

THE PRESIDENT HAS SEEN
12/5/95

THE WHITE HOUSE
WASHINGTON

November 27, 1995

95 NOV 27 P 5: 07 BC
Leon : Good memo FYJ
Lester : Good memo - FYJ
BC

INFORMATION

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco *CR*

SUBJECT: (Academic Health Centers) and Budget Strategy *file*

I. SUMMARY

After reviewing John Young's (Co-Chair of the President's Committee of Advisors on Science and Technology) letter and suggestions on how to support academic health centers, you asked for an update of where our health/budget policy and strategy stands with regard to this issue. Chris Jennings has provided us with the following update:

By any definition, academic health centers would fare better under your balanced budget plan than they would under the Republican's budget. However, despite personal appeals by Leon and other senior White House officials, the association that represents academic health centers nationally -- the American Association of Medical Colleges (AAMC) -- has refused to be publicly critical of the Republican plan.

Out of fear that the academic health centers would play the "quality" card, the Republicans actively courted their support (or at least non-opposition). Their negotiations produced a \$13.5 billion Graduate Medical Education (GME) trust fund.

The source of financing the new Republican GME fund is unclear and certainly may not be permanent. Even if one assumes the new account will be fully funded, it would not come close to offsetting the deep Republican Medicare and Medicaid cuts that will hurt academic health centers. Moreover, it would still leave these institutions in much worse shape (at least \$4-5 billion over seven years) than they would find themselves under your balanced budget plan.

Despite acknowledging the above shortcomings, the leadership of the AAMC fears alienating the Congressional Republicans. (The AAMC also says they fear their silence on the budget front may harm their relationship with the Administration.) However, we do not anticipate a change in their "play both sides of the track" strategy -- at least until later in the game.

Origin of
#2
Equation

II. DISCUSSION

Not all representatives of academic health centers have remained silent about the Republican health care cuts. Those from Boston and New York have been critical, but the elite national press rarely picks them up.

Although some in the AAMC privately concede that their stay quiet strategy may well end up costing them big money, they have chosen this course for three reasons. First, unlike the Republicans, they do not believe we would ever do anything that is hostile to their concerns. Second, they successfully bargained for their significant GME trust fund. And lastly, they well understand that the Republicans will be drafting the details of any final deal and they want to have "friends on the inside" when they do.

Based on our current academic health care policy, their calculated assumption that we would take care of them is not unfounded. In fact, your proposal incorporates every recommendation made by Dr. Young. It:

- Establishes a new Commission to develop specific policies that address the long-term private and public funding challenges academic health centers face in an increasingly cost-conscious and competitive environment;

- Keeps cuts in Graduate Medical Education (GME), Disproportionate Share (DSH), and Medicaid to a minimum (about \$12 billion less than what the Republicans advocate); and

- * Proactively responds to the academic health centers' number one legislative priority -- the establishment of a new GME fund that is financed by a reduction in Medicare reimbursement to HMOs. (Most Medicare HMOs are not contracting out with academic health centers but are being reimbursed by Medicare as though they are; the new \$5-7 billion fund would be used to create incentives for HMOs to contract out with academic health centers.)

The AAMC likes the Republicans' trust fund concept because it opens the door to the possibility of non-Medicare generated financial support. However, their first priority is the GME fund proposal included in your balanced budget plan. This is because, unlike the Republican trust fund, they know they can count on the money being there. (Not surprisingly, they would like us to support the retention of the Republican trust fund -- no matter how little the money.)

We will continue to meet with the representatives of the academic health center community to seek their support in the upcoming negotiations. They may come on board later in the process.

THE PRESIDENT HAS SE
11-20-95

EXECUTIVE OFFICE OF THE PRESIDENT
PRESIDENT'S COMMITTEE OF ADVISORS ON SCIENCE AND TECHNOLOGY
WASHINGTON, D.C. 20500

95 NOV 14 P12:28

November 8, 1995

President William J. Clinton
The White House
1600 Pennsylvania Avenue, N.W.
Washington, DC 20500

*Big vision - we need
to discuss it in
of our most
budget
strategy*
Leon / EP / C

Dear Mr. President:

The significant accomplishments in American biomedical research and our innovations in medical care are widely respected throughout the country and, indeed, the world. These achievements have occurred primarily at our Nation's academic health centers. Since World War II, the Federal government has played a vital role in the support of academic health centers and has done so on a bipartisan basis.

Your Administration's 1994 health care reform plan acknowledged the important contribution to our quality of life made by academic health centers and provided a mechanism to mitigate the loss of significant revenue that these institutions are now experiencing. In the absence of comprehensive health care reform, academic health centers are beginning to show signs of serious stress. Although they represent only six percent of the Nation's non-Federal acute care hospitals, these institutions provide more than half of the care for the indigent and uninsured populations. The prospect of sharp reductions in Medicare, Medicaid, and Disproportionate Share (DSH) expenditures, coupled with the erosion of clinical revenues resulting from the emergence of managed care, could have a devastating impact on the Nation's capacity to support medical research and education and the system that provides medical care to its most vulnerable citizens.

Academic health centers develop the biomedical knowledge and clinical techniques needed for new and improved treatments, train the Nation's physicians and provide unique patient care resources. In the long term, biomedical research conducted in these centers offers our citizens the best potential to enhance their quality of life and control medical expenditures with cost-effective methods for disease prevention and management.

Historically, the Federal government has assumed responsibility for a majority of the support for fundamental biomedical research and graduate medical education as a public investment that contributes broadly to the health of Americans. In 1995, the Federal investment in academic health centers for biomedical research and education was about one percent of total health care expenditures. Measured by any standard, this very modest rate of investment in an area of extraordinarily rapid advancement in knowledge and technology has had a remarkable yield. In addition, the Federal government provides, through the Medicaid and DSH programs, significant support for low-income patient care delivered in academic health centers.

President William J. Clinton

November 8, 1995

Page 2

Clinical revenues derived from medical practice programs conducted by the faculty of academic health centers have been another very significant source of funds for these programs of research, education and indigent care. Current changes in the health care system, including Medicare and Medicaid reform, driven by Federal and State fiscal concerns and the emergence of managed care, also threaten to eliminate this critical support for biomedical research and medical education.

We recognize the need to slow the rate of growth in health care costs and endorse efforts to address this need. Both public and private elements of the health care system need to be carefully examined and restructured to enhance medical efficacy and cost-effectiveness. However, it is also essential that in this process, the crucial public benefits that are contributed uniquely by academic health centers be recognized, and that their continued strength remain an important priority in the ongoing health care debate.

A panel of your Committee of Advisors on Science and Technology (PCAST) examined these issues and reached the following conclusions:

- **Sharing the Responsibility** -- The education of competent physicians and scientists, and the production of new biomedical knowledge and technologies, represent vital public necessities. To date, only the Federal government has supported these functions explicitly through the Graduate Medical Education (GME) mechanisms of the Medicare program. With a few notable exceptions, other payers do not contribute to this support. We affirm the principle that responsibility for supporting the missions of academic health centers and their contributions to the well-being of society should be broadly shared by all who benefit.
- **Care for the Indigent and Uninsured** -- Historically, academic health centers have provided care for a disproportionate share of the indigent and uninsured populations and have received a Medicare payment adjustment for this service. It is likely that this responsibility can only increase in the developing private and public medical care marketplaces. With the trend toward managed care, others are even less likely to provide this service because of its resource-intensive nature.
- **Current Debate** -- A satisfactory disposition of these critically important and complex issues is unlikely to emerge from the heat of the current public debate, with its intense and narrow focus on budgetary concerns.

President William J. Clinton

November 8, 1995

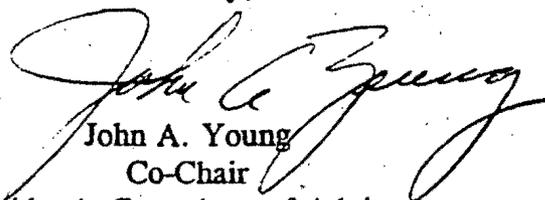
Page 3

To support and sustain the Nation's academic health centers in the immediate future and over the longer term, PCAST therefore respectfully suggests that you consider the following recommendations:

- **Expert Commission** -- We recommend that an expert commission, credible to the President, the Congress and the public, be established to develop and recommend specific policies to address the preservation of the research and educational capacity of the Nation's academic health centers, and the supply, composition and support of the future health care work force. The commission should carefully consider the implementation of an equitable mechanism to achieve these objectives. The commission should also determine the most effective way to allocate training funds in furthering the goals of a rational workforce policy to ensure that the numbers and competencies of health care professionals are responsive to the Nation's needs. We believe that such an approach can best ensure the future vitality of our biomedical research enterprise and the highest quality of our Nation's medical care.
- **Graduate Medical Education (GME)** -- In the interim, in revising the Medicare program, the Administration should continue to resist disproportionate decreases in the GME accounts. Further, the funds for GME that are currently melded into the premiums paid to all Medicare managed care providers (the Average Adjusted Per Capita Cost formula) should be redirected to accomplish their intended objectives. This may entail developing a process that provides these payments directly to caregivers and institutions that are involved in graduate medical education.
- **Disproportionate Share** -- If academic health centers are to continue their role of disproportionately caring for the indigent and uninsured populations, then appropriate resources must be provided. This will almost certainly remain a responsibility of the government.

PCAST believes that the academic health centers are a national resource that, together with our research universities, must be sustained for the good of the Nation. We hope that you will find these recommendations helpful.

Sincerely,



John A. Young

Co-Chair

President's Committee of Advisors
on Science and Technology

Updating Medicare Benefits to Parallel Private Sector Benefits. In recent years, many private plans, particularly managed care plans, have added an array of preventive benefits at little or no charge, while the Medicare benefits package has added very few preventive benefits. This has resulted in a disparity between Medicare and private sector benefits. This proposal updates the Medicare benefit package to make it more comparable to private sector benefit packages.

Enhanced Quality of Life. Prevention of pneumonia, influenza, and hepatitis B mean enhanced quality of life for beneficiaries who otherwise would have become ill, some with costly medical needs that result from their illness. Higher payments for these injections mean that more providers will engage in outreach program to immunize beneficiaries and more beneficiaries will be immunized. Early detection of cancers and other serious conditions can result in less costly treatment, enhanced quality of life, and, in some cases, a greater likelihood of cure.

AARP NEWS

For further inquiry, contact American Association of Retired Persons • Communications Division
601 E Street, N.W. • Washington, D.C. 20049 • (202) 434-2560

AARP STATEMENT ON THE BUDGET RECONCILIATION ACT OF 1995 November 16, 1995

The American Association of Retired Persons (AARP) remains very concerned about the magnitude of reductions to Medicare and Medicaid contained in the conference report to the Budget Reconciliation Act. While the report includes some further improvements, Congress still has a long way to go.

The Association is pleased that the Medicare Part-B deductible remains at \$100 a year, as in the House bill. But the total cuts to Medicare and Medicaid over seven years are still too much, too fast, and enforcement of nursing home quality standards has been further weakened in the report.

Four hundred billion dollars in cuts from these two major health care programs that serve older and low-income Americans do not meet the fairness test. Reductions in Medicare called for in the conference report are much more than is necessary to keep the program solvent into the next decade.

Millions of American families depend on Medicare and Medicaid for their basic health care coverage, for protection against the high cost of long-term care and for financial security. These protections, for Americans of all ages, are now at risk.

Cutting \$164 billion from Medicaid over the next seven years is far more than the program can shoulder. Frail, older Americans, most of whom are single, elderly women who have worked hard all of their lives, and children from low-income families would be the hardest hit by such drastic cuts.

At this juncture in the budget debate, it's a shame that a veto is necessary, but unfortunately, there is no other alternative. AARP will continue to work with Congress and the Administration to get fair legislation that ensures future Medicare solvency and reduces the federal budget deficit.

###

For additional information, please contact Susan Schauer at
202/434-2560.

October 27, 1995

Health Division
Office of Management and Budget
Executive Office of the President

Please route to: Nancy-Ann Min
Through: Barry Clendenin *BC*
Mark Miller *MM*
Subject: Budget Impact of the AMA's "Deal" with
the House Leadership
From: John Richardson *JR*

Decision needed _____
Please sign _____
Per your request
Please comment _____
For your information
Informational copies for:
T. Hill, A. Tumlinson,
HFB/HD Chrons.

Background. CBO scored the physician payment reductions in the original House Medicare bill as saving \$26.4 billion over seven years. The Senate bill includes payment reductions scored at \$22.6 billion over the same period.

On October 10, the American Medical Association (AMA) announced its support for the House majority's Medicare plan. Initial press reports described the AMA's endorsement as the result of "winning concessions worth billions of dollars in future fees for physicians." (*Wall Street Journal*, October 11, 1995, p. A2)

In contrast, Rep. Bill Thomas (R-Calif.) told reporters on October 10 "that the 'sum and substance' of the AMA deal would be '\$200-\$300 mil.' in the physician adjustment. ...Thomas asserted that the final CBO score for the bill 'will be above' \$26 bil. He added that 'there's no way we're going that close to the Senate.'" (*Health News Daily*, October 12, 1995, p. 6)

The Final Numbers: A \$300 Million "Deal." The attached table displays CBO's scoring of the physician payment reductions in the House Medicare bill as reported by the Ways and Means Committee and as passed by the House on October 19. The table illustrates three key points:

- total savings from physician cuts over seven years are only \$300 million lower in the final bill than in the original bill;
- savings in FY 1996 are \$300 million lower than in the original bill;
- savings in FY 2000-2002 are higher in the final bill.

Two Key Changes in Final House Bill. The final House bill makes two changes to the provisions of the original bill:

1. The 1996 conversion factor for all physician services is increased from \$34.60 to \$35.42. This is the same conversion factor found in the Senate bill, but the seven-year savings are not the same as the \$22.6 billion in Senate bill. This is true because of the second change in the final House bill;
2. The floor on physician fee cuts is lowered in 1998 and after¹. This change allows deeper physician fee cuts when spending for physician services exceeds spending targets (i.e., the volume performance standard). Based on the larger savings scored by CBO in 2000 and after, we presume that CBO projects deeper physician fee cuts in 2000-2002 in the final House bill than in the original bill.

The Physician Perspective: A Sure Benefit in 1996 and Uncertain (But Scorable) Costs in Future. By increasing the 1996 conversion factor from \$34.60 to \$35.42, the revised House bill increases the 1996 conversion factor by 2.4 percent compared to the original bill.² CBO has scored more savings in FY 2000-2002 because of the lower floor on payment reductions, but these savings will not materialize fully if physicians are able to keep increases in volume and spending growth below CBO's predictions.

Other Benefits for Organized Medicine in the House Medicare Bill. The House Medicare bill includes several other provisions supported actively by organized medicine:

- antitrust relief and ability to create provider sponsored organizations (PSOs) that could contract directly with Medicare beneficiaries to provide care. PSOs would have less stringent solvency and regulatory standards than traditional health insurers.

PSOs would enable physicians (and allied providers) to bypass insurance companies and the associated "constraints" on the practice of medicine (e.g., Byzantine administrative processes, utilization review). Physicians also could create PSO fee-for-service products that are exempt from Medicare's balance-billing limits. PSOs also could increase adverse

¹Under current law, there is no limit on the upward "performance adjustment" (i.e., the adjustment made to the Medicare Economic Index (MEI) to reflect actual growth in physician spending relative to the target rate of growth). There is a lower limit of -5 percentage points.

Both versions of the House bill would set an upper limit of +3 percentage points on performance adjustments. The original House bill would have set a lower limit of -7 percentage points. In the final bill, the lower limit is set at -7 percentage points for 1997, -7.75 percentage points for 1998, and -8 percentage points for 1999 and after.

²Organized medicine seems to have accepted that the 1996 conversion factor will be cut, not just frozen. Compared to the three 1995 conversion factors for physician services, a single conversion factor of \$35.42 is a cut of 10.2 percent for surgical services and a cut of 2.6 percent for primary care services. The conversion factor for all other services would increase by 2.3 percent. This pattern suggests little policy rationale for the \$35.42 figure. In contrast, the President's proposal would increase the primary care conversion factor slightly and freeze the others at their 1995 levels.

risk selection because providers, with intimate knowledge of beneficiaries' health status, will be making insurance risk decisions about the same beneficiaries.

- a \$250,000 limit on noneconomic damages in malpractice suits;
- medical savings accounts, which would require beneficiaries to set aside funds specifically for health care, would not have a managed care intermediary between the patient and provider, and would not have balance-billing limits;
- fewer restrictions on balance-billing in the expanded coverage options for Medicare beneficiaries, including authorized out-of-network services in managed care plans;
- lifting the physician self-referral ban from several health services currently subject to "Stark I and II" provisions, and creating new exemptions for services covered by the ban (e.g., direct supervision and shared facility exemptions);
- increase the government's burden of proof in anti-kickback criminal prosecutions; and
- eliminating almost all CLIA requirements for physician office laboratories.

Attachment

Medicare Physician Spending Cuts Under Two Versions of HR 2425

(CBO baseline and scoring, outlays in billions of dollars, by fiscal year)

	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>1996-2002</u>
Baseline Spending	32.7	36.8	40.4	43.9	47.9	52.3	57.3	63.1	341.6
<i>Growth</i>	9.8%	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%	9.4%
HR 2425 Reported Out of Ways and Means Committee									
Spending Cuts	0	-0.7	-1.8	-2.9	-3.8	-4.7	-5.7	-6.8	-26.4
New Baseline	32.7	36.1	38.6	41.0	44.1	47.6	51.6	56.3	315.2
<i>Growth</i>	9.8%	10.3%	6.8%	6.3%	7.4%	8.1%	8.4%	9.1%	7.7%
HR 2425 Passed By the House									
Spending Cuts	0	-0.4	-1.3	-2.4	-3.6	-4.8	-6.1	-7.5	-26.1
New Baseline	32.7	36.4	39.1	41.5	44.3	47.5	51.2	55.6	315.5
<i>Growth</i>	9.8%	11.2%	7.3%	6.2%	6.6%	7.3%	7.8%	8.6%	7.3%
Difference Between Committee and House-Passed Bills									
New Baseline	0	0.3	0.5	0.5	0.2	-0.1	-0.4	-0.7	0.3

AMA Agreement with Speaker Gingrich

- Last night, in a closed door meeting, the American Medical Association (AMA) reached an agreement with Speaker Gingrich on the House Republican Medicare restructuring proposal. Although the details have not been shared with the public, it is clear that they have succeeded in placing their interest above that of their patients.
- The deal they cut shows their true vision for Medicare. They want to push Medicare beneficiaries into their so-called "Medicare-Plus" plans. It is actually going to be Medicare "Minus."
- So what did the AMA get to sign on to such unprecedented Medicare cuts?
 - **Number One.** They secured a provision to permit doctors and health insurance plans to overcharge beneficiaries as much as they want in the new Republican managed care plans.
 - **Number Two.** They reduced the physician cut by about \$3-5 billion dollars which will simply shift a greater proportion of the cuts to beneficiaries and other health care providers who are already being unfairly burdened.
 - **Number Three.** They got a cap on medical malpractice damages, so that victims of 'bad apple' doctors cannot be adequately compensated.
- So who are the losers?
 - The losers are the patients of the AMA physicians.
 - The losers are health care providers who are going to bear a greater share of the cuts.
 - The losers are the entire health care system and the patients it serves.
- It is ironic that this deal was struck when, according to the AMA, the average physician's income is \$189,000 a year, while the average Medicare beneficiary's income is \$13,000.
- It is also clear that the AMA does not represent all doctors, many of whom continue to fight against the dramatic and excessive Republican cuts in Medicare and Medicaid. This is exemplified by the fact that the percentage of doctors and medical students in the AMA has dropped from 70% to 40%.

October 11, 1995

TO: Interested Parties
FROM: Chris Jennings
SUBJECT: Likely Details of AMA's Deal with Speaker Gingrich

The AMA's deal has not been released. However, preliminary reports indicate that the AMA obtained several significant provisions in exchange for their support of the House Medicare plan, including the following:

- (1) Balance Billing. Medicare beneficiaries who enroll in the new private fee-for-service or high deductible MSA plan would lose their current law "balance billing" protection (i.e., limits on how much physicians can charge beneficiaries). This is particularly a problem because there is no requirement that physicians stay in fee-for-service (i.e., physicians could abandon regular Medicare and only see beneficiaries in plans where they can balance bill).
- (2) Medicare Payments. Press Reports are unclear about the concessions that the AMA obtained last night, but reports are that AMA received \$3 to \$5 billion less in savings and was protected against decreases. Since the Medicare physician payment savings in the House bill was scored by CBO at \$26 billion, the savings would now be scored at \$21 to \$23 billion.
- (3) Malpractice Reform. Establishes numerous medical malpractice liability reforms including placing stringent limits (\$250,000) on non-economic damages.
- (4) Anti-Trust Exemption. Creates a broad anti-trust exemption for medical self-regulatory entities and substantially relaxes the anti-trust exemption for provider service networks. (The FTC and the Justice Department strongly object to these provisions and believe that they would encourage anti-competitive conduct and raise health care costs to consumers).
- (5) Physician Service Organizations. Allows physicians and other providers to form managed care arrangements under Medicare, but does not subject them to same rules as HMOs (also supported by the Administration).
- (6) CLIA Exemption. Exempts physician office labs from quality requirements despite the fact that to date more quality problems have been identified with physician office labs than other settings.

- (7) Referrals. Virtually eliminates the prohibitions on referring to facilities in which the physician has ownership interest or other financial relationship.
- (8) Anti-Kickback. Makes it more difficult to prosecute abusive kick-back arrangements (which creates double whammy with the changes in referrals).

One possibility to obtain "scored savings" while being spared the "real" cuts would be some type of fall-back mechanism. The fallback mechanism would be "scored" off the higher (CBO) baseline but would be "spared" the cuts because they would never materialize off the Administration baseline. All the provider groups seem to be trying to cut deals for fall-back mechanisms scored from the higher CBO baseline instead of traditional real cuts.

The AMA deal with the House is incredibly sweet.

- o AMA has obtained extensive "real" concessions that they have long wanted and which would fundamentally change Medicare's relationship with physicians and create plenty of opportunity for physicians to improve their financial status at the expense of beneficiaries.

This analysis is obviously preliminary. As we get more specifics, we will give you updates. Hope you find this helpful.

American Medical Association

Physicians dedicated to the health of America



Lonnie R. Bristow, MD
President

515 North State Street
Chicago, Illinois 60610

312 464-4466
312 464-5543 Fax

December 11, 1995

The Honorable William J. Clinton
President of the United States
The White House
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. President:

Physicians and their patients urge you to intensify efforts to reach an agreement with Congressional leaders on reforms that will preserve and modernize the Medicare program. The American Medical Association has spent almost a decade advocating comprehensive reform that will assure the solvency and quality of the Medicare program. We believe that can best be achieved by offering Medicare patients more choices, greater incentives for cost conscious behavior and by removing counter-productive regulatory barriers.

We appreciate your efforts to limit the amount of Medicare spending reductions. We also commend your proposal for a transition to a single conversion factor.

Precise analysis of the Administration's Medicare reform proposal is complicated by the use of different spending baselines and uncertainty regarding other budgetary assumptions. Our preliminary review indicates that, if measured on the same baseline as used by Congress, the spending reductions for physician services proposed by the Administration may exceed the level contained in the House-Senate conference agreement (not including the fail-safe mechanism). We also believe that the physician update formula in the House-Senate conference package will do more to help preserve access for Medicare patients by providing some possibility of increases where warranted by rising practice costs. Moreover, several proposals in the Administration's plan would continue a Medicare price control approach that will undermine the availability of quality care by restricting choice. It is wiser and far more efficient to let information and choice restrict "high cost" medical staffs and payments for assistants at surgery, practice overhead costs and automated lab tests.

We recognize that the Administration's plan does not include a "fail-safe" or "lookback" mechanism imposing additional automatic provider payment reductions if spending targets are exceeded. The AMA has expressed concerns regarding several aspects of the "fail-safe" mechanism. While the "fail-safe" mechanism would defer potential spending reductions, physicians are also at risk of being penalized for factors beyond their control.

The Honorable William J. Clinton
President of the United States
December 11, 1995

Page 2

As you know, the AMA supports reforms increasing both competition and personal responsibility in the Medicare program. We urge the Administration not to restrict beneficiary choice by withholding a medical savings account (MSA) option. MSA's will not unduly burden traditional Medicare which we, like you, want very much to remain a viable option. The relatively small number of beneficiaries expected to choose MSA's should be allowed to tailor their Medicare benefits to their particular health care needs. Leading economists agree that adverse selection problems can easily be solved by technical means; indeed, because the same problem must be solved for all the other expanded options, including HMO's, MSA's should not be singled out and disallowed for this reason. It is unfair to deny the elderly an option that will be available to the rest of the American people.

We are pleased that the Administration supports the concept of provider service organizations. On several occasions, you have expressed support for antitrust relief to facilitate the development of physician sponsored networks. As part of Medicare reform, we again urge you to support changes in antitrust enforcement policy that would apply rule of reason analysis to physician networks rather than per se rules.

Competition should be structured at the plan level rather than carving out specific services. Competitive bidding for clinical lab and certain radiological services is contrary to the operation of many integrated systems of care. The Health Care Financing Administration is not equipped to make purchasing decisions for hundreds of different markets. Quality would be superseded by lowest cost considerations. Elderly patients, especially those with limited means of transportation, may experience delays in receiving necessary treatment as a result of competitive bidding carve outs.

The AMA urges the Administration to embrace two key regulatory reform proposals contained in the House-Senate conference report. The AMA, the Medical Group Management Association and several medical specialty societies have presented substantial evidence to support changes in Stark I and II self-referral prohibitions. The changes in Stark I and II rules will help to lower Medicare costs and halt unnecessary disruptions in patient care.

Extensive evidence has been offered to support reducing existing federal regulation of physician office laboratories. Patient access has declined as a result of costly regulatory requirements. At a time of limited resources, patients would be better served if Health Care Financing Administration staff focused on more serious problems than processing reviews for physician office labs. Pap smears, which were the source of concern behind the 1988 amendments, would continue to be regulated under the CLIA reforms contained in the House-Senate conference report. The AMA, the American College of Obstetricians and

The Honorable William J. Clinton
President of the United States
December 11, 1995

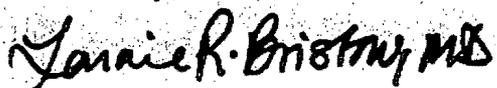
Page 3

Gynecologists, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Society of Internal Medicine, the American Academy of Dermatology and the American Urological Association strongly support the CLIA reform provision in the House-Senate conference report.

All stakeholders should contribute to efforts to preserve and protect the Medicare program. Most policy experts believe that it is fiscally unsound to allow Medicare Part B premiums to drop to 25% of program costs. It is unfair to ask younger workers to pay a higher subsidy for those Medicare beneficiaries who are capable of paying premiums at the 31.5% level. Physicians will accept significant payment restrictions in Medicare and will honor their obligations to put patients first and to care for the needy, however it affects their income.

The AMA looks forward to working with the Administration and Congress throughout the budget negotiations to build support for the passage of necessary reforms to preserve and protect the Medicare program for current and future beneficiaries.

Sincerely,



Lonnie R. Bristow, MD



Bringing lifetimes of experience and leadership to serve all generations.

AARP OPPOSES RAISING THE AGE OF ELIGIBILITY FOR MEDICARE

The Senate Finance Committee's proposal would raise the current age of Medicare eligibility from 65 to 67 over the period of 2003 to 2027. AARP opposes this measure because it would mean that fewer older Americans would be able to get the health care they need at a time when they need it most.

- While increasing Medicare's eligibility age would lower the Federal government's costs, it could actually raise total health care costs for the country, simultaneously burdening businesses and creating new disincentives to employ older workers.
- Unlike Social Security -- which allows an individual to receive early retirement benefits at age 62 -- Medicare does not provide an option for early health care coverage. Therefore, delaying Medicare's eligibility age would mean that many older persons would go without health care coverage or pay exorbitant private health insurance premiums for an additional period of time.
- One of the most vulnerable segments of the population is the so-called early retiree group -- those people who are approaching age 65, but who are not yet eligible for Medicare. These individuals must rely on employer-provided coverage when it exists or private individual coverage if they can afford to purchase it. Raising the eligibility age for Medicare would increase the ranks of this vulnerable group.
- Although most Americans get health care coverage through an employer, 80 percent of 65-69 year olds in 1992 were not even in the workforce. Thus, if Medicare eligibility is delayed, these individuals would face the challenge of finding affordable private coverage without pre-existing condition exclusions. Even those older Americans who do work face dwindling retiree health coverage -- only 45 percent of workers in mid-size and larger firms were slated to receive retiree health benefits in 1993 as compared to two-thirds in the mid-1980s. Raising the eligibility age would only worsen these situations. In addition, a higher eligibility threshold could actually create a disincentive for employers to hire older workers if they believe it would add to their health care costs.



- For those individuals who must buy health insurance in the private market, it would cost significantly more to purchase the current Medicare package in the private market today than through the Medicare program. This is because Medicare's large risk pool spreads the cost of coverage among millions of older Americans. In addition, Medicare generally pays providers less than they are paid in the private market and operates with only a 2 percent overhead. As a result, shifting individuals from Medicare coverage to private coverage could actually increase total health care spending and be counter-productive to economic growth.

AARP Federal Affairs
10/9/95

Baseline

September 14, 1995

TO: Dick Morris
FROM: Chris Jennings
RE: Request for Baseline Analysis

Attached is a quick explanation of the difference in CBO and OMB baselines for both Medicare and Medicaid programs. It is drafted in such a way to make a defensible case for arguing that our baseline is more advisable to use than the CBO baseline.

As you know, most elite economists will argue that the differences are not overly significant. Therefore, this group of "validators" might not be very receptive to suggestions that one baseline is better than another. Having said this, I think you'll find this analysis helpful to make our case.

Call me with questions.

Comparison of CBO and OMB Baselines Medicare

- The OMB baseline has been closer to actual spending than the CBO baseline for six of the past eight years for which there is data (FY 1987 - FY 1995).

Fiscal Year	OMB	CBO	Actual Spending
1987	78	80	80
1988	85	90	86*
1989	94	96	94*
1990	110	112	107*
1991	114	116	114*
1992	127	127	129
1993	143	142	143*
1994	164	167	160*

* indicates years in which OMB projection closer to actual spending than CBO projection

- Projecting baseline spending is a complex process requiring multiple assumptions. There are interactions between private and public spending that cannot always be anticipated. Small differences in assumptions can translate into large differences in projections.
- The difference between the President's Budget and CBO February Medicare baselines is initially relatively small but grows larger over time. Over 7 years, CBO projects \$71 billion more in spending than OMB, or a difference of only 4 percent. This difference in spending is largely driven by a few spending categories.
 - The largest differences are in home health, physicians, hospice, and SNF expenditures. Different assumptions about the rate of growth in these services results in large differences over time.
 - Projecting physician spending is difficult because the rate of growth in expenditures has been unstable year to year. This is most likely due to the changes occurring in the health marketplace, and to the large impact of the private sector on physician expenditures.
 - CBO and OMB projections for hospital spending, which represents the largest category of Medicare expenditures, are very similar.

- The process for making baseline projections is slightly different for CBO versus OMB. One explanation for this difference is OMB's access to data which CBO does not have.
 - CBO only has access to aggregated expenditure data from the treasury while OMB, through HCFA, has access to historical data from carriers, who process Part B claims, and intermediaries, who process Part A claims, which provides them with more detailed data including utilization.

Comparison of CBO and OMB Baselines

MEDICAID:

- The OMB Medicaid baseline is developed by HCFA actuaries by using a detailed and sophisticated forecasting model that includes:
 - historical spending data;
 - the most recent estimates from the states;
 - the Administration's economic and demographic assumptions; and
 - assumptions for changes in enrollment (both Medicaid only and for linked programs -- AFDC and SSI).
- CBO develops its Medicaid baseline by using the same historical data with fewer details of beneficiary and benefits categories.
- The CBO and OMB baselines are driven by assumptions. Minor differences can result in significant dollar differences between the original estimates and the actual spending.
 - National projections are difficult because programmatic changes in state programs can completely change actual spending (e.g. DSH).
- There is a \$64 billion difference between the OMB and the CBO baseline projections over the next seven years. There are significant differences in assumptions about program growth that produce this difference.

For example, the growth in enrollees and benefits are significantly different.

- For enrollee growth, the OMB projected growth rate is 3.8 percent and the CBO rate is 3.0 percent;
- Long-term care spending is projected to grow 8.2 percent annually under the OMB baseline compared to 10 percent for CBO; and
- OMB projects the DSH program to grow at 6.8 percent annually compared to 3.6 percent for CBO.

These result in an overall annual growth rate for the CBO baseline of 10.2 percent compared to the OMB baseline which grows at 9.3 percent annually. The corresponding per capita growth rates are 7.0 percent and 5.3 percent for CBO and OMB respectively.

MEDICAID

CBO and OMB Baseline Projections (Federal Outlays in Billions)

Fiscal Year	Projections*		Actual
	CBO	OMB	
1987	\$26	\$26	\$27
1988	\$30	\$28	\$30
1989	\$34	\$33	\$35
1990	\$38	\$37	\$41
1991	\$45	\$45	\$53
1992	\$57	\$60	\$68
1993	\$80	\$85	\$76
1994	\$92	\$92	\$82
1995	\$96	\$96	**\$88
1996	\$99	\$96	
1997	\$110	\$105	
1998	\$122	\$115	
1999	\$135	\$125	
2000	\$148	\$136	
2001	\$163	\$150	
2002	\$178	\$164	

*February OMB and January CBO projections beginning in 1986.

**Latest HCFA estimate of 1995 spending.

September 27, 1995

TO: Laura Tyson
Carol Rasco
Gene Sperling

FROM: Chris Jennings

RE: Baseline Analysis

Attached is a quick explanation of the difference in CBO and OMB baselines for both Medicare and Medicaid programs. It is drafted in such a way to make a defensible case for arguing that our baseline is more advisable to use than the CBO baseline.

The most important finding from this analysis is that the OMB Medicare baseline has been closer to actual spending than the CBO baseline for six of the past eight years. The Medicaid baselines comparisons can also be used to back up our contention that, as far as overall expenditures are concerned, we are no worse than CBO and most definitely always have access to more up-to-date data.

As you know, most elite economists will argue that the differences are not overly significant. Therefore, this group of "validators" might not be very receptive to suggestions that one baseline is better than another. Having said this, I believe this analysis may be helpful to make our case.

Lastly, I am trying to get the specific differences between our official baseline and the baseline that the Medicare actuaries use exclusively for the long term Medicare Trust Fund expenditures projections. There is a differences between the two, but as I understand it there is little to no difference inside the immediate budget window. I hope to have a conference call to get final clarification on this sometime today.

I hope this information is helpful, please call me with questions.

Comparison of CBO and OMB Baselines Medicare

- The OMB baseline has been closer to actual spending than the CBO baseline for six of the past eight years for which there is data (FY 1987 - FY 1995).

Fiscal Year	OMB	CBO	Actual Spending
1987	78	80	80
1988	85	90	86*
1989	94	96	94*
1990	110	112	107*
1991	114	116	114*
1992	127	127	129
1993	143	142	143*
1994	164	167	160*

* indicates years in which OMB projection closer to actual spending than CBO projection

- Projecting baseline spending is a complex process requiring multiple assumptions. There are interactions between private and public spending that cannot always be anticipated. Small differences in assumptions can translate into large differences in projections.
- The difference between the President's Budget and CBO February Medicare baselines is initially relatively small but grows larger over time. Over 7 years, CBO projects \$71 billion more in spending than OMB, or a difference of only 4 percent. This difference in spending is largely driven by a few spending categories.
 - The largest differences are in home health, physicians, hospice, and SNF expenditures. Different assumptions about the rate of growth in these services results in large differences over time.
 - Projecting physician spending is difficult because the rate of growth in expenditures has been unstable year to year. This is most likely due to the changes occurring in the health marketplace, and to the large impact of the private sector on physician expenditures.
 - CBO and OMB projections for hospital spending, which represents the largest category of Medicare expenditures, are very similar.

● The process for making baseline projections is slightly different for CBO versus OMB. One explanation for this difference is OMB's access to data which CBO does not have.

— CBO only has access to aggregated expenditure data from the treasury while OMB, through HCFA, has access to historical data from carriers, who process Part B claims, and intermediaries, who process Part A claims, which provides them with more detailed data including utilization.

Comparison of CBO and OMB Baselines

MEDICAID:

- The OMB Medicaid baseline is developed by HCFA actuaries by using a detailed and sophisticated forecasting model that includes:
 - historical spending data;
 - the most recent estimates from the states;
 - the Administration's economic and demographic assumptions; and
 - assumptions for changes in enrollment (both Medicaid only and for linked programs -- AFDC and SSI).
- CBO develops its Medicaid baseline by using the same historical data with fewer details of beneficiary and benefits categories.
- The CBO and OMB baselines are driven by assumptions. Minor differences can result in significant dollar differences between the original estimates and the actual spending.
 - National projections are difficult because programmatic changes in state programs can completely change actual spending (e.g. DSH).
- There is a \$64 billion difference between the OMB and the CBO baseline projections over the next seven years. There are significant differences in assumptions about program growth that produce this difference.

For example, the growth in enrollees and benefits are significantly different.

- For enrollee growth, the OMB projected growth rate is 3.8 percent and the CBO rate is 3.0 percent;
- Long-term care spending is projected to grow 8.2 percent annually under the OMB baseline compared to 10 percent for CBO; and
- OMB projects the DSH program to grow at 6.8 percent annually compared to 3.6 percent for CBO.

These result in an overall annual growth rate for the CBO baseline of 10.2 percent compared to the OMB baseline which grows at 9.3 percent annually. The corresponding per capita growth rates are 7.0 percent and 5.3 percent for CBO and OMB respectively.

MEDICAID

CBO and OMB Baseline Projections (Federal Outlays in Billions)

Fiscal Year	Projections*		Actual
	CBO	OMB	
1987	\$26	\$26	\$27
1988	\$30	\$28	\$30
1989	\$34	\$33	\$35
1990	\$38	\$37	\$41
1991	\$45	\$45	\$53
1992	\$57	\$60	\$68
1993	\$80	\$85	\$76
1994	\$92	\$92	\$82
1995	\$96	\$96	**\$88
1996	\$99	\$96	
1997	\$110	\$105	
1998	\$122	\$115	
1999	\$135	\$125	
2000	\$148	\$136	
2001	\$163	\$150	
2002	\$178	\$164	

*February OMB and January CBO projections beginning in 1986.

**Latest HCFA estimate of 1995 spending.

NANCY LANDON KASSEBAUM KANSAS CHAIRMAN

JAMES M. JEFFORDS VERMONT
DAN COAHN INDIANA
LLOYD CEAGA NEW HAMPSHIRE
BILL COHEN TENNESSEE
MIKE DOWNS OHIO
JOHN ASHCROFT MISSOURI
SPENCER ABRAHAM MICHIGAN
BLADE GUNTON WASHINGTON

EDWARD M. KENNEDY MASSACHUSETTS
CLAYBORN BELL RHODE ISLAND
CHRISTOPHER J. DODD CONNECTICUT
PAUL SIMON ILLINOIS
TONY HARKIN IOWA
BARBARA A. MIKULSKI MARYLAND
PAUL WELLSTONE MINNESOTA

SUSAN HARTZ STAFF DIRECTOR
MCKEITHEN@SENATE.GOV

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

TO:

Chris Jennings (URGENT)

FR:

David Nexon

DATE & TIME:

NUMBER OF PAGES:

COVER + 3

RETURN FAX NUMBER:

(202) 224-3533

588-0002

IF THERE IS TROUBLE RECEIVING THIS FAX, PLEASE CALL
(202) 224-7675.

MESSAGE:

Please deliver to Chris Jennings ASAP

FAX NUMBER:

456 - 7431

TO: CHRIS JENNINGS

FROM: David Nexon

DATE: 9/15/95

SUBJECT: ACADEMIC HEALTH CENTERS

A handwritten signature in cursive script, appearing to read "felt", is written over the subject line.

Per our discussion, attached are rough talking points, the phone number for Robin Lippner, and suggestions as to who should be called.

TALKING POINTS--ACADEMIC HEALTH CENTERS

--It is very important you not put yourself in the position of appearing to support the Republican Medicare plan. Your appearing to say that the plan will protect quality would be devastating for the Democratic effort to defeat it or cut it back.

--The promises they have made to you are fool's gold. You need to look at the total impact of their program, not just on IME and DME but on the market-basket, disproportionate share payments, bad debt payments, whether they are doing anything meaningful on AAPCC, Medicaid cuts, and what their "look-back" will entail in additional cuts.

--The money they are proposing to finance their program with is funny money. I doubt cuts in "corporate welfare" are going to last beyond the markup. I'm sure that they will not last beyond conference--and they are certainly not proposing dedicated funds, in any event.

--You have to look at the end game. The end game is going to be a negotiated deal between the Republicans and the President. Once they've gotten their press conference, they have absolutely no interest in protecting you.

--We will be helpful to you in cutting the final deal, because we know how you important you are to quality care. In particular, we want to work on moderating any IME/DME cuts to reasonable levels and to making sure that the AAPCC issue is addressed. But we will also have lots of other priorities, and if you have undercut the President's position, it will be very hard to persuade him that he should spend any chips protecting you.

CALLS

--The most important calls, which should be made immediately, are to:

Dick Knapp 828-0410
Jordan Cohen, M.D. (President of AAMC--can reach him through Dick's office)

--Additional calls that would be useful are:

✓ Herb Pardes, Columbia University → (212) 305-3592
~~Michael Johns, Johns Hopkins 410 955-3180~~

Jim Mongan (Truman Medical Center) 816-556-3153

Ralph Muller (University of Chicago) 312-702-6240

Robin Lippner 588-0002 would know who in the California group should be called.

MEMORANDUM

TO: Interested Parties September 28, 1995
FROM: Chris Jennings
RE: CBO (Financial Coercion) Reference and Backup to "Managed Care" Scoring Description

Attached you will find a copy of CBO memo to the Senate Finance Committee staff that outlines the breakout of how CBO scores Medicare Choice. This is the memo that no doubt was used by Robert Pear in today's New York Times article.

As you will note, only \$7.1 billion out of the total \$47.5 billion in savings cited by the Senate Finance Committee would be attributed to managed care savings. \$42.6 billion of savings is produced solely by the fact that the Finance Committee plan has placed a cap on the growth of the managed care plans being utilized by the current Medicare population. Another interesting finding worth noting is that CBO scores Medical Savings Account as \$2.3 billion coster to the Medicare program as a result of adverse selection.

Lastly, in their analysis, CBO assumes that the elimination of the state requirement to help pay for low-income elderly beneficiaries premiums, co-payments, and deductibles will result in increased enrollment in managed care for these beneficiaries who can no longer afford their fee-for-services plan.

We are trying to get a sense of how many beneficiaries and how much money is assumed in that projection, but the most important fact, of course, is that CBO clearly states that the beneficiaries would move into these plans as a result of negative financial incentives.

You should feel free to use and circulate as you please. Don't hesitate to call me at 456-5560.

MEMORANDUM

September 27, 1995

TO: Julie James
Bruce Lesley

FROM: Murray Ross 

SUBJECT: Estimating savings from Medicare Choice in the Chairman's Mark

CBO's estimate of savings from Medicare Choice is the net result of changes in spending from three sources:

- o lower updates on payments made on behalf of current enrollees (strictly speaking, the share of Medicare beneficiaries enrolled in risk contracts under current law);
- o savings associated with new enrollees (the estimated fraction of Medicare beneficiaries moving from traditional fee-for-service to Choice plans other than high deductible plans); and
- o payments on behalf of beneficiaries choosing the high deductible insurance/medical savings account option.

Over seven years, CBO estimates that savings on current enrollees would total \$42.6 billion (see attached table). Savings on new enrollees would total about \$7.1 billion. Payments to Choice enrollees with high deductible plans would cost about \$2.3 billion as a result of adverse selection not fully compensated for by risk adjustment. The net savings attributed to Medicare Choice is \$47.5 billion.

CBO's estimate assumes that enrollment in Choice plans (including high deductible plans) would reach about 22% of Medicare beneficiaries by 2002, compared with the 14% of beneficiaries projected to be covered by risk plans in the CBO baseline. Most of the increase is attributable to CBO's assumptions about beneficiaries' responses to the new government-coordinated open enrollment process and expanded choices. CBO assumed that there would be a short-run increase in enrollment reflecting these factors, but a slightly lower rate of growth in future enrollment. In addition, CBO assumed that eliminating the entitlement to cost-sharing for Medicaid eligibles and QMBs would increase enrollment as those beneficiaries sought out plans with lower cost-sharing requirements.

CBO ASSUMPTIONS UNDERLYING CALCULATION OF MEDICARE CHOICE SAVINGS

CHANGE IN SPENDING (Billions of dollars)	Fiscal Years							Total
	1996	1997	1998	1999	2000	2001	2002	
Baseline Enrollees	-0.4	-1.9	-3.6	-5.4	-7.5	-10.2	-13.7	-42.6
New Enrollees (excluding high deductible plans)	-0.0	-0.1	-0.7	-1.0	-1.3	-1.8	-2.3	-7.1
High-Deductible Plans/MSAs	0.0	0.4	0.4	0.4	0.4	0.4	0.4	2.3
Total	-0.4	-1.5	-3.9	-6.0	-8.4	-11.6	-15.7	-47.5

MANAGED CARE ENROLLMENT (As percent of all Medicare beneficiaries)	1996	1997	1998	1999	2000	2001	2002
CBO Baseline (risk contracts only)	8	9	10	11	12	13	14
Medicare Choice	8	13	17	19	20	21	22
Risk Plans	8	12	16	18	19	20	21
High-Deductible Plans/MSAs	0	1	1	1	1	1	1

Note: Change in spending is difference from Budget Resolution baseline.

Source: Preliminary Congressional Budget Office estimates based on policy in Chairman's mark and discussions with Committee staff.

DRAFT**DRAFT EDITORIAL**

When one of our family members is ill, what do we want for them? The answer is simple: the best medical care possible, provided by highly trained professionals, and backed up by state-of-the-art research. And who educates those professionals, conducts that research, and provides care and service in communities like _____? It is academic health centers and teaching hospitals [like _____]. But today, the unique mission of these institutions is at risk. Proposed Congressional cuts in Medicare and Medicaid, coupled with changes in the private market, threaten the funding that academic health centers need to continue to serve as a cornerstone of our nation's health care system.

The Congressional Budget Proposal

Let's look first at the federal budget. The Congress proposes reductions of \$452 billion in Medicare and Medicaid over the next seven years -- \$270 billion in Medicare, and \$182 billion in Medicaid. Those are staggering numbers -- four times larger than anything ever enacted. But to understand their true impact, it is useful to look at what those cuts will mean for the growth in spending per person in each of these programs. Private health insurance spending per person will increase by about 7.1 percent annually over the next seven years, according to the Congressional Budget Office (CBO). The Congressional Medicare cuts would bring Medicare spending per beneficiary down to a growth rate of about 4.9 percent annually -- or 30 percent below the private sector growth rate for each of the next seven years. The Congressional Medicaid cuts are even worse -- bringing the Medicaid growth rate down to about 1.4 percent per beneficiary annually -- or 80 percent below the private sector growth rate.

OPTIONAL FORM 99 (7-80)

FAX TRANSMITTAL# of pages **3**

To Chris Jennings	From Jack Ebelcer
Dept./Agency WtH	Phone # 690-6870
Fax # 456-7028	Fax # 401-2027321

1

The result? The purchasing power of these two essential health programs will lag significantly behind the private market each year for the next seven years. The beneficiaries and their families will pay more and, most likely, get less. Specifically, each Medicare beneficiary will pay about \$2,825 more (\$5,650 per couple) over the next seven years, assuming that 50 percent of the Medicare cut comes from beneficiaries [Replace with state-specific data for area in which provider is located]. And, the federal Medicaid cut would force states to cut services, reduce provider payments, and eliminate coverage for about 8.8 million children, elderly, and disabled Americans by the year 2002.

Impact on academic health centers

What does all this mean for academic health centers and teaching hospitals like _____? We intend to continue to take a leadership role in research and the education of professionals needed for the future. [Insert local example of some innovations?] We are also striving to remain competitive as the health system changes and becomes more cost-conscious. [Insert example of cost cutting].

But the fact remains that it costs more for us to provide care because our education and research mission adds to our patient care costs. Medicare has historically been a major source of financing for medical education. Medicaid has served as a payor for poor and sick populations who would otherwise strain hospitals' ability to both provide quality health care and education. In addition, we provide a substantial amount of indigent care for individuals who do not have health insurance. [Insert local indigent care \$ or #].

The reality is that while private payers have borne some of these costs, in the increasingly competitive private health market, private payers seeking the lowest cost services for their

enrollees are not likely to pay the extra costs of facilities that also provide education and research.

The support of Medicare and Medicaid for the unique mission of academic health centers will be reduced dramatically by the Medicare and Medicaid cuts proposed by Congress. The magnitude of the cuts means that academic health centers will face great pressures. This lessens the ability of academic health centers to train professionals, conduct research leading to future break-throughs, and absorb the costs of providing care to the rising number of uninsured Americans.

Will the results be dramatic -- immediate shutdowns, or quick, visible declines in the quality of care? Probably not: slow, steady disinvestment in education and research are never very visible at first. But they have lagged effects that may be even more debilitating in the long run -- because today's education and research directly affects tomorrow's care. When your family -- and your children's families -- need health care ten, twenty, or thirty years from now, do you want the health professionals then in practice to be the product of excellence in education -- or of a slowly defunded education and research system?

[provider] is committed to maintaining and enhancing the quality of our education, research, and service. That is our core mission -- and reflects the needs and aspirations of our community and our patients. Deep budgetary reductions that prevent us from meeting your needs -- now and in the future -- must be opposed.

Budget RL

THE WHITE HOUSE
WASHINGTON

July 31, 1995

MEMORANDUM FOR BUDGET WORKING GROUP

FROM: ERSKINE BOWLES 
SUBJECT: Follow-up From 9:00 a.m. Meeting

- **Surrogate/Validators** memos are due to Leslie Thornton by COB today [Fax #401-0596]. The following offices were asked to prepare a lists of people who can be our validators, their strengths, and what types of issues we can mobilize them on:

- Public Liaison
- Health Care
- Environment/Public Safety
- Education
- Welfare
- Tax
- Technology

- **Op-Eds:** We need by Thursday, *Washington Post* response to Barbour Op-Ed, hopefully *New York Times op-ed* before Thursday as well. Need to come to closure ASAP on whether we should use outside validator or Administration official.
[Waldman]
- **Pena FAA Testimony (Wednesday)** We need to see Pena's testimony ASAP and coordinate message.
[Silverman/Waldman]
- **NBC Brokaw Piece Tuesday Night on Economic Recovery** -- Rubin involved.
POTUS?
[Waldman/Glynn]
- **Medicare Trust Fund:** We Need to put together simple language to combat GOP claim that Medicare Trust Fund is going to run out of money.
[Jennings]

■ **Medicare Education:**

1. Need HHS officials to do basic education on Medicare -- Shalala, Vladeck, Feder, and others. Add to travel.
[Silverman / Yager]
2. Finalize reporter education lunches/meetings with Tyson and others. Need lists of reporters, schedule, and principals' commitments.
[Melody / Moffett / Sperling]

■ **GOP Medicare Events:** We need a memo by COB today with details for Thursday's GOP Medicare rally and Monday Gingrich teleconference. [Berman / Yager]

■ **House Recess Materials:** Packets for House Recess need to go to Hill Thursday night. Barbara Chow will coordinate.

[Chow]

■ **Interview Proposals:** We need a proposal for POTUS/VPOTUS interviews between now and recess.

[Waldman]

Budget File

THE WHITE HOUSE
WASHINGTON

July 21, 1995

MEMORANDUM FOR THE PRESIDENT

FROM: ERSKINE BOWLES
LAURA TYSON

SUBJECT: Update on Budget Working Group Activities

This week, the Budget Working Group began daily meetings to plan and implement an aggressive campaign to market your balanced budget proposal. The purpose of this campaign is to mobilize all possible resources in an effort to educate the American people about your budget priorities in order to strengthen your leverage for negotiations with Congress.

We clearly have a four week period to influence the debate.

WEEK 1: MONDAY, JULY 17 -- SUNDAY, JULY 23, 1995

- **Budget Theme:** Primary White House focus this week was on Affirmative Action. Our budget goal this week was to use other members of the Administration to lay a foundation for our critique of the Republican Medicare proposals.
- **Medicare Vouchers:** This week, we attacked Republican Medicare voucher proposals. We argued that under their voucher proposal, beneficiaries face a simple, cruel choice: they can choose to pay more or choose to get less.

Strategy. Following the Robert Pear story in the *New York Times* on Monday, July 17, which suggested that the GOP Medicare proposal would raise costs for millions of beneficiaries, we built a strategy for the week around Judy Feder's testimony before the House Commerce Committee and HCFA Administrator Bruce Vladeck's testimony before the Ways and Means Health Subcommittee. Both were very critical of Republican voucher proposals, focusing on: (1) how the Republicans would constrain spending far below the private sector; and (2) how much more beneficiaries would pay under the Republican plan to stay in a plan that allowed them to choose their own doctor.

Amplification. We worked closely with the Democrats on the Hill to develop one, clear message. Democratic Senators held a press conference following Administrator Vladeck's testimony and talking points were widely distributed to Democrats on the hill. Members of the Cabinet and Sub-Cabinet conducted print and radio interviews into 50 targeted markets. Secretary Shalala, Dr. Tyson, Alice Rivlin, and Gene Sperling interviewed with the major national newspapers.

Media Coverage. Our attack received significant positive press coverage (including the *New York Times*, the *Washington Post*, the *Wall Street Journal*, *USA Today*, *AP*). On Friday, July 21, *CNN* aired a story in their hourly news-reel on the heat the Republicans are feeling over Medicare cuts.

- **Appropriations:** This week, attention was also focused on the Appropriations bills moving through the House.

Analysis & Talking Points. OMB provided in-depth analyses of the key appropriations bills, with specific attention paid to the Labor-HHS and VA/HUD bills, since they represent the bulk of the your domestic discretionary spending priorities. OMB produced and distributed side-by-side charts comparing the extreme GOP cuts with your balance budget proposal.

Rapid Response. OMB, Political Affairs, Cabinet Affairs, Public Liaison, Legislative Affairs, and Media Affairs has developed a strategy to pressure moderate and vulnerable Republicans and make their appropriations votes uncomfortable.

- Bonnie Campbell conducted radio interviews into targeted markets following the Violence Against Women vote, July 20.
- Secretary Cisneros released a strong statement on home ownership deduction following Arney flat tax comments, July 20.
- Secretary Glickman, Deputy Secretary Rominger, and Assistant Secretaries Haas and Dunn conducted radio and television interviews into targeted rural markets following the Agriculture appropriations vote, July 21.
- Law Enforcement: Public Liaison faxed OMB impact document on Commerce / State / Justice appropriations to law enforcement. We have specifically asked NAPO to pick three cities that they are especially strong in (Los Angeles included) to do op-eds for next week describing the impact such cuts would have on their community.

OMB and Cabinet Affairs are also compiling a daily "Pork Report," chronicling the GOP pork in the Appropriations bills.

- **National Conference of State Legislators (July 20):** Our goal on this speech was to insert a veto message into your remarks without overshadowing the law enforcement message. The strategy worked, and your veto threat was covered by the *Wall Street Journal*, *New York Times*, and the *Washington Post*.
- **State-by-State Numbers on GOP Education Cuts:** OMB, NEC, DoEd, and DOL worked together to develop a state-by-state analysis for release Friday, July 21, 1995. Over 50 reporters were targeted for calls by Cabinet and Senior White House Staff. 50 Separate press releases were prepared for each state. When the Committee did not finish within the news cycle, we decided to hold this report for release Monday, July 24, in conjunction with your Boys Nation Speech.

WEEK 2: MONDAY, JULY 24, -- SUNDAY, JULY 31, 1995

- **Common Ground Speech on the Budget (Monday, July 24).** This speech will draw the Balanced Budget Debate into the Common Ground framework you have enunciated over the past few weeks.

Message. For years, there has been common ground on investing in education, protecting seniors through Medicare, preserving the environment and consumer safety, and keeping the tax system fair. There is also a consensus on balancing the budget; but we should do it in a way that reflects these other priorities. That is what your balanced budget does. Republicans have turned their back on our common ground by cutting education and Medicare to finance tax cuts for the well-off.

Amplification.

- Communications is preparing a press document highlighting the Republican movement from the common ground on the issues of Education, Health Care For Seniors, Helping Working Families, and Environment/Public Safety.
- George Stephanopoulos and Dr. Tyson will host a breakfast with Network Correspondents the morning of the speech.
- Director Rivlin, Dr. Tyson, and George Stephanopoulos will brief columnists.
- Director Rivlin and Dr. Tyson will brief business journalists.
- The Economic team (Reich, Rubin, Ron Brown, Tyson, Rivlin) will attend your address and conduct regional media afterwards on North Lawn.
- Your speech will be mailed to top 150 editorial boards, African-American, Hispanic, women's and older American press.

Education State-by-State. In conjunction with your Monday speech, the Administration will also release Monday the state-by-state impacts of the Republican cuts.

- Our plans include regional media conference calls by Secretaries Reich and Riley and by White House staff.
- The following Governors will issue releases on how the Education/Labor/HHS appropriations bill will impact their state: Caperton, Nelson, Bob Miller, Romer, Glendening, Carper, Knowles, Carnahan, Gray David (Lt. Gov. CA), Lt. Gov. of VA--Beyer.
- Education Committee Chairs in the state legislatures from the following states will send out press releases on how the Education/Labor/HHS appropriations bill will impact their state: Arkansas, Kentucky, Louisiana, Mississippi, Missouri, New York, Oklahoma, California, Massachusetts, and Oregon.
- The Democratic Legislative Leadership in the following states will issue releases: Ohio, Minnesota, and Michigan.
- Over 100 education and advocacy groups will also emphasize the extreme cuts.
- Public Liaison is mailing the state-by-state document to thousands of education groups for their use over the next four weeks, with special emphasis on the recess and back-to-school activities.

• **Medicare 30th Anniversary Event (Tuesday, July 25).** You will join Senator Daschle and Congressman Gephardt at an event sponsored by the National Council of Senior Citizens to celebrate the Democrats' commitment to preserving and improving Medicare as we celebrate its 30th anniversary.

Message. For years, both parties have agreed on the need to protect the health of the elderly through Medicare. Now, Republicans are abandoning our common ground with unprecedented cuts in Medicare--including large increases in out-of-pocket costs for seniors--just to finance a tax cut for the well-off.

Amplification. During the week, we will release state-by-state data on the impact of Republican Medicare and Medicaid cuts. Cabinet and Democratic Governors will amplify the message.

- HHS and White House officials will saturate targeted regional radio markets.
- Public Liaison will conduct a joint briefing with the Democratic Leadership congressional staff for the national senior groups on Monday, July 24 to brief them on our join Medicare/Medicaid message for the Anniversary week and walk through with them the new state-by-state Medicaid/Medicare impact numbers.

- **Empowerment Zones/Urban Report (Wednesday, July 26):** The current plan is to release the Urban Report, stressing your New Covenant approach to assisting and empowering communities.

The report will reflect a consensus that neither the old top-down approach nor a pure free market approach will work. The approach we have taken, which includes Empowerment Zones, Community Policing, CRA, and Community Development Banks, reflects a new approach that requires community and individual responsibility as well as federal, state and local partnership.

This also offers common ground for those on all sides of the affirmative action debate who agree that there must be a positive economic approach to increasing economic opportunity and entrepreneurship in distressed areas. Republican budget cuts will be mentioned as an example of the wrong way. But the focus will be on the positive policy and its connection to the place-oriented aspect of your Affirmative Action proposal.

- The Vice President and Secretary Cisneros may brief reporters on urban issues following your speech.

- **Democratic Mayors Visit White House (Wednesday, July 26):** On Wednesday, 26 democratic Mayors will have a political and budget strategy briefing by Leon Panetta and Harold Ickes and then proceed to the Residence for a reception with you.

- Media Affairs will book interviews for Mayors and other local officials from targeted markets for North Lawn stake-out on Wednesday following the community empowerment speech.

- **American Federation of Teachers (Friday, July 28):** Education and Family values. Details being finalized.

- **Medicare 30th Anniversary Radio Address (taped Friday, July 28).** You will tape the Radio Address before an audience of seniors. We are hoping that Senator Gore will join you and the Vice President for the event to acknowledge the Senator's contribution and commitment to Medicare. The event should provide photos and quotes for stories that will appear on Sunday, July 30 (the actual date of the signing).

Message. For years, both parties have agreed on the need to protect the health of the elderly through Medicare. Now, Republicans are abandoning our common ground with unprecedented cuts in Medicare--including large increases in out-of-pocket costs for seniors--just to finance a tax cut for the well-off.

Amplification.

- Your radio address will be mailed to top 150 editorial boards, African-American, Hispanic, women's and older American press.
- Regional press stories

FUTURE ACTIVITIES

- A message team is meeting to develop budget themes and events for the first two weeks of August. An Environmental / Public Health / And Consumer Safety group is up and running and feeding event ideas to this group. Event proposals will be ready for you in the next 2 days.
- We have also been meeting regularly with education and advocacy groups to strategize about "Back to School" activities in September as well as a Save Student Aid week.