

Withdrawal/Redaction Sheet

Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
01. memo	Steve Gleason to Aan Wheat etal. Re: Campaign Strategy on Health-Related Issues (1 page)	7/23/96	Personal Misfile
02. position papers	1992 Clinton-Gore Camapign Materials (42 pages)	1992	Personal Misfile

COLLECTION:

Clinton Presidential Records
 Domestic Plocy Council
 Chris Jennings (Subject File)
 OA/Box Number: 23756 Box 6

FOLDER TITLE:

Clinton-Gore Campaign Materials [5]

gf10

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the 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 advise 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]

C. Closed in accordance with restrictions contained in donor's deed of gift.

PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
- b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
- b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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FAX ID NUMBER: 202/296-3997

THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

FACSIMILE TRANSMISSION COVER SHEET

Date: 8/12/96

Message From: Jack Brasel

Message To: Chris Jennings

Fax ID Number: 456-5542

- Urgent Delivery
- Normal Delivery
- 8 Number of Pages (Including Cover Sheet)

Special Instructions/Comments:

Chris: I can't find the letter you referenced. Do any of them help?

WASHINGTON OFFICE
1875 Eye Street, NW
Suite 1000
Washington, DC 20006-2213
Phone 202-296-3993
Fax 202-296-3897

PLEASE NOTE OUR NEW ADDRESS!!!! PHONE/FAX NUMBER REMAINS THE SAME



Letter sent: Broadcast fax P.2/2
U.S. Senate

AMERICA'S HOSPITALS AND HEALTH SYSTEMS

May 16, 1996

Dear Senator:

On behalf of the undersigned organizations representing hospitals and health systems, we strongly urge your support of any amendment to S. Con. Res. 57 (the FY 1997 Budget Resolution) which lowers reductions to Medicare. We cite in particular an amendment to be offered by Sen. Jay Rockefeller (D-WV) to restore \$50 billion to the Medicare program.

While it appears that the overall Medicare budget reductions of \$165 billion included in S. Con. Res. 57 are roughly the same as those in the last Republican offer in January, the budget drastically changes how the reductions would be allocated within the program. The FY 1997 budget proposal achieves the total reduction by saving \$124 billion from Part A Medicare (the Hospital Insurance Trust Fund) and \$44 billion from Part B.

The net result is that in S. Con. Res. 57, the reductions in Part A have increased by approximately \$25 billion. Not only are these unprecedented reductions, but they would have a disproportionate adverse impact on hospitals. To achieve reductions of this magnitude, Congress may need to adopt policies that would freeze or actually reduce payment rates per beneficiary.

Hospitals and health systems support a reasonable deficit reduction package, and believe that changes in Medicare are sorely needed to keep the Part A trust fund solvent. Many of us have supported various proposals that achieve a balanced budget with reductions in Medicare. However, we are gravely concerned about the level of Medicare Part A reductions proposed in S. Con. Res. 57.

Again, we ask you to support any amendments that temper the level of reductions to Medicare Part A, including Sen. Rockefeller's amendment to restore \$50 billion to the Medicare program, and seek a more balanced approach to achieving savings.

Sincerely,

American Hospital Association
American Association of Eye and Ear Hospitals
Association of American Medical Colleges
Catholic Health Association
Federation of American Health Systems
InterHealth
National Association of Public Hospitals and Health Systems
Premier, Inc.
VHA Inc.

Letter also sent to Chairman Archer
and Chairman Bliley

May 10, 1996

The Honorable William Roth, Jr.
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Roth:

The undersigned organizations representing hospitals and health systems have reviewed the Fiscal Year 1997 (FY 97) House and Senate Budget Committee proposal, particularly with respect to the Medicare and Medicaid programs.

While it appears that the overall Medicare budget reductions of \$167 billion are roughly the same as those in the last Republican offer in January, the Budget Committees have significantly changed the allocation of reductions within the program. While it is difficult to assess the overall impact of the budget resolution in the absence of greater detail, now larger Medicare Part A reductions mean hospitals are likely to experience actual reductions in payment rates under the committees' proposal.

The budget resolution now includes lower budget reductions in Part B of Medicare, while the reductions in Part A have increased by approximately \$25 billion since the January offer. While the FY 97 budget resolution offers a milder overall approach to deficit reduction compared to last year's resolution, its impact on hospitals appears worse. To achieve reductions of this magnitude, Congress may need to adopt policies resulting in payment rates per beneficiary that would be frozen or actually reduced.

We also have serious concerns about the Budget Committees' Medicaid reductions. We would like to take this opportunity to reiterate our support for maintaining the entitlement nature of the Medicaid program to ensure that those who have coverage today will continue to have coverage tomorrow. Furthermore, we support maintaining current law provider assessment restrictions and Boren amendment payment safeguards. While the overall reductions are somewhat lower than the January offer, if combined with corresponding state reductions through lower state matching requirements or new provider assessments, these reductions could be quite significant for providers.

Hospitals and health systems support the need to adopt a reasonable deficit reduction package, and believe that changes in Medicare are needed to keep the Part A trust fund solvent. Many of us have supported various proposals that achieve a balanced budget with reductions in Medicare and Medicaid. However, we are gravely concerned about the level of reductions proposed by the Budget Committees in these programs.

Chairman Roth
May 10, 1996
Page 2

We strongly urge you to reconsider both the overall level of Medicare and Medicaid reductions included in the budget resolution and, in your capacity as chairman of the authorizing committee, adjust the allocation between Parts A and B proposed by the Budget Committees.

American Association of Eye and Ear Hospitals
American Hospital Association
American Osteopathic Healthcare Association
Association of American Medical Colleges
Catholic Health Association
Federation of American Health Systems
InterHealth
National Association of Children's Hospitals
National Association of Public Hospitals and Health Systems
Premier

Association of American Medical Colleges
Catholic Health Association of the United States
InterHealth
National Association of Children's Hospitals
and Related Institutions
National Association of Public Hospitals

May 24, 1995

The Honorable Richard Gephardt
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Representative Gephardt:

Our five national health care associations -- Association of American Medical Colleges, Catholic Health Association, InterHealth, National Association of Children's Hospitals and Related Institutions, and National Association of Public Hospitals -- strongly oppose proposals that would eliminate federal minimum standards for Medicaid eligibility.

Medicaid is the joint federal/state program that pays for the health care of more than 31 million mothers and children of low income families as well as elderly and disabled Americans of low and moderate incomes. Medicaid has become increasingly important as the number of uninsured Americans continues to grow. From 1992 to 1993, the number of uninsured Americans grew from 40.1 million to 41.2 million. Children accounted for eight in ten newly uninsured Americans. Without Medicaid, 28% of all Americans and 40% of all children would be uninsured.

Currently, however, several Congressional leaders and governors are proposing major cuts in the future level of federal Medicaid funding and replacing the federal Medicaid entitlement for eligible individuals with a block grant that would give each state a fixed sum of funds plus flexibility to set its own eligibility standards.

Depending on how they were defined, block grants could end Medicaid as a program which entitles eligible individuals to health care regardless of the state in which they reside. Instead, Medicaid could become a program that entitles states to federal funds regardless of the level of health coverage the state provides. If the annual growth rate in federal Medicaid spending were cut in half and the funds were turned into block grants, it would be virtually impossible for many states to absorb the funding cuts without using their new flexibility to limit Medicaid eligibility and services.

According to the most recent available data, Medicaid covered 12 percent of the U.S. population in 1993 -- separate from the 16 percent of Americans who were uninsured. Medicaid plays an even larger role for specific populations. For example, in 1993, Medicaid

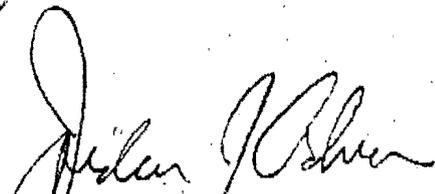
Page 2

covered nearly one in four children and one in three infants, regardless of family income. It covered nearly one in three non-elderly Americans with family incomes below 200% of the federal poverty standard and more than three in five non-elderly Americans with incomes below 100% of poverty.

Since the 1980s, when Congress delinked Medicaid eligibility from welfare eligibility, Medicaid has become a health care program that fosters employment. For example, children represent half of all Medicaid recipients, and nearly three in five Medicaid covered children live in low income families with working adults.

Instead of ending federal minimum eligibility standards for Medicaid, our five associations believe the nation must take steps to achieve universal health coverage, beginning with steps to expand and adequately finance coverage, while avoiding deterioration of current coverage in public programs such as Medicaid. Our five associations believe that, at a minimum, federal law should maintain current national Medicaid eligibility requirements and look to the future to expand coverage for uninsured Americans.

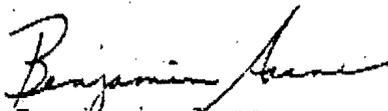
Sincerely,



Jordan J. Cohen, M.D.
President
Association of American
Medical Colleges



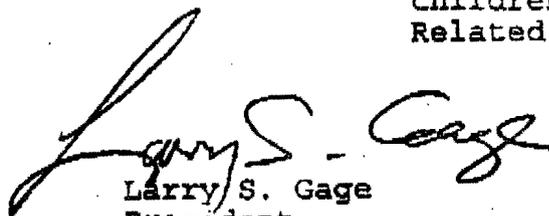
John E. Curley, Jr.
President/CEO
Catholic Health Association
of the United States



Benjamin Aune
President and CEO
InterHealth



Lawrence A. McAndrews
President and CEO
National Association of
Children's Hospitals and
Related Institutions



Larry S. Gage
President
National Association
of Public Hospitals

**InterHealth
AmHS Institute
American Hospital Association
American Medical Association
The Cleveland Clinic Foundation
American Health Care Association
Federation of American Health Systems
National Association of Public Hospitals
Association of American Medical Colleges
American Osteopathic Hospital Association
American Society of Health-System Pharmacists
National Association of Psychiatric Health Systems
National Association of Children's Hospitals and Related Institutions
American Association of Eye and Ear Hospitals
Healthcare Financial Management Association
Volunteer Trustees of Non-Profit Hospitals
National Council of Community Hospitals
American Society of Internal Medicine
American Rehabilitation Association
American Diabetes Association
Catholic Health Association
VHA Inc**

May 17, 1995

The Honorable
United States Senate
Washington, DC 20510

Dear Senator

On behalf of the organizations listed above, we are writing to express our serious concern for the Medicare and Medicaid programs as the Senate begins consideration of its fiscal year (FY) 1996 budget resolution.

From the outset, let us say that we understand that changes are necessary in Medicare and Medicaid...programs that provide health care to millions of elderly, disabled, women and children. We share your goal of restructuring these programs to bring to them the same types of cost-effective health care delivery that are holding down costs in the private sector. Many of our organizations have proposed significant and far-reaching solutions to the problems facing these two important programs. We know that savings in the system can be achieved, and we are willing to accept some reductions through this restructuring.

May 17, 1995
page 2

The proposals put forward by the Senate Budget Committee, however, go too far too fast. The Senate Budget Committee plan, for instance, calls for unprecedented savings in the Medicare program of \$141 billion over five years and \$236 billion over seven years. It is important to note that these numbers are almost three times larger than the level of savings achieved as part of the five-year package in OBRA '93. In addition, the Senate Budget Committee proposes Medicaid spending reductions of \$175 billion over seven years. Such dramatic reductions will seriously jeopardize the ability of doctors, hospitals and others to continue providing high-quality health care to our nation's elderly, disabled, women and children. Furthermore, reductions of this magnitude will undermine efforts to restructure the health care system.

While we pledge to work with you to find workable solutions to the problems facing these programs, we urge you to moderate the level of proposed reductions in Medicare and Medicaid recently approved by the Senate Budget Committee.

Sincerely,

The Above-Listed Organizations

income greater than \$100,000 and couples with income greater than \$75,000 a year. (Income thresholds would not be indexed for inflation under this option.) The additional premium would rise with income. Consequently, the basic and additional premiums combined would reach a level equal to 100 percent of SMI costs for individuals with income of \$100,000 or more and couples with income of \$150,000 or more a year. That income-related premium would yield \$13.8 billion in additional revenues over the next six years.

The basic premium level in this scenario is identical to the 1995 proposal by the Congress to freeze premiums at the then-prevailing 31.5 percent level. If the 31.5 percent premium had been enacted in 1995, the premium increase in 1996 would have been fairly modest compared with 1995 premium amounts. If that premium option was enacted this year, however, the premium increase in 1997 would be a sizable hike over the 1996 premium, which slipped to 25 percent of SMI costs.

Under the \$200 billion savings scenario, more than 90 percent of the 37 million Medicare beneficiaries would pay only the basic premium of \$54.20 a month in 1997. That basic premium would rise to \$75.20 by 2002--an increase of \$20.50 compared with current law. About 2.8 million beneficiaries in 1997 would pay an additional premium amount, although only about 600,000 would pay the maximum premium. On average, the remaining beneficiaries would pay \$39 a month in addition to the basic premium in 1997.

The larger basic premium under this budget scenario would raise the costs of state Medicaid programs, which pay the premiums and cost-sharing requirements for people who are eligible for both Medicare and Medicaid. CBO estimates that total Medicaid spending would increase by about \$4.4 billion between 1997 and 2002 because of higher Medicare premium payments. Of that amount, about \$2.5 billion would represent additional costs to the states.

Trust Fund Status. The more aggressive cost cutting called for under the \$200 billion savings scenario would contribute only modestly to the solvency of the HI trust fund. HI outlays would diminish by \$89 billion compared with current law during this period, extending the trust fund's date of insolvency to 2004.

Six-Year Savings Target: \$300 Billion

A six-year savings target of \$300 billion would represent a sharp break with past Medicare policies. Reductions in payment updates in the traditional fee-for-service sector needed to meet this target would be draconian. Payment growth for risk-based plans would also be slashed. Moreover, beneficiaries would probably find their own costs rising substantially.

Yet, as Chapter 7 explains, spending reductions on this order of magnitude might become inevitable as demand for Medicare-covered services skyrockets with the aging of the baby-boom generation. Policies adopted in the next few years could lay the groundwork for addressing the long-term financing crisis. Such policies would encourage greater efficiency in delivering services, as well as more realistic expectations on the part of providers and beneficiaries about Medicare's ability to finance those services.

Increasing the second scenario's savings options by 50 percent gives a sense of how deep the spending reductions could be under a \$300 billion savings target. The PPS hospital update would drop by about 9 percentage points rather than by 6 percentage points. That policy would lead to an actual reduction in hospital payments rather than a slowing in the rate of growth as under the \$200 billion savings scenario. By 2002, Medicare spending for hospital services would fall just below the 1996 spending level--even though the number of beneficiaries would grow by 8 percent over the same period.

Overall physician spending would grow by 3 percentage points less than the growth of real GDP per capita--a drop of 2 percentage points from the \$200 billion savings scenario. Since real GDP per capita is projected to grow by about 4 percent a year, that drop implies that Medicare spending on physician services would decline by \$2.5 billion between 1996 and 2002. By 2002, the conversion factor that the physician fee schedule uses to determine payments for individual services would plummet to half its 1996 value.

Even those reductions in Medicare spending for hospital, physician, and other services in the fee-for-service sector would be insufficient to meet the \$300 billion savings target. Average payments to risk-based

Plans would also have to be pared compared with the \$200 billion savings scenario. In addition, the costs to beneficiaries would rise by \$20 billion. That jump is equivalent to raising the base SMI premium to almost 40 percent of SMI costs while retaining the income-related premium.

A \$300 billion savings target met in this way would reduce growth in Medicare spending per enrollee to 2.2 percent a year between 1996 and 2002. With the number of beneficiaries growing at 1.3 percent a year over this period, those policies would allow total Medicare spending to increase by about \$45 billion, representing an average aggregate growth rate of 3.5 percent a year.

To meet the \$300 billion savings target, the decrease in revenues to providers and the increase in costs to beneficiaries would need to be substantial and could have broad repercussions. Access to particular providers and services plus the overall quality of care in Medicare might be threatened, unless the private health market also operated under tight payment limits imposed by insurers. Heftier costs to beneficiaries might cause people to drop their SMI coverage to save on prepayment payments. If higher cost-sharing requirements were part of the policy package, other beneficiaries might be discouraged from getting necessary care because of higher out-of-pocket costs. Medicaid costs could also increase sharply if Medicare premiums and cost-sharing requirements were raised substantially. Moreover, states might seek additional authority to limit those costs by restricting standards for Medicaid eligibility.

Those potentially dire consequences of a tight Medicare budget are not, however, inevitable. The policy challenge is to balance the need to control federal Medicare spending with the need to maintain reasonable access to care. Nontraditional approaches to the pricing and delivery of care, such as broadening the range of eligible health plans, competitive payment methods, or converting to a defined contribution system, could lead to a necessary transformation of the Medicare program. If beneficiaries and providers accepted the lower spending levels as a permanent feature of Medicare rather than as a temporary problem, they also be more likely to accept the need for that transformation. Such a process could be an orderly one--if it was given enough lead time.

II. Medicaid

The Medicaid program, established under title XIX of the Social Security Act, is the nation's major program providing medical and long-term care services to low-income populations. In recent years, the program's expenditures have soared dramatically, representing a growing share of the federal budget: for example, between 1990 and 1995, federal Medicaid spending grew at an average annual rate of almost 17 percent. In fiscal year 1996, the federal government will spend \$96 billion on Medicaid--about 6 percent of all federal outlays. Under current law, CBO projects that federal Medicaid expenditures will rise to \$166 billion by 2002, accounting for almost 8 percent of federal outlays in that year (see Table 6-8).

Slowing the rate of growth of Medicaid spending has, therefore, become an important component of any effort to balance the federal budget. Because Medicaid now accounts for over 14 percent of states' expenditures from their general funds, it is also a major priority for the states, which on average finance 43 percent of Medicaid spending. The emphasis on curtailing Medicaid expenditures represents a distinct change in philosophy from the late 1980s, when the priorities of the program were to expand eligibility and coverage.

Medicaid generally covers four broad categories of beneficiaries: poor elderly people, poor disabled people, poor and near-poor children and pregnant women, and certain other adults in low-income families. (The majority of those other adults receive cash welfare benefits.) Recently, however, the federal government has granted waivers to several states, allowing them to expand coverage to a broader low-income population.

CBO projects that 37 million people (about 14 percent of the population) will receive Medicaid benefits in 1996. Under current law, the number of Medicaid beneficiaries is projected to climb at an average rate of 2.7 percent a year between 1996 and 2002, reaching 43 million in 2002 (see Table 6-9). CBO projects, however, that Medicaid benefit payments will grow considerably faster over the period, at an average annual rate of over 10 percent. In addition to the increasing number of beneficiaries, that growth rate reflects benefit payments per beneficiary that are projected to grow at about 7 percent a year.