

WITHDRAWAL SHEET

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File Folder: Domestic Policy Council – Documentary Annex II Date: Oct. 26, 2004

DOCUMENT NO. & TYPE	SUBJECT/TITLE	DATE	RESTRICTION
1. Memo	Bruce Reed & Elena Kagan to Chief of Staff re: Tobacco Negotiations, 8pp.	5/10/98	P5
2. Memo	Bruce Reed & Elena Kagan to POTUS re: Tobacco Negotiations Status Report, 4pp.	5/12/98	P5
3. Memo	Bruce Reed & Elena Kagan to POTUS & VPOTUS re: Federal Tobacco Claims, 2pp.	9/30/98	P5

RESTRICTIONS

P1 National security classified information [(a)(1) of the PRA].
P2 Relating to appointment to Federal office [(a)(2) of the PRA].

P3 Release would violate a Federal statute [(a)(3) of the PRA].
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA].
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA].
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA].

PRM Personal records misfile defined in accordance with 44 USC 2201 (3).

B1 National security classified information [(b) (1) of the FOIA].
B2 Release could disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA].
B3 Release would violate a Federal statute [(b)(3) of the FOIA].
B4 Release would disclose trade secrets or confidential commercial financial information [(b)(4) of the FOIA].
B5 Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA].
B7 Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA].
B8 Release would disclose information concerning the regulation of financial institutions [(b)(9) of the FOIA].
B9 Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA].

THE WHITE HOUSE
WASHINGTON

April 19, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed

SUBJECT: Needle Exchange

You should try to make a final decision on needle exchange today. If you decide to go forward with the "demonstration" option, Shalala would like to announce it tomorrow to ward off a press conference AIDS groups have called for tomorrow morning to demand her resignation. If you decide to certify the science but rule out federal funds, we should announce that soon to stop Republican attacks over the issue.

Under the demonstration proposal, HHS would certify that needle exchange programs reduce HIV transmission without increasing drug use, and allow federal prevention funds to be used for those programs in up to 8 communities hardest hit by drug-related HIV. Communities that ranked among the highest in the overall rate or number of drug-related HIV cases or drug-related HIV cases among women of childbearing age would be eligible, but only 8 would be permitted to use federal funds. Over the next year, CDC would evaluate these 8 communities to determine whether their programs were working and whether they were making an effective link to drug treatment before deciding whether to expand the number of eligible communities.

A program would also have to 1) be legal in that state and community; 2) make referrals to drug treatment; 3) comply with hazardous waste disposal standards; 4) replace syringes on a one-for-one basis; and 5) agree to research and evaluation. HHS estimates that only about 27 communities have the capacity to meet these requirements.

You still have the option to certify the science but rule out the use of federal funds on the grounds that this should be a local decision, not a national political debate. Contrary to her earlier statement to Erskine, Shalala opposes this option, as would the AIDS community. (We do not know how much the AIDS and scientific communities will criticize the demonstration option.)

Several Republican members of Congress and the RNC have already issued statements attacking the Administration over needle exchange. They will almost certainly attach a ban on federal funds to the supplemental bill, to tobacco legislation, and to the Labor/HHS appropriations bill in the fall. The AIDS community would want you to veto legislation over this issue, but we have always refused to do so in the past.

Whatever you decide, we will inform Shalala and McCaffrey, and roll out the decision to key members and groups.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 1
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 2
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THE WHITE HOUSE

WASHINGTON

May 11, 1998

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Charles Ruff

SUBJECT: Assisted Suicide Legislation

The Justice Department has determined that the Drug Enforcement Administration (DEA) has no authority under the Controlled Substances Act (CSA) to take adverse action against physicians who assist patients in ending their lives by prescribing controlled substances pursuant to Oregon's "Death with Dignity Act." The Department conducted its legal analysis in response to letters sent by Senator Hatch and Congressman Hyde urging the Department, through DEA, to invoke the CSA against physicians who assist in patient suicide under the Oregon law.

The Justice Department has completed draft letters to Congressman Hyde and Senator Hatch explaining its legal conclusions. The letters will not be forwarded to Congress until we have developed a roll-out strategy, including a position on federal legislation prohibiting physician-assisted suicide.

As you will recall, the Catholic Health Association (CHA) has informed us that Hatch and Hyde are prepared to introduce legislation amending the CSA in the event the Attorney General concludes that the CSA does not authorize the DEA to pursue physicians who assist patients in committing suicide. They may even introduce this legislation before receiving the Department of Justice's opinion letter. In assessing the possible options for responding to Hatch's and Hyde's likely initiative, we held meetings within the White House and with the Departments of Justice and Health and Human Services (including the FDA).

Justice believes that the Administration should not support the Hatch/Hyde proposal. Justice thinks that DEA's approach to enforcing the narcotics laws is inconsistent with the kind of sensitivity that would be needed in pursuing doctors who are assisting terminally ill patients to commit suicide. Justice is also concerned with the resource drain on the DEA if that agency were tasked with enforcement duty. Justice also worries that this new task would damage DEA's relationship with the medical profession, on which it often relies in pursuing narcotics law violations.

The Justice Department also cites principles of federalism in support of its position against a legislative change. The federal government has deferred to the states as the primary regulators of the medical profession. Especially on such a hotly contested issue as assisted suicide, Justice believes there is good reason to continue this tradition of deference to local

decisionmaking.

HHS/FDA concurs with Justice's position, stressing especially the historic deference given to states in regulating the medical profession. HHS/FDA also worries that a new federal law authorizing the federal government to take adverse action against doctors who assist their patients to commit suicide would exacerbate the problem of physicians' underprescribing pain medications for terminally ill patients.

Your longstanding opposition to the practice of assisted suicide is not necessarily inconsistent with the agencies' positions. You could argue that assisted suicide is wrong, but that it is not a matter that should be handled by federal narcotics agents. Or more broadly, you could argue that it is not a matter to be dealt with by the federal government at all, but instead should be left to state and local decisionmaking. Nor is last year's "Assisted Suicide Funding Restriction Act" inconsistent with a refusal to support a legislative change. The Funding Restriction Act bans the use of federal funds to pay for or promote assisted suicide. Nothing in the Act authorizes the federal government to take adverse action against a private physician for assisting in a suicide in a non-federal facility.

We detail below four options for responding to the expected Hyde/Hatch initiative. These options are: (1) support the Hyde/Hatch legislation; (2) oppose the Hyde/Hatch DEA approach, but suggest openness to alternatives and work with Hatch and Hyde to develop a better bill; (3) engage in a "Kick the Can" strategy, suggesting openness to alternatives, but attempting to ensure that no congressional action is taken; and (4) oppose the Hyde/Hatch legislation outright.

1. **Endorse Hyde/Hatch Legislative Alternative.** After the Justice Department's legal interpretation is released, we could endorse the expected introduction of the Hatch/Hyde legislation authorizing the DEA to pursue criminal actions against physicians prescribing medications for assisted suicides.

Pros

- Appears consistent with your longstanding opposition to assisted suicide.
- Avoids inevitable conflict with the Congress, where the Hatch/Hyde legislation is likely to be popular.

Cons

- Conflicts with historic practice of allowing states to regulate the medical profession, and does so with regard to a hotly contested and emotional issue on which local decisionmaking may be particularly appropriate.

- Places authority to act against doctors in an agency ill-equipped to perform this function, in a way that could interfere with the agency's primary mission.
- Ignores danger, noted by many physicians' groups and even the Catholic Health Association, that a federal law of this kind will lead doctors to under-medicate terminally ill patients for fear of federal prosecution.

2. **Oppose Hatch/Hyde legislation, but suggest openness to alternatives.** Under this option, you would welcome the intent of the Hatch/Hyde bill, based on your longstanding opposition to assisted suicide, but raise concerns about using federal drug agents and resources to address this issue. You would advise Republicans of ways to implement the intent of their legislation in a more workable fashion, perhaps suggesting alternative enforcement agencies (such as FDA) or alternative enforcement mechanisms (such as reducing Federal support for Medicaid for states permitting assisted suicide). You would try seriously to find common ground with the Republicans on a workable legislative alternative to DEA enforcement.

Pros

- Appears consistent with your longstanding opposition to assisted suicide and shows that you are seriously concerned about this issue.
- Takes an approach that recognizes the problems with using DEA resources and agents to address this issue.

Cons

- Assumes that we can develop a workable alternative approach, when we may not be able to do so. For example, direct regulation of doctors through HHS/FDA also raises serious issues, and enforcement mechanisms directed toward states, such as reduction of Medicaid dollars, would raise widespread protests of federal micro-management and intrusion.
- Raises expectations that a legislative solution can be achieved, when it may be virtually impossible to reach consensus.

3. **"Kick the Can" Strategy.** Under this option, you would also express openness to addressing this issue through federal legislation, but rather than trying to reach agreement, you would attempt to forestall legislative action. You would try to delay long enough to allow the medical groups, states, and others to communicate that federal approaches in this area are ill-advised. These objections could make Congress conclude that it does not have time to draft thoughtful legislation this year.

Pros

- Allows you to reiterate your strong position against assisted suicide, while preventing problematic federal legislation.
- Provides sufficient time to air the many issues surrounding assisted suicide legislation, perhaps even educating physicians and the public about the problem of undermedicating terminally ill patients

Cons

- May make us look indecisive and weak.
- May be viewed with skepticism on the Hill and make us vulnerable to the charge that we are trying to have it both ways.

4. **Oppose Hatch/Hyde legislation outright.** Under this option, you would tell the Hill that, although you believe that assisted suicide is immoral, you cannot support legislation that intrudes on state responsibility over this issue and diverts limited law enforcement resources for this purpose.

Pros

- Takes a strong position consistent with agency views on the undesirability of federal legislation in this area: respects federalism principles; protects law enforcement priorities; and prevents further undermedication of patients due to physicians' fear of criminal prosecution.

Cons

- May appear inconsistent with your longstanding opposition to assisted suicide.
- Risks major confrontation with the Congress, which almost certainly will pass federal legislation over your objection.

The Departments of Justice and Health and Human Services support Option 4 and strongly oppose Option 1. Of the middle options, they would prefer Option 3 to Option 2. The Counsel's office agrees with the agencies: Chuck believes both that the DEA should not regulate medical practice and that federal legislation in this area conflicts with federalism principles. The DPC agrees that federal legislation in this area makes little sense, but believes that the "Kick the Can" strategy may be the best way to prevent it; the DPC therefore recommends Option 3.

THE WHITE HOUSE
WASHINGTON

May 14, 1998

MEMORANDUM FOR THE CHIEF OF STAFF

FROM: Bruce Reed
SUBJECT: Youth Lookbacks

The other side has agreed to \$1,000 per youth smoker on the company-by-company penalty if we agree to an industrywide cap of \$4 billion. I believe this is a good deal for us.

Here are the facts. Industrywide penalties are passed directly to price, and are designed to drive up the price to discourage teens from smoking. Company-specific penalties are designed not to drive up the price of cigarettes (as the industrywide penalties do), but to come straight out of the companies' bottom line if they sell to kids. Companies cannot pass company-specific penalties onto price, because any price differential between companies (even a few pennies) will wreak havoc on their share of the adult market. That is why these companies always increase their prices in lock-step, as they did earlier this week.

So when some say our company-specific penalty is a fraction of a penny a point, that's the wrong measure. We've already got an industrywide penalty that gets up to at least 35 cents a pack [\$4 billion non-deductible = nearly \$6 billion pre-tax, divided by our estimated volume of 17 billion packs in 2003 = about 35 cents a pack. If CBO estimates volume at 12 billion packs, our industrywide penalty could reach 50 cents a pack.] The purpose of a company-specific penalty is to change company behavior by imposing a serious disincentive.

Here are a few ways to make our proposal more easily understood:

1. Without a company-specific penalty, any company can still make a profit by selling to kids. At \$1,000 per youth smoker, our proposal will force a company to surrender twice the lifetime profits it makes from addicting a teen in the first place. (It's really more than twice, when you count the \$150-250 in lost profits from the industrywide penalty.)
2. The companies sell 500 million packs a year to teenagers. A 12-point miss would cost the companies \$500 million that they can't pass on to price -- that's \$1 a pack for every pack they sell to teenagers. A 25-point miss would cost \$1 billion -- or \$2 a pack for every pack they sell to teenagers. To put it another way, that's 8 cents a pack for every percentage point miss.
3. This penalty is uncapped, and comes straight out of after-tax profits. The total after-tax profits of the domestic tobacco industry are \$5 billion (\$7.5 billion pre-tax). Treasury

estimates that after-tax profits will drop to \$3.4 billion in 2003 under the McCain bill. (CBO volume assumptions could reduce that another 25-33%.) The company-specific penalties reduce the companies profits by \$400 million for every 10 points. A 30-point miss would reduce profits by \$1.2 billion, or 1/3 of total profits. A 60-point miss would reduce profits by \$2.4 billion, or 2/3 of total projected profits. Either scenario could put RJR out of business if it continues aggressively marketing to kids. Even Philip Morris (which accounts for nearly 2/3 of industry profits, or a projected \$2.4 billion in 2003) would be in real danger, especially since it has over 60% of the youth market.

4. We strengthened provisions to ensure that any company that misses its targets by more than 20% will lose liability protections altogether. This will cause the companies and industry analysts real heartburn.

Here's an easy example one can use if anyone tries to argue that our penalties are so small the companies will just pass them onto price. Let's split the difference between OMB and CBO and assume volume is 15 million packs. Philip Morris's market share is 50%, or 7.5 million packs. A 30-point miss would cost PM about \$740 million. If PM passed that along to price, it would have to raise the price of Marlboros by 10 cents a pack. But PM can't afford to sell Marlboros for 10 cents a pack more than RJR sells Winstons. That's \$1.00 a carton. A few years ago, PM nearly put RJR out of business on "Marlboro Friday," when it made Marlboros a few cents a pack cheaper than Winstons. RJR has never recovered.

MISS BY DIFFERENT AMOUNTS (Using Daily Rate)
COMPANY PENALTY IS \$1,000 PER KID

Effects In 2008 (\$ Millions)

PERCENTAGE POINT MISS	PENALTY STRUCTURE Industry Company	CAPS Ind / Comp	INDUSTRY SURCHARGE	TOTAL	COMPANY SURCHARGES				
					PM	RJR	Lorillard	B&W	Other
10	80 / 160 / 240 \$1,000 per kid	\$4B / None	1200	403	247	62	51	5	37
20	80 / 160 / 240 \$1,000 per kid	\$4B / None	3600	805	494	125	102	10	75
30	80 / 160 / 240 \$1,000 per kid	\$4B / None	4000	1208	740	187	153	14	112
40	80 / 160 / 240 \$1,000 per kid	\$4B / None	4000	1611	987	250	205	19	150
50	80 / 160 / 240 \$1,000 per kid	\$4B / None	4000	2013	1234	312	256	24	187
60	80 / 160 / 240 \$1,000 per kid	\$4B / None	4000	2416	1481	374	307	29	225

THE WHITE HOUSE
WASHINGTON

5 11: 118
SERIALS 1-1012

May 19, 1998

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MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed and Chris Jennings
RE: NGA Agreement on Tobacco Spending
cc: Erskine Bowles, Larry Stein, Gene Sperling, Mickey Ibarra, Elena Kagan

Letter to Governor
L. J. ...
...
...

Attached is a one page summary of the agreement we reached with NGA on Friday night regarding the allocation of the Federal portion of the state spending options. Keeping in mind the interests of all the parties, we believe we achieved a strong agreement. It has the support of OMB, HHS, and, of course, DPC/NEC. In short, we agreed to:

- **Commit that states would be allocated \$196 billion from the overall Federal settlement.** (The \$196 billion figure is viewed as a sacred, inviolable number.) Since we are now assuming a \$500 billion (or so) total from the legislation, the 40 percent state investment figure we have been carrying matches well with this number.
- **Use the restricted funds for seven existing programs related to children or health.** Among these, child care is the largest programmatic option. We succeeded in eliminating over 10 categories that the states desired; in so doing, we also were successful in assuring that grant options that could syphon large dollars away from our priorities did not make this list. As the attached table illustrates, we project that states will likely spend at least \$5 billion on the Child Care and Development Block Grant over the next 5 years.
- **A 50/50 split between restricted versus unrestricted funds.** We reached an agreement on the 50/50 split because we allowed the states to spend a portion of their restricted dollars (6 percent) on buying down the state portion of the state match of the new Childrens Health Insurance Program (CHIP).
- **Children's health outreach.** The Governors accepted our budget proposals for outreach that, among other things, allow schools and child care referral centers to enroll children in Medicaid ("presumptive eligibility"). These options are critical in light of a new study that shows that 4.7 million children who are uninsured are already eligible for Medicaid.
- **Include strong language prohibiting substitution of Federal for state funds.** This language assures a maintenance of effort for grant options that now have a state match.

The Governors did succeed in taking our class size program off the list. We agreed to remove it only after it became clear that any compromise on this issue would water down our education priorities to the extent that it would be viewed as a loss. The DPC, NEC, and OMB education advisors all concurred with this decision.

The result of our compromise makes it a virtual certainty that significant, new dollars will be invested in child care by the states. Realizing this, the child care staff within the White House are generally quite pleased. We have asked them to try to get some validation in this regard. Unfortunately, and not too surprisingly, the child advocates want more money and more strings than our compromise guarantees. Therefore, they probably cannot be counted on to say anything overly positive in public until the last vote is counted.

Finally, over the weekend, we had a number of conversations with both NGA and the advocates of various Administration priorities. It became clear that we are likely headed towards a difficult predicament on expected floor amendments. On the one hand, if we support expected Democratic amendments (e.g., an amendment that requires more spending and administrative strings on the child care option), we risk being accused of bargaining in bad faith by the Governors. On the other hand, if we oppose these amendments, many on our side of the aisle will criticize us for not even supporting our own budget priorities.

Legislative Amendment Strategy for State-Based Investments. Keeping in mind the interest of all parties, we have worked out a position that neither pleases nor totally alienates anyone. Our positioning strategy on all state-based investment amendments is:

1. We oppose any amendment that changes either the overall allocation of the tobacco funds (40 percent for states, not lower than \$196 billion over 25 years) or the split between the restricted and unrestricted (50/50) within the state funds.
2. We will oppose any amendment that adds, subtracts, or earmarks options from the restricted share portion of state funds, with one exception: **We will not oppose (nor actively support) amendments that reflect Administration budget priorities.** (In response to NGA's criticism that we appeared to be backing away from the initial agreement, we did agree to oppose amendments that reflect our priorities should any one such amendment be successful in passing the Senate.)
3. We will oppose amendments that totally prescribe (e.g., fixed percentages for each spending option) the restricted share of the state funds, even if one of the options is an Administration budget priority.

Today, before votes begin, we plan on meeting to review likely amendments to the tobacco bill to ensure we have a Administration-wide position on these and other types of amendments.

STATE TOBACCO SETTLEMENT FUNDS

May 15, 1998

- **\$196 billion over 25 years** from the legislation will be allocated to states from a trust fund. These grants will be a mandatory, permanent appropriation. Federal spending for new options on children's health outreach will be netted from this amount:
- **50 percent** of the grants may be used by states for any purpose. The remaining 50 percent will be used for specified restricted purposes, described below.
- **Options for restricted funds.** States can use the restricted funds in any amount that they choose (except for CHIP) to add to any one or all of the following options:
 - Maternal and Child Health Bureau's Title V program
 - Child Care and Development Block Grant
 - Child welfare programs (Title IV-B)
 - Substance Abuse and Mental Health Services Administration grant programs
 - Safe and Drug-Free Schools program
 - Professional Development (Eisenhower) grants
 - Match for the Children's Health Insurance Program (limited to 6 percent of restricted funds)
- **Each program's current matching rules** will be used except for an increased Federal match of 80 percent for child care block grant funds above the appropriated amount.
- **Supplement, not supplanting spending:** Funds from the restricted portion of the grants may not be used as state match for Federal programs (except for CHIP). There will be a maintenance of effort on a program-specific basis, that consists of:
 - 95 percent of the FFY 1997 state spending on the programs listed below, trended by the lower of inflation (CPI) or the Federal appropriation growth.
- **Options for the use of restricted funds will be re-assessed every 5 years.** An independent organization (e.g., General Accounting Office or National Academy of Sciences) will conduct evaluations and assessments of spending options every 5 years, and make recommendations on improvements.

SPENDING OPTIONS UNDER THE RESTRICTED SHARE OF THE STATE FUNDS
Additional Federal Funding over 5 Years
If States Increase Spending in Each Program Equally

	Fiscal Year 1997		5-Year Spending With Equal Increases \$ billions
	Federal Spend. \$ billions	Percent of Total	
Maternal & Child Health	0.70	10%	1.30
Child Care & Development Block Grant	2.70	40%	5.00
Child Welfare Programs (IV-B)	0.50	7%	0.93
Substance Abuse & Mental Health Adm. programs	1.60	24%	2.96
Safe & Drug Free Schools	0.50	7%	0.93
Professional Dev'l (Eisenhower) grants	0.35	5%	0.65
Children's Health Insurance Program match (6%)*	0.41	6%	0.75
TOTAL	6.76	100%	12.50

* "Fiscal Year Spending in 1997" is a place holder that assures that 6 percent of the total is reserved for CHIP

98 JUN 12 09:32

THE WHITE HOUSE
WASHINGTONDR. PETER HAN SESA
6-16-98

June 12, 1998

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Charles F.C. Ruff

SUBJECT: Hyde Amendment Application to Medicare and Abortion Coverage Requirements for Catholic Provider Sponsored Organizations

As you know, some women of child-bearing age qualify for Medicare because they receive Social Security Disability Insurance (SSDI). Senator Nickles has asked HHS whether the Hyde Amendment's restrictions on government funding of abortion apply to the Medicare program. He also has asked whether health plans that refuse, on religious grounds, to provide abortion services can still become Provider Sponsored Organizations (PSOs) eligible for Medicare payments.

We believe that we must respond quickly to Senator Nickles to have any chance of avoiding another legislative confrontation over abortion policy. This memo provides background information and policy options for your consideration.

Background

Earlier this year, the Catholic Health Association (CHA) contacted HHS and the White House about a ruling by a HCFA regional office that a Catholic-run PSO could participate in Medicare only if it agreed to cover qualified abortions for women with disabilities. The CHA vehemently objected to this ruling and asked if we could intervene administratively. At the same time, the CHA contacted Senator Nickles' office. The CHA discussed with Nickles both whether the Hyde Amendment applies to Medicare and whether Catholic PSOs can decline to provide all abortions (even those permitted under Hyde) because of their religious objections. The Senator, clearly sensing another abortion wedge issue, wrote to Donna Shalala to obtain the Department's formal position on both of these issues.

Medicare and Abortion coverage. Five million non-elderly disabled Americans — including two million women — receive Medicare coverage by virtue of their SSDI eligibility. The Medicare program currently covers about 500 abortions each year, while denying claims in another 100-200 cases. These figures are consistent with those from the Reagan and Bush Administrations.

In 1991, HCFA issued a reimbursement directive stating that Medicare would cover abortion services only in cases where the life of the mother was endangered. (Prior to this.

time, there was no clear guidance on the subject.) This directive, which comported with the then-existing Hyde Amendment, is actually more restrictive than the current Hyde amendment, because it fails to cover abortions arising from rape and incest. The directive, however, has not been modified, and remains the only policy guidance on abortion coverage under the Medicare program.

Although we believe that most Medicare carrier medical directors have largely complied with this directive, some may have covered other kinds of abortions — e.g., abortions arising from rape or incest, abortions involving deformed fetuses, or other medically necessary abortions. In particular, carriers may have decided to cover some very difficult cases involving the one-third of women on Medicare disability who have some serious mental impairment (about 700,000 women). Such individual coverage decisions may help explain why no one on the pro-choice side of the abortion debate has ever complained about our coverage policy.

Legislative and Political Environment. The Nickles' letter has started yet another controversial abortion debate. The CHA is working with Senator Nickles and others on drafting legislation to make clear that Hyde applies to Medicare, as well as to exempt organizations with ethical or religious objections from any abortion coverage requirements. (CHA and Nickles have gotten the impression from HHS that Hyde does not apply to Medicare and that the religious convictions of Catholic PSOs cannot be fully accommodated.) Absent administrative action, there is no doubt that we will see this issue raised on some appropriations bill. At the same time, the womens' groups have become aware of this issue and are urging the Administration to adopt a generous Medicare abortion coverage policy.

In the next few months, the Administration will have to deal with several other controversial abortion issues. Most notably, the Republicans will bring up the partial-birth abortion legislation sometime prior to the November elections. In addition, Republicans in both the House and Senate will attempt to pass a bill, which most in the Administration strongly oppose, to prohibit transferring a minor across state lines to bypass parental consent requirements. Finally, we can expect the usual abortion riders to appear on appropriations bills.

Options

All of your advisors (HHS, OMB, and DPC) agree that we should offer the CHA a new administrative option that allows Catholic health plans to participate in Medicare without covering any abortions, so long as they accept a slightly reduced capitated payment. We do not know whether CHA will accept this offer, but we think it may do so, particularly if the offer is combined with CHA's preferred outcome on the Hyde issue.

The outstanding question is whether Hyde applies to Medicare. We all agree that we should inform Nickles that current Medicare policy, as set out in the 1991 directive, is to

cover only abortions necessary to protect the life of the mother. We also all agree that because this "life of the mother" standard is more restrictive than the current Hyde amendment, we should modify the directive to cover at least abortions arising from rape and incest. We have not reached consensus, however, on whether we also should cover any other abortions (i.e., abortions that Hyde generally prevents the federal government from funding). We see two viable options:

Option 1: Rule that the current Hyde Amendment (allowing funding where the life of the woman is in danger or in cases of rape and incest) applies to Medicare. Under this option, we would take the position that since some Hyde-covered appropriated funds are deposited into the Medicare Trust Fund, all Medicare expenditures must abide by the Hyde restrictions. We then would update our Medicare coverage policy to reflect the current, comparatively expansive Hyde Amendment. DPC and OMB support this option.

Pros:

- This option is most likely to avoid a legislative showdown on abortion funding that we are unlikely to win.
- This option is consistent with our current position on Medicaid funding, and will cover more abortions than the current policy allows.
- This option will enhance our ability to reach an agreement with the CHA on the PSO abortion coverage issue.

Cons:

- This option may expose us to criticism about non-coverage of extremely sympathetic cases involving vulnerable and disabled women.
- This option will anger womens' groups, which would prefer us to provide Medicare coverage of the widest possible range of abortions, even if doing so would provoke the Republicans to enact contrary legislation.

Option 2: Rule that Medicare can cover abortions necessary to protect the health of the woman (in addition to abortions allowed by Hyde). Under this option, we would segregate appropriated funds from non-appropriated funds (payroll taxes, premiums, etc.) in the Medicare Trust Fund and use the non-appropriated (and hence unrestricted) funds to pay for the health-related abortions. HHS supports this option.

Pros:

- This option will ensure that all abortions necessary to protect a woman's health are

covered, and will allow us to avoid criticism arising from non-coverage of highly sympathetic cases involving vulnerable and disabled women.

- This option will assuage the womens' groups by providing for Medicare coverage of a larger class of abortions.

Cons:

- This option will virtually guarantee a legislative battle with Nickles and his allies on the appropriateness of using public funds to pay for abortions. We should expect to lose this battle and to have to veto a bill over government funding of abortion.
- This option diverges from this Administration's past practice on government funding of abortions.
- This option might well undermine our ability to reach agreement with the CHA on the PSO abortion coverage issue.

Recommendations

As noted, DPC (Bruce, Chris, and Elena) and OMB support Option 1, because (1) it is most consistent with this Administration's prior practice on government funding of abortions and (2) it stands the best chance of avoiding a high-profile legislative battle -- on both the Hyde and PSO issues -- that we are unlikely to win. HHS supports Option (2) because of the special vulnerability of the population seeking abortion services under the Medicare program. Counsel's Office takes no position as between the two options.

THE WHITE HOUSE

THE PRESIDENT HAS SEEN

WASHINGTON

6-16-98

June 16, 1998

Copied
Reed
Ruff
COG

MEMORANDUM FROM THE PRESIDENT

FROM: SEAN MALONEY *SM*

SUBJECT: Medicare Coverage of Abortions

The attached Reed/Ruff memo asks you to decide whether the Hyde Amendment's abortion-funding prohibitions should apply to Medicare.

Background. Medicare covers about 500 abortions/year; about the same as during the Reagan/Bush Administrations. (Some 2 million non-elderly women qualify for Medicare through SSDI.) In 1991, HCFA issued a reimbursement directive, tracking the Hyde Amendment, which stated that Medicare would cover abortions only where the mother's life was endangered. Congress later expanded the Hyde exception to encompass rape/incest, but the HCFA directive did not change, leaving it more restrictive than Hyde. Some Medicare carrier medical directors, however, may be covering abortions in cases of rape, incest, deformed fetuses, or mentally impaired mothers. This may explain why pro-choice groups have never complained about the HCFA directive. Recently, the Catholic Health Association (CHA) complained to us and to Senator Nickles about a HCFA regional-office ruling that a Catholic-run Provider Sponsored Organization (PSO) could participate in Medicare only if it agreed to cover qualified abortions for disabled women. Senator Nickles then wrote Secretary Shalala asking whether the Hyde Amendment applies to Medicare, and whether religion-based health plans that do not offer abortion services can qualify as PSOs under Medicare.

Options/Views. All of your advisers agree (i) that we should offer the CHA a new administrative option that lets Catholic plans participate in Medicare without covering abortions; and (ii) that we should broaden the 1991 HCFA directive to track Hyde and permit funding in cases of rape/incest. HHS disagrees with the rest of your advisers, however, over whether Medicare might also cover other types of abortions. Two options are presented:

Option 1: Rule that Hyde applies to Medicare -- say all Medicare expenditures must abide by the Hyde restrictions because some Hyde-covered appropriated funds are deposited into the Medicare Trust Fund; would avoid a showdown with Congress; covers more abortions than the current HCFA directive; helps a possible agreement with Catholic plans. *DPC, OMB, Podesta, Sylvia, Maria, and Audrey Haynes support Option 1; Sylvia expresses some concern about angering women's groups when Nickles may do little more than reaffirm Hyde's applicability.*

Option 2: Rule that Medicare can cover abortions necessary to protect a woman's health -- could segregate appropriated funds (covered by Hyde) from non-appropriated funds (e.g., payroll taxes, premiums) in the Medicare Trust Fund; could use non-appropriated funds to cover health-related abortions; would permit abortion coverage for vulnerable and disabled women; would please women's groups; *HHS supports this option.*

Approve Option 1

Approve Option 2

Discuss

THE WHITE HOUSE

WASHINGTON

June 22, 1998

6-23-98

captured
Reed
Jennings
COS

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed
Chris Jennings

RE: Legislation to require health plan coverage of contraceptives

Later this week, an appropriations bill may come to the floor with an amendment that would require contraceptive coverage by all plans participating in the Federal Employee Health Benefits Plan. This amendment was sponsored by Congressman Lowey and passed by the House Appropriations Committee last week by a vote of 28 to 26. At the same time, Senator Snowe is considering introducing on the Senate floor a bill that would require this coverage by all health plans. For the reasons that follow, your advisors (DPC, Women's Office, Communications, OMB) generally agree that we should support the Lowey amendment, but be silent on -- or, if pushed take a "do not support" position on -- the Snowe bill.

Most health plans cover at least some kind of prescription contraceptives. An estimated 93 percent of HMOs cover at least one prescription contraceptive, and about 40 percent cover all five of the most commonly used methods: the pill, diaphragm, IUDs, Norplant and Depo-Provera. The plans that participate in FEHBP are fairly representative of most plans: 90 percent cover some type of contraception and about 20 percent cover all five methods.

The benefits of contraceptive coverage are clear. Approximately 60 percent of all pregnancies in the U.S. are unintended, and these pregnancies surely result in many unnecessary abortions. In addition, the cost of requiring plans to cover prescription contraceptives may be negligible. CBO, when assessing the Lowey amendment, found that the cost of the coverage would be fully offset by the reduction in the cost of childbirth.

These pieces of legislation nonetheless raise two difficult issues. First, the health policy community usually opposes mandating particular benefits for fear that coverage decisions will become political rather than substantive and, in most cases, will add to the cost of health insurance. We generally agree with the policy community on this point, and worry that if we go down this road any further, we will find it difficult to oppose benefits mandates that are politically popular but poor policy. Second, Republicans would almost inevitably charge that this mandate -- especially if extended to all health plans, rather than only those in the FEHBP -- is reminiscent of the "micromanagement benefit design approach" taken in the Health Security Act. But some argue, in response, that a governmental role is more warranted for this benefit than for most others, because of concerns about gender discrimination in health decisions.

Taking these concerns into account, your advisors recommend that we support the Lowey amendment but remain silent (or, if pushed, take a "do not support" position) on the Snowe bill. While these positions may appear contradictory, we believe that we can distinguish between them. We would be saying that contraception is an important benefit that all plans should cover, but that the best way to promote such coverage is through making FEHBP a model, rather than imposing a private mandate. Of course, this stance will make it harder for us to reject other coverage requirements on FEHBP plans in the future, but because we often make coverage decisions for Federal programs, this precedent is not as troublesome as it would be in the private arena. And while this stance will not fully satisfy the women's groups (who would also like us to endorse Snowe), we will be supporting the proposal with the greater likelihood of success.

We therefore recommend that you support a contraceptive coverage requirement for FEHBP plans, but not a mandate for private sector plans. We also all agree -- and think that Lowey will as well -- that it is necessary to have a conscience exception to this requirement so that Catholic health plans can participate in FEHBP. If you agree with our recommendation, we propose that HHS and OPM, rather than the White House, convey this policy position to Congress.

- Agree
- Disagree
- Let's Discuss

*remain silent on Snowe
 for now - do not do + do not support
 on Snowe
 do not support*

THE WHITE HOUSE

WASHINGTON

August 11, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: GENE SPERLING
BRUCE REED
CHRIS JENNINGS

SUBJECT: LONG-TERM CARE INITIATIVE

cc. THE VICE PRESIDENT, ERSKINE BOWLES, ROBERT RUBIN,
JACK LEW, SYLVIA MATTHEWS, JANET YELLEN, MARIA
ECHAVESTE, JOHN PODESTA, RON KLAIN, LARRY STEIN,
RAHM EMANUEL, PAUL BEGALA, ELENA KAGAN

Per your request, an interagency NEC/DPC process examined long-term care policy options, specifically how long-term care options could be added to our tax cut package. This memo summarizes our recommendations on both the best policy and the advisability of announcing such an initiative in August or September or waiting until the State of the Union.

We developed a long-term care initiative that both assists people who provide or pay for long-term care and encourages workers to purchase high-quality, private long-term care insurance. The centerpiece of the initiative is a broad-based, non-refundable tax credit for people with long-term care needs or for families who house and care for such relatives. The credit could help defray the costs of formal care (e.g., home health care) and informal care (e.g., assisting parents who are bed-ridden). Second, to complement the ongoing work of your Task Force on the Employment of Adults with Disabilities, we could introduce a tax credit of up to \$5,000 for impairment-related work expenses incurred by disabled individuals. Third, we could announce support for offering private long-term care insurance to Federal employees, which would have virtually no costs and bipartisan support. The long-term care tax options cost a total of \$4 billion over 5 years and \$14 billion over 10 years, and would be fully funded by savings from postponing or modifying our budget revenue proposals, plus a few offsets that were in the Senate IRS bill, but that were not included in the final bill, or in your FY 1998 budget.

The timing of an announcement of a long-term care initiative in a modified tax package depends on a number of factors that will be discussed later in the memo.

BACKGROUND

This policy initiative is motivated by an interest to address long-term care and issues facing the chronically ill, particularly the elderly.

Unlike Social Security and Medicare, long-term care has received little attention. Republicans have begun to raise policy options (e.g., MSAs for long-term care in their Patient Protection Act), but not aggressively. Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major concern for the elderly and their families. Medicare pays for only a limited amount of long-term care, and private insurance even less -- only 10 percent of home health care and 5 percent of nursing home care. As a result, long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries.

Concern about long-term care costs is not limited to the elderly and people with disabilities. Their children, other relatives and friends provide a large amount of formal and informal long-term care. According to an HHS study that has not yet been released, one in three Americans voluntarily provide some unpaid informal care to an ill or disabled family member or friend. Over 90 percent of people with three or more limitations in activities of daily living (ADLs) living in the community receive some kind of informal care, most often from a spouse or relative. This means that middle-class families may find themselves caring both for their parents and their children.

A second motivation for this initiative is to make our targeted tax cut package include a more progressive, senior-focused tax option. Most people with long-term care needs have lower incomes: For example, the poverty rate for the elderly with two or more limitations in ADLs is twice as high as the rate for all elderly.

POLICIES

The proposed long-term care initiative would consist of three policies: two new tax credits plus offering quality private long-term care insurance to federal workers. Savings to pay for this initiative would come from new offsets and savings from postponing or modifying our existing tax cut proposals.

1. Long-term care tax credit

The centerpiece of the long-term care initiative would be a tax credit for people with long-term care needs or the families who house and care for such relatives. A \$500, non-refundable credit would cost \$3.9 billion over 5 years and \$12.4 billion over 10 years (according to preliminary Treasury estimates) and would help a total of 3.4 million chronically ill individuals (described below). People with long-term care needs are defined as having two or more limitations in ADLs (bathing, dressing, eating, toileting, transferring and incontinence management) lasting for longer than six months or severe cognitive impairment, as certified by a doctor. Virtually all people who meet these criteria need some type of long-term care. The credit would be given on

the basis of illness rather than expenses because, otherwise, it would not help people who receive unpaid long-term care. For example, a wife who cares for her husband herself rather than paying someone to do it would not receive a credit if it were based on receipts for long-term care expenses. This approach is also easier to administer than alternatives. About 1.7 million chronically ill individuals would directly get this credit on their own tax returns.

Certain families with "dependents" with long-term care needs could also receive the credit. Under current law, adults can be claimed by tax filers as dependents if they are related, have very low income, and receive at least half of their support from the tax payer (among other criteria). Adult dependents are generally not required to file tax returns themselves. For the purpose of this credit, we would broaden the definition of a "dependent" to include a person who needs long-term care (described above), lives with the family member, and generally does not have any income tax liability. Because by definition they live in the community, dependents are rarely nursing home residents. Simply stated, this allows families (other than spouses) who house and care for relatives needing long-term care to apply for the credit on their behalf. This improves the ability of the credit to help people who do not have enough income to file tax returns, although it does not help the elderly with no tax liability living alone or outside of their relatives' homes. Another 1.7 million families would get the credit in this way.

Over half of the chronically ill individuals benefiting from this credit are elderly, since the need for long-term care increases with age. Preliminary conversations with aging advocates suggest that this tax credit would be well received. However, private long-term care insurers could oppose the credit for fear that it will decrease interest in insurance since people may think that the credit protects them against long-term care costs.

Key Issues

Should the credit be refundable? A large proportion of people with long-term care needs are low-income and do not have tax liability. Refundability could improve the effectiveness of this policy at reaching its target population.

Pro:

- An additional several hundred thousand people would benefit from the credit if it were refundable, and, for those with a low tax liability, they would get the full amount of the credit.

Cons:

- It adds complexity to the policy because it creates a need to exclude certain groups. A large number of non-filers with long-term care needs are already receiving assistance through SSI and Medicaid if in a nursing home. Because a refundable credit would count against their eligibility for these programs, it makes sense to exclude them from the credit. However, this would be difficult, administratively and politically.
- It could jeopardize the initiative. Although we have been successful in our support for

the refundability of the E.I.T.C. despite the strong Republican opposition, adding another refundable credit could risk the passage of the initiative and potentially undermine support for existing refundable credits as well.

- This proposal, as a refundable credit, may not be administrable at acceptable levels of compliance and intrusiveness.

Should we give a larger credit to few people or a smaller credit to more people? If we make the definition of needing long-term care stricter (i.e., three or more ADL limitations as opposed to two), fewer people would be eligible but we could increase the credit amount within the budget constraints.

Pros:

- Raising the credit amount to \$1,000 would make the amount more meaningful. For example, it is enough to purchase a few hours of respite care per week.
- Eligibility based on two or more limitations in ADLs could be more subject to fraud, since it is a less strict standard.

Con:

- Even with \$500 credit and the broader definition of needing long-term care, the policy helps a subset of the people who need long-term care or their families. According to one estimate, about 50 million Americans provide some type of informal long-term care to family and friends.
- Because most people meeting the stricter definition (three plus limitations in ADLs) are ill enough to require institutionalization, even a \$1,000 may be perceived as being too small relative to the larger costs incurred by these people and their family.

2. Tax credit for impairment-related work expenses for people with disabilities

To complement the work of the Task Force on Employment of Adults with Disabilities, people with disabilities could receive a new tax credit of up to \$5,000 for their impairment-related work expenses. This credit could be used to offset expenses for personal care in the workplace, for example, which is often a pre-condition for leaving home for work. A similar credit was in the Health Security Act and a Republican "return-to-work" proposal this year. It costs about \$500 million over 5 years, \$1.2 billion over 10 years, and helps about 300,000.

Key Issue

Should this credit remain as part of the long-term care initiative or be saved for a separate announcement? Although this credit can be considered a long-term care policy, it also fits in the context of return-to-work policies for people with disabilities and could be announced by itself or in the State of the Union.

Pro:

- Omission of a policy for people with disabilities within a long-term care initiative would be noticed. There is a heightened attention to disability issues both in Congress and the community, and especially close attention is being paid to Administration actions. Even the aging advocates support including people with disabilities to avoid this criticism.

Cons:

- The disability community seems happy with the Administration's work on the Jeffords-Kennedy legislation, so that an additional policy at this point may not be needed.
- Since we do not exclude people under age 65 from the long-term care tax credit, we would be helping people with more severe disabilities even if we dropped this specific credit. The overlap between the two credits, however, may be low.

3. Offering private long-term care insurance to Federal workers

The third piece of the initiative is the small but symbolic non-tax option to offer Federal employees and annuitants a range of high-quality private long-term care insurance policies. There would be no Federal contribution for this coverage, but Office of Personnel Management (OPM) would set standards for the plans and sort them into benefit classes (e.g., "core" policy plus several types of "enhanced" policies) to facilitate informed choice. A seriously flawed bill to allow an open-ended long-term care insurance option was introduced by Representative Mica (R-FL) last week. Democratic members of the Civil Service Subcommittee, plus some Republicans (e.g., Connie Morrella), have expressed interest in a substitute. Proposing an alternative would add to our series of policies for Federal workers that demonstrates our leadership as a responsible employer.

Key Issues. None on policy grounds, although it is not a tax policy like the others. However, your advisors recommend that we act on this as soon as possible to preempt the Republicans from claiming the policy.

4. Offsets

This long-term care initiative would cost about \$4 billion over 5 years and \$14 billion over 10 years. It could be offset by modifying our existing tax package and adding a few new policies. First, we would postpone the effective date of our proposed tax initiatives until January 1, 2000. Given the Year 2000 problem, we would probably have to do so regardless. Second, we would scale back the child and dependent care credit (make it a 40 percent credit as opposed to 50 percent and slow the phase-down). Third, we would add two new policies that were in the Senate IRS package, but weren't included in the final bill and that were in your FY 1998 budget. The first is to modify the Foreign Tax Credit carryover rules; the second is to reform the treatment of Foreign Oil and Gas Income and dual capacity taxpayers.

Key Issues. None on policy grounds, although like any offsets, they are not universally liked.

RECOMMENDATIONS. Your advisors (Chief of Staff, Office of the Vice President, NEC, DPC, CEA, Legislative Affairs, Treasury and OMB) generally agree on all of the components of this long-term care initiative. On the issue of refundability of the long-term care tax credit, we recommend against it. In particular, NEC, DPC Treasury and Legislative Affairs fear that making the credit refundable could spur an overall attack against refundability and jeopardize the gains that we have made on the E.I.T.C. It does, however, leave us somewhat vulnerable to criticisms that it is regressive. We suggest responding to this concern by stating that we are willing to work with Congress to make this credit more progressive. There is also agreement to choose a broader definition of eligibility (two plus limitations in ADLs) even though we would have to lower the credit to make it affordable. This could help broaden the base of support for the initiative. Finally, even though the credit for people with disabilities could be part of the long-term care package, we recommend making it a separate announcement. NEC/DPC think that this credit might be best announced in the State of the Union, since it is likely to be recommended by the Task Force's November report and such an announcement would be viewed as acting on that recommendation.

Long-term care tax credit:

- Include refundable credit
- Include non-refundable credit (RECOMMENDED)
- Do not include in the package

Tax credit for impairment-related expenses for people with disabilities:

- Include tax credit for people with disabilities
- Do not include in the package (RECOMMENDED)

Offering private long-term care insurance to federal employees:

- Include in package (RECOMMENDED)
- Do not include in the package

Discuss some or all options further

ISSUES RELATED TO THE TIMING OF AN ANNOUNCEMENT

Assuming that the long-term care initiative and modified tax cut package are acceptable on policy grounds, the next question is about timing of an announcement. The following outlines the pros and cons of announcing this initiative in August or early September.

Pros:

- **Secures ownership of the long-term care issue.** A strong, affirmative long-term care message would not only be popular amongst the elderly, people with disabilities and most

advocacy groups, but it would probably be well received by validators who think that this is the great, untouched baby-boom issue. This could complement and affirm your leadership on major, societal issues facing the country in the next century.

- **Provides an alternative to private long-term care insurance and MSAs as the only solution to the problem.** In September, the Republicans will probably take up the Mica federal employees' private long-term care insurance proposal and the Senate Patient Bill of Rights legislation that expands MSAs to include long-term care expenses. The mainstream advocates are concerned about the singular focus on private long-term care insurance and MSAs, since they will not come close to covering the costs of long-term care. Even the insurance industry, in its most optimistic projections, does not foresee that private insurance will cover even half of long-term care costs in thirty years. However, in the absence of alternatives, some may feel some pressure to support the Republicans' proposals.
- **Confirms our support for responsible tax cuts.** Presenting a tax cut package with explicit offsets would reaffirm that we support tax cuts, so long as they are paid for. As such, it could complement our Save Social Security First message. These credits also are attractive alternatives to some of the Republican proposals, since they focus on the elderly and people with disabilities who have lower income.

Cons:

- **Could provide impetus for an unacceptable tax cut this year.** The proposal would come at a time when Congressional Democrats, especially in the House, see the Social Security First message as strong and simple. They would probably perceive a new tax package as clouding that message. Also, Gingrich has been musing about settling for a tax cut this year of \$70 billion or even less, so that our announcement of a revised tax package of about \$30 billion could be read as a sign that we are willing to deal with the Republicans on their tax package in September and make our rule of not using the surplus less clear as well. Finally, given that our revenue raising provisions are unpopular on the Hill, an announcement with an attractive set of options could increase the chances of a tax cut that taps the surplus.
- **Democrats may prefer marriage penalty regardless.** The new package could have somewhat limited value for Congressional Democrats because it does not include marriage penalty relief, which is their main concern.
- **May appear political and not receive the attention and validation that it deserves.** Since it is unusual to propose policies with budget implications outside of the State of the Union and Budget process, the timing of the announcement, rather than the substance of it, may be what the press focuses on.

RECOMMENDATIONS. Your advisors generally do not recommend an August or early September announcement. The importance of this initiative to your overall policy agenda would probably be obscured by a media focused on the timing. Moreover, Republicans could seize on the announcement to generate momentum in September for their tax package or one that uses the surplus. It appears, at this point, that Democrats think that inaction on the tax front is a good outcome for them.

However, we think that the question of timing should be revisited in mid-September. At that point, we will have a better sense of the potential ramifications of the announcement for Congress. We can also assess when and how we can make this announcement so it clearly gets the attention it deserves and puts you in a leadership role on this important issue.

- _____ Announce in August or early September
- _____ Revisit timing decision in mid-September (RECOMMENDED)
- _____ Discuss further

THE WHITE HOUSE

WASHINGTON

August 25, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed
Chris Jennings

SUBJECT: New Department of Labor Regulations

You are tentatively scheduled to use this week's radio address to announce the release of a new Department of Labor (DOL) regulation that will require all self-insured health plans, which cover over 50 million Americans, to provide a standard internal appeals process for enrollees. This action builds on the series of initiatives Federal agencies have taken in response to your Executive Memorandum instructing all Federal health plans to come into compliance with the Quality Commission's Patients' Bill of Rights. Because DOL can do no more than require an appeals process, your announcement underscores the need for Congress to pass a strong, enforceable Patients' Bill of Rights.

Background on Executive Action on Patients' Bill of Rights

Over the past few months, you have made a number of announcements to bring Federal health plans, which serve 85 million Americans, into compliance with the Patients' Bill of Rights. In June, the Department of Health and Human Services released new regulations to bring Medicare into compliance, and it will implement similar regulations for Medicaid in late September or October. In July, you announced that the Department of Veterans' Affairs had established a new, rapid external appeals process for its 3 million beneficiaries. In August, you announced that the Department of Defense had directed all military health plans, which serve 8 million Americans, to come into compliance with the Patients' Bill of Rights. At your Kentucky rally, you announced a new regulation prohibiting "gag" clauses in plans participating in the Federal Employees Health Benefits Program (FEHBP), which serves 9 million federal employees and their dependents. The Office of Personnel Management will take other steps to bring FEHBP into virtual compliance by late September.

Department of Labor Internal Appeals Regulations

The Department of Labor has certain limited authority to regulate self-insured plans. Firms with these plans, which generally have over 100 employees, have elected to self-insure to avoid state regulations and premiums and to have more flexibility to design health plans for their employees. The Department of Labor has extremely limited authority to bring these health plans into compliance with the Patients' Bill of Rights. The Department cannot require self-insured plans to provide most of the consumer protections outlined in the Patients' Bill of Rights, such as

access to specialists, emergency care protections, or an external appeals mechanism. But because DOL has authority under ERISA to regulate how plans evaluate claims, it can require all health plans to provide an internal appeals process to all served employees.

The regulation DOL would issue under this authority would: (1) require plans to notify enrollees of their appeal rights under the plan; (2) drastically reduce the time plans have to respond to non-emergency appeals (from 90 days to 15 days), and require plans to respond to emergency appeals within 72 hours; (3) give enrollees greater access to documents used in reviewing their claims; and (4) require the plan to provide a full appeals process before terminating or reducing benefits for an enrollee in urgent circumstances.

Consumer groups believe this regulation is long overdue and will give it strong support. The business community also will be generally supportive of the regulation, although for a bad reason: they will hope that the regulation bolsters their claim that federal patients' rights legislation is not needed. For this reason, in announcing this regulation, we must clearly articulate the limitations of our authority in this area and reiterate our call for strong, enforceable federal legislation.

Conclusion

Release of this regulation will underscore two important points. First, it will show that you are committed to taking all the action within your authority to bring federal health plans into compliance with the Patients' Bill of Rights. Second, by virtue of the regulation's inescapable limitations, it will highlight the need for federal legislation to ensure that all Americans have needed health care protections.

THIS FORM MARKS THE FILE LOCATION OF ITEM NUMBER 3
LISTED IN THE WITHDRAWAL SHEET AT THE FRONT OF THIS FOLDER.

THE WHITE HOUSE
WASHINGTON

2730-1
AUG 1999
99 FEB 6 PM 7:40

February 4, 1999

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed, Chris Jennings, Elena Kagan, Dan Marcus (Counsel's Office)

SUBJECT: Grijalva v. Shalala

John Podesta held a meeting last night with staff from the DPC, Counsel's office, OLA, OVP, OMB, and HHS to discuss whether the Solicitor General and HHS should petition the Supreme Court for a writ of certiorari in Grijalva v. Shalala. The cert petition, which is due on Wednesday, would seek to vacate a decision (1) holding that Medicare HMOs are "state actors" and, as such, required to provide enrollees with constitutional due process and (2) requiring the Secretary of HHS to ensure that all Medicare HMOs comply with specific notice and hearing requirements when seeking to deny or reduce medical benefits.

You previously noted (on a copy of a New York Times article attached to this memo) that this is a "tricky issue," and your comment, if anything, understates the difficulty and political sensitivity of the decision. HHS objects to the administrative burdens that the district court's injunction imposes and worries that these onerous requirements -- as well as the fear of being subject to other constitutional standards -- will drive some HMOs from the Medicare program. Many Congressional Democrats and health advocates, however, believe that contesting the ruling below will undermine our effort to enact patients' rights legislation and perhaps threaten federal enforcement of Medicaid requirements.

Background

In Grijalva, a nationwide class of individuals enrolled in Medicare HMOs alleged that the HMOs were failing to provide the notice and appeal rights guaranteed by the Due Process Clause of the Constitution. The district court (Judge Alfredo Marquez) agreed that Medicare HMOs were state actors and, as such, required to provide constitutional due process; he also found that the notice and appeal procedures then in existence failed to meet constitutional requirements. The judge issued an injunction specifying precise notice, hearing, and appeal procedures, including a requirement that review of an HMO's decision to deny, terminate, or reduce services take place prior to implementing that decision. The injunction also commanded the Secretary to terminate contracts with any Medicare HMO failing to comply with these requirements. The District Court stayed this injunction pending completion of the appeals process, so the injunction has not yet gone into effect.

THE WHITE HOUSE
WASHINGTON

May 21, 1999

MEMORANDUM FOR THE PRESIDENT

FROM: GENE SPERLING
LARRY STEIN
BRUCE REED
CHRIS JENNINGS

SUBJECT: KEY MEDICARE ISSUES AND LEGISLATIVE UPDATE

Breaux-Thomas Proposal and the Medicare Commission. Despite failing to receive the endorsement of the Medicare Commission, Senator Breaux and Congressman Thomas have committed to introducing their Medicare reform proposal and may do so as early as next week. Their proposal's centerpiece is a premium support option that changes the way that Medicare pays health plans, including traditional Medicare. It includes a limited, although inadequate prescription drug benefit. And, most notably, it does not include your surplus proposal or any explicit commitment to add needed new financing for the Medicare program to deal with the doubling of the beneficiary population - from 40 to 80 million over the next 35 years.

Our major criticism of the premium support proposal is that its design, according to the Medicare actuary, would explicitly increase Medicare premiums for the traditional program by between 10 and 20 percent. This would have the effect of financially coercing Medicare beneficiaries into HMOs - not encouraging them through lower premiums for private plans. Although the Breaux-Thomas proposal maintains the current premium for beneficiaries who live in counties with no private plan options, this exemption would, for the first time in Medicare history, create different premiums for traditional Medicare based on where a beneficiary lives. Moreover, it creates a false sense of security - should even one small HMO plan enter an area, the premium protection would end. This would leave some beneficiaries the "choice" of joining the new plan or paying 10 to 20 percent more to stay in traditional Medicare. Other criticisms of the Breaux-Thomas plan include: the lack of any new financing, raising the age eligibility to 67 percent without any policy to protect against increasing uninsured, and a Medicaid rather than Medicare prescription drug benefit that only helps beneficiaries whose income is below \$11,000 (single), and, while some limited copays may deserve consideration, they have an open-ended 10 percent home health copay that could impose significant costs on the sickest beneficiaries.

Publicly, we have praised Senator Breaux for tackling such an important challenge and thanked him for including certain policies like the modernizing the traditional program and recognizing the importance of prescription drugs. However, as we commend Senator Breaux for his constructive contributions, we also point out the shortcomings in his plan. As we do this, we reiterate your statement that it is incumbent upon us to put forward an alternative that: (1) makes Medicare more efficient and competitive; (2) maintains and modernizes Medicare's guaranteed benefits, including a prescription drug benefit; and (3) assures adequate financing by dedicating part of the surplus for Medicare.

Status and Timing of Reform Plan. While we have been careful to not commit to any specific release date for your proposal, we have said that you wish to get it out with enough time left for the Congress to act this year. With this in mind, we are working toward having a plan available for public presentation as soon as mid-June. We are scheduled to meet with you in early June to review options and present recommendations.

If asked about timing, we would recommend that you say that it is your hope to get the proposal out early this summer and preferably in June. However, you should reiterate that you do not think it is wise to commit to a specific date; it is far more important that we get the policy work done right, have all the provisions scored by the Medicare actuary, and develop and implement an effective roll-out of the policy with the Democratic Leadership and others.

Provider Concerns about Balanced Budget Act. Provider savings will not be easy to come by this year, since all major provider groups have launched a campaign not just against additional savings for reform, but to support "give backs" from the Balanced Budget Act itself. Even conservative Democrats like Senators Conrad, Moynihan, Baucus and Bingaman are considering "fixing" or undoing BBA '97 reductions, especially for academic health centers, rural hospitals, nursing homes, home health care providers and others.

Our goal is to have some fixes where clearly well justified while still getting some moderate new savings. As such, we are proactively seeking administrative interventions that could moderate the effects of the BBA. Administrative actions would be the priority since, pending OMB approval, this spending would neither require legislation nor offsets. Moreover, acting administratively rather than legislatively could avert, or at least postpone, opening up the Balanced Budget Act which could drain away the resources necessary to help fund a prescription drug benefit. We are examining legislative options for your consideration, bearing these risks in mind. If we conclude that administrative actions are inadequate, limited legislative fixes could help avoid a negative response to your Medicare reform proposal.

In response to questions, we would recommend that you acknowledge the many serious concerns being raised by providers about their financial status. You can advise the members that we are reviewing these concerns carefully to evaluate whether there is justification for administrative and/or Medicare interventions. If there is, we believe that we should include them. You should advise them, however, that it would be dangerous to open up the BBA in the absence of detailed evidence that Medicare is the problem and should be the solution. If we over-react or act prematurely, we risk starting a bidding war that could seriously undermine our recent successes in strengthening the Medicare program and balancing the budget.

SPECIFIC POLICY ISSUES:

- 1. Competitive Alternatives to Premium Support.** Modernization can be divided into two categories: modernization of the traditional Medicare program and competition among managed care plans. One of the positive contributions of the Medicare Commission was to unanimously support making the traditional Medicare program more competitive (e.g., allow for more competitive pricing; greater ability to contract out for services; high-cost case management). Your Medicare advisors also think that these ideas are worth pursuing.

Most of the controversy, however, surrounds whether there can be competition in managed care that avoids the downside (higher traditional Medicare premiums) of the Breaux-Thomas plan. We are reviewing policies for price competition in managed care that meet several criteria: the traditional Medicare premium is protected to avoid financial coercion into managed care; Medicare's benefits are clear and strongly guaranteed; and competition is based on price and quality, not benefits which are easier to manipulate to attract healthy beneficiaries. Although these options do not produce large savings, they have the potential to bridge the differences between advocates of premium support and the traditional program. Supporters could view this as a step in the right direction since, for the first time, beneficiaries could get lower premiums for choosing low-cost plans. Opponents could be assured that their major concern about premium support – that it undermines traditional Medicare – has been addressed. Conversely, conservative Democrats could argue that it does not go far enough, while base Democrats could continue to fear that Republicans will hijack the proposal to set us on the path towards a capped voucher system that privatizes Medicare.

Given the sensitivity of this issue, we recommend that you simply state that you are examining all options, but will not veer from your principles. Specifically, you will reject competition that results in higher traditional Medicare premiums but you are also open to new ways to inject more competition into the Medicare program. You can stress the importance of choice, not coercion.

- 2. Drug Benefit: Design.** All health care providers and experts agree that a plan to reform Medicare for the twenty-first century must include prescription drug coverage. Prescription drugs have become an essential part of health care. They complement medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitute for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and offer new treatments where there previously were none (e.g; drugs for HIV/AIDS). Their importance will grow as the understanding of genetics increases. The potential for health improvements and possibly lower health care costs is greatest for the elderly and people with disabilities, whose health conditions often can be effectively managed through drugs.

Although the Breaux-Thomas plan acknowledges the importance of prescription drug coverage, it provides an affordable option only for beneficiaries with incomes below 135 percent of poverty (\$11,000 for a single beneficiary). Moreover, the current sources of coverage for Medicare beneficiaries – retiree health insurance and Medigap – have become more expensive and less accessible. Those beneficiaries with coverage have seen the amount of this coverage decline. Less than half of beneficiaries enrolled in Medicare managed care have coverage for expenses above \$1,000 or 2,000. This makes targeting only the uninsured or low-income inefficient and inequitable. As such, we are examining options that provide a voluntary, affordable Medicare insurance option for all beneficiaries.

The challenge is to design a drug benefit that is meaningful and affordable to both the program and its beneficiaries. We are also contemplating an option to provide for catastrophic coverage once the cap is met. It is important to note that, whatever design we chose, beneficiaries can use the 10 to 15 percent discount that the private contractors or pharmacy benefit managers (PBMs) get through negotiation before, during and after the coverage ends. This is a big advantage for beneficiaries who now buy drugs at retail prices. Medicaid would pay for the premiums and cost sharing for low-income beneficiaries through the QMB and SLMB programs.

A number of Senators have strong opinions on how the drug benefit should be designed. Senators Kennedy and Rockefeller proposed a more costly benefit that includes both some up-front coverage (20 percent coinsurance after a \$200 deductible, up to \$1,500 in spending) and some catastrophic coverage (0 percent coinsurance after \$4,200 in total expenses or \$3,000 in out-of-pocket spending). This reflects the desire to ensure that beneficiaries with low to moderate costs are helped while protecting the sickest. You should praise them for their leadership on this issue. Senators Graham and Wyden suggest that costs should be reduced by either raising the deductible, limiting the types of drugs covered, or restricting the coverage to low-income beneficiaries only. We have concluded that these are unworkable or flawed approaches, but would also recommend that they be acknowledged for their interest in this issue.

We feel it is important to not signal the direction of our benefit, but you should know that we are currently exploring an option with no deductible, where we would pay half of the costs of prescription drugs up to \$5,000.

- 3. Drug benefit: Costs and Offsets.** The options that we are considering have 10-year costs that fall between \$150 and 200 billion, significantly less than Kennedy-Rockefeller legislation whose costs are at least \$300 billion over 10 years (note: we do not advise that you discuss numbers with Senators since they are not public). These costs are net of beneficiary premium payments.

Your advisors have been striving to fully fund the prescription drug benefit from savings from competition, providers, and beneficiaries. However, the constraints on these savings options make it clear that only a very limited drug benefit can be financed in this way. As such, we are examining options for additional financing that include an additional tobacco tax, a portion of the surplus dollars dedicated to Medicare, and/or additional provider and beneficiary contributions.

Some Congressional Democrats (mostly the base) have advocated for using either part of Medicare's 15 percent, or an extra amount from the surplus, for prescription drugs. The primary rationale is the enormous contribution that Medicare has made to the balanced budget and surplus; the Medicare Trustees and the Congressional Budget Office project that Medicare spending is over \$200 billion lower than originally projected when the BBA was passed. It also appears possible that the trust fund could still be extended to 2025 or so with approximately one-third of the surplus used for the drug benefit. Others, particularly the moderate Senators and the Blue Dogs, have expressed concerns that this would undermine your surplus framework. Instead, they recommend proposing additional tobacco tax revenue for the benefit as well as larger beneficiary and provider cuts. Some within your economic team would advocate taking this approach as an opening position, recognizing that the surplus would likely be used to fund the benefit in the bill that gets signed. We are examining these options' policy or political viability. Since there is a clear split in Congress, and differences of opinion among your budget advisors as well, we suggest that you avoid any comments on financing sources at this point, but reassure the Senators that our plan will be fully, credibly financed.

4. **Surplus for Medicare Solvency.** A few Senators (Breaux, Kerrey, Hollings) and some conservative House members continue to express concerns over dedicating 15 percent of the surplus to Medicare. In Senator Hollings' case, it stems from a belief that this is more of a budget game than a serious approach buying down debt. Senator Breaux adopts the same IOU criticism, but the primary reason for his current opposition is that he believes that it fractures his bipartisan coalition for his reform package, since Republicans are adamantly opposed to the surplus dedication. Only Senators Breaux and Kerrey voted against using the surplus for Medicare in the budget resolution.

Clearly, major structural reform, program savings and beneficiary contributions combined cannot offset the costs associated with the doubling of Medicare enrollment that will occur when the baby boom generation retires. In fact, if reductions in growth alone were used to extend the life of the Medicare Trust Fund, spending growth per beneficiary would have to be limited to below inflation, 3 percent per year -- in every year -- to get to 2025. Every independent Medicare expert affirms that greater revenue is needed to fund the program into the future (note: 15 percent of the surplus gets to 2027 on the 1999 trustees' baseline). This rate is well below projected private health insurance spending per person (7.3 percent). Moreover, since this growth rate is below general inflation, the value of Medicare spending per beneficiary would erode.

Senator Kerrey argues as if the general revenues going to Medicare would somehow be reserved for non-defense discretionary if they were not dedicated to Medicare. Most feel, however, that without a "Medicare block," the general revenue would go to a fiscally irresponsible tax cut as opposed to a fiscally responsible plan to pay down debt and to help Medicare solvency.

5. **Income-Related Premium.** We are contemplating an income-related premium in our policy review. You have supported this policy in the past (1992, 1993, and 1997) as a progressive form of increasing beneficiary contributions in the context of an acceptable package of broader reforms. In the past, our support has been conditional on several parameters. First, the 75 percent premium subsidy would not be fully phased out, in order to keep high-income beneficiaries in the program. Second, it should target truly high-income beneficiaries and be indexed to keep up with inflation (an earlier version of the Commission plan began at \$24,000 for single beneficiaries, \$30,000 for couples, affecting about 30 percent or 12 million beneficiaries, which is problematic). And, third, it should be administered by Treasury since it can collect this premium more efficiently than HHS, thus producing more revenue.

Large numbers of moderate/centrist Democrats and Republicans strongly support the income-related premium as do elite validators (other than those who consider Medicare a pure social insurance program). Interestingly, the far left of the Democratic party (Gephardt, Waxman, Kennedy) and the far right of the Republican party (Senator Gramm) oppose this proposal. The Democrats' main arguments are that the income-related premium opens the door to means-testing since it could easily be lowered in the future, and if it only hits the highest income, it does not raise enough revenue to justify the policy. In contrast, Senator Gramm insisted that the income-related premium be dropped from the final Breaux-Thomas proposal because he believes it to be a tax that affects one of the Republican core constituencies.

Given your past support for this policy and the need to come up with beneficiary as well as provider savings, you probably should indicate an openness to the income-related premium if asked. Almost all of your advisors support this. The base Democrats concerns can be allayed somewhat if you reassure them that it will be targeted truly at the higher income beneficiaries. More importantly, it is useful to remind them that it is much more progressive than an across-the-board premium increase or aggressive cost sharing increases, which would be needed to raise comparable contributions.

6. **Cost Sharing.** The Breaux-Thomas proposal includes reforms intended to rationalize Medicare's patchwork of cost sharing. In some cases, this means adding copays where none exist, and other, it is reducing excessive or unnecessary cost sharing. Specifically, it would eliminate preventive service cost sharing and hospital copays after 60 days, and create one, combined, budget-neutral deductible of \$400 (today, the Part A deductible is \$768 per hospitalization and \$100 for Part B). It would also add an unlimited home health copay of 10 percent and 20 percent lab and nursing home coinsurance. Finally, it would prohibit Medigap from covering the new \$400 deductible. Although the intent was to produce a budget-neutral package, it ended up saving \$20-40 billion over 10 years.

Centrist Democrats are inclined to support beneficiary cost sharing because they believe it has a positive impact on excess utilization of services. Base Democrats argue that it will not affect utilization since most beneficiaries have supplemental coverage, and for those without coverage, it will significantly increase costs.

Your advisors are reviewing options with the primary goal of simplifying Medicare's cost and making it more similar to that of private health plans. We are contemplating eliminating cost sharing for preventive services (since cost sharing discourages use); rationalizing the nursing home copay (from nearly \$100 per day for days 21 to 100 to a straight 20 percent coinsurance); and adding a new Medicare option to purchase (without subsidies) lower cost sharing (a Medicare version of Medigap). This last option, of eliminating the need for supplemental coverage by offering better coverage within Medicare, is widely recommended by experts like Bob Reischauer and Laura Tyson. Additionally, we are reviewing options to add copays where there currently are none: a reduced, capped home care copayment and 20 percent coinsurance on clinical lab services. This package of cost sharing savings could either be budget neutral or save money, which may be justifiable in the context of adding a new prescription drug benefit. If asked, we would recommend that you be non-committal in this area, but acknowledge that cost sharing options are being considered.

7. **Age Eligibility Increase.** The Breaux-Thomas proposal would increase the Medicare age eligibility from 65 to 67. Some support this policy, arguing that it conforms Medicare to Social Security. However, Social Security provides the option for a partial benefit at age 62 and through age 67. In contrast, the Breaux-Thomas proposal provides for no such option for people at age 62 and no specific coverage option for people ages 65 to 67.

Per your guidance, we are opposing this policy for several reasons. First, people in their early 60s are already at risk of becoming uninsured. The fastest growing number of uninsured Americans are those between the ages 55 and 65. One recent study projects that the number of uninsured ages 61-64 will increase by over 40 percent by 2005 (from 3 million to 4.25 million). As a consequence, people ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states,

it is the most expensive and inaccessible insurance option for older Americans. It was for these reasons that you proposed allowing certain people ages 55 to 65 to buy into Medicare. As a note, Senator Daschle feels strongly that you include this budget proposal in your Medicare reform plan as well.

These problems would be worse for people ages 65 to 67 if they did not have Medicare. Nearly one in ten or about 4 million Medicare beneficiaries are age 65 to 67. If they were to lose Medicare and their uninsured rate is the same as that of 64 year olds, it could be assumed that nearly 600,000 people would become uninsured. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance. This policy would also likely increase employer and state Medicaid costs, since these payers would continue to be the primary insurer for these beneficiaries.

Some proponents of raising the age eligibility have suggested that these problems can be avoided if coupled with a Medicare buy-in for people ages 66 and 67. It is true that, relative to the coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. If similar take-up rates occurred in the 65 to 66 year old population, only a small number of those who would lose Medicare would opt for coverage through the buy-in. The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about over half of people ages 65 and 66 have income below 300 percent of poverty (about \$27,000 for a single), the cost of subsidies would be high.

There appears to be a growing recognition of the shortcomings of increasing Medicare's eligibility age. As a consequence, although the Finance Committee supported this provision in 1997, it is unclear whether this policy could pass today. In fact, Senator Breaux has recently indicated that he would likely drop this provision from his package. We would therefore recommend that you reiterate your strong opposition to this policy, particularly since there is no viable policy to address the problems that recent studies affirm will occur.

Reed/EL
Jennings
Podesta

THE PRESIDENT'S OFFICE
10-19-99

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THE WHITE HOUSE
WASHINGTON

October 18, 1999

ACTION MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed
Chris Jennings

SUBJECT: Assisted Suicide Legislation

*Self-funded to send letter
but I'm basically OK
on that point - if pain
relief not sufficient
& no alternative
to keep on life support
normal*

*Wojcik
BC*

On Wednesday, the House is tentatively scheduled to vote on H.R. 2260, the Pain Relief Promotion Act of 1999. As you will recall, this legislation, sponsored by Congressman Hyde, modifies the Controlled Substances Act (CSA) to create criminal penalties for the use of a controlled substance in physician assisted suicides. It also takes new steps to protect the appropriate provision of palliative care, a significant modification to the previous version of this legislation.

While the Department of Justice strongly supports the palliative care provisions of the bill, it has strong concerns about the federalism issues it raises and the penalty structure it creates. They would like to forward the attached letter of opposition to the House Judiciary Committee, outlining these concerns. This letter does not include a veto threat. We recommend that the letter be sent, but that the White House refrain from public comment on the legislation.

BACKGROUND

Representative Hyde introduced the H.R. 2260 this summer. It is the second generation of the legislation known as the Lethal Drug Abuse Prevention Act of 1998 (LDAP). As you will recall, you and virtually every respected consumer and health care provider group, including the AMA, opposed LDAP because of the fear that the legislation would inhibit pain relief for the terminally ill. The provisions of most concern to provider and consumer groups included the establishment of broad prosecutorial authority for law enforcement officials, allowing the investigation of health care providers that were suspected of planning to use or of having used a controlled substance to assist in a suicide, and the absence of a proactive statement protecting the provision of appropriate palliative care.

H.R. 2260 would make physician-assisted suicide using controlled substances subject to administrative, civil, and criminal sanctions, and effectively ban the practice in all 50 states. However, Representative Hyde has modified the old version of this legislation to incorporate an explicit statement that using a controlled substance to alleviate pain and discomfort is a legitimate medical purpose, even if the use of the controlled substance increases the likelihood of death. It also narrows prosecutorial authority to suspected cases of the use of a controlled substance in an assisted suicide, and requires local, state, and Federal law enforcement personnel to receive information on palliative care in continuing education programs. Because

of these modifications, the bill is now supported by many of the groups who previously opposed it, including the AMA, the National Hospice Association, and the National Academy of Pain Management.

Notwithstanding the modifications to the bill, a number of provider organizations, including the American Nurses Association and the American Academy of Family Physicians, still oppose this legislation because they feel that H.R. 2260 will place the Department of Justice in the position of regulating the practice of medicine, which is traditionally the purview of the states. In addition, since this legislation would effectively nullify the Oregon Death With Dignity Act, Governor Kitzhaber and Senator Wyden view this legislation as an unnecessary intrusion into state policy making and oppose its passage.

The Justice Department is very supportive of the new provisions protecting appropriate palliative care. However, because H.R. 2260 effectively blocks all state policy-making on the issue of physician assisted suicide, the Attorney General shares the federalism concerns of the Oregon delegation. In addition, she believes that the legislation establishes criminal and administrative sanctions that will be burdensome and difficult to implement and enforce.

RECOMMENDATION

The Department of Justice wants to ensure that their concerns are not construed as opposition to the legislation's intent. The Attorney General, like you, strongly opposes physician assisted suicide, but believes the legislation's approach can be improved. Although she has no interest in engaging in a protracted dispute with Senator Nickles (who has introduced a similar bill in the Senate) and Congressman Hyde, she feels strongly that her Department should formally voice their concerns to the Congress, with the hope of an opportunity to address some of them, particularly the criminal and administrative penalty provisions, in conference.

We would recommend that the Department of Justice be permitted to forward this letter. Having said this, and given the cross-currents of opinion on this issue and on this bill, we believe that there should not be a strong White House public statement on the legislation until and unless it has been submitted to you for signature.



U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

Honorable Henry Hyde
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This letter presents the views of the Department of Justice on H.R. 2260, the "Pain Relief Promotion Act of 1999."

H.R. 2260 makes two changes to federal drug law as it relates to the use of controlled substances by terminally ill patients. First, the bill clarifies that controlled substances may be used to alleviate pain in the course of providing palliative care to terminally ill patients. The bill also funds research and education on the appropriate use of controlled substances for this purpose. The Department strongly supports these provisions of H.R. 2260.

Second, H.R. 2260 states that the use of controlled substances to assist a terminally ill person in committing suicide is not authorized by federal law. The Department opposes physician-assisted suicide, but is concerned about the propriety of a federal law that would unquestionably make physician-assisted suicide a federal crime with harsh mandatory penalties. Imposing such penalties would also effectively block State policy making on this issue at a time when, as the Supreme Court recently noted in Washington v. Glucksberg, 117 S. Ct. 2258, 2275 (1997), the States are still "engaged in an earnest and profound debate about the morality, legality, and practicality of physician-assisted suicide."

Palliative Care

Section 101 of H.R. 2260 amends section 303 of the CSA, 21 U.S.C. § 823, to specify that the use of controlled substances to "alleviat[e] pain or discomfort in the usual course of professional practice" is a "legitimate medical purpose" under the Controlled Substances Act, 21 U.S.C. § 841, "even if the use of such a substance may increase the risk of death." Because a physician who acts with a "legitimate medical purpose" is acting

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in compliance with the Act,¹ H.R. 2260 creates a "safe harbor" against administrative and criminal sanctions when controlled substances are used for palliative care. Sections 102, 201 and 202 amend the CSA and the Public Health Service Act (42 U.S.C. § 299) to authorize the Attorney General, the Administrator of the Agency for Health Care Policy and Research, and the Secretary of the Health and Human Services Department to conduct research on palliative care, to collect and distribute guidelines for the administration of palliative care, and to award grants, cooperative agreements, and contracts to health schools and other institutions to provide education and training on palliative care.

The Department fully supports these measures. H.R. 2260 would eliminate any ambiguity about the legality of using controlled substances to alleviate the pain and suffering of the terminally ill by reducing any perceived threat of administrative and criminal sanctions in this context. The Department accordingly supports those portions of H.R. 2260 addressing palliative care.

Physician Assisted Suicide

H.R. 2260 would amend section 303 (21 U.S.C. 823) of the Controlled Substances Act (CSA) to provide that "[n]othing in this section authorizes intentionally dispensing, distributing, or administering a controlled substance for the purpose of causing death or assisting another person in causing death." By withdrawing authorization under the CSA, H.R. 2260 would make it a federal crime for a physician to dispense a controlled substance to aid a suicide.² A physician who prescribes the controlled substances most commonly used to aid a suicide would, because he necessarily intends death to result, face a 20-year mandatory minimum sentence in federal prison (as well as civil and administrative sanctions under the Act).³

¹ See, e.g., 21 C.F.R. § 1306.04(a) (authorizing prescriptions only for "legitimate medical purposes").

² The criminal provisions of the CSA are triggered by the absence of proper authorization. See 21 U.S.C. § 841(a) ("Except as authorized by this subchapter, it shall be unlawful . . .") (emphasis added).

³ See 21 U.S.C. § 841(b)(1)(C) (setting 20 year mandatory minimum sentence when death results from the distribution of a Schedule II substance); 21 C.F.R. § 1308.12(a)-(c) (defining Schedule II substances). Schedule III drugs, which are sometimes used, do not carry any mandatory minimum sentence. See 21 U.S.C. § 841(b)(1)(D).

Thank you for this opportunity to present our views. The Office of Management and Budget has advised us that from the standpoint of the Administration, there is no objection to the submission of this letter. Please do not hesitate to call upon us if we may be of further assistance.

Sincerely,

Robert Raben
Assistant Attorney General

cc: Honorable John Conyers, Jr.
Ranking Minority Member

to do. H.R. 2260's prohibitions would only reach controlled substances, which are most often used as sedatives and not as the actual agents of death. As a result, H.R. 2260 might well result in physician-assisted suicides that do not use sedatives and pain-controlling substances that are accordingly more painful.

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THE WHITE HOUSE
WASHINGTON

FEBRUARY 4, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed

SUBJECT: Campaign to Reinvent Government

- I. **ACTION-FORCING EVENT:** On Tuesday, February 9, you are tentatively scheduled to announce a series of executive orders and other actions designed to streamline the Federal Government. We have prepared a working draft of legislation to create a board with broad statutory authority to reinvent government. This legislation is entitled the "Campaign To Reinvent Government Act Of 1993," and would do the following:
- ◆ Establish a board of 7 members (4 Democrats and 3 Republicans), appointed by the President, that would lead a campaign to reinvent government. The board would have nine months to conduct a performance audit of the Federal Government. With your approval, it would then submit legislation to consolidate, streamline, or eliminate Federal departments, agencies, commissions, and programs; devolve responsibilities from the Federal Government to the States and establish criteria for awarding performance grants and federal grant waivers; implement civil service reform; reduce red tape; and implement performance-based budgeting.
 - ◆ Require Congress to vote up or down, with no amendments and limited debate, on the recommendations of the board.
 - ◆ Assuming passage of the legislation, direct the Office of Management and Budget, in association with the heads of all affected agencies and departments, to implement the recommendations of the board.
- II. **BACKGROUND/ANALYSIS:** This legislation would give you broad authority

to cut spending, reduce bureaucracy, and eliminate unnecessary layers of management -- and demonstrate that you will do everything in your power to make government work better before you ask the middle class to work harder. The review board is based on John Sharp's highly successful performance audit in Texas, and enjoys broad bipartisan support. Senators Glenn, Roth, Lieberman, and Campbell have prepared similar legislation.

In proposing this legislation, you will need to decide who should head it. John Sharp, Phil Lader, and David Osborne are obvious candidates. Warren Rudman could be considered for one of the Republican slots.

III. RECOMMENDATION: We recommend that you announce next week that you will be sending to Congress legislation to create the Campaign to Reinvent Government.

IV. DECISION:

____ Approve ____ Approve as amended ____ Reject ____ No action

FEBRUARY 8, 1993

MEMORANDUM FOR JOHN PODESTA

FROM:

Bruce Reed *BR*

SUBJECT:

Reinventing Government Decision Memos

I am sending along decision memos for the executive orders and Presidential memoranda you should have received from OMB:

1. Executive Order to Reduce the Bureaucracy by 100,000
2. Executive Order to Cut Administrative Costs
3. Executive Order to Reduce Advisory Commissions by 33%
4. Memorandum to Restrict Use of Government Aircraft
5. Memorandum to Reduce Use of Government Vehicles
6. Memorandum to Reduce Various Perks

I have been working under the assumption that the White House staff cuts would be announced on Tuesday, and that these other measures would be announced on Wednesday. Let me know if that has changed.

THE WHITE HOUSE
WASHINGTON

February 8, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED *BR*

SUBJECT: Executive Order Reducing the Bureaucracy by at Least 100,000 Positions

I. ACTION-FORCING EVENT: You are tentatively scheduled to announce reductions in the federal bureaucracy on Wednesday, February 10, 1993.

II. BACKGROUND\ANALYSIS: This Executive Order seeks to satisfy your campaign pledge to cut the federal bureaucracy by at least 100,000 positions through attrition, as a way to eliminate unnecessary layers of management and improve productivity.

One of every six dollars we spend on domestic programs goes to wages and benefits for federal workers -- not counting administrative costs. Eliminating 100,000 positions in the bureaucracy would save \$3-4 billion a year by FY 1996.

This measure will reduce the government's civilian workforce of 2.2 million people by four percent over the next three years. It orders OMB to issue detailed instructions directing executive departments and agencies with over 100 employees to achieve 25 percent of the cuts in FY 1993, 62.5 percent by the end of FY 1994 and 100 percent by FY 1995. At least ten percent of the reductions would come from management (Senior Executive Service, GS-14 and GS-15). Independent agencies are requested to make similar reductions voluntarily.

III. RECOMMENDATION: This action will help fulfill one of your most visible campaign promises. I recommend that you approve the proposed Executive Order.

IV. DECISION:

Approve Approve as amended Reject No action

THE WHITE HOUSE
WASHINGTON

February 8, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED *B.R.*

SUBJECT: Proposed Executive Order To Cut Administrative Costs

I. ACTION-FORCING EVENT: You are tentatively scheduled to announce reductions in executive branch administrative costs on Wednesday, February 10, 1993.

II. BACKGROUND\ANALYSIS: This proposed Executive Order is intended to satisfy your campaign pledge to cut administrative costs in the executive branch by three percent. The Order directs executive agencies and departments to break out administrative costs (to be defined by the Office of Management and Budget) as a separate line item category in their budget requests to OMB. The Order further directs that future budget requests must reflect reductions in the agencies' and departments' administrative expenses of one percent in FY 1994, three percent in FY 1995, six percent in FY 1996, and eleven percent in FY 1997 off the 1993 baseline. Independent agencies are requested to reduce their administrative expenses by the same amounts.

OMB estimates that these cuts would save \$2.4 billion a year by FY 1997.

III. RECOMMENDATION: I recommend that you sign the proposed Executive Order.

IV. DECISION:

Approve Approve as amended Reject No action

THE WHITE HOUSE

WASHINGTON

February 8, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED *BR*

SUBJECT: Proposed Executive Order Reducing Advisory Commissions

I. ACTION-FORCING EVENT: You are tentatively scheduled to announce reductions in unnecessary advisory commissions on Wednesday, February 10, 1993.

II. BACKGROUND/ANALYSIS: This Executive Order seeks to eliminate unnecessary executive branch advisory commissions. There are over 1,100 advisory commissions, approximately 700 of which have been created even though they are not required by statute.

These commissions issue 1,000 reports a year, cost taxpayers approximately \$150 million per year, and are spreading like kudzu. The State Department has an Advisory Committee of the International Commission on the Conservation of Atlantic Tunas and an Advisory Committee to the Inter-American Tropical Tuna Commission. The Transportation Department has a Commercial Fishing Industry Vessel Advisory Committee, a National Boating Safety Advisory Committee, a National Offshore Safety Advisory Committee, a Navigation Safety Advisory Council, and a Towing Safety Advisory Committee.

This proposed Order directs the Office of Management and Budget (OMB) to ensure that executive agencies and departments terminate not less than one-third of those advisory commissions not required by statute. Within 90 days after the date of the Order, executive agencies would be required to submit to OMB: 1) a justification for the continued existence or a recommendation for the termination of each nonstatutory committee and 2) a recommendation to Congress to continue or to terminate any advisory committee required by statute. Agencies and departments would be prohibited from creating or sponsoring any new advisory commission except in compelling circumstances and only with the

approval of the Director of OMB. Independent agencies are requested to comply voluntarily.

III. RECOMMENDATION: It is time to clean house in Washington. I recommend that you approve the proposed Executive Order.

IV. DECISION:

Approve Approve as amended Reject No action

THE WHITE HOUSE

WASHINGTON

February 8, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED *BR*

SUBJECT: Restricted Use of Government Aircraft

I. ACTION-FORCING EVENT: You are tentatively scheduled to announce reductions in government perks and privileges on Wednesday, February 10.

II. BACKGROUND/ANALYSIS: This Memorandum limits use of government aircraft to select officials (Secretary of State, Secretary of Defense, Attorney General, Director of the FBI, and Director of the CIA), and requires that they (1) use the authority only when the particular circumstances require its use and upon approval of the White House Counsel Office; and (2) reimburse at full coach fare. This differs from current practice which allows agency heads to decide for themselves what represents "required use."

This action would make it explicit that you intend only a limited number of officials to have special access, and remove the presumption that every trip by even that limited group must be on government aircraft.

III. RECOMMENDATION: The memory of John Sununu is still fresh. I recommend that you approve issuance of this Presidential Memorandum.

IV. DECISION:

Approve Approve As Amended Reject No Action

THE WHITE HOUSE
WASHINGTON

February 8, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED *BR*

SUBJECT: Proposed Presidential Memorandum Reducing Use Of Government Vehicles By High-Level Government Officials

I. ACTION-FORCING EVENT: You are tentatively scheduled to announce reductions in executive branch perks and privileges on Wednesday, February 10, 1993.

II. BACKGROUND/ANALYSIS: The Presidential Memorandum would reduce the use of limousines by high-level government officials as follows:

Under current law, the President may designate six Executive Branch employees and ten additional officers for daily home-to-work transportation. In addition, each member of the Cabinet is authorized to designate a principal deputy to receive this "portal-to-portal" service.

The proposed Presidential Memorandum would limit portal-to-portal service to Cabinet members, the National Security Advisor and the White House Chief of Staff.

The proposed Memorandum also directs each federal department or agency to reduce the number of executive motor vehicles (except armored vehicles) that it owns or leases by 50 percent by the end of fiscal year 1993.

III. RECOMMENDATION: Portal-to-portal service was one of the most brazen abuses of privilege in the Bush Administration. Reducing home-to-work service will demonstrate your commitment to saving taxpayer dollars (without decreasing government efficiency) and show that you're not going to let your Administration lose touch with ordinary people. I recommend that you approve issuance of this proposed Presidential Memorandum.

IV. DECISION

Approve Approve as amended Reject No Action

THE PRESIDENT HAS SEEN

2/10/93

THE WHITE HOUSE

WASHINGTON

February 8, 1993

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED *BR*

SUBJECT: Proposed Presidential Memorandum To Reduce Various Perks

I. ACTION-FORCING EVENT: You are tentatively scheduled to announce reductions in executive branch perks and privileges on Wednesday, February 10, 1993.

II. BACKGROUND/ANALYSIS: The Presidential Memorandum would reduce perks of Executive Branch employees in the following ways:

Executive Dining Facilities - The Memorandum directs departments and agencies to recover costs for meals served in Executive Dining Rooms, including the White House Executive Mess. It also encourages Secretaries to voluntarily close dining rooms if they are not essential for the conduct of government business.

Fitness Club Facilities - The Memorandum ends the practice of paying for employees' membership at private health clubs (except where an employee's official duties require maintaining physical fitness). Agencies are directed to recover operating and equipment costs from employees who use fitness rooms provided by the agency.

Golf Courses - Government-owned golf courses would be opened to the public (except where the Secretary of Defense designates the course as exempted for security purposes in exceptional circumstances). The Memorandum directs that the costs of operation be recovered from users except in certain limited circumstances.

Conferences - The Memorandum requires that decisions on conference sites and employee attendance be based upon cost effectiveness. The Office of Management and Budget will issue further instructions necessary to implement this requirement.

Medical Services - Agencies are directed, to the extent permitted by law, to charge at least a nominal fee for medical services provided to their employees by the Public Health Service. Certain services, such as emergency care and occupational health

TO: Carol Rasco
FROM: Bruce Reed
DATE: February 24, 1993
SUBJECT: National Performance Review

As the Administration comes under increasing pressure to produce more spending cuts, we desperately need to demonstrate that we're doing everything we can to put our own house in order and root out government waste.

Toward that end, Phil Lader and I have been discussing an across-the-board audit of every federal program, similar to the highly successful performance review pioneered by Comptroller John Sharp in Texas. This National Performance Review would be carried out by an internal team under the direction of the White House and OMB, and would enlist front-line federal workers and the general public in a high-profile search for ways not only to cut wasteful spending, but to improve services and make government work better. The team would be given a six-month deadline, and its recommendations would be presented to Congress for one or more up-or-down votes in the fall.

The President met with Ann Richards and John Sharp during the campaign to find out about the Texas Performance Review, and indicated his support for the general idea to you earlier this month. We would like to present him with a full-fledged proposal as soon as possible. The President's political advisers want to unveil this idea next week.

The Texas Model

Texas launched its Performance Review in 1991 to address a \$4.6 billion budget shortfall. John Sharp formed a team of 100 auditors from 16 state agencies to conduct a sweeping review of how the Texas state government does business. They set up a waste hotline for employees and taxpayers, held public hearings around the state, and interviewed hundreds of front-line workers. After five months, the Performance Review presented recommendations for savings of \$5.2 billion, half of which the Legislature adopted. A second review proposed recommendations last month on how to save another \$4.5 billion.

The Texas audit was based on a conscious inside-outside strategy: By making a lot of noise about government waste, the Review made it virtually impossible for the Legislature to vote against budget cuts -- and by enlisting public employees in the process, it built broad support for change from within.

A National Performance Review

At the national level, a Texas-style audit would look like this:

1. Each Cabinet Secretary would assign 5 to 10 people from his or her department to work with OMB career staff and the White House on an intensive six-month audit. The team should include front-line workers as well as managers, auditors, and CFOs.

2. The Review would be divided into 8-10 teams, organized along functional lines rather than by agency. One team would look at federal-state relations to recommend ways to limit unfunded mandates, streamline the waiver process, devolve federal responsibilities, etc. Others would examine service delivery, the budget process, procurement, and so on.

3. The teams would look not only for wasteful spending, but for ways to eliminate unnecessary layers of management, reduce duplication of effort, treat taxpayers more like customers, and make government more responsive to the people. Each team would review existing analyses of government practices and past efforts at government reform, interview public sector managers and employees, and consult with management experts in the private and public sectors.

4. An 800-number would be established for public employees and taxpayers to call in tips on wasteful spending, and to recommend ways to improve government services. We could hold town hall meetings on the subject as well.

5. Over the next several weeks, we would work with Congress on legislation to seek broader reorganization authority, which would give the audit greater latitude to recommend sweeping changes. This legislation would not be crucial to the audit's success, but it is vital to our long-term efforts to reinvent government.

6. The Performance Review would have no more than 6 months to produce its recommendations. These recommendations would be submitted to Congress as soon as possible, either as a single package or in a series of up-or-down votes.

7. Any good ideas we find before the Labor Day deadline could be released early to be included in the economic package, as a way to maintain public pressure for spending restraint.

Key Questions

Before we go public with this idea, we need to resolve a few basic questions:

1. Who's In Charge? Obviously, OMB will play a central role in this endeavor, both in conducting the audit and carrying out its recommendations. The audit must be part of our broader Reinventing Government efforts -- Phil Lader and I will present some more ideas along those lines next week. But there might be some advantage to making it a Presidential initiative, and turning it over to the Vice-President (who is undoubtedly interested in the subject) or someone like John Sharp (who would do a superb job, because he's done it before).

2. How Can We Involve Congress? Several members of Congress (Lieberman, Glenn, Roth, Kerrey, Krueger, Campbell, and others) have introduced legislation to create a commission that would serve the same purpose as our performance review. Phil Lader and others don't like the commission idea, because it sounds too much like business as usual. They're probably right. But we should still find a way (perhaps a review committee or President's Council) to help sympathetic members of Congress share in the credit.

March 1, 1993

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: Bruce Reed

SUBJECT: Reinventing Government Announcement on Wednesday

Per our conversation last night, we are preparing for Wednesday's announcement of a Texas-style "National Performance Review," headed by the Vice President. We are looking either at a visit to a specific agency (HUD or HHS) or an event that brings employees from across the government to the Old Executive Office Building.

We expect this announcement to include:

1. Official designation of the Vice President to head the Administration's Campaign to Reinvent Government, and announcement of Phil Lader's role at OMB. We would also like to name Al From, David Osborne, and John Sharp as unpaid senior advisers on reinventing government.

2. Formation of a government-wide National Performance Review to examine every federal program and service. Each Cabinet Secretary will be asked to assign 5 to 10 people -- managers, auditors, and front-line workers -- to devote a portion of their time to the project for up to six months. The goal of the Review is not to produce another report, but to make specific recommendations for action, agency by agency.

The Review teams will look at existing analyses by GAO, CFOs, and Inspectors General for immediate action; evaluate the efficiency of every federal department; ask federal workers and the American people to make specific suggestions on how to improve services and cut bureaucratic waste, by calling an 800-number (every agency already has one) or writing the Vice President; recommend ways to streamline the bureaucracy by eliminating unnecessary layers of management and reducing duplication of effort; look for ways to improve services through better use of technology and by making government programs more responsive to the customers they serve; suggest changes that would reward performance, give managers more flexibility, and put more decision-making power in the hands of front-line workers; and identify top priorities for performance-based management decisions.

This will not be another study -- Washington has had too many studies. The Review will act on existing wisdom and recommendations by real people to produce real results. We don't intend to create new jobs, spend new money, or generate new paperwork in the process.

3. Statements by John Sharp on how the Performance Review worked in Texas, and by David Osborne on what reinventing government can accomplish.

4. Recognition of congressional efforts to join in the President's war on waste. Several members of Congress have proposed legislation to create either a Performance Review or a Reinventing Government Commission. We are currently planning to invite Senators Glenn, Lieberman, Krueger, and Roth, and Reps. Conyers and Gordon.

5. Expression of support for legislation to begin performance measurements -- including the Roth bill on performance-based budgeting.

A few questions remain for Wednesday:

1. What precise role can we give outsiders like Sharp, Osborne, and From?
We want to create a broad circle of advisers -- perhaps including the members of Congress listed above -- without triggering the open-meeting laws under the Federal Advisory Committee Act. Texas made extensive use of free help from private consultants and auditors; we should too, if we can.

2. Are we planning to submit legislation asking Congress for broader powers through reorganization authority? If we're serious about reinventing government, we'll need it, but Howard Paster suggests that we wait as long as possible, so we don't raise jurisdictional issues in Congress that could jeopardize the economic plan. We don't need to decide anytime soon.

3. How should we proceed in developing a strategy for the campaign to reinvent government? The key areas include:

- a) Devolution of responsibilities to the states;
- b) Reorganization of departments and agencies;
- c) Sunset laws;
- d) Incentives to reward performance, productivity, and innovation, including an Innovation Fund;
- e) Regular Presidential visits to agencies to meet with managers and policymakers and hold town meetings with employees;
- f) Truth in spending laws;
- g) Regulatory reform;
- h) Civil service reform;
- i) Procurement changes; and
- j) Pilot restructuring of departments.