



THE DIRECTOR

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

December 14, 1999

cc Eric
Chris
+ return

MEMORANDUM FOR GENE SPERLING
BRUCE REED
NEAL LANE
GEORGE FRAMPTON

FROM: Jack Lew
Sylvia Mathews

SUBJECT: FY 2001 Initiative Proposals

Attached for your review is a table listing the initiatives discussed in the policy councils' memorandums to the President. I would appreciate if you could review the document to ensure that all of your proposals have been included and help us fill in the missing cost information for the proposals. We may discuss these issues with the President as early as Thursday, so it would be helpful to get any comments and information you can provide as soon as possible tomorrow morning. If you have any questions or comments, please call Rob Nabors at x55604.

- ① Bioterrorism
- ② NIH - 0 400
- ③ Global AIDS
- ④ ~~Other~~ Vaccine

Dis party

excise for R. Blaw
FY 2001 Initiative Proposals
(\$ in billions)

2 (LH)
70-

NSF
Energy
D&D

2003

	FY 2001 Cost	FY 2001-2005 Cost	FY 2001-2010 Cost
Science and Technology for the 21st Century	1.500		
Restoring balance by focusing on university-based research			
Correct disparities between disciplines			
Breakthrough research for the New Millennium			
NIH 420 + 154 - 8594			
Millennium fund for University Research	**	28.000	
Double University-based Research in five years			
Clean Energy for the 21st Century	0.204		
Global Clean Energy in the 21st Century	0.183		
Clean Air Bond	0.021		
A Permanent Lands Legacy	1.350		
Greening the Globe	0.150		
Global Forest Fund	0.100		
Debt-For-Nature	0.050		
Clean Waters Across America	3.000		
Wastewater systems improvements	1.500		
Reduce contamination from farming/ranching	0.500		
Restoration of wetlands & Gulf of Mexico Dead Zone	0.500		
Assist States with Great Lakes pollution	0.500		
Building More Livable Communities		1.400	
Better America Bonds (\$1.4 B over five years)			
Expanding transportation choices			
Next generation of brownfields redevelopment			
Strengthening and Modernizing Medicare			
Plan to Strengthen and Modernize Medicare			
Medicare Preventive Benefit Authority			
Immunosuppressive Drug Extension Adjustment		0.100	
Cancer Clinical Trials (three years 2002-2004)		0.750	

7

[Redacted]

FY 2001 Initiative Proposals
(\$ in billions)

	FY 2001 Cost	FY 2001-2005 Cost	FY 2001-2010 Cost
Improving Access to Affordable Health Insurance Coverage			
Family Health Insurance Initiative		5 to 18	
Medicaid Option to Cover Poor Adults			
Tax Credit for Individual Insurance to Address Current Tax Inequity		15.000	35.000
Encouraging Small Businesses to Offer Health Insurance		1.000	2.500
Medicare Buy-In for Certain 55 to 65 Year Olds		1.800	2.900
Medicaid Coverage for Certain Women with Breast Cancer		0.300	
All Federal Workers have Access to Employer Based Insurance			
Tax Credit for COBRA Continuation Coverage			
Finishing the Job of Targeting and Enrolling Uninsured Children			
Encouraging School-Based Outreach		1.000	3.000
Ensuring Seamless Health Insurance Coverage for Children		0.500	
Long-Term Care Initiative - show in budget		6.000	
Discretionary Initiatives			
Preventing Medical Errors	0.060		
Internet Drug Sales	0.011		
Preventing Breast and Prostate Cancer	0.020		
Improving Nursing Home Quality	0.031		
Education Funds for Children's Hospitals	0.104		
Addressing Mental Illness	0.100		
HIV and AIDS	0.100		
Access for Uninsured Americans	0.100		
Investment in Biomedical Research	.5 to 1.5		
Safeguards Against Scientific and Biomedical Abuses			
Early Childhood/Universal Preschool			
Increase Head Start Funding	0.800		30 to 40
Early Childhood Learning Fund	0.400		
Universal Afterschool	0.550		20 to 30

above passback

Gun Enforcement

FY 2001 Initiative Proposals
(\$ in billions)

	FY 2001 Cost	FY 2001-2005 Cost	FY 2001-2010 Cost
<i>School construction</i> <i>Class size</i>			
Turning Around Every Failing School	0.300		3 TO 5
Closing the Digital Divide	0.770		10.000
Community Technology Centers	0.070		
Develop Universal Internet Access	0.100		
Teacher Training for the Internet	0.100		
School Internet Modernization Fund	0.500		
Closing the Opportunity Gap for College	0.420		10.000
Keeping Students On Track to College	0.250		
AP Courses Online and Test Prep for Poor Kids	0.070		
Refundable Hope Scholarship and Pell Grant Increase			
Challenging Students to Complete College	0.100		
Demanding Responsible Fatherhood	0.250		5.000
Rewarding Work and Family	1.000		10 to 15
Expanding Housing Vouchers		3 to 6	
Expanding Health Coverage			
Extend CHIP to Parents		5 to 18	10 to 35
Outreach to Enroll Uninsured Children In Medicaid	0.200		3.000
Restore Option to Cover Legal Immigrants			3.000
Progressive Savings Accounts			
Rewarding Work and Family Through the EITC and Child Care			
Making the EITC Even More Pro-Work			11.000
EITC Increases for three children			8.000
Child Care Block Grant in Discretionary Budget	0.800		
Making the Dependent Care Tax Credit Refundable		4.000	8.000
New Markets Initiative and Empowerment Zones			
Expanded New Markets Tax Credit			4.000
Expanded Empowerment Zones Credit			
Expanded Low-Income Housing Tax Credit			3.2+

FY 2001 Initiative Proposals
(\$ in billions)

	FY 2001 Cost	FY 2001-2005 Cost	FY 2001-2010 Cost
Making Homeownership More Affordable			
Expanding Faith-based Involvement			

CDL CofA

- Child Care Initiative

- NIH

- Everything else?

St L. 2. Sillion

Head Start - ~~not the key~~ Nope

FDA - science capacity.

→ medical ~~error~~ error

Food safety

Building - yes

Uniform safety not

Mental health no

Rice white at 100 million no

Rice processors - Asthma

Auditors > Fraud - mandatory

Admiral's pie



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FY 2001 Initiative Proposals
(\$ in billions)

Making Homeownership More Affordable
Expanding Faith-based Involvement

**FY 2001
Cost**

**FY 2001-2005
Cost**

**FY 2001-2010
Cost**

December 13, 1999

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING
CHRIS JENNINGS

CC: JOHN PODESTA

SUBJ: HEALTH CARE IDEAS FOR STATE OF THE UNION/BUDGET

Strengthening and Modernizing Medicare

1. Plan To Strengthen and Modernize Medicare. Your plan from June will need to be modified since the re-estimate for the prescription drug benefit is considerably higher, savings on the new baseline are lower (as is the appetite for savings in Congress), and the April Trustees' report will likely show an improvement in Medicare solvency absent any actions. Changes to the plan are being considered and will be discussed separately with you.

2. Medicare Preventive Benefit Authority. This proposal would allow HHS to add new preventive benefits to Medicare and is consistent with a recommendation by the Institute of Medicine released this week. (Also under consideration is a limit on all allowable cost expansions). It builds on the preventive initiative in the Medicare plan, which eliminates cost sharing for preventive services, authorizes additional studies and a smoking cessation demonstration. (Cost: not yet estimated).

3. Immunosuppressive Drug Extension Adjustment. Currently, Medicare pays for immunosuppressive drugs that prevent rejection of transplanted organs. This coverage extends for three years after the transplant. The Balanced Budget Refinement Act added a flawed, dollar-limited 8-month extension on coverage of immunosuppressive drugs. This proposal would make the extension one year rather than 8 months, would remove the funding cap, and remove the time limit. (Cost: roughly \$100 million over 5 years).

4. Cancer Clinical Trials. This three-year demonstration would cover the patient care costs associated with certain clinical trials for Medicare beneficiaries. This proposal was in the President's FY 1999 and 2000 budgets, and has been a Vice Presidential priority. (Cost: \$750 million for 2002-04).

Improving Access to Affordable Health Insurance Coverage

5. Family Health Insurance Initiative. Over 85 percent of the parents of uninsured children in families with income below 200 percent of poverty are themselves uninsured. This option, included in the Gore health proposal, would provide states with the same incentives to cover parents as children under Medicaid and the Children's Health Insurance Program (CHIP). Specifically, a state could receive a higher federal matching rate for expanding coverage to the parents of children currently eligible for Medicaid or CHIP, if that state has expanded to 200 percent of poverty for children. This enhanced matching rate would be drawn from the CHIP allotments that would be increased to help pay for the entire family. States would cover the parents in the same program as their children. Since most uninsured children also have uninsured parents, this is an efficient way to bring down the numbers of the uninsured. It could also increase enrollment of children, since parents are more likely to enroll their children if they, too, can get health coverage. (Cost: from \$5 billion to \$18 billion over 5 years depending on who receives the enhanced match and whether the allotments are raised).

6. Medicaid Option to Cover Poor Adults. Currently, states can cover only adults who are parents through Medicaid. This policy would remove this "categorical" eligibility, replacing it with a straight income-related eligibility. This approach has been taken by several states through Medicaid 1115 waivers, and fully moves Medicaid to an income-related – rather than welfare-related – health insurance program. HHS has developed this as a possible alternative to the parents' initiative. (Cost is unknown, but likely less than the family initiative since there is no higher matching rate and states would prefer to expand to working parents than all poor adults).

7. Tax Credit for Individual Insurance to Address Current Tax Inequity. Unlike employees who work at firms that provide coverage, workers who have no access to employer-based insurance and who buy it for themselves receive absolutely no tax subsidy. To address this inequity, this policy (supported by the Vice President) would give people without access to employer-based insurance a tax credit, equal to 25 percent of the cost of coverage and similar in value to the 100 percent tax deduction employers now receive, for purchasing individual insurance. This credit could only be used for qualified individual insurance plans or Medicare, Medicaid, or CHIP buy-in options. Because the credit is relatively small, it likely would not have an adverse incentive impact on employers now offering to drop coverage. But while it would be popular, it would not be expected to increase take-up in coverage for the currently uninsured. (Cost still being estimated but about \$15 over 5 years, \$35 over 10 years).

8. Encouraging Small Businesses To Offer Health Insurance. Workers in small businesses are more likely to be uninsured. This initiative would encourage small businesses to offer health insurance through: (1) a new tax credit for small businesses who join coalitions; (2) tax-exempt status for foundation contributions to create coalitions; and (3) technical assistance. It would be different from last year's proposal because the credit would be increased to 25 percent of the employer contribution, and all firms (not just those that previously did not offer coverage) would be eligible for the credit. (Cost still being estimated, but about \$1 billion over 5 years, \$2.5 billion over 10 years).

9. Medicare Buy-In for Certain 55 to 65 Year Olds. The fastest growing group of uninsured are those ages 55 to 65. Between 1997 and 1998, the proportion of people in this age group who were uninsured increased by 5 percent, from 14.3 to 15.0 percent. All of this increase occurred among people above poverty, with a dramatic jump for those with income between 300 and 400 percent of poverty. This initiative expands the health options available for older Americans by: enabling Americans aged 62 to 65 to buy into Medicare; providing a similar Medicare buy-in for vulnerable displaced workers ages 55 and older; and providing COBRA to Americans ages 55 and older whose companies reneged on their commitment to provide retiree health benefits. This proposal was in the last two budgets. (Cost: \$1.8 billion over 5 years, \$2.9 billion over 10 years).

10. Medicaid Coverage for Certain Women with Breast Cancer. This proposal is the Breast and Cervical Cancer Prevention Act (HR 1070) that has 272 House cosponsors and passed unanimously by the House Commerce Committee (a Senate bill has not yet been marked up). It would give states the option to provide temporary Medicaid coverage to uninsured women who have learned that they have breast or cervical cancer through a CDC screening program. States would get the CHIP match rate for this group. It is important to note that most policy analysts think that covering selected disease categories and/or people participating in a particular program is a troubling precedent. However, if there are no coverage expansions for this group, it would hard not to include this initiative in our budget. (Cost: about \$300 million over 5 years).

11. Ensuring that All Workers Paid by the Federal Government Have Access to Employer-Based Insurance. This policy would allow all types of temporary government employees to access the Federal Employees' Health Benefits Program. Currently, FEHBP serves only permanent federal employees. (Cost estimate and more details pending).

12. Tax Credit for COBRA Continuation Coverage. Currently, employers must offer departing employees the option of buying into their health plan at a premium of 102 percent. Intended to ensure coverage during the transition to new jobs, this policy has proven unaffordable to some people and burdensome to employers. To address these concerns, our new proposal would provide a tax credit of 30 percent for this coverage to the employer whose employee takes this option. This subsidy would be split equally between reduced employer cost and lower premiums for participants (87 percent). (Cost estimate pending).

Finishing the Job of Targeting and Enrolling Uninsured Children

13. Enrollment. Sites like schools and child care centers are natural places to reach out to uninsured children. To tap into these resources, this proposal would (1) allow school lunch application information to be shared with Medicaid and CHIP for outreach; (2) let enrollment in the school lunch program serve as a proxy for Medicaid or CHIP eligibility while formal applications are being processed; and (3) more broadly apply the presumptive eligibility option in Medicaid to homeless programs, TANF and CHIP eligibility workers, and others who are in a position to do preliminary assessments of children's eligibility for Medicaid or CHIP. (Cost: estimate pending – likely about \$1 billion over 5 years, nearly \$3 billion over 10 years).

14. Simplifying and Coordinating Enrollment. To ensure that children do not fall through the cracks of different eligibility rules for Medicaid and CHIP, this proposal would require that states conform Medicaid eligibility for children to that of CHIP in the following respects: (1) assets tests; (2) mail-in application; (3) redetermination period; and (4) eligibility to age 21. Thus, a state could not have simpler enrollment and redetermination processes for its CHIP program than it has for its Medicaid program. (Cost: pending – likely less than \$500 million over 5 years).

Long-Term Care

15. Long-Term Care Initiative. An initiative that has already been well received and has already begun to receive bipartisan support is the long-term care proposal. Last year, you proposed a major, seven-part initiative that would: (1) provide a \$1,000 tax credit for people with long-term care needs or their families to offset the costs of care; (2) create a new Family Caregivers Program that offers respite services, information, and other assistance; (3) offer private long-term care insurance to Federal employees; (4) improve nursing home quality; (5) expand Medicaid options for community-based services; (6) encourage assisted living facilities for Medicaid beneficiaries; and (7) conduct a \$10 million education campaign on long-term care for Medicare beneficiaries. (Cost: about \$6 billion over 5 years)

Discretionary Initiatives

16. Preventing Medical Errors. This initiative will develop new avenues for the prevention of medical errors. It will include the IOM's recommendation of \$35 million to establish a Center for Patient Safety at HHS and include new efforts to strengthen FDA's voluntary adverse event reporting system from health professionals and consumers, and implement new requirements for the naming, labeling, and packaging of drugs that are designed to prevent medical errors. FDA estimates that with adequate funding, it could reduce adverse events by 10 percent and save approximately 10,000 lives annually. This initiative could be combined with regulatory actions to ensure patient safety, including requiring hospitals participating in Medicare to implement error reduction programs. (Cost: \$60 million).

17. Internet Drug Sales. We would provide new funds for the investigation, identification, and prosecution of entities selling over the Internet unapproved new drugs, counterfeit drugs, prescription drugs without a valid prescription, expired or illegally diverted pharmaceuticals, and products based on fraudulent health claims. It would establish new certification requirements for all Internet pharmacy sites to ensure that they meet all state and federal requirements. It would create new civil money penalties of up to \$100,000 for dispensing without a valid prescription over the Internet or for selling drugs without federal certification; and provide FDA with new administrative subpoena authority to build a case against offenders. (Cost: \$10 million).

18. Preventing Breast and Prostate Cancer. This initiative will fully fund the National Environmental Health Laboratory, which evaluates the exposure of men, women, and children to toxic substances that cause cancer. Funds will also be used to assist state and local public health officials to ensure thorough investigation of cancer clusters and to rapidly evaluate the local

impact of public health disasters, such as chemical spills and groundwater contamination. (Cost: \$15 million).

19. Improving Nursing Home Quality. This initiative provides mandatory and discretionary funds to HCFA to help States strengthen nursing home enforcement tools and increase federal oversight of nursing home quality and safety standards. Funding will be provided for new enforcement provisions and increased surveys of repeat offenders and improve surveyor training. (Cost: \$31 million).

20. Providing Education Funds to Children's Hospitals. Medicare has invested billions of dollars in graduate medical education to hospitals since 1966. However, because of its current distribution formula, free-standing children's hospitals are forced to shoulder the majority of the cost of training pediatricians, placing them at a severe financial disadvantage. This initiative will augment last year's investment in these critical health care providers. (Cost: \$104 million).

21. Addressing Mental Illness. This proposal will increase funding for treatment for the severely mentally ill and establish a new local mental health enhancement program that would provide new prevention, early intervention, and treatment services for Americans with less severe mental illnesses. (Cost: \$100 million).

22. HIV and AIDS. This initiative would increase our current proposed investment in the Ryan White program and the AIDS Drug Assistance Program (ADAP), which provide critical services for people with HIV/AIDS. In addition, it would establish a strategic plan designed to reduce new HIV infections by 50 percent in three years. The new prevention initiative would: help 150,000 individuals not aware of their infection learn of their status and find prevention counseling and treatment services; expand community prevention planning, with a special emphasis on racial and ethnic minorities, women, injection drug users and their partners, and young gay men; and build a data infrastructure to assist local public health officials in targeting their prevention efforts. The new investment in Ryan White and ADAP would shorten the waiting time needed to access the comprehensive range of drugs needed to effectively treat this disease. (Cost: \$150 million).

23. Access for Uninsured Americans. This proposal would create a new grant program for community-based providers to develop comprehensive systems of care, develop linked financial and telecommunication systems, and fill the service gaps that exist in many communities, especially primary care, mental health, and substance abuse services. It would: hold providers accountable for health outcomes by helping them develop the systems to appropriately monitor and manage patient needs; preserve access to critical tertiary care services financial support to large public hospitals; and provide new services to the uninsured, including primary care, and mental health services. (Cost: \$75 million).

24. Investment in Biomedical Research. The potential breakthroughs in diagnoses, treatments and cures resulting from the nation's increasing investment in biomedical research are impressive. They include: decoding the complete gene sequence by the spring of 2000, developing new treatments to delay the onset of Parkinson's, Alzheimer's and cancer, and new

interventions to prevent paralysis with spinal cord injuries. The Administration's last budget dedicated a \$360 million increase to the NIH, which is far short of the over \$2 billion that was included in the final budget. This has resulted in criticism from the scientific and patient advocacy communities. (Cost: \$500 million to \$1.5 billion).

25. Safeguards Against Scientific and Biomedical Abuses. This package addresses the perils of some of the new scientific breakthroughs of our day. These include inappropriate patenting and licensing of genetic material, the insufficient provision of protections to human subjects in clinical trials, and the continuing threat of bioterrorism. Under consideration are a host of initiatives to address these potential problems, including legislation to prohibit the use of genetic information in all health insurance policies and employment decisions.

AGENDA: MEDICARE DEPUTIES MEETING
December 13, 1999

Mr. Gm
Medicaid health plan

I. Savings packages

- Review high, medium and low packages
- Review list of anti-fraud policies

II. Issues with GME carve-out

- Should IME, DME or both be carved out; should kids' GME be added
- What are the major bills, proposals in this area

IME DME → *Good thing*
TRUST FUND

III. Issues with DSH carve-out

IV. Drug benefit

- Minimum needed for Wednesday meeting: June option rescored
- Additional runs:

	02	03	04	05	06	07	08
- Original	2000	2000	3000	3000	4000	4000	5000
- Lower cap	--	2000	3000	indexed to inflation			
- Lower cap with \$5,000 out-of-pocket limit							
- Lower cap with \$10,000 out-of-pocket limit							
- Low-income / low-cost benefit
 - Expand Medicaid to 200 percent of poverty
 - Allow all Medicare beneficiaries to use Medicaid drug rebate program
 - Allow all Medicare beneficiaries to join purchasing coalitions

V. Agenda for Principals' meeting

- Review of solvency issue (changing baseline, minimum goal)
- Savings (high, medium and low options)
- GME / DSH carve-out (effect on solvency, political issues)
- Prescription drug benefit (issues)
- Overall financing / framework for Medicare



President's Medicare Plan Under the FY 2000 MSR Baseline

	<u>FY 2001</u>	<u>FY 2002</u>	<u>FY 2003</u>	<u>FY 2004</u>	<u>FY 2005</u>	<u>FY 2006</u>	<u>FY 2007</u>	<u>FY 2008</u>	<u>FY 2009</u>	<u>FY 2010</u>	<u>FY 01-05</u>	<u>FY 01-10</u>
CBO 1999 Baseline												
DSH	4.9	4.5	5.7	5.9	6.2	6.4	6.7	7.1	7.4	7.7	27.2	62.5
IME	3.5	3.7	3.9	4	4.2	4.4	4.6	4.8	5	5.2	19.3	43.3
DME	3.1	3.4	3.6	3.8	4.1	4.3	4.6	4.9	5.2	5.5	18.0	42.5
All medical education	6.6	7.1	7.5	7.8	8.3	8.7	9.2	9.7	10.2	10.8	37.3	85.9

1. SOLVENCY

ALL NUMBERS ARE VERY PRELIMINARY AND BASED ON APPROXIMATIONS

Total Surplus for Medicare Solvency Over 10 Years (these numbers do not include the \$145 billion needed for net prescription drugs)		
	Trustees baseline	Hypothetical new baseline*
Current law	2014	2020
\$40 billion (savings only)	2016	2023
\$100 billion	2018	2024
\$150 billion	2020	2025
\$200 billion	2021	2026
\$250 billion	2022	2027
\$300 billion	2023	2028
\$350 billion	2024	2029
\$400 billion	2025	2030
\$450 billion	2026	2030
SAVINGS TOGETHER WITH SURPLUS FOR SPECIFIC PARTS OF MEDICARE		
Direct Medical Education (\$83 billion total of surplus)	2019	2025
Disproportionate Share Hospitals (\$103 billion total of surplus)	2020	2026

* Assumes that half of the benefit surprise in 1999 and \$1 billion of the revenue surprise carry forward into the level of the new baseline. Specifically, this assumes the new baseline is lowered by \$6 billion growing with benefits (half of the \$12 billion Trustees prediction error for 1999) and \$1 billion and growing with taxable wages (out of the \$7 billion Trustees prediction error for 1999). Over 10 years, this provides \$92 billion for Medicare.

Rules of Thumb For Alternative Policies

- **Higher savings:** With \$80 billion of savings over 10 years, the same amount of surplus buys an additional 1 to 2 years of solvency.
- **No savings:** Without any savings, the same amount of surplus over 10 years buys 1 to 2 years less of solvency.
- **Outyear transfers:** With \$150 billion in transfers over 2011-2015, the same amount of 10-year surplus buys an additional 1 to 3 years of solvency.

2. SAVINGS

	<u>2000-09</u>	<u>2001-2010*</u>		
	Trustees'	Original	Medium	Low
Competitive Defined Benefits Proposal	-\$9	-\$12	-\$12	-\$12
Modernizing Traditional Medicare	-\$25	-\$24	-\$11	-\$6
BBA Extenders	-\$45	-\$59	-\$10	--
Cost Sharing / Preventive Benefits	-\$8	-\$9	-\$9	-\$9
Quality Assurance Fund (Give-Backs)	-\$7.5	--	--	--
Anti-Fraud and Abuse	--	--	-\$10	-\$10
Medicare Buy-In	--	+\$3	+\$3	+\$3
Interactions	+\$6	+\$9	+\$5	+\$4
TOTAL	-\$73 b	-\$91	-\$44	-\$30
<i>HI (Part A) Only</i>		-\$86	-\$40	-\$29

*VERY preliminary estimates; subject to change.

Original plan: Effective dates pushed back one year except for BBA extenders which are in effect from 2003-10 (extra year) and competitive defined benefit (2003, permanent

Medium plan: Reduces extenders by 75 percent; in effect from 2003-2007; modernization reduced by 60 percent as placeholders for policy changes.

Low plan: No extenders; modernization reduced by 75 percent as placeholder for policy changes

**III. PRESCRIPTION DRUG BENEFIT
VERY DRAFT, PRELIMINARY SCORING**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001-05	2001-10
June Scoring												
50% Premium, 2002 Start	-	5.0	11.0	12.6	14.1	16.0	17.7	19.7	21.8	24.0	42.7	141.9
Monthly Premium		\$24	\$25	\$31	\$32	\$38	\$39	\$44	\$47	\$50		
								Old Budget Period			(28.6)	(117.9)
Current Preliminary Scoring												
50% Premium, 2003 Start	-	-	7.2	16.5	20.0	22.7	25.9	28.6	32.0	35.5	43.7	188.3
Monthly Premium			\$33	\$41	\$45	\$54	\$57	\$64	\$69	\$74		
50% Premium, 2002 Start		6.8	15.6	18.9	21.4	24.4	27.0	30.2	33.5	41.2	62.6	218.9
Monthly Premium			\$35	\$47	\$49	\$58	\$59	\$67	\$72	\$86		
35% Premium, 2002 Start		8.8	20.2	24.6	27.8	31.7	35.1	39.3	43.5	53.6	81.4	284.6
Monthly Premium			\$25	\$33	\$34	\$41	\$42	\$47	\$51	\$60		

↓
46 53

188.3

218.9

284.6

162

CLOSE HOLD/
TURN IN AT END OF MEETING

6

AGENDA: MEDICARE
December 9, 1999

OUTLINE

- 1. Solvency**
- 2. Savings**
- 3. Prescription Drugs**

1. SOLVENCY

ALL NUMBERS ARE VERY PRELIMINARY AND BASED ON APPROXIMATIONS

Total Surplus for Medicare Solvency Over 10 Years (these numbers do not include the \$145 billion needed for net prescription drugs)		
	Trustees baseline	Hypothetical new baseline
Current law	2014	2020
\$40 billion (savings only)	2016	2023
\$100 billion	2018	2024
\$150 billion	2020	2025
\$200 billion	2021	2026
\$250 billion	2022	2027
\$300 billion	2023	2028
\$350 billion	2024	2029
\$400 billion	2025	2030
\$450 billion	2026	2030
SAVINGS TOGETHER WITH SURPLUS FOR SPECIFIC PARTS OF MEDICARE		
Direct Medical Education (\$83 billion total of surplus)	2019	2025
Disproportionate Share Hospitals (\$103 billion total of surplus)	2020	2026

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Rules of Thumb For Alternative Policies

- **Higher savings:** With \$80 billion of savings over 10 years, the same amount of surplus buys an additional 1 to 2 years of solvency.
- **No savings:** Without any savings, the same amount of surplus over 10 years buys 1 to 2 years less of solvency.
- **Outyear transfers:** With \$150 billion in transfers over 2011-2015, the same amount of 10-year surplus buys an additional 1 to 3 years of solvency.

2. SAVINGS

	<u>2000-09</u>	<u>2001-2010*</u>		
	Trustees'	Original	Medium	Low
Competitive Defined Benefits Proposal	-\$9	-\$12	-\$12	-\$12
Modernizing Traditional Medicare	-\$25	-\$24	-\$11	-\$6
BBA Extenders	-\$45	-\$59	-\$10	--
Cost Sharing / Preventive Benefits	-\$8	-\$9	-\$9	-\$9
Quality Assurance Fund (Give-Backs)	-\$7.5	--	--	--
Anti-Fraud and Abuse	--	--	-\$10	-\$10
Medicare Buy-In	--	+\$3	+\$3	+\$3
Interactions	+\$6	+\$9	+\$5	+\$4
TOTAL	-\$73 b	-\$91	-\$44	-\$30
<i>HI (Part A) Only</i>		-\$86	-\$40	-\$29

*VERY preliminary estimates; subject to change.

Original plan: Effective dates pushed back one year except for BBA extenders which are in effect from 2003-10 (extra year) and competitive defined benefit (2003, permanent)

Medium plan: Reduces extenders by 75 percent; in effect from 2003-2007; modernization reduced by 60 percent as placeholders for policy changes

Low plan: No extenders; modernization reduced by 75 percent as placeholder for policy changes

**III. PRESCRIPTION DRUG BENEFIT
VERY DRAFT, PRELIMINARY SCORING**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2001-05	2001-10
June Scoring												
50% Premium, 2002 Start	-	5.0	11.0	12.6	14.1	16.0	17.7	19.7	21.8	24.0	42.7	141.9
Monthly Premium		\$24	\$25	\$31	\$32	\$38	\$39	\$44	\$47	\$50		
								<i>Old Budget Period</i>			(28.6)	(117.9)
Current Preliminary Scoring												
50% Premium, 2003 Start	-	-	7.2	16.5	20.0	22.7	25.9	28.6	32.0	35.5	43.7	188.3
Monthly Premium			\$33	\$41	\$45	\$54	\$57	\$64	\$69	\$74		
50% Premium, 2002 Start		6.8	15.6	18.9	21.4	24.4	27.0	30.2	33.5	41.2	62.6	218.9
Monthly Premium			\$35	\$47	\$49	\$58	\$59	\$67	\$72	\$86		
35% Premium, 2002 Start		8.8	20.2	24.6	27.8	31.7	35.1	39.3	43.5	53.6	81.4	284.6
Monthly Premium			\$25	\$33	\$34	\$41	\$42	\$47	\$51	\$60		

AGENDA: MEDICARE
December 9, 1999

OUTLINE

- 1. Solvency**
- 2. Savings**
- 3. Prescription Drugs**

1. SOLVENCY

ALL NUMBERS ARE VERY PRELIMINARY AND BASED ON APPROXIMATIONS

Total Surplus for Medicare Solvency Over 10 Years (these numbers do not include the \$145 billion needed for net prescription drugs)		
	Trustees baseline	Hypothetical new baseline*
Current law	2014	2020
\$40 billion (savings only)	2016	2023
\$100 billion	2018	2024
\$150 billion	2020	2025
\$200 billion	2021	2026
\$250 billion	2022	2027
\$300 billion	2023	2028
\$350 billion	2024	2029
\$400 billion	2025	2030
\$450 billion	2026	2030
SAVINGS TOGETHER WITH SURPLUS FOR SPECIFIC PARTS OF MEDICARE		
Direct Medical Education (\$83 billion total of surplus)	2019	2025
Disproportionate Share Hospitals (\$103 billion total of surplus)	2020	2026

* Assumes that half of the benefit surprise in 1999 and \$1 billion of the revenue surprise carry forward into the *level* of the new baseline. Specifically, this assumes the new baseline is lowered by \$6 billion growing with benefits (half of the \$12 billion Trustees prediction error for 1999) and \$1 billion and growing with taxable wages (out of the \$7 billion Trustees prediction error for 1999). Over 10 years, this provides \$92 billion for Medicare.

Rules of Thumb For Alternative Policies

- **Higher savings:** With \$80 billion of savings over 10 years, the same amount of surplus buys an additional 1 to 2 years of solvency.
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SENT TO Jason

DRAFT: AGENDA FOR HEALTH CARE MEETING
December x, 1999

OUTLINE

Medicare:

- 1. Review of 1999 Medicare Reform Plan**
- 2. Current Cost Projections and Preliminary Status of Trust Fund**
- 3. Reactions and Pressures on the Plan Since June**
- 4. Possible Policy Changes**

Health Insurance Coverage Expansions:

- 1. Context / Environment**
- 2. Policy Options**

MEDICARE:

1. REVIEW OF 1999 MEDICARE REFORM PLAN

• Major Policies:	2000-09
◦ Competitive Defined Benefits Proposal	-\$9 b
◦ Modernizing Traditional Medicare	-\$25 b
◦ BBA Extenders	-\$45 b
◦ Cost Sharing Changes / Preventive Benefits	-\$8 b
◦ Quality Assurance Fund (Give-Backs)	+\$7.5 b
◦ Interactions	+\$6 b
TOTAL:	-\$73 b
• Prescription Drug Benefit	+\$119 b
• Surplus:	
◦ For Prescription Drugs	\$46 b
◦ For Solvency	\$328 b
TOTAL:	\$374 b
• Impact on the Trust Fund of Plan:	2030*

* Note: This was adjusted from 2027 due to an estimating error.

**2. CURRENT COST PROJECTIONS AND
PRELIMINARY STATUS OF TRUST FUND**

	<u>Scoring for 2001-2010</u>		
	Original	New	Change
• Major Policies:			
◦ Competitive Defined Benefits Proposal	-\$11		\$x b
◦ Modernizing Traditional Medicare	-\$29		\$x b
◦ BBA Extenders	-\$57		-\$x b
◦ Cost Sharing Changes / Preventive Benefits	-\$10		-\$x b
◦ Quality Assurance Fund (Give-Backs)	+\$7.5	\$0	-\$7.5 b
◦ Interactions	+\$7		\$x b
TOTAL:	-\$92 b		-\$x b
• Prescription Drug Benefit	+\$142		+\$x b
• Surplus			
◦ For Prescription Drugs	\$50	\$x ¹	+\$x b
◦ For Solvency	\$464	\$x ²	-\$x b
TOTAL:	\$514	\$x³	+\$x b
• Impact on the Trust Fund of Plan:		2014 with BBRA / no plan	
		20xx with BBRA / with plan	

¹ Amount to fill in gap between new drug costs and new savings, assuming no other changes

² Residual of one-third of surplus dedicated to Medicare and amount needed for drug gap

³ One-third of on-budget surplus, per lock-box legislation

3. REACTIONS TO THE PLAN SINCE JUNE

- **Congressional Democrats**
 - Support prescription drugs in concept, but:
 - Conservative Democrats worry about cost
 - Liberal Democrats fear that along with prescription drugs will come other compromises on premium support, Medicare Board, etc.
 - Use Allen bill as vehicle to criticize drug industry while not committing to policy
 - Still view Medicare reform as important block against tax cuts
- **Congressional Republicans**
 - Generally moving towards supporting a universal drug benefit, but poorly subsidized, income-related options and only in the context of broader reforms
 - Support privatizing Medicare management as “reform”
 - Strongly oppose dedicating surplus to Trust Fund
- **Elite Validators**
 - Generally like our plan, although some (like *Post* editorial board) think its reforms do not go far enough fast enough, and fear cost of prescription drugs.
 - Strong support for debt reduction could be translated into support for surplus transfers to solvency (with more work)
 - Beginning to doubt our commitment to the plan since we have not yet introduced legislation, have not set up Congressional strategy
- **Advocates**
 - Like base Democrats, strongly support the drug benefit but would like it to be more generous, and worried about reform compromises
- **Health Care Providers**
 - May support surplus dedication to Trust Fund now that give-backs are passed
 - Strongly oppose BBA extenders and will likely advocate for more give-backs
 - Oppose using provider savings for prescription drugs, concerned about Board

4. POSSIBLE POLICY CHANGES

Individual Policy Changes:

- **Effective dates:** In the original plan, modernization, prescription drugs, cost sharing changes start in 2002; competition, extenders in 2003. Should this change?
- **BBA extenders:** Some policies have to be modified due to BBRA changes. Should we modify more (e.g., lower hospital update reduction) or drop some / all (e.g., hospice payment reduction)?
- **Modernizing traditional Medicare:** The largest savers in this package are also the most controversial: the Centers of Excellence and the PPO option. Should we include?
- **Prescription drug benefit:** Do we re-consider the addition of some type of stop-loss coverage for the drug benefit?
- **Preventive benefits:** Should we contemplate giving the authority to add low-cost preventive benefits to Medicare?

Financing Changes:

- **How do we finance the additional gap between drug benefit costs and savings?**
 - Additional surplus
 - Tobacco tax
- **What is our goal for Medicare Trust Fund solvency?**
 - A particular number of additional years of solvency
 - A particular dollar amount

HEALTH INSURANCE COVERAGE EXPANSIONS:

1. CONTEXT / ENVIRONMENT

- **Growing number of uninsured**
 - **Up from 39 million in 1993 to 44 million in 1998**
 - **More of a middle-class problem.** The uninsured rate among those with income 200-400 percent of poverty (about \$33,000 and \$65,800 for a family of four) increased from 13.5 to 14.6 percent between 1997 and 1998, or by about 850,000.
 - **Although growing, Medicaid and CHIP enrollment still low.**

- **Interest in Congress**
 - Democrats increasingly looking to us for ideas, particularly as a block to tax cuts
 - Republicans have been using their “concern” about this issue as a reason to oppose patient bill of rights, fund tax breaks

- **Major issue in next year’s election**
 - Gore and Bradley have made coverage expansions their central issue

2. POLICY OPTIONS

Carry-Over Policies:

- **Medicare buy-in for certain 55 to 65 year olds.**
- **Completing Medicare in Jeffords-Kennedy Work Incentives Improvement Act.** The bill limited the Medicare coverage to an additional 4 ½ years; we had supported a demonstration of allowing for several years of coverage without the arbitrary limit.
- **Outreach to enroll uninsured children, with emphasis on schools.**
 - Allowing workers in schools, child care centers, etc to temporarily enroll children in Medicaid while the full application is processed (presumptive eligibility)
- **Restoring state options to cover legal immigrants**
- **Encouraging small businesses to offer health insurance through coalitions.**

New Ideas:

- **Covering low-income parents through Medicaid and the State Children's Health Insurance Program.** New policy that builds on the fact that most uninsured children have parents who are also uninsured. Promotes family health insurance coverage.
- **Additional outreach to enroll uninsured children, with emphasis on schools.**
 - Letting states to draw from their CHIP allotments the same, enhanced match rate for any newly enrolled child over a base-year number
 - Sharing school lunch information with Medicaid and CHIP for outreach
 - Allowing states to automatically enroll children in school lunch in Medicaid
 - Creating a new state grant program to help enroll uninsured, homeless children.
- **Tax credit for individual insurance to address current tax inequity.** Not necessarily a coverage provision, it address the lack of tax incentive to purchase individual health insurance.

THE WHITE HOUSE

WASHINGTON

November 24, 1999

MEMORANDUM FOR MARIA ECHAVESTE

FROM: GENE B. SPERLING

SUBJECT: FY 2001 BUDGET IDEAS

This memorandum provides a brief description of new ideas we are considering for the 2001 budget.

Education

- *Stay in College:* To address the rising, especially among minorities, college drop out rate by increasing appropriations for grant programs and encouraging colleges to front-load grants (for example, award a student's 4-year eligibility for Pell Grants in the first 2 years.) To create partnerships with colleges and businesses, similar to the GEAR UP program that would help provide guidance on course selections for solid career tracks, internships, work-study and mentoring that would make transitioning into the work world easier

Children

- *Universal 0-5 Preschool:* An initiative combining child care, early learning, Head Start and parenting education for a major and universal 0-5 initiative.

Poverty

- *Expand the Widow Benefit for Social Security to 75 Percent of the Couples' Benefit and Provide a Credit (\$10,000?) for up to Five Years Spent Raising Children:* The President could move further in endorsing a specific widow poverty option. He could also say that he would like us to get together and *do this option in a paid for manner that does not affect solvency.*

Taxes

- *Eliminate the Marriage Tax Penalty – for the EITC Also:* Make the standard deduction for married couples double that of single filers. An alternative proposal could be better targeted and thus provide more for those who pay a penalty. It could also be pitched as being pro working family. We could make a new deduction that would be a fraction of the lower earner's income – so that couples with only one earner would not get marriage penalty relief, but couples who paid the largest penalty (those who earned about the same amount) would get the largest bonus. EITC marriage tax relief would be an integral part of this proposal.

Banking Reform/Financial Services

- *Financial Privacy*: Initiative to protect personal financial privacy as an overarching administration goal in the President's final year in office that would deal with consumer protection issues and fixing problems with the Financial Modernization bill.
- *America Saves Initiative/financial Literacy*: A Clinton initiative to encourage savings and financial literacy for all Americans with a separate New Markets focus.

New Markets/Economic Development

- *Propose New \$100 Million Broadband Deployment Initiative for New Market Areas*: Provides grants to states and local areas to plan for and install high-speed Internet access infrastructure to help attract new business and job opportunities in our Nation's under-served communities.
- *Internet Access for Rural America*: Fiber optic cable is replacing traditional copper and coax cable as the primary source of data transmission. In rural areas, however, the small numbers of users per mile make the cost of installing fiber optic cable prohibitively expensive. In the Pacific Northwest, the Department of Energy's Bonneville Power Administration (BPA) has installed fiber optic cable within its right-of-way to provide communications between its facilities. In order that it has room to expand its data transmission capacity in the future, BPA's fiber optic cable contains excess capacity which BPA's has begun leasing to public utility districts (PUD) so that they may offer data transmission access to internet providers and their rural customers. BPA simply provides the backbone of the system, and the PUDs have to pay for the cost of local interfaces. The President could propose expanding such a program to all of the Federal power administrations, bringing affordable Internet access to a much greater geographic area.
- *Digital Divide*: Launch a bold initiative to help close the digital divide, by:
 - Expanding support for Community Technology Centers (currently at \$32 million);
 - Providing tax incentives for broadband investment in distressed urban and rural communities;
 - Encouraging the development of content that will help empower low-income families (e.g. adult literacy, English as a Second Language, local information on child care, health care, transportation, information needed to start own micro-enterprise); and
 - Subsidizing PC and Internet access to the home for low-income households;
 - Encouraging the private sector to provide PCs and Internet access with a "telecommuting tax credit."
- *Native American/New Markets Initiative*:

Health

- *Encouraging Small Businesses To Offer Health Insurance*: Creating a new tax credit for small businesses who decide to offer coverage by joining coalitions; encouraging private foundations to support coalitions by allowing their contributions towards these organizations to be tax exempt; offering technical assistance to small business coalitions from the Office of Personnel Management. This proposal was in the President's FY 2000 budget. (Costs: \$100 million over 5 years).

- *\$1,000 Tax Credit for Workers with Disabilities:* Provide workers with significant disabilities with an annual \$1,000 tax credit to help cover the formal and informal costs that are associated with and even prerequisites for employment, such as special transportation and technology needs. (Costs: \$700 million over 5 years)
- *Expanding Assistive Technology:* This proposal would double the budget for assistive technologies that enable people with disabilities to work. (Cost: \$35 million for 2001)
- *Keeping Out of Institutions and Getting to Work:* Provide support staff for the disabled allowing more people with disabilities to live at home and to contribute to the workforce. Furthermore this would free up people who are now taking time out from their jobs to help out their disabled relatives.

Reinventing Government

- *Green Pages in the Phone Book – Government Service and Hotline Numbers:* Develop a Green Pages section in the phone book that would describe in plain English basic rights and regulations the Government enforces, and services it provides with 1-800 numbers to find out more.

Child Labor

- *Call for a New Global Effort To Educate Children to Avoid Child Labor:* Presidential appeal to the international community to provide resources to reduce child labor by extending primary education to all children in poor developing country – (Cost – UNICEF estimate: \$7 billion annual global)

Trade

- *Increased Trade Compliance in China:* Devote a small amount of money (e.g., \$5 million) to increase the number of people at ITA working to ensure that China is complying with our trade agreements (30 people). This could also meet the requests of the AFL-CIO and NAM, who have both asked for increased trade compliance funding. And it could help build support for China WTO.

Savings

- *Son of USAs:* Tax policies modeled on Universal Savings Account that are potentially less expensive that would provide SEED money to help families establish the habit of saving for retirement.

HighTech

- *Information Technology for the Twenty-First Century:* This is the second year of a multi-year effort to significantly expand our investment in information technology research in three areas (VP has called for doubling IT research over 5 years): (1) Fundamental IT research: (2) Scientific and other applications of IT: (3) Economic, ethical, legal and social implications of the Information Cost: Last year's request was an increase of \$366 million.
- *Internet for Economic Development Initiative:* To expand Internet and its applications in 11 developing countries. Elements of initiative include: policy reform (encouraging developing countries to adopt Internet and e-commerce friendly policies); training of people in developing countries; support for applications of Internet – including e-commerce for small and medium-sized enterprises, distance learning, and telemedicine. *Cost:* \$45 million.

Manufacturing

- *Manufacturing Initiative:* To strengthen the competitiveness of US Manufacturing. This preliminary list of proposed initiatives have been grouped as follows:
 - Incumbent worker training;
 - Increasing manufacturing exports;
 - Development and diffusion of technologies;
 - Sustainable manufacturing

HEALTH CARE INITIATIVES: Draft: 11/23/99

MEDICARE REFORM AND PRESCRIPTION DRUG COVERAGE

- **President's plan to strengthen and modernize Medicare.** This would be our same plan, with several potential modifications to reflect likely higher prescription drug cost estimates, reduced baseline spending and lessened appetite for provider payment reductions, and likely improved Medicare trust fund solvency: (1) drop BBA extenders – in the wake of the Balanced Budget Refinement Act, these policies are not credible; (2) dedicate more surplus / tobacco tax to help pay for drug benefit; and (3) dedicate less of the surplus to trust fund solvency.
- **Policies to reduce fraud, abuse and overpayments.** This would include new and previously supported policies to reduce overpayments, fraud and abuse. We could also rescind some of the managed care payment increases in the give-back bill.
- **Medicare preventive benefit authority.** This proposal would allow the Secretary to add new preventive benefits to Medicare if (1) their cost when fully implemented costs less than a fixed dollar threshold and (2) they have been proven to be cost effective.
- **Low-income premium / cost sharing protections for seniors.** To address the very low participation rates by Medicare beneficiaries in Medicaid cost sharing protection programs, this proposal would allow SSI eligibility workers to give Medicare beneficiaries presumptive eligibility for these programs.
- **Cancer clinical trials*.** A three-year demonstration would cover the patient care costs associated with certain clinical trials. This proposal was in the President's FY 1999 and 2000 budgets. (Cost: \$750 million over 3 year)

HEALTH INSURANCE COVERAGE OPTIONS

- **Addressing arbitrary limit on Medicare coverage for people with disabilities.** In the compromise on the Work Incentives Improvement Act, its Medicare benefit was limited to an additional 4 and a half years. This policy postpones rather than eliminates the disincentive to work since Medicare provides the necessary coverage that is often unavailable or unaffordable on the job. (Cost: \$0 for 2001-05, about \$200 million for 2006-10)
- **Medicare buy-in for certain 55 to 65 year olds.** This initiative expands the health options available for older Americans by: enabling Americans aged 62 to 65 to buy into Medicare; providing a similar Medicare buy-in for vulnerable displaced workers ages 55 and older; and providing COBRA to Americans ages 55 and older whose companies reneged on their commitment to provide retiree health benefits. This proposal was in the last two budgets. (Cost: about \$1.6 billion over 5 years)

- Allowing states to cover of parents of children in Medicaid and Children's Health Insurance Program (CHIP)*.** This option, which was included in the Gore health proposal, would allow states to use their enhanced Federal match rate from their CHIP allotments to cover parents of eligible children. This has the benefit not only of efficiently enrolling uninsured adults (since most parents of uninsured children are also uninsured) but could increase enrollment of children since there is a greater incentive for the family to enroll them. (Cost: being scored by OMB)
- Outreach to enroll uninsured children in Medicaid and CHIP, with emphasis on schools*.** A number of proposals could decrease the number of uninsured children including allowing: (1) school lunch application information to be shared with Medicaid and CHIP for outreach; (2) states let school lunch workers (and TANF and other workers) give "presumptive eligibility" to children while their formal applications are being processed; and (3) deemed or adjunctive eligibility, meaning that a child enrolled in school lunch (or Food Stamps or WIC) are automatically enrolled in Medicaid or CHIP; and (4) states to draw from their CHIP allotments the same, enhanced match rate for any newly enrolled child over a base-year number. (Cost: being scored by OMB)
- Restoring state options to cover legal immigrants.** Welfare reform prohibited states from providing health insurance for certain legal immigrants. This proposal would restore this option for pregnant women and children in Medicaid and CHIP. This proposal was in the last two budgets. (Cost: \$300 million over 5 years)
- Encouraging small businesses to offer health insurance.** This initiative would encourage small businesses to offer health insurance through: (1) a new tax credit for small businesses who join coalitions; (2) tax-exempt status for foundation contributions to create coalitions; and (3) technical assistance. This proposal was in last year's budget and could be broadened. (Cost: \$100 million / 5 years)
- Tax credit for individual insurance to address current tax inequity*.** Unlike employees who work at firms that provide coverage, workers who are not offered insurance by their employers and buy it for themselves receive absolutely no tax subsidy. To address this inequity, this policy would give people without access to employer-based insurance a tax credit, equal to 25 percent of the cost of coverage and similar in value to the 100 percent tax deduction employers now receive, for purchasing individual insurance. Because the credit is relatively small, it likely would not have an adverse incentive impact on employers now offering to drop coverage. However, although it would be popular, it would be relatively unsuccessful at leading to much pick up in coverage for the currently uninsured. (Cost: roughly \$35 billion/5 years)
- Accelerating the tax deduction for the self-insured.** This policy, included in the Republican "access" bill attached to the Norwood-Dingell Patients' Bill of Rights, would expedite the implementation of the 100 percent deduction of health insurance for self-employed to take full effect in 2001. (Cost: about \$3 billion over 5 years)

QUALITY & CONSUMER PROTECTIONS

- **Patients' Bill of Rights.** The President will continue to encourage Congress to pass the bipartisan, Norwood-Dingell legislation. We would anticipate that, like last year, we would not offset the costs of the revenue loss associated with this legislation.
- **Privacy protections.** We could initiate and/or endorse legislation to expand our authority to regulate in this area to include paper claims (not just electronic claims), to provide for greater enforcement authority to ensure the protections promised are real, and to allow earlier implementation of these protections.
- **Promoting outcomes-oriented health care.** The use of technology, outcome measurement standards, and private-public collaborations have great potential to improve health care quality and cost-effectiveness. An intensive research-based and Federal coordination effort would encourage more appropriate and cost-effective medical interventions. A relatively modest investment in this area – as long as it is combined with necessary privacy protections – would go a long way assuring the utilization of best health care practices. Such an emphasis would be embraced by many in the business and consumer communities [note: may have relatively modest discretionary costs].

POTENTIAL/ PERILS OF NEW TECHNOLOGIES AND BIOMEDICAL SCIENCE

- **Investment in biomedical research.*** The potential breakthroughs in diagnoses, treatments and cures resulting from the nation's increasing investment in biomedical research are impressive. They include: decoding the complete gene sequence by the spring of 2000 the development of new treatments to delay the onset of Parkinson's, Alzheimers', and cancer, and new interventions to prevent paralysis with spinal cord injuries. The Administration's last budget dedicated a \$360 million increase to the NIH, which is far short of the over \$2 billion that was included in the final budget. This has resulted in criticism from the scientific and patients' advocacy communities and may suggest a significant bump up in the President's FY 2001 budget. (Cost: Probably between \$500 million and \$1.5 billion)
- **Interventions to guard against technological and scientific abuses.** In the wake of the excitement and extraordinary potential of scientific breakthroughs are a wide range of concerns, including the inappropriate patenting and licensing of genetic material, the insufficient provision of protections to human subjects in clinical trials, the sale of unapproved or unsafe drug products over the internet, and the continuing threat of bioterrorism. Under consideration during the next several weeks will be a host of initiatives to address these potential problems, including legislation to prohibit the use of genetic information in all health insurance policies and employment decisions. (Cost: to be determined based on final policy calls)

FAMILY SUPPORT (placeholder for broad-based initiative that extends beyond health)

- **Long-term care initiative.** As a part of any family policy-oriented section of the State of the Union Address, a logical initiative that has already been well received and has already begun to receive bipartisan support is the President's long-term care proposal. Last year, the President proposed a major, seven-part initiative that would: (1) provide a \$1,000 tax credit for people with long-term care needs or their families to offset the costs of care; (2) create a new Family Caregivers Program that offers respite services, information, and other assistance;* (3) offer private long-term care insurance to Federal employees; (4) improve nursing home quality; (5) expand Medicaid options for community-based services; (6) encourage assisted living facilities for Medicaid beneficiaries; and (7) conduct a \$10 million education campaign on long-term care for Medicare beneficiaries. (Cost: About \$6 billion over 5 years).

* These proposals have either been initiated by or are of great interest to the Vice President's office. They need to be discussed in the broader context of if and/or how we are including such proposals in the President's budget.

INTERNAL NOTES ON MEDICARE

BACKGROUND / NEW DEVELOPMENTS

- **Medicare baseline spending dropped for first time in program history.** The actual spending in 1999 is \$9 billion lower than midsession review and \$1.5 billion lower than 1998. This helps justify BBA give-back legislation, since it supports the claim that CBO and others underestimated the savings from the BBA, but makes traditional Medicare savings and BBA extenders harder to advocate.
- **Success at constraining program growth will likely extend the life of Medicare trust fund well beyond 2015.** While next April's trustees' report will no doubt show the trust fund's financial health has significantly improved (even after taking into account the BBA provider give-back legislation), Medicare's projected insolvency date will almost certainly precede that of Social Security by 5 to 20 years.
- **Appetite for Medicare reform has lessened, although the elite validators, Republicans, and some Democrats would oppose a drug benefit outside of the context of broader reform.** Recent success in extending the life of the trust fund has dampened the perception of a Medicare crisis and consequently interest in difficult reforms. Clearly, many Republicans would not even contemplate the drug benefit in the absence of a Breaux-Thomas premium support program and a new HCFA Board. Base Democrats do not want to engage in serious discussions for fear that the trade-offs won't be worth the package that emerges.
- **Public and Congressional support for an optional, universally accessible Medicare prescription drug benefit has markedly increased.** Senators Breaux, Snowe and Wyden are now advocating universal -- albeit flawed -- drug benefits. The Republican leadership seems to be suggesting that this issue is a priority for them as well.
- **Interest in a catastrophic benefit is increasing, but so is the overall cost of drug coverage, particularly back-ended protections.** While adding some type of catastrophic coverage could broaden support, it would be more costly, have higher cost growth, result in higher premiums, and potentially suffer from lack of popularity among beneficiaries that killed the Medicare catastrophic benefit in the late 1980s.

MAJOR QUESTIONS

- **What is the desired outcome for Medicare reform?** At the end of the day, are we seeking to pass some version of a Medicare reform plan this year -- which will entail necessary compromises -- or do we stand by the original plan and risk Congress not acting on it? If we engage, we would likely have to make compromises like:

- A phase-in or demonstration of premium support;
 - A Medicare Board, that would remove some of the executive branch's authority over Medicare;
 - A low-income drug benefit plus our Medicare savings proposals.
- **Should we shift public emphasis on Medicare from broader reform to prescription drugs?** Our plan has confirmed our commitment to making Medicare more efficient, competitive and solvent among the academics and elite media. Congressional Republicans and some Senate Democrats also view the prescription drug benefit as necessary but not central provision in Medicare reforms. However, most Congressional Democrats and the public in general see prescription drugs as the engine, and would prefer few -- or at least non-controversial -- reforms to the program.
 - **Can we propose Medicare savings that come from extending BBA provisions?** A large proportion of the savings in our Medicare reform plan came from extending BBA provisions. In addition, we proposed freezing hospital payments in our original FY 2000 budget. In light of the BBA give-back legislation, it may be difficult to re-proposed these policies.
 - **Do we modify the overall amount of the surplus going to Medicare or, within that amount, the allocation between solvency and prescription drugs?** We probably will need much less surplus dedication to extend the life of the Medicare trust fund through 2027. Thus, we could lower the surplus dedicated to Medicare and achieve the same trust fund solvency effect. However, this would lower the amount of debt reduction. We also potentially undermine our reputation as being concerned about the trust fund and entitlement reform in general. As for prescription drugs, it is highly unlikely that we will be able to finance the same drug benefit without additional financing sources. This is because the drug benefit will likely cost more and the available offsets will be significantly reduced. Without additional dedication of surplus for the benefit, non-Medicare financing will likely be necessary.
 - **Do we consider linking a tobacco tax to the Medicare drug benefit?** This strategy appeared to be successful in the Snowe-Wyden bill, that was supported by 54 Senators. At the same time, it may limit our budget options and make our prescription drug proposal the enemy of the tobacco as well as the pharmaceutical lobby.
 - **Do we modify the prescription drug benefit to include more catastrophic coverage?** One of the major criticisms that our prescription drug benefit has received is that it is not "real" insurance because it does not protect against catastrophic costs. Should we consider a design like the Rockefeller-Kennedy plan that adds an out-of-pocket limit, which could be more expensive given higher projected prescription drug inflation?

DRAFT 11/23/99: PUBLIC HEALTH PROPOSALS FOR FY 2001 BUDGET

MANDATORY

Preventing and treating asthma (\$100 million over 5 years). This initiative would create a demonstration program to develop appropriate disease treatment protocols and beneficiary and provider outreach and education programs for the treatment of asthma in children enrolled in the Medicaid program. The grant funds provide an incentive for more effective spending for outreach, case management, and treatment benefits to reduce costly asthma-related medical crises (such as emergency room visits and hospital stays) and to improve quality of life (such as school attendance) for children with asthma. In addition, up to 20 percent of the disease management grant funds would be used as a performance bonus fund to provide awards to states that document a reduction in Medicaid costs and/or improved health outcomes through disease management efforts against a pre-demonstration baseline.

Problem statement: Over the past 15 years, the number of children afflicted with asthma has doubled to total about 6 million. Minority children and low income children experience disproportionate rates of asthma related deaths – in 1995, the rate of death from asthma in African American children was 11.5 per million, over 4 times the rate in white children. Studies of individual state experience indicate that many of the deaths, hospitalizations, and emergency room visits due to asthma are preventable through intensive case management and use of appropriate clinical practices, which improve health outcomes, reduce inpatient hospitalization, lower total costs, and increase consumer and physician knowledge.

History: This proposal, funded at \$50 million, was included in the President's FY 2000 budget. It was not included in the final budget agreement.

Providing critical dental services to low-income children (\$__ million). This initiative provides demonstration funds to states for: 1) implementing new efforts to educate low-income families about the availability of comprehensive dental services for children enrolled in the Medicaid program; 2) using health care providers and peer counselors to identify high risk patients for intensive interventions; 3) and increasing the participation of dentists in the state's Medicaid program to a provider to patient ratio of X to Y. In addition, 20 percent of the grant funds would be used as performance bonuses to provide funds to states who document an increase in children receiving services and/or a decrease in expenditures on emergency oral care.

Problem statement: Chronically poor oral health is associated with diminished growth in toddlers, compromised nutrition in children, and cardiac dysfunction in adults. Eighty percent of tooth decay is estimated to occur in only 25 percent of children, and twice as much decay is untreated in children aged six to 18 years old with family incomes below the poverty line as in children with higher family incomes. Although children enrolled in Medicaid are entitled to comprehensive dental

services, only 18 percent of Medicaid eligible children received even one preventive dental service. One third of the children presenting at emergency rooms for dental problems children have abscessed teeth; one quarter of them have draining oral lesions. The majority of these children, each of whom could have avoided the operating room if they had accessed preventive dental care, are enrolled in the Medicaid program. Children miss almost 850,000 schools days each year because of dental concerns.

History: This initiative was not included in the President's FY 2000 budget.

 **Effective diagnosis of lead poisoning in low-income children (\$__ million).** This initiative would provide Medicaid reimbursement for the paint chip test necessary to conclusively identify the presence of lead based paint in households where children are at risk of lead poisoning. If lead based paint is present, state Medicaid agencies will be required to conduct comprehensive lead screening for all children in the household under EPSDT. Children do not have to be diagnosed with elevated blood lead levels in order to have their homes tested. In addition, \$X million would be used as a performance bonus for states that document an increase in required screening for lead poisoning in children against a confirmed baseline.

Problem statement: The burden of this disease falls disproportionately on low-income families and families of color. Children served by Federal health programs are five times more likely to have a harmful blood lead level than other children. A CDC study indicated that three-fourths of all the children (nearly 700,000 children nationwide) found to have an elevated blood lead level were enrolled in Medicaid or WIC or were within the target population for the Health Center Program. Despite current Federal policies, most children in federal health care programs have not been screened, and Medicaid does not reimburse for critical environmental tests to determine the source of lead paint in homes. GAO estimates that there are 400,000 children in Federal health care programs have undetected elevated blood lead levels. Childhood lead poisoning is associated with lower educational achievement, higher rates of high school drop-out, and increased behavioral problems.

History: This proposal was not included in the President's FY 2000 Budget.

DISCRETIONARY

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Preventing the sale of unapproved or unsafe drug products over the Internet (\$20 million). This initiative would launch strong new efforts to investigate, identify, and assist in the prosecution of entities selling unapproved new drugs, counterfeit drugs, prescription drugs without a valid prescription, expired or illegally diverted pharmaceuticals, and the marketing of products based on fraudulent health claims. In addition, it would establish new Federal certification requirements for all internet pharmacy sites to ensure that internet pharmacies meet all state and Federal requirements. This would provide the national Federal authority necessary for a coordinated prosecution of rogue internet sites, maintains the integrity of state enforcement mechanisms, and provides a clear consumer identification mechanism.

New Penalties

Problem statement: Although Congress and state legislatures have enacted laws to protect patients from the use of unsafe drugs, counterfeit drugs, and the improper practice of medicine and pharmacy, the internet makes it possible to bypass these safeguards. On-line prescribers, who are often not licensed health care professionals, may not take a medical history and do not perform physical exams; rather, they rely on consumer self-diagnosis, which increases the likelihood that the consumer will experience harmful side effects due to the medication itself or to the medication's interaction with another drug. In addition, on-line pharmacies are often not licensed; in a survey of 200 on-line pharmacies conducted by the National Association of Boards of Pharmacy, 43 percent of these 200 sites were unlicensed operations. Some on-line pharmacies may not employ licensed pharmacists, removing an important safety check for consumers. In addition, there is the possibility that consumers may receive the wrong drug or a different version of the brand name drug they thought they were buying.

History: This proposal was not included in the President's FY 2000 Budget.

Protecting against and preventing bioterrorist attacks (\$38 million). This initiative would: train epidemic intelligence officers who can coordinate with state health departments and other intelligence officers to identify and respond to attacks; develop a Metropolitan Medical Response System, a mass casualty emergency response system, that includes primary care, emergency transportation, and decontamination abilities that will be critical to save lives in the event of an attack; and improve research to develop new vaccines and antibiotics that could be used in the event of an attack.

Problem statement: Bioterrorism is becoming an increasing threat that has the potential to injure or kill millions of Americans through deadly diseases, such as anthrax. While law enforcement and intelligence agencies seek to thwart these kinds of attacks, when prevention fails, we need a system in place that is prepared to manage and minimize the public health consequences. Unfortunately, unlike many

types of attacks, bioterrorist threats could go for days or even weeks without being detected as they could be noticed only when clusters of deaths or a series of illnesses begin to emerge. Therefore, it is critical that the nation's public health system is equipped to both detect and respond to this potential problem.

History: The FY 2000 budget agreement fully funds the President's request of an additional \$52 million for bioterrorism prevention.

Expanding efforts to prevent breast, ovarian and prostate cancer (\$20 million).

This initiative will fully fund the National Environmental Health Laboratory, which systematically evaluates the exposure of men, women, and children to toxic substances that cause cancer in order to guide national cancer prevention efforts. In addition, funds will be used to assist state and local public health officials in their investigation of cancer clusters and in their efforts to rapidly evaluate the impact of public health disasters, such as chemical spills and groundwater contamination.

Problem statement: While most cancers are going down, rates of breast cancer are on the rise. Breast cancer has become the second largest cause of cancer death in women, after lung cancer, and the leading cause of death for women between the ages of 35 and 54. Researchers estimate that 173,000 women will be diagnosed with breast cancer in the coming year, and about 43,000 women will die from it. Most scientists believe that this is due to exposure of toxic substances in the environment.

In addition, prostate cancer is the most common type of cancer found in American men, other than skin cancer. Researchers estimate that there will be about 179,300 new cases of prostate cancer in the United States this year, and about 37,000 men will die of this disease. Only 10 percent of the prostate cancer cases are attributable to genetic predisposition. Many scientists are concerned that a large fraction of the remaining 90 percent are caused by exposure to toxins.

History: This proposal was not included in the President's FY 2000 Budget.

Supporting graduate medical education at children's hospitals (\$285 million).

This proposal would provide children's hospitals with Federal financing for graduate medical education commensurate to that received by other teaching hospitals through the discretionary grant program created by the FY 2000 budget agreement.

Problem statement: The children's hospitals play an essential role in the education of the nation's physicians, training 25 percent of pediatricians and over half of many pediatric subspecialists. Since there are physician shortages in some areas of pediatric subspecialty care, these hospitals are critical to maintaining an adequate practitioner supply. Teaching hospitals receive an average of \$76,000 in Federal GME funding per resident, as opposed to the \$400 per resident received by children's hospitals.

History: This proposal, funded at \$40 million, was included in the President's FY 2000 budget and included in the final budget agreement. Because the Congress

allocated a higher level of funding (\$__ million), it may be worthwhile to address the remaining inequity in reimbursement.

Increasing prevention and treatment services for individuals with mental illness (\$__ million). This proposal will increase funding for treatment for the severely mentally ill and establish a new local mental health enhancement program that would provide new prevention, early intervention, and treatment services for Americans with less severe mental illnesses.

Problem statement: In 1998, more than 63 million Americans experienced some type of mental disorder. Of these Americans, 6.7 million – including 1.1 million children and adolescents – were disabled by the most severe and persistent mental illnesses. The costs per year of mental illnesses to this Nation in health care dollars spent and productivity lost are just over \$150 billion, with \$16 billion due to depression alone.

History: The President's FY 2000 Budget requested a \$67 million increase over the FY 1999 level (\$289M). The final budget included an increase of \$64 million. HHS has identified a significant increase in resources dedicated to mental health as part of the Secretary's top priorities.

Investing in promising biomedical research (\$__ million). The potential breakthroughs in diagnoses, treatments and cures resulting from the nation's increasing investment in biomedical research are impressive. To help realize these new possibilities, the President's FY 2001 should continue the increased level of commitment that has been established over the past years.

History: The President's FY 2000 Budget included a \$320 million increase over FY 1999 funding. The final budget agreement included \$2.3 billion for NIH.

Eliminating racial health disparities (\$__ million). This initiative would fund new incentives to public health programs to target disparities, including creating incentives for communities to develop effective private-public cardiovascular outreach campaigns and developing new networks with managed care and minority-based organizations.

Problem statement: Minorities suffer as much as five times the rate for certain diseases and mortality rates, such as cancer, diabetes, heart disease, immunizations, HIV/AIDS, and infant mortality. In fact, infant mortality rates are 2½ times higher for African-Americans and 1½ times higher for Native Americans, and African-American men under 65 suffer from prostate cancer at nearly twice the rate of whites.

History: The President's FY 2000 Budget included an increase of \$25 million over the FY 1999 funding level, for total funding of \$35 million. The final budget agreement included \$30 million for this initiative.

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AIDS
55

\$500 → \$15