of uninsured children through practical, incremental reforms. We believe this problem requires a multi-faceted, bipartisan strategy that involves a pragmatic series of incremental steps by both federal and state governments, as well as the private sector.
- We want to build on the knowledge gained by numerous states that have taken steps to help families who cannot afford to purchase insurance for their children. States have formed partnerships with providers, insurers, philanthropic organizations and businesses to solve the problem of uninsured children. These states have found that by localizing the problem of uninsurance, they can develop and reach achievable goals. They have established strong provider networks, administrative efficiencies and strong outreach to their eligible families. Through the success of these efforts, other states are replicating programs to insure children.
- We believe ours is a good approach. There are other approaches that have merit as well. We look forward to working with members of Congress in both parties to enact meaningful legislation this year.

## UNINSURED CHILDREN ELIGIBLE FOR MEDICAID

### QUESTION:

How many of the 3 million children eligible for Medicaid but not enrolled are uninsured?

### ANSWER:

We believe most of the 3 million children who are currently eligible for Medicaid but not enrolled have no other access to health insurance.

Our goal is to enroll 1.6 million of these children by the end of year 2000.

## PRESIDENT CLINTON'S CHILDREN'S HEALTH INITIATIVE

### QUESTION:

The President has said he hopes to cover 5 million of the uninsured children in four years. How will you achieve that?

### ANSWER:

The President's goal is based on sound understanding of the characteristics of uninsured children. Since there is no single reason why a child is uninsured, no single solution effectively and efficiently addresses this problem. Our proposal has three parts:

#### Children Losing Employer-Based Insurance

- **Workers Between Jobs.** The President's proposal to help children whose parents lose their health insurance when they lose their job provides states with funds to help temporarily uninsured workers pay for continuing health insurance.  
(+ 700,000 kids by 2000)

#### Children Above the Poverty Line

- **State Partnership Grants.** States will receive \$3.75 billion over the next five years to develop innovative methods to insure children.  
(+ 1 million kids by 2000)

#### Medicaid-Eligible Children

- **Medicaid Continuous Eligibility.** States will have the option of providing 12 months of continuous Medicaid coverage to any child who becomes eligible for coverage during the year.  
(+ 1 million kids by 2000)
- **Medicaid Outreach.** The Federal government will work with the States to reach some of the estimated 3 million children who are currently eligible for Medicaid but are not enrolled.  
(+ 1.6 million kids by 2000)

## President Clinton's Children's Health Initiative - cont'd

- Adolescents age 14-18. Current law requires states to expand Medicaid coverage to poor children between the ages of 14 and 18.  
(+ 1 million kids by 2000)

### Summary:

Workers Between Jobs	0.7 million
Partnership Grants	1 million
Continuous Eligibility	1 million
Medicaid Outreach	1.6 million
Adolescents (14-18)	1 million
TOTAL Approximately	5 million

### Other information:

These are the Department of Health and Human Services estimates.  
Illustrative estimates of potential coverage assume all states and partners participate in programs. Estimates do not account for overlap between target populations.

HC-Medicare

MEMORANDUM

February 12, 1997

TO: Bruce Reed  
FR: Chris Jennings  
RE: Medicare premiums and structural reforms  
cc: Elena Kagan

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Attached is a Medicare premium chart that illustrates our projections for Part B premiums under our current Medicare proposal as well as projections for premiums under our proposal and the Republican proposal during last year's budget debate. It also includes our current projections of what the Part B premium would be if the home health expenditures that are reallocated to Part B were included in our premium calculations.

As you will note, our current projections show that our Part B premium will be \$63.80 in 2002, about \$11 more than current law (because it extends current law to maintain the Part B premium at 25 percent of program costs as we did in the last two budgets). This premium is still about \$25 less than the CBO projection of the vetoed Republican budget.

In addition, these numbers show that including the home health services reallocated to Part B in the Part B premium, would raise it about \$11 in 2002, an amount that is about \$14 less per month than the Republican budget that the President vetoed. You should also note that the current additional savings for including the home health expenditures in the Part B premium are projected to be \$20 billion (not \$17 billion) over five years. None of this information is conceptually new, but I thought that you might find it useful to have it all in one place.

Finally, I am attaching a 3-page document that summarizes the structural reforms in our Medicare plan. This may help make the case that the President's Medicare reform is as much about structural change as it is about achieving savings to extend the life of the Trust Fund. You and other principals might find it useful in discussions to make this point.

I hope this information is helpful. Please call me at 6-5560 with any questions.

### Medicare Part B Premiums under Current Law and the President's Budgets

	1996	1997	1998	1999	2000	2001	2002 1998-2002
Current OMB Baseline	\$42.50	\$43.80	\$47.40	\$48.70	\$50.00	\$51.30	\$52.70
President's 5-Year Balanced Budget 2/6/97 (OMB scoring, 2/97, relative to OMB January 1997 baseline)	\$42.50	\$43.80	\$47.30	\$50.90	\$54.40	\$58.60	\$63.80
President's 7-Year Balanced Budget 12/7/95 (CBO scoring, 12/95, relative to CBO December 1995 baseline)	\$42.50	\$45.50	\$49.50	\$53.40	\$59.50	\$64.60	\$70.40
GOP 7-Year Balanced Budget 12/95 (CBO scoring, 12/95, relative to CBO December 1995 baseline)	\$51.40	\$54.90	\$58.60	\$62.80	\$70.70	\$77.20	\$84.60
Vetoed GOP 7-Year Balanced Budget 11/95 (CBO scoring, 11/95, relative to CBO March 1995 baseline)	\$53.70	\$57.00	\$59.30	\$64.10	\$73.10	\$80.10	\$88.90
President's 5-Year Balanced Budget 2/6/97 With the Home Health Transfer Included in Premiums (OMB scoring, 2/97, relative to OMB January 1997 baseline)	\$42.50	\$43.80	\$55.90	\$59.90	\$63.60	\$68.60	\$74.60
Revenue from Premium on Home Health (FY, Billions)			\$2.9	\$4.0	\$4.2	\$4.5	\$4.9
							\$20.5

Note: These premiums are relative to different baselines; thus, the President's same policy produces different premiums due to the baseline differences.

## **The President's FY 1998 Budget: Medicare Structural Reforms in the President's Budget**

**The President's Budget modernizes Medicare and brings it into the 21st century through a number of major structural changes.**

### **FEE-FOR-SERVICE PAYMENT REFORM**

- **Building on the success of prospective payment for inpatient hospital, the President's Budget would move to prospective payment systems for:**
  - **Skilled nursing facilities (SNF).** Driven primarily by increases in intensity of services, SNF is one of the fastest growing Medicare benefits. The budget would establish a per-diem SNF prospective payment system beginning in 1998, which would reimburse for all costs (routine, ancillary, and capital).
  - **Home health services.** Medicare's retrospective reimbursement rates do not help control volume, contributing to the increasingly high expenditures in this area. The President's budget implements a prospective payment system in 1999, which pays home health agencies based on characteristics of the patients, not on how many services agencies provide.
  - **Hospital outpatient departments (OPDs).**

**Implements prospective payment system.** OPDs are still paid, in part, on a per cost basis. To help constrain the costs of OPDs, which are projected to nearly double between FY 1997 and FY 2002, the President's budget would move to a prospective payment system for these services starting in 1999, which for the first time, would create incentives for efficiencies.

**Addresses the current inequity in coinsurance for hospital outpatient fees.** Due to flaws in the current reimbursement methodology, OPDs receive a total payment for certain services that exceed the 100 percent Medicare "rate." Since coinsurance is a function of hospital charges and since charges are significantly greater than Medicare's payment rates, beneficiaries pay nearly a 50-percent copayment for outpatient department services, as oppose to the 20-percent rate for other Part B services. The President's proposal assures that by 2007, coinsurance will be reduced to the traditional 20-percent level.

## IMPLEMENT SUCCESSFUL PURCHASING APPROACHES

- **Adopts approaches to purchasing health care services that have proved successful in other areas.** These approaches to purchasing health care services have been used successfully by the private sector and other federal and state purchasers that have been tested under Medicare's demonstration authority.
- **Centers of Excellence.** Since 1991, the Health Care Financing Administration has been conducting a demonstration that pays facilities a single flat fee to provide all diagnostic and physician services associated with coronary artery bypass graft (CABG) surgery. Medicare has achieved an average of 12 percent savings for the CABG. This proposal would make the "centers of excellence" a permanent part of Medicare expanding it to include heart procedures, knee surgery, and hip replacement surgery.
- **Competitive Bidding.** To help implement more competitive strategies in managing payment for durable medical equipment, laboratories, and other items and supplies, the President's proposal would establish competitive bidding for these items.
- **Purchasing Through Global Payments.** This enables the Secretary to selectively contract with providers and suppliers to receive global payments for a package of services for a specific condition or need of an individual. Providers would be selected on the basis of their ability to provide high quality services, to improve coordination of care, and to offer additional benefits. Beneficiaries would voluntarily elect on a month-to-month basis to participate in such an arrangement.
- **Flexible Purchasing Authority.** This authorizes the Secretary to negotiate alternative administrative arrangements, excluding changes in quality standards or conditions of participation, with providers who agree to provide price discounts to Medicare. Savings from these arrangements could be given directly to the beneficiaries who use them.

## MANAGED CARE PAYMENT REFORMS

The President's Budget would reform the payment methodology for managed care plans.

- **Addresses flaws in payment methodology for managed care.** The reforms will create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly in rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor, will reduce geographical variation in current payment rates.

- **Carves out GME, IME, and DSH payments from managed care.** Eliminates medical education and disproportionate share hospital payments from the HMO reimbursement formula and provide this money directly to teaching and disproportionate share hospitals for managed care enrollees and to academic health centers.
- **Adjusts payment rates to reduce Medicare's current overpayment of managed care.** Currently, this overpayment exists because managed care enrollees are typically healthier than Medicare beneficiaries who remain in fee-for-service. This is a temporary adjustment until we implement a risk-adjusted payment system which is expected to be in place by no later than 2002.

## **NEW CHOICES FOR BENEFICIARIES**

- **Establishes new private health plan options.** The budget increases the number of plans -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities. These options will meet strong quality standards and include consumer protections. The plans would be required to compete on cost and quality, not on the health status of enrollees.
- **Replaces 50/50 rule with quality measurement system.** The Secretary, in consultation with consumers and the industry, will develop a system for quality measurement. Once this system is in place, the current requirement that requires managed care plans to maintain a level of private enrollment at least equal to the public program enrollment will be eliminated.
- **Provides beneficiaries with comparative information to help them choose the plan that best meets their needs.** Similar to the FEHBP program, this proposal would enable beneficiaries to examine and compare all of the information about their coverage options.
- **Develops a process with the National Association of Insurance Commissioners to better standardize benefits.** This proposal creates a process to standardize some of the additional benefits provided by managed care plans and revises standard Medigap packages so that Medicare beneficiaries can make an apples to apples comparison when evaluating their coverage options.
- **Establishes an annual coordinated open enrollment period for all managed care and Medigap plans.** These new Medigap protections would make it possible for beneficiaries to switch back from a managed care plan to traditional Medicare without being underwritten by insurers for private supplemental insurance coverage. This should encourage more beneficiaries to choose managed care plans because they would be assured that they could always go back to fee-for-service.

File  
H.Care - Medicare

### MEDICARE ISSUES

1. **Deeper Cuts**
  - Why do you say you have split the difference with Republicans?
  - How do you get from the \$116 to \$138?
2. **Home Health Transfer**
  - A gimmick.
  - Not included in the Part B premium.
3. **Managed Care Cuts**
  - Reducing from 95% to 90%.
  - Geographic disparity (rural areas).
4. **High-Income Premium**
  - Reports say you are willing to consider high-income premium.
  - Will you move to this later?
5. **Medicare Commission**
  - Do you plan to have one?
  - Aren't you just putting off the hard choices?

### MEDICAID ISSUES

1. **Overall Savings**
  - Many (base Dems./Liberal groups) believe \$22 billion too high.
  - Why extensive cuts when baseline has fallen so much.
  - Others won't think we go far enough. Can squeeze more savings.
2. **Per Capita Cap**
  - Advocates and Governors fear index will be further constrained in this or future year's budget talks.
  - Governors believe it to be an unfunded mandate.
  - Another formula fight.
3. **DSH**
  - High vs. Low.
  - Policy vs. Politics.
4. **Flexibility**
  - Governors want a great deal.
  - Liberal base opposes excessive flexibility.
  - Boren Amendment politics.

## COVERAGE EXPANSION

### **Workers In-Between Jobs**

-- Defensible policy but so far, few strong advocates.

### **Children's Coverage Options**

1. **Our Policy**
2. **Democrat's Policy**
3. **Republican's Policy**

### **Health Care Quality**

1. **Our Quality Initiatives**

-- Administrative legislative/regulatory initiatives.

2. **Hill Initiatives**
3. **Quality Commission**

HCare - Medicare

MEMORANDUM

TO: Interested Parties

January 5, 1997

FR: Gene S. and Chris J.

RE: Pear's *NY Times* Article on Medicare Premiums/Home Health Policy

Attached are DRAFT talking points and Q&As to help respond to inquiries about Robert Pear's Sunday *NY Times* article on Medicare premiums and our home health care policy. Our position, of course, is to not comment on any specific item in the upcoming budget. However, the enclosed should help respond to general questions about the article and our home health care policy.

We anticipate a number of press and Hill inquiries following-up on this article. Please review and provide any edits to Chris J. by 10:00 am tomorrow morning.

## TALKING POINTS ON *NY TIMES* MEDICARE PREMIUM STORY

(General: We do not comment on any element of the budget before it is released by the President.)

**PREMIUM INCREASES.** It is no secret that the President reviews every Medicare option with a sensitivity to how proposals will affect beneficiaries. Recent Census Bureau data reveals that fully two-thirds of older Americans have incomes less than \$25,000. Moreover, the Urban Institute has recently estimated that the elderly already spend over one-fifth of their out-of-pocket income on health care.

**INTEGRITY OF PRESIDENT'S HOME HEALTH CARE AND BALANCED BUDGET PROPOSALS.** The President's clear and overriding goal is to balance the Federal budget by 2002, extend the life of the Medicare Trust Fund until the middle of the next decade, and to protect our values. His upcoming budget proposal will achieve all of these goals. The home health policy mentioned in the *NY Times* is also consistent with these goals. It is good policy, has received bipartisan support, and makes it possible to strengthen the Trust Fund without indirectly harming beneficiaries through excessive hospital, doctor and other provider cuts. While the policy reallocates a portion of Trust Fund expenditures into general revenues, it does so in the context of plan that strengthens Medicare and eliminates the deficit.

- **GOOD POLICY.** The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits – the most rapidly increasing part of the benefit – have no place in Part A side (the Hospital Insurance Trust Fund) of the program. In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit.
- **BIPARTISAN SUPPORT.** The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new. Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. It was also included in the House-passed budget in 1995 -- a proposal that virtually every Republican House Member voted for -- including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.
- **PROTECTS AGAINST EXCESSIVE CUTS.** The absence of the home health policy would necessitate excessive Medicare cuts that would threaten quality health care for millions of beneficiaries. In addition to desire to focus attention on home health care, we advocated the home health proposal last year was because it enabled us to strengthen the Trust Fund without excessive cuts in hospital, physician, nursing home and other important provider payments.

## Q&As ON *NY TIMES* MEDICARE PREMIUM STORY

- Q. Isn't this home health care transfer just a gimmick that simply shifts dollars around and pushes out the needed tough medicine that Medicare requires?**
- A.** No it is not. The home health policy mentioned in article has been supported by Republicans and Democrats, and is not new. Reallocating the portion of home health care expenditures that are associated with more chronic care was a proposal included in our last budget. It was also included in the House-passed budget in 1995 -- a proposal that virtually every Republican House Member voted for -- including Ways and Means Chairman Archer and his Health Subcommittee Chairman, Bill Thomas. In fact, a similar allocation of expenditures was the law of the land prior to 1980.
- Q. Regardless of past positions on this issue, Republicans now clearly oppose it on the grounds that it is a gimmick and is flawed policy. How can you defend it?**
- A.** The home health provision is good policy because it focuses on one of the most costly services in Medicare; home health services in excess of 100 visits -- the most rapidly increasing part of the benefit -- have no place in Part A side (the Hospital Insurance Trust Fund) of the program. In combination with the Administration's proposal to establish a new prospective payment system for home health care, the proposal would constrain the growth and utilization of this benefit. Such an intervention is long overdue.
- Q. Even if it is defensible policy, if it is included in this year's budget, shouldn't it be included in the Part B premium -- like every other service in the Part B side of the program?**
- A.** I cannot comment on this year's budget before it is released. However, the President is clearly concerned about any proposal's impact on beneficiaries. Recent Census Bureau data reveals that fully two-thirds of older Americans have incomes less than \$25,000. Moreover, the Urban Institute has recently estimated that the elderly already spend over one-fifth of their out-of-pocket income on health care.
- Q. Doesn't this policy simply add to the deficit, which would require even greater contributions from taxpayers to support the program?**
- A.** While the policy reallocates a portion of Trust Fund expenditures into general revenues, it does so in the context of plan that strengthens Medicare and eliminates the deficit. His last budget did just that and his next budget will do the same.

# Clinton Drafts Budget on Familiar Lines

## Besides Restoring Some Cuts In Welfare, '97 Proposals Mostly Follow '96 Goals

By JACKIE CALMES  
And LAURIE MCCINLEY

Staff Reporters of THE WALL STREET JOURNAL  
WASHINGTON — As President Clinton embarks on a new term, he is preparing to lay out what is basically an old budget plan as his first major act.

Among the few new initiatives are Mr. Clinton's proposals to restore some cuts in the Republican-sponsored welfare bill that he signed into law last year. In his budget request planned for Feb. 6, he will propose to add more than \$16 billion over five years for welfare, most of that to restore food-stamp benefits and other cuts to legal immigrants who were targeted in the law.

About \$3 billion of that amount, over three years, would flow to state and local government in grants to train welfare recipients for jobs, as Mr. Clinton promised in his re-election campaign. And employers who hire welfare recipients would qualify for \$400 million in tax breaks.

But in most respects, the Clinton budget for fiscal 1998, which begins Oct. 1, will track last year's unrealized blueprint for reaching a balanced budget in 2002. And for all the talk of resolving the fiscal stalemate between the White House and Congress, Republicans are likely to be disappointed by Mr. Clinton's proposals on such hot buttons as Medicare and Medicaid, defense and tax cuts.

Clinton aides candidly describe the budget as the opening bid for the expected negotiations with congressional Republicans later this year rather than the president's bottom line, essentially a repeat of a tactic Mr. Clinton employed with some political success in 1995.

The president will call for saving \$100

billion through 2002 in the Medicare health-insurance program for the elderly, mostly through reduced payments to health-maintenance organizations, doctors, hospitals and other providers. GOP leaders have urged Mr. Clinton to seek deeper savings for Medicare, which is projected to be insolvent by 2001, and to look to beneficiaries as well as providers for those savings.

About \$20 billion of the savings would come from reduced Medicare payments to HMOs, a proposal that the industry is vigorously opposing. Administration officials say the HMOs are overpaid by the existing formulas.

The administration is also expected to propose an expanded package of Medicare benefits geared toward disease prevention. Mammograms, for example, would be covered every year, rather than every other year as they are now, and the 20% copayment would be eliminated.

Screening for colon cancer and diabetes also would be covered. The proposal is similar to one recently introduced by Rep. William Thomas (R., Calif.), chairman of the House Ways and Means health subcommittee and is likely to win bipartisan support.

While the administration wants to shield beneficiaries from added costs, the president will recycle a proposal to set their monthly premiums for doctor visits and other outpatient services at levels designed to cover 25% of program costs through 2002. The beneficiaries' premiums, now \$43.80 a month, presumably would rise with program costs, as they do now. Without such a change the premiums would be lower after 1999.

For Medicaid, the health-insurance program for the poor, the proposed five-year savings of about \$20 billion are much less than either the administration or Congress proposed previously, largely because projected costs are rising less rapidly. About a third of the savings would come from imposing a cap on spending for each recipient, but the president is insisting that all qualified persons remain enti-

### Clinton Budget Highlights

Major elements of President Clinton's 1998 budget plan would:

- Increase welfare spending by \$16 billion over five years
- Save \$100 billion in Medicare, and about \$20 billion in Medicaid
- Call for family and education tax cuts
- Increase by \$40 million the main federal program for services for people with AIDS

led to the health coverage. The limits are drawing fire from liberals on Capitol Hill and elsewhere. The president is expected to propose that some of the Medicaid savings go to expand coverage for uninsured children.

The White House also plans to request funds for a new nationwide computer system designed to speed payment of Medicare claims. The White House Office of Management and Budget had opposed funding the system, but Health and Human Services Secretary Donna Shalala appealed the decision and prevailed.

The administration also plans to propose a \$40 million increase in funding for the Ryan White Care Act, the \$1 billion-a-year program that funds medical and social services for people with AIDS. The increase is likely to disappoint AIDS activists who have pressed the administration for much higher funding given the high cost of the new, breakthrough AIDS drugs. Mr. Clinton is expected to seek an additional \$20 million in AIDS-prevention funding, and a 4% increase in the budget for the National Institutes of Health.

For defense, the president will continue to seek less spending than the GOP Congress, which supports a more costly missile-defense system and other weaponry. Mr. Clinton's 1998 proposal is expected to be roughly \$260 billion, \$5 billion lower than current levels. In another national-security proposal, Mr. Clinton will seek \$100 million in 1998 as a down payment on a U.S. debt to the United Nations that exceeds \$1 billion. While the remainder would be contingent on further U.N. overhaul efforts, even the proposed down payment is likely to raise hackles among GOP critics of the international body.

The president also will revive his proposed five-year tax cuts of nearly \$100 billion, chiefly a \$500-per-child income-tax credit for most families and tax breaks for college tuition.

In another move sure to draw Republican criticism, the president's budget, like last year's, will assume that his tax cuts are suspended after 2000 if the deficit doesn't fall by as much as his budget office projects.

Congress's Republican leaders already have signaled opposition to administration calls to alter the new welfare law, which was designed to save \$55 billion through 2002. At the same time, GOP governors with large legal-immigrant populations are contacting their states' representatives to complain about the cutbacks.

~~Clinton~~  
~~Administration~~  
~~Welfare~~

Bruce -

Is this true? If combined with support for the D'Amato bill and the proposal on line by most times (assuming there are not all overlapping), we begin to have a whole breast cancer initiative. Ethen

Mr. Hauptmann denies acquiring any shares through Peter the Great. He says he is unaware of that firm's activities with Gazprom stock, stating that it joined him later as an investor in his Gazprom deal. He also says his group didn't acquire nearly as much as 3.3% of Gazprom's stock, the figure insiders give as ECM's stake before the swap with Gazprom.

In going into Russia at all, he was investing in a risky and illiquid market, Mr. Hauptmann adds. He notes he has unique investments throughout the world, including stakes in a Dead Sea magnesium mine and a brandy factory in Moldova.

As for Mr. Fellegi, he denies being involved in the program insiders describe for buying Gazprom shares. He won't discuss details of his dealings in Russia. He does observe, however, that Gazprom's charter "clearly stated right from the privatization . . . that 9% of the shares are reserved for foreign shareholders, and foreign shareholders can buy any amount of shares only with the prior consent of the board of directors. So there was a possibility to create those shares."

By early 1995, Messrs. Hauptmann and Fellegi had entered into high-level negotiations with Gazprom officials on becoming foreign shareholders. Mr. Hauptmann says the approach was simple: They worked through various intermediaries to gain the confidence of top management, culminating in the summer of 1995 in a special board resolution allowing three Hauptmann-controlled holding companies in Cyprus to become registered foreign owners of 200 million shares.

Mr. Hauptmann says his investor group bought shares only after obtaining this board approval (the resolution actually is dated April 1995). He won't specify from whom the group bought shares.

#### Another Scenario

Investment bankers, attorneys and several other people describe a much different deal, saying its linchpin was a swap in which the Hauptmann interests exchanged about three-quarters of the domestically owned Gazprom stock (about 600 million shares) for the right to treat the 200 million or so remaining shares as foreign-owned.

A Moscow-based U.S. investment banker and another Western investment banker who were involved in the October offering say they were told that a portion of the relinquished shares went to some Gazprom people with the authority to approve the deal. But an investment banker who says he was involved in the share swap itself says the shares were simply sent, in two lumps, to a company that Gazprom executives designated. "Gazprom said that was where they wanted us to send the shares, and that is what we did," he says. "Only God and the people in that company knew where those shares went."

With foreign-ownership approval in hand, ECM's investment group began trying to sell some of its shares. Among others, the investment group included hedge funds—large private partnerships—then managed by Michael Steinhardt, the now mostly retired U.S. fund manager, and by San Antonio Capital Management in Texas. Some investors say the hedge funds were aware of a Gazprom share swap but didn't know where the shares went.

#### Placing the Shares

Among buyers that the investment group found was Capital Group International's Emerging Markets Growth Fund. In September 1995 it bought 160,000 shares in an entity whose sole asset was Gazprom shares, paying 80 cents a share, a fund statement shows. A spokesman for the fund's ultimate parent, Capital Research in Los Angeles, says it bought after "a very extensive examination of the transactions involved" but wasn't aware of any share swap.

Then last October came the international offering of 1.15% of Gazprom stock, underwritten by nine leading investment banks led by Morgan Stanley Group and Dresdner Kleinwort Benson. The securities trade in the U.S. as American depositary receipts, though not on a U.S. exchange, and also in London. Gazprom also let the foreign investors who got in early convert their stock into ADRs, in return for which they agreed not to sell any they still own until about a year from now. "There are book profits, nice book profits," is all Mr. Hauptmann will say.

Gazprom has promised to protect the price of shares it sells abroad by keeping the far more numerous domestic shares off the international market. But the gas company's secretive ways have kept some foreign investors from buying. "We'd never be able to know anything we needed to know," says Ian Hague, whose Firebird Partners in New York manages a private limited partnership investing in Russia. Despite the completed international offering, no audited profit-and-loss statements are expected until the spring.

Meanwhile, the share registry is closed to the public. Only a party that owns 1% of the shares in a Russian company can view it, Gazprom, with right of first refusal over the sale of its domestic shares, largely controls who can amass 1%.

One former Gazprom official observes that there have always been two principal secrets within the company: "The first is who owns the shares, and the second is how much they charge for the gas."

2/2

## It's a Shame We Have None

By DAN M. KAHAN

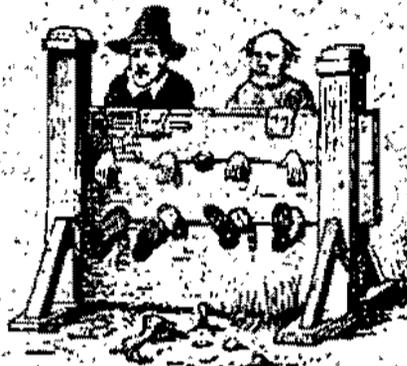
Shame is making a comeback in American criminal law. Courts in New York, Texas and other states have ordered drunk drivers to display brightly colored "DUI" bumper stickers. Florida and Oregon judges require nonviolent sex offenders to post warning signs on their property. In Tennessee, burglars must permit their victims to enter their homes and help themselves; in Hoboken, N.J., people convicted of public urination—even affluent stockbrokers—must sweep city streets.

Judges are counting on the pain of public humiliation to discourage lawbreaking. But a growing chorus of skeptics deride the new punishments as gimmicky and cruel. Their attitude is ill-conceived. In truth, shame's power to express moral condemnation makes it a potentially effective, and politically viable, alternative to imprisonment.

With the majority of inmates serving time for nonviolent crimes, reformers have long contended that cheaper, less severe alternatives, like fines and community service, would be as effective as imprisonment. But the call for "alternative sanctions" has little political resonance. Indeed, legislators have extended prison to many offenses, including white-collar crimes, previously punished only with probation.

It would be a mistake, though, to infer that the public rejects alternative sanctions because they aren't painful enough. The real complaint is that fines and inconspicuous community service send the wrong message. Americans expect punishment not just to protect them from harm, but also to express their indignation about crime. Imprisonment clearly, does so,

while the conventional alternatives send a much more ambiguous signal. Fines suggest that offenders may buy the privilege of breaking the law. Community service sends an even more confusing message: Normally, we admire people who educate the retarded, install smoke detectors in nursing homes, restore dilapidated low-income housing and the like. Saying that such services are fit punishments for crim-



inals insults those who serve their communities voluntarily.

The lesson for reformers is that they can't hope to replace imprisonment unless they find alternative sanctions that unambiguously express reproach. Because shaming penalties satisfy the public's demand for condemnation, judges have been able to impose them for a wide range of serious offenses normally punished by imprisonment, from embezzlement and toxic-waste dumping to drunk driving and drug possession—the kinds of offenses for which reformers have long advocated conventional alternative sanctions.

But will shame be an effective deterrent? Yes. Studies show that most people refrain from crime less because they fear formal penalties than because they've internalized community values and value the respect of their peers. Shaming punishments tap these dispositions just as effectively as fines and community service, which have already been shown to be reasonably effective for nonviolent offenses.

The critics' suggestion that shaming is cruel is even harder to credit. To be sure, shame hurts. But it isn't nearly as painful as imprisonment. Not surprisingly, offenders almost always choose shaming over jail time when given the choice.

What makes shame attractive to the public—its power to express moral condemnation—is exactly what makes it objectionable to some critics. We live in an age of relativism and skepticism, in which some view moralizing as an inappropriate function for the law. Those who are squeamish about moralizing may be able to rationalize imprisonment at least in some cases, on the grounds that it removes dangerous individuals from society. No such rationalization is possible when the very purpose of a punishment is to inflict shame.

But discomfort with public moralizing is a singularly unconvincing reason to oppose shaming punishments. The needless brutality—not to mention the financial waste—of imprisoning offenders who could be effectively shamed is too high a price to pay for the fiction that we live in a nonjudgmental society.

*Mr. Kahan teaches constitutional and criminal law at the University of Chicago Law School.*

To Bruce / Dennis -  
Have you seen them?  
Do you think there's a  
way of scrubbing looking  
into this trend?  
Elena

Miss

## Lippo's Chinese Connections

By PETER SCHWEIZER  
The many questionable contributions to the Democratic Party and President Clinton's legal defense fund are as much about U.S. national security as they are about White House influence peddling.

Questions swirling around former Deputy Assistant Commerce Secretary John Huang, the Lippo Group of Indonesia and the fund-raising activities of Charles Yan Lin Tite may well be linked by the shadow efforts of the Chinese military to influence U.S. foreign and military policy. Both the Democratic Party and the president's legal defense fund have returned vast contributions, yet considerable security damage will continue to occur unless the matter is fully investigated.

The most recent revelation concerns the fact that Charlie Tite arranged for President Clinton to meet with Wang Jun, a Chinese arms merchant, at a Feb. 6, 1996, White House coffee social. Mr. Wang is chairman of Poly Technologies, which is owned and run by the Chinese People's Liberation Army. Poly Technologies is a front company under China's General Staff Department's Equipment and Technology Department, and the Chinese Commission of Science, Technology and Industry for National Defense. The latter, known as Costind, is in charge of military research and development, testing and production. Among Costind's more important state functions is control of the technical and professional work at the PLA's strategic missile force.

Almost all high-level Costind officials have military rank. PLA Gen. Ding Hengqiao has been the director since June 1985 and has the bureaucratic rank of a minister. Four of the five deputy directors of Costind are lieutenant generals. Costind

and front companies such as Poly Technologies, Yuanwang Group Corporation, New Era Corporation and Galaxy New Technology Corporation have three important functions.

First, they manage arms sales to countries such as Iran, Iraq, North Korea and Pakistan. Second, they acquire advanced dual-use technologies to assist in modernizing the PLA. Finally, they serve as consultants for intelligence operations. The U.S. Defense Intelligence Agency reports that these organizations are "key to supporting the unformed services and China's industrial base and to acquiring military and dual-use technology." DIA officer Nicholas Effimades identified Poly Technologies as a cover for such activities in his book "Chinese Intelligence Operations."

The PLA's links extend to the Lippo Group; Costind, through the Yuanwang Group Corp. and New Era Corp., has run several joint ventures with Lippo. Recently, Lippo and a U.S. firm, Entergy Corp., signed a \$1 billion deal to build a nuclear power plant in China. The deal was negotiated with help from the U.S. Commerce Department and Costind, which also runs the Chinese nuclear research program.

Given the PLA's link to these fund-raising scandals, what could it possibly be after? The most direct answer is access to high technology, particularly so-called dual-use technologies, which have both civilian and military applications. The Commerce Department, where Mr. Huang worked, is responsible for licensing exports of U.S. dual-use items. And by any measure, the Clinton administration has been very willing to grant the PLA access to such critical technologies.

On Sept. 14, 1994, the Commerce De-

partment approved the export of machine tools to China, "despite the strong warnings from U.S. military and intelligence officials," notes South Carolina Rep. Floyd Spence, chairman of the House National Security Committee. The machine tools were to be used to produce parts for commercial aircraft that would be built in China under a contract with McDonnell Douglas. According to the General Accounting Office, however, some of the more sophisticated machine tools were shipped to the Nanchang Aircraft Co., which produces fighter aircraft and cruise missiles for the PLA. As the



John Huang

principal deputy assistant commerce secretary with a strong interest in Asian commercial affairs, Mr. Huang would have played a significant role in this decision.

Even after officials became aware of this diversion, the wheels of enforcement moved very slowly. The Commerce Department did not formally investigate the export-control violations until six months after they were first reported; the GAO noted in a recent report.

The Commerce Department's Los Angeles field office recommended that Commerce issue a temporary denial order against the PLA's China National Aero-Technology Import & Export Association and its subsidiaries. Commerce rejected that recommendation; the Los Angeles office subsequently referred the case to the Department of Justice for consideration. An investigation is pending.

In April 1994, the Commerce Department created a new general license category, allowing nearly all dual-use telecommunications items to be exported to civilian customers in China without licenses. AT&T sold advanced asynchronous transfer mode and synchronous digital hierarchy telecommunications equipment without review to Huawei, a joint venture partly owned by Galaxy New Technology; several members of its board are PLA officers. Pentagon officials warned Commerce that such dual-use technologies would be enormously beneficial for the Chinese military in sharing intelligence, imagery and video among several locations, as well as in command and control of military operations. Again, the warnings fell on deaf ears.

These and other possible links between PLA-managed companies and the White House and Democratic Party fund-raising occur alongside the Clinton administration's inaction in the face of dangerous activities by the Chinese military. In addition to passing sensitive ballistic-missile and nuclear-weapons-related technologies to rogue states, the PLA is operating under the assumption that the U.S. is a rival, not a friend. In 1993 the PLA High Command published a textbook titled "Can the Chinese Army Win the Next War?" In it, the U.S. is identified as the "principal adversary"; most of its war scenarios center on armed conflict with America.

Mr. Schweizer is co-author, with Reagan Administration Defense Secretary Caspar Weinberger, of "The Next War," just released by Regnery.

By JAN HOFFMAN

PITTSFIELD, Ill. — In the gray winter light, the views along the road into this small town in western Illinois are severe but serene — stretches of brown, stubbled cornfields interrupted only by the occasional farmhouse. Abruptly a driver's reverie is jolted by the green plywood and white-lettered sign at the end of Glenn Meyer's driveway. "Warning," it reads. "A Violent Felon Lives Here. Travel At Your Own Risk."

The sign is a condition of the probation sentence given to Mr. Meyer, a 62-year-old farmer, for having bashed another farmer in the face with a truck fuel pump. The judge intended the sign to alert people about Mr. Meyer's dangerous streak and to shame him into behaving. But Mr. Meyer is unrepentant. [On Tuesday, he went before the Illinois Supreme Court to challenge the imposition of the sign.]

Judicially created public humiliations like this are being introduced in courtrooms across the country, usually as alternatives to incarceration. Known as shaming penalties — after punishments like the stocks favored by 17th-century Puritans — they usually take the form of a mea culpa message to the community.

Drunk drivers have to put special license plates on their cars. Convicted shoplifters must take out advertisements in their local newspapers, running their photographs and announcing their crimes. And men in cities around the country who are convicted of soliciting prostitutes are identified on newspapers, radio shows and billboards.

In November, a judge in Port St. Lucie, Fla., ordered a woman to place an advertisement in her local paper saying she had bought drugs in front of her children. This summer, at the behest of a judge in Houston, a man who pleaded guilty to domestic violence stood on the steps of City Hall, facing lunchtime workers, reporters and battered women's advocates, and apologized for hitting his estranged wife.

Proponents of shaming penalties say they address the needs of a public weary of crime, frustrated by the failures of the criminal justice system and yet unwilling to pay for prison expansion.

"The penalties can satisfy the public's need for dramatic moral condemnation in a way that's effective

Continued on Page B10, Column 1

Continued From Page A1

and just," said Prof. Dan Kahan of the University of Chicago law school. "And they result in the outcome you want: less imprisonment."

Critics say the penalties have a bread-and-circuses quality that blunts whatever rehabilitative function they may have and often cross the line into ridicule. Judith Libby, Mr. Meyer's lawyer, offered her bottom-line critique. "Mostly," Ms. Libby said, "they're just mean."

## Judge Seeks Balance In the Punishment

When it came time to sentence Mr. Meyer, whom a jury convicted of aggravated battery in June 1995, Judge Thomas L. Brownfield had a difficult decision. Mr. Meyer had a previous conviction for aggravated battery for stomping an insurance adjuster on his farm and an acquittal for scuffling with a collection agent.

In the 1995 episode, Gary Mason, a farmer from nearby Beardstown, had tried to return a truck fuel pump to Mr. Meyer, who runs a modest salvage yard. In the ensuing argument, Mr. Meyer swung the metal-encased pump at Mr. Mason, smashing his nose and eye socket.

The state's attorney urged incarceration. By law, Mr. Meyer could have received a sentence ranging from 2 to 10 years. But many in Pittsfield, with a population of 4,500, saw Mr. Meyer as a good-hearted, thoughtful neighbor. Dozens wrote letters to the judge on his behalf.

"He's as mild a mannered man you'd ever want to meet," said Bruce Lightle, the former chairman of the Pike County board. "We've been friends for more than 40 years and I've never seen him angry."

A social worker testified at a hearing that Mr. Meyer, who was taking antidepressant medication, seemed capable of controlling his temper.

Still, Judge Brownfield said that if Mr. Meyer had not had an elderly mother at home, he would have sentenced him to the maximum. In trying to balance retribution with compassion, the judge gave Mr. Meyer probation but confined him to his home for a year, allowing him to leave only to keep doctors' appointments and to attend church.

In addition, he had to pay a \$7,500 fine and Mr. Mason's medical bills, which reached nearly \$10,000. And Mr. Meyer had to make and post the warning sign for 30 months, of which about 16 remain.

"I try to take rehabilitation into consideration as well as protecting the public," the judge said. "I certainly feel more comfortable knowing that someone who may not know Mr. Meyer will have some warning."

The judge added that since the sign went up, there have been no other incidents of violence.

If the setting for a modern shaming penalty could approximate that of the early American colonists, Pittsfield might qualify. With something of the intimacy of 17th-century rural towns like Salem, Mass., Pittsfield is a church-going farming community with a village green and coffee shop waitresses who serve the regulars scrambled eggs with a side

of fresh gossip.

But Colonial towns were bound even more tightly than Pittsfield: An offender would be put in stocks in front of neighbors who shared a church, a leader and iron-clad values. The most frequently prosecuted offense was fornication.

Jail as punishment was relatively unknown in America. A penalty was intentionally exacted in full view of the community, which represented an ideal of behavior that the shamed one should emulate.

## Penalties That Shame Reflect Nostalgic Urges

"The point of the punishment was to teach them a lesson and also make it possible to reintegrate themselves into the community," said Lawrence Friedman, a Stanford law professor.

By the 19th century, public punishment was looked down upon as undignified spectacle. The community was no longer a paragon of morality, and now understood to have corrupting influence as well. Prisons were established, and offenders were sent there for their own good.

In modern times, Americans no longer associate prison with rehabilitation; its purpose is strictly punitive. Still, the public complains about defendants serving short sentences in prisons that offer television, weight rooms and the opportunity to learn advanced criminal skills.

The return to shaming penalties, which began in the 1980's with mortified Wall Street traders appearing on the nightly news in handcuffs, is to some extent a nostalgic longing for an era when a community and its principles were so uniform that people could police themselves.

"The penalties bring the community back into sentencing and punishing policies," said Robert Teir of the American Alliance for Rights and Responsibilities, a public-interest group that filed a brief supporting Mr. Meyer's warning sign. "And they give the community a sense of empowerment that jailing or letting someone go without a punishment does not do."

## Florida Judge Likes Public Confessions

Local judges, many of whom are elected, have seized on shaming penalties as an alternative to prison. Judges in Arkansas and Wisconsin have ordered shoplifters to parade in front of the stores they have robbed, carrying placards admitting their guilt. A Memphis judge has given thieves probation if they permit victims to pluck something from the thief's home. An Ohio judge ordered a man convicted of harassing his ex-wife to let her spit in his face.

In recent months, the judge in Port St. Lucie, Fla., Larry Schack, has structured many sentences to include a public confession.

The New York Times

THURSDAY, JANUARY 16, 1997

1/2

In October, Judge Schack ordered a man who had admitted molesting prepubescent girls to put a warning sign on his front door that had to be printed in block print capitals, large enough to fill the entire sign and at the height of five feet from the floor.

The judge also recently announced plans to sentence defendants to apologize to victims in speeches of at least a minute on the courthouse steps at noon, and to give the news media 48 hours notice.

Appellate courts rarely review such sentences, because they usually come as a result of a guilty plea. Florida and Oregon appellate courts have upheld isolated shaming penalties. But in 1995, New York's Court of Appeals rejected a Nassau County judge's efforts to compel a drunk driver to carry special license plates. And last May, the Tennessee Supreme Court struck down the requirement that a man who pleaded guilty to molesting teen-age boys post a warning at his Memphis home.

Professor Kahan of the University of Chicago said such punishments were preferable to fines, which make a defendant appear as if he is buying his way out of an offense, or community service, which, he said, sends an ambiguous message.

"People have positive associations with community service," he said. "How can you be condemning a person if you make him fix dilapidated housing? And people who do that for a living are terribly insulted."

Even those skeptical of the penalties, whose effectiveness has never been studied, concede that they have value in cohesive communities. Bar organizations publish lists of lawyers who have been sanctioned, because peers consider publicity a humiliating deterrent. Some Native American tribes and the Amish use a form of shaming known as shunning.

"But it's understood in these communities that there is something the shamed one can do to get back in," said Toni Massaro, a law professor at the University of Arizona.

By contrast, Professor Massaro added, most penalties by local judges are whimsical, coarsely drafted and do not have restorative components.

"They are merely expressions of disgust," she said. "We can get behind it, but it's not likely to stop the behavior."

And most communities include diverse groups with different responses to crimes and punishment. Fine-tuning a punishment to elicit shame can be difficult. During the Vietnam War, a draft dodger's peers considered him a hero, not a criminal. Urban high school students might applaud a teen-ager for stealing a Mercedes, not condemn him.

Shame itself, say legal philosophers and psychologists, is a volatile, primal and poorly understood emotion. June Tangney, a professor of psychology at George Mason University who has studied over 10,000 people to distinguish feelings of shame from guilt, said such penalties, when crudely applied, could backfire. People made to feel ashamed can react angrily and blame others. But if defendants can feel guilt, Professor Tangney said, they are more likely to want to make reparation.

Here in Pittsfield, Mr. Meyer's warning sign has met with strong but mixed reactions. Friends of the family say it is too harsh. Some people who have tasted his temper say he got off easy. Mr. Mason, the farmer who caught the fuel pump in his eye, said he was simply relieved that others were being cautioned about Mr. Meyer.

Vicki Thayer, a waitress at the Red Dome Inn, said that she did not think that the sign was unjust but that it was unfair.

"Half the town beats up their wives, Ms. Thayer said, "and gets off with a slap on the wrist."

Mr. Lightle, the former county board chairman, said his friend was angry and embarrassed by the sign. The family resented it deeply, he said; Mr. Meyer's wife moved out.

Whether the sign will change Mr. Meyer's behavior remains to be seen. He failed to report to probation several times and missed some restitution payments, court records show.

Ms. Libby, who spoke on her client's behalf, said he did not feel ashamed about the dust-up that led to the punishment. On the contrary, "Mr. Meyer says he feels that the sign is illegal and that the court knows it's illegal," she said. "He has always professed his innocence and he still does."

The New York Times

THURSDAY, JANUARY 16, 1997

2/2

# The New York Times

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## Vision and Reform

The arctic temperature gripping Washington this weekend is not the only blast of inclement weather surrounding the inauguration. President Clinton's oath-taking today takes place in an atmosphere chilled by scandal, contentiousness and widespread public disappointment in the ethics of Mr. Clinton and House Speaker Newt Gingrich. This is a moment when both parties need to pause and think soberly about past mistakes and put forward an agenda to drive tainted money, reckless fund-raising and special interests out of national campaigns. The problem is that like their leaders, both national parties are in denial about the public's deep-rooted fervor for clean politics and the equally deep-rooted longing for trustworthy leaders.

Inaugural speeches must offer an expansive vision, but they also need a strong, specific anchor. The issue of clean politics, therefore, offers a huge opportunity for Mr. Clinton to step forward in a largely unoccupied area of leadership. We hope to hear at the heart of Mr. Clinton's speech a pledge to clean up his party's fund-raising practices and push Congress toward the campaign reform promised in his first inaugural address. With that commitment as a foundation, Mr. Clinton can use his speech to convey a sense of broad national purpose that is energizing, responsive and realistic on many fronts.

Since Mr. Clinton will be making the last inaugural address of the 20th century, he needs to guide Americans toward his vision of the century to come. Based on advance word from the White House, it sounds as if he will try to do just that. The President, his aides say, intends to focus on an appeal for racial healing, as well as programs to help Americans adjust to an economy driven by revolutions in information and technology. We hope that in the process he will build on one of the finest moments of his first term, when he defended affirmative action as a necessary tool to redress the heavy legacy of racial injustice in America.

Four years ago, Mr. Clinton's inauguration speech seemed to usher in a new era of government activism. Now, marking a different approach, he must say how government can still prepare Americans for rapid economic changes while honoring his new-found commitment to a balanced budget. Recent economic improvements may make it easier to reduce the deficit, but eliminating the deficit alto-

gether will be extremely difficult if Mr. Clinton is also to preserve education, environment and health programs and reform welfare without warring against the undefended poor. Mr. Clinton's greatest gifts lie in summoning Americans to a sense of community, and starting, today, on these issues, those abilities will be tested to their utmost.

In preparing for the subject, he would do well to look at the valedictory comments by departing Labor Secretary Robert Reich, who noted in a recent speech that growing economic inequality in the United States is jeopardizing the social compact that has long kept the country together. A similar breaking apart of the compact can be seen in the attempts by some to turn Social Security into a voluntary investment program in which the well-to-do would inevitably benefit the most and to let public education atrophy for lack of funds.

In foreign policy, the most urgent philosophical issue Mr. Clinton needs to join is how to square the United States' economic interests with its human rights and security concerns, particularly with China. The President has done more than his recent predecessors to educate Americans on the importance of competing for markets and investments abroad. But he has not told Americans how the country can keep pace economically and still push for its values and for curbing the proliferation of nuclear weapons and other arms.

More than most re-elected Presidents, Mr. Clinton still comes across to Americans as unfinished and unpredictable. It is particularly interesting that his inauguration has been preceded by a revealing glimpse of his Presidency in the form of Dick Morris's book, "Behind the Oval Office." It portrays Mr. Clinton as endlessly torn by conflicting impulses, defending and attacking government at the same time and being wary of just about all his advisers — a solitary man for all his gregariousness.

After all the gyrations and reinventions of the last four years, the public hungers for a President who presents a clearer image because both his goals and personality are fixed. History will remember Mr. Clinton for winning re-election, but it will measure him by what he learned from the victory. Bill Clinton's second inaugural address will be our first report on that question.

## Alternative Sentencing

A farmer named Glenn Meyer could have been sentenced to 2 to 10 years in prison when he shattered a neighbor's face without provocation, using a spare truck part. Instead, a judge sentenced Mr. Meyer to probation — and ordered him to post a sign in his driveway that reads: "A Violent Felon Lives Here. Travel at Your Own Risk." Mr. Meyer remains stolidly unrepentant and has even challenged the sign in court, arguing that the judge exceeded his authority.

The sign arises from an increasingly popular strategy used by judges who wish to cut imprisonment costs — while shaming offenders into reforming their conduct. The so-called "shaming" sentences resonate with a deep societal need for moral condemnation. Research on the effectiveness of shaming is almost nonexistent. But scattered evidence suggests that the strategy is effective with juvenile offenders who are forced to apologize in public or adults whose identities are made public in morally loaded nonviolent crimes like check kiting, drunken driving or soliciting prostitutes. Even so, Mr. Meyer's steadfast resistance illustrates the futility of trying to induce shame in someone who may indeed be incapable of feeling it.

The shaming sentences have a good deal in common with strategies once used by American Indian tribes or groups like the Amish, both of whom shunned members who broke societal rules. According to a recent study by the University of Chicago legal scholar Dan Kahan, shaming sentences are becoming increasingly popular in a variety of crimes, including drunken driving, larceny, embezzlement, assault, burglary, illegal waste dumping and even drug distribution. Mr. Kahan argues that the new penalties are emerging as a serious rival to imprisonment "because they do

something that conventional alternative sanctions don't do: Express appropriate moral condemnation" — and free up badly needed jail space for serious offenders.

Many judges accept this logic. Some require petty offenders to display body signs or bumper stickers noting that they have been convicted of writing bad checks or driving while intoxicated. Another form of punishment involves public contrition, requiring offenders to publicly recite their crimes, while apologizing to those who were hurt.

Public condemnation is undeniably appealing. But the courts need to understand that society has gone this way before and found the method lacking. Punishments of all sorts were once administered in public in the interest of deterring further crime and satisfying the need for moral opprobrium. In the late 18th century, legal punishments were moved inside prison walls after societies determined that they had become mere entertainment. Early Americans turned to prisons because traditional penalties — like the stocks or public whippings — had lost the power to shame. Public disgrace lost much of its potency as cities became large enough to offer anonymity and the ties that bound citizens together loosened and then, in many places, dissolved.

Shaming is clearly useful for minor offenses, particularly those involving juveniles. It may have broader applications for more serious offenses, but judges should be cautious about using it on hardened offenders or the flamboyantly unrepentant. Also, guidelines are probably needed to discourage judges from idiosyncratic sentences. Law enforcement agencies should begin serious research into the question of when the sentences work and when they do not.

## Latin Democracies Do Not Need F-16's

If President Clinton cherishes the democratic and economic revival that has transformed much of Latin America in the 1990's, he will overrule the recommendations of his departing Secretaries of Defense and State and maintain the ban on exporting advanced weapons to the region.

The Pentagon, pleading the case of American arms exporters and eager potential customers like the Chilean military, has long favored elimination of the restrictions. The ban was first imposed by President Carter, in response to the belligerent rhetoric and human rights abuses of Latin American military regimes. The State Department, reflecting the Administration's goal of curbing regional arms races and encouraging poor countries to shift scarce resources from military to civilian needs, argued for maintaining the ban.

But just before leaving office, Secretary of State Warren Christopher has reconsidered his views and joined with outgoing Defense Secretary William Perry in recommending an end to the ban. Madeleine Albright, nominated as Mr. Christo-

pher's successor, has generally championed restraints on arms sales, but has not yet specifically addressed the Latin American question.

Those who favor arms sales note that with the exception of Cuba, all Latin American governments are now headed by elected civilians. But selling expensive, high-tech weapons like F-16 fighter planes is no way to nurture these developing democracies. Significantly, the loudest Latin voice for unrestricted arms sales comes from Chile, where the military is not yet under full civilian control. If F-16's are sold to Chile, neighbors like Argentina and Brazil will feel compelled to catch up.

Although the United States is the largest arms seller to Latin America, other countries also sell weapons to the region and some are ready to sell high-tech equipment. But when Belarus recently sold two types of advanced aircraft to Peru, Washington rightly tried to discourage the deals, warning that they threatened regional stability. It is hard to see why that logic should not apply to American sales as well.

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

January 6, 1998

REMARKS BY THE PRESIDENT  
AT EVENT ON MEDICARE

The Roosevelt Room

11:40 A.M. EST

THE PRESIDENT: Thank you, Ruth. I think she has made clearer than I could ever hope to that for many Americans, access to quality health care can mean the difference between a secure, healthy and productive life, and the enormous burden of illness and worry and enormous financial strain.

Today, the proposals I am making are designed to address the problems of some of our most vulnerable older Americans. I propose three new health care options that would give them the security they deserve. The centerpiece of our plan will let many more of these Americans buy into one of our nation's greatest achievements, Medicare.

When Medicare was first enacted, President Johnson said -- and I quote -- "It proved that the vitality of our democracy can shape the oldest of our values to the needs and obligations of changing times." Once again we are faced with changing times -- a new economy that changes the way we work and the way we live; new technologies and medical breakthroughs, holding out hope for longer, healthier lives; a new century brimming with promise, but still full of challenge and much more rapid change. The values remain the same, but the new times demand that we find new ways to create opportunity for all Americans.

For the past five years we have had an economic strategy designed to expand opportunity and strengthen our families in changing times -- insisting on fiscal responsibility, expanding trade, investing in all our people. Yesterday I announced that the budget I will submit to Congress in three weeks will be a balanced budget, the first one in 30 years. Within this balanced budget we propose to expand health care access for millions of Americans.

Last summer, with the balanced budget agreement I signed, we took action to extend the life of the Medicare trust fund until at least 2010, and we appointed a Medicare commission to make sure that Medicare can meet the needs of the baby boom generation. We took action to root out fraud and abuse in the Medicare system, assigning more prosecutors, shutting down fly-by-night home health care providers, taking steps to put an end to overpayments for prescription drugs. Since I took office, we have saved over \$20 billion in health care claims -- money that would have been wasted, gone instead to provide quality health care for some of our most vulnerable citizens.

We want to continue to do everything possible to ensure that the same system that served our parents can also serve our children. That means bringing Medicare into the 21st century in a fiscally responsible way that recognizes the changing needs of our people in a new era.

We know that for different reasons more and more

of them lose their health coverage when their spouse becomes eligible for Medicare and loses his or her health insurance at work. That's the story we heard today.

Some lose their coverage when they lose their jobs because of downsizing or layoffs. Still others lose their insurance when their employers unexpectedly drop their retirement health care plans. These people have spent their lifetimes working hard, supporting their families, contributing to society. And just at the time they most need health care, they are least attractive to health insurers who demand higher premiums or deny coverage outright.

The legislation that I propose today recognizes these new conditions and takes action to expand access to health care to millions of Americans. First, for the first time, people between the ages of 62 and 65, will be able to buy into the Medicare program at a fixed premium rate that for many is far more affordable than private insurance, but firmly based in the actual cost of insuring people in this age group, and, as you just heard from what Ruth said, far, far more affordable than the out-of-pocket costs that people have to pay if they need it.

This is an entirely new way of adapting a program that has worked in the past to the needs of the future. It is a fiscally responsible plan that finances itself by charging an affordable premium up front and a small payment later to ensure that that this places no new burdens on Medicare. It will provide access to health care for hundreds of thousands of Americans, and it is clearly the right thing to do.

Second, statistics show that older Americans who lose their jobs are much less likely to find new employment, and far too often when they lose their jobs they also lose their health insurance. Under this proposal, people between the ages of 55 and 65 who have been laid off or displaced will also be able to buy into Medicare early, protecting them against the debilitating costs of unforeseen illness.

Third, we know that in recent years too many employers have walked away from their commitments to provide retirement health benefits to longtime, loyal employees. Under our proposal, these employees, also between the ages of 55 and 65, will be allowed to buy into their former employer's health plans until they qualify for Medicare. And thank you, Congressman, for your long fight on this issue.

Taken together, these steps will help to take our health care system into the 21st century, providing more American families with the health care they need to thrive, maintaining the fiscal responsibility that is giving more Americans the chance to live out their dreams, shaping our most enduring values to meet the needs of changing times. It is the right thing to do. And thank you, Ruth, for demonstrating that to us today.

Thank you very much. (Applause.)

END

11:50 A.M. EST

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

December 5, 1997

REMARKS BY THE PRESIDENT  
IN ANNOUNCING MEDICARE COMMISSION APPOINTMENTS

The South Grounds

2:25 P.M. EST

THE PRESIDENT: Today I want to discuss our continued economic progress and important steps we must take to continue it. For the last five years we have pursued a comprehensive economic strategy to spur growth, to increase income, to create jobs and keep the American Dream alive and well in a new century. Today we see the latest evidence that our economy is growing steady and strong, that the American Dream is, in fact, alive and well.

Last month the economy created 400,000 new jobs. Unemployment is now 4.6 percent, the lowest in a quarter century. There were more new manufacturing jobs in the past year than in any year in three decades. Inflation remains low and appears to be poised to continue at its low rate. And after lagging for years, wages finally are rising again. Our economy is the strongest in a generation.

This continuing prosperity is due to the ingenuity and the enterprise and the hard work of the American people who are creating the economy of the future. It is also the result of our economic strategy of cutting the deficit, investing in education and our future, and expanding our exports through trade agreements. This year's balanced budget law both honors our values and continues that progress. It extends opportunity to our children with the most significant new investment in health care in a generation, and in education in a generation. It offers tax cuts for college and provides for health insurance for up to 5 million children. It honors our duty to our parents by extending the lifetime of the Medicare trust fund until 2010.

Now we have more to do to strengthen Medicare while preserving its commitment to older Americans. Medicare is at the core of our historic social compact -- our recognition of the duty we owe to one another. It has been one of the great achievements of this century and now we have an obligation to strengthen it for the next century, to ensure that it is as strong for our children as it has been for our parents, and to ensure that the baby boomers have access to quality affordable health care when we retire.

The Medicare reforms I signed into law this year were the product of strong cooperation among Democrats and Republicans, the President and the Congress. The balanced budget law establishes also a commission to continue this bipartisan progress and draft comprehensive reform.

Today I am pleased to announce my appointees to the commission. They include Stuart Altman, a highly respected health care expert who has worked for Presidents of both parties; Dr. Laura Tyson, who served our nation well as Chair of the National Economic Council and Chair of the Council of Economic Advisors in our administration; Bruce Vladic, who directed the Medicare program for four years as administrator of the Health Care Financing Agency; and, Anthony Watson, the CEO of a major progressive managed care plan in New York that has pioneered support for fair treatment of patients while providing quality care.

MORE

These are distinguished, respected, highly skilled experts. They understand health care and share our unshakable commitment to the values represented by Medicare. I expect them to work as strong partners with the other commissioners and I look forward to their proposals to keep Medicare at the core of the American dream in the new century.

Thank you.

Q Will you recess-appoint Bill Lann Lee next week?

Q -- economy is so great --

THE PRESIDENT: One at a time.

Q Are you really thinking of a tax cut?

THE PRESIDENT: No, I don't believe that's a fair interpretation of what I said yesterday in my comments. What I said was -- I was asked about proposals for tax reform, and what I said was that I thought any tax reform that was adopted had to be fair, good for the economy, not burden the deficit, and make the system simpler. That was the context in which that discussion occurred.

Then there was a separate discussion about the discussion that is going around town here about what ought to be done with the surplus. Some people say we should have a tax cut with a surplus; some people say we should spend more money with the surplus; some people say we should apply it to the debt. What I tried to point out yesterday is there is not a surplus. The people who say there is a surplus are talking about the difference in the projected line of deficit to 2002 when we adopted the balanced budget law and I signed it and the projected line now.

Now, no doubt this news today is good news. It augers for stronger growth in this quarter and it may well mean that we will have a better prediction in terms of the size of the deficit and eliminating it altogether now than we did at the time the balanced budget law was passed, at the time of the mid-session review last August. The only point I tried to make is all those are still estimates. And it's good to have a good estimate, but we don't want to spend money we don't yet have.

The thing that has driven this economic recovery is getting interest rates down, getting investment up, creating a framework in which the American economy could grow, and bringing down the deficit from \$300 billion a year to \$23 billion a year is a big part of that. So before we make any unduly rash decisions about the future, let's make sure that we're taking care of the economy because that's -- the best thing you can do for Americans' incomes is to give them a strong economy.

Q Will you recess-appoint Bill Lann Lee next week?

Q Are you looking at a flat tax, Mr. President?

Q Mr. President, are you concerned --

THE PRESIDENT: I can't hear all of you.

Q Will you recess-appoint Bill Lann Lee next week?

Q Mr. President, are you concerned that the Southeast Asia financial crisis will affect the U.S. economy?

THE PRESIDENT: I'll answer this, but let me answer this one first. What I would like to say today, and all I am going to say today, is Bill Lann Lee's personal story, his work experience, his

integrity, and his fitness for this job are absolutely beyond question. He should not be denied the job because he disagrees with the Republicans in the Senate on whether affirmative action is or is not good policy. The only thing he's required to do is to enforce the law as the Supreme Court hands it down or as the Congress passes it, and to recuse in the case of any kind of personal conflict -- which he said he would do in the case of the California law, which is now moot.

So I believe -- I will say again -- he is entitled to a vote. The senators ought to vote on him. No one has put forward a credible reason for why this man should not be appointed. Surely the fact that he agrees with the President who wishes to appoint him on the question of what kind of affirmative action programs we should or shouldn't have, surely that should not disqualify him for this position. That is the point I have made. I still think that he ought to be able to serve.

Yes, now go ahead.

Q Mr. President, are you concerned that the Southeast Asia financial blowout, which seems to be ongoing still, is going to eat into these economic growth figures that you revealed today?

THE PRESIDENT: Well, first of all, I think we all have to acknowledge that our economies are interrelated. About a third of our growth over the last five years has been due to our ability to sell more American products around the world -- about a third. And anything which undermines our ability to continue to sell more American products around the world -- any action taken abroad or at home is not good for our future growth prospects.

Now, that's one of the reasons that I have moved so aggressively to work with our allies in Asia and in Europe and with the International Monetary Fund and the World Bank to try to stabilize the situation.

On the other hand, let me remind you that there is enormous productive power in these Asian economies. They have some financial difficulties now, which have to be addressed in a disciplined way. If you see the rapid recovery that Mexico had within the space of two years, you see that these strong Asian economies can do exactly the same thing in perhaps less time if they face their challenges directly. So I think that the appropriate response is to do what was done in Indonesia, to do what was done in South Korea.

The Japanese statements of the last few days are heartening about what they intend to do with their own financial institutions and protecting the depositors. All this is basically good news. So they've hit a rough patch in their financial institutions and markets, but underlying productivity and potential in Asia is enormous. Yes, I'm concerned about its impact on Americans, and that's one of the reasons I've been so actively involved in trying to deal with it, but I don't think we should become pessimistic. I think we should just be determined to work through these things as quickly as possible.

Q Mr. President --

Q Mr. President --

THE PRESIDENT: One at a time, one at a time. Go ahead.

Q Mr. President, should Larry Lawrence have been buried in Arlington National Cemetery?

THE PRESIDENT: Well, that depends on what the facts are. The questions which have been raised are serious, and I have asked the State Department to conduct an inquiry to find out whether, in fact, the basis of his eligibility is true or not. That's a fact question. And let's wait until we see what the facts are, and then we can all draw our conclusions from that. But the questions themselves are serious. I think the other question you might ask is, were the people involved in the decision in any way at fault. I don't think they were. They acted on the facts as they knew them. The original inquiry into the background check was done -- for the ambassador -- was done by the State Department. I've asked them, therefore, to follow up, try to find out the facts. When we get the facts, then I think we can make our judgments on it.

Q Have you made an indefinite commitment to keep American troops in Haiti?

THE PRESIDENT: Have I made an indefinite commitment? No. But I have made a deficit commitment to continue to be involved there in ways that I think are appropriate. Keep in mind, we have a very modest troop presence there now and we are participating as a minority partner, if you will, in the civilian police. With the withdrawal of the United Nations forces, the primary work of maintaining security has shifted to the international police force working with the Haitian police. Our military presence there -- it largely involves a lot of public works. We are doing some public works projects which we've been asked to continue to finish, try to accelerate. And of course, I think it does contribute to the stability of the area. But our presence there cannot be indefinite, and it will not be indefinite. But I think that we should have these withdrawals in a staged fashion and we should know what the next stage is before we take any precipitous action. The American people should know it's not a military operation.

Q Saddam Hussein seems not to be satisfied with the way -- this arrangement of the U.N. Security Council. What do you feel and what do you think can be done about it?

THE PRESIDENT: Well, I certainly think he's exposed his motives and his real concerns to the entire world today. You know, it wasn't very long ago -- how many days ago was it that he had this symbolic funeral for children, blaming the world community in general and the United States in particular for the death of Iraqi children.

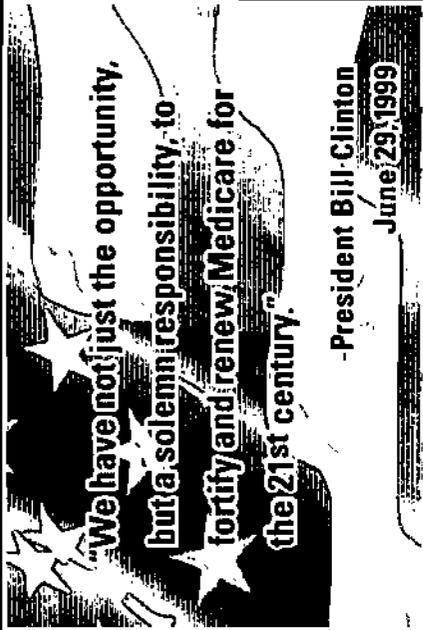
Let me remind you, when we got the United Nations resolution passed, we and the others who supported it -- 986 -- to allow him to sell oil to get food and medicine for his people, even while he was continuing to resist getting rid of his entire chemical and biological weapons arsenal, he delayed the full implementation of that for a year and a half. He is in no position to point the finger at anyone else in the world for the suffering of his own people. And once again today, he has proved that he is responsible for the suffering of his own people.

The rest of us are more than happy to let him sell oil in amounts necessary to generate the cash to alleviate the human suffering of the people of Iraq. That's what 986 was all about. This is not about 986. This is about some other way that he can manipulate the feelings of people beyond the borders of Iraq, even if he has to let innocent children die to do it, so he can continue to pursue a weapons of mass destruction program. And it's wrong and the world community should not let him get away with it.

Thank you.

END

2:39 P.M. EST



## The President's Plan

- ★ Modernizes Medicare's Benefits, including a Prescription Drug Benefit and Preventive Care
- ★ Makes Medicare More Competitive and Efficient
- ★ Strengthens Medicare's Financing for the 21st Century

## Modernizes Medicare's Benefits.

### Offers a New Voluntary Prescription Drug Benefit.

★ Three Out of Four Older Americans Lack Decent, Dependable Private-Sector Prescription Drug Coverage. At least 13 million Medicare beneficiaries have no prescription drug coverage. Millions more have unreliable Medigap or limited Medicare HMO drug coverage. Only one in four Medicare beneficiaries has retiree drug coverage, which is the only meaningful form of private coverage.

### ★ New Drug Benefit Option Makes Prescriptions Available and Affordable for All Beneficiaries.

The Clinton-Gore Administration is taking a long-overdue step to ensure that all Medicare beneficiaries can have access to affordable prescription drugs.

★ Provides Meaningful Coverage. 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).

### ★ Affordable Premiums and No Deductibles.

The drug benefit would have no deductible and will cost about \$24 per month beginning in 2002 and \$44 per month when fully phased-in. This is one-half to one-third of the typical cost of private Medigap premiums.

★ Majority of Drug Benefit Costs Offset by Savings. This benefit would cost \$118 billion over 10 years – less than 10 percent of total Medicare spending. Over 60 percent of the costs are offset by the proposal's savings. The rest comes from the federal budget surplus – representing less than one-twentieth of the available surplus.

### Ensures Access to Essential Preventive Services.

★ Preventive Services Are Important to the Well-Being of Seniors and Americans with Disabilities. Older Americans are the fastest growing age group in the U.S. and carry the greatest risk of developing chronic disease and disability. About 88 percent of those over the age of 65 have at least one chronic health condition, many of which are preventable, if detected early.

### ★ Makes Preventive Services Much More Affordable.

The President's Plan eliminates existing copayments and deductibles for every preventive service covered by Medicare, including:

- ✓ annual mammograms for all beneficiaries,
- ✓ cervical cancer screening and pelvic exams,
- ✓ tests to help detect osteoporosis (bone mass measurements),
- ✓ colorectal cancer screening,
- ✓ prostate cancer screening,
- ✓ flu and pneumonia vaccinations, and
- ✓ diabetes self-management.

### ★ Ensures Access to Latest Preventive Services.

The Plan does not stop at removing financial barriers. It invests in a nationwide education campaign to address the lack of knowledge about the importance and availability of preventive services. Finally, it launches studies of the cost-effectiveness and scientific merits of additional preventive services.

## Makes Medicare More Competitive, Efficient and Accessible.

- **Makes Managed Care Payments More Competitive.** For the first time, managed care plans would compete on price and quality, giving beneficiaries lower premiums in return.
- **Modernizes Traditional Medicare.** The Plan gives traditional Medicare successful private-sector management tools to improve quality and reduce costs.
- **Ensures Quality Care.** Recognizing that some policies in the Balanced Budget Act of 1997 may limit doctors', hospitals' and other providers' ability to deliver needed services, the President's Plan sets aside a \$7.5 billion quality assurance fund. This fund, plus administrative actions, will protect Medicare beneficiaries against any erosion of health care quality.

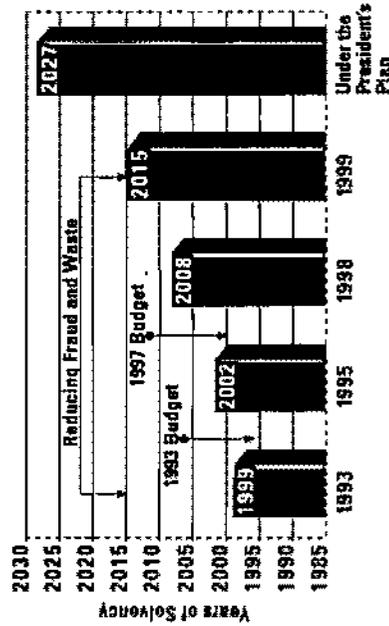
## Strengthens Medicare's Financing for the 21st Century.

- **Extends the Life of the Medicare Trust Fund for a Quarter of a Century, to 2027.** The President's Plan would dedicate 15 percent of the budget surplus to strengthen Medicare. This amount, when combined with Part A savings, would extend the life of the Medicare Trust Fund for a quarter century, to 2027.
- **Securing Medicare Will Avoid the Need to Excessively Cut Doctors', Hospitals' and Other Providers' Payments.** Without the budget surplus dedication, Medicare spending growth per beneficiary would have to be held to under 3 percent per person each and every year to keep Medicare solvent until 2027. This rate is about 60 percent below projected private health insurance spending per person (73 percent).

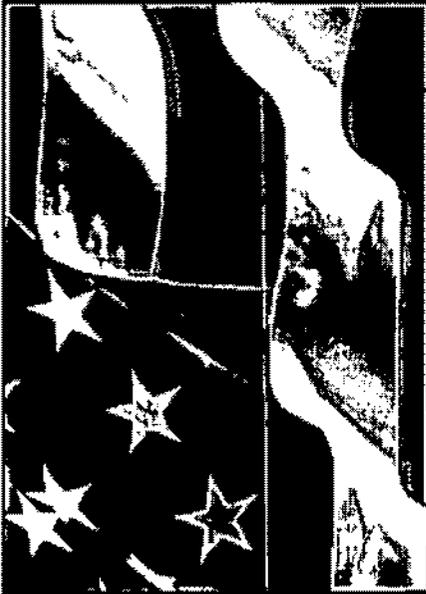
- **Improves Access to Medigap.** The Plan includes policies that make Medigap more accessible to beneficiaries with disabilities and those losing access to managed care plans.

- **Offers Medicare Buy-In to Many People Ages 55-65.** The Plan also provides a new insurance option for vulnerable people ages 55 to 65. They could buy into Medicare by paying the full premium (most up-front, the rest after they turn age 65). The Plan would also help people ages 55 to 65 whose employers drop their retiree health coverage. It allows them to buy into their former employer's plan until they turn age 65.

## Securing Medicare for More Than a Quarter Century



Extending the Solvency of Medicare to 2027

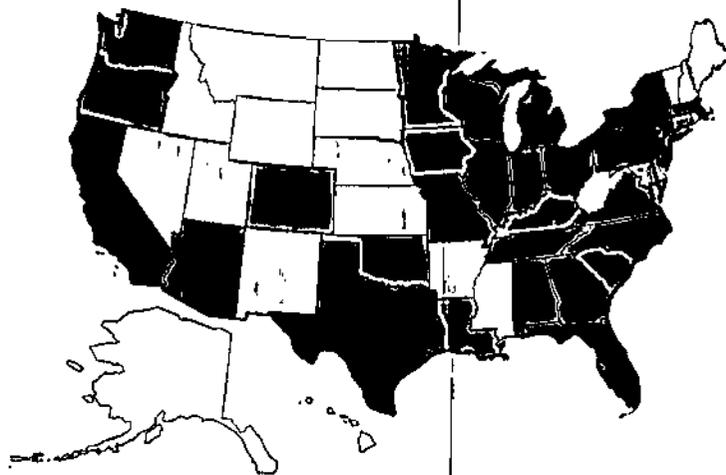


## The President's Plan to Strengthen and Modernize Medicare for the 21st Century



**AMERICA'S SENIORS AND MEDICARE:  
CHALLENGES FOR TODAY AND TOMORROW**

**A STATE-BY-STATE STATUS REPORT**



**February 29, 2000**

*National Economic Council / Domestic Policy Council  
The White House*

**AMERICA'S SENIORS AND MEDICARE:  
CHALLENGES FOR TODAY AND TOMORROW  
STATE-BY-STATE STATUS REPORT:  
EXECUTIVE SUMMARY**

Medicare has successfully improved the health and quality of life for millions of seniors and people with disabilities. Yet, enrollment will double over the next 30 years (from 39 to 80 million beneficiaries); Medicare has not been given the tools it needs to be as competitive and efficient as it needs to be in the 21<sup>st</sup> century; and despite modern medicine's reliance on pharmaceuticals, the program does not cover prescription drugs. This report provides a state-by-state break-out of the overwhelming demographic and health care challenges confronting the Medicare program.<sup>1</sup> Key findings include:

**MILLIONS OF AMERICANS RELY ON MEDICARE**

- **Medicare beneficiaries comprise an important and growing part of all states' residents.** While over half (54 percent) of beneficiaries live in the 10 most populated states, states with the highest concentration of elderly are often smaller (Arkansas, Florida, Iowa, North and South Dakota, Pennsylvania, Rhode Island, and West Virginia). Nationwide, nearly 5 million Medicare beneficiaries are non-elderly people with disabilities. States with the highest proportion of disabled beneficiaries tend to be in the south (e.g., Mississippi, Kentucky, West Virginia, Alabama, and South Carolina).
  - **Women beneficiaries outnumber men in all states.** Nationwide, 57 percent of Medicare beneficiaries (22 million) are women. This distribution of women to men is remarkably consistent across all states, ranging from 51 to 59 percent.
  - **40 states have more than 1 in 10 beneficiaries age 85 or older.** These 4 million beneficiaries have spent almost one-quarter of their lives on Medicare. States in the upper midwest (e.g., North and South Dakota, Minnesota, Nebraska, Kansas, and Iowa) have the highest proportion of "old elderly."
  - **In 15 states, more than half of Medicare beneficiaries live in rural areas.** In fact, in Mississippi, Montana, North and South Dakota, Vermont and Wyoming, over two-thirds of beneficiaries live in rural areas. The 9 million beneficiaries nationwide (about one-fourth of all beneficiaries) living in rural America typically have few to no options for managed care or prescription drug coverage.
- **Poverty among the elderly has been reduced by nearly two-thirds since Medicare was created.** Medicare has contributed to this dramatic improvement by helping seniors pay for the potentially devastating cost of health care when they can least afford it. Nationwide, the elderly poverty rate declined from 29 to 11 percent from 1968 and 1998. In 10 states, the elderly poverty rate fell by 75 percent or more.

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<sup>1</sup> The backup tables include information on the District of Columbia; because of lack of data, the territories are not included in this analysis.

## **MEDICARE ENROLLMENT WILL SURGE**

- **30 states will have one-fifth or more of their population who are elderly in 2025 – compared to no states today.** About 62 million Americans will be age 65 or older in 2025 compared to 35 million today. In Florida, where 18 percent of state residents are elderly today, about 5.5 million people – over 25 percent of residents – will be elderly in 2025 as the baby boom generation retires. Nationwide, this demographic increase is over 75 percent from 2000 to 2025, and is over 100 percent in 15 states.
- **8 states have more than a third of their 55 to 65 year olds who have no or undependable health insurance.** People ages 55 to 65 are the fastest growing group of uninsured – and are at great risk of becoming sick. About 6 million people age 55 to 65 are uninsured or have individual insurance, which is typically age-rated, underwritten based on health status, and can be denied. The baby boom generation is about to turn age 55 – which will create an even bigger access problem.

## **MEDICARE BENEFICIARIES NEED PRESCRIPTION DRUG COVERAGE**

- **16 states have 20 percent or fewer firms offering health insurance to retirees.** Nationally, 22 percent of firms offer health insurance to retirees older than age 65. No state has more than 30 percent of firms offering this coverage. Trends suggest that this coverage will continue to decline, so that very few seniors will get their prescription drug coverage through their former employers in the future.
- **Individual Medigap insurance with prescription drug coverage costs twice as much in high-cost states.** The average premium for a 65-year old for Medigap Plan H that includes drug coverage among other benefits is about \$135 per month, but exceeds \$150 in 9 states. The part of the premium that is attributable to drugs alone can be \$90 per month or \$1,080 per year for coverage that is limited to \$1,250 per year with a \$250 deductible. Moreover, in most states, insurers “age rate” or increase premiums as people get older, making insurance more expensive when seniors can least afford to pay for it.
- **There are no Medicare managed care basic plans with prescription drug coverage in 15 states.** About 2 out of every 5 Medicare beneficiaries lacks this prescription drug option. Medicare managed care plans have, in the recent past, offered prescription drug coverage to attract beneficiaries. However, this coverage is becoming limited. Nationwide, nearly three-quarters of plans cap benefits at or below \$1,000, compared to 35 percent in 1998. Similarly, the proportion of plans that limit drug coverage to \$500 or lower has increase by 50 percent between 1998 (from 19 to 32 percent).
- **Most seniors are middle income and would not benefit from a low-income prescription drug benefit.** About 15.6 million or half (49 percent) of all elderly have income between \$15,000 and \$50,000. Only in Louisiana, Mississippi, New Mexico, Rhode Island, South Carolina and Texas are there more poor than middle class seniors. Nationwide, over half of beneficiaries without drug coverage have income above 150 percent of poverty (\$12,750 for a single, \$15,000 for a couple). Thus, a prescription drug benefit targeted to low-income will not help most seniors.

## HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers depend on over \$200 billion a year in Medicare spending, accounting for one-fifth of all funding.** This does not even count beneficiary payments which comprise nearly half of their total health spending. Medicare spending exceeds 20 percent of all health spending in 12 states. Nationwide, over 5,100 hospitals, 800,000 physicians and nearly 15,000 nursing homes care for Medicare beneficiaries.

## PRESIDENT'S PLAN FOR STRENGTHENING & MODERNIZING MEDICARE

The President's FY 2001 budget dedicates \$432 billion over 10 years – the equivalent of over half of the non-Social Security surplus – to strengthen and modernize Medicare. This plan makes Medicare more fiscally sound, competitive, and efficient and it modernizes Medicare's benefits, including the provision of a long-overdue prescription drug benefit. The reforms coupled with the surplus dedication would extend the life of its trust fund to at least 2025.

- **Making Medicare more competitive and efficient.** Since taking office, President Clinton has worked to reduce Medicare growth and fraud and extend the life of the Medicare Trust Fund from 1999 to 2015. He has proposed to build on these efforts by: (1) expanding anti-fraud policies; (2) making both Medicare managed care and the traditional program more competitive, efficient and high quality; and (3) constraining out-year program growth. Savings total \$71 billion over 10 years.
- **Allocating \$299 billion over 10 years to Trust Fund solvency.** It would be impossible to pay for a doubling in Medicare enrollment through provider payment savings or beneficiary premium increases alone. To address the future financing shortfall, the budget dedicates \$299 billion of the non-Social Security surplus to Medicare which helps to extend the Trust Fund through 2025, and reduces publicly held debt since funds could not be used for tax cuts or new spending.
- **Modernizing Medicare's benefits.** Unlike virtually all private health plans, Medicare does not cover prescription drugs. Yet over half of beneficiaries spend more than \$500 annually on medications and over three in five lack dependable insurance coverage for drugs. The President's plan:
  - **Establishes a new voluntary Medicare prescription drug benefit that is affordable to all beneficiaries and the program.** The drug benefit, which costs \$160 billion over 10 years, would be:
    - **Accessible and voluntary.** Optional for all beneficiaries. Provides financial incentives for employers to develop and retain their retiree health coverage

- ***Affordable for beneficiaries and the program.*** Premiums of \$26 per month in the first year with no premiums for low-income beneficiaries. Provides privately-negotiated discounts, gained by pooling beneficiaries' purchasing power, for all drug expenses. Has no deductible and pays for half of each beneficiary's drug costs from the first prescription filled each year up to \$5,000 in spending when fully phased in. Discounts continue after limit.
- ***Competitively and efficiently administered.*** Competitively selects private benefit manager for enrollees in traditional program. No price controls, no new bureaucracy. Integrated into current eligibility and enrollment systems.
- ***High-quality, necessary medications.*** Private entities that use formularies must ensure access to medications off formulary that a physician certifies as medically necessary. Use of state-of-the-art quality improvement tools.

- **Creates a Medicare reserve fund to add protections for catastrophic drug costs.** To build on the President's prescription drug benefit, the budget includes a reserve fund of \$35 billion for 2006-2010, available to design protections for beneficiaries with extremely high drug spending. This reserve will permit the Administration to work with Congress to design this enhanced prescription drug benefit. If no consensus emerges, the reserve would be used for debt reduction.
- **Improves preventive benefits in Medicare.** This proposal would eliminate the existing deductible and copayments for preventive services (e.g., colorectal cancer screening, bone mass measurements, and mammographies).
- **Creates health insurance options for people ages 55 to 65.** The plan would allow people ages 62 through 65 and displaced workers ages 55 to 65 to pay premiums to buy into Medicare. It also would require employers who drop previously promised retiree coverage to allow early retirees with limited alternatives to have access to COBRA continuation coverage until they reach age 65 and qualify for Medicare. To make this policy more affordable, the President proposes a tax credit, equal to 25 percent of the premium, for participants in the Medicare buy-in and a similar credit for COBRA.

Table 1. Importance of Medicare

STATE	Beneficiaries		Disabled Beneficiaries 3	Women		Age 85 +		Rural		Poverty Rate	
	All Beneficiaries 1	Aged Beneficiaries 2		# 4	%	# 5	%	# 6	%	1968 7	1998
Alabama	669,000	551,000	118,000	385,000	58%	66,000	10%	244,000	36%	41%	13%
Alaska	38,000	32,000	6,000	20,000	51%	2,000	6%	19,000	51%	*	3%
Arizona	651,000	573,000	78,000	357,000	55%	60,000	9%	91,000	14%	13%	10%
Arkansas	433,000	357,000	76,000	243,000	56%	45,000	10%	258,000	60%	42%	17%
California	3,783,000	3,348,000	435,000	2,129,000	56%	394,000	10%	168,000	4%	20%	9%
Colorado	451,000	389,000	62,000	253,000	56%	45,000	10%	83,000	19%	24%	3%
Connecticut	510,000	456,000	54,000	297,000	58%	60,000	12%	16,000	3%	14%	4%
Delaware	108,000	95,000	13,000	61,000	57%	10,000	9%	30,000	27%	30%	9%
DC	76,000	67,000	9,000	46,000	60%	10,000	14%	-	0%	27%	18%
Florida	2,761,000	2,477,000	284,000	1,558,000	56%	295,000	11%	219,000	8%	30%	9%
Georgia	885,000	730,000	155,000	514,000	58%	83,000	9%	350,000	40%	43%	11%
Hawaii	159,000	146,000	13,000	86,000	54%	15,000	10%	43,000	27%	24%	8%
Idaho	159,000	140,000	19,000	87,000	55%	17,000	11%	105,000	66%	25%	8%
Illinois	1,626,000	1,440,000	186,000	946,000	58%	185,000	11%	343,000	21%	27%	12%
Indiana	841,000	732,000	109,000	486,000	58%	86,000	10%	259,000	31%	28%	9%
Iowa	476,000	429,000	47,000	276,000	58%	62,000	13%	300,000	63%	33%	6%
Kansas	389,000	348,000	41,000	225,000	58%	50,000	13%	203,000	52%	41%	9%
Kentucky	610,000	487,000	123,000	339,000	56%	57,000	9%	342,000	56%	42%	14%
Louisiana	596,000	495,000	101,000	333,000	56%	63,000	11%	162,000	27%	35%	16%
Maine	211,000	178,000	33,000	118,000	56%	22,000	11%	98,000	46%	25%	17%
Maryland	628,000	559,000	69,000	364,000	58%	63,000	10%	59,000	9%	20%	10%
Massachusetts	951,000	827,000	124,000	556,000	59%	112,000	12%	15,000	2%	19%	8%
Michigan	1,379,000	1,191,000	188,000	785,000	57%	136,000	10%	294,000	21%	25%	10%
Minnesota	644,000	577,000	67,000	368,000	57%	81,000	13%	258,000	40%	32%	10%
Mississippi	411,000	328,000	83,000	236,000	57%	43,000	11%	287,000	70%	53%	20%
Missouri	850,000	735,000	115,000	489,000	58%	97,000	11%	319,000	38%	30%	8%
Montana	134,000	117,000	17,000	73,000	54%	15,000	11%	103,000	77%	34%	10%
Nebraska	251,000	227,000	24,000	146,000	58%	33,000	13%	149,000	59%	28%	10%
Nevada	223,000	195,000	28,000	117,000	52%	15,000	7%	25,000	11%	50%	9%
New Hampshire	164,000	143,000	21,000	93,000	57%	18,000	11%	55,000	34%	23%	9%
New Jersey	1,188,000	1,064,000	124,000	696,000	59%	129,000	11%	-	0%	25%	8%
New Mexico	225,000	193,000	32,000	121,000	54%	21,000	10%	104,000	46%	49%	16%
New York	2,666,000	2,320,000	346,000	1,555,000	58%	310,000	12%	235,000	9%	23%	15%
North Carolina	1,095,000	917,000	178,000	636,000	58%	100,000	9%	437,000	40%	37%	11%
North Dakota	103,000	93,000	10,000	58,000	56%	14,000	14%	69,000	67%	12%	14%
Ohio	1,689,000	1,476,000	213,000	973,000	58%	170,000	10%	325,000	19%	25%	9%
Oklahoma	500,000	435,000	65,000	285,000	57%	56,000	11%	236,000	47%	44%	10%
Oregon	481,000	428,000	53,000	269,000	56%	53,000	11%	171,000	36%	31%	10%
Pennsylvania	2,089,000	1,874,000	215,000	1,219,000	58%	224,000	11%	342,000	16%	23%	8%
Rhode Island	170,000	148,000	22,000	100,000	59%	20,000	12%	-	0%	14%	10%
South Carolina	545,000	449,000	96,000	314,000	58%	46,000	9%	184,000	34%	29%	15%
South Dakota	118,000	106,000	12,000	67,000	57%	15,000	13%	85,000	72%	14%	13%
Tennessee	807,000	669,000	138,000	465,000	58%	78,000	10%	307,000	38%	43%	12%
Texas	2,196,000	1,924,000	272,000	1,243,000	57%	222,000	10%	509,000	23%	33%	13%
Utah	198,000	176,000	22,000	109,000	55%	20,000	10%	55,000	28%	29%	5%
Vermont	86,000	74,000	12,000	49,000	57%	10,000	11%	64,000	75%	41%	8%
Virginia	864,000	742,000	122,000	495,000	57%	82,000	9%	440,000	51%	29%	11%
Washington	718,000	632,000	86,000	400,000	56%	77,000	11%	160,000	22%	28%	8%
West Virginia	335,000	272,000	63,000	183,000	55%	32,000	9%	199,000	59%	41%	16%
Wisconsin	775,000	689,000	86,000	443,000	57%	91,000	12%	291,000	38%	28%	6%
Wyoming	64,000	56,000	8,000	34,000	54%	6,000	10%	44,000	69%	42%	10%
TOTAL	37,979,000	33,106,000	4,873,000	21,680,000	57%	4,016,000	11%	9,154,000	24%	29%	11%

1-6. Data from the U.S. Health Care Financing Administration, for 1998. Excludes residents of foreign countries, of unknown residence, and in territories.

7. Data from the U.S. Department of Commerce, Census Bureau.

Table 2. Demographic Trends

STATE	Seniors: 2000		Seniors: 2025		55-65 Uninsured/ Individual Insured	
	#	%	#	%	3	
Alabama	582,000	13%	1,069,000	21%	104,000	27%
Alaska	38,000	6%	92,000	10%	9,000	23%
Arizona	635,000	13%	1,368,000	21%	119,000	33%
Arkansas	377,000	14%	731,000	24%	88,000	39%
California	3,387,000	10%	6,424,000	13%	768,000	32%
Colorado	452,000	11%	1,044,000	20%	93,000	30%
Connecticut	461,000	14%	671,000	18%	80,000	26%
Delaware	97,000	13%	165,000	19%	11,000	17%
DC	69,000	13%	92,000	14%	10,000	25%
Florida	2,755,000	18%	5,453,000	26%	1,426,000	33%
Georgia	779,000	10%	1,668,000	17%	158,000	30%
Hawaii	157,000	12%	289,000	16%	16,000	20%
Idaho	157,000	12%	374,000	22%	30,000	31%
Illinois	1,484,000	12%	2,234,000	17%	227,000	24%
Indiana	763,000	13%	1,260,000	19%	134,000	30%
Iowa	442,000	15%	686,000	23%	86,000	34%
Kansas	359,000	13%	605,000	20%	57,000	31%
Kentucky	509,000	13%	917,000	21%	76,000	23%
Louisiana	523,000	12%	945,000	18%	111,000	30%
Maine	172,000	14%	304,000	21%	31,000	23%
Maryland	589,000	11%	1,029,000	16%	102,000	24%
Massachusetts	843,000	14%	1,252,000	18%	103,000	21%
Michigan	1,197,000	12%	1,821,000	18%	144,000	20%
Minnesota	596,000	12%	1,099,000	20%	100,000	24%
Mississippi	344,000	12%	615,000	20%	75,000	34%
Missouri	755,000	14%	1,258,000	20%	104,000	23%
Montana	128,000	13%	274,000	24%	23,000	34%
Nebraska	239,000	14%	405,000	21%	47,000	37%
Nevada	219,000	12%	486,000	21%	41,000	26%
New Hampshire	142,000	12%	273,000	19%	20,000	21%
New Jersey	1,090,000	13%	1,634,000	17%	179,000	26%
New Mexico	206,000	11%	441,000	17%	43,000	31%
New York	2,338,000	13%	3,263,000	17%	386,000	24%
North Carolina	991,000	13%	2,004,000	21%	200,000	31%
North Dakota	99,000	15%	166,000	23%	20,000	39%
Ohio	1,325,000	13%	2,305,000	20%	191,000	21%
Oklahoma	472,000	14%	828,000	22%	85,000	28%
Oregon	471,000	14%	1,054,000	24%	93,000	31%
Pennsylvania	1,595,000	16%	2,659,000	21%	277,000	25%
Rhode Island	148,000	15%	214,000	19%	21,000	26%
South Carolina	478,000	12%	963,000	21%	108,000	30%
South Dakota	110,000	14%	188,000	22%	23,000	38%
Tennessee	707,000	12%	1,335,000	20%	150,000	28%
Texas	2,101,000	10%	4,364,000	16%	475,000	33%
Utah	202,000	9%	495,000	17%	27,000	20%
Vermont	73,000	12%	138,000	20%	15,000	30%
Virginia	788,000	11%	1,515,000	18%	136,000	21%
Washington	685,000	12%	1,380,000	20%	129,000	26%
West Virginia	287,000	16%	460,000	25%	53,000	30%
Wisconsin	705,000	13%	1,200,000	21%	112,000	26%
Wyoming	62,000	12%	145,000	21%	14,000	34%
TOTAL	34,707,000	13%	61,954,000	19%	6,130,000	28%

1. Projections of State Population by Age: 1005-2025. Series A projections. U.S. Department of Commerce, Census Bureau.  
 2. March 1997-1999 CPS averages for individually insured and uninsured. Note: small cell size.

**Table 3. Prescription Drugs**

STATE	Firms Offering Coverage 1	Medigap Avg. Premiums 2	Access to Medicare Managed Care Basic Plans w/Drugs 3		Income Distribution of People Ages 65 +					
					<\$15,000	\$15-50,000	\$50,000+	<\$15,000	\$15-50,000	\$50,000 +
					4					
Alabama	19%	\$124	0	0%	242,000	248,000	84,000	42%	43%	15%
Alaska	na	na	0	0%	19,000	15,000	7,000	29%	48%	23%
Arizona	22%	na	618,329	94%	179,000	287,000	96,000	32%	51%	17%
Arkansas	14%	\$158	0	0%	164,000	165,000	26,000	46%	46%	7%
California	19%	na	3,365,276	93%	1,237,000	1,541,000	605,000	37%	46%	18%
Colorado	25%	\$135	387,696	83%	111,000	171,000	66,000	32%	49%	19%
Connecticut	24%	\$207	559,603	97%	130,000	235,000	77,000	29%	53%	17%
Delaware	na	\$120	65,492	60%	38,000	46,000	15,000	38%	46%	15%
DC	na	na	71,448	100%	36,000	25,000	12,000	49%	34%	16%
Florida	20%	\$167	2,380,337	82%	925,000	1,294,000	353,000	36%	50%	14%
Georgia	24%	\$215	312,886	37%	273,000	368,000	101,000	37%	50%	14%
Hawaii	29%	na	148,794	100%	157,000	77,000	26,000	36%	48%	16%
Idaho	na	na	45,058	29%	148,000	72,000	16,000	35%	53%	12%
Illinois	25%	\$131	1,031,593	63%	497,000	678,000	156,000	37%	51%	12%
Indiana	21%	na	314,114	38%	266,000	357,000	78,000	38%	51%	11%
Iowa	17%	\$114	0	0%	111,000	218,000	44,000	30%	58%	12%
Kansas	21%	\$126	84,574	22%	120,000	198,000	52,000	32%	54%	14%
Kentucky	20%	na	161,963	28%	187,000	221,000	59,000	40%	47%	13%
Louisiana	24%	na	332,643	52%	244,000	205,000	51,000	49%	41%	10%
Maine	20%	\$197	124,069	62%	60,000	94,000	11,000	36%	57%	7%
Maryland	23%	na	530,113	81%	216,000	275,000	129,000	35%	44%	21%
Massachusetts	25%	na	981,848	97%	286,000	378,000	93,000	38%	50%	12%
Michigan	28%	\$166	745,704	54%	409,000	640,000	151,000	34%	53%	13%
Minnesota	19%	na	0	0%	161,000	260,000	53,000	34%	55%	11%
Mississippi	17%	\$140	0	0%	166,000	112,000	29,000	54%	36%	9%
Missouri	18%	\$136	536,078	61%	235,000	390,000	111,000	32%	53%	15%
Montana	na	\$111	0	0%	33,000	62,000	10,000	31%	59%	10%
Nebraska	22%	\$111	0	0%	84,000	108,000	21,000	39%	51%	10%
Nevada	20%	\$143	184,359	86%	75,000	94,000	34,000	37%	46%	17%
New Hampshire	na	\$105	80,957	48%	44,000	76,000	14,000	33%	57%	10%
New Jersey	20%	na	1,255,239	100%	371,000	424,000	142,000	40%	45%	15%
New Mexico	20%	\$141	110,771	52%	84,000	78,000	37,000	42%	39%	19%
New York	24%	\$159	2,154,414	80%	973,000	1,028,000	340,000	42%	44%	15%
North Carolina	22%	\$125	0	0%	346,000	428,000	114,000	39%	48%	13%
North Dakota	na	\$122	0	0%	34,000	43,000	9,000	40%	50%	10%
Ohio	28%	\$131	1,537,564	83%	519,000	766,000	136,000	37%	54%	10%
Oklahoma	22%	\$112	377,159	75%	157,000	225,000	56,000	36%	51%	13%
Oregon	21%	\$119	256,842	53%	124,000	212,000	48,000	32%	55%	13%
Pennsylvania	22%	\$142	1,918,911	81%	608,000	881,000	177,000	36%	53%	11%
Rhode Island	na	\$107	179,263	92%	75,000	68,000	14,000	48%	43%	9%
South Carolina	21%	\$142	0	0%	195,000	181,000	35,000	47%	44%	9%
South Dakota	na	\$113	0	0%	36,000	55,000	8,000	36%	56%	8%
Tennessee	24%	na	106,671	14%	245,000	296,000	69,000	40%	49%	11%
Texas	19%	\$124	1,533,910	69%	795,000	781,000	254,000	43%	43%	14%
Utah	21%	\$113	0	0%	46,000	111,000	30,000	25%	59%	16%
Vermont	na	\$155	0	0%	23,000	36,000	7,000	35%	55%	11%
Virginia	23%	\$98	244,746	30%	267,000	364,000	150,000	34%	47%	19%
Washington	17%	\$159	434,817	59%	155,000	270,000	98,000	30%	52%	19%
West Virginia	19%	\$116	0	0%	133,000	139,000	28,000	44%	46%	9%
Wisconsin	23%	na	331,034	42%	200,000	325,000	82,000	33%	54%	14%
Wyoming	na	\$123	0	0%	21,000	26,000	7,000	39%	48%	13%
<b>TOTAL</b>	<b>22%</b>	<b>\$136</b>	<b>23,504,275</b>	<b>61%</b>	<b>12,050,000</b>	<b>15,647,000</b>	<b>4,421,000</b>	<b>38%</b>	<b>49%</b>	<b>14%</b>

1. Private-sector establishments offering retirees 65+ insurance, 1996. 1996 MEPS Insurance Component, U.S. Agency for Health Care Policy & Research.
2. Average Medigap premiums for a 65 year old for Plan H. From state insurance commissioners' data.
3. Data from 2000 Medicare + Choice plan submissions. Note: This is just for basic plans. Plans may charge an extra premium for drugs.
4. March 1997-1999 average CPS.

Table 4. Medicare Spending and Health Care Providers

STATE	Benefit Spending \$ Millions 1	Medicare Share of Total Spending 2	Hospitals 1997 3	Physicians 1998 4	Nursing Homes 1997 5
Alabama	3,561	22%	110	9,700	219
Alaska	160	6%	22	1,400	16
Arizona	2,986	21%	69	11,100	164
Arkansas	1,929	23%	78	8,900	207
California	122,558	18%	425	96,600	1,319
Colorado	2,279	16%	65	12,600	206
Connecticut	3,128	18%	33	11,900	251
Delaware	405	17%	6	2,300	39
DC	922	14%	10	4,200	21
Florida	17,903	28%	203	41,500	719
Georgia	4,287	18%	161	18,500	315
Hawaii	639	14%	23	3,900	38
Idaho	601	17%	43	2,500	86
Illinois	8,490	18%	198	31,900	631
Indiana	4,263	19%	115	15,300	507
Iowa	1,810	20%	117	8,500	263
Kansas	1,809	19%	127	6,800	283
Kentucky	2,897	21%	103	9,100	318
Louisiana	4,293	21%	126	13,200	220
Maine	793	18%	39	4,400	133
Maryland	3,642	18%	50	18,600	232
Massachusetts	5,807	20%	85	27,500	521
Michigan	7,711	20%	163	28,200	383
Minnesota	2,798	15%	143	15,400	435
Mississippi	2,216	22%	101	5,300	151
Missouri	4,695	22%	121	16,300	482
Montana	534	19%	48	2,600	102
Nebraska	1,680	17%	91	4,200	154
Nevada	1,105	20%	27	3,400	43
New Hampshire	648	14%	26	4,200	63
New Jersey	6,908	19%	88	27,400	275
New Mexico	829	15%	42	4,000	73
New York	17,065	18%	223	73,800	662
North Carolina	5,296	20%	130	17,600	399
North Dakota	480	19%	47	2,200	88
Ohio	8,835	19%	176	31,900	856
Oklahoma	2,373	21%	123	7,300	220
Oregon	1,832	19%	62	9,400	130
Pennsylvania	13,183	24%	203	50,100	769
Rhode Island	1,022	19%	11	3,300	100
South Carolina	2,563	17%	62	8,400	178
South Dakota	504	19%	39	2,200	83
Tennessee	4,728	22%	125	14,800	273
Texas	14,666	18%	386	49,000	1,105
Utah	888	15%	41	4,900	81
Vermont	289	16%	14	2,100	40
Virginia	3,657	16%	96	16,800	218
Washington	2,883	16%	89	16,400	280
West Virginia	1,528	21%	53	4,700	101
Wisconsin	3,267	17%	125	16,100	361
Wyoming	218	15%	25	1,200	33
TOTAL	208,963	19%	5,108	801,600	14,852

1. 1999 spending from the Health Care Financing Administration

2. Medicare share of total personal health care expenditures, 1993. Health Care Financing Review, Fall 1995.

3-6. From 1998 Data Compendium from the Health Care Financing Administration.

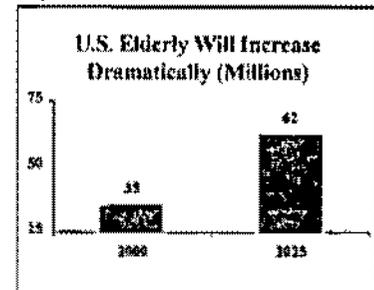
# UNITED STATES: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 38 MILLION AMERICANS

- 33.1 million seniors and 4.9 million people with disabilities rely on Medicare.
  - About 21.7 million Medicare beneficiaries (57 percent) are women.
  - About 4.0 million Medicare beneficiaries (11 percent) are age 85 and older.
  - About 9.1 million Medicare beneficiaries (24 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among U.S. elderly fell from 29 to 11 percent since Medicare was created.

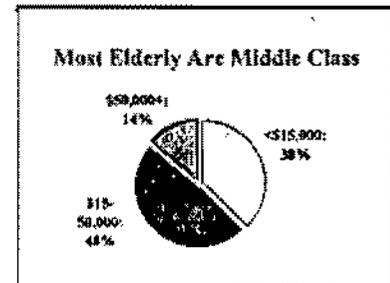
## MEDICARE ENROLLMENT WILL SURGE

- The number of seniors in United States will rise from 34.7 million in 2000 to 62 million in 2025. The percent of residents in the United States who are elderly will increase from 13 to 19 percent.
- About 6.1 million people (28%) ages 55 to 65 in the United States, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of U.S. firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have it. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 23.5 million or 61 percent of Medicare beneficiaries nationwide have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 15.6 million elderly in United States are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers depend on over \$200 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in United States. This is critical to:
  - 5,108 hospitals, 801,600 physicians, 14,852 nursing homes, and other health care providers.

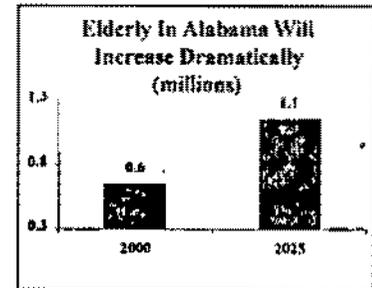
# ALABAMA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 669,000 IN ALABAMA

- 551,000 seniors and 118,000 people with disabilities in Alabama rely on Medicare.
  - About 385,000 Medicare beneficiaries in Alabama (58 percent) are women.
  - About 66,000 Medicare beneficiaries in Alabama (10 percent) are age 85 and older.
  - About 244,000 Medicare beneficiaries in Alabama (36 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Alabama fell from 41 to 13 percent since Medicare was created.

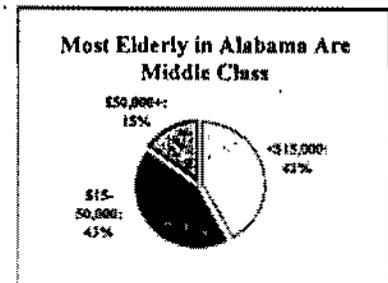
## MEDICARE ENROLLMENT WILL SURGE IN ALABAMA

- The number of seniors in Alabama will rise from 582,000 in 2000 to 1,069,000 in 2025. The percent of residents in Alabama who are elderly will increase from 13 to 21 percent.
- About 104,000 people (27%) ages 55 to 65 in Alabama, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## ALABAMA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 19 percent of Alabama firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$124 in Alabama, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Alabama. No Medicare beneficiaries in Alabama have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 248,000 of all elderly in Alabama are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## ALABAMA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Alabama depend on \$4 billion in Medicare spending. Medicare pays for 22 percent of all personal health care expenditures in Alabama. This is critical to:
  - 110 hospitals, 9,700 physicians, 219 nursing homes, and other providers in Alabama.

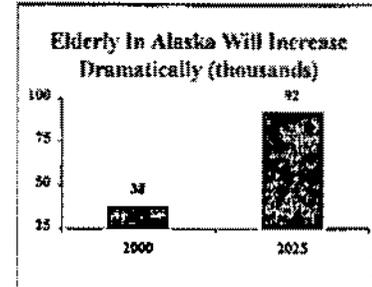
# ALASKA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 38,000 IN ALASKA

- **32,000 seniors and 6,000 people with disabilities in Alaska rely on Medicare.**
  - About 20,000 Medicare beneficiaries in Alaska (51 percent) are women.
  - About 2,000 Medicare beneficiaries in Alaska (6 percent) are age 85 and older.
  - About 19,000 Medicare beneficiaries in Alaska (51 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly nationwide fell from 29 to 11 percent since Medicare was created.**

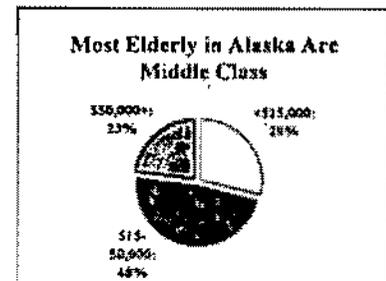
## MEDICARE ENROLLMENT WILL SURGE IN ALASKA

- **The number of seniors in Alaska will rise from 38,000 in 2000 to 92,000 in 2025.** The percent of residents in Alaska who are elderly will increase from 6 to 10 percent.
- **About 9,000 people (23%) ages 55 to 65 in Alaska, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## ALASKA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of firms nationwide offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Alaska.** No Medicare beneficiaries in Alaska have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 15,000 of all elderly in Alaska are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## ALASKA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Alaska depend on \$160 million in Medicare spending.** Medicare pays for 6 percent of all personal health care expenditures in Alaska. This is critical to:
  - 22 hospitals, 1,400 physicians, 16 nursing homes, and other providers in Alaska.

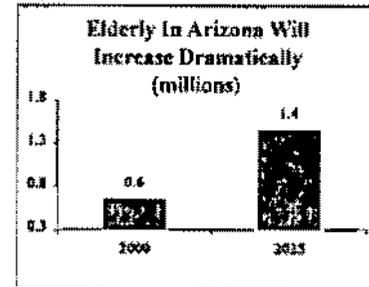
# ARIZONA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 651,000 IN ARIZONA

- 573,000 seniors and 78,000 people with disabilities in Arizona rely on Medicare.
  - About 357,000 Medicare beneficiaries in Arizona (55 percent) are women.
  - About 60,000 Medicare beneficiaries in Arizona (9 percent) are age 85 and older.
  - About 91,000 Medicare beneficiaries in Arizona (14 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Arizona fell from 13 to 10 percent since Medicare was created.

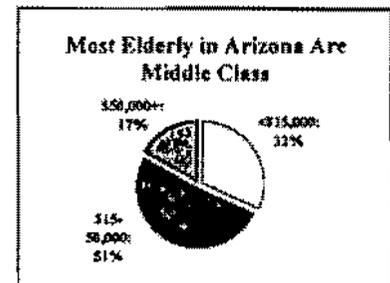
## MEDICARE ENROLLMENT WILL SURGE IN ARIZONA

- The number of seniors in Arizona will rise from 635,000 in 2000 to 1,368,000 in 2025. The percent of residents in Arizona who are elderly will increase from 13 to 21 percent.
- About 119,000 people (33%) ages 55 to 65 in Arizona, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## ARIZONA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of Arizona firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 618,329 or 94 percent of Medicare beneficiaries in Arizona have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 287,000 of all elderly in Arizona are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## ARIZONA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Arizona depend on \$3 billion in Medicare spending. Medicare pays for 21 percent of all personal health care expenditures in Arizona. This is critical to:
  - 69 hospitals, 11,100 physicians, 164 nursing homes, and other providers in Arizona.

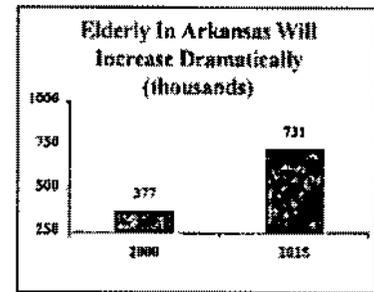
# ARKANSAS: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 433,000 IN ARKANSAS

- 357,000 seniors and 76,000 people with disabilities in Arkansas rely on Medicare.
  - About 243,000 Medicare beneficiaries in Arkansas (56 percent) are women.
  - About 45,000 Medicare beneficiaries in Arkansas (10 percent) are age 85 and older.
  - About 258,000 Medicare beneficiaries in Arkansas (60 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Arkansas fell from 42 to 17 percent since Medicare was created.

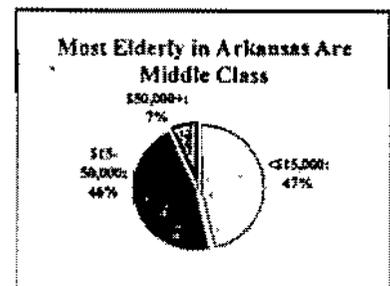
## MEDICARE ENROLLMENT WILL SURGE IN ARKANSAS

- The number of seniors in Arkansas will rise from 377,000 in 2000 to 731,000 in 2025. The percent of residents in Arkansas who are elderly will increase from 14 to 24 percent.
- About 88,000 people (39%) ages 55 to 65 in Arkansas, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## ARKANSAS SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 14 percent of Arkansas firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$158 in Arkansas, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Arkansas requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Arkansas. No Medicare beneficiaries in Arkansas have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 165,000 of all elderly in Arkansas are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## ARKANSAS HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Arkansas depend on \$2 billion in Medicare spending. Medicare pays for 23 percent of all personal health care expenditures in Arkansas. This is critical to:
  - 78 hospitals, 6,900 physicians, 207 nursing homes, and other providers in Arkansas.

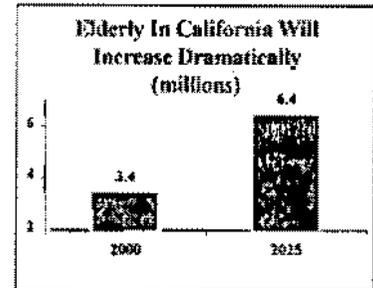
# CALIFORNIA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 3,783,000 IN CALIFORNIA

- **3,348,000 seniors and 435,000 people with disabilities in California rely on Medicare.**
  - About 2,129,000 Medicare beneficiaries in California (56 percent) are women.
  - About 394,000 Medicare beneficiaries in California (10 percent) are age 85 and older.
  - About 168,000 Medicare beneficiaries in California (4 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in California fell from 20 to 9 percent since Medicare was created.**

## MEDICARE ENROLLMENT WILL SURGE IN CALIFORNIA

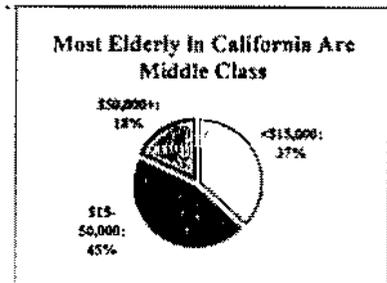
- **The number of seniors in California will rise from 3,387,000 in 2000 to 6,424,000 in 2025.** The percent of residents in California who are elderly will increase from 10 to 13 percent.



- **About 768,000 people (32%) ages 55 to 65 in California, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.

## CALIFORNIA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 19 percent of California firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited.** About 3,365,276 or 93 percent of Medicare beneficiaries in California have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 1,541,000 of all elderly in California are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## CALIFORNIA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in California depend on \$23 billion in Medicare spending.** Medicare pays for 18 percent of all personal health care expenditures in California. This is critical to:
  - 425 hospitals, 96,600 physicians, 1,319 nursing homes, and other providers in California.

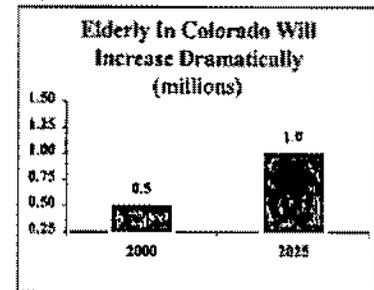
# COLORADO: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 451,000 IN COLORADO

- 389,000 seniors and 62,000 people with disabilities in Colorado rely on Medicare.
  - About 253,000 Medicare beneficiaries in Colorado (56 percent) are women.
  - About 45,000 Medicare beneficiaries in Colorado (10 percent) are age 85 and older.
  - About 83,000 Medicare beneficiaries in Colorado (19 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Colorado fell from 24 to 3 percent since Medicare was created.

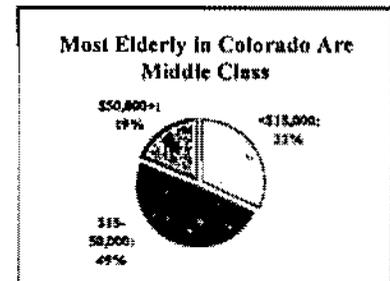
## MEDICARE ENROLLMENT WILL SURGE IN COLORADO

- The number of seniors in Colorado will rise from 452,000 in 2000 to 1,044,000 in 2025. The percent of residents in Colorado who are elderly will increase from 11 to 20 percent.
- About 93,000 people (30%) ages 55 to 65 in Colorado, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## COLORADO SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 25 percent of Colorado firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$135 in Colorado, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 387,696 or 83 percent of Medicare beneficiaries in Colorado have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 171,000 of all elderly in Colorado are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## COLORADO HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Colorado depend on \$2 billion in Medicare spending. Medicare pays for 16 percent of all personal health care expenditures in Colorado. This is critical to:
  - 65 hospitals, 12,600 physicians, 206 nursing homes, and other providers in Colorado.

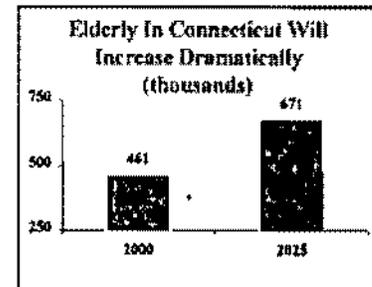
# CONNECTICUT: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 510,000 IN CONNECTICUT

- 456,000 seniors and 54,000 people with disabilities in Connecticut rely on Medicare.
  - About 297,000 Medicare beneficiaries in Connecticut (58 percent) are women.
  - About 60,000 Medicare beneficiaries in Connecticut (12 percent) are age 85 and older.
  - About 16,000 Medicare beneficiaries in Connecticut (3 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Connecticut fell from 14 to 4 percent since Medicare was created.

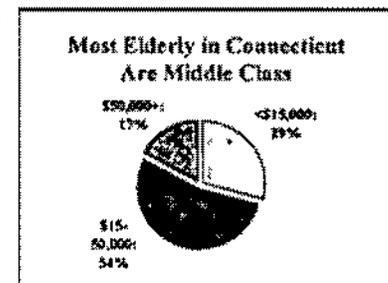
## MEDICARE ENROLLMENT WILL SURGE IN CONNECTICUT

- The number of seniors in Connecticut will rise from 461,000 in 2000 to 671,000 in 2025. The percent of residents in Connecticut who are elderly will increase from 14 to 18 percent.
- About 80,000 people (26%) ages 55 to 65 in Connecticut, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## CONNECTICUT SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 24 percent of Connecticut firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$207 in Connecticut, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Connecticut requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 559,603 or 97 percent of Medicare beneficiaries in Connecticut have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 235,000 of all elderly in Connecticut are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## CONNECTICUT HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Connecticut depend on \$3 billion in Medicare spending. Medicare pays for 18 percent of all personal health care expenditures in Connecticut. This is critical to:
  - 33 hospitals, 11,900 physicians, 251 nursing homes, and other providers in Connecticut.

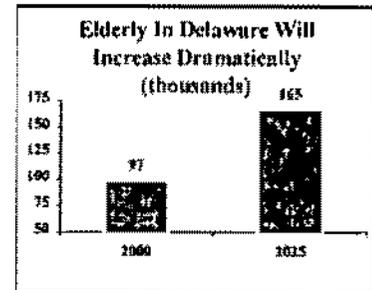
# DELAWARE: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 108,000 IN DELAWARE

- 95,000 seniors and 13,000 people with disabilities in Delaware rely on Medicare.
  - About 61,000 Medicare beneficiaries in Delaware (57 percent) are women.
  - About 10,000 Medicare beneficiaries in Delaware (9 percent) are age 85 and older.
  - About 30,000 Medicare beneficiaries in Delaware (27 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Delaware fell from 30 to 9 percent since Medicare was created.

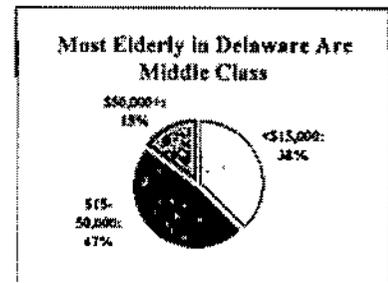
## MEDICARE ENROLLMENT WILL SURGE IN DELAWARE

- The number of seniors in Delaware will rise from 97,000 in 2000 to 165,000 in 2025. The percent of residents in Delaware who are elderly will increase from 13 to 19 percent.
- About 11,000 people (17%) ages 55 to 65 in Delaware, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## DELAWARE SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of firms nationwide offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$120 in Delaware, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Delaware. About 65,492 or 60 percent of Medicare beneficiaries in Delaware have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 46,000 of all elderly in Delaware are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## DELAWARE HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Delaware depend on \$405 million in Medicare spending. Medicare pays for 17 percent of all personal health care expenditures in Delaware. This is critical to:
  - 6 hospitals, 2,300 physicians, 39 nursing homes, and other providers in Delaware.

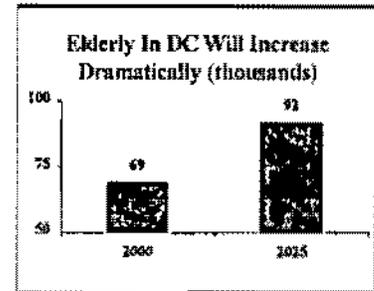
# DISTRICT OF COLUMBIA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 76,000 IN DISTRICT OF COLUMBIA

- **67,000 seniors and 9,000 people with disabilities in District of Columbia rely on Medicare.**
  - About 46,000 Medicare beneficiaries in District of Columbia (60 percent) are women.
  - About 10,000 Medicare beneficiaries in District of Columbia (14 percent) are age 85 and older.
  - About - Medicare beneficiaries in District of Columbia (- percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in DC fell from 27 to 18 percent since Medicare was created.**

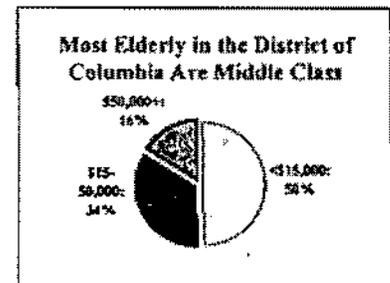
## MEDICARE ENROLLMENT WILL SURGE IN DC

- **The number of seniors in District of Columbia will rise from 69,000 in 2000 to 92,000 in 2025.** The percent of residents in District of Columbia who are elderly will increase from 13 to 14 percent.
- **About 10,000 people (25%) ages 55 to 65 in District of Columbia, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## DISTRICT OF COLUMBIA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of firms nationwide offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited.** About 71,448 or 100 percent of Medicare beneficiaries in District of Columbia have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 25,000 of all elderly in District of Columbia are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## DISTRICT OF COLUMBIA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in District of Columbia depend on \$1 billion in Medicare spending.** Medicare pays for 14 percent of all personal health care expenditures in District of Columbia. This is critical to:
  - 10 hospitals, 4,200 physicians, 21 nursing homes, and other providers in District of Columbia.

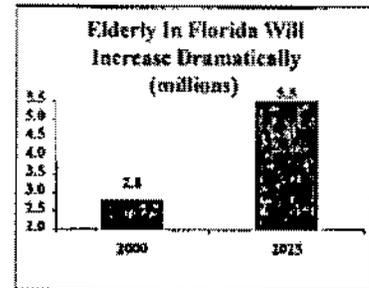
# FLORIDA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 2,761,000 IN FLORIDA

- 2,477,000 seniors and 284,000 people with disabilities in Florida rely on Medicare.
  - About 1,538,000 Medicare beneficiaries in Florida (56 percent) are women.
  - About 295,000 Medicare beneficiaries in Florida (11 percent) are age 85 and older.
  - About 219,000 Medicare beneficiaries in Florida (8 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Florida fell from 30 to 9 percent since Medicare was created.

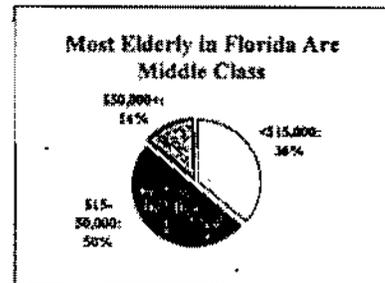
## MEDICARE ENROLLMENT WILL SURGE IN FLORIDA

- The number of seniors in Florida will rise from 2,755,000 in 2000 to 5,453,000 in 2025. The percent of residents in Florida who are elderly will increase from 18 to 26 percent.
- About 426,000 people (33%) ages 55 to 65 in Florida, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## FLORIDA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 20 percent of Florida firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$167 in Florida, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Florida prohibits attained-age rating. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 2,380,337 or 82 percent of Medicare beneficiaries in Florida have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 1,294,000 of all elderly in Florida are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## FLORIDA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Florida depend on \$18 billion in Medicare spending. Medicare pays for 28 percent of all personal health care expenditures in Florida. This is critical to:
  - 203 hospitals, 41,500 physicians, 719 nursing homes, and other providers in Florida.

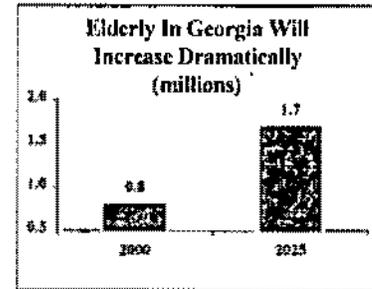
# GEORGIA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 885,000 IN GEORGIA

- 730,000 seniors and 155,000 people with disabilities in Georgia rely on Medicare.
  - About 514,000 Medicare beneficiaries in Georgia (58 percent) are women.
  - About 83,000 Medicare beneficiaries in Georgia (9 percent) are age 85 and older.
  - About 350,000 Medicare beneficiaries in Georgia (40 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Georgia fell from 43 to 11 percent since Medicare was created.

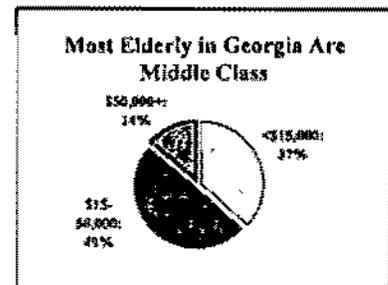
## MEDICARE ENROLLMENT WILL SURGE IN GEORGIA

- The number of seniors in Georgia will rise from 779,000 in 2000 to 1,668,000 in 2025. The percent of residents in Georgia who are elderly will increase from 10 to 17 percent.
- About 158,000 people (30%) ages 55 to 65 in Georgia, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## GEORGIA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 24 percent of Georgia firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$215 in Georgia, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Georgia prohibits attained-age rating. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Georgia. About 312,886 or 37 percent of Medicare beneficiaries in Georgia have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 368,000 of all elderly in Georgia are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## GEORGIA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Georgia depend on \$4 billion in Medicare spending. Medicare pays for 18 percent of all personal health care expenditures in Georgia. This is critical to:
  - 161 hospitals, 18,500 physicians, 315 nursing homes, and other providers in Georgia.

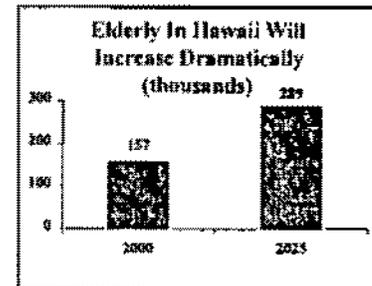
# HAWAII: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 159,000 IN HAWAII

- 146,000 seniors and 13,000 people with disabilities in Hawaii rely on Medicare.
  - About 86,000 Medicare beneficiaries in Hawaii (54 percent) are women.
  - About 15,000 Medicare beneficiaries in Hawaii (10 percent) are age 85 and older.
  - About 43,000 Medicare beneficiaries in Hawaii (27 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Hawaii fell from 24 to 8 percent since Medicare was created.

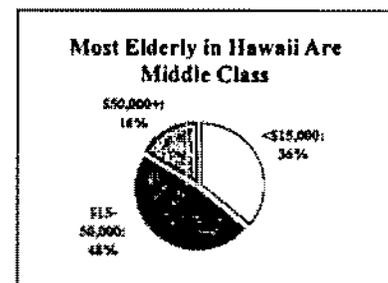
## MEDICARE ENROLLMENT WILL SURGE IN HAWAII

- The number of seniors in Hawaii will rise from 157,000 in 2000 to 289,000 in 2025. The percent of residents in Hawaii who are elderly will increase from 12 to 16 percent.
- About 16,000 people (20%) ages 55 to 65 in Hawaii, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## HAWAII SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 29 percent of Hawaii firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 148,794 or 100 percent of Medicare beneficiaries in Hawaii have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 77,000 of all elderly in Hawaii are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## HAWAII HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Hawaii depend on \$1 billion in Medicare spending. Medicare pays for 14 percent of all personal health care expenditures in Hawaii. This is critical to:
  - 23 hospitals, 3,900 physicians, 38 nursing homes, and other providers in Hawaii.

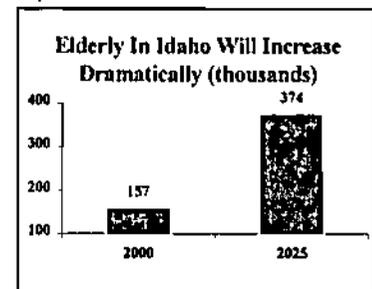
## IDAHO: THE NEED FOR MEDICARE REFORM

### MEDICARE PROVIDES CRITICAL HEALTH CARE TO 159,000 IN IDAHO

- **140,000 seniors and 19,000 people with disabilities in Idaho rely on Medicare.**
  - About 87,000 Medicare beneficiaries in Idaho (55 percent) are women.
  - About 17,000 Medicare beneficiaries in Idaho (11 percent) are age 85 and older.
  - About 105,000 Medicare beneficiaries in Idaho (66 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Idaho fell from 25 to 8 percent since Medicare was created.**

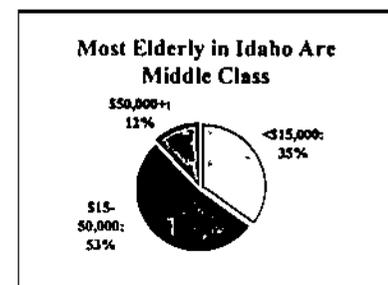
### MEDICARE ENROLLMENT WILL SURGE IN IDAHO

- **The number of seniors in Idaho will rise from 157,000 in 2000 to 374,000 in 2025.** The percent of residents in Idaho who are elderly will increase from 12 to 22 percent.
- **About 30,000 people (31%) ages 55 to 65 in Idaho, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



### IDAHO SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of firms nationwide offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Idaho prohibits attained-age rating. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Idaho.** About 45,058 or 29 percent of Medicare beneficiaries in Idaho have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 72,000 of all elderly in Idaho are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



### IDAHO HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Idaho depend on \$1 billion in Medicare spending.** Medicare pays for 17 percent of all personal health care expenditures in Idaho. This is critical to:
  - 43 hospitals, 2,500 physicians, 86 nursing homes, and other providers in Idaho.

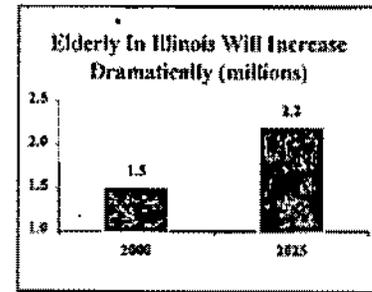
# ILLINOIS: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 1,626,000 IN ILLINOIS

- 1,440,000 seniors and 186,000 people with disabilities in Illinois rely on Medicare.
  - About 946,000 Medicare beneficiaries in Illinois (58 percent) are women.
  - About 185,000 Medicare beneficiaries in Illinois (11 percent) are age 85 and older.
  - About 343,000 Medicare beneficiaries in Illinois (21 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Illinois fell from 27 to 12 percent since Medicare was created.

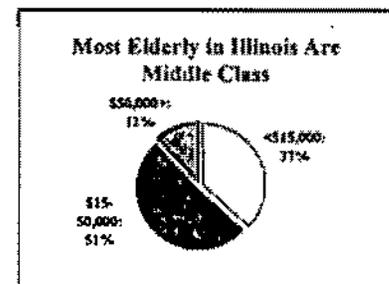
## MEDICARE ENROLLMENT WILL SURGE IN ILLINOIS

- The number of seniors in Illinois will rise from 1,484,000 in 2000 to 2,234,000 in 2025. The percent of residents in Illinois who are elderly will increase from 12 to 17 percent.
- About 227,000 people (24%) ages 55 to 65 in Illinois, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## ILLINOIS SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 25 percent of Illinois firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$131 in Illinois, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Illinois. About 1,031,593 or 63 percent of Medicare beneficiaries in Illinois have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 678,000 of all elderly in Illinois are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## ILLINOIS HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Illinois depend on \$8 billion in Medicare spending. Medicare pays for 18 percent of all personal health care expenditures in Illinois. This is critical to:
  - 198 hospitals, 31,900 physicians, 631 nursing homes, and other providers in Illinois.

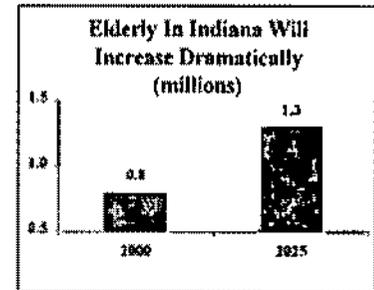
# INDIANA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 841,000 IN INDIANA

- 732,000 seniors and 109,000 people with disabilities in Indiana rely on Medicare.
  - About 486,000 Medicare beneficiaries in Indiana (58 percent) are women.
  - About 86,000 Medicare beneficiaries in Indiana (10 percent) are age 85 and older.
  - About 259,000 Medicare beneficiaries in Indiana (31 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Indiana fell from 28 to 9 percent since Medicare was created.

## MEDICARE ENROLLMENT WILL SURGE IN INDIANA

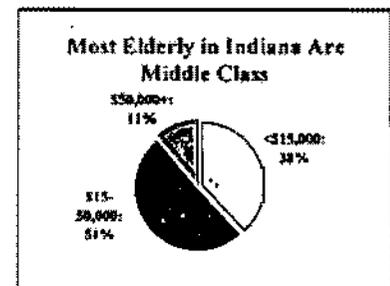
- The number of seniors in Indiana will rise from 763,000 in 2000 to 1,260,000 in 2025. The percent of residents in Indiana who are elderly will increase from 13 to 19 percent.



- About 134,000 people (30%) ages 55 to 65 in Indiana, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.

## INDIANA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 21 percent of Indiana firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Indiana. About 314,114 or 38 percent of Medicare beneficiaries in Indiana have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 357,000 of all elderly in Indiana are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## INDIANA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Indiana depend on \$4 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in Indiana. This is critical to:
  - 115 hospitals, 15,300 physicians, 507 nursing homes, and other providers in Indiana.

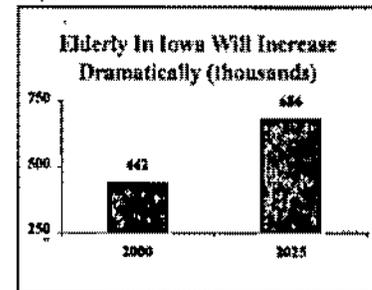
# IOWA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 476,000 IN IOWA

- 429,000 seniors and 47,000 people with disabilities in Iowa rely on Medicare.
  - About 276,000 Medicare beneficiaries in Iowa (58 percent) are women.
  - About 62,000 Medicare beneficiaries in Iowa (13 percent) are age 85 and older.
  - About 300,000 Medicare beneficiaries in Iowa (63 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Iowa fell from 35 to 6 percent since Medicare was created.

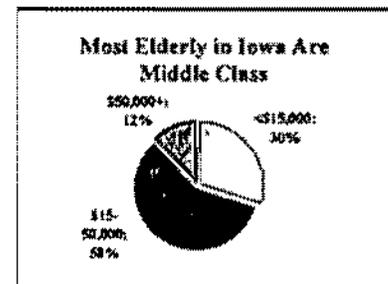
## MEDICARE ENROLLMENT WILL SURGE IN IOWA

- The number of seniors in Iowa will rise from 442,000 in 2000 to 686,000 in 2025. The percent of residents in Iowa who are elderly will increase from 15 to 23 percent.
- About 86,000 people (34%) ages 55 to 65 in Iowa, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## IOWA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 17 percent of Iowa firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$114 in Iowa, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Iowa. No Medicare beneficiaries in Iowa have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 218,000 of all elderly in Iowa are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## IOWA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Iowa depend on \$2 billion in Medicare spending. Medicare pays for 20 percent of all personal health care expenditures in Iowa. This is critical to:
  - 117 hospitals, 8,500 physicians, 263 nursing homes, and other providers in Iowa.

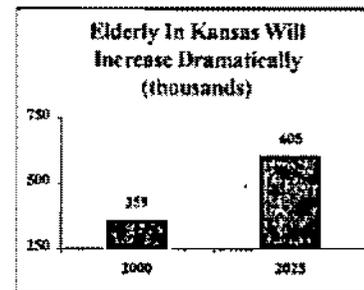
# KANSAS: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 389,000 IN KANSAS

- 348,000 seniors and 41,000 people with disabilities in Kansas rely on Medicare.
  - About 225,000 Medicare beneficiaries in Kansas (58 percent) are women.
  - About 50,000 Medicare beneficiaries in Kansas (13 percent) are age 85 and older.
  - About 203,000 Medicare beneficiaries in Kansas (52 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Kansas fell from 41 to 9 percent since Medicare was created.

## MEDICARE ENROLLMENT WILL SURGE IN KANSAS

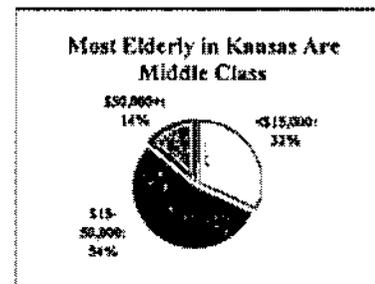
- The number of seniors in Kansas will rise from 359,000 in 2000 to 605,000 in 2025. The percent of residents in Kansas who are elderly will increase from 13 to 20 percent.



- About 57,000 people (31%) ages 55 to 65 in Kansas, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.

## KANSAS SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 21 percent of Kansas firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$126 in Kansas, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Kansas. About 84,574 or 22 percent of Medicare beneficiaries in Kansas have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 198,000 of all elderly in Kansas are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## KANSAS HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Kansas depend on \$2 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in Kansas. This is critical to:
  - 127 hospitals, 6,800 physicians, 285 nursing homes, and other providers in Kansas.

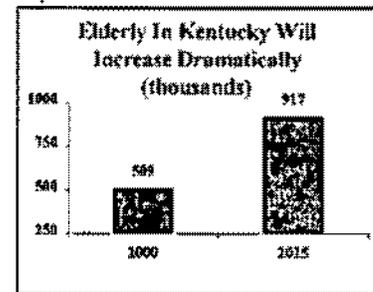
# KENTUCKY: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 610,000 IN KENTUCKY

- 487,000 seniors and 123,000 people with disabilities in Kentucky rely on Medicare.
  - About 339,000 Medicare beneficiaries in Kentucky (56 percent) are women.
  - About 57,000 Medicare beneficiaries in Kentucky (9 percent) are age 85 and older.
  - About 342,000 Medicare beneficiaries in Kentucky (56 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Kentucky fell from 42 to 14 percent since Medicare was created.

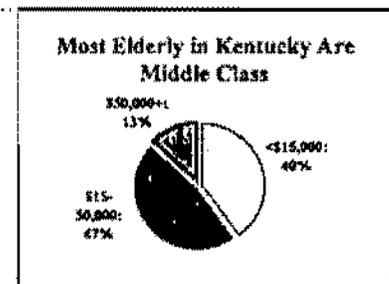
## MEDICARE ENROLLMENT WILL SURGE IN KENTUCKY

- The number of seniors in Kentucky will rise from 509,000 in 2000 to 917,000 in 2025. The percent of residents in Kentucky who are elderly will increase from 13 to 21 percent.
- About 76,000 people (23%) ages 55 to 65 in Kentucky, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## KENTUCKY SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 20 percent of Kentucky firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Kentucky. About 161,963 or 28 percent of Medicare beneficiaries in Kentucky have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 221,000 of all elderly in Kentucky are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## KENTUCKY HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Kentucky depend on \$3 billion in Medicare spending. Medicare pays for 21 percent of all personal health care expenditures in Kentucky. This is critical to:
  - 103 hospitals, 9,100 physicians, 318 nursing homes, and other providers in Kentucky.

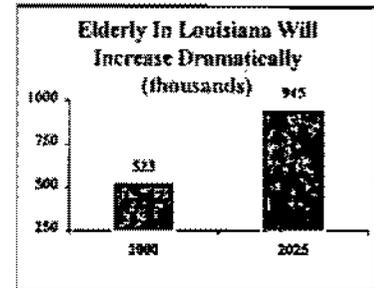
# LOUISIANA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 596,000 IN LOUISIANA

- 495,000 seniors and 101,000 people with disabilities in Louisiana rely on Medicare.
  - About 333,000 Medicare beneficiaries in Louisiana (56 percent) are women.
  - About 63,000 Medicare beneficiaries in Louisiana (11 percent) are age 85 and older.
  - About 162,000 Medicare beneficiaries in Louisiana (27 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Louisiana fell from 35 to 16 percent since Medicare was created.

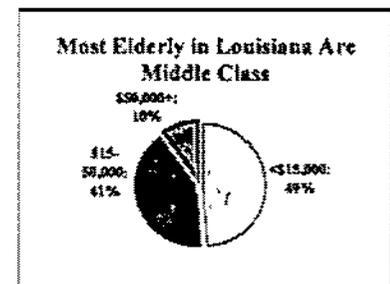
## MEDICARE ENROLLMENT WILL SURGE IN LOUISIANA

- The number of seniors in Louisiana will rise from 523,000 in 2000 to 945,000 in 2025. The percent of residents in Louisiana who are elderly will increase from 12 to 18 percent.
- About 111,000 people (30%) ages 55 to 65 in Louisiana, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## LOUISIANA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 24 percent of Louisiana firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Louisiana. About 332,643 or 52 percent of Medicare beneficiaries in Louisiana have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 205,000 of all elderly in Louisiana are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## LOUISIANA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Louisiana depend on \$4 billion in Medicare spending. Medicare pays for 21 percent of all personal health care expenditures in Louisiana. This is critical to:
  - 126 hospitals, 13,200 physicians, 220 nursing homes, and other providers in Louisiana.

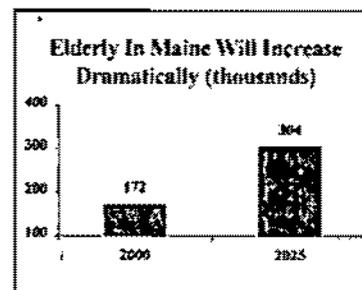
# MAINE: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 211,000 IN MAINE

- 178,000 seniors and 33,000 people with disabilities in Maine rely on Medicare.
  - About 118,000 Medicare beneficiaries in Maine (56 percent) are women.
  - About 22,000 Medicare beneficiaries in Maine (11 percent) are age 85 and older.
  - About 98,000 Medicare beneficiaries in Maine (46 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Maine fell from 25 to 17 percent since Medicare was created.

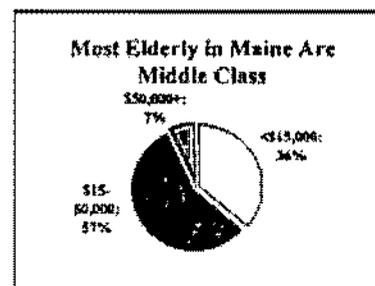
## MEDICARE ENROLLMENT WILL SURGE IN MAINE

- The number of seniors in Maine will rise from 172,000 in 2000 to 304,000 in 2025. The percent of residents in Maine who are elderly will increase from 14 to 21 percent.
- About 31,000 people (23%) ages 55 to 65 in Maine, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## MAINE SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 20 percent of Maine firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$197 in Maine, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Maine requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Maine. About 124,069 or 62 percent of Medicare beneficiaries in Maine have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 94,000 of all elderly in Maine are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## MAINE HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Maine depend on \$1 billion in Medicare spending. Medicare pays for 18 percent of all personal health care expenditures in Maine. This is critical to:
  - 39 hospitals, 4,400 physicians, 135 nursing homes, and other providers in Maine.

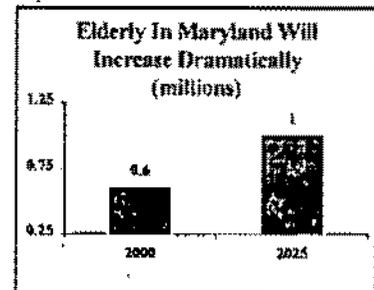
# MARYLAND: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 628,000 IN MARYLAND

- 559,000 seniors and 69,000 people with disabilities in Maryland rely on Medicare.
  - About 364,000 Medicare beneficiaries in Maryland (58 percent) are women.
  - About 63,000 Medicare beneficiaries in Maryland (10 percent) are age 85 and older.
  - About 59,000 Medicare beneficiaries in Maryland (9 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Maryland fell from 20 to 10 percent since Medicare was created.

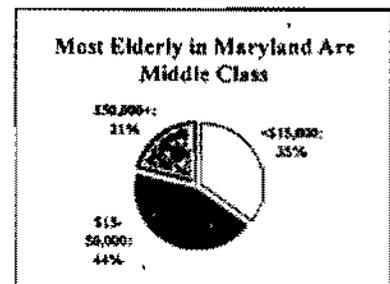
## MEDICARE ENROLLMENT WILL SURGE IN MARYLAND

- The number of seniors in Maryland will rise from 589,000 in 2000 to 1,029,000 in 2025. The percent of residents in Maryland who are elderly will increase from 11 to 16 percent.
- About 102,000 people (24%) ages 55 to 65 in Maryland, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## MARYLAND SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 23 percent of Maryland firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 530,113 or 81 percent of Medicare beneficiaries in Maryland have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 275,000 of all elderly in Maryland are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## MARYLAND HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Maryland depend on \$4 billion in Medicare spending. Medicare pays for 18 percent of all personal health care expenditures in Maryland. This is critical to:
  - 50 hospitals, 18,600 physicians, 232 nursing homes, and other providers in Maryland.

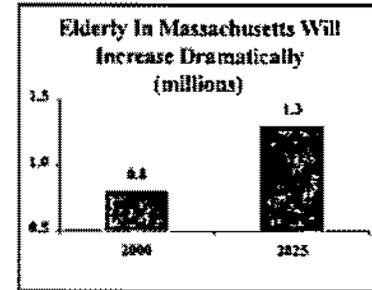
## MASSACHUSETTS: THE NEED FOR MEDICARE REFORM

### MEDICARE PROVIDES CRITICAL HEALTH CARE TO 951,000 IN MASSACHUSETTS

- **827,000 seniors and 124,000 people with disabilities in Massachusetts rely on Medicare.**
  - About 556,000 Medicare beneficiaries in Massachusetts (59 percent) are women.
  - About 112,000 Medicare beneficiaries in Massachusetts (12 percent) are age 85 and older.
  - About 15,000 Medicare beneficiaries in Massachusetts (2 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Massachusetts fell from 19 to 8 percent since Medicare was created.**

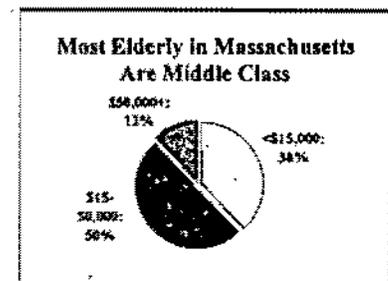
### MEDICARE ENROLLMENT WILL SURGE IN MASSACHUSETTS

- **The number of seniors in Massachusetts will rise from 843,000 in 2000 to 1,252,000 in 2025.** The percent of residents in Massachusetts who are elderly will increase from 14 to 18 percent.
- **About 103,000 people (21%) ages 55 to 65 in Massachusetts, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



### MASSACHUSETTS SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 25 percent of Massachusetts firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Massachusetts requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited.** About 981,848 or 97 percent of Medicare beneficiaries in Massachusetts have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 378,000 of all elderly in Massachusetts are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



### MASSACHUSETTS HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Massachusetts depend on \$6 billion in Medicare spending.** Medicare pays for 20 percent of all personal health care expenditures in Massachusetts. This is critical to:
  - 85 hospitals, 27,500 physicians, 521 nursing homes, and other providers in Massachusetts.

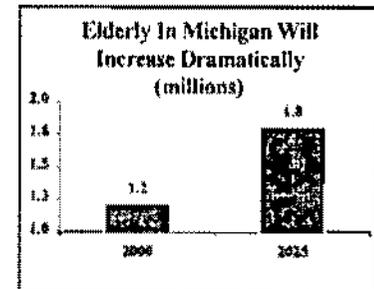
## MICHIGAN: THE NEED FOR MEDICARE REFORM

### MEDICARE PROVIDES CRITICAL HEALTH CARE TO 1,379,000 IN MICHIGAN

- 1,191,000 seniors and 188,000 people with disabilities in Michigan rely on Medicare.
  - About 785,000 Medicare beneficiaries in Michigan (57 percent) are women.
  - About 136,000 Medicare beneficiaries in Michigan (10 percent) are age 85 and older.
  - About 294,000 Medicare beneficiaries in Michigan (21 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Michigan fell from 25 to 10 percent since Medicare was created.

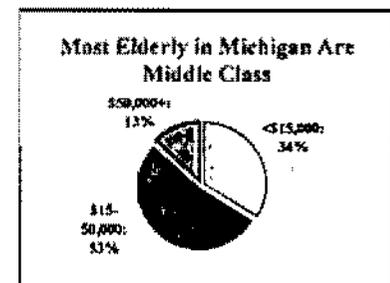
### MEDICARE ENROLLMENT WILL SURGE IN MICHIGAN

- The number of seniors in Michigan will rise from 1,197,000 in 2000 to 1,821,000 in 2025. The percent of residents in Michigan who are elderly will increase from 12 to 18 percent.
- About 144,000 people (20%) ages 55 to 65 in Michigan, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



### MICHIGAN SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 28 percent of Michigan firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$166 in Michigan, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Michigan. About 745,704 or 54 percent of Medicare beneficiaries in Michigan have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 640,000 of all elderly in Michigan are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



### MICHIGAN HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Michigan depend on \$8 billion in Medicare spending. Medicare pays for 20 percent of all personal health care expenditures in Michigan. This is critical to:
  - 163 hospitals, 28,200 physicians, 385 nursing homes, and other providers in Michigan.

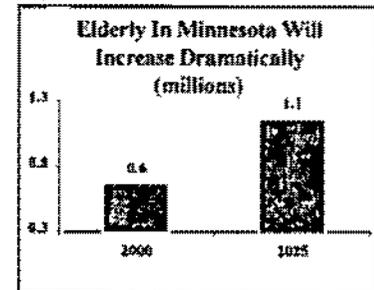
# MINNESOTA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 644,000 IN MINNESOTA

- **577,000 seniors and 67,000 people with disabilities in Minnesota rely on Medicare.**
  - About 368,000 Medicare beneficiaries in Minnesota (57 percent) are women.
  - About 81,000 Medicare beneficiaries in Minnesota (13 percent) are age 85 and older.
  - About 258,000 Medicare beneficiaries in Minnesota (40 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Minnesota fell from 32 to 10 percent since Medicare was created.**

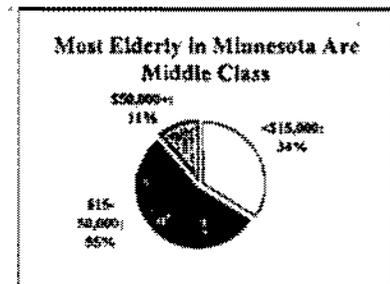
## MEDICARE ENROLLMENT WILL SURGE IN MINNESOTA

- **The number of seniors in Minnesota will rise from 596,000 in 2000 to 1,099,000 in 2025.** The percent of residents in Minnesota who are elderly will increase from 12 to 20 percent.
- **About 100,000 people (24%) ages 55 to 65 in Minnesota, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## MINNESOTA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 19 percent of Minnesota firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Minnesota requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Minnesota.** No Medicare beneficiaries in Minnesota have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 260,000 of all elderly in Minnesota are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## MINNESOTA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Minnesota depend on \$3 billion in Medicare spending.** Medicare pays for 15 percent of all personal health care expenditures in Minnesota. This is critical to:
  - 143 hospitals, 15,400 physicians, 435 nursing homes, and other providers in Minnesota.

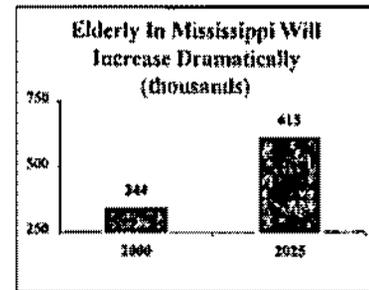
# MISSISSIPPI: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 411,000 IN MISSISSIPPI

- 328,000 seniors and 83,000 people with disabilities in Mississippi rely on Medicare.
  - About 236,000 Medicare beneficiaries in Mississippi (57 percent) are women.
  - About 43,000 Medicare beneficiaries in Mississippi (11 percent) are age 85 and older.
  - About 287,000 Medicare beneficiaries in Mississippi (70 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Mississippi fell from 55 to 20 percent since Medicare was created.

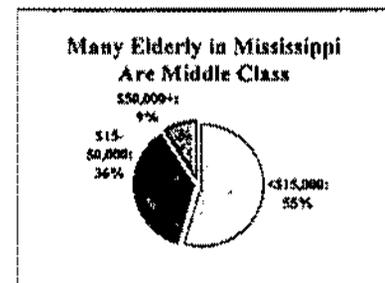
## MEDICARE ENROLLMENT WILL SURGE IN MISSISSIPPI

- The number of seniors in Mississippi will rise from 344,000 in 2000 to 615,000 in 2025. The percent of residents in Mississippi who are elderly will increase from 12 to 20 percent.
- About 75,000 people (34%) ages 55 to 65 in Mississippi, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## MISSISSIPPI SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 17 percent of Mississippi firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$140 in Mississippi, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Mississippi. No Medicare beneficiaries in Mississippi have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 112,000 of all elderly in Mississippi are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## MISSISSIPPI HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Mississippi depend on \$2 billion in Medicare spending. Medicare pays for 22 percent of all personal health care expenditures in Mississippi. This is critical to:
  - 101 hospitals, 5,300 physicians, 151 nursing homes, and other providers in Mississippi.

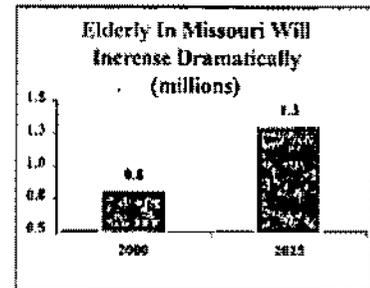
# MISSOURI: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 850,000 IN MISSOURI

- 735,000 seniors and 115,000 people with disabilities in Missouri rely on Medicare.
  - About 489,000 Medicare beneficiaries in Missouri (58 percent) are women.
  - About 97,000 Medicare beneficiaries in Missouri (11 percent) are age 85 and older.
  - About 319,000 Medicare beneficiaries in Missouri (38 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Missouri fell from 30 to 8 percent since Medicare was created.

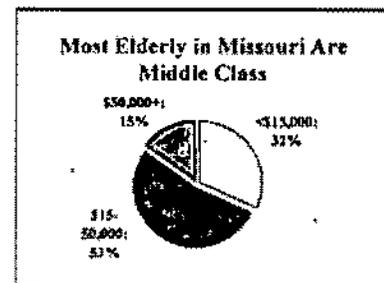
## MEDICARE ENROLLMENT WILL SURGE IN MISSOURI

- The number of seniors in Missouri will rise from 755,000 in 2000 to 1,258,000 in 2025. The percent of residents in Missouri who are elderly will increase from 14 to 20 percent.
- About 104,000 people (23%) ages 55 to 65 in Missouri, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## MISSOURI SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 18 percent of Missouri firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 in Missouri, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Missouri prohibits attained-age rating. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Missouri. About 536,078 or 61 percent of Medicare beneficiaries in Missouri have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 390,000 of all elderly in Missouri are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## MISSOURI HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Missouri depend on \$5 billion in Medicare spending. Medicare pays for 22 percent of all personal health care expenditures in Missouri. This is critical to:
  - 121 hospitals, 16,300 physicians, 482 nursing homes, and other providers in Missouri.

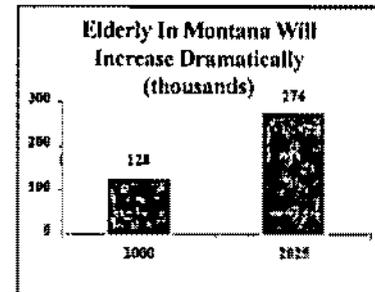
# MONTANA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 134,000 IN MONTANA

- 117,000 seniors and 17,000 people with disabilities in Montana rely on Medicare.
  - About 73,000 Medicare beneficiaries in Montana (54 percent) are women.
  - About 15,000 Medicare beneficiaries in Montana (11 percent) are age 85 and older.
  - About 103,000 Medicare beneficiaries in Montana (77 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Montana fell from 34 to 10 percent since Medicare was created.

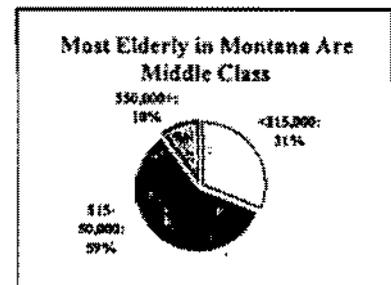
## MEDICARE ENROLLMENT WILL SURGE IN MONTANA

- The number of seniors in Montana will rise from 128,000 in 2000 to 274,000 in 2025. The percent of residents in Montana who are elderly will increase from 13 to 24 percent.
- About 23,000 people (34%) ages 55 to 65 in Montana, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## MONTANA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of firms nationwide offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$111 in Montana, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Montana. No Medicare beneficiaries in Montana have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 62,000 of all elderly in Montana are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## MONTANA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Montana depend on \$1 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in Montana. This is critical to:
  - 48 hospitals, 2,600 physicians, 102 nursing homes, and other providers in Montana.

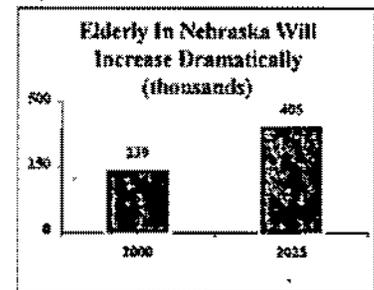
# NEBRASKA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 251,000 IN NEBRASKA

- 227,000 seniors and 24,000 people with disabilities in Nebraska rely on Medicare.
  - About 146,000 Medicare beneficiaries in Nebraska (58 percent) are women.
  - About 33,000 Medicare beneficiaries in Nebraska (13 percent) are age 85 and older.
  - About 149,000 Medicare beneficiaries in Nebraska (59 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Nebraska fell from 28 to 10 percent since Medicare was created.

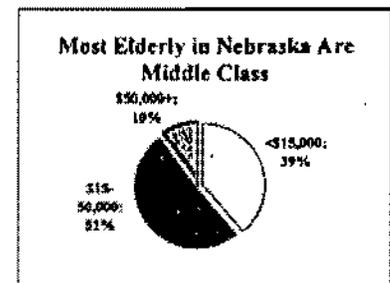
## MEDICARE ENROLLMENT WILL SURGE IN NEBRASKA

- The number of seniors in Nebraska will rise from 239,000 in 2000 to 405,000 in 2025. The percent of residents in Nebraska who are elderly will increase from 14 to 21 percent.
- About 47,000 people (37%) ages 55 to 65 in Nebraska, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NEBRASKA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of Nebraska firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$111 in Nebraska, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Nebraska. No Medicare beneficiaries in Nebraska have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 108,000 of all elderly in Nebraska are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## NEBRASKA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Nebraska depend on \$1 billion in Medicare spending. Medicare pays for 17 percent of all personal health care expenditures in Nebraska. This is critical to:
  - 91 hospitals, 4,200 physicians, 154 nursing homes, and other providers in Nebraska.

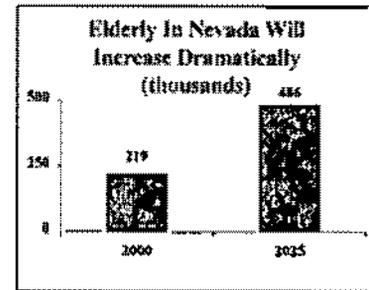
# NEVADA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 223,000 IN NEVADA

- 195,000 seniors and 28,000 people with disabilities in Nevada rely on Medicare.
  - About 117,000 Medicare beneficiaries in Nevada (52 percent) are women.
  - About 15,000 Medicare beneficiaries in Nevada (7 percent) are age 85 and older.
  - About 25,000 Medicare beneficiaries in Nevada (11 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Nevada fell from 50 to 9 percent since Medicare was created.

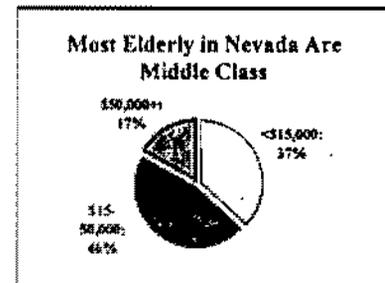
## MEDICARE ENROLLMENT WILL SURGE IN NEVADA

- The number of seniors in Nevada will rise from 219,000 in 2000 to 486,000 in 2025. The percent of residents in Nevada who are elderly will increase from 12 to 21 percent.
- About 41,000 people (26%) ages 55 to 65 in Nevada, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NEVADA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 20 percent of Nevada firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$143 in Nevada, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 184,359 or 86 percent of Medicare beneficiaries in Nevada have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 94,000 of all elderly in Nevada are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## NEVADA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Nevada depend on \$1 billion in Medicare spending. Medicare pays for 20 percent of all personal health care expenditures in Nevada. This is critical to:
  - 27 hospitals, 3,400 physicians, 43 nursing homes, and other providers in Nevada.

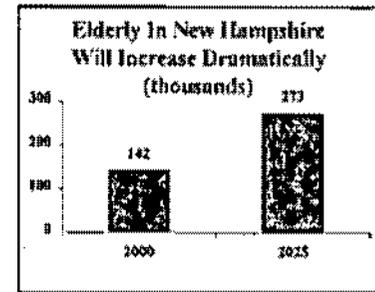
# NEW HAMPSHIRE: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 164,000 IN NEW HAMPSHIRE

- 143,000 seniors and 21,000 people with disabilities in New Hampshire rely on Medicare.
  - About 93,000 Medicare beneficiaries in New Hampshire (57 percent) are women.
  - About 18,000 Medicare beneficiaries in New Hampshire (11 percent) are age 85 and older.
  - About 55,000 Medicare beneficiaries in New Hampshire (34 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in New Hampshire fell from 23 to 9 percent since Medicare was created.

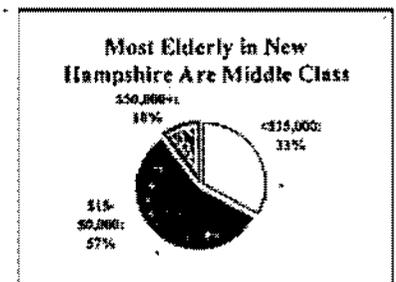
## ENROLLMENT WILL SURGE IN NEW HAMPSHIRE

- The number of seniors in New Hampshire will rise from 142,000 in 2000 to 273,000 in 2025. The percent of residents in New Hampshire who are elderly will increase from 12 to 19 percent.
- About 20,000 people (21%) ages 55 to 65 in New Hampshire, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NEW HAMPSHIRE SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of firms nationwide offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$105 in New Hampshire, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in New Hampshire. About 80,957 or 48 percent of Medicare beneficiaries in New Hampshire have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or \$500.
- About 76,000 of all elderly in New Hampshire are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## NEW HAMPSHIRE HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in New Hampshire depend on \$1 billion in Medicare spending. Medicare pays for 14 percent of all personal health care expenditures in New Hampshire. This is critical to:
  - 26 hospitals, 4,200 physicians, 63 nursing homes, and other providers in New Hampshire.

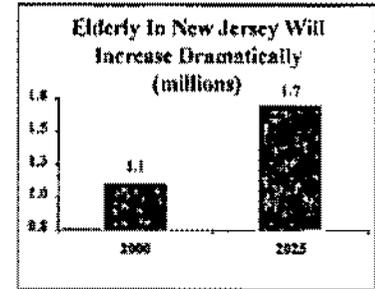
# NEW JERSEY: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 1,188,000 IN NEW JERSEY

- 1,064,000 seniors and 124,000 people with disabilities in New Jersey rely on Medicare.
  - About 696,000 Medicare beneficiaries in New Jersey (59 percent) are women.
  - About 129,000 Medicare beneficiaries in New Jersey (11 percent) are age 85 and older.
  - About - Medicare beneficiaries in New Jersey (- percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in New Jersey fell from 25 to 8 percent since Medicare was created.

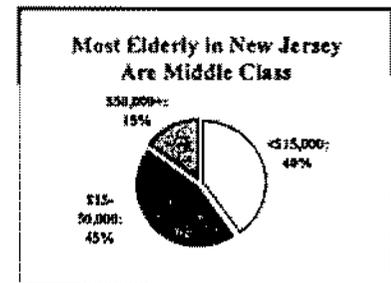
## MEDICARE ENROLLMENT WILL SURGE IN NEW JERSEY

- The number of seniors in New Jersey will rise from 1,090,000 in 2000 to 1,654,000 in 2025. The percent of residents in New Jersey who are elderly will increase from 13 to 17 percent.
- About 179,000 people (26%) ages 55 to 65 in New Jersey, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NEW JERSEY SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 20 percent of New Jersey firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 1,255,239 or 100 percent of Medicare beneficiaries in New Jersey have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 424,000 of all elderly in New Jersey are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## NEW JERSEY HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in New Jersey depend on \$7 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in New Jersey. This is critical to:
  - 88 hospitals, 27,400 physicians, 275 nursing homes, and other providers in New Jersey.

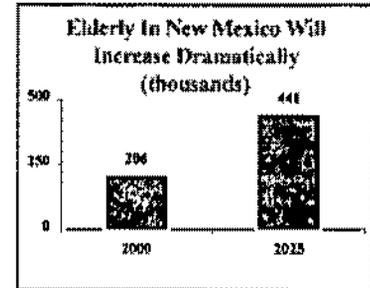
# NEW MEXICO: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 225,000 IN NEW MEXICO

- 193,000 seniors and 32,000 people with disabilities in New Mexico rely on Medicare.
  - About 121,000 Medicare beneficiaries in New Mexico (54 percent) are women.
  - About 21,000 Medicare beneficiaries in New Mexico (10 percent) are age 85 and older.
  - About 104,000 Medicare beneficiaries in New Mexico (46 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in New Mexico fell from 49 to 16 percent since Medicare was created.

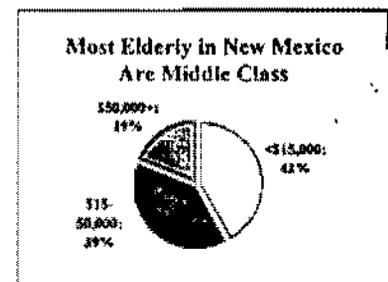
## MEDICARE ENROLLMENT WILL SURGE IN NEW MEXICO

- The number of seniors in New Mexico will rise from 206,000 in 2000 to 441,000 in 2025. The percent of residents in New Mexico who are elderly will increase from 11 to 17 percent.
- About 43,000 people (31%) ages 55 to 65 in New Mexico, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NEW MEXICO SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 20 percent of New Mexico firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$141 in New Mexico, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in New Mexico. About 110,771 or 52 percent of Medicare beneficiaries in New Mexico have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or \$500.
- About 78,000 of all elderly in New Mexico are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## NEW MEXICO HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in New Mexico depend on \$1 billion in Medicare spending. Medicare pays for 15 percent of all personal health care expenditures in New Mexico. This is critical to:
  - 42 hospitals, 4,000 physicians, 73 nursing homes, and other providers in New Mexico.

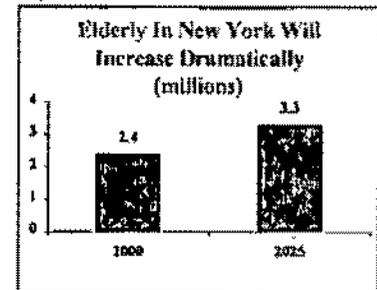
# NEW YORK: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 2,666,000 IN NEW YORK

- **2,320,000 seniors and 346,000 people with disabilities in New York rely on Medicare.**
  - About 1,555,000 Medicare beneficiaries in New York (58 percent) are women.
  - About 310,000 Medicare beneficiaries in New York (12 percent) are age 85 and older.
  - About 235,000 Medicare beneficiaries in New York (9 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in New York fell from 23 to 15 percent since Medicare was created.**

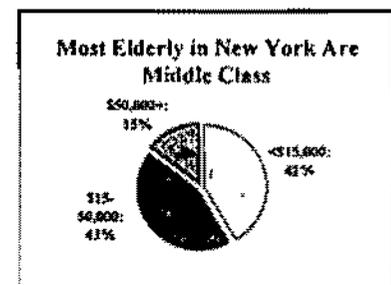
## MEDICARE ENROLLMENT WILL SURGE IN NEW YORK

- **The number of seniors in New York will rise from 2,358,000 in 2000 to 3,263,000 in 2025.** The percent of residents in New York who are elderly will increase from 13 to 17 percent.
- **About 386,000 people (24%) ages 55 to 65 in New York, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NEW YORK SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 24 percent of New York firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$159 in New York, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. New York requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited.** About 2,154,414 or 80 percent of Medicare beneficiaries in New York have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 1,028,000 of all elderly in New York are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## NEW YORK HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in New York depend on \$17 billion in Medicare spending.** Medicare pays for 18 percent of all personal health care expenditures in New York. This is critical to:
  - 223 hospitals, 73,800 physicians, 662 nursing homes, and other providers in New York.

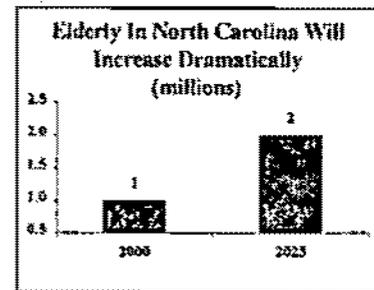
# NORTH CAROLINA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 1,095,000 IN NORTH CAROLINA

- 917,000 seniors and 178,000 people with disabilities in North Carolina rely on Medicare.
  - About 636,000 Medicare beneficiaries in North Carolina (58 percent) are women.
  - About 100,000 Medicare beneficiaries in North Carolina (9 percent) are age 85 and older.
  - About 437,000 Medicare beneficiaries in North Carolina (40 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in NC fell from 37 to 11 percent since Medicare was created.

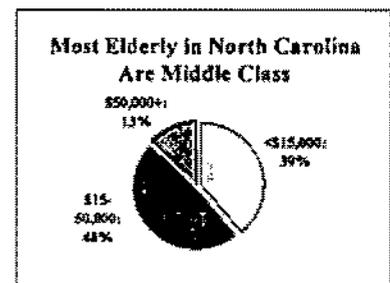
## MEDICARE ENROLLMENT WILL SURGE IN NC

- The number of seniors in North Carolina will rise from 991,000 in 2000 to 2,004,000 in 2025. The percent of residents in North Carolina who are elderly will increase from 13 to 21 percent.
- About 200,000 people (31%) ages 55 to 65 in North Carolina, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NORTH CAROLINA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of North Carolina firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$125 in North Carolina, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in North Carolina. No Medicare beneficiaries in North Carolina have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 428,000 of all elderly in North Carolina are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## NORTH CAROLINA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in North Carolina depend on \$5 billion in Medicare spending. Medicare pays for 20 percent of all personal health care expenditures in North Carolina. This is critical to:
  - 130 hospitals, 17,600 physicians, 399 nursing homes, and other providers in North Carolina.

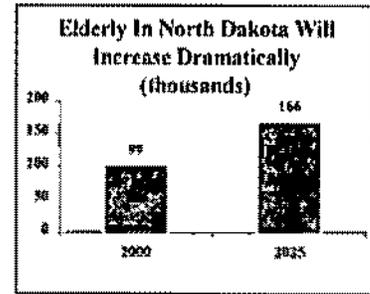
# NORTH DAKOTA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 103,000 IN NORTH DAKOTA

- **93,000 seniors and 10,000 people with disabilities in North Dakota rely on Medicare.**
  - About 58,000 Medicare beneficiaries in North Dakota (56 percent) are women.
  - About 14,000 Medicare beneficiaries in North Dakota (14 percent) are age 85 and older.
  - About 69,000 Medicare beneficiaries in North Dakota (67 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in North Dakota fell from 12 to 14 percent since Medicare was created.**

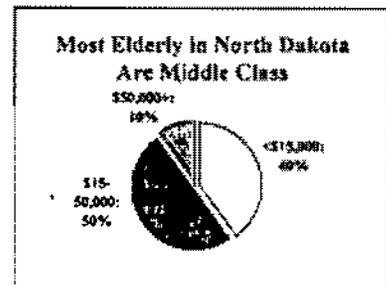
## MEDICARE ENROLLMENT WILL SURGE IN NORTH DAKOTA

- **The number of seniors in North Dakota will rise from 99,000 in 2000 to 166,000 in 2025.** The percent of residents in North Dakota who are elderly will increase from 15 to 23 percent.
- **About 20,000 people (39%) ages 55 to 65 in North Dakota, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## NORTH DAKOTA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of firms nationwide offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$122 in North Dakota, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in North Dakota.** No Medicare beneficiaries in North Dakota have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 43,000 of all elderly in North Dakota are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## ND HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in North Dakota depend on \$480 million in Medicare spending.** Medicare pays for 19 percent of all personal health care expenditures in North Dakota. This helps:
  - 47 hospitals, 2,200 physicians, 88 nursing homes, and other providers in North Dakota.

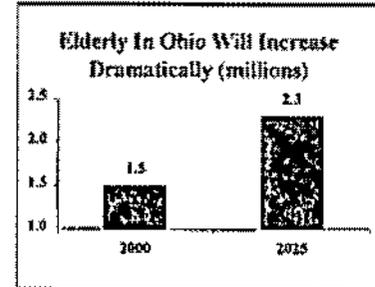
# OHIO: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 1,689,000 IN OHIO

- 1,476,000 seniors and 213,000 people with disabilities in Ohio rely on Medicare.
  - About 973,000 Medicare beneficiaries in Ohio (58 percent) are women.
  - About 170,000 Medicare beneficiaries in Ohio (10 percent) are age 85 and older.
  - About 325,000 Medicare beneficiaries in Ohio (19 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Ohio fell from 25 to 9 percent since Medicare was created.

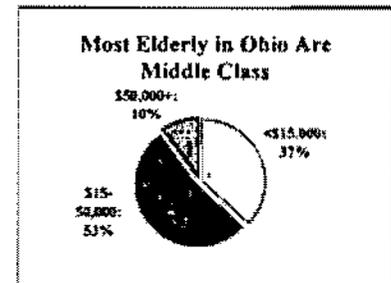
## MEDICARE ENROLLMENT WILL SURGE IN OHIO

- The number of seniors in Ohio will rise from 1,525,000 in 2000 to 2,305,000 in 2025. The percent of residents in Ohio who are elderly will increase from 13 to 20 percent.
- About 191,000 people (21%) ages 55 to 65 in Ohio, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## OHIO SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 28 percent of Ohio firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$131 in Ohio, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 1,537,564 or 83 percent of Medicare beneficiaries in Ohio have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 766,000 of all elderly in Ohio are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## OHIO HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Ohio depend on \$9 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in Ohio. This is critical to:
  - 176 hospitals, 31,900 physicians, 856 nursing homes, and other providers in Ohio.

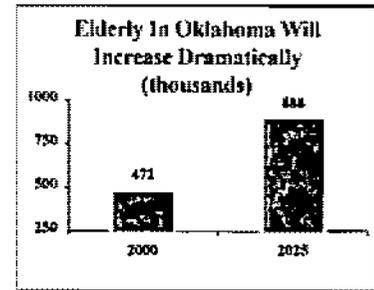
# OKLAHOMA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 500,000 IN OKLAHOMA

- 435,000 seniors and 65,000 people with disabilities in Oklahoma rely on Medicare.
  - About 285,000 Medicare beneficiaries in Oklahoma (57 percent) are women.
  - About 56,000 Medicare beneficiaries in Oklahoma (11 percent) are age 85 and older.
  - About 236,000 Medicare beneficiaries in Oklahoma (47 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Oklahoma fell from 44 to 10 percent since Medicare was created.

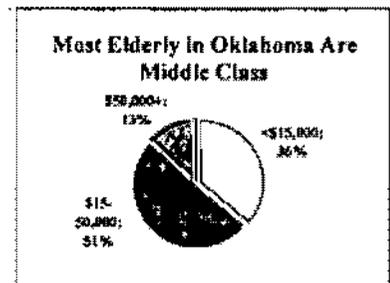
## MEDICARE ENROLLMENT WILL SURGE IN OKLAHOMA

- The number of seniors in Oklahoma will rise from 472,000 in 2000 to 888,000 in 2025. The percent of residents in Oklahoma who are elderly will increase from 14 to 22 percent.
- About 85,000 people (28%) ages 55 to 65 in Oklahoma, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## OKLAHOMA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of Oklahoma firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$112 in Oklahoma, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 377,159 or 75 percent of Medicare beneficiaries in Oklahoma have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 225,000 of all elderly in Oklahoma are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## OKLAHOMA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Oklahoma depend on \$2 billion in Medicare spending. Medicare pays for 21 percent of all personal health care expenditures in Oklahoma. This is critical to:
  - 123 hospitals, 7,300 physicians, 220 nursing homes, and other providers in Oklahoma.

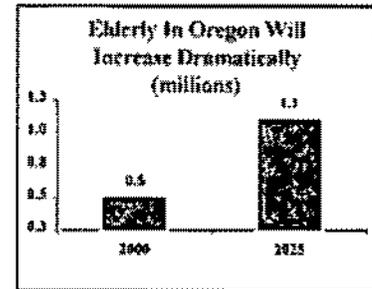
# OREGON: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 481,000 IN OREGON

- **428,000 seniors and 53,000 people with disabilities in Oregon rely on Medicare.**
  - About 269,000 Medicare beneficiaries in Oregon (56 percent) are women.
  - About 53,000 Medicare beneficiaries in Oregon (11 percent) are age 85 and older.
  - About 171,000 Medicare beneficiaries in Oregon (36 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Oregon fell from 31 to 10 percent since Medicare was created.**

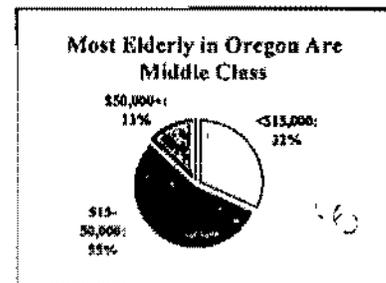
## MEDICARE ENROLLMENT WILL SURGE IN OREGON

- **The number of seniors in Oregon will rise from 471,000 in 2000 to 1,054,000 in 2025.** The percent of residents in Oregon who are elderly will increase from 14 to 24 percent.
- **About 93,000 people (31%) ages 55 to 65 in Oregon, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## OREGON SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 21 percent of Oregon firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$119 in Oregon, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Oregon.** About 256,842 or 53 percent of Medicare beneficiaries in Oregon have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 212,000 of all elderly in Oregon are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## OREGON HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Oregon depend on \$2 billion in Medicare spending.** Medicare pays for 19 percent of all personal health care expenditures in Oregon. This is critical to:
  - 62 hospitals, 9,400 physicians, 130 nursing homes, and other providers in Oregon.

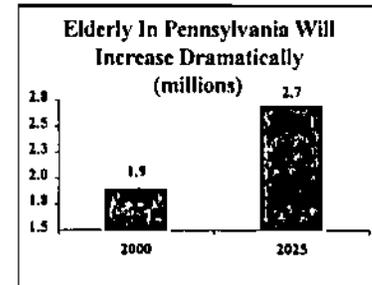
# PENNSYLVANIA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 2,089,000 IN PENNSYLVANIA

- **1,874,000 seniors and 215,000 people with disabilities in Pennsylvania rely on Medicare.**
  - About 1,219,000 Medicare beneficiaries in Pennsylvania (58 percent) are women.
  - About 224,000 Medicare beneficiaries in Pennsylvania (11 percent) are age 85 and older.
  - About 342,000 Medicare beneficiaries in Pennsylvania (16 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Pennsylvania fell from 23 to 8 percent since Medicare was created.**

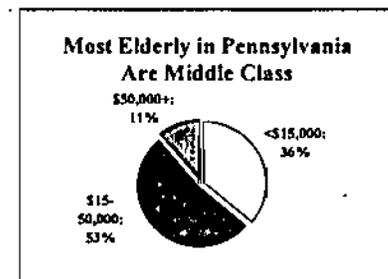
## MEDICARE ENROLLMENT WILL SURGE IN PENNSYLVANIA

- **The number of seniors in Pennsylvania will rise from 1,899,000 in 2000 to 2,659,000 in 2025.** The percent of residents in Pennsylvania who are elderly will increase from 16 to 21 percent.
- **About 277,000 people (25%) ages 55 to 65 in Pennsylvania, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## PENNSYLVANIA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of Pennsylvania firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$142 in Pennsylvania, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited.** About 1,918,911 or 81 percent of Medicare beneficiaries in Pennsylvania have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 881,000 of all elderly in Pennsylvania are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## PENNSYLVANIA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Pennsylvania depend on \$13 billion in Medicare spending.** Medicare pays for 24 percent of all personal health care expenditures in Pennsylvania. This is critical to:
  - 203 hospitals, 50,100 physicians, 769 nursing homes, and other providers in Pennsylvania.

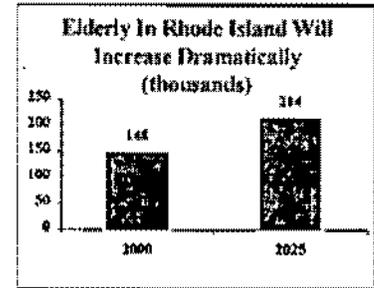
# RHODE ISLAND: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 170,000 IN RHODE ISLAND

- 148,000 seniors and 22,000 people with disabilities in Rhode Island rely on Medicare.
  - About 100,000 Medicare beneficiaries in Rhode Island (59 percent) are women.
  - About 20,000 Medicare beneficiaries in Rhode Island (12 percent) are age 85 and older.
  - About - Medicare beneficiaries in Rhode Island (- percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Rhode Island fell from 14 to 10 percent since Medicare was created.

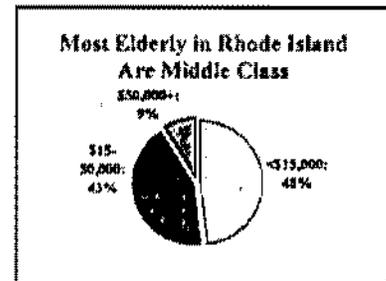
## MEDICARE ENROLLMENT WILL SURGE IN RHODE ISLAND

- The number of seniors in Rhode Island will rise from 148,000 in 2000 to 214,000 in 2025. The percent of residents in Rhode Island who are elderly will increase from 15 to 19 percent.
- About 21,000 people (26%) ages 55 to 65 in Rhode Island, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## RHODE ISLAND SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of firms nationwide offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$107 in Rhode Island, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 179,263 or 92 percent of Medicare beneficiaries in Rhode Island have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 68,000 of all elderly in Rhode Island are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## RHODE ISLAND HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Rhode Island depend on \$1 billion in Medicare spending. Medicare pays for 19 percent of all personal health care expenditures in Rhode Island. This is critical to:
  - 11 hospitals, 3,300 physicians, 100 nursing homes, and other providers in Rhode Island.

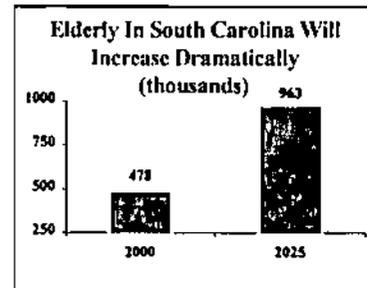
# SOUTH CAROLINA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 545,000 IN SOUTH CAROLINA

- **449,000 seniors and 96,000 people with disabilities in South Carolina rely on Medicare.**
  - About 314,000 Medicare beneficiaries in South Carolina (58 percent) are women.
  - About 46,000 Medicare beneficiaries in South Carolina (9 percent) are age 85 and older.
  - About 184,000 Medicare beneficiaries in South Carolina (34 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in South Carolina fell from 29 to 15 percent since Medicare was created.**

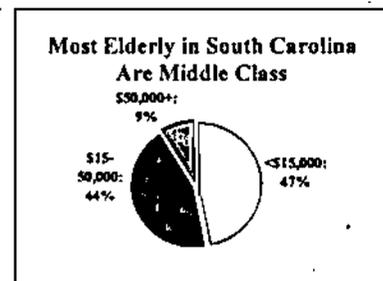
## MEDICARE ENROLLMENT WILL SURGE IN S. CAROLINA

- **The number of seniors in South Carolina will rise from 478,000 in 2000 to 963,000 in 2025.** The percent of residents in South Carolina who are elderly will increase from 12 to 21 percent.
- **About 108,000 people (30%) ages 55 to 65 in South Carolina, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## SOUTH CAROLINA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 21 percent of South Carolina firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$142 in South Carolina, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in South Carolina.** No Medicare beneficiaries in South Carolina have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 181,000 of all elderly in South Carolina are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## SC HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in South Carolina depend on \$3 billion in Medicare spending.** Medicare pays for 17 percent of all personal health care expenditures in South Carolina. This is critical to:
  - 62 hospitals, 8,400 physicians, 178 nursing homes, and other providers in South Carolina.

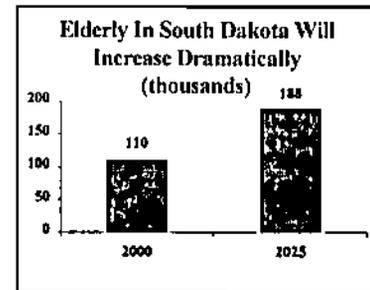
# SOUTH DAKOTA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 118,000 IN SOUTH DAKOTA

- **106,000 seniors and 12,000 people with disabilities in South Dakota rely on Medicare.**
  - About 67,000 Medicare beneficiaries in South Dakota (57 percent) are women.
  - About 15,000 Medicare beneficiaries in South Dakota (13 percent) are age 85 and older.
  - About 85,000 Medicare beneficiaries in South Dakota (72 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in South Dakota fell from 14 to 13 percent since Medicare was created.**

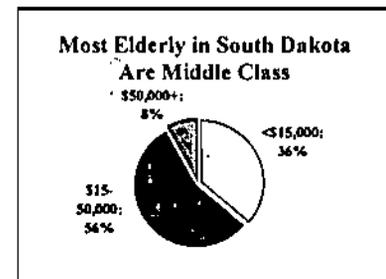
## MEDICARE ENROLLMENT WILL SURGE IN SOUTH DAKOTA

- **The number of seniors in South Dakota will rise from 110,000 in 2000 to 188,000 in 2025.** The percent of residents in South Dakota who are elderly will increase from 14 to 22 percent.
- **About 23,000 people (38%) ages 55 to 65 in South Dakota, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## SOUTH DAKOTA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of firms nationwide offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$113 in South Dakota, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in South Dakota.** No Medicare beneficiaries in South Dakota have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 55,000 of all elderly in South Dakota are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## SOUTH DAKOTA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in South Dakota depend on \$1 billion in Medicare spending.** Medicare pays for 19 percent of all personal health care expenditures in South Dakota. This is critical to:
  - 59 hospitals, 2,200 physicians, 83 nursing homes, and other providers in South Dakota.

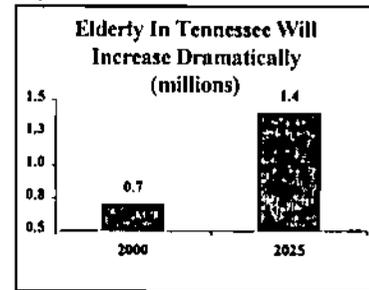
# TENNESSEE: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 807,000 IN TENNESSEE

- **669,000 seniors and 138,000 people with disabilities in Tennessee rely on Medicare.**
  - About 465,000 Medicare beneficiaries in Tennessee (58 percent) are women.
  - About 78,000 Medicare beneficiaries in Tennessee (10 percent) are age 85 and older.
  - About 307,000 Medicare beneficiaries in Tennessee (38 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Tennessee fell from 43 to 12 percent since Medicare was created.**

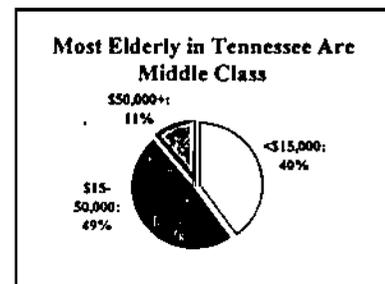
## MEDICARE ENROLLMENT WILL SURGE IN TENNESSEE

- **The number of seniors in Tennessee will rise from 707,000 in 2000 to 1,355,000 in 2025.** The percent of residents in Tennessee who are elderly will increase from 12 to 20 percent.
- **About 150,000 people (28%) ages 55 to 65 in Tennessee, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## TENNESSEE SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 24 percent of Tennessee firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Tennessee.** About 106,671 or 14 percent of Medicare beneficiaries in Tennessee have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 296,000 of all elderly in Tennessee are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## TENNESSEE HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Tennessee depend on \$5 billion in Medicare spending.** Medicare pays for 22 percent of all personal health care expenditures in Tennessee. This is critical to:
  - 125 hospitals, 14,800 physicians, 273 nursing homes, and other providers in Tennessee.

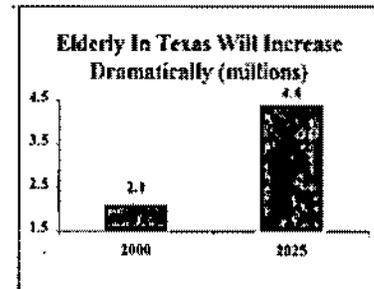
# TEXAS: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 2,196,000 IN TEXAS

- 1,924,000 seniors and 272,000 people with disabilities in Texas rely on Medicare.
  - About 1,243,000 Medicare beneficiaries in Texas (57 percent) are women.
  - About 222,000 Medicare beneficiaries in Texas (10 percent) are age 85 and older.
  - About 509,000 Medicare beneficiaries in Texas (23 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Texas fell from 33 to 13 percent since Medicare was created.

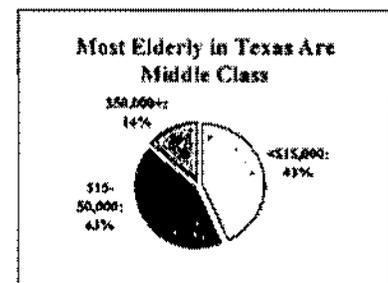
## MEDICARE ENROLLMENT WILL SURGE IN TEXAS

- The number of seniors in Texas will rise from 2,101,000 in 2000 to 4,364,000 in 2025. The percent of residents in Texas who are elderly will increase from 10 to 16 percent.
- About 475,000 people (33%) ages 55 to 65 in Texas, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## TEXAS SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 19 percent of Texas firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$124 in Texas, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited. About 1,533,910 or 69 percent of Medicare beneficiaries in Texas have the option of enrolling in a basic managed care plan that offers prescription drugs. However, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 781,000 of all elderly in Texas are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## TEXAS HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Texas depend on \$15 billion in Medicare spending. Medicare pays for 18 percent of all personal health care expenditures in Texas. This is critical to:
  - 386 hospitals, 49,000 physicians, 1,105 nursing homes, and other providers in Texas.

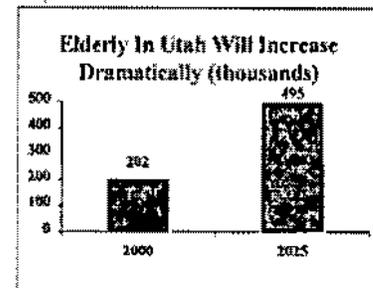
# UTAH: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 198,000 IN UTAH

- 176,000 seniors and 22,000 people with disabilities in Utah rely on Medicare.
  - About 109,000 Medicare beneficiaries in Utah (55 percent) are women.
  - About 20,000 Medicare beneficiaries in Utah (10 percent) are age 85 and older.
  - About 55,000 Medicare beneficiaries in Utah (28 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Utah fell from 29 to 5 percent since Medicare was created.

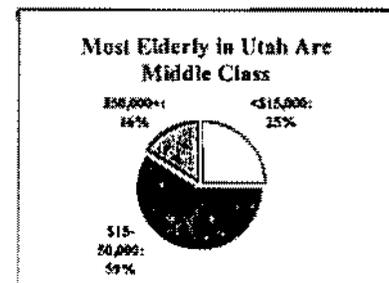
## MEDICARE ENROLLMENT WILL SURGE IN UTAH

- The number of seniors in Utah will rise from 202,000 in 2000 to 495,000 in 2025. The percent of residents in Utah who are elderly will increase from 9 to 17 percent.
- About 27,000 people (20%) ages 55 to 65 in Utah, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## UTAH SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 21 percent of Utah firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$113 in Utah, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Utah. No Medicare beneficiaries in Utah have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 111,000 of all elderly in Utah are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## UTAH HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Utah depend on \$1 billion in Medicare spending. Medicare pays for 15 percent of all personal health care expenditures in Utah. This is critical to:
  - 41 hospitals, 4,900 physicians, 81 nursing homes, and other providers in Utah.

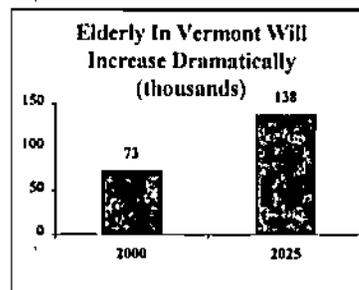
# VERMONT: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 86,000 IN VERMONT

- 74,000 seniors and 12,000 people with disabilities in Vermont rely on Medicare.
  - About 49,000 Medicare beneficiaries in Vermont (57 percent) are women.
  - About 10,000 Medicare beneficiaries in Vermont (11 percent) are age 85 and older.
  - About 64,000 Medicare beneficiaries in Vermont (75 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Vermont fell from 41 to 8 percent since Medicare was created.

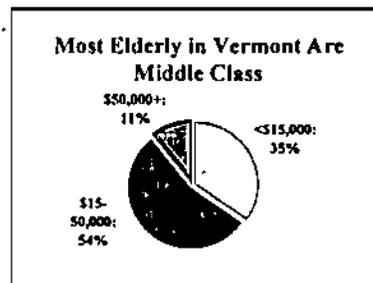
## MEDICARE ENROLLMENT WILL SURGE IN VERMONT

- The number of seniors in Vermont will rise from 73,000 in 2000 to 138,000 in 2025. The percent of residents in Vermont who are elderly will increase from 12 to 20 percent.
- About 15,000 people (30%) ages 55 to 65 in Vermont, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## VERMONT SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 22 percent of firms nationwide offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$155 in Vermont, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Vermont requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Vermont. No Medicare beneficiaries in Vermont have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 36,000 of all elderly in Vermont are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## VERMONT HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Vermont depend on \$289 million in Medicare spending. Medicare pays for 16 percent of all personal health care expenditures in Vermont. This is critical to:
  - 14 hospitals, 2,100 physicians, 40 nursing homes, and other providers in Vermont.

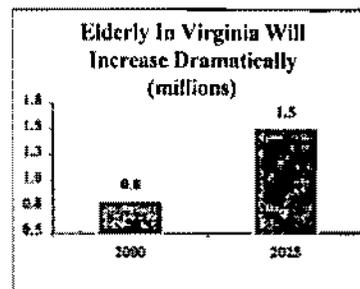
# VIRGINIA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 864,000 IN VIRGINIA

- 742,000 seniors and 122,000 people with disabilities in Virginia rely on Medicare.
  - About 495,000 Medicare beneficiaries in Virginia (57 percent) are women.
  - About 82,000 Medicare beneficiaries in Virginia (9 percent) are age 85 and older.
  - About 440,000 Medicare beneficiaries in Virginia (51 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Virginia fell from 29 to 11 percent since Medicare was created.

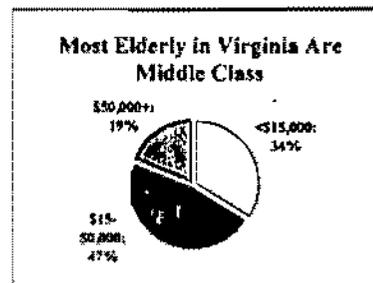
## MEDICARE ENROLLMENT WILL SURGE IN VIRGINIA

- The number of seniors in Virginia will rise from 788,000 in 2000 to 1,515,000 in 2025. The percent of residents in Virginia who are elderly will increase from 11 to 18 percent.
- About 136,000 people (21%) ages 55 to 65 in Virginia, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## VIRGINIA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 23 percent of Virginia firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$98 in Virginia, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Virginia. About 244,746 or 30 percent of Medicare beneficiaries in Virginia have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 364,000 of all elderly in Virginia are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## VIRGINIA HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Virginia depend on \$4 billion in Medicare spending. Medicare pays for 16 percent of all personal health care expenditures in Virginia. This is critical to:
  - 96 hospitals, 16,800 physicians, 218 nursing homes, and other providers in Virginia.

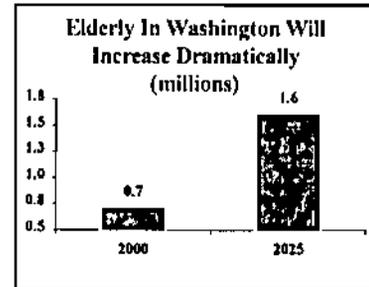
# WASHINGTON: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 718,000 IN WASHINGTON

- **632,000 seniors and 86,000 people with disabilities in Washington rely on Medicare.**
  - About 400,000 Medicare beneficiaries in Washington (56 percent) are women.
  - About 77,000 Medicare beneficiaries in Washington (11 percent) are age 85 and older.
  - About 160,000 Medicare beneficiaries in Washington (22 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Washington fell from 28 to 8 percent since Medicare was created.**

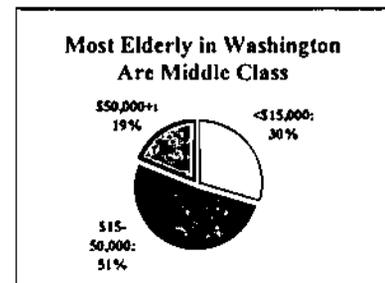
## MEDICARE ENROLLMENT WILL SURGE IN WASHINGTON

- **The number of seniors in Washington will rise from 685,000 in 2000 to 1,580,000 in 2025.** The percent of residents in Washington who are elderly will increase from 12 to 20 percent.
- **About 129,000 people (26%) ages 55 to 65 in Washington, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## WASHINGTON SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 17 percent of Washington firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$159 in Washington, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly. Washington requires community-rated premiums. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Washington.** About 434,817 or 59 percent of Medicare beneficiaries in Washington have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 270,000 of all elderly in Washington are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## WASHINGTON HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Washington depend on \$3 billion in Medicare spending.** Medicare pays for 16 percent of all personal health care expenditures in Washington. This is critical to:
  - 89 hospitals, 16,400 physicians, 280 nursing homes, and other providers in Washington.

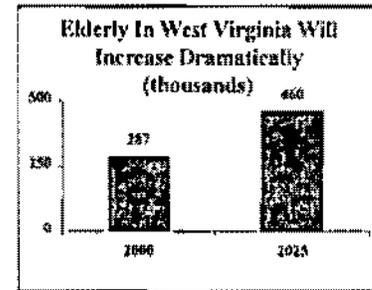
# WEST VIRGINIA: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 335,000 IN WEST VIRGINIA

- **272,000 seniors and 63,000 people with disabilities in West Virginia rely on Medicare.**
  - About 183,000 Medicare beneficiaries in West Virginia (55 percent) are women.
  - About 32,000 Medicare beneficiaries in West Virginia (9 percent) are age 85 and older.
  - About 199,000 Medicare beneficiaries in West Virginia (59 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in West Virginia fell from 41 to 16 percent since Medicare was created.**

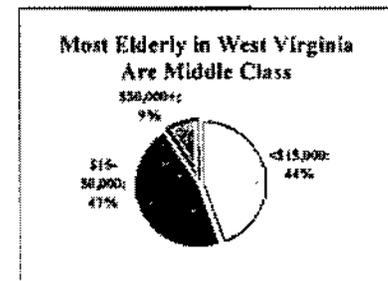
## MEDICARE ENROLLMENT WILL SURGE IN WEST VIRGINIA

- **The number of seniors in West Virginia will rise from 287,000 in 2000 to 460,000 in 2025.** The percent of residents in West Virginia who are elderly will increase from 16 to 25 percent.
- **About 53,000 people (30%) ages 55 to 65 in West Virginia, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## WEST VIRGINIA SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 19 percent of West Virginia firms offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$116 in West Virginia, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in West Virginia.** No Medicare beneficiaries in West Virginia have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 139,000 of all elderly in West Virginia are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## WEST VIRGINIA HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in West Virginia depend on \$2 billion in Medicare spending.** Medicare pays for 21 percent of all personal health care expenditures in West Virginia. This is critical to:
  - 53 hospitals, 4,700 physicians, 101 nursing homes, and other providers in West Virginia.

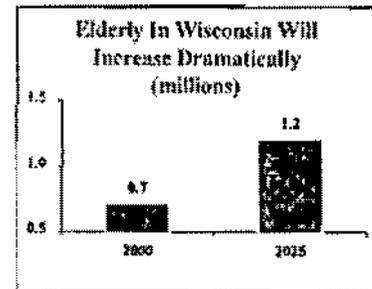
# WISCONSIN: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 775,000 IN WISCONSIN

- 689,000 seniors and 86,000 people with disabilities in Wisconsin rely on Medicare.
  - About 443,000 Medicare beneficiaries in Wisconsin (57 percent) are women.
  - About 91,000 Medicare beneficiaries in Wisconsin (12 percent) are age 85 and older.
  - About 291,000 Medicare beneficiaries in Wisconsin (38 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- Poverty among the elderly in Wisconsin fell from 28 to 6 percent since Medicare was created.

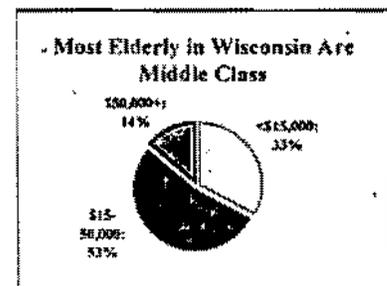
## MEDICARE ENROLLMENT WILL SURGE IN WISCONSIN

- The number of seniors in Wisconsin will rise from 705,000 in 2000 to 1,200,000 in 2025. The percent of residents in Wisconsin who are elderly will increase from 13 to 21 percent.
- About 112,000 people (26%) ages 55 to 65 in Wisconsin, who are not yet eligible for Medicare, are uninsured or individually insured. People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## WISCONSIN SENIORS NEED PRESCRIPTION DRUG COVERAGE

- Only 23 percent of Wisconsin firms offer retiree health insurance. Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- The monthly premium for Medigap insurance including prescription drugs averages \$136 nationwide, which is out of reach for many seniors. Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- Access to prescription drug coverage through Medicare managed care is limited in Wisconsin. About 331,034 or 42 percent of Medicare beneficiaries in Wisconsin have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- About 325,000 of all elderly in Wisconsin are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.



## WISCONSIN HEALTH CARE PROVIDERS RELY ON MEDICARE

- Health care providers in Wisconsin depend on \$3 billion in Medicare spending. Medicare pays for 17 percent of all personal health care expenditures in Wisconsin. This is critical to:
  - 125 hospitals, 16,100 physicians, 361 nursing homes, and other providers in Wisconsin.

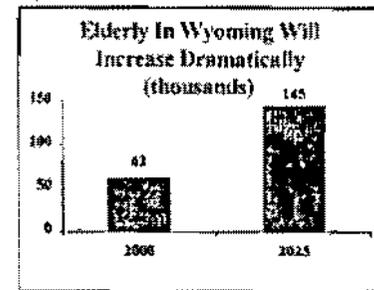
# WYOMING: THE NEED FOR MEDICARE REFORM

## MEDICARE PROVIDES CRITICAL HEALTH CARE TO 64,000 IN WYOMING

- **56,000 seniors and 8,000 people with disabilities in Wyoming rely on Medicare.**
  - About 34,000 Medicare beneficiaries in Wyoming (54 percent) are women.
  - About 6,000 Medicare beneficiaries in Wyoming (10 percent) are age 85 and older.
  - About 44,000 Medicare beneficiaries in Wyoming (69 percent) live in rural areas, with limited or no options for managed care or prescription drug coverage.
- **Poverty among the elderly in Wyoming fell from 42 to 10 percent since Medicare was created.**

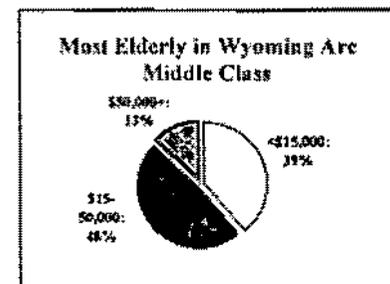
## MEDICARE ENROLLMENT WILL SURGE IN WYOMING

- **The number of seniors in Wyoming will rise from 62,000 in 2000 to 145,000 in 2025.** The percent of residents in Wyoming who are elderly will increase from 12 to 21 percent.
- **About 14,000 people (35%) ages 55 to 65 in Wyoming, who are not yet eligible for Medicare, are uninsured or individually insured.** People age 55 to 65 are the fastest growing group of uninsured. The same demographic trend will affect this age group, making this problem even worse in the near future.



## WYOMING SENIORS NEED PRESCRIPTION DRUG COVERAGE

- **Only 22 percent of firms nationwide offer retiree health insurance.** Retiree health insurance provides good prescription drug coverage, but only one-quarter of Medicare beneficiaries nationwide have this coverage. This will be lower in the future since 25 percent fewer firms offered retiree health in 1998 than 1994.
- **The monthly premium for Medigap insurance including prescription drugs averages \$123 in Wyoming, which is out of reach for many seniors.** Medigap (supplemental health insurance for beneficiaries) has plans that include prescription drugs, but these plans are typically costly and their premiums increase dramatically with age. Only about 1 in 10 Medicare beneficiaries nationwide purchases Medigap with drug coverage, and the extra cost is about \$90 per month.
- **Access to prescription drug coverage through Medicare managed care is limited in Wyoming.** No Medicare beneficiaries in Wyoming have the option of enrolling in a basic managed care plan that offers prescription drugs. Moreover, nationwide, an increasing number of plans are capping their drug coverage at \$1,000 or even \$500.
- **About 26,000 of all elderly in Wyoming are middle class (\$15-50,000) and would not be eligible for a low-income prescription drug benefit.**



## WYOMING HEALTH CARE PROVIDERS RELY ON MEDICARE

- **Health care providers in Wyoming depend on \$218 million in Medicare spending.** Medicare pays for 15 percent of all personal health care expenditures in Wyoming. This is critical to:
  - 25 hospitals, 1,200 physicians, 33 nursing homes, and other providers in Wyoming.