

SEP 20 1996

1 96

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala

DES

Today, 10 million—14 percent—of children are uninsured. Ninety percent of all uninsured children come from working families. Addressing the needs of these children requires a multi-dimensional approach:

- increase insurance coverage through Medicaid by reaching those eligible but not enrolled;
- guarantee twelve month eligibility for those children already enrolled in Medicaid;
- enhance partnerships with the states and private sector to help provide insurance for children; and
- expand access to community based care.

THE CHILDREN'S HEALTH INITIATIVE

Our goal ought to be to improve the insurance and access needs of half of the 10 million uninsured children. Because there is no single reason why these children are uninsured, no single solution effectively and efficiently addresses the problem. We also know that enrollment in insurance does not ensure access to quality care.

We must fulfill the promise of our existing programs and build upon innovative state programs for uninsured children. We must also allow states and communities to target efforts that best meet the needs of their children. Our initiative does not include federal subsidies to families with uninsured children because subsidies are generally costly, may require very high subsidy levels to attract the currently uninsured into a program, and may inadvertently substitute for employer subsidized insurance. The overall investment is almost \$12 billion over five years, of which \$4.7 billion has no scoring implications. The specific provisions and costs for the initiative to address the important health care needs of our nation's children are discussed below (see attached chart).

I. Medicaid Initiatives

A. Work with states to fulfill the promise of Medicaid for children who are already eligible under current law. An estimated 3 million children are currently eligible for Medicaid but not

PAGE 2 - MEMORANDUM FOR THE PRESIDENT

enrolled. Our proposal assumes that up to two-thirds of these children could be enrolled into Medicaid with enhanced outreach and other efforts targeted at enrolling eligible children. Full enrollment of all Medicaid eligible individuals has been a challenge since the enactment of Medicaid, and this challenge will continue as the new welfare reform bill is implemented. We must:

- eliminate barriers to effective enrollment of eligible children through managed care and other Medicaid state programs;
- streamline eligibility by enhancing the federal/state partnership and providing best-practice models and other technical assistance to states;
- increase coordination with other federal programs (day care, Head Start, school health, community health centers, food stamps, WIC) to improve outreach and enrollment;
- increase collaboration with foundations and insurers/managed care organizations to identify innovative ways to improve enrollment;
- develop public information campaigns to inform the public about opportunities to enroll in Medicaid; and
- encourage state use of 1115 authority to expand Medicaid coverage and enrollment.

This initiative will cover an additional two million children. This off-budget proposal will increase the cost of the Medicaid baseline by \$4.7 billion for FY 1998-2002.

B. Extend continuous coverage for children age 1 year and older. In 1990, Congress required continuous eligibility for pregnant women throughout their pregnancy and for three months postpartum, and for infants through the first 12 months of life. This proposal will provide states with the option to allow continuous coverage to children for one year after eligibility is determined. Doing so will guarantee more stable coverage for children and better continuity of health care services. In addition, it will reduce the administrative burden on Medicaid officials, health care providers, social service providers, and families who are required to refile paperwork for children's eligibility determination.

This initiative will cover an additional 1.25 million children. This proposal is estimated to cost \$3.5 billion for FY 1998-2002.

PAGE 3 - MEMORANDUM FOR THE PRESIDENT

II. State Demonstrations

Provide funding for states to support innovative partnerships to insure children not otherwise qualified to receive Medicaid or employer sponsored benefits. Numerous states have joined forces with insurers, providers, employers, schools, corporations and others to develop innovative ways to provide coverage to uninsured children. We ought to provide matching funds to expand the number of states participating in such programs and to increase the number of uninsured children who have access to such programs. States will be given wide latitude in program design but will be required to assure the receipt of critical services including well-child care and other related services to reduce childhood morbidity and mortality. To manage costs, programs may include cost-sharing, managed care, and competitive bidding.

- Under this program, States will be encouraged to enhance efforts to enroll eligible children in Medicaid and to expand coverage to other children by creating new opportunities for insurance coverage thereby creating a seamless system of care for children in their state.

- For children not otherwise eligible for Medicaid, States will establish income guidelines, eligibility criteria including limits on access to employer-subsidized insurance, benefits, copayments and premiums up to the full cost of the program. States may limit coverage of items and services under the project, but will be required to assure the receipt of critical services including well-child care and other related services to reduce morbidity and mortality.

- Evaluations will be conducted on the effect of these efforts to learn about: (1) access to health care; (2) changes in health care insurance coverage; (3) costs with respect to health care; (4) benefits, premiums and cost sharing.

This initiative will cover an additional 1.5 million children per year. It is estimated to cost \$750 million per year, for a total of \$3.75 billion for FY 1998-2002.

III. Safety Net Initiatives

Enhance access to care through school health centers and consolidated health centers (CHCs). We will provide increased targeted funding for CHCs to enhance and expand services to working families and their children, including children enrolled in day care, Head Start programs, and schools. To strengthen the safety net of community-based providers in urban and rural areas, these funds will be directed to communities with high levels of uninsured children, including EZ/EC communities. Funds will be used to increase CHCs capacity to serve uninsured children and their families and to better meet the needs of those in their community whose insurance coverage is fragmented or incomplete. In addition to increasing their own capacity, CHCs will serve as a focal point for marshaling public and private community resources directed

PAGE 4 - MEMORANDUM FOR THE PRESIDENT

at child health and, with their partners, taking steps to mesh child health and related services into local integrated systems that serve children and their families.

We will also provide communities with the option of serving their children through school health centers. This effort will provide children with comprehensive primary care services including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services, health education and preventive dental care. School health centers will also be encouraged to link to other appropriate programs, including Healthy Start, state Maternal and Child Health, Head Start, Community Schools, and Empowerment Zones/Enterprise Communities. We will encourage programs to develop billing systems to collect third party payment and participate in a community-wide health care delivery system.

This initiative will serve an additional 250,000 children per year. The cost of these programs to the discretionary budget will be \$25 million per year, for a total cost of \$125 million for the FY 1998-2002.

I look forward to working with you to fulfill our promise to children by making health care more affordable and accessible through these efforts.

Attachment

Children's Health Care Coverage Initiatives

	Coverage by End of 2000	Cost in FY 02	5 Year Cost (FY 98-02)
1. Expanded Medicaid Outreach (off-budget) 66% Success Rate	2 million children	\$1.5 billion	\$4.7 billion
2. Enhanced State Partnerships	1.5 million children	\$750 million	\$3.75 billion
3. 12 Month Eligibility Option	1.25 million children	\$1.1 billion	\$3.5 billion
Totals	4.75 million children	\$3.35 billion	\$11.95 billion



DEC - 6 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala

I appreciate this opportunity to lay out for you the accomplishments of the Department of Health and Human Services during your first term and indicate the priorities of my Department for the second term. Four years ago, you and I agreed that the American people deserve a government that works better and costs less. I remain committed to continuing the real progress we have made thus far.

ACCOMPLISHMENTS

During the last four years, we have made great strides to protect and improve the health and welfare of the American people. Guided by the goals of a healthier and more independent citizenry, this Department has made progress in a variety of ways: increased coverage and choice in the Medicare and Medicaid programs; record-high rates of infant immunizations, the lowest rates of infant mortality in U.S. history, and significantly lower levels of preventable childhood disease; more and better treatment options for individuals living with AIDS; breakthroughs in breast cancer research; more children enrolled in Head Start; increased child support collections; and more people earning a paycheck rather than collecting a welfare check. Meanwhile, we continued our drive to improve customer service, tighten management, cut red tape, and reduce waste, fraud and abuse in all our programs.

Specifically, we have made progress in the following areas:

A. Improving Health Care

- Approved 15 statewide Medicaid waivers, expanding coverage for 2.2 million Americans;
- Protected coverage for 25 million working Americans through enactment of the Kennedy-Kassebaum Law;
- Extended the solvency of the Medicare trust fund into the 21st century;
- Reduced the rate of growth in Medicaid spending from 9 percent in FY93 to 3 percent in FY96;

- Expanded choice in both Medicare and Medicaid while adding important prevention benefits, such as flu shots;
- Improved access to promising treatments by cutting the median approval time for new drug and biologic products by 35 percent since the early 1990's;
- Achieved breakthrough scientific advances including the identification of genes for common disorders such as Parkinson's disease and prostate cancer;
- Collected more than \$15 billion in savings from anti-fraud and abuse activities; and,
- Increased funding for the Ryan White CARE Act by 158 percent, tripled funding for AIDS Drug Assistance Programs, and approved nine new drugs for treating AIDS in record time.

B. Reforming Welfare

- Approved 79 welfare reform waivers for 43 states -- more than all previous Administrations combined -- to give states the flexibility they need to promote work and protect children. As a result of these policies and the improved economy, the Nation's welfare rolls have decreased by over 2 million;
- Enacted a comprehensive, bipartisan welfare reform law;
- Imposed tough new child support enforcement measures. As a result, the Federal-State partnership collected a record \$11.8 billion in child support in 1996, an increase of nearly 50 percent since 1992. In addition, paternity establishments increased by over 50 percent from 1992 to 1996;
- Increased child care funding and provided new grants to help states improve the health and safety of child care programs; and,
- Expanded efforts to prevent out-of-wedlock teenage pregnancies and ensure that communities engage in local efforts to prevent teenage pregnancy. After rising steadily from 1986 to 1991, the birth rate for teens aged 15-19 declined for the fourth straight year in 1995, according to our preliminary figures.

C. Investing in Children and Families

- Launched a major initiative to restrict tobacco access and marketing to children in an effort to prevent kids from using tobacco products.

- Reduced the rates of infant mortality, Sudden Infant Death Syndrome (SIDS), and many common childhood diseases to all-time lows;
- Increased the rates of childhood immunization and early prenatal care to historic highs;
- Provided guidance for healthy lifestyles through dietary guidelines and the Surgeon General's Report on Physical Activity and Health;
- Expanded and improved Head Start by: increasing Head Start funding to serve 130,000 more children and their families, enhancing the quality of Head Start services, and launching a new initiative to serve infants and toddlers; and,
- In coordination with the Office of National Drug Control Policy, moved aggressively in prevention, treatment, research and public education about substance abuse -- with a particular focus on preventing substance abuse by young Americans.

D. Protecting Women's Health

- Assured women of a minimum of 48 hours in the hospital following vaginal delivery and 96 hours following cesarean delivery;
- Responded to the significant threat posed by breast cancer with increased efforts in research, prevention and treatment, including: the National Action Plan on Breast Cancer, new mammography quality standards, a new Office of Cancer Survivorship, and a dramatic increase in federal resources devoted to breast cancer research; and,
- Forged a partnership with the Department of Justice to combat domestic violence, through creating a toll-free HHS hot-line, establishing an advisory council on violence against women, and implementing the Violence Against Women Act.

E. Reinventing and Streamlining Government

- Reduced staffing by nearly 7,700 FTEs or 12 percent between 1993 and 1996, allowing HHS to achieve the President's streamlining goals nearly three years ahead of time; and,
- Eliminated an entire management level in the Department, flattening the organization; Delegated major new authorities to operating components.

SECOND TERM PRIORITIES

Although we have made great progress in the past four years, the Nation still faces tremendous health and human service challenges related to new technology, advances in biomedical research, demographic changes and transformations in the structure and delivery of health care and social services. In the second term, the Department plans to ensure that our public health and social services programs have the flexibility to address these changes and that they reflect the impact of health care reform and the transformation of welfare policies.

Specifically, we will continue to invest in the health and welfare of Americans by pursuing the following initiatives:

Ensure that Children Have Access to Health Insurance and Health Care Services: Today in the United States 10 million out of 70 million children are uninsured, and many more children are underinsured, with limited access to critical preventive and primary care services. We will continue to phase in coverage of 1 million children under current law. In order to expand health coverage for additional uninsured children, we will pursue a three-part strategy:

- Increase Medicaid enrollment among the 3 million children who are eligible for the program under current law but not yet enrolled;
- stimulate the expansion and replication of successful State efforts to increase health care coverage among their uninsured children through innovative public-private partnerships; and,
- Expand access to those community-based services which are positioned to serve high concentrations of uninsured children, e.g., school-based or school-linked health centers or Consolidated health Centers.

Improve Key Indices of Child Health: Building on our success to date, we will continue our progress in increasing early prenatal care for pregnant women, reducing infant mortality, and increasing childhood immunization rates.

Reduce Tobacco Use By Children: HHS will continue its efforts to develop and implement tobacco prevention and control programs that focus on reducing tobacco use among young children through the FDA regulations governing access and advertising and the implementation of the Synar regulations which require states to enforce their tobacco laws in order to receive federal funds.

Accelerate the Fight Against Drug Abuse: Since 1991, drug use among teenagers -- most notably marijuana use - has increased steadily. The Department plans to expand and enhance its ongoing comprehensive efforts to prevent substance abuse among young Americans, particularly marijuana use. We will continue to do ground-breaking research on treatment and prevention strategies and expand substance abuse efforts that include partnerships with families, communities, schools, religious organizations, businesses, and young people themselves.

Continue Our Progress in Fighting the War on AIDS: Our investment in basic research and AIDS research in particular has begun to pay significant dividends for people living with HIV/AIDS. New treatments, such as protease inhibitors, are offering a much-improved quality of life and the potential for extended life expectancy. We must continue this investment, especially in the areas of vaccine research and development, microbicide development, and prevention science. At the same time, we must continue to assure access to these new treatments through Medicaid, the Ryan White CARE Act, and other mechanisms:

Support Vital Medical Research: We will continue our investment in research to maintain our Nation's position of world leadership in the medical sciences. Scientific opportunities abound in areas such as AIDS, genetic medicine, the biology of brain disorders, basic pathogenesis research, the use of computers and advanced instrumentation, and therapeutic drug development.

Continue to Improve Women's Health: The Department will continue to focus increased resources and national attention on women's health issues, expanding our commitment to a comprehensive, science-based approach to address longstanding inequities in women's health. We will increase our efforts to improve women's lives, including fighting breast cancer and domestic violence; enhancing funding for women's health research and services; and focusing on reproductive health as well as addressing the needs of older women.

Help Move More People from Welfare to Work: HHS is firmly committed to the central goal of welfare reform: moving people from welfare to work. We will expand our investments in providing access to quality child care and stronger child support enforcement, to ensure that people can support themselves and their families. In addition, our highest priority is to work to ensure that, in the transition to the new welfare system, states have the flexibility they need in restoring health insurance to vulnerable groups such as legal immigrants, streamlining and simplifying their Medicaid eligibility rules and process, while protecting Medicaid coverage for all eligible individuals. We also will be working with other departments to address provisions in the law that reduced funding for food stamps for working families who have high shelter costs and hurt legal immigrants who fall on hard times through no fault of their own.

Maintain the Federal Guarantee of Medicaid for Low-Income Women, Children, and Frail Seniors: We must continue our efforts to preserve the Medicaid guarantee of coverage for families in poverty, those who are living with disabilities, and frail seniors in nursing homes. We will continue to support the efforts of individual states to expand coverage through the waiver process.

Ensure the Solvency on the Medicare Trust Fund While Making Improvements to that Vital Program: The Medicare program faces both a short-term and a long-term problem in terms of its financing. We need to stabilize the short-term financing of the Hospital Insurance (HI) Trust Fund so that it remains solvent into the middle of the next decade. At the same time, we must continue to restructure and improve the Medicare program so that it includes a greater emphasis on disease prevention among senior citizens and those who are living with disabilities.

Assist Small Business in Purchasing Health Insurance for Their Workers: The Kennedy-Kassebaum law provides new assistance to small businesses and their employees to purchase and maintain health care coverage. We should assist states in establishing voluntary health insurance purchasing cooperatives that will further reduce the cost of coverage to small firms.

Provide Health Care Coverage to Workers Between Jobs: As included in your balanced budget plan, we should provide states with funds to subsidize the purchase of insurance for up to six months for workers who are receiving unemployment compensation and who had previous employer-sponsored coverage while they were working. This is the logical next step to the Kennedy-Kassebaum law and would assist 3.1 million uninsured individuals a year including 700,000 children.

Assure the Quality of Care Delivered by Public and Private Health Plans: American consumers are understandably nervous about the rapidly changing health care marketplace. We will build on our successes of the first term by working with industry and consumers to establish better measures of quality and work to assure that quality in all types of health plans. The establishment of your new National Advisory Commission on Consumer Protection and Quality in the Health Care Industry will provide an ideal forum for the development of such policies.

Maintain a Policy of "Zero Tolerance" for Health Care Fraud and Abuse: The tremendous success of Operation Restore Trust and other efforts to assure program integrity in health care have led to record settlements in fraud cases. For the first time, Department program integrity efforts have contributed to a decline in Medicare growth. The Kennedy-Kassebaum law provides the Department with broad new authorities which we will use to reduce further the losses due to waste, fraud, and abuse.

Develop and Implement a Teen Pregnancy Prevention Strategy: Although we are encouraged by the recent decline in the teen birth rate, teen pregnancy remains a profound problem. Adhering to your call for a national campaign to reduce teen pregnancy and a provision in the new welfare law, HHS will establish and implement a national strategy to prevent teen pregnancy by Jan. 1, 1997, focusing on successful community efforts which incorporate five key principles: parental and adult involvement, abstinence, clear strategies for the future, community involvement and a sustained commitment.

Lead A "Girl Power!" Campaign: Studies show that girls tend to lose self-confidence and self-worth during the pivotal ages of 9 to 14. During that period, girls become less physically active, perform less well in school, and neglect their own interests and aspirations. To reverse these troubling trends, HHS has launched "Girl Power!", a multi-phase, national public education campaign to galvanize parents, schools, communities, religious organizations, health providers and other caring adults to make regular sustained efforts to reinforce girls' self confidence, by providing them with positive messages, meaningful opportunities, and accurate information on key health issues. We will continue our commitment to this important campaign by sending strong "no-use" messages about tobacco, alcohol, and illicit drugs; providing opportunities for girls to build skills and self-confidence in academics, arts, sports and other endeavors; addressing premature sexual activity; and focusing on physical activity, nutrition and mental health.

Launch a Collaborative Food Safety Initiative: In collaboration with the Department of Agriculture and the Environmental Protection Agency, we will enhance the safety of the food supply by detecting and responding to outbreaks of food borne disease more quickly. A new national early warning system will use the latest science to identify and track harmful food borne pathogens and speed critical information about them to public health officials throughout the country. We will also expand FDA's education and inspection of food processors, improve risk assessment for food pathogens, and provide better coordination of research efforts and responses to disease outbreaks.

Work to Create a "SafeAmerica": We have made a great deal of progress in making Americans safer in their homes, on the job, and in the course of their daily lives. We must increase this investment by working to reduce unintentional injuries, the cause of 150,000 deaths a year among children, youth, and young adults.

Expand and Improve Protections for Children: Tens of thousands of our Nation's children live without permanent homes and caring families. Incidence of child abuse and neglect nearly doubled in the United States between 1986 and 1993. HHS is committed to promoting what every child in America deserves -- loving parents and a healthy, stable home. Therefore, we will take steps, including providing technical assistance and financial incentives to states; creating initiatives to involve community leaders, parents, and the business and faith communities; and developing a public awareness campaign to increase adoptions and other permanent placements for waiting children in the foster care program.

* * *

This memorandum provides a brief outline of some of my priority initiatives and goals for the second term. I look forward to further discussions with you on these critical issues and to working to accomplish our objectives in the next four years.

In conclusion, Mr. President, we have made a tremendous start in improving the health and welfare of the American people. We have made important changes in Federal laws and worked with States and local governments to improve the ability of programs to meet the needs of the people they serve. Targeted investments in efforts to protect the health and safety of Americans in the course of their daily lives have enabled more Americans to live longer and more productive lives. We must maintain this course in the four years ahead so that we can truly prepare this Nation for the demands of the New Century.



DEC 2 1996

MEMORANDUM TO THE PRESIDENT

I would like to share with you an analysis of recent poverty trends and the role Federal safety net programs have had in ameliorating poverty.

In September, the Bureau of the Census reported that poverty in America declined in 1995: overall, the percentage of people who are poor in America dropped from 14.5 percent in 1994 to 13.8 percent or about 1 in 7 Americans. For children, the poverty rate was down by a full percentage point from the previous year to 20.8 percent or 1 in 5 children, and for the elderly, the rate dropped from 11.7 percent to 10.5 percent.

This downward trend is certainly good news for the country, although the percentage of people who remain in poverty--especially the percentage of children-- is troubling.

Poverty Trends Over Time

There are a number of ways to look at poverty trends (see Table One). The number of people who are poor before taxes or any government support ("pre-transfer poor") is an indicator of how well Americans are doing on their own.

Pre-transfer poverty for adults and children has fluctuated over time and in general is considerably higher during recessions. In 1995, one in five Americans was pre-transfer poor while one in four children and one out of two seniors was pre-transfer poor. For all groups this poverty rate was down significantly from its peak in 1993. Clearly Americans of all ages are doing better as the economy moves beyond the recession.

The "official" poverty rate takes into account government cash assistance, including social insurance programs (Social Security and Workmen's Compensation) and means-tested income support programs (Supplemental Security Income and Aid to Families with Dependent Children).

The performance of government cash transfers in reducing poverty for the elderly is remarkable. In 1995, almost 80 percent of pre-transfer poor elderly were removed from poverty, dropping their poverty rate from 49.9 percent to 10.5 percent. This is primarily due to Social Security benefits. Unfortunately, the impact of cash transfers on children is much less impressive. In 1995, child poverty was reduced by just 14 percent (from 24.2 percent to 20.8 percent) as a result of government support.

12-13/96/100015

Defining Poverty

As measured by the U.S. Bureau of the Census, the current official definition of poverty measures pretax money income, including government cash transfers (AFDC and SSI benefits) but excluding income gains or losses attributable to capital gains. The official measure does not include the value of non-cash benefits, many of which are means-tested and directly targeted toward the poor (child care, child support enforcement, JOBS, emergency assistance and foster care, Medicaid, SSI, Food Stamps, child nutrition programs, and housing subsidies). The official measure also excludes tax transfers, such as the Earned Income Tax Credit. Consequently, the current official measure does not capture the full extent to which our nation's safety net programs ameliorate poverty -- only 18 percent of Federal expenditures for low income families are included in the official statistics. If all noncash transfers were included with the exception of Medicaid, 56 percent of Federal safety net expenditures could have a significant additional anti-poverty effect. (Medicaid is excluded because of the difficulty in assigning a dollar value to it and to private health insurance).

Recently, there has been much discussion regarding the appropriate measure of poverty. A National Academy of Sciences report recommended a number of changes in how poverty is measured, including expanding the definition of what counts as income for people of all income levels to include noncash benefits and exclude out of pocket expenses for medical and child care. In addition, the report recommended modifying the poverty threshold. While no change in method of measuring poverty has been made to date, it is useful to assess the impacts of noncash government transfers on poverty to capture the fuller effect of the safety net.

Effectiveness of Safety Net Programs

Table Two measures the effectiveness of our Federal anti-poverty programs. The table uses published Census data to compare the number of *pre-transfer poor*, or those who were poor before benefits from safety net programs are counted, to the number of *post-transfer poor*, or the number of those in poverty after benefits from safety net programs are counted.

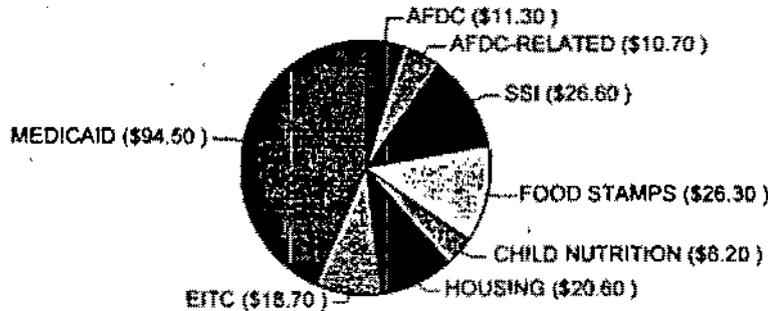
Over the past fifteen years, cash benefits have removed significant numbers of people from poverty. In 1980, cash benefits moved approximately 17.6 million people out of poverty, lowering the pre-transfer poverty rate of 20.8 percent to the official rate of 13.0 percent. The effectiveness of cash benefits increased in 1995. Approximately 21.4 million people were removed from poverty, reducing the overall number of poor from 57.8 million to 36.4 million. In percentage terms, the poverty rate was reduced by over one-third, from 21.9 to 13.8 percent.

When both cash and noncash government benefits are counted, the number of pre-transfer poor who are removed from poverty increases even more significantly. While cash benefits moved approximately 21.4 million people above poverty in 1995, counting noncash benefits (including benefits from programs such as Food Stamps, Housing Assistance, and School Lunches) lifts an additional 9.2 million people out of poverty.

SOCIAL SAFETY NET PROGRAMS

Total = \$216.3 Billion FY 1996

Source: Census estimates, FY97 President's Budget



The combination of cash and noncash benefits dropped the pre-transfer poverty rate of 21.9 percent to 10.3 percent -- the lowest post-transfer rate since 1980. In total, nearly 53 percent of the pre-transfer poor would be lifted out of poverty, if both cash and noncash benefits are counted.

A combination of cash and noncash benefits provided by safety net programs have a much greater impact in reducing child poverty than cash benefits alone have. In 1995, 2.4 million children -- 14.1 percent of all pre-transfer poor children -- were removed from poverty by cash transfer benefits. The combination of cash and noncash benefits lifted 7.1 million children above the poverty line--41.3 percent of all pre-transfer poor children. Thus the post-transfer child poverty rate counting both cash and noncash benefits is 14.2 percent, down from the official definition rate of 20.8 percent.

Of particular note is the effect of the Earned Income Tax Credit, a Federal refundable tax credit designed exclusively for working Americans. The number of families and children assisted by the EITC has increased steadily since the early 1990's, when your legislation significantly expanded it. Analysis of published data from the Census Bureau indicates that in 1995, the EITC rewarded the work of 15 million working families and alone removed 3.2 million people from poverty, 1.6 million of whom were children. In 1995, the EITC was responsible for moving nearly 10 percent of all pre-transfer poor children from poverty.

Effects of Safety Net Programs During Recessionary Periods

An important characteristic of government benefits, whether cash or noncash, has been that they expand during recessionary periods to counteract the increases in poverty that naturally occur. As can be seen in Table Two, the safety net programs performed better during the recession of the early 1990's than during the recession in the early 1980's.

When poverty crested during the recession of the early 1980's, the number of pre-transfer poor was nearly 53.3 million. During 1983, when safety net programs had been weakened as a result of the Reagan-era policy changes, cash and non-cash benefits lifted 44.8 percent of the pre-transfer poor out of poverty. In 1993, however, when the safety net programs were considerably stronger and EITC expansions had begun to take effect, cash and non-cash benefits were able to lift 48.3 percent of pre-transfer individuals out of poverty. Furthermore, as the recessionary effects have receded and the economy has continued to improve, the array of safety net programs has been able to lift even more people out of poverty. In 1995, nearly 30.6 million people, or 53 percent of the pre-transfer poor, were lifted out of poverty. Historically, this represents the most effective performance ever of our nation's safety net.

Conclusion

While critics may continue to discount the viability and importance of the Federal safety net, it is clear that our anti-poverty programs have been effective in safeguarding poor children and families. In 1995 alone, more than 30 million people--greater than half of all who were pre-transfer poor--were lifted out of poverty as a direct result of government benefits. In sum, our anti-poverty programs continue to lift more people out of poverty than ever before.

Clearly, as the Personal Responsibility and Work Opportunity Act is implemented, we will need to look at the effects on poverty of a wide range of Federal and state policy changes. The Act itself requires that each state report child poverty data annually and calls for the state to submit a corrective action plan to reduce child poverty if its rate increases by five percent or more within a year. The Act also gives the Department resources to conduct research and evaluation studies, requires that states collect and submit a large amount of data annually, and directs the Census Bureau to launch a new longitudinal study of children and families. All of these mechanisms should yield important new information. In addition, the first report to the Congress required by the Welfare Indicators Act of 1994 calls for the annual reporting of indicators of welfare dependence. The report also supports reporting on the status of children. The report has just been submitted to the Congress; it was prepared by HHS with the assistance of a bipartisan advisory board that supported tracking the poverty levels and status of children as welfare reform progresses. During the next year, we will narrow the list of data elements to be tracked and prepare the first annual report of the data.

Your successful battles to expand the EITC and increase the minimum wage will significantly help the working poor in the coming years. In the second term, we will move ahead to increase employment opportunities for low income individuals, solidify mechanisms for collecting the information and data that will be vital to assessing the impact of federal and state policy changes, and fix the flawed parts of the new welfare law you identified in July--including the Food Stamps and immigration provisions. All of these actions are necessary to ensure that the downward trend in poverty continues.



Donna E. Shalala

Table One

**Poverty Trends
1980-1995**

Definition	1980	1983	1985	1987	1990	1993	1995
Pre-Transfer Poor							
<u>All persons:</u>							
Rate	20.8	23.0	21.3	20.4	20.5	23.4	21.9
Total Number	46,806	53,291	50,395	49,160	50,972	60,671	57,758
<u>Children</u>							
Rate	22.0	25.9	23.7	23.0	23.5	26.3	24.2
Total Number	13,841	16,144	14,902	14,558	15,287	18,198	17,077
<u>Seniors</u>							
Rate	54.2	50.4	49.2	47.6	46.4	50.8	49.9
Total Number	13,380	13,262	13,442	13,560	13,963	15,636	15,797
Official Definition, including cash benefits							
<u>All persons:</u>							
Rate	13.0	15.2	14.0	13.4	13.5	15.1	13.8
Total Number	29,254	35,218	33,123	32,292	33,567	39,151	36,395
<u>Children</u>							
Rate	18.3	22.3	20.7	20.3	20.6	22.7	20.8
Total Number	11,513	13,900	13,015	12,849	13,400	15,727	14,665
<u>Seniors</u>							
Rate	15.7	13.8	12.6	12.5	12.2	12.2	10.5
Total Number	3,876	3,631	3,443	3,561	3,671	3,755	3,324
Post-Transfer, including Non-Cash Transfer							
<u>All Persons</u>							
Rate	10.1	12.7	11.7	11.0	10.9	12.1	10.3
Total Number	22,728	29,426	27,681	26,508	27,102	31,373	27,164
<u>Children</u>							
Rate	13.5	18.2	16.8	16.1	15.8	17.5	14.2
Total Number	8,493	11,345	10,563	10,190	10,278	12,126	10,020
<u>Seniors</u>							
Rate	11.7	10.1	9.7	9.3	9.5	9.5	8.5
Total Number	2,888	2,658	2,650	2,649	2,859	2,924	2,691

Table Two

**Persons Removed From Poverty Resulting From
Government Transfers**

	1980	1983	1985	1987	1990	1993	1995
ALL PERSONS							
Pre-Transfer Poor, All Persons	46,806	53,291	50,395	49,160	50,972	60,671	57,758
Number of Persons Removed							
Using Official Definition	17,552	18,073	17,271	16,869	17,405	21,520	21,362
Percent of Pre-Transfer Poor	37.5%	33.9%	34.3%	34.3%	34.1%	35.5%	37.0%
Including Non-Cash Transfers (def. 14)	24,078	23,865	22,713	22,652	23,870	29,298	30,593
Percent of Pre-Transfer Poor	51.4%	44.8%	45.1%	46.1%	46.8%	48.3%	53.0%
<i>Additional Impact of Including</i>							
Non-Cash Transfers	6,526	5,793	5,442	5,784	6,465	7,778	9,231
Percent of Pre-Transfer Poor	13.9%	10.9%	10.8%	11.8%	12.7%	12.8%	16.0%
Removed as Result of EITC	675	463	237	723	1,243	1,815	3,165
Percent of Pre-Transfer Poor	1.4%	0.9%	0.5%	1.5%	2.4%	3.0%	5.5%
CHILDREN							
Pre-Transfer Poor, Children under 18	13,841	16,144	14,902	14,558	15,287	18,198	17,077
Number of Children Removed							
Using Official Definition	2,328	2,244	1,886	1,709	1,886	2,471	2,412
Percent of Pre-Transfer Poor Children	16.8%	13.9%	12.7%	11.7%	12.3%	13.6%	14.1%
Including Non-Cash Transfers (def. 14)	5,348	4,800	4,338	4,367	5,009	6,072	7,057
Percent of Pre-Transfer Poor Children	38.6%	29.7%	29.1%	30.0%	32.8%	33.4%	41.3%
<i>Additional Impact of Including Non-Cash Transfers</i>							
Number of Pre-Transfer Poor Children	3,020	2,556	2,452	2,658	3,122	3,601	4,645
Percent of Pre-Transfer Poor Children	21.8%	15.8%	16.5%	18.3%	20.4%	19.8%	27.2%
Removed as Result of EITC	315	187	189	316	520	832	1,623
Percent of Pre-Transfer Poor Children	2.3%	1.2%	1.3%	2.2%	3.4%	4.6%	9.5%
ELDERLY							
Pre-Transfer Poor, Elderly	13,380	13,262	13,442	13,560	13,963	15,636	15,797
Number of Elderly Removed							
Using Official Definition	9,504	9,631	10,000	9,999	10,292	11,881	12,473
Percent of Pre-Transfer Poor Elderly	71.0%	72.6%	74.4%	73.7%	73.7%	76.0%	79.0%
Including Non-Cash Transfers (def. 14)	10,492	10,604	10,792	10,911	11,104	12,712	13,106
Percent of Pre-Transfer Poor Elderly	78.4%	80.0%	80.3%	80.5%	79.5%	81.3%	83.0%
<i>Additional Impact of Including Non-Cash Transfers</i>							
Number of Pre-Transfer Poor Elderly	987	974	792	912	813	831	633
Percent of Pre-Transfer Poor Elderly	7.4%	7.3%	5.9%	6.7%	5.8%	5.3%	4.0%
Removed as Result of EITC	0	26	0	0	0	62	32
Percent of Pre-Transfer Poor Elderly	0.0%	0.2%	0.0%	0.0%	0.0%	0.4%	0.2%



MEMORANDUM FOR THE PRESIDENT

SUBJECT: New Initiative to Protect Americans' Food Supply

PURPOSE

We wanted to let you know about a joint initiative we are proposing, to reduce death and disease caused by food poisoning. This food safety initiative, which is now under consideration as part of the FY 1998 budget process, would affect every American but would involve only a modest amount of new funding (about \$100 million).

BACKGROUND

Last month's outbreak of E. coli-contaminated apple juice sickened dozens and killed one child. There was a similar outbreak involving hamburger in the northwest during the early days of your Administration. Although those outbreaks received nationwide publicity, the reality is that every year millions of Americans are sickened, and an estimated 9,000 die, from E. coli, Salmonella, Cryptosporidium and other foodborne "pathogens."

Hospitalization costs alone for these illnesses are over \$3 billion a year, and costs for lost productivity have been estimated to range, for seven specific pathogens, between \$6 and \$9 billion; total costs for all food poisonings are likely to be much higher. In August, you announced that USDA was adopting modern requirements to make meat and poultry safer. Last year, HHS adopted similar requirements for seafood. This initiative would strengthen those programs and implement important measures to make the rest of the food supply safer.

Today, our understanding of many pathogens is limited; for some, we do not even know how much must be present in food to cause illness. The public health system has limited means to identify and track the causes of foodborne illness; and Federal, State, and local food safety agencies need to improve coordination for more effective response to outbreaks of illness. Years go by before most non-meat plants receive an FDA or State inspection, and increasing quantities of imported foods flow into this country daily with little scrutiny by FDA inspectors. And food processors, restaurateurs, supermarket managers, and consumers often lack basic understanding of the threat of foodborne contaminants and how to protect against them.

12/12/1996 0021

During the past three months, experts at our two departments and the EPA have worked intensively to develop a highly targeted initiative to address this issue; a summary has been shared with your staff. OSTP and State health officials have also been involved in the development of this plan, which addresses one of the initiatives identified in your recent report, "Meeting the Challenge: A Research Agenda for America's Health, Safety, and Food (1996)."

PROPOSAL

The good news is that we have the scientific talent and wherewithal to reduce the number of illnesses that do occur and to ensure that the United States will have a safer food supply. We believe that this Administration should launch a major new initiative next year that will positively affect the lives of all Americans. We would work through this initiative to reinvent the currently inadequate system devised by Theodore Roosevelt at the turn of the century into one that incorporates the science and technology of the 21st Century. Moreover, these gains can be achieved with a relatively small investment in new resources--around \$100 million--that can yield enormous benefits in health and public confidence in the food supply. Indeed, it is estimated that we can prevent 2 to 9 million illnesses, head-off up to 3,000 deaths, and save society billions of dollars in preventable health care costs each year.

The proposed interagency food safety initiative includes the following actions:

- o Build up the "early warning" and surveillance systems for foodborne illnesses and track them to their cause.
- o Increase FDA's inspections of food processors and imported foods, and improve collaboration with States in that area.
- o Better coordinate when disease outbreaks occur, including electronic communication among Federal, State, and local health authorities.
- o Expand education of food processors, retailers, restauranteurs, and consumers about the latest safe food processing, storage, and handling techniques.
- o Improve risk assessment for food pathogens, so that regulators can make the most cost-effective decisions.
- o Expand and better coordinate Federal research efforts on pathogens that pose the highest risk to the public.

In addition, we recognize that fundamental change of the food safety system is necessary, and we propose the development of a comprehensive, strategic plan to improve the food safety infrastructure through broad-based discussions involving all stakeholders.

A number of industry, academic, and other reports, such as those of GAO and NAS, have indicated that such reforms are necessary. We believe, therefore, that this initiative will be well received by the food industry and the general public. This interagency food safety initiative can be a significant feature of your domestic agenda for the coming year, and will accomplish an historic advance in public health. If you concur, we will coordinate further preparation of this program with your staff.



Donna E. Shalala
Secretary of
Health and Human Services

Daniel R. Glickman
Secretary of Agriculture



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

OCT 31 1996

MEMORANDUM TO THE PRESIDENT

I want to share with you some interesting statistical trends on teenage pregnancy.

Earlier this month, our National Center for Health Statistics (NCHS) published a report of preliminary 1995 data that indicates that the teen birth rate in the United States had declined for the fourth year in a row. The rate of teen births in 1995 was 8 percent lower than in 1991. The teen abortion rate has been declining since 1985. Black and Hispanic teen birth rates are 2 ½ times higher than white teen birth rates. While the black teen birth rate has dropped 17 percent between 1991 and 1995, the Hispanic teen birth rate has not declined. However, in 1994, 30 percent of the Hispanic teens were married, while only 4 percent of black teens were married. The Center will release a final analysis of the 1995 data in December.

This week, Child Trends, Inc.--a nonprofit, nonpartisan research firm--released a reanalysis of 1994 National Center for Health Statistics data. This analysis revealed that the drop in teen birth rates is happening across the country--in 46 states. Twelve states had decreases in the birth rate of 10 percent or more between 1991 and 1994. Those states include: Alaska (15 percent), Idaho (13 percent), Maine (18 percent), Michigan (12 percent), Montana (13 percent), Ohio (10 percent), South Dakota (10 percent), Utah (10 percent), Vermont (15 percent), Washington (11 percent), Wisconsin (11 percent), and Wyoming (11 percent). The four states that either had no change or an increase in their teen birth rate are Connecticut, New York, Nebraska, and Rhode Island.

While teen birth rates remain much too high, the overall, sustained decrease is certainly heartening. The fact that the decrease has happened in nearly every state indicates that there is a broad change in the society. We don't have answers to why this has happened but can certainly postulate that there are a number of factors including the extraordinary efforts of religious and community leaders, heads of non-profit organizations and foundations, teachers, and government leaders led by you over the past few years. The improved economy--which provides more life options to our teenagers--also helped.



Donna E. Shalala

10/31/1996 0040



L/C
PO-4-4

October 11, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala *Donna E Shalala*

SUBJECT: Administration Tobacco Control Initiatives

Throughout your Presidency, you have consistently supported a comprehensive and innovative set of public health measures designed to protect the American people from the dangers caused by tobacco use. In fact, you set the tone for the Administration's unprecedented efforts in your first month of office when you banned smoking from the White House.

Reducing Youth Tobacco Use. Soon after taking office we learned that despite the recent decreases in adult tobacco use, underage smoking was on the rise. In response, the Administration's most senior health officials, FDA Commissioner David Kessler, Assistant Secretary for Health Philip Lee, and myself, decided to focus on the problem of underage tobacco use. Two key initiatives emerged in our planning: first, the regulation implementing the Synar Amendment requiring all states to enact and to enforce laws prohibiting the sale or distribution of tobacco products to minors; second, the FDA's regulation reducing youth access to tobacco products and restricting tobacco advertisements that appeal to young people. Together, these measures constitute the cornerstone of our effort to reduce by half youth tobacco use by 2002.

In August 1993, six months into your first term, HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) issued the proposed Synar regulation. In early 1994, shortly after the close of the comment period on the Synar regulation, the FDA -- with your knowledge and support -- began to outline a proposed regulation of cigarettes and smokeless tobacco products as part of our public health strategy to reduce tobacco use by children. Also in 1994, the Office of the Surgeon General issued its important report, Preventing Tobacco Use Among Young People, which examined the increase in and the tragic health consequences of early tobacco use.

Following the close of the public comment period, SAMHSA began to revise the Synar regulation in light of the thousands of comments it received from, among others, state and local health departments, legislators, and public health experts. In late 1994, the final Synar regulation was submitted to OMB for consideration: a lengthy period ensued as the Department negotiated with OMB on several issues, including providing states maximum flexibility to develop effective strategies for reducing the illegal sale of tobacco products to minors.

10/15/96/0034

ESS
P-ACC/P-CT

As the Department was completing its work revising the final Synar regulation, the proposed FDA regulation moved to final approval by me and you. In August 1995 you announced FDA's proposal to regulate tobacco products to protect young people from tobacco products, focusing in particular on the billions of dollars the tobacco industry spends every year on advertising and promotions that children find so appealing. At that point, we needed to ensure that the Synar and FDA regulations, both of which were critical to the achievement of our public health objectives, were consistent and complementary.

The Administration issued the final Synar regulation in January 1996. In August 1996, the Administration, having considered literally hundreds of thousands of public comments, issued the final FDA regulation. The issuance of these regulations was the culmination of many months of evidence gathering, research, and consultation with state government officials and public health experts.

OTHER HHS TOBACCO-RELATED INITIATIVES

Support for State and Local Tobacco Prevention Activities. Your leadership has also been critical in our effort to increase federal funding for tobacco protection activities. Since 1993, the Administration has supported development of tobacco control programs at the state and local level through the National Cancer Institute and the Centers for Disease Control and Prevention, investing more than \$100 million in state and local programs to reduce the adverse health consequences of tobacco.

Promoting Adult Tobacco Cessation. The Administration has also taken measures to help adults to quit smoking. Early this year, after more than two years of careful study, HHS issued the first clinical care guidelines for medical practitioners on smoking cessation, encouraging greater numbers of health professionals to counsel their patients about the benefits of quitting. In addition, this year the FDA approved the sale of nicotine gum and nicotine patches as over-the-counter drug products, making these products more readily available to the public.

As you reminded us at the Rose Garden ceremony announcing the FDA final regulation, it is no accident that previous presidents never contemplated regulating the sale and promotion of tobacco products. Your support of the FDA initiative as well as the other policies enacted during your term in office, demonstrates your remarkable political courage. In sum, without your unqualified support from DAY ONE, few of the measures discussed here would have come to fruition. Moreover, given your leadership, it is certain that these initiatives will be implemented quickly and effectively.



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

SEP 27 1996

MEMORANDUM TO THE PRESIDENT

SUBJECT: NATIONAL FAMILY CAREGIVERS WEEK 1996

The week of Thanksgiving has long been celebrated as a time for our Nation to give thanks for its many blessings, but also as a week to acknowledge the countless contributions made on a daily basis by our family caregivers, in particular on behalf of our elderly. This has been done through a traditionally-recognized week called, "National Family Caregivers Week."

As our population ages, more older persons are suffering from chronic illnesses and will need to be prepared to deal with potentially disabling conditions. Moreover, individuals with lifelong disabilities are living longer and may require assistance in caring for themselves as they age. Caregivers often fall in to care for family members, sometimes at a moment's notice, when a family member becomes ill, has an accident or needs assistance. While caregiving has no gender bounds, women provide 80 percent of the informal care their families receive. Caregivers reduce the incidence of premature institutionalization and unnecessary hospitalization by maintaining their loved ones in the community and within their own familiar surroundings.

For many years, "National Family Caregivers Week" was a congressionally-designated week signed by the President and issued as a formal proclamation. Because Congress has changed their policy with regard to commemorative resolutions, there has been no formal proclamation of "National Family Caregivers Week" since 1994 when you signed the last official proclamation. Many national organizations, however, still celebrate this special week and would like to know that it is still important on a national level.

As a tribute to these special individuals who sacrifice so much on behalf of their family members, I would like to request that you issue the attached resolution honoring family caregivers during this year's Thanksgiving Week. This simple gesture would show your own concern, appreciation and leadership on behalf of families and family members.


Donna E. Shalala

10/1/96/10060

National Family Caregivers Week, November 24 - November 30, 1996

By the President of the United States of America

A Proclamation

By 2030 one in five Americans will be aged 65 and older as compared to one in eight today, and the absolute number of older Americans will double from 34 million now to about 69 million. As our population ages, more older persons are suffering from chronic illnesses and will need to be prepared to deal with potential disabling conditions. Moreover, individuals with lifelong disabilities are living longer and may require assistance in caring for themselves as they age. These demographic shifts coupled with a overwhelming preference of individuals to age at home even when no coordinated system of home- and community-based care is available for them, threaten to overwhelm families with the burdens of caregiving.

When someone we love becomes ill, has an accident, or needs assistance, we can all become caregivers at a moment's notice. Care is most often provided by family members. While caregiving has no gender bounds, women provide 80 percent of the informal care their families receive. Caregivers often sacrifice their own employment opportunities to bring comfort into the lives of loved ones. Selflessly offering their energy and love to those in need, family caregivers have earned our heartfelt gratitude and profound respect.

The week of Thanksgiving is particularly appropriate for giving thanks to and honoring our nation's countless number of citizens who care for loved ones unable to care for themselves. The true value of the comfort and reassurance provided by these individuals cannot be fully realized in monetary terms. Caregivers reduce premature institutionalization and unnecessary hospitalization by maintaining their loved ones in the community, saving taxpayers countless dollars.

As we celebrate the contributions of caregivers to their families and communities, let us recognize the challenges these unique individuals must confront on a daily basis in fulfilling multiple and often conflicting roles of caregiving for their aging relatives, caring for young children and working outside their homes. Let us commend the vital role they play in ensuring that our Nation's elders can age with grace and dignity. Thanks to caregivers, many older Americans are able to age with maximum independence and dignity.

NOW, THEREFORE I, WILLIAM J. CLINTON, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 24 through 30, 1996 as National Family Caregivers Week. I call upon Government officials, businesses, communities, volunteers, educators, and all the people of the United States to acknowledge the contributions made by caregivers this week and throughout the year.

IN WITNESS WHEREOF.....



THE DEPUTY SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

4/c

SEP 27 1996

MEMORANDUM FOR ANNE MCGUIRE

SUBJECT: NATIONAL FAMILY CAREGIVERS WEEK 1996

I have attached a memorandum to the President, which requests that he issue a proclamation before November 24th celebrating the week of Thanksgiving 1996 (November 24th through 30th) as "National Family Caregivers Week". I have also attached a draft proclamation for your information.

I appreciate your assistance to honor this request from the Secretary.


Kevin Thurm

Attachments

Prepared by ACA/Proehl

10/1/96 50 58



MAY 28 1996

MEMORANDUM FOR THE PRESIDENT

SUBJECT: National Domestic Violence Hotline -- Update

I am pleased to give you an update on the National Domestic Violence Hotline. Since its launch on February 21, 1996, the Hotline already has proved to be a critical crisis assistance, counseling and referral resource for victims of domestic violence, their friends and family members, and others across the country.

WHO IS USING THE HOTLINE

Between February 21 and May 14, Hotline staff responded to 20,852 calls (an average of nearly 249 calls per day). About 60 percent of these calls were from victims of domestic violence; about 17 percent were from family members or friends and about 5 percent were from advocates or service providers. The remainder of calls came from the general public, including media, police, students, hospitals, and others.

A formal analysis of the calls is being completed; however, some initial patterns have been identified:

Victims of domestic violence and batterers

- The majority of the callers were first-time help seekers who saw the number and decided to call.
- Many callers were not ready to be referred to local services; they simply wanted to talk about their situation, get information and receive support.
- In the last month, the number of batterers seeking help increased from about 2 percent to 10 percent of calls. A television movie entitled "Unforgivable" which was followed by a public service announcement (PSA) directed at batterers, seems to have had a tremendous impact on the viewing audience.

Family and friends

- Approximately 17 percent of the callers were family and friends concerned about a loved one. Each caller received a packet of informational material geared toward educating the caller on issues of domestic violence, as well providing support for taking next steps in helping a family member or friend.

5/02/1996 0015

- A small number of callers were abusers who saw they had a problem and wanted help. Hotline operators are trained to understand a callers situation and make referrals to available community resources, including programs aimed at batterers and drug or alcohol treatment centers.
- Almost one in five callers stated that children were involved. If enough information is available, Hotline operators will make a referral to child protective services.
- In the first month, about 18 percent of the calls were prank calls, hang-ups or calls from people who were angry at those who help victims of domestic violence. However this number has declined to about 2 percent. Hotline staff indicate that television talk shows or PSAs on domestic violence appear to have a significant impact on the frequency of these types of calls.

Need for services and resources

- Many calls came from people who were not aware of services in their area.
- A number of calls were from individuals who were frustrated with the lack of local enforcement of their protective orders. In such cases Hotline operators may help connect the caller to local agencies responsible for enforcing protective orders.
- Calls also came from disabled women and women with alcohol and drug problems who were having difficulty getting services in their local community.
- The Hotline is being used as a clearinghouse when new developments in law or public policy require quick, accurate assistance to those affected. When the Immigration and Naturalization Service issued regulations regarding the Violence Against Women Act and immigrant battered women, the Hotline helped hundreds of women and service providers who had questions about the new regulations.

Expressing gratitude

- Domestic violence survivors are calling to thank the Hotline and the President for being there for women who need help now -- recognizing that there had been no national service available for them when they needed it.

MEDIA ATTENTION

Print. There has been a tremendous amount of print coverage of the Hotline in local and national publications. I also wrote a letter to the editor that was published in a number of newspapers as well as incorporated into various editorials.

Television. Over 80 percent of callers say they heard about the Hotline on television. All of the major network and national morning shows covered the Hotline opening and announced the

telephone number. Public Service Announcements on NBC aired numerous times throughout the Hotline's first month of operation. Television shows that featured the Hotline's number included The Oprah Winfrey Show, The Leeza Gibbons Show, The Rolanda Show, Show de Christina (in Spanish), and NBC's Real Life. The number also appeared frequently on MTV.

Radio. During the first month of operations, Hotline management conducted radio interviews in: San Diego, San Francisco, Chicago, Massachusetts, Arkansas, Texas, and Maryland. Information about the Hotline also aired on the Wake Up America and Ivanhoe Broadcasting syndicated systems. In addition, HHS made information about the Hotline available to every radio station in the country.

OPERATIONS

Availability. The Hotline is answered 24 hours per day, seven days a week, with services available in English and Spanish and for the hearing-impaired on all shifts; translators in other languages are also available. About 7 percent of the callers have been Spanish-speakers. Peak call time is 4:00 - 5:00 PM CST.

Conference calls. Hotline staff are making significant numbers of conference calls to local shelters when a second call would be long distance for the caller, or would show up on the caller's telephone bill, possibly endangering her. Hotline staff may stay on the line to assist the caller in accessing community services and to provide support.

Referral capacity. The Hotline currently has approximately 2,000 services listed in the database. Information on about 20-35 new service resources is added each week.

Requests for information. Since opening, the Hotline has responded to over 650 requests for materials publicizing the Hotline, including stickers for the telephone and brochures. All of the original 30,000 brochures have been distributed and another 30,000 have been printed.

I will continue to provide you regular updates on the Hotline through the Weekly White House Report.



Donna E. Shalala



MAY 28 1996

MEMORANDUM FOR ANN MCGUIRE

Attached please find a memorandum to the President from Secretary Shalala, updating him on the use of the National Domestic Violence Hotline. Secretary Shalala also will continue to provide regular updates on the Hotline through the Weekly Report.

A handwritten signature in black ink, appearing to read 'K. Thurm', with a horizontal line extending to the right.

Kevin Thurm



MAY 8 1996

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Incremental Health Care Reform -- Covering the Class of '96

Summary

In one of your upcoming commencement speeches, you could call for a voluntary, private sector campaign to address better the health coverage needs of young adults — who often lose health coverage as dependents when they graduate from college.

Introduction

In the past year, you have effectively focused public and Congressional attention on the need for incremental health care reforms, with the centerpiece being insurance reforms. That effort, coupled with your strong stand in updating and preserving Medicare and Medicaid, is proving successful, and provides a model for future strategies — a modular approach to health care reform.

We should continue to target our efforts on gaps that occur in the transitions among parts of the health care system — as individuals move from job to job, as they age from one form of coverage to another, or as the system itself changes. I have been reviewing potential approaches, and one in particular suggests itself for immediate attention. That is to call on employers, insurers, and the National Association of Insurance Commissioners to develop model programs to address coverage needs for young adults.

As you may know, many young adults now lose health insurance coverage as they become independent; such as graduating from college. My own department's General Counsel discovered the problem first-hand shortly after her son's graduation. When her son went in to fill a prescription last June, he was informed that he was no longer covered by the family's health insurance policy, and his mother, while surprised, immediately took action to purchase supplemental insurance. Just weeks later, a serious bicycle accident put him in the hospital for two different surgical operations — which would have cost the family thousands of dollars if he had not discovered that he was uninsured because of his college graduation.

Calling on insurance companies to design policies to address this gap in coverage would have special appeal to two important groups: young adults age 18-24, who either don't have health insurance or are realizing its cost for the first time, and their parents, who are increasingly concerned about their children's safe transition to independence. And it gives you the

996-0084

opportunity to simultaneously address the high-profile issues of health care, corporate responsibility, and the government's role in supporting families, through a voluntary, non-regulatory approach.

The proposal could be announced in one of your upcoming commencement speeches, which would guarantee you a supportive audience and a visible platform. It could also be followed by a meeting with insurers, interviews with college newspapers, specialty press outreach to target media like MTV, and visits to college campuses this fall.

Background

Young adults are the population most likely to be uninsured: 27 percent of 18-24 year olds are uninsured, compared with 15 percent of the population as a whole. Health insurance gaps are the norm as these individuals make a transition from coverage as dependents to coverage in the work force.

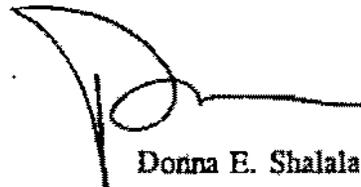
In general, children are considered dependents through age 18-21, depending on state law. Full-time students are covered generally through age 22 or 23. Many states provide for a continuation of coverage option when dependency status ceases; certain provisions in the insurance reforms recently passed by the House and Senate, if enacted, will provide for the availability of individual policies for such individuals.

Proposal

You would call on employers and insurers, working with the National Association of Insurance Commissioners (NAIC), to create a campaign to better address the coverage needs of this population. The campaign would include:

- model family health insurance program(s) for states, with a uniform extended age through which young adults would be able to be carried as dependents;
- an educational campaign on the purchase of health insurance for young adults.

I have talked informally with some major insurers about this proposal. If you are interested in pursuing this matter, I will follow-up with more detailed discussions with the key parties to set the stage for an announcement during the spring graduation season.



Donna E. Shalala

Attachments

90-4-17
4/c



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

APR 25 1996

MEMORANDUM FOR THE PRESIDENT

I enthusiastically endorse the enclosed proclamation declaring July 1, 1996, as "Centers for Disease Control and Prevention Day."

Since 1946, the Centers for Disease Control and Prevention (CDC) has evolved from its early beginning as a new unit of the U.S. Public Health Service called Malaria Control in War Areas to an organization that can meet our present public health challenges, such as chronic diseases, injuries, workplace hazards, birth defects and disabilities, environmental hazards, and newly emerging infectious threats.

This year commemorates CDC's dedication and contributions toward promoting health and quality of life for the American people by preventing and controlling disease, injury, and disability. It is also an excellent opportunity to salute CDC's employees, both past and present, as talented, committed individuals dedicated to providing national and international leadership in improving public health.

I recommend that you sign this proclamation and officially declare July 1, 1996, as "Centers for Disease Control and Prevention Day."

Donna E. Shalala

Enclosure

4/26/1996 0007

Prepared by CDC/Hanelson

CENTERS FOR DISEASE CONTROL AND PREVENTION DAY

By the President of the United States of America

A Proclamation

WHEREAS the Centers for Disease Control and Prevention (CDC)--the Nation's prevention agency--is celebrating 50 years of service to Americans and people around the globe. CDC was created as a "Center of Excellence" in 1946 from a small organization established in Atlanta, Georgia, during World War II to combat malaria in our troops. Since that time, CDC has become the Nation's first line of defense against diseases, injuries, and disabilities.

WHEREAS CDC's history is highlighted by notable achievements. For example, in the ongoing battle against infectious diseases, the agency played a key role in the eradication of smallpox and the discovery of the causes of Legionnaire's disease, toxic shock syndrome, and the mysterious fatal disease in the Southwest later identified as a new hantavirus infection. CDC has also led efforts to control and prevent such scourges as polio and other vaccine-preventable diseases, breast and cervical cancer, lead poisoning, tuberculosis, and AIDS. Recently, CDC has provided global leadership in the control of emerging infectious diseases. Examples of this role include CDC's investigation and control of the plague outbreak in India and the Ebola outbreak in Africa.

WHEREAS using the same sound principles and scientific approach that successfully protects the Nation and the World from deadly infections, CDC has evolved to meet contemporary challenges to life and health. Today, CDC's innovative programs address a range of public health problems, including chronic diseases, injuries, workplace hazards, birth defects and disabilities, environmental hazards, and newly emerging infectious threats. The agency also gathers and analyses scientific data to monitor the health of the population, provide a solid foundation for decision-making, and detect risk factors for poor health. Recognizing the role of personal responsibility in achieving and maintaining good health, CDC also helps Americans by promoting healthier lifestyle choices.

WHEREAS the people of the United States--and the world--are safer and healthier because of CDC's 50 years of illustrious achievement. CDC and its public health partners have made prevention both a science and a practical reality. Although technology and medical advancements have worked wonders--they can be expensive and are not always available to everyone. CDC has shown us that prevention not only saves lives but saves money.

THEREFORE, I congratulate CDC on its first 50 years of excellence and encourage its continued vigilance and commitment to serve as the Nation's sentinel for health. At the same time, I challenge the people of this country to join me in ensuring that our children have safe, healthy communities in which to live. Not only can we stop smoking, immunize our children, and exercise regularly, but we can work together to make sure we have healthy schools, clean water, and safe neighborhoods and workplaces. Through these efforts, we can help realize CDC's vision: Healthy People in a Healthy World--Through Prevention.

NOW, THEREFORE, I, WILLIAM JEFFERSON CLINTON, President of the United States of America, do hereby proclaim July 1, 1996, as the Centers for Disease Control and Prevention Day. I call upon the people of the United States to join me in observing this important public health occasion.

BILL CLINTON



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

MAR 28 1996

TO: The Secretary

Through: DS

COS

ES

J. H. Lee for C. D. Cooley

FROM: Director

Centers for Disease Control and Prevention

SUBJECT: Presidential Proclamation of July 1, 1996, as Centers
for Disease Control and Prevention Day

ISSUE

In recognition of the Centers for Disease Control and Prevention's (CDC) 50th anniversary, I am requesting that President Clinton sign the attached Proclamation declaring July 1, 1996, as CDC Day.

DISCUSSION

Since 1946, CDC has evolved from its early beginning as a new unit of the U.S. Public Health Service called Malaria Control in War Areas to an organization that can meet our present public health challenges, such as chronic diseases, injuries, workplace hazards, birth defects and disabilities, environmental hazards, and newly emerging infectious threats.

This year commemorates CDC's dedication and contributions toward promoting health and quality of life for the American people by preventing and controlling disease, injury, and disability. This is also an excellent opportunity to salute CDC's employees, both past and present, as talented, committed individuals dedicated to

providing national and international leadership in improving public health.

RECOMMENDATION

I recommend that you sign the attached Memorandum to the President and forward the Proclamation to the President (Tab A) for signature.

for Candice Nowicki
David Satcher, M.D., Ph.D.

Attachment

Tab A - Memorandum to the President With Attachment



4/c

APR 25 1996

MEMORANDUM FOR LEEANN INADOMI

Attached is a request to the President, from Secretary Shalala, that he sign the enclosed Presidential Proclamation making July 1, 1996, the Centers for Disease Control and Prevention Day. As you know, 1996 marks the 50th anniversary of the CDC.



Kevin Thurm

Attachments

Prepared by COC/Harelson



4/c

APR 3 - 1996

MEMORANDUM FOR THE PRESIDENT

Please find attached a copy of an article, "*The Last Straw? Cigarette Advertising and Realized Market Shares Among Youths and Adults, 1979-1993*" which was published today in the Journal of Marketing. The Campaign for Tobacco-Free Kids held a press conference about this study and it was carried live on CSPAN-2 this morning.

- o The article describes a sophisticated econometric analysis which analyzed the effect of advertising expenditures from 1979 to 1993 for the nine most popular brands of cigarettes on teen brand preference in comparison to the effect on adults.
- o The results indicate that the effect of cigarette advertising expenditures on brand preference is three times greater for teens than for adults.
- o The authors conclude that regardless of the "intent" of cigarette advertisers, there is clearly an "effect" on teens, and this "effect" is greater on teens than on adults.
- o This study did not look at the issue of whether cigarette advertising caused kids to start to smoke, but rather focused on the effect of advertising on brand preference. Other studies, including the 1994 Surgeon General's Report, conclude that cigarette advertising is a risk factor for starting to smoke.

The study was authored by marketing professors at the University of British Columbia and Federal researchers at the Centers for Disease Control and Prevention (CDC).

Donna E. Shalala

Attachment

Prepared by ES/Cooley

94-18-1996-0037



L/C
90-4-7

APR 2 1996

MEMORANDUM FOR THE PRESIDENT

The Department of Health and Human Services will host the Annual National Donor Recognition Ceremony on Sunday, April 14, 1996 at NIH. Together with a host of private sector organizations, HHS will honor organ donors from across the country who have recently given their organs or tissues to help save and improve lives.

I am writing to seek your leadership in this effort. While Governor of Arkansas, you were successful in bringing organ donation to the attention of the people in your State. The need for this type of attention is now more critical than ever. With nine Americans dying each day because of the organ shortage, and with more than 44,500 on a national waiting list that grows daily, we need to take every possible step to stimulate media attention to this critical donor shortage and increase the number of Americans willing to donate.

I am asking that you send a letter to all Federal employees encouraging them to become organ, tissue, and bone marrow donors. A letter from you would be a key step in increasing all types of donations and reversing the current organ shortage.

The issue of donation is not new to the Federal workforce. In 1992, the Office of Personnel Management recommended to agency heads that they permit the use of annual, sick, and administrative leave for any Federal worker participating as a live organ or bone marrow donor.

Further, there is growing support on the Hill around this issue. Representative John Moakley and Senator Bill First, M.D., sent a letter to their colleagues in Congress (copy enclosed) urging them to choose to be an organ donor and to talk to their families about their intent. On December 7, 1995, Representative Moakley, a liver recipient himself, addressed his colleagues on the House floor about the need for donation and encouraged their participation as a potential donor (statement enclosed).

A suggested letter to Federal employees is enclosed for your consideration. Thank you for your leadership and personal commitment to this very worthwhile cause.

Donna E. Shalala

Prepared by HRS/Fishback

04-04-1996-0041



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

JAN 24 1996

Health Resources and
Services Administration
Rockville MD 20857

TO: The Secretary

SUBJECT: Request Federal Workers to Become Organ and Marrow Donors and Request Your Participation in the Annual National Donor Recognition Ceremony -- ACTION

FROM: Administrator

ISSUE

I am seeking your assistance with projects related to organ and marrow donation. First, I am requesting that you ask President Clinton to send a letter to all Federal workers asking them to consider becoming an organ and marrow donor. Secondly, I would like to invite your participation at the Annual National Donor Recognition Ceremony to be held on Sunday, April 14, 1996, at the Natcher Auditorium on the NIH Campus.

DISCUSSION

As a governor, Mr. Clinton supported organ donation. As President of this country, he could have an even greater impact as a proactive supporter of organ and marrow donation. Recently, Representative John J. Moakley and Senator Bill Frist, M.D., sent a joint letter (Tab A) to their colleagues in Congress urging them to designate themselves as organ donors and talk to their families about their intentions. On December 7, 1995, Representative Moakley, a liver recipient himself, on the House floor addressed his colleagues about the need for donation and encouraged their participation as potential donors. We believe this is an appropriate time to encourage anatomical donation throughout the Federal workforce.

Attached are two sample letters (Tab B). The first one is to the President asking for his assistance to provide leadership to a national effort to increase the number of organ and bone marrow donors. The other is an example of a letter he could send to Federal employees requesting they consider the ultimate gift of becoming an organ and bone marrow donor. HRSA staff would be pleased to revise these as necessary or assist in any other capacity.

With reference to the National Donor Recognition Ceremony, this is a special program to honor those who already have donated their organs and tissues. It is sponsored annually by

96-0025

HRSA's Division of Transplantation, together with a host of private sector transplant-related organizations. It is a good example of a true private-public partnership. Transplant organizations from across the country send donor family members to participate in this Ceremony, which generally attracts approximately 400 people. While the primary purpose of the program is to honor organ and tissue donors, another goal is to stimulate media attention to the critical donor shortage. Last year, every major network covered this program and Good Morning America allotted a full 11 minutes to the Ceremony and its participants. A copy of last year's program is attached at Tab C. We would hope you would speak at this event.

With nine Americans dying each day because of the organ shortage, and with more than 44,000 on a national waiting list that grows daily, we need to take every possible step to increase the number of Americans willing to donate.

RECOMMENDATION

We recommend you approve the two sample letters to the President and participate in the Annual National Donor Recognition Ceremony.

DECISION

Approve the two sample letters to the President.

Approved _____ Disapproved _____ Date _____

Participate in the Annual National Donor Recognition Ceremony.

Approved _____ Disapproved _____ Date _____

Ciro V. Sumaya
Ciro V. Sumaya, M.D., M.P.H.T.M.

Attachments:

- Tab A - Letter to Colleagues
- Tab B - Sample Letters
- Tab C - Last Year's Program

*but ask with idea
letters
need
rewrite*



APR 2 1996

MEMORANDUM FOR LEE ANN INADOMI

Attached is a memorandum from Secretary Shalala to The President requesting that he send a message to all Federal employees encouraging them to become organ, tissue, and bone marrow donors.

The Department will host the Annual National Donor Recognition Ceremony on Sunday, April 14, 1996 at NIH. We expect that this ceremony will receive some press attention, so this would be a timely message. More than 44,500 Americans are on a national waiting list for organs that grows daily. The President's leadership in increasing organ donations will be greatly appreciated.

A handwritten signature in cursive script that reads "Kevin Thurm" with a small mark to the right.

Kevin Thurm

Attachment



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

MAR 6 1996

MEMORANDUM TO THE PRESIDENT

SUBJECT: Executive Action on Welfare Reform

Our Administration has made considerable progress in reforming the federal welfare system, even as congressional action has been stalled. As you noted in January in your State of the Union address, AFDC caseloads are down. Food Stamp rolls are down. Work participation rates and child support collections are up. And 37 governors-- Democrats and Republicans--have taken advantage of demonstration waivers issued by HHS to demand work, require responsibility, and protect children.

We now have the opportunity to take further executive action in the areas of work and responsibility, and to address the special needs of teen parents, even as we continue to work with Congress on bipartisan legislation. The actions I have outlined below would not only highlight your commitment to welfare reform, but could genuinely encourage the states to step up their own commitments to change. I believe these executive actions would spur Congress forward on bipartisan national legislation, and, if legislation is not forthcoming, would enhance the Administration's independent progress on welfare reform.

I propose four areas of action. While these proposals are severable, we see them as a package. I recommend that you issue a Presidential Memorandum instructing the Department to take action in all four areas as soon as possible.

Background

A major goal of welfare reform is to help AFDC recipients achieve economic self-sufficiency. This focus also underpinned the Family Support Act, which established the JOBS program in 1988. HHS has the authority to implement immediately proposals that strengthen the states' JOBS obligations and affect the recipients participating in JOBS programs and to urge similar changes for AFDC recipients not in the JOBS programs, bringing closer together activities and expectations for the two groups. New regulations would be required in order to place additional mandates on states and recipients in the AFDC population who do not participate in the JOBS programs.

Personal Responsibility Plans

Proposal: Require States to have Personal Responsibility Plans in place for most welfare recipients.

As a condition of receiving JOBS funding, every two years, states must submit State Plans for administering their JOBS programs. The submission and review of State Plans provide a forum for shaping the administration of the JOBS programs. As one element of program administration, states must ensure that JOBS participants receive employability status assessments and have individual employability plans. Typically, these individual plans have been oriented significantly toward education and training.

The next State Plan submissions for the JOBS programs are due this summer. We propose to require states, in their summer submissions, to commit to a work-based reorientation of their JOBS participants' individual employability plans. Prior to the summer State Plan submissions, the Department would prescribe the components of employability plans necessary to transform them into genuine Personal Responsibility Plans focused on job search, work and activities directed at quick movement of JOBS participants into the labor force.

At the same time, we would urge states to institute similar, work-based Personal Responsibility Plans for all recipients who can work, even for those who are not JOBS participants. States implementing that practice would significantly expand the scope and reach of work-based planning for their beneficiary population. Through regulation, we could make Personal Responsibility Plans a requirement for all AFDC recipients who are able to work.

Require Teens to Stay in School

Proposal: Seek to keep minor parents in school, and encourage States to make minor parents live at home.

The Family Support Act requires that JOBS participants who are minor parents and who have not graduated from high school stay in school as a condition of receiving benefits. That Act, in addition, permits states to require minor parents to live at home and to receive assistance in the form of protective payments to their own parents. Because the latter is an explicit State option in the statute, living at home could not be made a federal requirement through executive action.

As part of the executive action, HHS would have states describe how they will ensure that JOBS-participating minor parents stay in school. In addition, we would strongly urge states to take advantage of their option to require minor parents to live at home whenever appropriate and could provide public recognition for States exercising that option.

Work Requirements

Proposal: Establish and strengthen work requirements.

Two distinct actions are necessary in order to establish and strengthen work requirements: One, our new Personal Responsibility Plans should be extended to cover all AFDC recipients able to work and should be reoriented toward work. Two, new and expanded state work participation rates should be established.

The Family Support Act required that states have specified percentages of their non-exempt AFDC recipients participating in the JOBS program each year. Those participation rate standards expired in 1995. (AFDC-UP participation rates, which cover a very small part of the caseload, are currently at 60 percent, and remain in place through 1998.)

Rather than set new participation rates for just the JOBS programs, all states should aim for participation by all non-exempt recipients in work or activities leading toward work. States should set performance goals for participation and for placements. We can implement these goals incrementally.

First, in structuring this summer's round of State JOBS Plans, we would require states to incorporate the new work focus, as noted above. Additionally, we would urge states to create individual employability assessments for non-JOBS participants and to direct those employability plans, too, toward work. Second, we would redefine "participation." We would make clear that both unsubsidized and subsidized work count as participation, and that those who leave the caseload for work should be counted for six months. The requirement of 20 hours per week of work would continue to provide the basis for the participation rate.

We would establish new participation goals. In calculating the rate of participation, we would ask the states to report not only data on JOBS participants but also information on the whole non-exempt caseload working or directly preparing for work. We would suggest that participation goals for that combined population (i.e., JOBS participants and others) be set at 30 percent in 1997, 35 percent in 1998 and 40 percent in 1999. (We would separately retain the currently established requirement for the AFDC-UP recipients.)

These goals would serve as guidance to states as they plan to meet the obligations that regulations would impose on them and their recipients once such regulations are published and gain the force of law.

To ensure that these work requirements do not become unfunded mandates, states would be reminded that, under current law, they can draw down federal funding not only for

their JOBS programs but also, as they need it, for the administration of work programs for those who are not JOBS participants, and for child care expenses for all participants.

Focus on Performance

Proposal: Reallocate quality control (QC) resources toward employment-related goals, and recognize high performing States in a White House ceremony.

We do not have the authority under current law to institute a performance bonus for job placements. We can, however, take three important steps to focus on performance.

First, as noted above, we would urge that State Plans spell out participation goals. We would work with states on their plans to ensure reporting consistent with state flexibility. The Department would develop regulations that would make this proposal legally enforceable.

Second, we can reshape our Quality Control (QC) system to focus on performance. The current QC system is designed to assess payment accuracy and focuses exclusively on monitoring compliance with eligibility requirements. Substantial state and federal resources are devoted to carrying out extensive case reviews and assessing penalties against the states for overpayments. A Federal-State workgroup (our "QC Academy") last year recommended that we redirect some of these monitoring and auditing resources toward broader performance goals, such as employment and placements. As part of the executive action, HHS would modify the QC requirements so that the states and the federal government redirect resources to monitoring and improving performance.

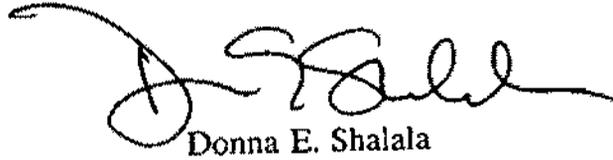
Third, we could hold a White House ceremony in May or June to recognize the progress states have made in increasing work participation, and to give special recognition to those States with the best performance or the most improvement in 1995.

Recommendation

These executive actions, combined with our ongoing work to facilitate state-by-state reforms would make significant, additional progress toward national welfare reform even if the Congress fails to pass an acceptable bipartisan bill. Prior consultation with the Governors would help to ensure successful implementation of these actions.

Page 5

I recommend that you issue a Presidential Memorandum directing my Department to take the actions outlined above.

A handwritten signature in black ink, appearing to read "D. Shalala", with a long horizontal flourish extending to the right.

Donna E. Shalala



PO-5-9
L/C

JAN 19 1996

MEMORANDUM FOR THE PRESIDENT

SUBJECT: Latest Michigan and California Welfare Initiatives

Two new state welfare reform proposals illustrate both the risks to poor children if block grants are enacted and the high degree of flexibility for reform that already exists under current law. Michigan's proposed Project Zero (publicized in Thursday's New York Times) is reasonable, consistent with the welfare objectives of this Administration, and it appears that it can be implemented with no waivers beyond those the State currently has. In contrast, California's new proposal will have severe effects on families, involves huge budget cuts, and does less to address the real needs of poor families and their children. California's plan cannot be implemented under current law. These two State proposals constitute two more reasons for staying with the current funding structure.

Michigan's Project Zero

There is no Project Zero plan yet, only a concept. (It is separate from the earlier legislation enacted by the State to implement a block grant were it to become federal law.) For Project Zero, the State is doing a survey of AFDC recipients at six pilot sites around the State to assess what are the barriers to work. Then they will aggressively try and target services to overcome those barriers. Pre-survey expectations are that the greatest barriers will be child care, transportation, job counseling, substance abuse and depression, as well as more transitional services for people that are already working. Once the survey results are in, the State will design the details of the program, the aim of which is to have everyone working. The newspaper account also suggested that the State would guarantee child care and transportation.

The project builds upon Michigan's "To Strengthen Michigan Families" Initiative. Under the Initiative, the State has signed social contracts with recipients, implemented a more generous \$200 and 20 percent income disregard and encouraged recipients who are unable to find work to do community service for 20 hours a week. Individuals who refuse to look for or participate in assigned work can be sanctioned.

Under our booming economy, Michigan employment is up (they claim 30 percent of their recipients are working and this is due, in part, to their generous disregard policy) and AFDC caseloads have dropped more than in many other States. The Project Zero concept is reasonable. As States work to put a greater proportion of their AFDC recipients into jobs, they will be forced to work with the more disadvantaged families in the caseload. Families in the middle and lower tiers will have more barriers and service needs.

California (Governor Wilson's 1996 Budget Proposal)

In his 1996 budget proposal, Governor Wilson has proposed to redesign California's welfare system by devolving responsibility for these programs to the counties. The proposed redesign also includes reduction of grant levels and flat grants not adjusted to household size. The California plan would produce enormous savings as a result of cuts in benefits and services, thereby reducing the State's welfare expenditures to 76 percent of its past spending, which is just above the Conference requirement for state maintenance of effort. While California has some of the highest AFDC benefits in the country, Governor Wilson's proposal is an early sign of the race to the bottom that you have predicted.

AFDC recipients would be assigned to one of four groups based on expectations for employment and each group would be subject to a different program structure. AFDC recipients who have some work history or are employable would be eligible for cash benefits for two years, with grant levels reduced after 6 and 12 months of benefits. These persons would immediately begin job search upon entering the program and would receive minimal services.

A second group would comprise AFDC recipients with no work history, including teen mothers. This group of recipients would be ineligible for cash benefits; they would receive vouchers for rent, food, etc. instead. The value of the voucher would be equivalent to the cash benefit amount. These recipients would receive case management services, and be subject to a 5-year time limit. A person can move out of this group and begin receiving cash benefits once she gains employment.

A third group would be recipients with disabilities or who have children with disabilities. These families would receive a cash grant, and would most likely be exempt from a time limit. The fourth group would be child-only AFDC cases. They would receive cash benefits with reduced grant amounts and time limits.

California's new plan is billed as an aggressive effort to help families find work and, appears to address the different levels of job readiness among recipients. It is severe, however, because employable recipients have a 2-year time limit with declining benefit levels during the two years. Few services are provided to this group. Families that have many employment barriers are only eligible for vouchers and are able to receive them for only five years.

Caseworkers are given enormous discretion in the treatment of individuals in terms of grant amounts, duration of time limits and services provided, for example. Considerable inequities would ensue. It is not easy to differentiate those that are employable from those that are less employable. Mothers with considerable employment barriers could be miscategorized and

subject only to a 2-year limit. The effectiveness of using vouchers in place of cash for people that are hard-to-employ has not been carefully tested. It is not clear what needed services including substance abuse treatment and job preparation would be available. The proposal contains far more risks to poor families and children.

Analysis

Michigan does not appear to require any waivers beyond the ones it already has to do Project Zero. The State can do all of its initiative under current law and under the Daschle bill. Unlike the Republican Congressional proposal, Project Zero recognizes that additional services, as well as transitional health care coverage, are needed to help welfare families to work. The plan does not entail inflexible time limits or family caps to narrow eligibility and throw families off of cash assistance. Project Zero has a very different focus from the Republican plan in Congress that Governor Engler praises and it is much closer to the welfare reform proposed by this Administration and the House and Senate Democrats.

Michigan believes that the Republican Conference Bill's block grants will provide financing advantages to them. Federal funding would be held to FY 94 levels and with the flexibility of the block grants, the State believes it could channel the surplus resources to services needed to overcome the employment barriers. However, the Republican conference agreement mandates stringent work requirements far exceeding current participation levels in Michigan. The State will have to spend much of the capped block grant resources not spent on cash benefits to create work slots. Furthermore, if there is a recession, more resources under the capped block grant will have to go to benefits as well as work slots, absorbing any surplus that could have been targeted on services.

Michigan is allocating \$40 million to fund child care services. Under current law, this new State money would be subject to a federal match. The State could spend only half as much and draw down the same amount in federal dollars to come up with the \$40 million.

Michigan is therefore mistaken in believing it would be better off with the block grant. It is better off with current law or under the Daschle bill or the Coalition bill. In order to pursue its risky proposal, California would be better off with the block grant, because it could not implement its proposed plan under current law or the various Democratic proposals.

As noted earlier, the Project Zero concept is different from their implementing language for a block grant. This language also eliminates the entitlement to cash benefits and provides no guarantee of benefits if appropriations are not adequate.

Recommendation:

The Republican leadership might tinker with the Conference bill which you vetoed, but it is very difficult to repair it in a way that avoids great damage. As you have already said clearly, the Democratic alternatives proposed in the two Houses of Congress protect children and families most effectively.

Governor Engler criticized your veto of the Congressional Republican welfare bill during his State of the State address this week. Our response should be that the Michigan Governor's welfare proposals are closer in structure to our proposals than the extreme proposals of the Republican Congress. I hope Congressional Republicans will heed your call to work with your Administration to develop welfare reform that ensures flexibility to states, addresses the needs of poor families, and protects children.



Donna E. Shalala