

EFFECTIVENESS OF CHILDREN'S HEALTH INITIATIVES*The
Children's
Health*

Q. TODAY'S NEW YORK TIMES REPORTED THAT NEITHER THE HOUSE NOR THE SENATE'S CHILDREN HEALTH INSURANCE PLANS WILL ACHIEVE MUCH COVERAGE. HOW DO YOU RESPOND?

A. We believe that CBO estimates are excessively low. CBO assumes that states will prefer to use the money to offset existing spending -- not to expand coverage. We believe this lack of trust in the states is unwarranted and not backed up by recent experience. Specifically:

- **Most states have expanded Medicaid for children well above the minimum levels required under current law. Over 30 states have taken up a Medicaid option to cover more children.**
- **More expansions proposed. This year alone, over 15 states will expand Medicaid or state programs for children.**
- **Strong response to private initiatives. Private foundations (such as Robert Wood Johnson) report that they are flooded with responses from states interested in expanding children's coverage. This interest exists even though states would have more "strings" and have to put up real money to receive the private funding.**
- **Non-political career policy experts at the Department of Health and Human Services believe that a carefully structured initiative will increase the number of children with health insurance well beyond CBO estimates.**

CBO analysis does underscore the importance of ensuring tight targeting of funds and state accountability. Although flawed, the analysis does reinforce the President's belief that the investment should be used wisely to ensure that as many uninsured children as possible receive meaningful health coverage. This is why we support:

- **New coverage not existing coverage. The President supports strong provisions (called maintenance of effort requirements) to prevent the new funds from replacing existing funds for children's health coverage. States should use the new investment to leverage not reduce their current spending.**
- **Deletion of provisions that provide for services rather than insurance coverage. The House bill would allow states to spend all of their money on one service or to offset the reductions to disproportionate share hospitals (DSH). This will not translate into meaningful coverage for children that protects their families from excessive cost sharing.**

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today the President joined Kaiser Permanente in announcing that the health plan will give \$100 million to provide health care coverage to up to 50,000 uninsured children in California. Kaiser is responding to the President's challenge at the Summit on Service, and their initiative complements the President's commitment to a national effort to extend health insurance.

This President will continue to fight hard to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President fought hard to ensure that the balanced budget agreement included \$16 billion to provide meaningful health care coverage to uninsured children. The President also supports the action by the Senate Finance Committee to raise a 20 cent tobacco tax to allocate additional Federal support for children's health.

The President outlined the principles he will use in evaluating children's health initiatives emerging from the Budget Agreement. The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful:** from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted:** through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

The Balanced Budget and the Kaiser announcement build on the President's previous successes in strengthening health care coverage for children.

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law, the President helped millions of Americans -- and their children -- keep their health care coverage when they change jobs.
- **Children and Medicaid.** Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children. The Administration has partnered with states through Medicaid waivers to expand coverage to hundreds of thousands of children.
- **Children and the Environment.** The President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.
- **Children and Tobacco.** The President has also taken action to limit children's access to tobacco. Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.
- **Children and Immunization.** During the Clinton Administration, childhood immunizations have reached a historic high. The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- an historic high.

MEMORANDUM

June 23, 1997

TO: Bruce R., John H, Gene, Nancy-Ann, Jen K.

FR: Chris J. and Sarah B.

RE: Children's Health One-Pager and Q&As

Attached is a one-pager on children's health that will be used as background for the President's speech tomorrow on children's health with Kaiser Permanente. (Kaiser is announcing that they are donating \$100 million to cover up to 50,000 uninsured children in California). We have also included our most up-to-date Q&As on children's health, Medicare, and AIDS.

We hope you find this information helpful. Please call with any questions.

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CHILDREN'S HEALTH

Q: DO YOU BELIEVE THAT A CHILDREN'S HEALTH INITIATIVE CAN EMERGE FROM CONGRESS THAT YOU SUPPORT? DO YOU HAVE A PREFERENCE FOR HOUSE- OR SENATE-PASSED LEGISLATION?

A: Yes. We are working with the Congress to ensure that they produce a children's health initiative that provides meaningful health care coverage to millions of uninsured children. It is imperative that the single largest investment for children's health care since Medicaid was enacted in 1965 is efficiently spent to cover the most number of uninsured children.

I am committed to making sure that any investment in children's health care meets three principles: (1) that coverage is meaningful: from checkups to surgery -- children should get the care they need to grow up strong and healthy; (2) that coverage is targeted: through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and (3) that this investment supplements not supplants coverage: this investment should cover children who do not currently have insurance -- rather than new money to replace public or private money that already covers children.

I am optimistic that the House and certainly the Senate will improve their legislation. It is encouraging that Republicans and Democrats are working to ensure that the children's health package that is produced will ensure that benefits are meaningful and that low-income children are protected from excessive out-of-pocket costs. We will do everything that we can to work with these Members as the bill is debated on the House and Senate floor this week.

Q: WITH THE TOBACCO SETTLEMENT IN MIND, SENATOR LOTT RECENTLY IMPLIED THAT THE SETTLEMENT MIGHT UNDERMINE SUPPORT FOR THE TOBACCO TAX. DO YOU BELIEVE THAT THE CONGRESS SHOULD RESIST PASSING A TOBACCO TAX BEFORE THE FINAL TOBACCO AGREEMENT IS WORKED OUT?

A: No. The Finance Committee, on a bipartisan basis, passed out an increase in the tobacco tax to provide additional funding for children's health care coverage. The Congress should not alter its decisions based on an assumption that an acceptable tobacco settlement might be reached.

Q: DO YOU BELIEVE THAT RESOURCES FROM THE TOBACCO SETTLEMENT COULD COVER THE REST OF THE UNINSURED CHILDREN? HOW WOULD YOU RECOMMEND INVESTING THESE NEW DOLLARS?

A: We just heard the details of the tobacco settlement on Friday. Any final decisions about how any money from the potential settlement might be spent are obviously premature. The tobacco settlement could provide significant new funding for children's health and other public health initiatives. While we should be and are looking into possible options, we cannot count on any of these dollars. We should not let the possibility of additional revenue from a tobacco settlement undermine the investment for children that has already been agreed to in the balanced budget agreement.

Q: DO YOU SUPPORT THE TOBACCO TAX THAT WAS INCLUDED IN THE FINANCE COMMITTEE MARK-UP?

A: Yes. I do hope, however, that we can dedicate more of the savings from the revenue -- beyond the \$8 billion -- to other children's priorities.

Q: WHY DID YOU OPPOSE THE HATCH-KENNEDY LEGISLATION? AND WHY DID YOU NOT OPPOSE THE ADDITIONAL \$8 BILLION FOR CHILDREN'S HEALTH FROM TOBACCO REVENUE IN THE SENATE FINANCE MARK-UP. HOW DO YOU RECONCILE THIS INCONSISTENCY?

A: I have been supportive of using revenue raised from tobacco for health care since the beginning of his Administration. It was explicitly used as a revenue source for the Health Security Act.

I did not support adding the Hatch-Kennedy amendment in the context of the budget agreement because the Republican Leadership strongly asserted it would have undermined the budget deal and the \$16 billion already allocated for children's health care. I have repeatedly said how difficult it was for me to oppose that legislation, which encompasses goals I clearly support.

In the recent Finance Committee mark-up, the Republican Leadership accepted a down-sized tobacco tax (20 cents) and allocated some of the savings (\$8 billion) for children's health. Their support for this revenue source removes any barrier for me to support it.

Q. DO YOU BELIEVE THAT THE VOTE AGAINST THE CHAFEE-ROCKEFELLER CHILDREN'S AMENDMENT WAS A REJECTION OF THE YOUR HEALTH CARE PRIORITIES?

A. No. While we were disappointed that Chafee-Rockefeller amendment did not pass, the Senators made improvements that responded to a number of the concerns that I had raised about the Chairman's mark and the Commerce Committee bill.

Before the final compromise was reached, the original Finance legislation fell well short of assuring that the \$16 billion for children's health care was being effectively targeted to ensure that the greatest number of children would be given a meaningful benefits package. For example, it would have permitted states to use the \$16 billion for purposes other than expanding health insurance coverage to children, and it would have allowed states to offer health plans that would not have included many important benefits that children need.

I do, however, believe that we need to continue to work to ensure that the final bill includes provisions that guarantee that low-income children are not exposed to excessive cost sharing and to ensure that the benefit that is provided to children is meaningful.

I fought extremely hard to ensure that the \$16 billion for children's health was in the Budget Agreement. I will continue to work to ensure that the final children's health legislation provides children with a meaningful benefits package and covers the most children possible.

MEDICARE

Q: DO YOU SUPPORT THE INCOME-RELATED PREMIUM PROPOSAL THAT WAS IN THE SENATE FINANCE COMMITTEE MARK?

A: First, what passed the Senate Finance Committee was not an income-related premium but rather an income-related deductible that would allow high-income beneficiaries to pay deductibles beyond the current limit.

The proposal is also outside of what was decided in the Budget Agreement. We decided on what beneficiary savings were in the agreement and all assumed there would be no other beneficiary cost-sharing burdens.

I agree with the former Congressional Budget Office Director, Robert Reischauer that it would be administratively complex and potentially unworkable in a practical context. Regardless, it needs much consideration before we could support it as an addition to the Medicare program.

For this reason, we do not support this proposal in the context of the budget negotiations. However, we would be happy to have discussions with Senator Kerrey and others about this provision in another context.

Q: DO YOU SUPPORT EXTEND THE AGE OF MEDICARE AGE OF MEDICARE ELIGIBILITY OLDER AMERICANS FROM 65 TO 67 YEAR OLD?

A: **Raising the eligibility age for Medicare from 65 to 67 is not consistent with the spirit of the balanced budget agreement.** We do not support this provision in the context of the balanced budget negotiations. It was not thoroughly discussed in the budget agreement, and we believe that it raises a number of issues that have not been thoroughly considered.

Many early retirees would lose their private health insurance if Medicare was not available to them. There 4.1 million retirees between the ages of 55 and 64 -- 24 percent of all retirees. Having no alternative available, many would become uninsured while they were waiting for Medicare.

Health care coverage for early retirees is already dropping. The proportion of all retirees covered by health insurance from a former employer dropped from 37 percent in 1998 to 27 percent in 1994.

The decline in coverage among active workers, which decreases the likelihood of retiree health benefits, is a significant factor in this decline of coverage. The proportion of workers who with coverage from their employer upon reaching retirement declined from 65 percent in 1988 to 60 percent in 1994.

Only 30 percent of early retirees (age 55-64 years i.e. non-Medicare eligible) have health insurance from a former employer.

The cost of health care is also a significant factor for retirees. One-fourth of all retirees who elected not to carry their insurance into retirement reported they made their decision to drop insurance because it was too expensive.

Unlike Social Security, if we raised the age limit for Medicare, beneficiaries who retire early would not be eligible for a portion of benefits.

With Social Security, Americans who retire early are eligible for a portion of their benefits until they reach the age of eligibility. There are no options for partial benefits for Medicare beneficiaries who need access to health care coverage before they reach the age of eligibility.

Q: DO YOU SUPPORT THE HOME CARE COPAYMENT INCLUDED IN THE BILL FROM THE SENATE FINANCE COMMITTEE?

A: No. It is outside the context of the Budget Agreement and it needs further review before proceeding further in the legislative process.

We must remember that Medicare beneficiaries who use the home health services tend to be in poorer health. Two-thirds are women, and one-third live alone. Forty-three percent have incomes less than \$10,000. We would want to therefore make certain that a copayment would not place excessive burdens on beneficiaries who truly needed the benefit.

While we do not support this proposal in the context of the Budget Agreement, we do believe that proposals like it merit consideration in any serious review of options to address the long-term financing challenges confronting the Medicare program.

Q: THE HOUSE COMMERCE COMMITTEE, THE WAYS AND MEANS COMMITTEE AND THE SENATE FINANCE COMMITTEE ALL VOTED TO FORM A MEDICARE COMMISSION. DO YOU SUPPORT THIS AS WELL?

A: We have always indicated our support for a bipartisan process to address the long-term needs of the Medicare program. However, our first goal is to pass the Medicare reforms in the Budget Agreement that will extend the life of the trust fund for at least a decade. We still have lots of work to do on this deal to ensure that we get the provisions agreed to in the Budget Agreement.

A Commission similar to the different approaches outlined in Congress may or may not be the best bipartisan process. We will continue our conversations with the Democrat and Republican Leadership to determine the most advisable course of action.

AIDS

Q: WHAT IS YOUR POSITION ON THE MAYORS' RESOLUTION IN SUPPORT FOR FEDERAL FUNDING OF NEEDLE EXCHANGE PROGRAMS?

A: Current law prohibits the Administration from authorizing the use Federal funds for needle exchange programs unless there is conclusive evidence that they do not encourage drug use. Although there is strong evidence that indicates that needle exchange programs help reduce the spread of AIDS, we have not concluded our review on whether these programs increase the use of drugs.

We are consulting with HHS and the Office of National Drug Control Policy in this regard. But once again, we are explicitly prohibited from releasing Federal public health dollars until and unless a formal determination is made that the use of these programs does not increase drug use. It is important to point out that local communities remain can and do use non-Federal funds to support such programs.

Q: HOW DO YOU RESPOND TO AIDS ACTIVISTS CALL FOR MORE FUNDING OF PROTEASE INHIBITORS FOLLOWING UP THE HHS-ISSUED GUIDELINES LAST WEEK ON AIDS TREATMENT?

A: The Department is reviewing the budget implications of the new treatment guidelines for the AIDS Drug Assistance Programs (ADAP). We are working with states to determine whether our current budget does enough to help states treat those in need. If it becomes clear that there is a severe shortage in this area than we will -- as we always have -- make every effort to address these problems.

Last year, when we determined we needed more funding for this program to cover the then new protease inhibitor drugs, we sent two budget supplementals to the Hill. My Administration has nearly tripled funding for ADAP since I took office, and my current budget represents an 168 percent increase for Ryan White.

Q: WHY NOT EXPEND THIS KIND OF ENERGY AND RESOURCES ON A CURE FOR BREAST CANCER OR HEART DISEASE OR DIABETES AS IT SEEMS TO FOR AIDS?

A: This Administration has made a strong improving biomedical research an extremely important priority. We have increased investments in biomedical research at the National Institutes of Health by an impressive 16 percent since the I took office.

These additional investments has been used to increase investments in biomedical research in a number of important areas. For example, funding for breast cancer research has increased by 76 percent since 1993 .

MEMORANDUM

June 17, 1997

TO: Distribution

FR: Chris Jennings

RE: Senate Finance Committee Markup and Children's Health Initiative

Attached is a copy of the letter the President sent up to Senator Roth indicating his support for amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch to the Senate Finance Committee markup on children's health. The President also referenced his support for this amendment at the conclusion of his remarks at the Title IX event this morning.

Also attached is a one-page background on this amendment and the concerns we have about the underlying provisions Chairman Roth has in his mark, as well as a set of Q & A's on possible issues that may be raised by the media on this issue. Lastly, you will find a copy of the letter Frank Raines sent to Chairman Roth this morning that outlines our concerns with all of the provisions in the mark that are either inconsistent with either the Budget Agreement or our policy priorities.

I hope you find this information useful. If you have any questions, please don't hesitate to call me.

THE WHITE HOUSE

WASHINGTON

June 17, 1997

Dear Mr. Chairman:

I urge the Senate Finance Committee to adopt the bipartisan children's health amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch. As you know, I am extremely committed to using the \$16 billion for children's health to provide meaningful coverage for as many uninsured children as possible. The bipartisan amendment offers an opportunity to do just that.

It is critical that we continue to work together in this Congress to find ways to provide health care coverage for millions of uninsured children. As you know, over ten million children lack health care coverage -- and the impact on their families is profound. A recent study showed that nearly 40 percent of uninsured children go without the annual check-ups that all children need. One in four uninsured children do not have a regular doctor. And throughout the country, too many parents are living in fear that they may be forced to make the impossible choice between buying medicine for a sick child or food for an entire family.

Because of the importance of this problem, we need to work together to design the most effective way to invest the \$16 billion. The bipartisan amendment takes a major step toward this goal. This plan rationalizes Medicaid so that children in the same family are eligible for the same coverage. Children under 6 years old and under 133% of poverty -- about \$21,000 for a family of four -- are already eligible for Medicaid. The bipartisan plan provides incentives for states to cover older children up to this same income level. The plan also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. Resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program. In addition, this bipartisan plan offers meaningful coverage that protects vulnerable children from excessive costs.

The bipartisan initiative -- which balances protections for vulnerable children with flexibility to target middle-class children -- stands in sharp contrast to the Commerce Committee's proposal. The plan to simply put out a block grant, with few rules and no benefits requirements, will not result in meaningful coverage for many uninsured children. While your proposal improves

The Honorable William V. Roth, Jr.
Page Two

on the Commerce Committee's plan, the claim that it provides a choice between Medicaid and a grant approach is exaggerated. Given the incentives in the proposal, no rational state would choose Medicaid.

The bipartisan amendment merits strong and favorable support from the full Finance Committee. We should take advantage of this opportunity to significantly reduce the number of uninsured children. I look forward to working with you and others on the Finance Committee and in the Congress to achieve this end.

Sincerely,

A handwritten signature in cursive script that reads "Bill Clinton". The signature is written in dark ink and is positioned below the word "Sincerely,".

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

PRESIDENT ANNOUNCES SUPPORT FOR BIPARTISAN CHILDREN'S PLAN

Today, the President announced his support for the Senate bipartisan amendment to provide meaningful health coverage to uninsured children. Senators Chafee, Rockefeller, Jeffords and Hatch have designed a consensus proposal on how to invest the \$16 billion in the Balanced Budget Agreement. This proposal is consistent with the President's commitment to extending meaningful health coverage through the most cost-effective approach. This important legislation would result in the largest investment in children's health coverage since the enactment of Medicaid in 1965.

The bipartisan amendment protects vulnerable children while offering states flexibility. It:

- **Gives states incentives to rationalize Medicaid.** Today, Medicaid covers children under 6 years old with incomes up to 133% of poverty, or \$21,000 for a family of four. The bipartisan plan provides incentives for states to cover all children, regardless of age, up to this income level.
- **Funds innovative state programs to target middle-class uninsured children.** Unlike low-income children, middle-class uninsured children are difficult to target with a single program. A grant program gives states the resources and flexibility to find and cover these children.
- **Offers meaningful coverage that protects vulnerable children from excessive costs.** Children have a wide range of health needs. The bipartisan amendment assures that children covered through the initiative receive meaningful benefits without unaffordable cost sharing.

The Roth proposal, in contrast, does not balance protection for vulnerable children with state flexibility.

- **False choice.** The Roth proposal asserts that states have the choice of expanding coverage to children through a block grant or Medicaid. However, it is a false choice. The rules for the block grant are designed so that no rational state would chose Medicaid, regardless of its merits.
- **Splits families.** The Roth proposal allows states to use the block grant for older, low-income children and Medicaid for younger children. It makes no sense to give a child below 6 years old one type of coverage and a child above 6 years old different coverage.

The President encourages the Senate Finance Committee and the full Congress to support this bipartisan approach. We should take full advantage of this opportunity to provide meaningful health coverage to a significant number of uninsured children.

Questions and Answers

Q: In Robert Pear's *New York Times* story today, the Governors -- who you applaud for their innovative efforts in this area -- are claiming that states will never expand coverage under a proposal with so many strings attached. How do you respond to this letter?

A: As a former Governor, the President well understands that states need flexibility to design programs that best meet the needs of their populations. However, if the taxpayers are going to invest \$16 billion in children's health care, there needs to be some accountability for these dollars. We believe that this proposal contains important administrative and financial incentives that will help states expand their programs.

Q: Why don't you support Republican proposals that allow states to use all of the funding for grants?

A: We believe that we should build on the Medicaid program and encourage states to cover all children under 133 percent of poverty so that children in the same family -- whatever age -- are eligible for the same coverage. This approach offers meaningful coverage that protects vulnerable children from excessive costs. The Chafee-Rockefeller-Jeffords-Hatch amendment also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. We believe that resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program.

Q: How can you criticize the Roth grant proposal when your benefit package is less prescriptive than his?

A: Our approach always assumes a strong Medicaid base program. The Roth proposal establishes incentives for states to allocate the entire \$16 billion children's health investment to block grants, which would allow for less meaningful health insurance coverage. In so doing, it children 6 years of age and older at income levels less than 133 percent of poverty -- about \$21,000 for a family of four -- would not have the same benefit as their younger siblings.

Q: Are you saying that you will veto any proposal that is less prescriptive than the Chafee-Rockefeller Amendment?

A: We will have to evaluate all proposals that come up. There may strengthening provisions that make some sense. But there is no question that relative to all proposals on the table, that the Chafee-Rockefeller-Jeffords-Hatch amendment is far preferable.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

June 17, 1997

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing to express the views of the Administration on the Medicare, Medicaid, and children's health provisions under consideration by the Finance Committee, for inclusion in the FY 1998 budget reconciliation bill. The Administration's views on the other provisions in the Chairman's mark, including Welfare-to-Work, benefits for immigrants and unemployment insurance, will be provided separately.

Overall, the Administration finds much to support in the mark. It incorporates many of the proposals from the FY 1998 President's budget and is generally consistent with the Bipartisan Budget Agreement. It proposes Medicare structural reforms that constrain growth, extend the life of the Hospital Insurance (HI) Trust Fund for at least a decade, and improve preventive care benefits. In addition, the Committee's mark assures that hospitals will receive all of the funding to which they are entitled for graduate medical education and uncompensated care. All of these changes will help strengthen and modernize Medicare for the 21st century. It also allocates the full \$16 billion for children's coverage policies without dedicating any of this important investment to an inefficient tax approach.

Medicaid

In a number of areas related to Medicaid, however, the Administration has serious concerns with provisions that do not reflect the budget agreement. If the Committee were to proceed with its legislation in this form, we would be compelled to invoke the provisions of the agreement that call on the Administration and the bipartisan leadership to undertake remedial efforts to ensure that reconciliation legislation is consistent with the agreement.

Investments. After extended negotiations that preceded the budget agreement, the Administration and the Congressional leadership agreed to specified savings and investments in the Medicaid program over five years. Recognizing that premiums represent a significant burden on low-income beneficiaries, the agreement allocated \$1.5 billion to ease the impact of increasing Medicare premiums on this population. The Finance Committee mark failed to include this proposal. We strongly urge the Committee to include this proposal.

We are pleased that the Committee mark includes a higher matching payment for the Medicaid program in the District of Columbia and inflation adjustments for the Medicaid programs in Puerto Rico and the territories, but we are concerned that the increases are not sufficient. The matching rate proposed in the mark for the District of Columbia sunsets at the end of FY 2000 and is 10 percentage points lower than the matching rate of 70 percent proposed in the FY 1998 President's budget. It appears that the five-year spending associated with the inflation adjustments for Puerto Rico and the territories proposed in the mark is lower than the level proposed in the President's budget. We strongly urge the Committee to include these provisions at the level proposed in the President's budget.

Restoring Medicaid Benefits for Disabled Children. The budget agreement clearly includes the proposal to restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility. The Finance Committee mark failed to include this proposal. We strongly urge the Committee to include this provision and retain Medicaid benefits for approximately 30,000 children who could lose their health care coverage in FY 1998.

The Committee mark also includes a number of provisions that were not specifically addressed in the budget agreement, and about which the Administration has serious concerns. They include the following:

Disproportionate Share Hospital Savings. We have concerns about the details of the allocation of the disproportionate share hospital (DSH) payment reductions among States included in the mark. The Finance Committee mark may have unintended distributional effects among States. We recommend that the Committee revisit the FY 1998 President's budget proposal, which achieves savings by taking an equal percentage reduction off of states' total DSH spending, up to an "upper limit."

We are very concerned that the Finance Committee mark does not include any retargeting of DSH funds. As the Administration has stated previously, we believe that significant savings from DSH payments should be linked to an appropriate targeting mechanism. It is for this reason that we support proposals to assure that some DSH funds are directed to hospitals that serve a high proportion of low-income and uninsured patients.

Privatization. The Chairman's mark would allow the eligibility and enrollment determination functions of Federal and State health and human services benefits programs -- including Medicaid, WIC, and Food Stamps -- in ten States to be privatized and deems approved such a proposal from the State of Texas. While certain program functions, such as computer systems, can currently be contracted out to private entities, the certification of eligibility for benefits and related operations (such as obtaining and verifying information about income and other eligibility factors) should remain public functions. The Administration believes that changes to current law would not be in the best interest of program beneficiaries and strongly opposes this provision.

Medicaid Cost Sharing. The mark would allow States to require limited cost sharing for optional benefits. We are concerned that this proposal may compromise beneficiary access to quality care. Low-income Medicaid beneficiaries may forgo needed services if they cannot afford the copayments. We urge the Committee to revisit the FY 1998 President's budget proposal, which would allow nominal copayments only for HMO enrollees. This proposal grants States some flexibility and would allow HMOs to treat Medicaid enrollees in a manner similar to non-Medicaid enrollees, without compromising access to care:

Criminal Penalties for Asset Divestiture: The Finance Committee mark would amend Section 217 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to provide sanctions only against those who assist people to dispose of assets in order to qualify for Medicaid. We believe the better solution to the issues that the HIPAA provision created would be to repeal this section altogether.

Children's Health

The Chairman's mark does not include detailed specifics on the children's health provisions. However, we are encouraged by reports that a bipartisan group of Senators are proposing to use this investment to build on Medicaid for low-income children and offer States grants to give children in working families meaningful coverage.

We believe that the \$16 billion investment in children's health should be used for health insurance coverage. It is for this reason that the Administration supports proposals that only allow funds to be used for insurance, through Medicaid or a capped grant, and does not allow funds to be used for direct services. Under a direct services option, we are concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and children would not necessarily get meaningful coverage.

We urge the Committee to use the funds in the most cost-effective manner possible to expand coverage to children, as required by the agreement. The Chairman's mark includes both a Medicaid and a grant option; however, the mark should not discourage States from choosing the Medicaid option. We believe that Medicaid is a cost-effective approach to covering low-income children, and would like to work with you on strengthening this option. We also believe that the grant program should be designed to be as efficient as possible. The mark should provide appropriate details to assure that funds are used solely for the purposes intended by the agreement and not used to offset States' share of Medicaid.

It is our understanding that the alternative children's health coverage approach that is being developed by the bipartisan coalition of Senators includes provisions that address many, if not all, of these concerns. We look forward to working with the bipartisan coalition and the Committee on this high priority issue for the President and the Congress.

Medicare

Home Health Reallocation. It is our view that the home health reallocation in the budget agreement is not properly reflected in the Committee's mark. During the negotiations, we discussed at great length the shift of home health expenditures to Part B, and it was always understood to be immediate. The Committee's phase-in of the shift means a loss of two years of solvency on the Part A trust fund, two years which we can ill afford to lose. In addition, a phased-in reallocation would cause significant administrative problems regarding claims processing, appeals, and medical review for Medicare contractors. We urge the Committee to incorporate the same provision that was included in last week's House Commerce Committee bill.

Balance Billing Protections in Medicare Choice. While the Administration supports the introduction of new plan options for Medicare beneficiaries, we believe that any new options must be accompanied by appropriate beneficiary protections. We believe that inclusion of private fee-for-service plans in Medicare Choice without balance billing protections is unnecessary. Beneficiaries should not be exposed to billing in excess of current law protections. Also, we are concerned that this option will attract primarily healthy and wealthy beneficiaries and leave sicker and poorer beneficiaries in the more expensive, traditional Medicare program.

Medical Savings Accounts. While we have agreed to work to develop a demonstration of this concept for the Medicare population, we have concerns about the size and scale of the demonstration in the mark. The Committee's mark provides for a demonstration with 500,000 participants at a cost of approximately \$2 billion over five years, which is many times larger than any other Medicare demonstration. We believe the demonstration should be limited geographically for a trial period, which will enable us to design the demonstration to answer key policy questions. We have suggested limiting the demonstration to two states for a three-year period. Further, we strongly believe that the current law limits on balance billing should also be applied to this demonstration to protect beneficiaries from being subjected to unlimited additional charges.

Preventive Benefits. While the preventive benefits are largely the same as those advanced in the President's budget, we bring to your attention the proposal to waive coinsurance for mammograms. As you know, mammography saves lives, yet many Medicare beneficiaries fail to use this benefit. Research has found that copayments hinder women from fully taking advantage of this benefit. Thus, we continue to support waiving copayments for mammograms.

Home Health Copayments. We note that the Committee's mark would impose a Part B home health copayment of \$5 per visit, capped at an amount equal to the annual hospital deductible. Medicare beneficiaries who use home health services tend to be in poorer health than other Medicare beneficiaries. Two-thirds are women, and one-third live alone. Forty-three percent have incomes under \$10,000 per year. We are concerned that a copayment could limit beneficiary access to the benefit. Imposing a home health copay is not necessary to balance the

budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare.

Medicare Eligibility Age. Raising the eligibility age for Medicare is not necessary to balance the budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare. Moreover, this proposal does not contain provisions to address the fact that early retirees between the ages of 65-67 may not be able to obtain affordable insurance in the private market.

Prudent Purchasing. As you know, the Medicare program is governed by a strict set of provider payment rules that limit the ability of the Federal government to secure the most competitive terms available to other payers in the marketplace. We have advanced a set of proposals to allow Medicare, the nation's largest health insurer, to also take advantage of lower rates providers offer to other payers. At a time when we all agree that Medicare spending has been growing too quickly and the Federal budget faces increasing pressures for scarce resources, we do not understand why the Committee would miss the opportunity to take advantage of all these proposals to allow Medicare to be a more prudent purchaser. We propose adopting practices that work in the private sector. We should let them work in the public sector as well. These practices can work well to save taxpayers money and promote quality. We urge the Committee to include the President's proposals.

HI Tax for State and Local Workers. We note that the Committee's mark includes a proposal to extend the HI tax for State and local government employees. This proposal was not discussed in the negotiations surrounding the development of the budget agreement.

Commission. We note that the Committee's mark includes a Medicare commission. Establishing a bipartisan process that is mutually agreeable is essential to successfully address the challenges facing Medicare. We look forward to working with you on the development of the best possible bipartisan process to address the long-term financing challenges facing Medicare while simultaneously ensuring the sound restructuring of the program to provide high-quality care for our nation's senior citizens.

Cost Allocation Amendment

We understand that amendments may be offered during Committee consideration to prevent costs from increasing in Food Stamps and Medicaid due to cost-shifting for common functions from the TANF block grant, which places a cap on TANF administrative costs. We understand that the CBO baseline includes costs of over \$5 billion in FYs 98-02 because CBO assumes administrative cost-shifting from TANF to Food Stamps and Medicaid. This proposal seeks to reduce the extent of the cost-shift to Food Stamps and Medicaid, which could yield substantial savings against CBO's baseline.

While the Administration is generally supportive of this effort -- to prevent States from changing cost allocation plans in order to shift greater administrative costs from the capped TANF block grant to open-ended Food Stamp and Medicaid administrative costs that are matched by the Federal government -- we would need to carefully review the specific mechanism proposed. Furthermore, we would have very serious reservations about proposals that would cap Food Stamps and Medicaid administrative costs and would oppose a cap that would limit the ability of a State to manage its programs.

The budget negotiators discussed changes to the Food Stamp and Medicaid programs at considerable length. Any further savings in this area would require mutual agreement, as would the allocation of those savings either to deficit reduction or to new spending.

The budget agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. It is critical that we do so on a bipartisan basis.

I look forward to working with you to implement this historic agreement.

Sincerely,

A handwritten signature in black ink, appearing to read 'Franklin D. Raines', written in a cursive style.

Franklin D. Raines
Director

Identical letter sent to the Honorable Daniel Patrick Moynihan

Addendum

Medicare Choice. We would prefer to link the growth in payments for Medicare Choice plans to growth in the fee-for-service sector of Medicare, rather than having two separate growth targets. To do so may lead over time to an erosion of the value of the Medicare Choice benefit package and expose beneficiaries to increased premiums.

Medigap Reforms. The President's bill advanced a number of important Medigap reforms including annual open enrollment (as well as including information about Medigap plans in the annual open enrollment season informational materials), community rating, open enrollment for disabled and ESRD beneficiaries when they become entitled to Medicare, and portability protections similar to those enacted last year in HIPAA for the under-65 population. Many of these important protections were also advanced by bipartisan bills including those sponsored by Senators Chafee and Rockefeller. We urge your reconsideration of the merits of these proposals. They ensure that Medicare beneficiaries are able to purchase affordable Medigap policies to fill in the many areas not covered by Medicare. Medicare beneficiaries should be able to choose which Medigap plans to purchase, or Medicare Choice plans to enroll in, without artificial constraints.

Survey and Certification User Fee Proposal. The Committee mark does not contain a provision allowing HCFA to require state survey agencies to impose fees on health care providers for initial surveys required as a condition of participation in the Medicare program. This provision would authorize states to collect and retain fees from health care providers to cover the cost of initial surveys. Under the budget agreement, the discretionary funding level for HCFA Program Management assumes enactment of this mandatory, government receipt fee proposal. Adequate funding for survey and certification activities is essential to program integrity.

Hospital Capital Property Tax. We are concerned about the inclusion of this provision on the grounds that it results in an inequitable redistribution of inpatient hospital PPS funding among proprietary and not-for-profit hospitals.

Creation of Duplicative Managed Care Bureaucracy. We understand that an amendment may be offered that would establish a new bureaucracy in HHS to administer the managed care reforms in the mark. We would strongly oppose such an amendment. The implications for beneficiary services are serious: one agency is in a much better position to coordinate programs and policies that will permit the 38 million Medicare beneficiaries to make informed choices of the whole new array of plan options under the mark. In addition, at a time when we are trying to reduce the size of the Federal bureaucracy, it seems counter-productive to divide Federal administration of Medicare into two separate, largely duplicative agencies.

THE WHITE HOUSE
WASHINGTON

April 23, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings
cc: Bruce Reed, Gene Sperling, John Hilley, Melanne Verveer
SUBJECT: Introduction of a New Bipartisan Children's Health Bill

Tomorrow afternoon, Senator Chafee and Senator Rockefeller will lead a bipartisan group of at least 13 Senators (Hatch, Snowe, Collins, Jeffords, Breaux, Kerrey, Bingaman, Dodd, Kerry, D'Amato, and Kennedy) in introducing a new \$15 billion, Medicaid-based children's health coverage bill. They will suggest that their plan "targets" 5 million uninsured children, but their staffs are nervous about overpromising because estimates given to them by the Congressional Budget Office yesterday have, on a preliminary basis, projected a much lower number. Perhaps because of this, the sponsors will say that this legislation "complements," but does not replace the need for the Hatch-Kennedy grant program.

The Chafee/Rockefeller legislation includes: (1) your 12 month continuous coverage initiative; (2) an enhanced Federal match for children between 100 and 150 percent of poverty for those states that immediately cover all children up to age 18 to 100 percent of poverty (who are currently being phased-in over the next 5 years); and (3) a \$25 million a year state outreach grant. There will be no specific financing mechanism; apparently the sponsors agree with our current position that the more than \$120 billion in Medicare and Medicaid reductions that we are currently proposing is more than adequate to finance the \$15 billion investment. (As a reminder, we are currently carrying about \$19 billion for our new health coverage expansions.)

The introduction of yet another bipartisan children's health coverage bill clearly strengthens your hand in the balanced budget negotiations. It is particularly worth noting that a Chafee-Rockefeller type initiative can now easily be envisioned passing out of the Finance Committee since four of the Republican cosponsors sit on the Committee. This bill also helps respond to the Republican Budget Committee Chair's stated desire to avoid the establishment of new programs to address Presidential priorities.

We believe that the Chafee/Rockefeller bill still requires a good deal of work to most efficiently cover a greater number of uninsured children. It also seems likely that we will probably still need some type of grant program to build onto Medicaid improvements to get the most children for the least amount of money. Having said this, the introduction of this legislation undoubtably enhances the likelihood that a substantive children's coverage bill can emerge from the Congress.

THE PRESIDENT WORKED TO EXPAND COVERAGE FOR CHILDREN

**TEN MILLION AMERICAN CHILDREN TODAY
LACK HEALTH CARE COVERAGE.**

THE 1995 REPUBLICAN BUDGET WOULD HAVE MADE THE PROBLEM WORSE. IT WOULD HAVE:

- ✗ Created Block Grant that would have increased the number of uninsured children. The 1995 Republican budget even failed the "do no harm" in the areas of children's health. That budget eliminated the guarantee of a meaningful Medicaid package for poor children and attempted to replace Medicaid with an insufficiently funded block grant program.
- ✗ Would have forced states to decrease the number of insured children by as many as 3.8 million due to a lack of sufficient funds, according to a study by the Department of Health and Human Services.
- ✗ Eliminated the Medicaid phase-in for children between the ages of 13 and 18.

THE PRESIDENT'S CHILDREN'S HEALTH INITIATIVE EXPANDS HEALTH CARE COVERAGE FOR MILLIONS OF CHILDREN.

THE PRESIDENT FOUGHT TO ENSURE THAT ANY BALANCED BUDGET AGREEMENT EXPANDS CHILDREN'S HEALTH COVERAGE. HIS CHILDREN'S HEALTH INITIATIVE PROVIDES HEALTH COVERAGE FOR AS MANY AS 5 MILLION ADDITIONAL CHILDREN BY:

- ✓ **Improving Medicaid and Adding Medicaid Investments.** The President's budget works to enroll as many of the 3 million children who are eligible but not enrolled for Medicaid, to expand coverage to children who are above the current income eligibility standards, to provide additional coverage to children and legal immigrants.
- ✓ **A New Capped Mandatory Grant Program That Provides Additional Dollars to Leverage Federal dollars to Supplement States Efforts to cover uninsured children in working families.**

President Clinton Worked for Stronger Environmental Enforcement and Protection

PRESIDENT CLINTON WOULD NOT ACCEPT ANY BUDGET THAT DOES NOT INCREASE ENVIRONMENTAL PROTECTION

THE 1995 REPUBLICAN BUDGET WOULD HAVE MOVED THE COUNTRY BACKWARD IN OUR QUEST FOR A CLEANER ENVIRONMENT:

- X **Took Environmental Cop off the Beat.** It would have cut the enforcement of environmental laws by a quarter and let polluters off the hook.
- X **Slowed toxic waste cleanups.** It slashed funding -- 25 percent in the first year -- for toxic waste cleanup efforts. In all the Republican Budget would have cut EPA's budget by 22 percent.

President Clinton is working to move the country forward toward a cleaner environment:

ACCELERATE TOXIC WASTE CLEANUPS

- **Double the Pace of Superfund Cleanups.** In contrast to Republican efforts to slow cleanups down, the President is determined to nearly double the pace of Superfund cleanups. President Clinton has proposed:
 - ✓ **The cleanup of 500 additional sites** by the end of the year 2000 so millions of Americans can enter the next century in healthier neighborhoods.
 - ✓ **A \$650 million increase over 1997 for Superfund**, bringing total funding to \$2.1 billion in 1998.

EXPAND BROWNFIELDS REDEVELOPMENT INITIATIVE

- **Tax Incentives for Distressed Areas.** The President's Brownfields Initiative helps communities cleanup and redevelop contaminated areas with grants and targeted tax incentives, creating jobs and protecting public health.
 - ✓ **Funding is boosted \$75 million in 1998** to provide grants to communities for site assessment and development planning and to leverage state, local, and private funds to foster redevelopment.

IMPROVE AMERICANS' RIGHT TO KNOW ABOUT TOXICS

- **Expanding Community Right-to-Know.** The budget proposes \$49 million to expand the information people get about toxic threats to their families and communities.

MORE AGGRESSIVE CRIMINAL ENFORCEMENT OF POLLUTERS

- **Stepped-Up Enforcement.** President Clinton is committed to more aggressive enforcement efforts against polluters. President Clinton has proposed:
 - ✓ **Increased funding** to train state and local officials who work at the local level to enforce environmental laws.
 - ✓ **A 9 percent increase** to the account which funds EPA enforcement.

BETTER PROTECTION OF NATIONAL PARKS

- **Helping Preserve our National Heritage.** President Clinton is increasing by 6 percent (\$66m) the budget for national park operations to help improve park facilities and further protect our natural treasures. The President's has also proposed:
 - ✓ **An 8 percent increase (\$14m) for wildlife refuge operations**
 - ✓ **A 163 percent increase (\$205m) for Everglades restoration**
 - ✓ **Funding for the new Grand Staircase-Escalante National Monument** which comprises more than one and a half million acres encompassing hundreds of millions of years of geological and cultural history.

PROMOTE ENERGY EFFICIENCY AND RENEWABLE ENERGY

- President Clinton's budget contains **\$688 million for energy efficiency** and **\$330 million for solar and renewable energy**, increases of **25 percent** and **22 percent**, respectively, over 1997.

President Worked to Modernize and Strengthen Medicare and Medicaid

THE PRESIDENT REJECTED THE 1995 REPUBLICAN BUDGET IN LARGE PART BECAUSE OF DEEP CUTS IN MEDICARE AND MEDICAID.

THE 1995 REPUBLICAN BUDGET CONTAINED DANGEROUS MEDICARE STRUCTURAL REFORMS THAT WOULD HAVE UNDERMINED THE PROGRAM AND IMPOSED PREMIUMS AND BURDENS THAT WOULD HAVE HURT OLDER AND DISABLED AMERICANS. IT WOULD HAVE:

- ✘ **Increased premiums from 25% of Part B program costs to 31.5%.** These higher costs would have placed a large financial burden on Medicare beneficiaries -- three-quarters of whom have incomes below \$25,000. In 1996 alone, this would have increased costs per elderly couple by \$268.
- ✘ **Eliminated balance billing protections,** allowing doctors in the new private fee-for-service plan options to overcharge above Medicare's approved amount leaving the elderly vulnerable to higher costs and giving doctors in the fee-for-service program an incentive to switch to private health care plans, reducing access for beneficiaries in the traditional plan.
- ✘ **Encouraged "Cherry Picking" that would have harmed beneficiaries and damaged the Medicare program.** The Republican proposals would have introduced nationwide health plan options, such as medical savings accounts and risky "association" plans, that would have led to risk selection, thereby increasing the costs of what would be a sicker and weaker traditional Medicare program.
- ✘ **Included only \$100 million in investments in preventive benefits.**
- ✘ **Repealed the Medicaid program and replaced it with a block grant.** The plan would have eliminated the Federal guarantee Medicaid provides to poor families. In 2002 alone, 8 million people could have lost their health coverage, because of inadequate funding. In addition, as many as 330,000 people could have been denied nursing home coverage.
- ✘ **Eliminated the guarantee of Medicaid coverage of Medicare deductibles, copayments, and premiums** for older Americans and people with disabilities near or below the poverty line known as "Qualified Medicare Beneficiaries (QMBs)". They set aside less than half the money needed to cover premiums for QMBs and set aside no funding for deductibles or copayments. More than 5 million elderly and disabled poor Americans would have lost their guarantee that Medicaid covers Medicare cost-sharing.

TO MODERNIZE THE MEDICARE PROGRAM AND BRING IT INTO THE 21ST CENTURY, THIS BUDGET

- ✓ **Extends the life of the Medicare Trust Fund at least a decade.**
- ✓ **Makes positive structural reforms.** The President's budget contains a series of structural reforms which modernize the program, bringing in line with the private sector and preparing it for the baby boom generation. It:
 - ☞ *Increases the number of health plan options* -- including Preferred Provider Organizations and Provider Sponsored Organizations -- available to seniors and people with disabilities.
 - ☞ *Improves Medicare managed care payment methodology and informed beneficiary choice.* The President's budget addresses geographic disparities in payments; removes graduate medical education and disproportionate share hospital payments from managed care rates; and adjusts managed care rates for overpayments due to favorable selection.
 - ☞ *Guarantees that beneficiaries can enroll in Medigap plans annually without being subject to preexisting condition exclusions,* enabling beneficiaries to enroll in managed care without fearing that they would not be able to re-enroll in traditional Medicare.
 - ☞ *Builds on the successful hospital prospective payment system model,* implementing prospective payment systems for skilled nursing home facilities, home health, and hospital outpatient departments.
 - ☞ *Adopts successful approaches to purchasing other types of services,* including: competitive pricing for durable medical equipment; laboratories; other items and supplies; expanded "centers of excellence"; and increased flexibility from program rules in negotiating rates.
- ✓ **Expands preventive benefits.** The President's budget:
 - ☞ *Waives cost-sharing for mammography services and provides annual screening mammograms* for beneficiaries age 40 and older to help detect breast cancer;
 - ☞ *Establishes a diabetes self-management benefit;*
 - ☞ *Covers colorectal screening* (early detection of cancer can result in less costly treatment, enhanced quality of life, and, in some cases, greater likelihood of cure);
 - ☞ *Increases reimbursement rates for certain immunizations* to protect seniors from pneumonia, influenza, and hepatitis.

President Clinton Fought to Protect The Most Vulnerable People

Several provisions in last year's welfare reform bill had nothing to do with the goals of welfare reform. The President said so at the time and promised to work to correct these provisions. He fought to ensure that any agreement protects the most vulnerable in our society.

THE PRESIDENT FOUGHT TO BETTER PROTECT:

CHILDREN

- ✓ **Food Stamps.** Helps put food on the table for ten million American children each month. Last year's welfare reform bill cut food stamps too deeply -- especially for families with children with high housing costs. To help ameliorate these cuts, President Clinton restores the link between benefits for such families and housing costs.
- ✓ **Keeping the Federal Guarantee to Medicaid.** President Clinton fought to preserve the federal guarantee to Medicaid coverage for the vulnerable populations who depend on it.
- ✓ **Medicaid Preserved for Vulnerable Children.** President Clinton fought to allow children now receiving Medicaid to keep their coverage if they lose their SSI eligibility following last year's definitional change.
- ✓ **Medicaid for Legal Immigrant Children.** Because it is the right thing to do, the President worked to ensure that Medicaid covers legal immigrants children whose families are impoverished.

LEGAL IMMIGRANTS WITH DISABILITIES

- ✓ **Restore SSI and Medicaid.** President Clinton believes, as many Americans do, that law-abiding immigrants who pay taxes, play by the rules, but are disabled should have access to the basic benefits of SSI and Medicaid..

PEOPLE WHO WANT TO WORK BUT CAN'T FIND A JOB

- ✓ **Food Stamps for Childless Adults.** Last year's welfare reform bill harshly restricted food stamps to unemployed childless adults to three months over a 36 month period. This time restriction ignores that finding a job takes time. President Clinton proposes an alternative six month out of 12 restriction. Additionally, this budget establishes new funding to support close to an additional 400,000 more work slots from 1998 to 2002.

FINISH THE JOB OF WELFARE REFORM

- ✓ **Give States and cities the help they need to place the most disadvantaged welfare recipients in lasting jobs.** The Welfare-to-Work Jobs Challenge created by the President would make available the resources needed for States and cities to move one million of the hardest-to-serve recipients into paid employment and keep them there. States and localities could use the WTW Jobs Challenge funds for wage subsidies to private employers, transportation and other post-employment supportive services essential for job retention, and other effective job creation and placement strategies.

- ✓ **Provide incentives for private employers to give welfare recipients the chance they need.** Most welfare recipients very much want to work. The President's welfare-to-work tax credit allows employers to claim a credit of up to 50 percent of the first \$10,000 in wages paid during a year to a worker who had been on welfare for a prolonged period of time. The credit is available for up to two years of work, giving employers a considerable incentive to not just hire but make efforts to retain long-term welfare recipients.

THE WHITE HOUSE
WASHINGTON

H. Care - Children's Health

March 3, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings CCJ
SUBJECT: Response to the Glassman "Monster Kiddie Care" Op Ed
cc: Bruce Reed ✓

You recently forwarded a note referencing the James K. Glassman op ed piece entitled "Monster Kiddie Care". The First Lady saw this article, too, and asked us how we would respond to it. I am attaching for your information our response.

The critique of the Glassman op ed piece is consistent with the more thorough discussion of tax incentives in the February 21 memo on uninsured children. In our response to Glassman, we cite the weaknesses of the repealed 1990 child health tax credit. A more detailed summary of these weaknesses can be found in the attached two-page document.

RESPONSE TO "MONSTER KIDDIE CARE" OP ED

On February 11, 1997, James K. Glassman wrote an editorial in the *Washington Post* critical of proposals to increase coverage of children. On February 24, 1997, Lawrence McAndrews, president of the National Association of Children's Hospitals, wrote a response (see attachments). The Glassman article is extremely flawed in both its diagnosis of and prescription for the problem. Specifically, Glassman:

- **Misstates the facts.** Glassman implies that all of the \$162 billion in Medicaid spending is for children. In fact, only 15 percent, or about \$25 billion, is spent on poor children.
- **Misdiagnoses the "real" problem.** Glassman wrongly suggests that the "real problem" is the 1.5 million children whose parents earn more than \$40,000, and are willing to "take their chances" and not insure their children.
 - First, the 1.5 million children he cites represents only 15 percent of the 10 million uninsured children.
 - Second, many of these children are uninsured because their parents: (1) are not offered insurance in their jobs; (2) are offered but cannot afford family coverage because, unlike most American workers, their employers make little or no contribution toward coverage; or (3) did buy coverage through their employer but lost their ability to afford it when they lost or changed jobs.
 - Third, most of the 1.5 million children have incomes that are at or just above \$40,000, which is below 250 percent of poverty for a family of four — certainly not people who can easily afford to pay a full premium of at least \$6,000 (relative to the typical \$2,000 employee share of a policy when the employer contributes).
- **Prescribes two extreme and flawed solutions to address the problem:**
 1. **Tax incentives:** Glassman suggests a tax credit for children's health coverage — the same type of approach that was repealed in 1993 due to low participation, poor targeting, and fraudulent insurance practices. His tax credit would be available to anyone who qualifies for it with no overall funding limit — in other words, it would be an open ended entitlement. Ironically, this approach is more like one of the "vote-buying, bureaucracy-building monstrosities" that Glassman denounces than is the President's approach, which more efficiently covers uninsured children and does so with a cap on spending.
 2. **Charity:** Glassman asserts that charity can pick up where the tax credit leaves off: if "government gets out of the way, more charities will eagerly fill whatever gap is created." Although charities make a critical contribution, they are the first to acknowledge that they "cannot do the job alone", as the president of the National Association of Children's Hospitals wrote in response. The fact that meaningful government effort is needed to expand children's coverage is acknowledged by policy experts, consumer and child advocates, providers, insurers as well as the Republicans and Democrats Glassman cites.

HISTORY OF THE 1990 CHILD HEALTH TAX CREDIT

SUMMARY

In the Omnibus Budget Reconciliation Act (OBRA) of 1990, a tax credit for health insurance that covers children was added to the earned income tax credit (EITC). An EITC-eligible family could receive a tax credit for its health insurance premium payments if its plan was not an indemnity type and included coverage for children. It was administered as an end-of-the-year credit against taxes or refund if it exceeded the family's tax liability. Unlike the EITC, it could not be received in "advances". About 2.3 million families received the health tax credit in 1991 at a cost of \$496 million.

While the EITC remains in effect today, the health insurance credit was repealed in OBRA 1993 due primarily to: (1) low participation; (2) poor targeting of populations in need; (3) fraudulent insurance practices and oversight problems. Despite the Center on Budget and Policy Priorities' support of the EITC, Robert Greenstein testified to the child health tax credit's failure and supported its repeal — as did the Department of Treasury.

PROBLEMS WITH THE 1990 CHILD HEALTH TAX CREDIT

A General Accounting Office study and the Ways and Means Subcommittee on Oversight documented numerous problems with the policy, including:

- **Low participation:** GAO estimated that only about 26 percent of people eligible participated in the program. This is based on a division of 2.3 million into an estimated 8.8 million families eligible for the credit. It is not known how many of the 2.3 million participants gained coverage through the credit versus had coverage already.
- **Probably paid for coverage that would have been purchased anyway:** The policy did not differentiate between subsidizing existing versus new coverage. Thus, if the tax credit was not generous enough to induce uninsured families to purchase a policy, most of the subsidy went to families who would have been covered by health insurance anyway.
- **Amount insufficient to increase coverage:** In 1991, the average employee share of the family premium, according to a GAO study, was about \$1,025; the average credit was \$233. Thus, the GAO questioned the credit's ability to induce purchase of health insurance. The administration as well as the amount of the credit may also have decreased the effectiveness of the policy. Since the credit was only available at the end of the year, it was retrospective. Low-income families may have had "liquidity" problems: an inability to find the cash during the year to make the payments in hope of reimbursement in the next year.

- **Low awareness:** A GAO survey found that many EITC recipients who had purchased health insurance did not claim the credit. They cited lack of outreach as a major problem.
- **Plans told employees that they could not get any portion of their EITC if they did not purchase health insurance:** Some promotional material implied that the individual had to have health insurance premiums deducted from their paychecks in order to get the EITC advance. For example, an insurance plan in Texas had a notice that said, "COMPULSORY, NOT OPTIONAL: The credit for health insurance came into effect in 1991. Failure to comply can result in 'a penalty equal to the amount of the Advance EITC Payments not made'." Other plans also suggested IRS retribution would occur if they were denied access to employees.
- **Higher than expected premiums:** One of the most common complaints was that plans advertised that health insurance coverage was "free". Some plans falsely claimed that their premiums were totally covered by the health credit when in fact the health tax credit was insufficient and, unbeknownst to the employee, the remainder of the premium was deducted from the non-health EITC.
- **Ineligible and substandard policies:** Families often bought plans that did not qualify for the credit. Amount, duration and scope restrictions were often large, and some policies had pre-existing condition restrictions of 2 years. Some people bought cancer, dread disease, and other supplemental policies that were barely worth the paper that they were written on.
- **Limited information on plans:** People claiming the credit had to name the insurance plan (in 1991 only) and report the amount of the premium paid in filing for the tax credit. This minimal information made it very difficult if not impossible for Treasury to ensure that the credit was going to eligible families for the purchase of qualifying policies.

CONCLUSION

The experience with the OBRA 1990 child health tax credit has relevance to today's debate over insuring children. The Heritage Foundation has stated interest in reviving this particular policy and Senator Gramm has a comparable one in development. While some of the problems described above may be inherent in a tax incentive approach, others were specific to the structure of the 1990 child health tax credit and may be addressed through policy modifications (e.g., enlisting the states in the oversight of plans to reduce fraud).

Monster Kiddie Care

When politicians start talking about how they're going to help poor, sick kids, watch out. Something bigger and more pernicious is afoot—in the latest case, trying to achieve, piecemeal, the government-run health system the nation rejected after President Clinton was elected the first time.

Clinton says in his new budget that he wants to expand health care coverage to the growing numbers of American children who lack insurance. He's proposing to spend \$10 billion over the next five years, but that's a just for starters. Senate Democratic Leader Tom Daschle has a more ambitious plan that would assist families that make up to \$75,000 a year. Massachusetts Sen. Ted Kennedy and John Kerry want Washington to spend \$9 billion annually.

It won't be easy for Republicans in Congress to oppose kiddie care—and don't Democrats know it? But before everyone is swept up in the "compassionate" tide, let's examine some facts, as well as the heroic effort of one unlikely, uninvited charity.

First of all, the government already helps sick kids. Medicaid, the \$162 billion health program for the poor, covers children whose families earn up to 130 percent of the poverty level (even higher in some states). Three million kids who currently qualify for Medicaid don't receive the benefits because they may be in order, but not another entitlement.

In fact, the real problem is with the middle class. Michael Tanner of the Cato Institute points out that, according to the Census, 1.5 million families with incomes of more than \$40,000 a year don't insure their children. Why not?

"They've simply decided to spend the money elsewhere," Tanner says, insuring children is "actually" inexpensive—only about \$100 a month, he says—since kids are far healthier than adults. Still, some parents would rather

take their chances and pay out of their own pockets when a child breaks an arm. That's their decision, and the rest of us should not subsidize it.

Another reason parents don't insure kids is our insane tax system. Health insurance benefits provided by businesses to employees aren't counted as workers' income, so most of us don't buy our own health insurance directly, the way we buy life insurance, mutual funds or groceries. As a result, the marketplace doesn't provide the choices we truly want—including kiddie insurance that meets our own specifications.

There's an easy remedy. The current health-insurance exclusion removes federal tax revenues by \$85 billion a year—and most of that break kids' wealthier Americans. Why not give all Americans the same status in this regard? Instead of tax credits, which are like cash in their pockets, to use to purchase the health care they really want, there would still be children who need health care, especially in a catastrophe. But why should we assume that government is the answer?

Let's minimize, researching another story, if you run across one of the great untold tales in health care: the Shriners Hospital for Children. Yes, the same Shriners who wear funny hats and drive little motorbikes and bring out in dishboards with a Midwest motif. While the 685,000 Shriners evidently have fun, they also do remarkably good deeds, and, since they don't talk like Clinton and Kennedy, they don't get proper recognition.

For 75 years the Shriners have been building pediatric orthopedics and three that provide burn treatment. Last year, they admitted 22,000 children to the hospitals, performed 19,000 operations and recorded 221,000 outpatient visits.

All of this treatment is free. Completely, utterly free. The Shriners take no money from the government, no money from insurance companies or parents. Instead, the \$425 million it takes to run the hospitals this year (including \$20 million for research) comes from a \$5 billion endowment, which itself was built slowly with small and large private contributions, including some from grateful former patients.

The Shriners love their independence, as do the doctors in their hospitals. Members of the Congress are astonished to learn that the Shriners don't want Washington's money.

"If you start taking insurance money, or federal money," Gene Bragwell, chairman of the Shriners, told me, "then you have to do it their way."

In fact, the process can work the other way around. The Shriners help the government. They've just worked out an agreement with the Veterans Administration, at no charge, to treat spinal kids (a paralytic disease) in children of Vietnam veterans.

This new entitlement was based on bad science, but the Shriners don't care. As Ronald Fregel, a trustee of the Shriners Hospital, told me, "Our mission is to ensure that every child who has spinal bifida or some other crippling disease receives top-quality medical care, regardless of ability to pay."

What a wonderful credo! I suspect that if the government gets out of the way, more charities will eagerly fill whatever gap is created.

Still, politicians of both parties prefer vetoing, bureaucracy-building monstrosities like kiddie care. Instead of changing the tax code to open a competitive, robust health insurance market, they'd rather pass to the heads of sick children. In truth, the leaders are unkind. Shriners and millions of other compassionate private Americans.

The Washington Post

TUESDAY, FEBRUARY 11, 1997

THE PRESIDENT HAS SEEN

THE PRESIDENT HAS SEEN

4/5/97

What does UP/Origo group say?

File:
- Pops name
- Children's Health

THE WHITE HOUSE
WASHINGTON
April 11, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: TODD STERN

SUBJECT: Executive Order to Protect Children from Health/Safety Risks

Might want to see how a lot by requiring analysis of impact on kids & explanation of why preferable to reasonable alternatives - lighten burden a bit w/out @ burden

As a lead-in to the zero-three conference next week, you are tentatively scheduled to sign an Executive Order directing agencies to enhance their efforts to protect kids against environmental health and safety risks. There is broad agreement about most elements of the E.O., but disagreement as to the pivotal section, Section 5. The attached memo seeks your approval of one of three options concerning Section 5.

Wanted to sign up major item of potential impact on kids

Background. The proposed E.O. is designed to ensure a more coordinated approach to children's issues by (1) requiring all agencies to make protection of children a high priority in carrying out their statutory responsibilities and overall missions; (2) creating an interagency Task Force to establish a coordinated research agenda and initiatives for the Administration; and (3) requiring agencies to analyze and explain the effects of their regulations on children. It is this last requirement that is the subject of disagreement.

Section 5 -- Federal Regulatory Analysis. As drafted, Section 5 would require agencies to (1) assess the effects of proposed regulations on children if the proposed regs are economically significant and may have a disproportionate impact on kids; (2) assess the effects of reasonable alternatives to the planned reg that provide more or less protection for children than the planned reg; and (3) explain why the planned reg is preferable to the alternatives. Pros and cons are laid out in detail in the memo, but, in essence, the options and arguments are:

This is a... (unclear)

Option 1 -- approve proposed Order with Section 5 as drafted. Proponents argue that Section 5 provides the teeth to ensure that agencies will adhere to the policy of the Order and that without it the Order would be regarded as largely hortatory. Supported by DPC and CEQ.

Option 2 -- omit Section 5. Opponents argue that this is a novel requirement with unpredictable consequences, that it would impose a significant new regulatory burden, and that the requirement to explain why a more protective alternative wasn't chosen will open agencies to undue criticism. They argue that rather than imposing a new requirement in the E.O., the Task Force should consider appropriateness of regulatory standards. Supported by Treasury, Commerce and HHS.

Option 3 -- modify Section 5. The requirement that agencies analyze the effects of a proposed regulation on children would be retained, but the requirement for agencies to analyze more or less protective alternatives and to justify their decisions would be omitted. Supported by NEC.

Option 1 [checked] Option 2 Option 3 Discuss [checked]

Copied
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McGinty
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THE PRESIDENT HAS SEEN

4/15/97

THE WHITE HOUSE
WASHINGTON

April 10, 1997

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MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed
Gene Sperling
Katie McGinty

SUBJECT: Executive Order to Protect Children
From Environmental Health Risks and Safety Risks

You are tentatively scheduled to announce on April 16 an Executive Order, attached to this memo, directing agencies to enhance their efforts to protect children from environmental health and safety risks. Announcement of the Executive Order would immediately precede the White House Conference on Early Childhood Learning and Development.

There is broad consensus among agencies on the broad policy objectives of the proposed Executive Order, but three agencies -- Treasury, Commerce, and HHS -- have objected to the explicit requirement in the order that agencies identify risks to children in the analysis supporting their major regulations. DPC and CEQ strongly support issuing the Executive Order in its current form. In addition, all White House offices working on the Conference on Early Childhood Learning and Development would like you to issue the order in its current form, as part of a set of executive actions showing your commitment to protecting children. OMB's OIRA (Sally Katzen) also endorses the order because it advances the Administration's efforts to protect children, but believes that the decision to go forward must recognize that the order will impose additional burdens on agencies and inevitably lead to more stringent regulatory standards over time. NEC favors a compromise proposal discussed in the last section of this memo.

BACKGROUND

There is a growing body of evidence, highlighted by a 1993 study by the National Academy of Sciences (NAS) on the exposure of children to pesticides, demonstrating that children are at disproportionate risk from environmental health risks and safety risks. The report also concludes that federal regulatory standards often fail to consider these risks fully.

These disproportionate risks stem from several fundamental differences between children and adults, in terms of physiology and activity. Children are still developing, and thus are neurologically and immunologically more susceptible to certain risks. Children eat, drink and breathe more in proportion to their weight, exposing them to greater amounts of

4/15/97

contamination and pollution for their weight. Children are less able to protect themselves by use of judgment and skill (e.g. navigating traffic, reading and following warnings). Concurrent with their recognition of these factors, scientists have documented an alarming increase in the incidence of conditions in children that may be linked to environmental health risks and safety risks. These include childhood cancer, leukemia, and asthma, as well as childhood deaths and injuries from accidents.

WALK
OUT
97
FELIX

In many areas, your Administration has taken bold action to respond to the challenge posed by this new science. Your initiatives resulted in explicit protection for children in the Food Quality Protection Act and Safe Drinking Water Act; development of new standards for passive restraints in cars that are more protective of children; and administrative action to protect children from tobacco, lead, and other hazards. Each of these initiatives has met with strong popular and congressional support.

Despite these successes, there is no overall, coordinated approach to children's issues that highlights their priority, coordinates federal research, and ensures that federal regulations consistently account for disproportionate risks to children. The proposed Executive Order, which has been the subject of extensive discussion with affected agencies, would fill this gap with provisions to address each of these areas.¹

Policy: The proposed Executive Order requires all agencies to make the protection of children a high priority in implementing their statutory responsibilities and fulfilling their overall missions.

Research Coordination: The proposed Executive Order would create an interagency Task Force to establish a coordinated research agenda, to identify research and other initiatives the Administration will take to advance the protection of children's environmental health and safety, and to communicate with the public regarding these efforts.

Federal Regulatory Analysis: Most notably, the proposed Executive Order would, for the first time, require agencies to analyze and explain the effects of their rules on children. The primary goal of this provision is to link policy decisions to the emerging science regarding children's environmental health and safety. It is this part of the Order to which Treasury, Commerce, and HHS have objected -- perhaps not surprisingly, given that it imposes additional analytic requirements on agency rulemaking.

¹ This Executive Order would supersede President Reagan's Executive Order on Families, replacing it with a policy that better reflects the priorities of your Administration.

ISSUE FOR DECISION

Whether the Executive Order should include provisions requiring agencies to explicitly consider risks to children when deciding on major regulations.

Section 5 of the Executive Order would impose three requirements on agencies promulgating regulations, if the regulation is economically significant and the agency has reason to believe that it may have a disproportionate impact on children. Agencies would have to: 1) evaluate the effects of the planned regulation on children; 2) similarly assess the effects of reasonably feasible alternatives to the planned regulation; and 3) explain why the planned regulatory action is preferable to these other options.

Arguments For Inclusion of Section 5

- Section 5 is the key policy component of the proposed Executive Order, and would be an enduring part of your legacy in protecting children's health. It makes concrete and gives effect to the overall policy of the Order to identify and assess risks to children.
- Both the National Academy of Sciences and the Administration's own report, *Investing in our Children*, have highlighted the need to link regulatory decisions to available data and, where there is a lack of data, to a research agenda. Section 5 is the provision of the order that best ensures that agencies will make this link.
- Section 5 provides the structure and enforcement mechanism (through OMB oversight) necessary to ensure that agencies adhere to the general policy of the Executive Order. Without Section 5, the Executive Order's terms are largely hortatory.
- There is substantial bipartisan support for requiring special regulatory analysis with respect to risks to children. The provisions in the proposed Executive Order closely track, and broaden application of, provisions in the unanimously-enacted Food Quality Protection Act and the Safe Drinking Water Act requiring heightened analysis to protect children. This provision will build on the public support for giving special consideration to children's health in developing standards.
- Health experts and outside groups, aware of the prior reports and legislation, may deride the Executive Order as merely symbolic if Section 5 is omitted.
- Your previous Executive Order on regulatory review already requires similar analysis addressing cost, small business impact, and other issues. Failure to include Section 5 may generate criticism that we effectively are subordinating children's health to these other concerns.

Arguments Against Inclusion of Section 5

- Section 5 imposes a novel requirement on major rulemakings, with unpredictable consequences. The task force created by the proposed Executive Order should consider over time and with the benefits of experience the appropriateness of regulatory standards.
- Requiring agencies to acknowledge that a proposed regulation is not the most child-protective is likely to have a distorting effect on regulatory decisions. The result will be greater pressure on agencies to "ratchet up" their regulatory standards, with a corresponding (and potentially unjustified) increase in the costs and burden of regulation. This could undermine the Administration's program of regulatory reform.
- There is only limited experience with analyzing regulations in terms of risks to children, and this approach is not always well-received. Critics may cite costly Superfund cleanups based on the potential exposure of children to toxic waste sites, and analytical flaws in the public health data supporting EPA's recent Clean Air Act proposals on ozone and particulate matter.
- In cases where the Section 5 analysis does not prompt agencies to strengthen the relevant regulatory standards, it will provide a basis on which to criticize the agency's decision. (Some agencies characterize this as a "kick-me" requirement.) Requiring this analysis also may strengthen legal challenges to agency regulations, as requiring any regulatory analysis does.
- The regulatory resources of many agencies are already stretched thin, and blanket application of a new regulatory requirement could divert already tight resources and delay ongoing programs.
- Regulatory agencies have made important strides in this area and should have the opportunity to demonstrate this progress to the interagency task force before any regulatory requirements go into effect.

POSSIBLE ALTERNATIVE

The only compromise available is to retain Section 5, but include only the general requirement that agencies analyze the effects of a proposed regulation on children. This proposal would delete the explicit requirements that agencies undertake a comparative analysis and provide a justification for their decision. This option would diminish both the advantages and disadvantages of proceeding with Section 5 as currently drafted.

DECISION

- _____ Approve the Executive Order as drafted
- _____ Modify Section 5 of the Executive Order
- _____ Omit Section 5 of the Executive Order

ATTACHMENT

Proposed Executive Order

DRAFT

Executive Order

3-27-97

10:30 am

Protection of Children from Environmental
Health Risks and Safety Risks

By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby order as follows:

Section 1. Policy.

1-101. A growing body of scientific knowledge demonstrates that children may suffer disproportionately from environmental health risks and safety risks. These risks arise because: children's neurological, immunological, digestive and other bodily systems are still developing; children eat more food, drink more fluids, and breathe more air in proportion to their body weight than adults; children's size and weight may diminish their protection from standard safety features, and children's behavior patterns may make them more susceptible to accidents because they are less able to protect themselves. Therefore, to the extent permitted by law and appropriate and consistent with the agency's mission, each federal agency:

- (a) shall make it a high priority to identify and assess environmental health risks and safety risks that may disproportionately affect children; and
- (b) shall ensure that its policies, programs, activities, and standards address disproportionate risks to children that result from environmental health risks or safety risks.

1-102. Each independent regulatory agency is encouraged to participate in the implementation of this Executive order and comply with its provisions.

Sec. 2. Definitions. The following definitions shall apply to this order.

2-201. Federal agency means any authority of the United States that is an agency under 44 U.S.C. 3502(1) other than those considered to be independent regulatory agencies under 44 U.S.C.

3502(5). For purposes of this order, military departments, as defined in 5 U.S.C. 102, are covered under the auspices of the Department of Defense.

2-202. Covered regulatory action means any substantive action in a rulemaking initiated after the date of this Executive order, or for which a Notice of Proposed Rulemaking is published within one year of the date of this order, that is likely to result in a rule that may:

- (a) be "economically significant" under Executive Order 12866 (a rulemaking that has an annual effect on the economy of \$100 million or more or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities); and
- (b) concern an environmental health risk or safety risk ^{the agency has reason to believe} that may disproportionately affect children.

2-203. Environmental health risks and safety risks mean risks to health or to safety that are attributable to products or substances which the child is likely to come in contact with or ingest (such as the air we breathe, the food we eat, the water we drink or use for recreation, the soil we live on, and the products we use or are exposed to).

Sec. 3. Task Force on Environmental Health Risks and Safety Risks to Children.

3-301. There is hereby established the Task Force on Environmental Health Risks and Safety Risks to Children ("Task Force").

3-302. The Task Force will report to the President in consultation with the Domestic Policy Council, the National Science and Technology Council, the Council on Environmental Quality, and the Office of Management and Budget ("OMB").

3-303. Membership. The Task Force shall be composed of the:

- (a) Secretary of Health and Human Services, who shall serve as a Chair of the Council;
- (b) Administrator of the Environmental Protection Agency, who shall serve as a Chair of the Council;
- (c) Secretary of Education;
- (d) Secretary of Labor;
- (e) Attorney General;
- (f) Secretary of Energy;
- (g) Secretary of Housing and Urban Development;
- (h) Secretary of Agriculture;
- (i) Secretary of Transportation;
- (j) Director of the Office of Management and Budget;
- (k) Chair of the Council on Environmental Quality;
- (l) Chair of the Consumer Product Safety Commission;
- (m) Assistant to the President for Economic Policy;
- (n) Assistant to the President for Domestic Policy;
- (o) Assistant to the President and Director of the Office of Science and Technology Policy;
- (p) Chair, Council of Economic Advisers; and
- (q) Such other officials of Executive departments and agencies as the President may, from time to time, designate. Members of the Task Force may delegate their responsibilities under this order to subordinates.

3-304. Functions. The Task Force shall recommend to the President Federal strategies for children's environmental health and safety, within the limits of the Administration's budget, to include the following elements:

- (a) statements of principles, general policy, and targeted annual priorities to guide the federal approach to achieving the goals of this order;
- (b) a coordinated research agenda for the Federal Government, including steps to implement the review of research databases described in section 4 of this order;

- (c) recommendations for appropriate partnerships among Federal, State, tribal and local governments and the private, academic, and non-profit sectors;
- (d) proposals to enhance public outreach and communication to assist families in evaluating risks to children and in making informed consumer choices;
- (e) an identification of high-priority initiatives that the Federal Government has undertaken or will undertake in advancing protection of children's environmental health and safety; and
- (f) a statement regarding the desirability of new legislation to fulfill or promote the purposes of this Executive order.

3-305. The Task Force shall prepare a biennial report on research, data, or other information that would enhance our ability to understand, analyze, and respond to environmental health risks and safety risks to children. For purposes of this report, cabinet agencies and other agencies identified by the Task Force shall identify and specifically describe for the Task Force key data needs related to environmental health risks and safety risks to children that have arisen in the course of the agency's programs and activities. The Task Force shall incorporate agency submissions into its report and ensure that this report is publicly available and widely disseminated. The White House Office of Science and Technology Policy and the National Science and Technology Council shall ensure that this report is fully considered in establishing research priorities.

3-306. The Task Force shall exist for a period of four years from the first meeting. At least six months prior to the expiration of that period, the member agencies shall assess the need for continuation of the Task Force or its functions, and make appropriate recommendations to the President.

Sec. 4. Research Coordination and Integration.

4-401. Within six months of the date of this order, the Task Force shall develop or direct to be developed a review of

existing and planned data resources and a proposed plan for ensuring that researchers and federal research agencies have access to information on all research conducted or funded by the Federal Government that is related to adverse health risks in children resulting from exposure to environmental health risks or safety risks. The National Science and Technology Council shall review the plan.

4-402. The plan shall promote the sharing of information on academic and private research. It shall include recommendations to encourage that such data, to the extent permitted by law, is available to the public, the scientific and academic communities, and all federal agencies.

Sec. 5. Agency environmental health risk or safety risk regulations.

5-501. For each covered regulatory action submitted to OMB's Office of Information and Regulatory Affairs ("OIRA") for review pursuant to Executive Order 12066, the issuing agency shall provide to OIRA the following information developed as part of the agency's decisionmaking process, unless prohibited by law:

- (a) an evaluation of the environmental health or safety effects of the planned regulation on children;
- (b) an assessment of potentially effective and reasonably feasible alternatives to the planned regulation, identified by the agency or the public, that provide different degrees of protection to children; and
- (c) an explanation of why the planned regulation is preferable to the identified potential alternative(s).

5-502. In emergency situations, or when an agency is obligated by law to act more quickly than normal review procedures allow, the agency shall comply with the provisions of this section to the extent practicable. For those covered regulatory actions that are governed by a court-imposed or statutory deadline, the agency shall, to the extent practicable, schedule rulemaking proceedings so as to permit sufficient time for completing the analysis required by this section.

5-503. The analysis required by this section may be included as part of any other required analysis, and shall be made part of the administrative record for the covered regulatory action or otherwise made available to the public, to the extent permitted by law.

Sec. 6. Interagency Forum on Child and Family Statistics.

6-601. The Director of the OMB ("Director") shall convene an Interagency Forum on Child and Family Statistics ("Forum"), which will include representatives from the appropriate Federal statistics and research agencies. The Forum is to produce an annual compendium ("Report") of the most important indicators of the health and well-being of children.

6-602. The Forum shall determine the indicators to be included in the Report and identify the sources of data to be used for the indicators. The Forum shall provide an ongoing review of Federal activity in the collection of data on children and families, and shall make recommendations to improve the coordination of data collection and to reduce duplication and overlap.

6-603. The Report shall be published by the Forum in consultation with the National Institute for Child Health and Human Development. The Forum shall issue the first annual report to the President, through the Director, by July 31, 1997. The report shall be submitted annually thereafter, using the most recently available data.

Sec. 7. General provisions.

7-701. This order is intended only for internal management of the Executive Branch. This order is not intended, and should not be construed to create, any right, benefit, or trust responsibility, substantive or procedural, enforceable at law or equity by a party against the United States, its agencies, its officers, or its employees. This order shall not be construed to create any right to judicial review involving the compliance or noncompliance with this order by the United States, its agencies, its officers, or any other person.

7-702. Executive Order 12606 of September 2, 1987 is
revoked.

THE WHITE HOUSE,