

NLWJC - KAGAN

EMAILS RECEIVED

ARMS - BOX 020 - FOLDER -008

[12/06/1997 - 12/08/1997]

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Richard Socarides (CN=Richard Socarides/OU=WHO/O=EOP [WHO])

CREATION DATE/TIME: 6-DEC-1997 12:08:40.00

SUBJECT: Human Rights Campaign on Medicaid / HIV

TO: Karen E. Skelton (CN=Karen E. Skelton/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Ann F. Lewis (CN=Ann F. Lewis/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Maria Echaveste (CN=Maria Echaveste/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Craig T. Smith (CN=Craig T. Smith/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Sandra Thurman (CN=Sandra Thurman/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Philip G Dufour (CN=Philip G Dufour/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Donald H. Gips (CN=Donald H. Gips/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Maurice Daniel (CN=Maurice Daniel/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Joshua Gotbaum (CN=Joshua Gotbaum/OU=OMB/O=EOP @ EOP [OMB])

READ:UNKNOWN

TO: Christopher C. Jennings (CN=Christopher C. Jennings/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Sylvia M. Mathews (CN=Sylvia M. Mathews/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Todd A. Summers (CN=Todd A. Summers/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Heidi Kukis (CN=Heidi Kukis/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Toby Donenfeld (CN=Toby Donenfeld/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Virginia M. Terzano (CN=Virginia M. Terzano/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Ron Klain (CN=Ron Klain/O=OVP @ OVP [UNKNOWN])

READ: UNKNOWN

TEXT:

----- Forwarded by Richard Socarides/WHO/EOP on 12/06/97
12:04 PM -----

rwockner @ netcom.com
12/05/97 11:31:00 PM

Record Type: Record

To: Stuart D. Rosenstein, Richard Socarides
cc:
Subject: NC5562: HRC on Medicaid HIVer exclusion

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NEWS RELEASE from the
Human Rights Campaign
1101 14th Street NW
Washington, DC 20005
email: david.smith@hrc.org

FOR IMMEDIATE RELEASE
Friday, Dec. 5, 1997

HRC CALLS ON SHALALA TO STAND BY COMMITMENTS TO MAKE
LIFE-SAVING THERAPIES AVAILABLE TO LOW-INCOME PEOPLE WITH HIV

Dubs Continued Exclusion of People With HIV a 'Moral Outrage'

WASHINGTON -- Responding to reports that the Clinton administration has abandoned attempts to expand Medicaid coverage to low-income people who are HIV-infected, the Human Rights Campaign labeled the move a "moral outrage," and called upon Health and Human Services Secretary Donna Shalala to stand by the commitments of President Clinton and Vice President Gore to make new life- saving drugs available to people who cannot afford them.

An AIDS-specific expansion of the Medicaid program would allow states to enroll people who are HIV positive, who would otherwise be excluded from the program until they developed full-blown AIDS. Such an expansion will save resources because the high costs of hospitalization and treating opportunistic infections will be curtailed. Vice President Gore announced his support for such a Medicaid expansion in April and called on the Health Care Financing Administration to issue a report within 30 days on such an initiative.

According to The Washington Post and the Associated Press, the Health Care Financing Administration, which oversees Medicaid, has determined that expanding Medicaid to cover low-income people who are HIV-infected but who are not yet diagnosed with AIDS is too expensive.

"[S]everal proposals were tested and all were too expensive, Victor Zonana, a spokesman for the Department of Health and Human

Services, said Thursday," according to the Associated Press.

"For administration officials to acknowledge that new treatments administered early in the course of HIV disease save lives, and then fail to develop programs to make those treatments available is a moral outrage," said Winnie Stachelberg, political director of the Human Rights Campaign.

The administration's own guidelines for the treatment of HIV disease, released in June, clearly indicate that early treatment is essential. For the administration not to develop a comprehensive plan to ensure that these treatments are available to all those who need them is a life-threatening contradiction.

Stachelberg pledged that the Human Rights Campaign, working with its coalition partners, will continue to press the Clinton administration to rapidly develop a solution to this problem. "People's lives are at stake," Stachelberg said. "'Too expensive' is an unacceptable excuse for not making these treatments available to people who cannot otherwise afford them."

The Human Rights Campaign is the largest national lesbian and gay political organization, with members throughout the country. It effectively lobbies Congress, provides campaign support and educates the public to ensure that lesbian and gay Americans can be open, honest and safe at home, at work and in the community.

===== ATTACHMENT 1 =====
ATT CREATION TIME/DATE: 0 00:00:00.00

TEXT:

RFC-822-headers:

Received: from conversion.pmdf.eop.gov by PMDF.EOP.GOV (PMDF V5.0-4 #6879)
id <01IQTZOJGTC000Y37K@PMDF.EOP.GOV>; Fri, 05 Dec 1997 23:34:40 -0500 (EST)

Received: from storm.eop.gov (storm.eop.gov)
by PMDF.EOP.GOV (PMDF V5.0-4 #6879) id <01IQTZOGFEFKG0152UZ@PMDF.EOP.GOV>; Fri,

05 Dec 1997 23:34:35 -0500 (EST)

Received: from netcom9.netcom.com ([192.100.81.119])
by STORM.EOP.GOV (PMDF V5.1-7 #6879)

with ESMTTP id <01IQTZNQR0HW003MWL@STORM.EOP.GOV>; Fri,

05 Dec 1997 23:34:02 -0500 (EST)

Received: (from rwockner@localhost)

by netcom9.netcom.com (8.8.5-r-beta/8.8.5/(NETCOM v1.02)) id UAA17291; Fri,
05 Dec 1997 20:31:58 -0800 (PST)

===== END ATTACHMENT 1 =====

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Sarah A. Bianchi (CN=Sarah A. Bianchi/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 6-DEC-1997 19:32:43.00

SUBJECT: AIDS memo and race and health memo

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ: UNKNOWN

TEXT:

Race memo has one new sentence that OMB does not support the grant proposal but rather supports building on existing programs. ===== ATT ATT CREATION TIME/DATE: 0 00:00:00.00

TEXT:

Unable to convert ARMS_EXT: [ATTACH.D91]MAIL45960793A.316 to ASCII, The following is a HEX DUMP:

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December 6, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING

SUBJECT: New AIDS Initiative

Overview

We have developed an \$115 million initiative for your FY 1999 budget to improve AIDS treatment and prevention programs. This increase would go to expand programs that are critical to preventing and treating this epidemic, including the AIDS Assistance Drugs Programs (ADAP) which extends life-saving new treatment therapies to low-income and underserved populations. It would focus on three populations: women, minorities (the two populations with the fastest growing rate of AIDS), and children.

Background on AIDS Funding

Since you came into office, you have dramatically improved programs that extend treatment and prevention for people with AIDS. You have ensured that Medicaid covers protease inhibitors (a significant step for AIDS treatment, as Medicaid provides health coverage for half of all people with AIDS). Ryan White Programs have increased by 200 percent since FY 1993, funding for research at NIH has increased by 50 percent, and funding for the ADAP program has increased 450 percent since 1996.

However, the AIDS community was extremely critical of the Administration in the last budget because we failed to propose major increases in discretionary spending, and the Congress far out spent us in this area. Moreover, this spring the Vice President asked the Health Care Financing Administration to look into the feasibility of doing a budget neutral Medicaid demonstration to extend life saving therapies to Medicaid patients earlier, when treatments are thought to be more effective. After much analysis, HCFA concluded that even a modest demonstration would be quite costly and could not meet its budget neutrality requirements. Nevertheless, the Vice President's request raised expectations in the community, and they are disappointed that we will not be able to take such an approach. There is no doubt that the AIDS community is watching the Administration's actions closely, particularly with regard to the FY 1999 budget, and will push for your continued support for AIDS research and treatment.

The Proposal

The AIDS office is recommending, and we agree, that you propose an \$115 million increase in your FY 1999 budget. (OMB is currently recommending \$100 million). This funding could be spent in a number of ways. We could break out spending between existing discretionary programs that emphasize prevention and treatment. We recommend a substantial increase in the ADAP program (around \$70 million) as new treatments of this disease are increasingly proving effective and have not been extended to many who need them. We would also recommend modest increases to cities, states, and community health centers, all of whom are overwhelmed by this epidemic as well as the CDC prevention education programs, which could specifically focus on improving education for minorities and young people.

In response to the criticism HHS is receiving with regard to their finding that a budget neutral demo is not possible, Nancy-Ann Min DeParle is in the early stages of having HCFA determine if it is possible to develop legislative options for a modest Medicaid demonstration to expand eligibility to Medicaid for people with HIV earlier in the progression of their disease. By proposing legislation, this demonstration would not have to be budget neutral. It would be capped to a few states (and more likely communities within these states) and would cost \$40-\$50 million over five years (or \$8 to \$10 million per year). If we develop such an approach, we could lower the discretionary dollars to \$100 million. It would also send a signal that the Administration is willing to consider changing Medicaid to respond to the new treatment needs of this epidemic. We would have to find some Medicaid savings to finance that proposal.

Although the \$115 million that we are suggesting falls far short of the unrealistic \$400 million the AIDS advocates are pushing, it is a significant investment with justifiable policy that, according to the AIDS office, should be sufficient to help quiet any major criticism from the community.

December 4, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING

SUBJECT: **Race and Health Initiative**

Overview

As a major component of your race initiative, we have developed a proposal that would commit the nation to an ambitious goal of seeking to eliminate racial disparities in health care by the year 2010. There are severe disparities in a number of critical health areas for African-Americans, Hispanics, Native Americans, and Asian Americans. In some cases these minority groups suffer from diseases as much as five times as often as whites. To effectively reduce these disparities will require a Department-wide effort to find innovative approaches and apply them nationally across all health programs. The FY 1999 budget could take a two-pronged approach to this issue: (1) expanding our most effective public health programs and directing them to focus specifically on the problem of eliminating these disparities; and (2) funding competitive grants to thirty communities and monitoring them closely to improve our knowledge on how to close these gaps. New strategies learned through these grants would then be applied at a national level.

Racial Disparities in Health Care

The initiative would focus on the most severe racial disparities in the following health areas: infant mortality, cancer, heart disease and stroke, AIDS, immunizations, and diabetes. Some of these disparities are quite startling. For example, infant mortality rates are 2 ½ higher for African-Americans and 1½ times higher for American Indians and many Hispanic groups. For cancer, Vietnamese women suffer from cervical cancer at nearly five times the rate of whites, while Latinos have two to three times the rate of stomach cancer. African-Americans have a 35 percent higher cancer death rate. For example, African-American men under the age of 65 get diseases such as prostate cancer and heart disease at nearly twice the rate of whites, while Native Americans suffer from diabetes at nearly three times the average rate, while African-Americans suffer 70 percent higher rates. Racial and ethnic minorities account for 25 percent of the population yet make up 54 percent of all AIDS cases. The demographic changes that are anticipated over the next decade magnify the importance of addressing some of these disparities. As these minority populations with poorer health status are expected to grow, we have an opportunity to dramatically improve the future of the nation's health if we can find effective ways to close these gaps.

Validation

Proposing the ambitious goal of reducing these dramatic health disparities would receive overwhelming support from the public health community, by groups such as the American Public Health Association, the American Heart Association and the American Cancer Society as well as from minority groups such as the Intercultural Cancer Council, the American Indian Healthcare Association, the National Hispanic Council on Aging, the National Council of Black Churches.

Proposal

HHS is proposing to spend \$200 million in FY 1999 for this initiative, while OMB is currently recommending \$30 million and supports using these dollars to build on existing programs rather than the grant proposal discussed below. We believe that we can develop a strong initiative with \$100 million in your FY 1999 budget. This funding would be supplemented by a few other initiatives, such as the proposed increases in AIDS funding, some of which will be targeted specifically to minorities.

- **Improving Effective Public Health Approaches to These Problems.** We recommend that you propose \$70 million to apply some of our most effective public health approaches directly to reducing these disparities. These public health programs have strategies that have proven effective as well as longstanding relationships with the minority health community and other community organizations committed to addressing these problems. Partnering with these organizations, these programs would build on their existing new knowledge and proven public health strategies to focus on how to eliminate these disparities.
- **Thirty Community Grants to Develop New Strategies to Eliminate Disparities.** To eliminate racial disparities in health care will require developing new approaches to reducing these disparities, as we currently do not have the answers as to how to solve many of these problems. We recommend you propose \$30 million to target thirty communities that develop innovative and effective ways to address these disparities. Each community, chosen through a competitive grant process, would develop intensely-focused efforts to address one of the six health areas. HHS would develop a working group that includes outside minority health experts to assist and monitor these communities and apply approaches across all health programs. They would also hold periodic meetings and conferences to educate the public health and minority community about new effective strategies to reduce these disparities.
- **Begining Today to Reduce Disparities.** To ensure that we begin this initiative immediately, we are identifying ways in which the FY 1998 increases in these areas can be used to begin to address racial disparities. For example, AIDS education and training centers are beginning a new partnership with the Indian Health Service to develop new approaches to educate health providers about training and prevention. Also, the National Cancer Institute will expand efforts to help recruit more Hispanics into clinical trials.

Pediatric Labeling. This week, *The New York Times* reported that the pharmaceutical industry has raised ethical concerns about the Administration's pediatric labeling regulations. Specifically, the article reported that the industry was claiming that clinical trials required would unnecessarily expose children to inappropriate, and potentially harmful, doses of medication. This story, which primarily focused on the potential costs to pharmaceutical companies, did not back up its headlines with any substantive example. Nor did it suggest any concerns that the industry had not raised previously when you released the regulation in August. The article failed to mention that the regulation allows the FDA Commissioner to waive testing requirements for any trial that provides unacceptable health risks to children. Moreover, the American Association of Pediatrics and other consumer advocates immediately responded to this article by emphasizing the need for this regulation. They pointed out that it was unethical not to have this regulation and it exposed all the nation's children to medications that physicians have inadequate information about. As to the industry's concern about costs, it is also important to note that the FDA reform bill you recently signed into law contained a provision that would compensate companies for this testing through the six month extension of market exclusivity for these drugs. These facts may help explain why there was no media followup to this story.

Tobacco/Medicaid Testimony. On Monday HCFA's Nancy-Ann Min DeParle is testifying before the House Commerce Subcommittee on Health on the issue of Federal recoupment of the Medicaid portion of any state's tobacco settlement agreement. In her testimony, Nancy-Ann will praise states for their successful lawsuits against the tobacco industry and the settlements they have obtained. She will also point out how the Federal government, through the FDA, strengthened the hands of states in filing their suits in the first place. Her testimony has been designed avoid being confrontational but to simply state that the current statute does not give significant leeway with regard to recapturing overpayments. It will also reiterate our longstanding public position that it is our hope and expectation that the Federal/State allocation issue will be resolved in through a Federal legislative solution on this subject.

Medicaid AIDS Demonstration. Late this week, *The Washington Post* and *The New York Times* reported that the Department of Health and Human Services has concluded that an AIDS Medicaid demonstration would be extremely expensive and certainly would not meet the normal budget neutrality waiver requirement. This spring, the Vice President requested that HHS look into the feasibility of a demonstration program to allow AIDS patients to become eligible for Medicaid much earlier so they could access to promising therapies earlier when they are thought to be more effective, helping keep people with HIV healthier and more able to work. This request raised expectations in the AIDS community. However, it was learned through subsequent analysis that this program could cost well over \$8 billion and would certainly violate the Administration's budget neutrality rule for Medicaid demonstrations. The AIDS community was briefed on this problem and was generally accepting that the costs of such a demonstration would be significant. Notwithstanding the *Post's* suggestion that we are abandoning this concept altogether, we have currently requested that HCFA develop a legislative Medicaid demonstration proposal that would cap the costs yet still provide some earlier access to these

drugs in Medicaid. There is no doubt that the AIDS community is watching the Administration's actions closely, particularly with regard to the FY 1999 budget and will push for your continued support for AIDS research and treatment. We are preparing options for your consideration, both through Medicaid and the discretionary budget.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Sylvia M. Mathews (CN=Sylvia M. Mathews/OU=WHO/O=EOP [WHO])

CREATION DATE/TIME: 6-DEC-1997 13:55:09.00

SUBJECT: Women's Groups

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Christopher C. Jennings (CN=Christopher C. Jennings/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Ann F. Lewis (CN=Ann F. Lewis/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Jennifer L. Klein (CN=Jennifer L. Klein/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Susan M. Liss (CN=Susan M. Liss/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

TO: Audrey T. Haynes (CN=Audrey T. Haynes/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

CC: June G. Turner (CN=June G. Turner/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TEXT:

Some of the women's groups called and asked if they could come in and have a brainstorming session with us on how to go forward on family planning issues in a more strategic fashion. They have done some thinking and want to discuss it with us.

One specific thing they have raised and I thought that Chris might want to think about is they are suggesting increases to title 10 funding to make abortion less necessary.

Jen would you please make sure Melanne knows. (I couldn't get her on email.)

Thanks.

DRAFT, CONFIDENTIAL, CLOSE HOLD

December 6, 4:30pm

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING

SUBJECT: Access Reforms that Prepare Medicare for the Twenty-First Century

Overview

The Balanced Budget Act that you enacted took critically necessary steps to modernize the Medicare program and prepare it for the twenty-first century. It extended the life of the Trust Fund to 2010, invested in preventive benefits, provided more choice of plans for beneficiaries, strengthened our ongoing fraud activities, and lowered cost growth to slightly below the private sector through provider payment reforms and modest beneficiary payment increases. However, the Balanced Budget's policies do not address the long-term problems posed by the retirement of the baby boom generation.

The Medicare Commission was established to address the demographic challenges facing the program. However, a major policy and political question remains. Is there anything we can and should do prior to the March 1999 Commission deadline that could further strengthen the program and lay the groundwork for implementation of likely Commission recommendations?

The National Economic Council (NEC) and Domestic Policy Council (DPC) have led an interagency examination of several, targeted policy options. We examine options for coverage for pre-65 year olds, the income-related premium, and a project to increase awareness of private long-term care. In addition, our efforts to both improve benefits and promote research are combined in a proposal to cover the patient care costs of clinical cancer trials.

Your advisors have not reached consensus on the best policy or financing mechanisms for these options. It may well be the case, however, that the traditional Medicare savings available will not be sufficient to offset the costs of these proposals. As such, a decision to propose a pre-65 policy may be feasible only if the decision is made to propose an income-related premium or, much less likely, dollars from any residual tobacco savings.

A. PRE-65 HEALTH INSURANCE OPTIONS

People between 55 and 65 years old often face greater problems accessing affordable health insurance. They are at greater risk of having health problems, with twice the probability of experiencing heart disease, strokes and cancer as people ages 45 to 54. Yet their access to affordable employer coverage is often lower due to work and family transitions. Work transition increase as people approach 65, with many retiring or shifting to part-time work or self-employment as a bridge to retirement. Some of this transition is involuntary. Nearly half of people 55 to 65 years old who lose their jobs due to firms downsizing or closing do not get re-employed. Family transitions also reduce access to employer-based health insurance for the increased number of people who are widowed, divorced, or whose spouse has gotten Medicare and retired. As a result, the pre-65 year olds, more than any other age group, rely upon the individual health insurance market. Without the advantages of having their costs averaged with other younger people (as in employer-based insurance), these people often face relatively high premiums and, because of the practice of medical underwriting, may be unable to get coverage at any price if they have pre-existing medical conditions.

These access problems will increase due to two trends: the decline in retiree health coverage and the aging of the baby boom generation. Recently, firms have cut back on offering pre-65 retirees health coverage; only 40 percent of large firms now offer such coverage. In addition, in several small but notable cases (e.g., General Motors and Pabst Brewery), retirees' health benefits were dropped unexpectedly, despite the firm's commitment to the workers. These "broken promise" retirees do not have access to COBRA continuation coverage and could have difficulty finding affordable individual insurance. A more important trend is the demographics. The number of people 55 to 65 years old will increase to 30 million by 2005 and 35 million by 2010 — over a 50 percent increase. This could raise the number of uninsured in this age group from 3 million today to 4 million by 2005, not even taking into account the decline in retiree health coverage.

Policy Questions

Two central questions guide policy decisions in this area: what is the target population, and what is the best way to cover these people.

Who to Target. As with any incremental reform, targeting is essential to ensure that the policy does not unintentionally reduce employer health coverage. In this case, the concern is that a broad and generous policy could both encourage people to retire earlier or accelerate the decline in employer contributions and/or coverage. At the same time, the current level of employer dropping suggests that a policy for the affected people is needed. Although your advisors remain divided on the advisability of implementing a new policy in this area, we all agree that if you decide to move in this direction that any policy should include protections against substitution. The easiest way to accomplish this is limiting eligibility to a subset of the pre-65 year olds. There are two design approaches worthy of consideration.

The first approach is to limit eligibility by age. We recommend an age break of 62. The 6 million people age 62 to 65, compared to people ages 55 to 59, work less (x percent versus y percent), are more likely to have fair to poor health (26 versus 20 percent), and are more likely to be uninsured or buy individual insurance (28 versus 21 percent). In addition, it is also the age at which Social Security benefits can be accessed. Within this group, we could limit eligibility to those without access to employer or public insurance, and would require that they exhaust COBRA coverage before becoming eligible, to limit the incentive to retire or drop retiree coverage due to this option.

A second approach is to limit eligibility within the 55 to 65 year olds by a group's lack of access to employer-based insurance. Three groups have particular problems. (1) Displaced workers: About 60,000 people ages 55 to 65 lost their employer insurance when they became displaced workers (lost their job due to the firm closing, downsizing, etc). Only about one-thirds of these people get re-employed. (2) Medicare spouses: About 420,000 uninsured people are spouses (mostly wives) of Medicare beneficiaries. They may have lost employer coverage when their husbands turned 65 and retired. (3) "Broken promise" people: A small but vulnerable group is the pre-65 retirees who lose retiree health coverage due to a "broken promise" (employer unexpectedly terminates coverage).

How to Target. The second question is: what is the best way to increase access to affordable insurance? One approach is to extend COBRA continuation coverage for longer than 18 months. Currently, COBRA allows workers with insurance in firms with 20 or more employees (COBRA exempts small firms) to continue that coverage for 18 months by paying 102 percent of the premium. The major problems with this approach are that not all people are eligible, businesses will consider this an unfunded mandate, and such a policy could lead to discriminate against hiring older workers. Despite the difficulties of COBRA extensions, it appears to be the best option for the "broken promise" people, since the former employer would bear some of the costs of their decision to terminate coverage.

A second option, preferable for most of the target groups, is a Medicare "buy-in". Eligible people could buy into Medicare at the age-adjusted Medicare managed care payment rate, with an add-on for the extra risk of participants. Since the actuaries think that most participants will be sicker than average, this add-on will be costly. To attract healthier people and thus reduce the add-on, we could "amortize" it, meaning that the participant would pay it in installments with their Part B premium after they turn 65, not all at once. In other words, Medicare would pay part of the premium up front, with the beneficiaries paying back this amount over time. The HCFA Actuaries have estimated that this Medicare "loan" in a worse-case scenario would cost \$1.1 billion per year (this estimate assumes participation of no more than 300,000 people). Because they assumed only sick people would participate, that all 300,000 would enroll in one year, and because they did not take into account the pay-back from beneficiaries, the official estimates, expected next week, will probably be lower.

Policy Options and Preferences

Option 1. “Broken Promise” People Only. All your advisors recommend a policy to require employers who break their promise of retiree coverage allow those retirees to buy into their active employer plan at a rate of 150 percent of the premium (since this age group is more expensive) until age 65. This option has no cost to the Federal government. Treasury favors only this approach, due to concerns about an “encroaching entitlement” of a Medicare buy-in proposal.

Option 2. Medicare Buy-In for Select Groups. The second option is to allow a limited group of 55 to 65 year olds to buy into Medicare. OMB favors the Medicare spouses — primarily uninsured women ages 55 to 65 whose husbands are already on Medicare. They argue that if the goal is a limited test of a buy-in for the pre-65 year olds, this is a discrete group whose eligibility would likely have no effect on the general trend in retiree health coverage or retirement. Labor strongly supports policies to help displaced workers, since it fits with the broader theme of trying to improve the security of workers. While a Medicare buy-in would help more of these workers, in the absence of a buy-in, Labor would support a COBRA extension. Treasury is ambivalent about this option, except that they have major concerns about targeting displaced workers because in this age range it is hard to draw the line between what is involuntary retirement and what is voluntary retirement. HHS supports covering these select groups only if they are added to a 62 to 65 year old buy-in, since the administrative effort of doing a buy-in for so few people would be great. The fact that there will be low numbers of participants for these selected groups also means that the costs will be small.

Option 3. Medicare Buy-In for 62 to 65 years old plus selected groups. The third option is to limit eligibility to age 62 to 65 years old plus the Medicare spouses and displaced workers. HHS and NEC/DPC think that this is a narrow enough group to limit any effects on retiree health coverage or retirement. It also is more representative of the 65 to 67 year old population, giving a better sense of what would happen if Medicare eligibility were postponed to 67 years old. Some of Treasury’s concerns about this option would be allayed if the buy-in participants were enrolled only in managed care, so that the insurers and not Medicare would bear the risk. The cost of this option is not known yet but is likely to be less than \$5 billion over 5 years.

It is important to note that we are still waiting for the detailed analysis of these options from the Office of the Actuary. That will give all advisors a better sense of the implications of the choices and could alter recommendations.

B. INCOME-RELATED PREMIUM

It is likely that the pre-65 coverage initiative costs more than traditional Medicare savings could produce, needing revenue from a policy like an income-related premium. As you know, Medicare subsidizes 75 percent of the Part B premium for all beneficiaries, including the wealthiest. This is not only regressive; it ignores the fact that studies show that higher income beneficiaries actually cost Medicare more than poor beneficiaries.

Policy Options

Building from our position from last summer, the income-related premium would be administered by the Treasury Department, not HCFA or the Social Security Administration. Annually, eligible people would fill out a Medicare Premium Adjustment form (a separate form or a line on the 1040 form) and send a check to "The Medicare Trust Fund". The two open questions are: who pays and how much do they pay.

Who qualifies. Last summer, the Senate passed a policy where the extra premium payment began at \$50,000 for singles and \$65,000 for couples. However, we proposed higher thresholds in the Health Security Act: \$90,000 for singles and \$115,000 for couples. These thresholds determine how many people are paying the higher amount.

How much is the extra amount. The amount of the payment for the wealthiest beneficiaries is a second question. In the budget debate, we argued that would should not go to a 100 percent premium (no subsidy) because that could cause some healthy and wealthy people to opt out of Medicare. However, an analysis by the Treasury Department this fall found that the effects would be small (about 5% of beneficiaries who pay the full premium would drop). If we decided to change our past policy, it might be advisable to have a strategic discussion about the timing of announcing such a change. It could be an important in negotiating the give and take on this issue. Revenue will likely be at least \$8 billion over 5 years, depending on the policy.

Discussion

From a policy perspective, OMB and Treasury continue to support this policy, and would probably recommend that we begin at the \$50,000 / \$65,000 level and fully phase out the subsidy [check]. HHS has expressed strong concerns about this policy in light of the changed environment. They argue that Medicare has already contributed \$115 billion in savings and that we should wait for the Commission recommendations before the next round of major changes.

From DPC/NEC's perspective, it is a matter of balance. On one hand, it is almost certain that this policy will be recommended by the Medicare Commission. At that point, however, we will have no opportunity to direct any of its revenue toward important Medicare reforms like a Medicare buy-in. In addition, between the baseline and policy reductions, it is highly unlikely that there will be enough health savings in the future to redirect toward coverage initiatives. If we do not pursue the premium and have insufficient funding for coverage initiatives, this will be the first time that your budget will not include a new coverage expansion initiative, with the exception of the period in which we were debating health reform.

On the other hand, we need to seriously consider the fact that many Democrats and

possibly AARP would oppose the income-related premium for the same reason HHS cites. The one exception to this rule is if it is explicitly linked to the pre-65 policy. In addition, Republicans might take this opportunity to label this as a new tax and use it as an issue during the 1998 campaign. Even if he philosophically supports the premium, Speaker Gingrich might use the high-income premium's "tax" label as cover for his likely opposition to a Medicare buy-in.

C. ACCESS TO PRIVATE LONG-TERM CARE OPTIONS

A second idea to improve access to insurance focuses on long-term care. Unlike acute care, long-term care is not primarily financed by private insurance, which only pays 6 percent of its costs. Medicaid pays for 38 percent, Medicare pays for 16 percent, and families pay for one-third of the costs out of pocket. This large government role may not be sustainable as the baby boom generation retires. Today, one in four people over age 85 live in a nursing home. This could increase substantially as the proportion of elderly living to age 90 is projected to increase from 25 percent to 42 percent by 2050. Thus, it is important to encourage the development of private insurance options. The Kassebaum-Kennedy legislation took a step in this direction by clarifying that long-term care insurance was deductible. However, given people's general lack of understanding about the importance of long-term care insurance, more action is needed.

Information on Quality Private Long-Term Care Insurance

We propose to leverage our role in Medicare to improve the quality of and access to private policies. Medicare would allow certain private long-term care policies to be included in its general information on Medicare managed care. HCFA would work with insurers, state regulators, and other interested parties to develop a set of minimum standards. If a plan met these standards, it could be included in the new managed care information system. As a reminder, the BBA 1997 included provisions to provide annual information on managed care choices to beneficiaries. This proposal would build upon that system and would cost up to \$25 million over 5 years.

There is general agreement across agencies that this is an important first step, although there needs to be more discussion of its details. There is some concern at HHS that coming to an agreement on a set of standards could be difficult and that insurers may argue that our standards drive up the cost of the policies, making them unaffordable. However, these concerns may not be insurmountable with input from the industry.

D. MEDICARE COVERAGE OF CANCER CLINICAL TRIALS

We have developed a proposal that would expand Medicare to cover additional services associated with cancer clinical trials. This proposal would not only help Medicare beneficiaries, who represent a significant portion of cancer patients, but would set a standard to encourage the private industry to cover clinical trials. It would also almost inevitably increase participation in cancer clinical trials and would be particularly helpful for cancers, such as prostate cancer, that have inadequate treatments and have difficulty attracting participants. Because of the way our actuaries score this proposal (CBO would score it for less costs) and because we wanted to ensure we would be reimbursing for high quality trials, we have had to narrow our original proposal to something that may not be uniformly embraced by the advocates. It is, however, likely to be supported (with some minor adjustments) by Senators Mack and Rockefeller. Having said this, our current proposal is quite expensive and its opponents (in and outside the Administration) will criticize its precedence-setting potential to expand to other diseases, and in so doing, tap the Medicare Trust Fund at precisely the wrong time.

Background

Scientists and advocates alike agree that we are simply not making sufficient progress in treating cancer and that weaknesses in our current cancer clinical trials system are a significant part of this problem. For many cancers, such as lung cancer, prostate cancer, and ovarian cancer, we still have little success with treatments. Even where better treatments are available, the process of developing and assessing improved therapies is still too slow.

One significant problem with the current clinical trials system is that only 3 percent of all cancer patients participate. According to one former National Cancer Institute director, if 10 percent of all cancer patients participated in such trials then trials that currently take three to five years would only take one year. This would likely accelerate the improvements of treatments. Moreover, historically most insurers have covered clinical trials for children. As a consequence, nearly 70 percent of children with cancer participate in clinical trials. Scientists agree that this fact has helped improve cancer treatments for children, and some argue that this is one reason for the dramatically higher survival rates for children cancer patients.

One leading reason that patients do not participate in clinical trials is that a many insurers do not cover them or make it prohibitively difficult to participate. Changes in the health care delivery system have made it less likely that clinical trials will be covered. In fact, it is on average 30 to 40 percent more expensive to cover participants in managed care than traditional fee-for-service and far more burdensome. As a result, clinical trials, which seem to be undersubscribed, are having an even harder time finding participants. This problem has significant implications for research in all cancer areas, particularly for those cancers such as prostate cancer where scientists still do not have good answers about treatment and where clinical trials are particularly undersubscribed.

Expanding Medicare to cover cancer clinical trials would represent an important step for two reasons: First, nearly half of all cancer patients are older Americans covered by Medicare; and second, as the nation's largest insurer, Medicare plays a significant role in setting the standard for the insurance companies. A commitment from Medicare to cover clinical trials would go a long way in encouraging private insurance companies to agree to cover these trials.

Proposal

In response to the interest in the breast and prostate cancer patient advocate community, we have developed a proposal to expand Medicare to cover cancer clinical trials conducted at the National Cancer Institute and trials with comparable peer review. This initiative would cost \$1.7 billion over five years and would be paid for by a variety of Medicare anti-fraud offsets. There are options that cover a larger percentage of clinical trials, including a bill proposed by Senator Mack and Senator Rockefeller (co-sponsored by 26 Senators) that we believe goes too far by covering all FDA trials, many of which the experts believe do not meet a scientifically-meritorious standard.

Validators and Opponents

There is no question that this proposal is the highest priority for most of the cancer community as well as many in the women's community who believe this is an essential step to improve breast cancer treatment. However, the advocates have made it clear that they would strongly prefer the more expansive and expensive Rockefeller/Mack approach. We are working to determine whether we can modify our more limited proposal in a way that they would support.

HHS is supportive of this policy. OMB and Treasury, however, strongly oppose this proposal because they believe it is bad policy and sets an almost unstoppable precedence. While the DPC/NEC believes that OMB and Treasury raise valid concerns, we would support this proposal if we can develop an affordable option that both Senator Rockefeller and Senator Mack and the cancer community would strongly support. If we cannot obtain such support in short order, we would recommend not including it in the budget. We would be in a very good position to argue our likely support for a significant increase in biomedical research will also pay large dividends in cancer breakthroughs and are more than sufficient in this budget year. Finally, if it becomes clear that our final cost estimates for the Medicare buy-in are low enough to be financed by the available \$2 billion in traditional (anti-fraud) Medicare savings, the DPC and NEC would recommend giving serious consideration to use these limited dollars to support the Medicare buy-in proposal.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Jeanne Lambrew (CN=Jeanne Lambrew/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 6-DEC-1997 17:22:09.00

SUBJECT: Re: the medicare memo

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ: UNKNOWN

TEXT:

It went to OMB and Sperling at the same time, so I imagine tomorrow is morning is just fine.

Thanks.

DRAFT, CONFIDENTIAL, CLOSE HOLD

December 7

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING

SUBJECT: Reforms that Prepare Medicare for the Retirement of the Baby Boom Generation

Overview

The Balanced Budget Act that you enacted took critically necessary steps to modernize the Medicare program and prepare it for the twenty-first century. It extended the life of the Trust Fund to 2010, invested in preventive benefits, provided more choice of plans for beneficiaries, strengthened our ongoing fraud activities, and lowered cost growth to slightly below the private sector through provider payment reforms and modest beneficiary payment increases. However, the Balanced Budget's policies do not address the long-term problems posed by the retirement of the baby boom generation.

The Medicare Commission was established to address the demographic challenges facing the program. However, a major policy and political question remains. Is there anything we can and should do prior to the March 1999 Commission deadline that could further strengthen the program and lay the groundwork for implementation of likely Commission recommendations?

The National Economic Council (NEC) and Domestic Policy Council (DPC) have led an interagency examination of several, targeted policy options. We examine options for coverage for pre-65 year olds, the income-related premium, and a project to increase awareness of private long-term care. In addition, our efforts to both improve benefits and promote research are combined in a proposal to cover the patient care costs of clinical cancer trials.

Your advisors have not reached consensus on the best policies or financing mechanisms for these options, much less on agreement whether we should pursue these at all. OMB and to some extent Treasury have concerns about a pre-65 option, because it may open the door to subsidies for a costly population and have the unintended effect of reducing employer coverage. Both OMB and Treasury feel negatively about the clinical cancer trials proposal since it could set a precedent for every other disease group asking for the same treatment. In addition, it may well be the case, that the traditional Medicare savings available will not be sufficient to offset the costs of these proposals. As such, a decision to propose a pre-65 policy may be feasible only if the decision is made to propose an income-related premium or, much less likely, dollars from any residual tobacco savings. It is worth noting that an income-related premium would clearly be more politically viable to our Democratic base if it were linked to a benefit enhancement.

A. PRE-65 HEALTH INSURANCE OPTIONS

People between 55 and 65 years old often face greater problems accessing affordable health insurance. They are at greater risk of having health problems, with twice the probability of experiencing heart disease, strokes and cancer as people ages 45 to 54. Yet their access to affordable employer coverage is often lower due to work and family transitions. Work transition increase as people approach 65, with many retiring or shifting to part-time work or self-employment as a bridge to retirement. Some of this transition is involuntary. Nearly half of people 55 to 65 years old who lose their jobs due to firms downsizing or closing do not get re-employed. Family transitions also reduce access to employer-based health insurance for the increased number of people who are widowed, divorced, or whose spouse has gotten Medicare and retired. As a result, the pre-65 year olds, more than any other age group, rely upon the individual health insurance market. Without the advantages of having their costs averaged with other younger people (as in employer-based insurance), these people often face relatively high premiums and, because of the practice of medical underwriting, may be unable to get coverage at any price if they have pre-existing medical conditions.

These access problems will increase due to two trends: the decline in retiree health coverage and the aging of the baby boom generation. Recently, firms have cut back on offering pre-65 retirees health coverage; only 40 percent of large firms now offer such coverage. In addition, in several small but notable cases (e.g., General Motors and Pabst Brewery), retirees' health benefits were dropped unexpectedly, despite the firm's commitment to the workers. These "broken promise" retirees do not have access to COBRA continuation coverage and could have difficulty finding affordable individual insurance. A more important trend is the demographics. The number of people 55 to 65 years old will increase to 30 million by 2005 and 35 million by 2010 — over a 50 percent increase. This could raise the number of uninsured in this age group from 3 million today to 4 million by 2005, not even taking into account the decline in retiree health coverage.

Policy Questions

Two central questions guide policy decisions in this area: what is the target population, and what is the best way to cover these people.

Who to Target. As with any incremental reform, targeting is essential to ensure that the policy does not unintentionally reduce employer health coverage. In this case, the concern is that a broad and generous policy could both encourage people to retire earlier or accelerate the decline in employer contributions and/or coverage. At the same time, the current level of employer dropping suggests that a policy for the affected people is needed. Although your advisors remain divided on the advisability of implementing a new policy in this area, we all agree that if you decide to move in this direction that any policy should include protections against substitution. The easiest way to accomplish this is limiting eligibility to a subset of the pre-65 year olds. There are two design approaches worthy of consideration.

The first approach is to limit eligibility by age. We recommend an age break of 62. The 6 million people age 62 to 65, compared to people ages 55 to 59, work less (x percent versus y percent), are more likely to have fair to poor health (26 versus 20 percent), and are more likely to be uninsured or buy individual insurance (28 versus 21 percent). In addition, it is also the age at which Social Security benefits can be accessed. Within this group, we could limit eligibility to those without access to employer or public insurance, and would require that they exhaust COBRA coverage before becoming eligible, to limit the incentive to retire or drop retiree coverage due to this option.

A second approach is to limit eligibility within the 55 to 65 year olds by a group's lack of access to employer-based insurance. Three groups have particular problems. (1) Displaced workers: About 60,000 people ages 55 to 65 lost their employer insurance when they became displaced workers (lost their job due to the firm closing, downsizing, etc). Only about one-thirds of these people get re-employed. (2) Medicare spouses: About 420,000 uninsured people are spouses (mostly wives) of Medicare beneficiaries. They may have lost employer coverage when their husbands turned 65 and retired. (3) "Broken promise" people: A small but vulnerable group is the pre-65 retirees who lose retiree health coverage due to a "broken promise" (employer unexpectedly terminates coverage).

How to Target. The second question is: what is the best way to increase access to affordable insurance? One approach is to extend COBRA continuation coverage for longer than 18 months. Currently, COBRA allows workers with insurance in firms with 20 or more employees (COBRA exempts small firms) to continue that coverage for 18 months by paying 102 percent of the premium. The major problems with this approach are that not all people are eligible, businesses will consider this an unfunded mandate, and such a policy could lead to discriminate against hiring older workers. In addition, firms that do not want to cover their employees anyway could use this COBRA mandate as their excuse not to do so. Despite these difficulties, a COBRA extension appears to be the best option for the "broken promise" people, since the former employer would bear some of the costs of their decision to terminate coverage.

A second option, preferable for most of the target groups, is a Medicare "buy-in". Eligible people could buy into Medicare at the age-adjusted Medicare managed care payment rate, with an add-on for the extra risk of participants. Since the actuaries think that most participants will be sicker than average, this add-on will be costly. To attract healthier people and thus reduce the add-on, we could "amortize" it, meaning that the participant would pay it in installments with their Part B premium after they turn 65, not all at once. In other words, Medicare would pay part of the premium up front, with the beneficiaries paying back this amount over time. The HCFA Actuaries have estimated that this Medicare "loan" in a worse-case scenario would cost \$1.1 billion per year (this estimate assumes participation of no more than 300,000 people). Because they assumed only sick people would participate, that all 300,000 would enroll in one year, and because they did not take into account the pay-back from beneficiaries, the official estimates, expected next week, will probably be lower.

Policy Options and Preferences

Option 1. “Broken Promise” People Only. All your advisors recommend a policy to require employers who break their promise of retiree coverage allow those retirees to buy into their active employer plan at a rate of 150 percent of the premium (since this age group is more expensive) until age 65. This option has no cost to the Federal government.

Option 2. Medicare Buy-In for Select Groups. The second option is to allow a limited group of 55 to 65 year olds to buy into Medicare. OMB and Treasury favor the Medicare spouses — primarily uninsured women ages 55 to 65 whose husbands are already on Medicare. OMB favors only this and the “broken promise” option. They argue that if the goal is a limited test of a buy-in for the pre-65 year olds, this is a discrete group whose eligibility would likely have no effect on the general trend in retiree health coverage or retirement. Labor strongly supports policies to help displaced workers, since it fits with the broader theme of trying to improve the security of workers. While a Medicare buy-in would help more of these workers, in the absence of a buy-in, Labor would support a COBRA extension. HHS supports covering these select groups but is concerned that the enrollment be sufficient enough to justify the administrative expenses. The fact that there will be low numbers of participants for these selected groups also means that the costs will be small.

Option 3. Medicare Buy-In for 62 to 65 years old plus selected groups. The third option is to limit eligibility to age 62 to 65 years old plus the Medicare spouses and displaced workers. HHS and NEC/DPC think that this is a narrow enough group to limit significantly the effects on retiree health coverage or retirement. It also is more representative of the 65 to 67 year old population, giving a better sense of what would happen if Medicare eligibility were postponed to 67 years old. Although Treasury is concerned that this policy could become an underfinanced policy expansion, some of its concerns would be allayed if the buy-in participants were enrolled only in managed care. This would assure that the insurers and not Medicare would bear the risk. The cost of this option is not known yet but is likely to be less than \$5 billion over 5 years.

It is important to note that we are still waiting for the detailed analysis of these options from the Office of the Actuary. That will give all advisors a better sense of the implications of the choices and could alter recommendations.

B. ACCESS TO PRIVATE LONG-TERM CARE OPTIONS

A second idea to improve access to insurance focuses on long-term care. Unlike acute care, long-term care is not primarily financed by private insurance, which only pays 6 percent of its costs. Medicaid pays for 38 percent, Medicare pays for 16 percent, and families pay for one-third of the costs out of pocket. This large government role may not be sustainable as the baby boom generation retires. Today, one in four people over age 85 live in a nursing home. This could increase substantially as the proportion of elderly living to age 90 is projected to increase from 25 percent to 42 percent by 2050. Thus, it is important to encourage the development of private insurance options. The Kassebaum-Kennedy legislation took a step in this direction by clarifying that long-term care insurance was deductible. However, given people's general lack of understanding about the importance of long-term care insurance, more action is needed.

Information on Quality Private Long-Term Care Insurance

We propose to leverage our role in Medicare to improve the quality of and access to private policies. Medicare would allow certain private long-term care policies to be included in its general information on Medicare managed care. HCFA would work with insurers, state regulators, and other interested parties to develop a set of minimum standards. If a plan met these standards, it could be included in the new managed care information system. As a reminder, the BBA 1997 included provisions to provide annual information on managed care choices to beneficiaries. This proposal would build upon that system and would cost up to \$25 million over 5 years, distinct from the user fees currently authorized for the managed care information..

Some of your advisors think that this is an important first step, although there needs to be more discussion of its details. There is some concern at HHS that coming to an agreement on a set of standards could be difficult and that insurers may argue that our standards drive up the cost of the policies, making them unaffordable. However, these concerns may not be insurmountable with input from the industry.

C. MEDICARE COVERAGE OF CANCER CLINICAL TRIALS Hex-Dump Conversion

We have developed a proposal that would expand Medicare to cover additional services associated with cancer clinical trials. Today, Medicare does not cover the patient care costs associated with these trials. This proposal would not only help Medicare beneficiaries, who represent a significant portion of cancer patients, but would encourage the private industry to cover clinical trials for the people less than 65 years old. It would also almost inevitably increase participation in cancer clinical trials and would be particularly helpful for trials for cancers, such as prostate cancer, that have inadequate treatments and have difficulty attracting participants. Because of the way our actuaries score this proposal (CBO would score it for less costs) and because we wanted to ensure we would be reimbursing for high quality trials, we have had to narrow our original proposal to a level that may not be uniformly embraced by the advocates. It is, however, likely to be supported (with some increased funding) by Senators Mack and Rockefeller. Having said this, our current proposal is still quite expensive and its opponents (in and outside the Administration) will criticize its precedence-setting potential to expand to other diseases, and in so doing, tap the Medicare Trust Fund at precisely the wrong time.

Background

Scientists and advocates alike agree that we are simply not making sufficient progress in treating cancer and that weaknesses in our current cancer clinical trials system are a significant part of this problem. A major problem is the lack of insurance coverage of the health care services associated with the trials. Nearly half of all cancer patients are covered by Medicare, yet Medicare does not cover clinical trial patient care. This care can often be prohibitively expensive for cancer patients and their families. This may explain why only 3 percent of all cancer patients participate in trials. To illustrate the importance of coverage, historically most insurers have covered clinical trials for children. As a consequence, nearly 70 percent of children with cancer participate in clinical trials. Scientists agree that this fact has helped improve cancer treatments for children, and some argue that this is one reason for the dramatically higher survival rates for children cancer patients.

This problem has significant implications for research in all cancer areas, particularly for those cancers such as prostate cancer where scientists still do not have good answers about treatment and where clinical trials are particularly undersubscribed. According to one former National Cancer Institute director, if 10 percent of all cancer patients participated in such trials, then trials that currently take three to five years would only take one year. This would likely accelerate the improvements of treatments.

Expanding Medicare to cover cancer clinical trials would represent an important step for two reasons. First, all Americans covered by Medicare, not just those with resources, would have a choice of participating in cancer trials. Second, as the nation's largest insurer, Medicare plays a significant role in setting the standard for the insurance companies. A commitment from Medicare to cover clinical trials would go a long way in encouraging private insurance companies for the less than 65 year olds to agree to cover these trials.

Proposal

In response to the interest in the breast and prostate cancer patient advocate community, we have developed a proposal to expand Medicare to cover cancer clinical trials conducted at the National Cancer Institute and trials with comparable peer review. This initiative would cost \$1.7 billion over five years and would be paid for by a variety of Medicare anti-fraud offsets. There are options that cover a larger percentage of clinical trials, including a bill proposed by Senator Mack and Senator Rockefeller (co-sponsored by 26 Senators). This proposal may be too expansive by covering all FDA trials, many of which the experts believe do not meet a scientifically-meritorious standard. However, there are some trials above the \$1.7 billion proposals that could justifiably be included, but for costs.

Discussion

There is no question that this proposal is the highest priority for most of the cancer community as well as many in the women's community who believe this is an essential step to improve breast cancer treatment. However, the advocates have made it clear that they would strongly prefer the more expansive and expensive Rockefeller/Mack approach. We are working to determine whether we can modify our more limited proposal in a way that they would support.

HHS is supportive of this policy. OMB and Treasury, however, strongly oppose this proposal because they believe it is bad policy and sets an almost unstoppable precedence. They argue that the drug companies and other entities conducting the trials should pick up the patient care costs as well. They also believe that once we cover cancer trials, we will be under enormous pressure to cover other trials such as diabetes or heart disease.

While the DPC/NEC believes that OMB and Treasury raise valid concerns, we would support this proposal if we can develop an affordable option that both Senator Rockefeller and Senator Mack and the cancer community would strongly support. If we cannot obtain such support in short order, we would recommend not including it in the budget. We would be in a very good position to argue our likely support for a significant increase in biomedical research will also pay large dividends in cancer breakthroughs and are more than sufficient in this budget year. Finally, if it becomes clear that our final cost estimates for the Medicare buy-in are low enough to be financed by the available \$2 billion in traditional (anti-fraud) Medicare savings, the DPC and NEC would recommend giving serious consideration to use these limited dollars to support the Medicare buy-in proposal.

D. INCOME-RELATED PREMIUM

It is likely the combination of all of these proposals, particularly the pre-65 coverage initiative, will cost more than traditional Medicare savings could produce. This may lead to discussions of an income-related premium. As you know, Medicare subsidizes 75 percent of the Part B premium for all beneficiaries, including the wealthiest. This is not only regressive; it ignores the fact that studies show that higher income beneficiaries actually cost Medicare more than poor beneficiaries. However, this is moving away from the concept of social insurance.

Policy Options

Building from our position from last summer, the income-related premium would be administered by the Treasury Department, not HCFA or the Social Security Administration. Annually, eligible people would fill out a Medicare Premium Adjustment form (a separate form or a line on the 1040 form) and send a check to "The Medicare Trust Fund". The two open questions are: who pays and how much do they pay.

Who qualifies. Last summer, the Senate passed a policy where the extra premium payment began at \$50,000 for singles and \$65,000 for couples. However, we proposed higher thresholds in the Health Security Act: \$90,000 for singles and \$115,000 for couples. These thresholds determine how many people are paying the higher amount.

How much is the extra amount. The amount of the payment for the wealthiest beneficiaries is a second question. In the budget debate, we argued that would should not go to a 100 percent premium (no subsidy) because that could cause some healthy and wealthy people to opt out of Medicare. However, an analysis by the Treasury Department this fall found that the effects would be small (about 5% of beneficiaries who pay the full premium would drop). HHS would strongly object to changing our position and supporting an income-related premium that completely phases out the Part B subsidy. If we decided to change our past policy, it might be advisable to have a strategic discussion about the timing of announcing such a change. It could be an important in negotiating the give and take on this issue. Revenue will likely be at least \$8 billion over 5 years, depending on the policy.

Discussion

From a policy perspective, OMB and Treasury continue to support this policy, and would probably recommend that we begin at the \$50,000 / \$65,000 level and fully phase out the subsidy [check]. HHS believes that if an income-related premium is pursued, its savings are used for Medicare. They argue that Medicare has already contributed \$115 billion in savings and that we should wait for the Commission recommendations before the next round of major changes.

From DPC/NEC's perspective, it is a matter of balance. On one hand, it is almost certain that this policy will be recommended by the Medicare Commission. At that point, however, we will have no opportunity to direct any of its revenue toward important Medicare reforms like a Medicare buy-in. In addition, between the baseline and policy reductions, it is highly unlikely

that there will be enough health savings in the future to redirect toward coverage initiatives. If we do not pursue the premium and have insufficient funding for coverage initiatives, this will be the first time that your budget will not include a new coverage expansion initiative, with the exception of the period in which we were developing and debating Health Security. Act.

On the other hand, we need to seriously consider the fact that many Democrats and possibly AARP would oppose the income-related premium for the same reason HHS cites. The one exception to this rule is if it is explicitly linked to the pre-65 policy. In addition, Republicans might take this opportunity to label this as a new tax and use it as an issue during the 1998 campaign. Even if he philosophically supports the premium, Speaker Gingrich might use the high-income premium's "tax" label as cover for his likely opposition to a Medicare buy-in.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Julie A. Fernandes (CN=Julie A. Fernandes/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 7-DEC-1997 16:06:53.00

SUBJECT: INS/State and Medicaid

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TEXT:

This is in response to a memo that Diana and I received about a week ago from the Center on Budget and Policy Priorities re: immigrants re-entering the country or petitioning to adjust status being told that a condition of re-entry was the repayment of the value of Medicaid benefits previously recieved. The Center is also concerned that families are being instructed to dis-enroll family members (including citizen children) before they are permitted to re-enter or adjust.

----- Forwarded by Julie A. Fernandes/OPD/EOP on 12/07/97
04:08 PM -----

Julie A. Fernandes

12/05/97 06:40:10 PM

Record Type: Record

To: Diana Fortuna/OPD/EOP

cc: Cynthia A. Rice/OPD/EOP, Andrea Kane/OPD/EOP

Subject: INS/State and Medicaid

Diana,

I have been looking into the questions raised by the the memo we received from the Center of Budget and Policy Priorities.

According to Bob Bach at the INS, they are issuing the following guidance to the field (should be cleared by Commissioner on Monday):

1. INS inspectors should not be asking legal permanent residents who have been out of the country less than 6 months anything related to a public charge determination. These folks are not subject to "admission" (the trigger), but are "returning."

2. Though the inspectors can ask those seeking "admission" about current or prior use of Medicaid (as part of the totality test for public charge), whether they have received these benefits (or if their citizen children currently receive) should not be dispositive on the question. The INS guidance will remind the inspectors that prior use is not dispositive.

3. That entry or re-adjustment should not be delayed or denied contingent upon the "repayment" of legal Medicaid benefits received. However, if the person seeking "admission" has an outstanding debt to an agency, that is grounds for inadmissibility. But, in order for there to

be a debt, there must be a claim. Thus, the inspector should not in any way require the "repayment" of benefits legally received, or request that the person seeking admission disenroll children from the Medicaid program unless there is a claim from the state agency. If there is a debt, the inspector can tell the person that if the debt is repaid, the bar to their admission would be lifted.

4. On the question of prior or current use of food stamps, the INS guidance will instruct that unless practice prior to the enactment of TANF, use of food stamps can now be a factor in the totality determination of "public charge." However, INS is instructing that prior use of food stamps cannot be a "public charge" factor, since food stamps were not part of the calculation prior to the new welfare law. Also, if a use of food stamps by a citizen child can also not be a factor in determining whether the parent will be a public charge (the theory is that food stamps are necessarily supplemental, and thus don't predict future reliance on public benefits).

All of this guidance, of course, does not address whether State is giving similar guidance to its consular officers. State has very little control over what their consular officers do. There is no judicial review of any kind (administrative or otherwise). INS, HHS and State are having a meeting next week on this to determine if there is a way to get better control this in the consular offices.

Do you know whether (as was stated in the Center of Budget Priorities memo) the state Medicaid offices are permitted to disclose information of the legal use of benefits to the INS?

julie

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Jeanne Lambrew (CN=Jeanne Lambrew/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 7-DEC-1997 21:42:01.00

SUBJECT: coverage memo -- in case you don't already have enough to read

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ: UNKNOWN

TEXT:

===== ATTACHMENT 1 =====
ATT CREATION TIME/DATE: 0 00:00:00.00

TEXT:

Unable to convert ARMS_EXT: [ATTACH.D61]MAIL494097047.316 to ASCII,
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December 7, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING

SUBJECT: Health Insurance Coverage Initiatives in the FY 1999 Budget

Overview

Throughout your Administration, you have worked to enact legislation to expand access to affordable health insurance. Your signing of the Balanced Budget Act included an unprecedented \$24 billion investment for state-based children's health insurance programs. This historic initiative will clearly reduce the number of uninsured. However, there are other deserving populations whom we could target in our step-by-step reforms. These include the pre-65 year olds (referenced in the Medicare memo), workers between jobs, and workers in small businesses. In addition, we are working on proposals to expand Medicaid coverage to people with AIDS and disabilities through demonstration programs. The policy development of these proposals is still underway, but we reference them in this memo because we believe that they are sound and inexpensive enough to justify being considered for your FY 1999 budget.

Taken together, these are not large initiatives, summing to around \$10 billion over 5 years, which is less than half of investments in this year's budget and less than a fraction of the premium assistance in the Health Security Act. Having said this, none of your advisors believe that it will be possible to find \$10 billion in available resources for these investments. Most Medicare and Medicaid savings were included in last year's deficit reduction effort. There may be \$0.5 to 1 billion over 5 years in Medicaid savings, but those savings will be difficult to achieve and there may be other claims on them (e.g., child care). It could also be argued that, given the link between tobacco and health care, any residual revenue from the tobacco settlement or a tax could be considered for coverage initiatives, particularly those related to children.

Your advisors uniformly agree that we need to take all actions possible to achieve if not exceed your goal of increasing insurance coverage for 5 million children. A series of proposals are described to accomplish that goal. There is less agreement on whether we address a new group of uninsured people in this budget. Labor strongly supports the workers between jobs demonstration; of all health initiatives in the budget, it is their highest priority. OMB also supports that demonstration if sufficient funds are available. While HHS believes that this proposal has merit, they are skeptical that it will achieve significant support since it has not in the past three years of trying. The same holds true for the small group purchasing cooperatives.

A. CHILDREN'S HEALTH OUTREACH

The Children's Health Insurance Program (CHIP) provides funds for coverage of millions of working families' children, a population that previously had trouble affording coverage. It also builds upon a strong Medicaid program that this Administration has worked so hard to protect. However, important work remains to be done. In particular, we need to work with states to enroll the millions of uninsured children in these programs.

Medicaid eligible children are especially at risk of remaining uninsured. Over three million uninsured children are eligible for Medicaid. Educating and enrolling families about their options has always been a problem, but recently has become more challenging. The growth in the number of children covered by Medicaid leveled off in 1995 and, according to the Census, dropped by 6 percent in 1996. While some of this may be due to the lower number of children in poverty, some may also result from families' misunderstanding of their children's continued eligibility for Medicaid regardless of the changes in welfare.

Options to Increase Outreach for Medicaid and the Children's Health Insurance Program

To address the need for children's health outreach, we propose a series of policy options. First, we could offer states a bonus for enrolling new, uninsured children, giving them an incentive to find these children. Second, we could build upon a new option in the Balanced Budget Act called "presumptive eligibility", that essentially allows children to be given temporary Medicaid coverage while they are formally enrolled in CHIP or Medicaid. Third, we would clarify the law so that states may use their TANF allotments for outreach at 90 percent matching for all children, not just those transitioning from welfare. Finally, we will work on a series of policies to simplify the application and enrollment process, making easier to access the system. Together, these initiatives could cost \$0.5 to 1.5 billion over five years. Preliminary discussions with NGA and some children's advocates suggest they strongly support these efforts.

Enhanced match for outreach. One option for improving state outreach is to provide enhanced match to enroll new, uninsured children in Medicaid. At the end of the year, if a state can document that it has increased its enrollment over baseline, it receives an increased matching amount per newly covered child. This policy rewards states only if they succeed in outreach, rather than just matching activities that may or may not work. Its costs depend on the amount of the enhanced match, but estimates range from \$0.5 to 1 billion over five years.

Moving outreach to schools and child care sites. We could build upon the presumptive eligibility provision in the Balanced Budget Act to make it easier to enroll children in Medicaid and CHIP. This could be done by changing the law to allow schools and appropriate child care sites, at the states' option, to determine "presumptive eligibility". This means that certified people may, using a simple test, give a child up to two months of Medicaid coverage on the spot as the application is processed. Additionally, under the Balanced Budget, states that use presumptive eligibility must pay for its costs out of the CHIP allotment, reducing

the amount available for other coverage. States have advised us that this is a disincentive to take this option. HCFA actuaries preliminarily estimate that this would cost \$400 million over 5 years.

Accessing 90 percent funds for outreach. A third way to increase financing for children's health outreach is to clarify the uses of a special fund set aside in TANF for outreach for children losing welfare. This \$500 million fund is allocated to states with a 90 percent matching rate for outreach activities. We would expand its use to all children, not just welfare children. HCFA Actuaries preliminarily estimate that this would cost \$0.2 billion over 5 years (the cost of the new coverage generated by these efforts). NGA strongly supports this change.

Simplifying enrollment. A simple, accessible enrollment process from beginning to end could encourage more families to enroll their children in Medicaid or CHIP. To help create such a process, we propose several actions, all of which are low cost initiatives. First, we could streamline the application process by simplify Medicaid eligibility and by encouraging the use of simple, mail-in applications. HCFA has already developed a model, single application form for both Medicaid and CHIP. We could condition some of the financial incentives, described above, on using a single or simple application. Second, we are reviewing the feasibility and costs of a nationwide 1-800 number that will link families with their state or local offices. Such a number could be placed in public service announcements, on the bottom of school lunch program applications, and on children's goods like diaper boxes, for example, allowing families easy access to information.

Departmental Positions

There is unanimous support across agencies for focusing on children's health outreach. For HHS and Treasury, it is their first priority in all health initiatives. NEC/DPC believe that aggressive outreach will be needed to meet or exceed the Administration's goal of covering 5 million uninsured children. Although we believe this policy will receive validation by policy experts, children's advocates, and Governors alike, this package of outreach initiatives may be a communications challenge so soon after the enactment of the \$24 billion base children's health program. Given its importance, we should also consider how outreach could be done in the context of the tobacco settlement. Since one of the stated uses of the \$368 billion settlement was children's health, it is possible that we should fund this initiative in that way. We also could consider allowing states to keep some of the Federal funds if they use them for children's outreach.

B. WORKERS BETWEEN JOBS DEMONSTRATION

Families who lose health insurance while they are between jobs are a small but important group of uninsured Americans. These families pay for health insurance for most of their lives, but go through brief periods without coverage when they are temporarily unemployed. If they experience a catastrophic illness during this transition, the benefit of their years' worth of premium payments is lost. Worse, for families with an ill child or a worker with a chronic condition, the loss of health insurance while between jobs can make it financially impossible to regain coverage.

Limited Demonstration

This policy option is a modification of the program that we have carried in our last three budgets. It would award grants to several states to provide temporary premium assistance to eligible families. States would use this money to partially subsidize families' premium payments for up to 6 months. To truly test how best to address this population's needs, we would select states using a range of approaches like COBRA, Medicaid, or covering the parents of children covered by CHIP. Since it is a grant program, the costs are a policy choice. To give a sense of the coverage for the options, last year's \$10 billion proposal covered about 3.3 million people. If we assume the same set of policy parameters, a demonstration of \$1 billion over 5 years would cover about 300,000, of \$2.5 billion would cover about 700,000, and it would take about \$3.5 billion to cover about 1 million people.

Departmental Positions

On policy grounds, all of the agencies support this policy. It has been in our last three budgets because of its merits. This policy remains Labor's first priority. They view the unemployed uninsured as a particularly vulnerable and important group to target. They also believe that this is a particularly important policy in the context of the trade debate and worker insecurity issues. OMB would support this initiative if there are sufficient funds. HHS has always been supportive of this policy but feels as though circumstances have not changed to make this policy viable this year when it has not been in the past. They would focus the funds on the children's outreach option. DPC/NEC are concerned about dropping this policy altogether and do support a demonstration. However, if resources are limited, we would advocate for the children's outreach initiative before this proposal.

C. VOLUNTARY PURCHASING COOPERATIVES

Workers in small firms are most likely to be uninsured. About one-third of workers in firms with fewer than 10 employees lack health insurance — more than twice the nationwide average. While 88 percent of workers in firms with 250 or more workers are offered health insurance, only 41 percent of workers in firms with less than 10 workers are offered coverage. This results in large part from the fact that the small group health insurance market does not function as well as the large group market. Studies have shown that administrative costs are higher and that small businesses pay more for the same benefits as larger firms.

Grants to States

Given the disadvantages faced by small firms, the question is: are there policies that can make insurance more affordable for small businesses and their employees? In the last three budgets, we have included a policy to provide seed money for states to establish voluntary purchasing cooperatives. These cooperatives would allow small employers to pool their purchasing power to try to negotiate better rates for their employees. This year, we propose both the original policy and a variation: a competitive grant approach so that fewer states could apply for a smaller amount of money. The total costs would be \$50 to 100 million over 5 years.

Departmental Positions

All agencies remain supportive of this policy and believe it should be included in this year's budget. It is important that we have some initiative that illustrates our understanding that a major problem of lack of insurance continues to exist in the small employer community. In the past, we have been unable to get this policy passed into law primarily because it has been viewed as an alternative to an initiative proposed by Congressman Fawell. His approach would allow virtually all small businesses to self-insure and in so doing escape all state regulation. Governors and consumer groups have consistently opposed the Fawell approach, mostly because of their concerns that it would make the small business insurance market for those who elected not to self insure an even more unstable market than it already is. We have raised similar concerns and have also pointed out that a Fawell-type approach would eliminate all of the consumer protections state insurance regulation currently provides. Based on our preliminary conversations with Congressman Fawell, it may be that our impasse may be resolvable since this is his last year as a Member of Congress and there are some compromises that seem within reach.

D. AIDS DEMONSTRATION

As described in the memo on AIDS initiatives, the Health Care Financing Administration is looking into options to see if there is a feasible demonstration for providing Medicaid coverage for certain therapies earlier than when people have full-blown AIDS. This demonstration would allow a few states or cities to have a capped amount of funds to provide Medicaid coverage to people with AIDS earlier in the progression of the disease. The details and merits of such a policy are still in development, but we think that we could limit this funding to \$40 to 50 million over five years.

E. DEMONSTRATION FOR PEOPLE WITH DISABILITIES

A similar demonstration is being considered for people with disabilities. As you know from your meeting with the disability community, there is a strong desire to experiment with ways to encourage states to de-institutionalize people with disabilities. Often, these people could live in the community if they has Medicaid support. However, states have been reluctant to move extensively in this direction because for every one person that they move out of a nursing home due to this benefit, several who are already in the community but being cared for by their families would turn to Medicaid for help. For this same reason, HCFA is still trying to determine whether a limited demonstration is possible. The ideas being considered would both test options for encouraging de-institutionalization and develop a information strategy to encourage states to use models that work. If possible, we would limit funding to \$50 million over five years.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Thomas L. Freedman (CN=Thomas L. Freedman/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 14:10:25.00

SUBJECT: OSHA and Tobacco Hrngs .

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Jerold R. Mande (CN=Jerold R. Mande/OU=OSTP/O=EOP @ EOP [OSTP])
READ:UNKNOWN

TO: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

CC: Mary L. Smith (CN=Mary L. Smith/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TEXT:

OSHA has been asked to brief two committees on tobacco and indoor air quality in preparation for hearings in the Senate in January (Chafee) and the House (not settled on date). Emily Sheketoff, who called from OSHA, would like to know if they should go ahead and brief. In addition to briefing, the Senate would also like them to testify. Should I ask her in to see what they would say in a briefing?

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Robert M. Shireman (CN=Robert M. Shireman/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 23:43:34.00

SUBJECT: He may already have called you. . .

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

Terry Hartle, VP for govt relations at ACE, has talked to me on several occasions about wanting us to release the affirmative action guide for colleges. I suggested that he call you. I said that I thought that, in part, a decision on that was related to the issues that we discussed with Stan a couple weeks ago. I told him my recollection (perhaps wrong) was that Stan was supposed to get back to us after thinking about some issues. That was news to Terry, so if my recollection is correct, you may want to clarify with Terry or Stan.

DRAFT, CONFIDENTIAL, CLOSE HOLD
December 8

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING
CHRIS JENNINGS

SUBJECT: Reforms that Prepare Medicare for the Retirement of the Baby Boom Generation

Overview

The Balanced Budget Act (BBA) that you enacted took critically necessary steps to modernize the Medicare program and prepare it for the twenty-first century. It extended the life of the Trust Fund to 2010, invested in preventive benefits, provided more choice of plans for beneficiaries, strengthened our ongoing fraud activities, and lowered cost growth to slightly below the private sector rate through provider payment reforms and modest beneficiary payment increases. However, the BBA's policies were not intended to solve the long-term problems posed by the retirement of the baby boom generation.

The Medicare Commission was established to address the demographic challenges facing the program. However, a major policy and political question remains. Is there anything we can and should do prior to the March 1999 Commission deadline that could further strengthen the program and lay the groundwork for implementation of likely Commission recommendations?

The National Economic Council (NEC) and Domestic Policy Council (DPC) have led an interagency examination of several, targeted policy options. We examine options for coverage for pre-65 year olds, Medicare coverage of patient care costs associated with clinical trials, and a project to increase awareness of private long-term care insurance. Financing options to pay for this proposal follow this description.

Your advisors have differing views, both as to the advisability of pursuing any new proposals while the Medicare Commission is active, and which proposals to pursue if you do. OMB and to some extent Treasury have concerns about a pre-65 option, because it may open the door to subsidies for a costly population and have the unintended effect of reducing employer coverage. Both OMB and Treasury feel negatively about the clinical cancer trials proposal since it could set a precedent for every other disease group asking for the same treatment. In addition, it may well be the case, that the traditional Medicare savings alone will not be sufficient to offset the costs of these proposals. As such, a decision to propose a pre-65 policy may be feasible only if the decision is made to propose an income-related premium or, much less likely, dollars from any residual tobacco tax. It is worth noting that an income-related premium would clearly be more politically viable to our Democratic base if it were linked to a benefit expansion.

A. PRE-65 HEALTH INSURANCE OPTIONS

Although people between 55 and 65 years old are generally more likely to have insurance than the general population, they often face greater problems accessing affordable health insurance, especially those who are sick. They are at greater risk of having health problems, with twice the probability of experiencing heart disease, strokes and cancer as people ages 45 to 54. Yet their access to affordable employer coverage is often lower due to work and family transitions. Work transition increase as people approach 65, with many retiring or shifting to part-time work or self-employment as a bridge to retirement. Some of this transition is involuntary. Nearly half of people 55 to 65 years old who lose their jobs due to firms downsizing or closing do not get re-employed.

Family transitions also reduce access to employer-based health insurance for the increased number of people who are widowed, divorced, or whose spouse has gotten Medicare and retired. As a result, the pre-65 year olds, more than any other age group, rely upon the individual health insurance market. Without the advantages of having their costs averaged with other younger people (as in employer-based insurance), these people often face relatively high premiums and, because of the practice of medical underwriting, may be unable to get coverage at any price if they have pre-existing medical conditions. While the Kassebaum-Kennedy legislation improved access for people with pre-existing conditions, it did not restrict costs.

These access problems will increase due to two trends: the decline in retiree health coverage and the aging of the baby boom generation. Recently, firms have cut back on offering pre-65 retirees health coverage; in 1984 67 percent of large and mid-sized firms offered retiree insurance but in 1997 only 37 percent did (although decline may be slowing). In addition, in several small but notable cases (e.g., General Motors and Pabst Brewery), retirees' health benefits were dropped unilaterally, despite the firm's commitment to their retirees. These "broken promise" retirees do not have access to COBRA continuation coverage and could have difficulty finding affordable individual insurance. A more important trend is the demographics. The number of people 55 to 65 years old will increase from 22 to 30 million by 2005 and 35 million by 2010 — over a 50 percent increase. Assuming current rates of uninsurance, this could raise the number of uninsured in this age group from 3 million today to 4 million by 2005, without even taking into account the decline in retiree health coverage.

The last reason for considering the coverage issues of this age group is the likelihood of proposals to raise Medicare eligibility age to 67. The Federal government will be raising the normal Social Security retirement age to 67, and the Medicare Commission will likely consider this option for Medicare as well. The experience with covering a pre-65 age group now will teach us valuable lessons if we need to develop policy options for the 65 to 67 year olds.

Policy Questions. Two central questions guide policy decisions in this area: what is the target population, and what is the best way to cover these people.

Whom to Target? As with any incremental reform, targeting is essential to reduce the chance that the policy does not unintentionally offset or reduce employer health coverage. While this policy will not affect employers' decisions to offer coverage to their current workers, it may affect employers' decisions to cover retirees and employees' decisions to retire early. At the same time, the current level of employer dropping suggests that a policy for the affected people is needed. Although your advisors remain divided on the advisability of implementing a new policy in this area, we all agree that if you decide to move in this direction that any policy should include protections against substitution. The easiest way to accomplish this is limiting eligibility to a subset of the pre-65 year olds. There are two design approaches to achieve this.

The first approach is to limit eligibility by age. We recommend an age break of 62, which is already the most common retirement age. The 6 million people age 62 to 65, compared to people ages 55 to 59, work less (48 percent versus 74 percent), are more likely to have fair to poor health (26 versus 20 percent), and are more likely to be uninsured or buy individual insurance (28 versus 21 percent). In addition, it is also the age at which Social Security benefits can be accessed. Within this 6 million, we could limit eligibility to the 2 million without access to employer or public insurance, and would require that they exhaust COBRA coverage before becoming eligible, to reduce the incentive to retire or drop retiree coverage due to this option.

A second approach is to limit eligibility within a broader age group, e.g., 55 to 65 year olds, by a lack of access to employer-based insurance. Three groups have particular problems. (1) Displaced workers: About 60,000 people ages 55 to 65 lost their employer insurance when they became displaced workers (lost their job due to the firm closing, downsizing, etc). (2) Medicare spouses: About 420,000 uninsured people are spouses (almost all wives) of Medicare beneficiaries who may have lost employer-based family coverage when their husbands turned 65 and retired. This number could be larger if employers drop retirees' dependent coverage for these spouses due to this policy. (3) "Broken promise" people: A small but visible and vulnerable group is the pre-65 retirees who lose retiree health coverage due to a "broken promise" (employer unexpectedly terminates coverage).

How to Provide Coverage? The second question is: what is the best way to increase access to affordable insurance? One approach is to extend COBRA continuation coverage for longer than 18 months. Currently, COBRA allows workers with insurance in firms with 20 or more employees (COBRA exempts small firms) to continue that coverage for 18 months by paying 102 percent of the premium. The major problems with this approach are that not all people are eligible, businesses will consider this an unfunded mandate, and such a policy could lead to discrimination against hiring older workers. In addition, firms that do not want to cover their employees anyway could use this longer COBRA mandate as their excuse not to do so. Despite these difficulties, a COBRA extension appears to be the best option for the "broken promise" people, since the former employer would bear some of the costs of its decision to terminate coverage and COBRA could then serve as a "bridge to Medicare" for this population.

A second option, preferable for most of the target groups, is a Medicare “buy-in”. Eligible people could buy into Medicare at the age-adjusted Medicare payment rate, plus an add-on for the extra risk of participants. Since the actuaries think that most participants will be sicker than average, this add-on will be costly. To attract healthier people and make it possible for more people to take advantage of the benefit, we could defer payment of the additional cost until age 65 by “amortizing” this payment. The participant would make payments in installments with their Part B premium after they turn 65 for the rest. In other words, Medicare would pay part of the premium as a loan up front, with repayment by the beneficiaries. The HCFA actuaries have estimated that this Medicare loan in a worse-case scenario would cost \$1.1 billion per year (with participation of no more than 300,000 people). Because they assumed only sick people would participate, that all would enroll in one year, and because they did not take into account the pay-back from beneficiaries, the official estimates, expected soon, will probably be lower. Subsidies would be considerably more costly and your advisors agree that we cannot afford it.

Option 1. “Broken Promise” People Only. All your advisors recommend a policy that employers who break their promise of retiree coverage be required to allow those retirees to buy into their active employer plan at a rate of 150 percent of the premium (since this age group is more expensive) until age 65. This option has no cost to the Federal government.

Option 2. Medicare Buy-In for Select Groups. The second option is to allow a limited group of 55 to 65 year olds to buy into Medicare. If you decide to consider any of the Medicare buy-in proposals, OMB favors undertaking only the Medicare spouses — primarily uninsured women ages 55 to 65 whose husbands are already on Medicare. They argue that, if the goal is a limited test of a buy-in for the pre-65 year olds, this is a discrete group whose eligibility would likely have a smaller effect on the general trend in retiree health coverage or retirement. Labor strongly supports policies to help displaced workers, since it fits with the broader theme of trying to improve the security of workers. While a Medicare buy-in would help more of these workers, in the absence of a buy-in, Labor would support a COBRA extension. HHS supports covering these select groups but is concerned that the enrollment be sufficient enough to justify the administrative effort. The small size of these groups also means that the costs will be low.

Option 3. Medicare Buy-In for 62 to 65 years old plus selected groups. The third option is to permit eligibility for age 62 to 65 years old plus the Medicare spouses and displaced workers. The cost of this option is not known yet but could be as much as \$5 billion over 5 years. HHS and NEC/DPC think that this is a narrow enough group to limit significantly the effects on retiree health coverage or retirement. This group is also more representative of the 65 to 67 year old population, giving a better sense of what would happen if Medicare eligibility were postponed to 67 years old. Although Treasury is concerned that this policy could become an underfinanced policy expansion, some concerns would be allayed if the buy-in participants were enrolled only in managed care. This would mean that the insurers and not Medicare would bear the risk, but this could be politically difficult given the distrust of managed care. However, OMB thinks that this group is not narrow enough and the “unsubsidized entitlement” (the subsidy is in the financing) will not stay that way for long. It is important to note that we are

still waiting for actuarial analyses, which could alter the recommendations or your advisors.

B. PRIVATE LONG-TERM CARE OPTIONS

A second idea to improve access to insurance focuses on long-term care. Unlike acute care, long-term care is not primarily financed by private insurance, which only pays 6 percent of its costs. Medicaid pays for 38 percent, Medicare pays for 21 percent, and families pay for 28 of the costs out of pocket. This large government role may not be sustainable as the baby boom generation retires. Today, one in four people over age 85 live in a nursing home. This could increase substantially as the proportion of elderly living to age 90 is projected to increase from 25 percent to 42 percent by 2050. Thus, it is important to encourage the development of private insurance options. The Kassebaum-Kennedy legislation took a step in this direction by clarifying that certain long-term care insurance are tax deductible. However, given that many people incorrectly assume Medicare covers all of their long-term care needs and do not know about private long-term care insurance, more action is needed. This action could include providing information to Medicare beneficiaries about private insurance, funding a demonstration program to improve the quality and price of private insurance, or both. None of these options includes a new Medicare entitlement or subsidy.

Information on Quality Private Long-Term Care Insurance

We propose to leverage our role in Medicare to improve the quality of and access to private policies and clarify that Medicare is an acute care program. Medicare would allow certain private long-term care policies to be included in its general information on Medicare managed care. HCFA would work with insurers, state regulators, and other interested parties to develop a set of minimum standards. If a plan met these standards, it could be included in the new managed care information system. As a reminder, the BBA 1997 included provisions to provide annual information on managed care choices to beneficiaries. This proposal would build upon that system and would cost up to \$25 million in discretionary funds over 5 years (\$5 million in FY 1999), distinct from the user fees are currently authorized for the managed care information. The cost of a demonstration would depend on its size and policy parameters, but could be limited to \$100 to 300 million over 5 years.

We believe this proposal has significant potential and is worth further developing. There is some concern at HHS that coming to an agreement on a set of standards could be difficult and that insurers may argue that our standards drive up the cost of the policies, making them unaffordable. They also would prefer that the demonstration be funded through the mandatory budget. However, these concerns may not be insurmountable, especially since one objective of a demonstration could be to investigate high quality private options that are affordable.

C. MEDICARE COVERAGE OF CANCER CLINICAL TRIALS

Medicare has not traditionally covered patient care costs associated with clinical trials. Scientists and advocates believe that we are not making sufficient progress in treating cancer, in part because of low participation in these trials that stems from lack of Medicare's coverage. HHS and DPC have been working on an approach that covers patient care for a limited number of these trials. Because of concerns about cost potential, OMB and Treasury strongly oppose this option.

Nearly half of all cancer patients are covered by Medicare, yet Medicare does not cover patient care costs associated with these trials. This care can often be prohibitively expensive for cancer patients and their families, perhaps explaining why only 3 percent of all cancer patients participate in trials. Historically most insurers have covered clinical trials for children. As a consequence, nearly 70 percent of children with cancer participate in clinical trials. Scientists agree that this fact has helped improve cancer treatments for children, and some argue that this is one reason for the dramatically higher survival rates for children cancer patients.

This problem has significant implications for research in all cancer areas, particularly for those cancers like prostate cancer where scientists still have no good answers and where clinical trials are particularly undersubscribed. According to a former National Cancer Institute director, if 10 percent of all cancer patients participated in such trials, then trials that currently take three to five years would only take one year.

Expanding Medicare to cover cancer clinical trials would represent an important step for two reasons. First, all Americans covered by Medicare, not just those who can afford it, would have a choice of participating in cancer trials. Second, as the nation's largest insurer, Medicare plays a significant role in setting the standard for the insurance companies. A commitment from Medicare to cover clinical trials would go a long way in encouraging private insurance companies to agree to cover these trials.

Proposal

We have developed a proposal to expand Medicare to cover cancer clinical trials conducted at the NCI and trials with comparable peer review. In addition, we would require the National Cancer Policy Board to make further coverage recommendations, and HHS to assess the incremental costs of such trials compared to conventional Medicare-covered therapies. Assuming the true incremental costs are substantially less than the actuaries project, as we believe, additional trial coverage as recommended by the Board could occur. The initial coverage would cost \$1.7 billion over five years. Senators Mack and Rockefeller have developed a more expansive and expensive proposal (co-sponsored by 26 Senators), which covers all FDA trials, many of which the experts believe do not meet a scientifically-meritorious standard. While their support for our modest approach is not assured, their views will weigh heavily with patient groups and the cancer community. However, we do believe that there may be some trials above the \$1.7

billion proposal that could be justified on policy grounds.

A possible alternative way to cover clinical cancer trial's patient care costs is to directly dedicate resources from any significant increases that NIH / NCI receive in the upcoming budget. NCI could use these increase to simplify and centralize their clinical trials system, which has the potential to increase patient access. Although this may be a viable option, the cancer community has clearly stated their preference that extending Medicare coverage is their top priority in this area, as they believe that patients need better access to these cutting edge treatments.

Discussion

HHS is supportive of this policy and believes that it would not only give Medicare beneficiaries, who represent a significant portion of cancer patients, much-needed choices but would encourage the private industry to cover clinical trials as well. There is no question that this proposal is the highest priority for most of the cancer community as well as many in the women's community who believe it is an essential step to improve breast cancer treatment. However, the advocates have made it clear that they would strongly prefer the more expansive and expensive Rockefeller/Mack approach. We are working to determine whether we can modify our more limited proposal in a way that they would support.

OMB and Treasury oppose the Medicare coverage option strongly. They note that it would involve very substantial costs (\$1 to \$3 billion per year) to provide medical services that are experimental, and therefore are unlikely to help the majority of beneficiaries. Once an exception has been made for experimental cancer drugs and therapies, they argue there is no reason that similar support won't be demanded for experimentation with Alzheimer's, Parkinson's, and other maladies. As a result, these costs will grow as other therapies are included. They also believe that Congress would likely expand the proposal beyond coverage of only NCI trials-- given the fact that prime Hill sponsors favor broader coverage-- and such expanded coverage will be very costly (up to \$3 billion over five years).

OMB also does not believe that Medicare should lead the way on clinical trials, but rather drug companies should be the first to contribute to improving access for Medicare beneficiaries.

The DPC/NEC believes that OMB and Treasury raise some valid concerns. However, we would support this proposal if we can develop an affordable option that both Senator Rockefeller and Senator Mack and the cancer community would strongly support.

If we cannot obtain such support in short order, we would recommend not including it in the budget. We would be in a very good position to argue our likely support for a significant increase in biomedical research will also pay large dividends in cancer breakthroughs and are more than sufficient in this budget year. However, if we decide to not fully double the NIH budget, as described in a separate memo, this policy might be more important to reenforcing your commitment to research. Finally, if it becomes clear that our final cost estimates for the Medicare buy-in are low enough to be financed by the available \$2 billion in traditional (anti-fraud) Medicare savings, the DPC and NEC would

recommend giving serious consideration to use these limited dollars to support the Medicare buy-in proposal. However, HHS prefers that these offsets be used only for the clinical cancer trial proposal.

D. PAYING FOR INITIATIVES: AN INCOME-RELATED PREMIUM AND OTHER OPTIONS

We assume that the funding for these Medicare initiatives will require Medicare offsets. One approach is to use Medicare anti-fraud initiatives. HHS and OMB believe that this could total about \$2 billion over 5 years. This could fund some, but not all of the initiatives described above. To fund a more expansive series of initiatives, then you may need to move beyond this list to consider an income-related premium. As you know, Medicare subsidizes 75 percent of the Part B premium for all beneficiaries, including the wealthiest. This is not only regressive; it ignores the fact that studies show that higher income beneficiaries actually cost Medicare more than poor beneficiaries. However, this is moving away from the concept of social insurance.

Income-Related Premium Policy Options

Building from our position from last summer, the income-related premium would be administered by the Treasury Department, not HCFA or the Social Security Administration. Annually, eligible people would fill out a Medicare Premium Adjustment form (a separate form or a line on the 1040 form) and send a check to "The Medicare Trust Fund". The two open questions are: "Who pays?" and "How much?" Depending upon the design, this proposal could generate at least \$8 billion over five years.

Who pays. Last summer, the Senate passed a policy where the extra premium payment began at \$50,000 for singles and \$65,000 for couples. However, we proposed higher thresholds in the Health Security Act: \$90,000 for singles and \$115,000 for couples. These thresholds determine how many people are paying the higher amount.

How much. The amount of the payment for the wealthiest beneficiaries is a second question. In the budget debate, we argued that would should not go to a 100 percent premium (no subsidy) because that could cause some healthy and wealthy people to opt out of Medicare. However, an analysis by the Treasury Department this fall found that the effects would be small (about 5% of beneficiaries who pay the full premium would drop). HHS would strongly object to changing our position and supporting an income-related premium that completely phases out the Part B subsidy. If we decided to change our past policy, it might be advisable to have a strategic discussion about the timing of announcing such a change. It could be an important in negotiating the give and take on this issue.

Discussion

OMB's position ultimately depends upon the entire package of initiatives and savings being offered. OMB considers the income-related premium to be a sound policy option, but believes that it could be considered as a means of either offsetting Medicare Trust Fund insolvency or providing benefit expansions for the currently eligible Medicare population. HHS believes that if an income-related premium is pursued, its savings are used for Medicare. They argue that Medicare has already contributed \$115 billion in savings and it may make sense to preserve this option for the Commission recommendations; otherwise, the Commission could be left with fewer moderate options.

From DPC/NEC's perspective, it is a matter of balance. On one hand, it is almost certain that this policy will be recommended by the Medicare Commission. At that point, however, we will have less opportunity to direct any of its revenue toward important Medicare reforms like a Medicare buy-in. In addition, between the baseline and policy reductions, it is highly unlikely that there will be enough health savings in the future to redirect toward coverage initiatives. If we do not pursue the premium and have insufficient funding for coverage initiatives, this will be the first time that your budget will not include a new coverage expansion initiative, with the exception of the period in which we were developing and debating Health Security Act.

On the other hand, we need to seriously consider the fact that many Democrats and possibly AARP would oppose the income-related premium for the same reason HHS cites. A possible exception is if it is explicitly linked to a pre-65 policy. In addition, Republicans might take this opportunity to label this as a new tax and use it as an issue during the 1998 campaign. Even if he philosophically supports the premium, Speaker Gingrich might use the high-income premium's "tax" label as cover for his likely opposition to a Medicare buy-in.

December 7, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING
CHRIS JENNINGS

SUBJECT: Initiative to Reduce Racial Disparities in Health

To support your race initiative, we have developed possible proposals that would commit the nation to an ambitious goal of seeking to eliminate some of the most severe racial disparities in health care by the year 2010. African-Americans, Hispanics, Native Americans, and Asian Americans suffer from diseases up to five times as much as whites. To reduce these disparities HHS must make a sustained effort to find innovative approaches and apply them across all health programs. The FY 1999 budget could take a two-pronged approach to this issue: (1) expand our most effective public health programs and directing them to focus specifically on the problem of reducing these disparities; and (2) fund competitive grants to thirty communities and monitor them closely with the goal of applying the most effective new strategies at a national level.

Racial Disparities in Health Care

The initiative would focus on some of the most severe racial disparities in health care: infant mortality, cancer, heart disease and stroke, AIDS, immunizations, and diabetes. Some of these disparities are quite startling. For example, infant mortality rates are 2 ½ higher for African-Americans and 1½ times higher for American Indians and many Hispanic groups than they are for whites. African-Americans have a 35 percent higher cancer death rate than whites, and African-Americans under 65 suffer from prostate cancer at nearly twice the rate of whites. Similarly, Vietnamese women suffer from cervical cancer at nearly five times the rate of whites, while Latinos have two to three times the rate of stomach cancer. African-American men also suffer from heart disease at nearly twice the rate of whites. Native Americans suffer from diabetes at nearly three times the average rate, while African-Americans suffer 70 percent higher rates. Minorities account for 25 percent of the population yet make up 54 percent of all AIDS cases. The Demographic changes anticipated over the next decade magnify the importance of addressing these disparities. As minority populations grow, finding effective ways to close these gaps will become a critical aspect of improving the health of the nation.

Validation

An initiative that sets the ambitious goal of reducing these health disparities would receive overwhelming support from the public health groups such as the American Public Health Association, the American Heart Association and the American Cancer Society, as well as from minority groups such as the Intercultural Cancer Council, the American Indian Healthcare Association, the National Hispanic Council on Aging, the National Council of Black Churches.

Options

HHS is proposing to spend \$200 million in FY 1999 for this initiative. OMB is currently recommending \$30 million and supports using these dollars to build on existing HHS programs, rather than the grant proposal discussed below. They also believe this initiative can be greatly enhanced by refocusing and retargeting programs with existing dollars. The DPC/NEC agrees we can improve this effort with existing dollars, but believe that a strong initiative will require \$100 million in your FY 1999 budget. This funding would be supplemented by money from a few other initiatives, such as the proposed increases in AIDS funding, some of which will be targeted specifically to minorities.

- **Accelerating Current Effective Public Health Approaches to Eliminate Disparities.** We recommend that you propose \$70 million to apply some of our most effective public health approaches directly to reducing these disparities. Our best public health programs already use strategies and have longstanding relationships with community organizations. Partnering with these organizations, these programs would use additional funds to implement and adapt proven public health strategies in order to eliminate racial disparities. For example, CDC's breast and cervical cancer screening program already partners with community organization to target underserved communities. Additional dollars could be used to evaluate how their program could better reach minorities and also enable them to expand to their efforts to other cancers, such as prostate and colorectal cancer education.
- **Community Grants to Develop New Strategies to Eliminate Disparities.** Eliminating racial disparities in health care will require not only the focused application of existing knowledge and best practices, but also the development of new approaches. We recommend you propose \$30 million in FY 99 to enable thirty communities to develop innovative and effective ways to address these disparities. Each community, chosen through a competitive grant process, would commence an intensive program to address one of the six health areas. These grants will be used to develop new education, outreach, and preventive approaches that have not been attempted elsewhere. HHS would also hold periodic meetings and conferences to educate the public health and minority community about the new effective strategies learned by these communities and apply these approaches across all health programs. It is important to note that OMB believes that a major weakness of the grant proposal is the amount of time it would take to establish the necessary infrastructure to implement public health activities in each of the given communities and would prefer these dollars be spent on existing public health programs.
- **Beginning Today to Reduce Disparities.** To ensure that we begin this initiative immediately, we are identifying ways in which the FY 1998 increases in these areas can be used to begin to address racial disparities. For example, AIDS education and training centers are beginning a new partnership with the Indian Health Service to develop new approaches to educate health providers about training and prevention. Also, the National Cancer Institute will expand efforts to help recruit more Hispanics into clinical trials.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 11:30:07.00

SUBJECT: Re: memo styles

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

You're so right. If he had to read 9 pages every time he decided to spend \$50 million ...

Elena Kagan

12/07/97 01:29:53 PM

Record Type: Record

To: Bruce N. Reed/OPD/EOP

cc:

Subject: memo styles

If you want to see the nec-style memo taken to its most absurd lengths, check out the one on hispanic education. Really, do they think he has nothing better to do?

December 8, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING
CHRIS JENNINGS

SUBJECT: New AIDS Initiative

Overview

We have developed an \$115 million initiative for your FY 1999 budget to improve AIDS treatment and prevention programs. This increase would go to expand programs that are critical to preventing and treating this epidemic, including the AIDS Assistance Drugs Programs (ADAP) which extends life-saving new treatment therapies to low-income and underserved populations.

Background on AIDS Funding

Since you came into office, funding for AIDS programs that focus on treatment and prevention have improved dramatically. Medicaid, which provides coverage for half of all people with AIDS, now covers protease inhibitors. Funding for the Ryan White Program has increased by 200 percent since FY1993, funding for research at NIH has increased by 50 percent since that year, and funding for the ADAP program has increased 450 percent since 1996.

The AIDS community, however, has expressed disappointment with the Administration's recent efforts in this area. AIDS groups criticized the Administration for failing to propose major increases in discretionary spending in FY1998, which allowed the Congress to far outspend us in this area. And in just the last few weeks, the AIDS community reacted negatively to HCFA's conclusion, in response to the Vice President's inquiry, that budget neutrality requirements prohibit establishing a Medicaid demonstration to provide early treatment to relatively healthy HIV-infected individuals. There is no doubt that the AIDS community will be examining the Administration's FY 1999 budget submission closely.

Proposal

The AIDS office is recommending, and we agree, that you propose an \$115 million increase in your FY 1999 budget for AIDS treatment and prevention. (OMB is currently recommending \$100 million). We could allocate all of this spending to existing discretionary programs that emphasize prevention and treatment. We would recommend that the majority of this increase be allocated to the ADAP program on the grounds that new and effective treatments of this disease are not reaching many who need them. We also would recommend modest increases to a range of programs providing funds to states, cities, and community health centers, as well as the CDC prevention education programs.

Although the \$115 million that we are suggesting falls far short of the unrealistic \$400 million the AIDS advocates are pushing, it is a significant investment that will improve AIDS treatment and prevention and should be sufficient to help quiet any major criticism from the community.

Finally, in the wake of HCFA's decision on the Medicaid demonstration program discussed above, Nancy-Ann Min DeParle is looking into the possibility of a legislative proposal (which need not be budget neutral) for a model pilot project to expand eligibility to Medicaid for people with HIV earlier in the progression of their disease. As of this writing, we are dubious if such a proposal is feasible and whether it can be done in time for the budget process. However, the Vice President has requested that we review options in this regard.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Jason S. Goldberg (CN=Jason S. Goldberg/OU=WHO/O=EOP [WHO])

CREATION DATE/TIME: 8-DEC-1997 10:17:24.00

SUBJECT:

TO: Miriam H. Vogel (CN=Miriam H. Vogel/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michael Waldman (CN=Michael Waldman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jill M. Blickstein (CN=Jill M. Blickstein/OU=OMB/O=EOP @ EOP [OMB])
READ:UNKNOWN

TO: Marjorie Tarmey (CN=Marjorie Tarmey/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Peter A. Weissman (CN=Peter A. Weissman/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: June G. Turner (CN=June G. Turner/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Ruby Shamir (CN=Ruby Shamir/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michelle Crisci (CN=Michelle Crisci/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Eleanor S. Parker (CN=Eleanor S. Parker/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Janet L. Graves (CN=Janet L. Graves/OU=OMB/O=EOP @ EOP [OMB])
READ:UNKNOWN

TO: Laura K. Capps (CN=Laura K. Capps/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Antony J. Blinken (CN=Antony J. Blinken/OU=NSC/O=EOP @ EOP [NSC])
READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Cathy R. Mays (CN=Cathy R. Mays/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Terri J. Tingen (CN=Terri J. Tingen/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Sara M. Latham (CN=Sara M. Latham/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Kevin S. Moran (CN=Kevin S. Moran/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Scott R. Hynes (CN=Scott R. Hynes/O=OVP @ OVP [UNKNOWN])
READ:UNKNOWN

CC: SYLVIA (SKY) (Pager) #MATHEWS (SYLVIA (SKY) (Pager) #MATHEWS [UNKNOWN])
READ:UNKNOWN

CC: MARIA (SKY) (Pager) #ECHAVESTE (MARIA (SKY) (Pager) #ECHAVESTE [UNKNOWN])
READ:UNKNOWN

CC: BRUCE N. (Pager) #REED (BRUCE N. (Pager) #REED [UNKNOWN])
READ:UNKNOWN

CC: JILL M. (Pager) #BLICKSTEIN (JILL M. (Pager) #BLICKSTEIN [UNKNOWN])
READ:UNKNOWN

CC: MICHAEL A. (Pager) #WALDMAN (MICHAEL A. (Pager) #WALDMAN [UNKNOWN])
READ:UNKNOWN

CC: ANN F (Pager) #LEWIS (ANN F (Pager) #LEWIS [UNKNOWN])
READ:UNKNOWN

CC: SIDNEY (SKY) (Pager) #BLUMENTHAL (SIDNEY (SKY) (Pager) #BLUMENTHAL [UNKNOWN])
READ:UNKNOWN

CC: PAUL (Pager) #BEGALA (PAUL (Pager) #BEGALA [UNKNOWN])
READ:UNKNOWN

CC: RON (SKY) (Pager) #KLAIN (RON (SKY) (Pager) #KLAIN [UNKNOWN])
READ:UNKNOWN

CC: Demond T. Martin (CN=Demond T. Martin/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

CC: Nancy V. Hernreich (CN=Nancy V. Hernreich/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

CC: Carole A. Parmelee (CN=Carole A. Parmelee/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TEXT:

The POTUS State of the Union planning meeting today will start NOW

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
MIKE COHEN

SUBJECT: Proposed Budget Initiatives for Indian Education

Last July, a coalition of education-oriented groups from Indian Country proposed a Comprehensive Federal Indian Education policy statement, which emphasized the importance of Tribal governance of Indian Education, the preservation and revitalization of Native languages and cultures, and the need for equitable access to education resources. The coalition also proposed an Executive Order to implement this policy vision.

This proposal has been under review by DPC staff and the Domestic Policy Council Working Group on American Indians and Alaska Natives. Pending a determination as to whether the proposed Executive Order is desirable and likely to be effective in accomplishing its aims, we have begun to identify steps that can be taken right now to improve education for Native American students in schools controlled by the BIA and Tribes, as well as in the public schools attended by large numbers of Indian students.

The full set of initiatives we have developed summarized below. Most involve ensuring that new education proposals and existing funding streams effectively target resources to schools in Indian Country. In one area -- school construction and maintenance -- we are going further by proposing a significant increase in funds over previous appropriations levels.

Tribal School Construction Proposal

The BIA operates 185 residential and day schools serving 51,000 Native American students, approximately 10% of all Native American students in grades K-12. Enrollment in all BIA schools has increased by 25% since 1987. Enrollment in just the day schools has increased 47% since 1987 and 24% since 1992. Consequently, BIA schools have experienced significant problems with overcrowding. In addition, according to a forthcoming GAO report, BIA schools, compared to schools nationwide, (1) are generally in poorer physical condition; (2) have more "unsatisfactory environmental factors"; (3) more often lack key facilities required for education reform (e.g., science labs); and (4) are less able to support computer and communications technology. Overall, they are in worse condition than even inner-city schools.

We are recommending an increase of \$75 million over the FY 1998 appropriations (and an increase of \$69.4 million over the Department of Interior FY 1999 request) for three Bureau of Indian Affairs accounts for New School Construction, Facilities Improvement and Repairs, and Annual Operation and Maintenance.

The proposed increase would double funding for new school construction and for significant improvements and repairs of existing facilities. Compared to the BIA FY 1999 request, this step would double the number of new schools to be built from 2 to 4, and increase the number of schools undergoing significant improvements or repairs from 6 to 22. The higher budget request would also provide funds for needed portable classrooms, roof replacements, and other repairs. In addition, the annual maintenance budget would increase by 32%, which would help reduce the cost of future repairs.

| | FY98 Appropriations | FY99 BIA Request | FY99 DPC Recommendation |
|------------------------------------|---------------------|------------------|-------------------------|
| New School Construction | \$19.2 million | \$20.8 million | \$38.4 million |
| Facilities Improvement and Repairs | \$32.2 million | \$34.4 million | \$64.4 million |
| Operation and Maintenance | 74.6 million | \$76.6 million | \$98.2 million |
| Total | \$126 million | \$131.8 million | \$201 million |

The Tribes would view this proposal as a significant step forward in improving the quality of education for Indian students. Congressional delegations from the affected states also would receive the proposal warmly.

This proposal is especially important if you choose to propose a new school construction initiative on the tax side, because Tribes do not issue bonds for this purpose. Even if you choose to propose a school construction initiative on the spending side, this initiative would be valuable.

In the Administration's school construction proposal last year, 2% of the funds were set aside for a direct appropriation for Tribal schools, over and above the accounts discussed here. This funding, however, is contingent on the passage of a school construction proposal, and in any event, is insufficient to meet the Tribes' needs.

We have developed this proposal with the involvement and support of OMB, the Department of the Interior and the Department of Education.

Other Initiatives

We are working to make sure that other education initiatives that are proposed for FY99 include an appropriate set-aside for BIA schools and, where feasible, for public schools that serve a large concentration of Native American students. These include:

- Education Opportunity Zones. A percentage of grant funds will be set aside for administration by the BIA, and the Education Department will be encouraged to provide at least one grant to a rural school district with a large percentage of Native American students.
- Early Intervention College/School Partnerships. We are working to determine the best ways to ensure that Tribal Colleges can effectively participate in this initiative, as well as to fund other college/school partnerships in communities with a large percentage of Native American students.
- Child Care. The Child Care Block Grant already contains a set aside for administration by BIA. Proposed funding increases in this program will automatically benefit programs serving Native Americans on reservations.
- Technology. This year the BIA launched Access Native America, an initiative to implement the four pillars of your technology challenge and to connect all schools, classrooms, and libraries to the Department of Interior's Internet backbone by the year 2000. Within the past month, DPC arranged a meeting between BIA staff and the Schools and Libraries Corporation to help Tribal schools take advantage of the e-rate. As a result, the Corporation has agreed that BIA can apply for the e-rate on behalf of all Tribal schools, and BIA has begun to develop materials and plan training so that schools can complete the necessary applications.
- Teacher Preparation and Recruitment. This initiative, which you announced at the NAACP Convention on July 17, helps to prepare and recruit teachers to serve in high-poverty urban and rural communities. At the time this proposal was developed, we did not target funds to Tribal schools. We are in the process of preparing new legislative language to take care of that omission, and will work with our Congressional allies to incorporate it into our proposal.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Emily Bromberg (CN=Emily Bromberg/OU=WHO/O=EOP [.WHO])

CREATION DATE/TIME: 8-DEC-1997 11:19:12.00

SUBJECT:

TO: Jennifer L. Klein (CN=Jennifer L. Klein/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Nicole R. Rabner (CN=Nicole R. Rabner/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TEXT:

nobody really thought that i left that ridiculous article on the table after the child care meeting, did they? i, of course, did not. mickey must have (as is consistent with the fact that melanne commented on--that he sent it around to all of the senior staff!)

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Cynthia A. Rice (CN=Cynthia A. Rice/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 15:06:49.00

SUBJECT: NYC Caseload drop

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Christa Robinson (CN=Christa Robinson/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Andrea Kane (CN=Andrea Kane/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Diana Fortuna (CN=Diana Fortuna/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

Because the President is going to the Bronx on Wednesday, Christa thought Rahm might want NYC caseload numbers for the fact sheet. I got them, but it turns out they are not much to crow about, so I think we should leave them out.

Caseloads have dropped 15 percent in the New York State since Clinton became President and by slightly less than that -- 13 percent -- in New York City, compared to 27 percent in the nation as a whole. About 100,000 fewer people are on welfare in New York City (the rolls are down from about 770,000 to about 670,000 individuals).

DRAFT, CONFIDENTIAL, CLOSE HOLD
December 7, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING
CHRIS JENNINGS

SUBJECT: Health Insurance Coverage Initiatives in the FY 1999 Budget

Overview

Throughout your Administration, you have worked to enact legislation to expand access to affordable health insurance. Your signing of the Balanced Budget Act included an unprecedented \$24 billion investment for state-based children's health insurance programs. This historic initiative will clearly reduce the number of uninsured. However, there are other deserving populations whom we could target in our step-by-step reforms. These include the pre-65 year olds (referenced in the Medicare memo), workers between jobs, and workers in small businesses. In addition, we are working on possible proposals to expand Medicaid coverage to people with AIDS and disabilities through pilot programs. The policy development of these proposals is still underway, so we have not included them here.

Taken together, these are not large initiatives, summing to around \$10 billion over 5 years. This is less than half of the health investments enacted as part of the Balanced Budget Act and less than a fraction of the premium assistance proposed in the Health Security Act. Having said this, none of your advisors believe the Medicare and Medicaid savings left after last year's deficit reduction effort are sufficient to fund these initiatives. There may be \$0.5 to 1 billion over 5 years in Medicaid savings, but those savings will be difficult to achieve and there may be other claims on them (e.g., child care, benefits to immigrants). It could also be argued that, given the link between tobacco and health care, any residual revenue from the tobacco settlement or a tax could be considered for coverage initiatives, particularly those related to children.

Your advisors uniformly agree that we need to take all actions possible to achieve if not exceed your goal of increasing insurance coverage for 5 million children. A series of proposals are described to help accomplish that goal. There is less agreement on whether we address a new group of uninsured people in this budget. Labor strongly supports the workers between jobs demonstration; of all health initiatives in the budget, it is their highest priority. OMB also supports that demonstration if sufficient funds are available. While HHS believes that this proposal has merit, they are skeptical that it will achieve significant support since it has not in the past three years of trying.

A. CHILDREN'S HEALTH OUTREACH

The Children's Health Insurance Program (CHIP) provides funds for coverage of millions of working families' uninsured children, a population that previously had trouble affording coverage. It also builds upon a strong Medicaid program that this Administration has worked so hard to protect. However, important work remains to be done. In particular, we need to work with states to enroll the millions of uninsured children in these programs.

Medicaid eligible children are especially at risk of remaining uninsured. Over three million uninsured children are eligible for Medicaid. Educating families about their options and enrolling them in Medicaid has always been a problem, but it has recently become more challenging. The number of children covered by Medicaid leveled off in 1995 and, according to the Census, dropped by 6 percent in 1996. While some of this decline may be due to the lower number of children in poverty, some part may also result from families' misunderstanding of their children's continued eligibility for Medicaid regardless of the changes in welfare.

Options to Increase Outreach for Medicaid and the Children's Health Insurance Program

To address the need for children's health outreach, we propose a series of policy options. First, we could offer states enhanced match for enrolling children who are eligible but not previously enrolled in Medicaid, giving states an incentive to find these children. Second, we could build upon a new option in the Balanced Budget Act called "presumptive eligibility", that essentially allows children to be given temporary Medicaid coverage while they are being formally enrolled in CHIP or Medicaid. Third, we could modify the law to give states the flexibility to use their 90 percent matching for Medicaid outreach authorized as part of TANF for all children, not just those transitioning from welfare. Finally, we will continue to work on a series of policies to simplify the application and enrollment process, making it easier to access the system. Together, these initiatives could cost \$1.1 to 1.6 billion over five years (or more depending upon choices about the size of the incentive to states). Preliminary discussions with NGA and some children's advocates suggest they strongly support these efforts. In addition, the Administration is developing public-private partnerships to promote outreach.

Enhanced match for outreach. One option for improving state outreach is to provide enhanced match to enroll children who are eligible, but not previously enrolled in Medicaid. At the end of each year, if a state can document that it has increased its enrollment over its baseline, it would receive an increased matching amount per newly covered child or, alternatively, it could receive match through an increase in administrative payments. This policy rewards states only if they succeed in outreach, rather than just matching activities that may or may not work. Although its costs depend on the amount of the incentive and the ability to administer this system efficiently, we could probably constrain costs to \$0.5 to 1 billion over five years.

Moving outreach to schools and child care sites. We could build upon the presumptive eligibility provision in the Balanced Budget Act to make it easier to enroll children in Medicaid and CHIP. This could be done by changing the law to allow schools and appropriate child care sites, at the states' option, to determine "presumptive eligibility". This means that certified people may, using a simple test, give a child up to two months of Medicaid coverage on the spot as the formal application is processed. HCFA actuaries preliminarily estimate that this would cost \$400 million over 5 years (the cost of new coverage generated by these efforts). Also, under the BBA, states that use presumptive eligibility must pay for its costs out of the CHIP allotment, reducing the amount available for other coverage. States have advised us that this is a disincentive to take this new option. HCFA actuaries are still working on the costs.

Accessing 90 percent matching funds for outreach. A third way to increase funding for children's health outreach is to increase states' flexibility in using a special Medicaid fund set aside in TANF for outreach for children losing welfare. This \$500 million fund is currently allocated to states with a 90 percent matching rate for outreach activities to certain children. We could expand its use to all children, not just welfare children. HCFA actuaries preliminarily estimate that this would cost \$100 million over 5 years. NGA supports this change.

Simplifying enrollment. A simple, accessible enrollment process from beginning to end could encourage more families to enroll their children in Medicaid or CHIP. To help create such a process, we propose several actions, all of which are low cost initiatives. First, we could streamline the application process by simplifying Medicaid eligibility and by encouraging the use of simple, mail-in applications. HCFA has already developed a model, single application form for both Medicaid and CHIP. We could condition some of the financial incentives, described above, on using a single or simple application. Second, we are reviewing the feasibility and costs of a nationwide 1-800 number that will link families with their state or local offices. Such a number could be placed in public service announcements, on the bottom of school lunch program applications, and on children's goods like diaper boxes, for example, allowing families easy access to information.

Departmental Positions

There is unanimous support across agencies for focusing on children's health outreach. For HHS and Treasury, it is their first priority in all health initiatives. NEC/DPC and OMB believe that aggressive outreach will be needed to meet or exceed the Administration's goal of covering 5 million uninsured children. Although we believe this policy will receive validation by policy experts, children's advocates, and Governors alike, this package of outreach initiatives may be a communications challenge so soon after the enactment of the \$24 billion base children's health program. In addition, even if this new investment is made, we cannot guarantee that states will enroll all 3 million uninsured children who are eligible for Medicaid. Given the link between children's health and tobacco, we should also consider whether outreach could be done in the context of the tobacco settlement. We could, for example, consider

allowing states to keep some of the Federal funds if they use them for children's outreach.

B. WORKERS BETWEEN JOBS DEMONSTRATION

Families who lose health insurance while they are between jobs are a small but important group of uninsured Americans. These families pay for health insurance for most of their lives, but go through brief periods without coverage when they are temporarily unemployed. If they experience a catastrophic illness during this transition, the benefit of their years' worth of premium payments is lost. Worse, should a family lose insurance coverage during the period of unemployment, they will not be protected by the provisions of the Kassebaum-Kennedy legislation once they regain coverage. Coverage at that point could be subject to a new pre-existing condition exclusion period.

Limited Demonstration

This policy option is a modification of the program that we have carried in our last two budgets. It would award grants to several states to provide temporary premium assistance to eligible low-income families. States would use this money to partially subsidize families' premium payments for up to 6 months. To truly test how best to address this population's needs, we would select states using a range of approaches like a COBRA-based subsidy, Medicaid, or covering the parents of children covered by CHIP. Since it is a grant program, the costs are a policy choice. To give a sense of the coverage for the options, last year's \$10 billion proposal over four years covered about 3.3 million people with incomes below 240 percent of poverty. If we assume the same set of policy parameters, a demonstration of \$1 billion over 5 years would coverage about 230,000, of \$2.5 billion would cover about 600,000, and it would take about \$3.5 billion to cover about 800,000 people.

An alternative way to design a demonstration would be to scale back the income levels of the program. For instance, states could only receive assistance for persons whose income was less than 100 percent of the poverty level in all states. Such options would probably cost at least \$3 billion over five years. It is important to note that it would not be possible to use either Medicare or Medicaid savings to fund an initiative of this size.

Departmental Positions

On policy grounds, all of the agencies support this policy. It has been in our last two budgets because of its merits. This policy remains Labor's first priority. They view the unemployed uninsured as a particularly vulnerable and important group to target. They also believe that this is a particularly important policy in the context of the trade debate and worker insecurity issues. OMB would support this initiative if there are sufficient funds. HHS has always been supportive of this policy but feels as though circumstances have not changed to make this policy viable this year when it has not been in the past. They would focus the funds on the children's outreach option. DPC/NEC are concerned about dropping this policy altogether and do support a demonstration. However, if resources are limited, we would

advocate for the children's outreach initiative before this proposal.

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C. VOLUNTARY PURCHASING COOPERATIVES

Workers in small firms are most likely to be uninsured. Over a quarter of workers in firms with fewer than 10 employees lack health insurance — almost twice the nationwide average. While 88 percent of workers in firms with 250 or more workers are offered health insurance, only 41 percent of workers in firms with less than 10 workers are offered coverage. This results in large part from the fact that the small group health insurance market does not function as well as the large group market. Studies have shown that administrative costs are higher and that small businesses pay more for the same benefits as larger firms.

Grants to States

Given the disadvantages faced by small firms, the question is: are there policies that can make insurance more affordable for small businesses and their employees? In the last two budgets, we have included a policy to provide seed money for states to establish voluntary purchasing cooperatives. These cooperatives would allow small employers to pool their purchasing power to try to negotiate better rates for their employees. This year, we propose both the original policy and a variation: a competitive grant approach so that a more limited number of states could receive a smaller, but more targeted, pool of funds. The total costs would be \$50 to \$100 million over 5 years.

Departmental Positions

All agencies remain supportive of this policy and believe it should be included in this year's budget. It is important that we have some initiative that illustrates our understanding that a major problem of lack of insurance continues to exist in the small employer community. In the past, we have been unable to get this policy passed into law primarily because it has been viewed as an alternative to an initiative proposed by Congressman Fawell. His approach would make it easier for small businesses to self-insure and in so doing escape all state regulation. Governors and consumer groups have consistently opposed the Fawell approach, mostly because of the concern that the small group market will only be left with the most risky, most expensive groups, while all the low risk groups will move into the self-insured, non-regulated market. We have raised similar concerns and have also pointed out that a Fawell-type approach would eliminate all of the consumer protections state insurance regulation currently provides. Based on our preliminary conversations with Congressman Fawell, it may be that our impasse is resolvable since this is his last year as a Member of Congress and there are some compromises that seem within reach.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Diana Fortuna (CN=Diana Fortuna/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 17:36:47.00

SUBJECT: Children's SSI memo

TO: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

When you get a chance, you should take a look at the memo on the children's SSI report, since we may want to send it as early as cob Tuesday or Wednesday. (OMB is fine with it.)

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Thomas L. Freedman (CN=Thomas L. Freedman/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 11:36:07.00

SUBJECT: ADR and EEOC

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Mary L. Smith (CN=Mary L. Smith/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TEXT:

EEOC will come back to us by early afternoon with an estimate of how much it would cost to do ADR for everyone who wants it immediately, or if we ramped it up in three years. They say that it is really guesswork figuring how many people would want it-- they've hope to have done only 400 cases by the end of the first year of the program. I said figure it so that everyone could have the option. (Incidentally, they did have a succesful million settlement recently.)

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Cynthia A. Rice (CN=Cynthia A. Rice/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 13:04:15.00

SUBJECT: I spoke to Barbara Chow about a child support meeting

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

She was very hesitant to have one, saying that this proposal should be considered in the context of what initiatives people want to pay for, and that reviewed independently everyone would shoot it down. I said that it would be unfair to raise this only in the context of new initiatives because people would see it simply as a pay for without knowing there are policy objections.

I also said that even if we leave HHS of the loop, other people at the White House need to know, so they can prepare their bosses for the budget meetings, which she found difficult to argue against.

I think I'd like to send her a note, say we thought about it some more, and that we think I really need at a minimum to talk to Emily Bromberg and Emil Parker about it, whether or not we have a meeting. Okay?

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Diana Fortuna (CN=Diana Fortuna/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 09:54:13.00

SUBJECT: Re: Race Initiative Scheduling Memo, January 1998

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

I don't think CityYear has a program in D.C., so I'm not sure we can fit them into this event. But I'll check.

Elena Kagan

12/07/97 03:46:19 PM

Record Type: Record

To: Diana Fortuna/OPD/EOP

cc: Bruce N. Reed/OPD/EOP

Subject: Re: Race Initiative Scheduling Memo, January 1998

yes, as did bruce. let's get a request in to stephanie, along with a copy of the note the President wrote to us. Can we make a place for that Americorps program (CityYear??) that specifically focuses on race relations?

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Jason S. Goldberg (CN=Jason S. Goldberg/OU=WHO/O=EOP [WHO])

CREATION DATE/TIME: 8-DEC-1997 08:40:53.00

SUBJECT: POTUS State of the Union Mtg TODAY

TO: Miriam H. Vogel (CN=Miriam H. Vogel/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michael Waldman (CN=Michael Waldman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jill M. Blickstein (CN=Jill M. Blickstein/OU=OMB/O=EOP @ EOP [OMB])
READ:UNKNOWN

TO: Marjorie Tarmey (CN=Marjorie Tarmey/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Peter A. Weissman (CN=Peter A. Weissman/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: June G. Turner (CN=June G. Turner/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Ruby Shamir (CN=Ruby Shamir/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michelle Crisci (CN=Michelle Crisci/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Eleanor S. Parker (CN=Eleanor S. Parker/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Janet L. Graves (CN=Janet L. Graves/OU=OMB/O=EOP @ EOP [OMB])
READ:UNKNOWN

TO: Laura K. Capps (CN=Laura K. Capps/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Antony J. Blinken (CN=Antony J. Blinken/OU=NSC/O=EOP @ EOP [NSC])
READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Cathy R. Mays (CN=Cathy R. Mays/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Terri J. Tingen (CN=Terri J. Tingen/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Sara M. Latham (CN=Sara M. Latham/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Kevin S. Moran (CN=Kevin S. Moran/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Scott R. Hynes (CN=Scott R. Hynes/O=OVP @ OVP [UNKNOWN])
READ:UNKNOWN

CC: Demond T. Martin (CN=Demond T. Martin/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

CC: Nancy V. Hernreich (CN=Nancy V. Hernreich/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

CC: Carole A. Parmelee (CN=Carole A. Parmelee/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TEXT:

There will be a POTUS State of the Union planning meeting today at 10:15 a.m. in the Cabinet Room.

The following individuals are invited:

Erskine Bowles
Ron Klain
Paul Begala
Tony Blinken
Sid Blumenthal
Rahm Emanuel
Michael Waldman
Ann Lewis
Elena Kagan
Mark Penn
John Podesta
Sylvia Mathews
Doug Sosnik
Gene Sperling
Bruce Reed
Maria Echaveste
Sandy Berger
Frank Raines

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Thomas L. Freedman (CN=Thomas L. Freedman/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 12:45:50.00

SUBJECT: Conrad meeting

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

I think it would make sense to go ahead and do the Conrad meeting so they don't get the wrong idea.

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Paul J. Weinstein Jr. (CN=Paul J. Weinstein Jr./OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 20:25:04.00

SUBJECT: Budget Breakdown

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: William R. Kincaid (CN=William R. Kincaid/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Michael Cohen (CN=Michael Cohen/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Neera Tanden (CN=Neera Tanden/OU=WHO/O=EOP [WHO])

READ:UNKNOWN

CC: Nicole R. Rabner (CN=Nicole R. Rabner/OU=WHO/O=EOP [WHO])

READ:UNKNOWN

CC: Sarah A. Bianchi (CN=Sarah A. Bianchi/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Andrea Kane (CN=Andrea Kane/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Cynthia A. Rice (CN=Cynthia A. Rice/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Jose Cerda III (CN=Jose Cerda III/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Thomas L. Freedman (CN=Thomas L. Freedman/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Mary L. Smith (CN=Mary L. Smith/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Jeanne Lambrew (CN=Jeanne Lambrew/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Christopher C. Jennings (CN=Christopher C. Jennings/OU=OPD/O=EOP [OPD])

READ:UNKNOWN

CC: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP [WHO])

READ:UNKNOWN

CC: Julie A. Fernandes (CN=Julie A. Fernandes/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Tanya E. Martin (CN=Tanya E. Martin/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Jennifer L. Klein (CN=Jennifer L. Klein/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

CC: Leanne A. Shimabukuro (CN=Leanne A. Shimabukuro/OU=OPD/O=EOP @ EOP [OPD])

CHILD CARE

Tax Revenue Loss

| Proposal | FY 1999 | Five-Year |
|--|----------------|------------------|
| Modify the Child and Dependent Care Tax Credit (CDCTC) by raising the top rate from 30 percent (current law) to 50 percent and moving the phase-out range from \$10,000-\$28,000 (current law) to \$30,000-\$59,000. | \$270 million | \$5.2 billion |

| Proposal | FY 1999 | Five-Year |
|--|---|---|
| Provide a tax credit to businesses that incur costs related to providing child care services to their employees. | \$637 million (based on JCT costing of Senator Kohl's proposal) | \$2.6 billion (based on JCT costing of Senator Kohl's proposal) |

Discretionary Spending

| Proposal | FY 1999 | Five-Year |
|--|---|------------------|
| Increase federal investment in the Child Care and Development Block Grant (CCDBG) and structure the increased investment to include a new set-aside for standards enforcement. | \$800 million (\$700 million in HHS budget request) | \$4 billion |

| Proposal | FY 1999 | Five-Year |
|--|--|------------------|
| Establish the Child Care Provider Scholarship Fund | \$50 million (\$150 million in HHS budget request) | \$250 million |

| Proposal | FY 1999 | Five-Year |
|---|----------------|--|
| Expand the Child Care Apprenticeship Training | | Program to fund the training of child care |

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providers working toward a degree equivalent to the Child Development Associate degree, with on the job observation and practice.

FY 1999

\$10 million (DOL budget request)

Five-Year

\$27 million (DOL budget request)

Proposal

Establish a Child Care Research and Evaluation Fund to support data and research and technology development and utilization.

FY 1999

\$50 million (HHS budget request)

Five Year

\$250 million

Proposal

Establish an Early Learning and Quality Fund to provide challenge grants to communities for early learning and parent involvement activities.

FY 1999

\$200 to \$400 million (\$800 million in HHS budget request)

Five-Year

\$1 to \$2 billion

Proposal

Increase the Early Head Start (children 0-3) set-aside (5 percent under current law), while increasing overall funding in Head Start to ensure that boosting the set-aside does not reduce the resources available for children 3-5.

FY 1999

\$30 million

Five-Year

\$500 million (based on NEC option to double Early Head Start set-aside)

Proposal

Expand the 21st Century Community Learning Center Program to provide start-up funds to additional school-community

partnerships to establish before- and after-school programs for school-age children at public schools.

FY 1999

\$100 million (\$400 million in DOE request)

Five Year

\$500 million

Proposal

FY 1999

Five Year

Establish a demonstration project for states to test innovative approaches to assisting parents who to stay at home with their children.

N/A

N/A

CIVIL RIGHTS ENFORCEMENT

Discretionary Spending

| Proposal | FY 1999 | Five-Year |
|---|----------------|------------------|
| Civil Rights Enforcement Initiative -- The initiative involves EEOC and six agencies who have jurisdiction of civil rights enforcement. Funds will be used for activities such as alternative dispute resolution, increased compliance targeting, improved technology and data collection, and reduction in case backlog. | \$58 million | N/A |

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CRIME

Discretionary Spending

Proposal

FY 1999

Five-Year

Community-Based
Prosecutors & Justice

\$100 Million

\$500 Million

EDUCATION

Mandatory Spending

| Proposal | FY 1999 | Five-Year |
|---------------------|----------------|------------------|
| Class Size | \$615 Million | \$9.2 Billion |
| Proposal | FY 1999 | Five-Year |
| School Construction | \$5 Billion | \$5 Billion |

Discretionary Spending

| Proposal | FY 1999 | Five-Year Cost |
|---|----------------|-----------------------|
| Education Opportunity Zones ¹ | \$320 Million | \$1.1 Billion |
| Proposal | FY 1999 | Five-Year |
| School/College Partnership ² | \$300 Million | \$2.9 Billion |
| Proposal | FY 1999 | Five-Year |
| Hispanic Education Initiative | \$153 Million | \$765 Million |
| Proposal | FY 1999 | Five-Year |
| Indian Education Initiative | \$75 Million | \$375 Million |
| Proposal | FY 1999 | Five-Year |
| Technology Teacher Training \$100 Million | | \$500 Million |
| Proposal | FY 1999 | Five-Year |
| Learning on Demand | \$50 Million | \$250 Million |

¹This could be shifted to the mandatory spending side if necessary

²This could be shifted to the mandatory spending side if necessary

HEALTH CARE

Mandatory Spending

| Proposal | FY 1999 | Five-Year |
|--|------------------------|-----------------------|
| Medicare -- Pre-65 Coverage Initiative | Up to \$1 billion | Up to \$5 billion |
| Proposal | FY 1999 | Five-Year |
| Medicare -- Clinical Cancer Trial Coverage | \$200 to \$400 million | \$1.7 to \$2 billion |
| Proposal | FY 1999 | Five-Year |
| Medicare -- Private Long-Term Options | \$5 to \$50 million | \$25 to \$300 million |

Coverage Initiatives

| | | |
|--------------------------------------|------------------------|-----------------------|
| Proposal | FY 1999 | Five-Year |
| Children's Health Outreach | \$300 million | \$1 to \$2 billion |
| Proposal | FY 1999 | Five-Year |
| Workers Between Jobs Demonstration | \$250 to \$500 million | \$0.5 to \$3 billion |
| Proposal | FY 1999 | Five-Year |
| Voluntary Purchasing Cooperatives | \$10 to \$20 million | \$50 to \$100 million |
| Proposal | FY 1999 | Five-Year |
| National Institutes on Health Budget | \$1 billion | \$10 to \$15 billion |

Discretionary Spending

| Proposal | FY 1999 | Five-Year |
|----------------------------|----------------|------------------|
| Race and Health Initiative | \$100 million | N/A |
| AIDS Spending | \$115 million | N/A |

HOUSING/WELFARE

Mandatory Spending

| Proposal | FY 1999 | Five-Year |
|--|---------------------|------------------|
| 50,000 Welfare to Work Housing Vouchers | \$100-\$200 million | \$1.3 billion |

Tax Revenue Loss

| Proposal | FY 1999 | Five-Year |
|--|----------------|------------------|
| Raise the cap on the Low Income Housing Tax Credit (LIHTC) | \$120 million | \$600 million |

Discretionary Spending

| Proposal | FY 1999 | Five-Year |
|-----------------------------|----------------|------------------|
| Homeownership Initiative | \$30 million | \$150 million |

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Cynthia A. Rice (CN=Cynthia A. Rice/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 12:28:18.00

SUBJECT: I'm going to tell HHS they can send this California child support letter t

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Emily Bromberg (CN=Emily Bromberg/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Bruce N. Reed (CN=Bruce N. Reed/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TEXT:

unless any of you want to scrutinize further. Here's the description you all received Friday --

On November 20th, California and Lockheed Martin mutually decided to cancel their child support computer systems contract due to operational problems and cost overruns. This puts the state out of compliance with what is called the Advance Planning Document -- the plan that the state submits to HHS for approval in order to get federal funds to help pay for the computer systems costs.

HHS has drafted a letter from one of their OCSE staff to the state saying that the feds will not pay for any more computer systems development until the state submits, and has approved, a new Advanced Planning Document. (The rest of federal financial support for child support enforcement will continue to be provided.) Although this letter is from a mid-level staffer to the state welfare director, I reviewed it for content and tone. Do you want to see this letter?

Keep in mind that this letter is particular to California, because of its problems with its contractor. However, after January 1, HHS will need to send to all the states that do not have operating statewide computer systems a notice of intent to disapprove their child support enforcement plans. As you know, states without approved state plans get no federal child support dollars of any kind. However, states will continue to receive federal funds until the appeal process is concluded, which could last until 1999 (longer for judicial appeals)

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Jason S. Goldberg (CN=Jason S. Goldberg/OU=WHO/O=EOP [WHO])

CREATION DATE/TIME: 8-DEC-1997 10:05:27.00

SUBJECT: TIME CHANGE -- POTUS State of the Union Mtg TODAY

TO: Miriam H. Vogel (CN=Miriam H. Vogel/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michael Waldman (CN=Michael Waldman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Laura Emmett (CN=Laura Emmett/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jill M. Blickstein (CN=Jill M. Blickstein/OU=OMB/O=EOP @ EOP [OMB])
READ:UNKNOWN

TO: Marjorie Tarmey (CN=Marjorie Tarmey/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Peter A. Weissman (CN=Peter A. Weissman/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: June G. Turner (CN=June G. Turner/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Ruby Shamir (CN=Ruby Shamir/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michelle Crisci (CN=Michelle Crisci/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Eleanor S. Parker (CN=Eleanor S. Parker/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Janet L. Graves (CN=Janet L. Graves/OU=OMB/O=EOP @ EOP [OMB])
READ:UNKNOWN

TO: Laura K. Capps (CN=Laura K. Capps/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Antony J. Blinken (CN=Antony J. Blinken/OU=NSC/O=EOP @ EOP [NSC])
READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Cathy R. Mays (CN=Cathy R. Mays/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Terri J. Tingen (CN=Terri J. Tingen/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Sara M. Latham (CN=Sara M. Latham/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Kevin S. Moran (CN=Kevin S. Moran/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Scott R. Hynes (CN=Scott R. Hynes/O=OVP @ OVP [UNKNOWN])

READ:UNKNOWN

CC: Demond T. Martin (CN=Demond T. Martin/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

CC: Nancy V. Hernreich (CN=Nancy V. Hernreich/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

CC: Carole A. Parmelee (CN=Carole A. Parmelee/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TEXT:

The POTUS State of the Union planning meeting today will start at 10:30 a.m. at the earliest in the Cabinet Room.

The following individuals are invited:

Erskine Bowles
Ron Klain
Paul Begala
Tony Blinken
Sid Blumenthal
Rahm Emanuel
Michael Waldman
Ann Lewis
Elena Kagan
Mark Penn
John Podesta
Sylvia Mathews
Doug Sosnik
Gene Sperling
Bruce Reed
Maria Echaveste
Sandy Berger
Frank Raines

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Jeanne Lambrew (CN=Jeanne Lambrew/OU=OPD/O=EOP [OPD])

CREATION DATE/TIME: 8-DEC-1997 08:33:38.00

SUBJECT: Re: coverage memo -- in case you don't already have enough to read

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])

READ: UNKNOWN

TEXT:

This went to Depts. last night for review by 1pm today so it has yet to reflect their comments. Given that they all have been making alot, if you want to see those, we can get you a draft by 2ish. I don't know if you spoke with Chris after about 9pm last night, but apparently Sperling thinks that all of the health memos should go in simultaneously by COB today.

On another topic, per Chris's instructions, I wrote a note to Josh and his staff person saying that you / Chris and I might want to set up a meeting late this morning to go over tables for tobacco meeting later. Chris wasn't quite sure how you wanted to deal with this but he thought if nothing else we should put people on notice that we want to see the tables earlier than just being shown them at the meeting. Let me know what to do.

Thanks, Jeanne

RECORD TYPE: PRESIDENTIAL (NOTES MAIL)

CREATOR: Sean P. Maloney (CN=Sean P. Maloney/OU=WHO/O=EOP [WHO])

CREATION DATE/TIME: 8-DEC-1997 10:13:15.00

SUBJECT: The President's Trip to NY/FL

TO: Jonathan Orszag (CN=Jonathan Orszag/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Jonathan H. Adashek (CN=Jonathan H. Adashek/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Daniel Wexler (CN=Daniel Wexler/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Dorian V. Weaver (CN=Dorian V. Weaver/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Christopher Wayne (CN=Christopher Wayne/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michael Waldman (CN=Michael Waldman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Peter G. Umhofer (CN=Peter G. Umhofer/OU=CEQ/O=EOP @ EOP [CEQ])
READ:UNKNOWN

TO: Barry J. Toiv (CN=Barry J. Toiv/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Marjorie Tarmey (CN=Marjorie Tarmey/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Stephanie S. Streett (CN=Stephanie S. Streett/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Darby E. Stott (CN=Darby E. Stott/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Craig T. Smith (CN=Craig T. Smith/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Joshua Silverman (CN=Joshua Silverman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Laura D. Schwartz (CN=Laura D. Schwartz/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Christa Robinson (CN=Christa Robinson/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: John Podesta (CN=John Podesta/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jennifer M. Palmieri (CN=Jennifer M. Palmieri/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Elizabeth R. Newman (CN=Elizabeth R. Newman/OU=WHO/O=EOP @ EOP [WHO])

READ:UNKNOWN

TO: Kevin S. Moran (CN=Kevin S. Moran/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Linda L. Moore (CN=Linda L. Moore/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Anne E. McGuire (CN=Anne E. McGuire/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Sylvia M. Mathews (CN=Sylvia M. Mathews/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Bruce R. Lindsey (CN=Bruce R. Lindsey/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Christopher J. Lavery (CN=Christopher J. Lavery/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Karin Kullman (CN=Karin Kullman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Kirk T. Hanlin (CN=Kirk T. Hanlin/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Cynthia M. Jasso-Rotunno (CN=Cynthia M. Jasso-Rotunno/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Phu D. Huynh (CN=Phu D. Huynh/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Russell W. Horwitz (CN=Russell W. Horwitz/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Jason S. Goldberg (CN=Jason S. Goldberg/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: D. Stephen Goodin (CN=D. Stephen Goodin/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Andrew Friendly (CN=Andrew Friendly/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Shelley N. Fidler (CN=Shelley N. Fidler/OU=CEQ/O=EOP @ EOP [CEQ])
READ:UNKNOWN

TO: Anne M. Edwards (CN=Anne M. Edwards/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jennifer D. Dudley (CN=Jennifer D. Dudley/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Brenda B. Costello (CN=Brenda B. Costello/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Carolyn E. Cleveland (CN=Carolyn E. Cleveland/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jose Cerda III (CN=Jose Cerda III/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Emily Bromberg (CN=Emily Bromberg/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: David S. Beaubaire (CN=David S. Beaubaire/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Nicholas R. Baldick (CN=Nicholas R. Baldick/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Brenda M. Anders (CN=Brenda M. Anders/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Amy W. Tobe (CN=Amy W. Tobe/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jon P. Jennings (CN=Jon P. Jennings/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Cecily C. Williams (CN=Cecily C. Williams/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Paul J. Weinstein Jr. (CN=Paul J. Weinstein Jr./OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Christopher F. Walker (CN=Christopher F. Walker/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Ann F. Walker (CN=Ann F. Walker/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Beth A. Viola (CN=Beth A. Viola/OU=CEQ/O=EOP @ EOP [CEQ])
READ:UNKNOWN

TO: June G. Turner (CN=June G. Turner/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michael V. Terrell (CN=Michael V. Terrell/OU=CEQ/O=EOP @ EOP [CEQ])
READ:UNKNOWN

TO: Jordan Tamagni (CN=Jordan Tamagni/OU=WHO/O=EOP @ EOP [UNKNOWN])
READ:UNKNOWN

TO: Aviva Steinberg (CN=Aviva Steinberg/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Todd Stern (CN=Todd Stern/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Stephen B. Silverman (CN=Stephen B. Silverman/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jake Siewert (CN=Jake Siewert/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Dan K. Rosenthal (CN=Dan K. Rosenthal/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Sarah J. Reber (CN=Sarah J. Reber/OU=CEA/O=EOP @ EOP [CEA])

READ:UNKNOWN

TO: Simeona F. Pasquil (CN=Simeona F. Pasquil/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Peter R. Orszag (CN=Peter R. Orszag/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Mary Morrison (CN=Mary Morrison/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Minyon Moore (CN=Minyon Moore/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Megan C. Moloney (CN=Megan C. Moloney/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Andrew J. Mayock (CN=Andrew J. Mayock/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Joseph P. Lockhart (CN=Joseph P. Lockhart/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Ann F. Lewis (CN=Ann F. Lewis/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Sara M. Latham (CN=Sara M. Latham/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Joshua A. King (CN=Joshua A. King/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Elena Kagan (CN=Elena Kagan/OU=OPD/O=EOP @ EOP [OPD])
READ:UNKNOWN

TO: Katherine Hubbard (CN=Katherine Hubbard/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Nancy V. Hernreich (CN=Nancy V. Hernreich/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Laura A. Graham (CN=Laura A. Graham/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Jeremy M. Gaines (CN=Jeremy M. Gaines/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Karen E. Finney (CN=Karen E. Finney/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Paul K. Engskov (CN=Paul K. Engskov/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Maria Echaveste (CN=Maria Echaveste/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Suzanne Dale (CN=Suzanne Dale/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Michael Cohen (CN=Michael Cohen/OU=OPD/O=EOP @ EOP [OPD])

READ:UNKNOWN

TO: Daniel K. Chang (CN=Daniel K. Chang/OU=CEA/O=EOP @ EOP [CEA])
READ:UNKNOWN

TO: Laura K. Capps (CN=Laura K. Capps/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Debra D. Bird (CN=Debra D. Bird/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Barbara A. Barclay (CN=Barbara A. Barclay/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Kris M Balderston (CN=Kris M Balderston/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TO: Lori L. Anderson (CN=Lori L. Anderson/OU=WHO/O=EOP @ EOP [WHO])
READ:UNKNOWN

TEXT:

On Tuesday evening, December 9, 1997, the President will travel to New York City to tour the Jewish Heritage Museum and attend a Human Rights Day reception. On Wednesday, December 10, the President will tour a South Bronx neighborhood and attend a DCCC dinner and a DNC Hispanic gala, before flying to Miami, Florida. In Miami on Thursday, December 11, the President will attend a Coast Guard drug seizure event, a lunch for Buddy Mackay, a DNC gala and a DNC dinner, before returning to the White House.

Deadlines for the President's trip book are as follows:

NY & FL Background Memos

DUE MON. DEC. 8 AT 6:00 P.M.

- Political Memos
- CEQ Hot Issues
- Cabinet Affairs Hot Issues
- Accomplishments

NY Event Memos

DUE MON. DEC. 8 AT 6:00 P.M.

- Human Rights Day Museum Tour and Reception
- Charlotte Gardens Neighborhood Tour & Remarks
- DCCC Dinner
- DNC Hispanic Gala

FL Event Memos

DUE TUE. DEC. 9 AT 10 A.M.

- Coast Guard Drug Seizure Event
- Buddy Mackay Luncheon
- DNC Gala
- DNC dinner

Please call or e-mail me if you have any questions. Thanks.