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George Stephanopoulos

MEMORANDUM

To: Distribution

From: Chris Jennings
Jennifer Klein

Date: January 26, 1995

Re: Health Care Talking Points

cc: Secretary Rubin
Carol Rasco
Bill Galston
Gene Sperling
Sylvia Mathews
Jeremy Ben-Ami

Attached are the post State of the Union health care talking points. If you have any questions or concerns, please contact Chris (6-5560) or Jennifer (6-2599).

Health Care Questions and Answers - January 25, 1995

Q. How is the Administration going to proceed on health care reform?

The President remains firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses and Federal, State and local governments. While we did not reach agreement on legislation last year, there can be little disagreement that the problems remain. As the President stated in his December 27 letter to the Congressional Leadership and in the State of the Union Address, he believes that we should work and take a step-by-step approach to achieve these goals.

Q. Last year the Administration said that insurance reform could not really be achieved in the absence of universal coverage. Has the Administration backed away from this claim?

The Administration has not backed away from its commitment to provide Americans with real health security. As the President said in his State of the Union address, last year we bit off more than we could chew. This year we can and should take interim steps forward. We can address the unfairness in the insurance market, make coverage affordable for children and workers who lose their jobs, give self-employed workers the same tax treatment as other businesses, and help families get long-term care for a sick parent or disabled child. But all of this must be done in the broader context of eventually reaching universal coverage.

Q. The President says that he believes that we can make a start on expanding coverage. How will he pay for it?

The Administration wants to work with Congress to expand coverage and to ensure that any proposal can be paid for without increasing the deficit.

Q. Did the President draw a line in the sand on Medicare?

The President will not allow Medicare to be cut to pay for tax cuts. The President has consistently said that he opposes new Medicare cuts outside the context of health care reform.

Q. Will there be a health care reform proposal in the budget?

The President has not yet announced his budget.

Q. Will the President introduce health care legislation?

Everyone knows where the President stands on health care. His goals have not changed. He believes that we must act now to take the first steps toward these goals.

As he said in the State of the Union, the President is committed to work in a bipartisan fashion to put America on the road to health security. He will work with Congress as Democrats and Republicans develop proposals. The President has made it very clear that he will not give up the fight to guarantee affordable, high quality health care for the American people.

Q. What is the Administration's reaction to Senator Daschle's health care proposal?

Senator Daschle's proposal is consistent with the vision laid out by the President in his December 27 letter to the Congressional leadership. Both the President and Senator Daschle want to work with fellow Democrats and Republicans on health care reform. The nation's health care problems have not gone away and it is imperative that we move forward.

Q. How do you respond to the recent comments made by Senator Dole and Speaker Gingrich about health reform?

We welcome their desire to work together and look forward to discussing their ideas. We will be supportive as long as it moves our health care system toward the President's end goals of cost containment and insurance protection for all Americans.

TALKING POINTS ON HEALTH CARE REFORM -- January 25, 1995

Health reform is still the right thing to do. While there were honest differences of opinion on some issues last year, and while we know that mistakes were made, we are proud that we tried to pass meaningful health reform legislation. The problems remain. Without reform, health care costs will continue to rise and coverage will continue to decrease. American families, businesses, and governments will pay the price.

- The most recent data available indicates that the number of uninsured Americans rose by 1.1 million. 84 percent of the uninsured were in working families.
- By the end of the decade, health care costs per person will rise by more than 50 percent, from $3,300 in 1993 to over $5,000 by the year 2000.
- From 1970–1991, real wages and salaries rose a total of 0.4 percent while spending for health benefits increased 243 percent.
- In 1993, total health benefit costs per employee rose eight percent, nearly three times the rate of general inflation. And insurers charge small firms up to eight times more than large firms for administrative costs.

We remain firmly committed. We are firmly committed to guaranteeing health insurance for every American and to containing health care costs for families, businesses and Federal, State and local governments. The President reiterated this commitment in a December letter to the Congressional Leadership. In his letter, the President outlined his vision of how we can take the first steps toward reform.

We can take the first steps on a bipartisan basis. The President noted in his letter to the Congressional Leadership and in the State of the Union Address that Republicans and Democrats can and should:

- Reform the insurance market so that Americans no longer risk losing coverage when they change or lose a job, or a family member falls ill.
- Provide assistance to states to establish voluntary purchasing pools to help small businesses purchase affordable insurance.
- Make coverage affordable for and available to children.
- Help workers who lose their jobs keep their health insurance.
- Level the playing field for the self-employed, by giving them the same tax treatment as other businesses.
- Help families provide long term care for a sick parent or a disabled child.

No Medicare cuts to pay for tax cuts. The President will not allow Medicare to be cut in order to pay for tax cuts. In addition, the President has consistently said that he opposes new Medicare cuts outside the context of health care reform.

George

THE WHITE HOUSE

WASHINGTON

MEMORANDUM

TO: Distribution February 13, 1995

FR: Chris J.

RE: Senate Democrats' Health Press Conference and Principles

As you may know, Senator Daschle led a large contingency of Democratic Senators to a press conference today challenging the Republicans to move on health care reform. The questions focused largely around the Daschle bill, which incorporates many of the priorities layed out by the President in his December Congressional Leadership letter and his State of the Union Address.

It is unclear how much press coverage the event attracted, but it has made the wires. Since the Democrats are not talking about how they would finance their package, their event may be viewed as largely political by a health care press corps that is cynical and tired of this issue.

What may be the most newsworthy development is that 19 Democrats -- including some moderate to conservative Dems like Ford, Breaux, Pryor, Conrad and Bryan -- have signed onto a set of "Democratic Health Care Principles," which also mirror the President's health care "vision." Attached is that set of yet to be released principles, along with the current list of Members who have signed on.

DEMOCRATIC HEALTH CARE PRINCIPLES

We are committed to continuing the fight for health care reform, because we believe hard working American families deserve quality health care at a price they can afford. We are encouraged that members of the Republican leadership have stated they share our views on the importance of beginning the process of health care reform, and we look forward to working with the Majority to ensure that a bill is considered and passed this year.

As a first step, we believe Congress should pass reforms that enjoyed wide bipartisan support last year, including measures that:

-- Reform the insurance market

-- Provide 100% health insurance tax deductibility for the self-employed

-- Make coverage affordable for and available to children

-- Help workers who lose their jobs keep their health coverage

-- Make a wider range of home and community-based options accessible to and affordable for families caring for a sick parent or a disabled child

Members who have signed on:

Daschle
Akaka
Breaux
Bryan
Campbell
Conrad
Dodd
Feingold
Ford
Harkin
Inouye
Kennedy
Leahy
Levin
Mikulski
Pryor
Reid
Rockefeller
Wellstone

THE WHITE HOUSE

WASHINGTON

20 June 1994

MEMORANDUM TO DISTRIBUTION

FROM: Harold Ickes (HI)

SUBJECT: Health care and the '94 election

Attached is a 7 page draft memorandum regarding the effect of health care reform (universal coverage) on working, middle class families and the 1994 election. As this memo underscores, it is critical to emphasize that universal coverage benefits working American families. Those who oppose universal coverage are working against the interests of middle class America.

Distribution: Vice President Gore
Mrs. Gore
Secretary Bentsen
Secretary Shalala
Deputy Secretary Altman
Mack McLarty
George Stephanopoulos
Carol Rasco
Leon Panetta
David Gergen
Bob Rubin
Jack Quinn
Gene Sperling
Jerry Klepner
Don Baer

To:

Fr:

Re: Health Care and the 94 Election

June, 1994

Minority Whip Gingrich's activities over the past several days -- backed up by Senator Packwood and other Republican leaders -- have made it clear: they are approaching the legislative debate over health care from a harshly partisan perspective. Health Care will indeed define this fall's elections -- and Republicans are embarking on a political strategy that may cost them dearly. Once again, they are ignoring or even betraying the interests of the middle class, even in their own districts. Once again, they are arguing for perpetuating a system that does not value or reward work..

This coming week, HHS will release data showing that the percentage of uninsured Americans rose to 17% during the 80s. 85% of the uninsured are in working families. Here, good policy and good politics are in alignment. **Universal coverage is a middle class issue; the people who are dropped by the move to non-universal health insurance proposals are middle income working families -- families that will continue to have to pay for others' insurance when they cannot afford their own.** These facts are even more striking when viewed from a local electoral perspective. A simple, but important fact: *Likely Republican districts have large numbers of working uninsured people. These districts each have, on average, an estimated 56,166 working people who lack health insurance.*

Republicans who oppose workplace health insurance also pride themselves for opposing the President's economic program because it contained a tax rate increase on the rich. Yet, in the very districts they represent, *working uninsured people outnumber people who faced an income tax rate increase by substantially more than 10 - 1.*

> *In 1990, President Bush's budget policies raised taxes on the middle class and protected the wealthy. This strategy cost Republicans at the ballot box in the fall. In 1994, Republicans' health care policies are hurting the middle class and protecting employers and insurance companies. Thus, what we are fighting for legislatively -- because it is good policy -- will also be good politics, if we stick with it clearly and consistently.*

Overview

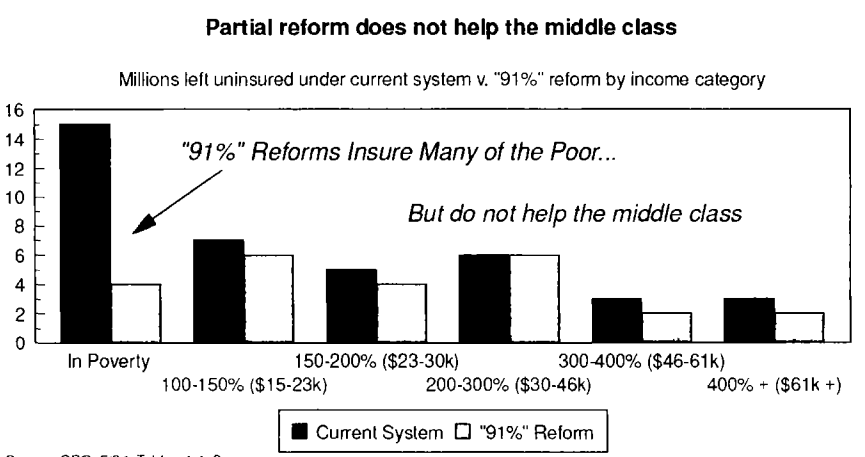
Health Care will be key to the 94 elections; it will play to our advantage if and only if we use every aspect of the debate to reinforce our key overall political/economic message -- Democrats believe in linking work and reward; we're on the side of the hard working middle class.

We know that the President's policy is right on the merits -- our argument is that the politics of the key health care issues work strongly in our favor for this fall. Let Republicans argue against

universal coverage. They still haven't found an answer to Wofford's dictum: "Everyone has the right to a doctor." Then let them tell voters they want an individual mandate or just provide extra COBRA coverage. Dole is right on this -- he pointed out to the Post that we will clean their clocks if Republicans persist in supporting a policy that would push all health care costs onto individuals. As he said, "I can already see the 30-second television spots which would say: 'Well, the Republicans didn't want your boss to pay for it, they want you to pay for it." Universal, work based health care that can't be taken away -- we win on this when we stay on the offense.

We need to stand firm on universal coverage in the workplace -- the most powerful idea that drives health care reform. We must not let the Republicans off the mat. Two strategies are crucial from a political perspective, one factual, one thematic.

First, the debate over universality is a debate about the middle class. **"Incremental" (non-universal) solutions represent a desertion of the middle class.** Even plans which claim "91%" coverage leave millions of working Americans without coverage. Those left uncovered won't be the poor, but will be working middle class families.



Source. CBO, 5/94; Tables 4-1, 2
Incomes categorized by percentage of poverty; dollar ranges shown for family of four.

Republicans, once again, are selling out the middle class in a show down, election-year vote. As in the Budget Deal of 1990, some elites may praise marginalism and moderation in the summer and September. But also as in 1990 (when the tax fairness issue added 9 Democratic seats to the House of Representatives), voters will be keeping a keen eye on their actual interests when they go to the polls in November.

Second, we need to discuss universality and overall reform in the context of work and reward: <u>everyone who works hard and plays by the rules deserves to have health care that can never be taken away</u>. It is wrong for people who work to have no health care; it is wrong for people who work to be forced to pay for the health care of people who aren't insured. Our system rights these wrongs -- their proposals don't.

Indeed, turning the health care debate into a debate about the values of work and reward is going to be the key to passing real health care reform (universal/work based) and turning late breaking 94 elections our way. Exposing incremental solutions as anti-middle class is the first step.

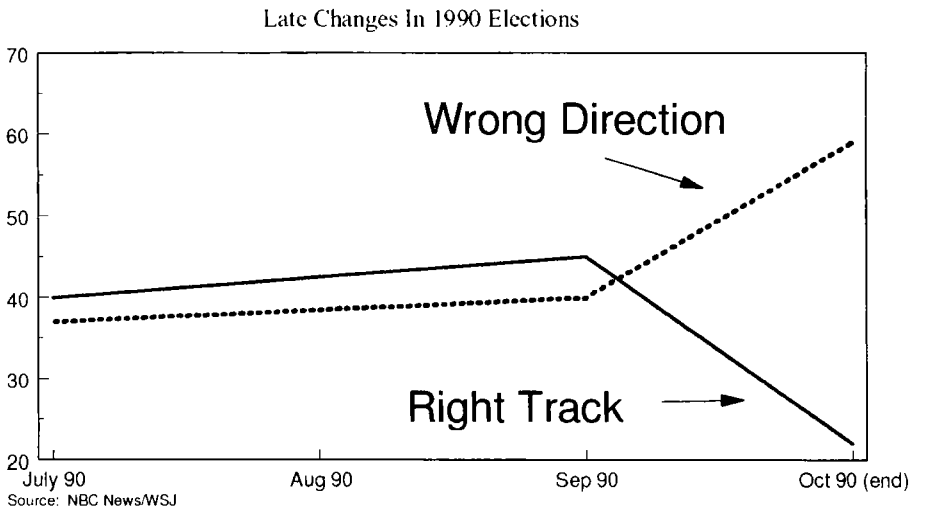
Simply stated:

	DEMS	REPS
Universality	Everyone guaranteed HC that can't be taken away	Wealthy held harmless, some gain for poor: millions of working, middle class still w/o insurance
Employer Mandate	Anyone who works gets Health Care	Employers are protected: individuals have to pay more

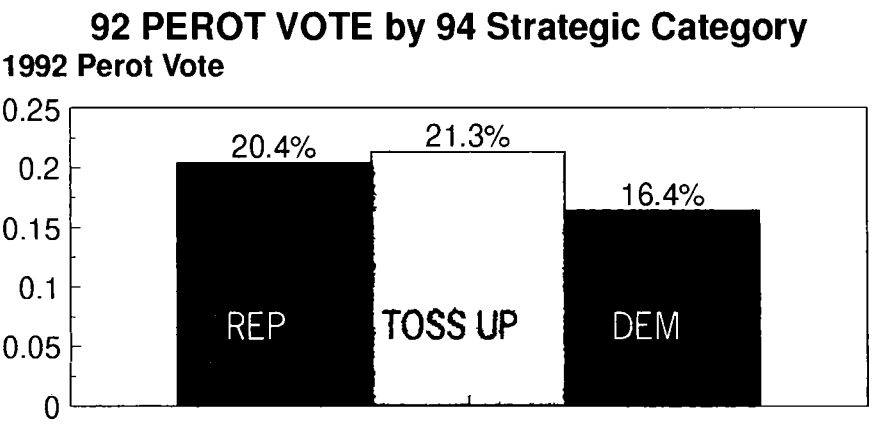
We are just twenty weeks away from election day for every House seat and 34 Senate seats -- 21 of them Democratic. We must keep our message clear and on point.

The 94 Elections and Middle Class Concerns

Health care is the make-or-break issue -- the centerpiece of Congressional activity. It will dominate the news from July through October, and leave the dominant impression in voters' minds about what their Member of Congress is doing in Washington. In sheer magnitude terms, it will be to 1994 what the Budget debate was to 1990. Swing voters are thus likely to break late, as they did in 1990. If anyone had forgotten how quickly political weather can change around off-year election time, they need only look at graph one -- voters opinion on "Right Track" v. "Wrong Direction" switched 43 points net in five weeks!

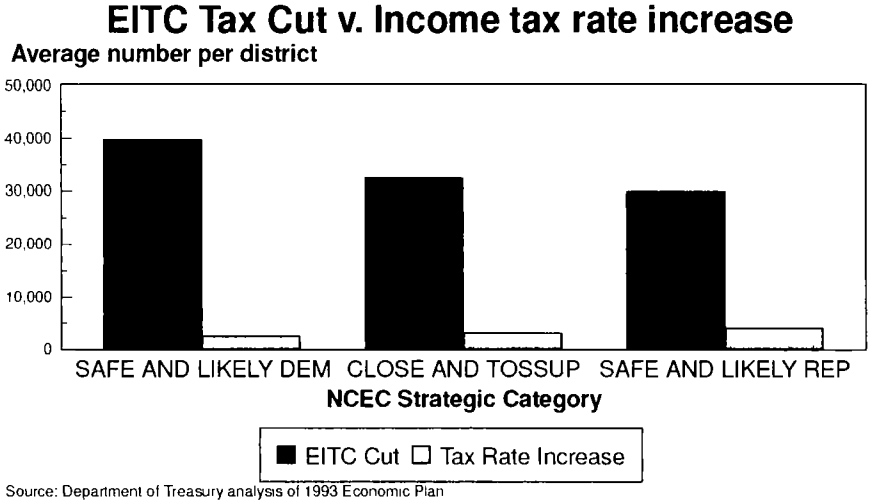


All the reviews of the fall campaign schedules point out that the members in tight races will be trying to persuade an audience whose central concerns remain focused on the value of work and playing by the rules. For example, key tight House races are more heavily weighted toward the Midwest and, as can be seen below, more heavily toward the middle class and the 92 Perot voter than safe districts. These voters want the sense that work is going to be rewarded. Universal, work based health care is one big step in the right direction -- it will provide tangible and direct benefit to everyday working families.



NCEC House Rankings

This will fit into the overall message that returned us to the White House and will continue to succeed for Democrats. This Administration is building a solid record of delivering for the middle-class and strengthening the link between work and reward. The Earned Income Tax Credit, which rewards work over welfare, has helped millions of Middle Class voters -- particularly strongly in Democratic and toss up districts. At the same time, the tax increase on the wealthy has hit an order of magnitude fewer people -- and hit people in Democratic and tossup districts the least. Besides these issues, in each one of these districts there are people who have benefited from 3 million new jobs, Family and Medical Leave, and college loans.



Source: Department of Treasury analysis of 1993 Economic Plan

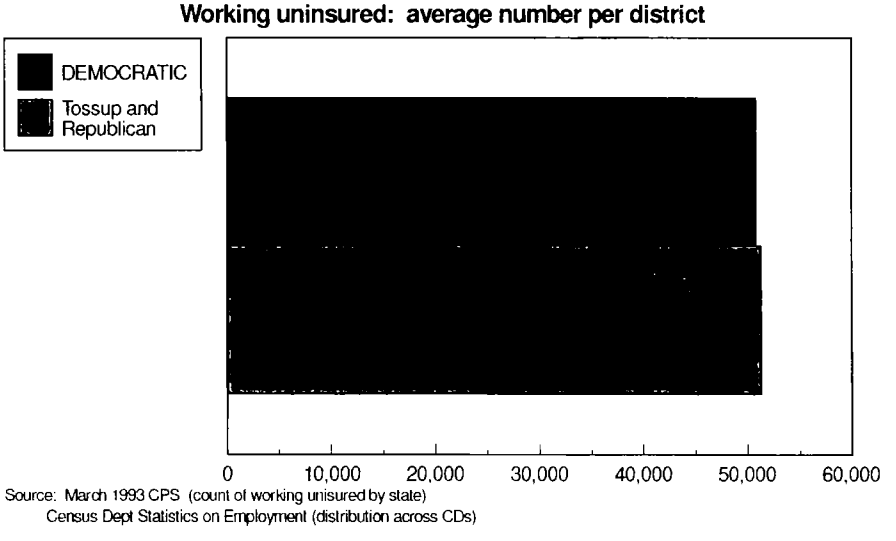
Localizing the message of accomplishment for the middle class will be a key challenge for the Democratic Party this fall -- and ensuring members use the most up to date local statistics on our economic progress will be an important tool. But the key decision variable -- this fall's key piece of "new information" in Popkin's terms -- will be Health Care. This will be true no matter

what the legislative outcome. A "no action" outcome will confirm many of voters worst suspicions about Washington; passing and signing comprehensive reform that values work will, alternatively, yield strong gains.

Health Care as a Middle Class/Work reward issue

The conventional wisdom has much of the health care debate wrong, particularly when it comes to the politics (as wrong, we might add, as these same pundits had the 1990 Budget debate). Some even argue that the politics of our proposal are working against our own interests in these key fall races -- that universality will be seen as a debate about people who aren't in the middle class and that the employer mandate will be seen as being about big government. Thus, the punditocracy argues, we at least ought to be quiet about all this or, better yet, cut a quick deal . They have it EXACTLY wrong:

85% of uninsured people in this country are in working families -- and the working and uninsured are strongly present in Republican districts. This fact benefits us on both universality and the employer mandate -- if Republicans try to walk away from guaranteed health care for every American, they will have to answer to working people *in their own districts. Again, "likely Republican" house seats have, on average, an estimated 56,166 working uninsured people, as many -- or in some cases more -- than many safe democratic seats.* For example, *Newt Gingrich has an estimated 83,700 working people in his Cobb County district who do not have health insurance, compared to only 7,500 who faced higher taxes because of the economic plan's tax increases on the wealthy.*



This means that, as the attached chart shows, making health care a work issue is as powerful in Republican as in Democratic districts.

The American people know how critical universality is as a test of seriousness of any plan. Indeed, a late May Harris poll found that 42% of independent voters consider universal coverage the most important goal for health reform, with no other goal receiving more than 16%. And in the same poll, 77% of all voters called universal coverage "absolutely essential" or "very

important" for reform. This is confirmed by many private and public polls: the Wall Street Journal and NBC News found -- in an open ended question -- that universality is offered by people as the most important goal of health care reform -- mentioned nearly twice as often as lower rates and nearly three times as often as the ability to choose your own doctor,

Non-universal reform -- the "91% strategy" -- has the potential for a serious political backlash because it hurts the middle class. Recent New York state insurance reforms without universal coverage raised rates by as much as 35% for the insured. **According to the Congressional Budget Office more than eighty percent of the people who would remain uninsured are middle-class, working families.** (See graph on page two). Even those low risk individuals who kept coverage would -- according to CBO -- face higher premiums and greater threats to the security of their coverage.

Note the similarity to 1990: the sitting President's most remembered promise (Bush: no new taxes; Clinton: universal health care) becomes the showdown issue in fall campaigns -- with the middle class on the chopping block.

As we noted above, once we establish that reform must be universal, the key question becomes who pays. And in the absence of a broad-based tax, it's either an employer and employees together or an individual without help. On this issue, Democrats are on strong ground. Democrats think all jobs should come with benefits. Why? Because it reflects a core Democratic value -- that people that work hard and play by the rules should be rewarded. Democrats should be proud to go out there and say: no matter what you do or where you work or how much you make, we believe in the simple premise that every job should have health benefits.

Meanwhile, on this critical question of who should pay for health insurance -- you or your boss, the Republicans give the wrong answer. By favoring an individual mandate, they take their traditional position: protecting businesses at the expense of families. A recent Citizen Action analysis indicates that the individual mandate could shift the burden of over $1.4 trillion from businesses to individuals -- including $168.6 billion in California alone.

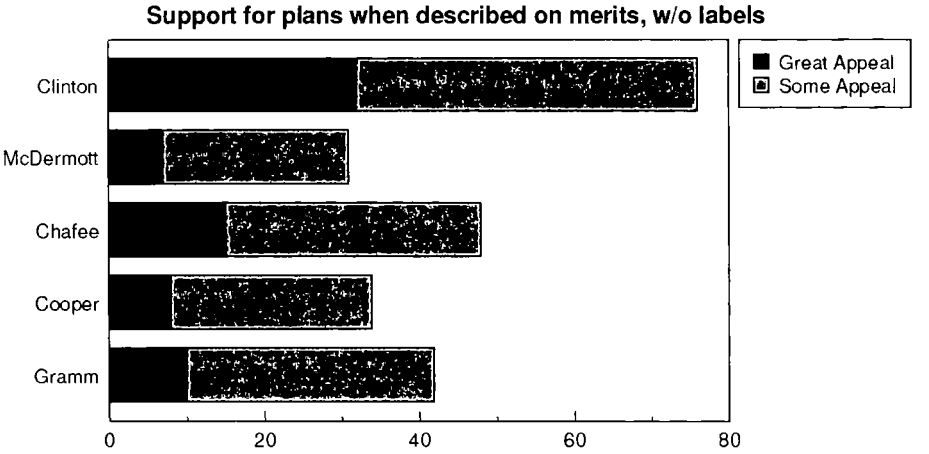
Middle-class voters know which approach works in their favor. Data from a leading Democratic pollster shows that a majority of Perot voters (54 to 35 percent) oppose health care reform with an individual mandate, while a majority favors it with an employer mandate (50 to 39 percent). Overall, voters support the employer mandate 54-35, and oppose the individual mandate 49-38.

IV. Message Strategy

We need to let our candidates know what they can do in practical, campaign oriented terms to advance this message. Particularly as the fall campaign takes shape, turning events to our advantage will require fewer new analyses and ed-board events, and more clear message guidelines. Our priorities should be clear:

1) Be aggressive on universality. Republicans who oppose universal coverage should be confronted on their stance directly. Their "I'll gladly consider insuring you Tuesday, for marginal reform today" approach, puts them on their weakest (and most broadly defining) ground -- they are the Party of the status quo. They are promoting a plan the sticks it to the middle class to protect their well financed interests. You cannot stay in the middle of the road by taking nothing but tiny steps -- incremental reform will continue the crisis. The degree of "populist" oratory needed may vary district to district -- but whether it is in a showdown midwest race or in a sunbelt satellite city, the face of the people left behind by incremental reform must be made vivid. **These are the faces of hard working people, like Jim Bryant, who the President mentioned in his radio address -- two jobs, 70 hours a week, and less security than a Medicaid recipient.**

2) Be aggressive on the employer mandate. (Listen to Bob Dole) Fight for health benefits guaranteed at work. Dole's analysis of our party advantage in this debate is all the more potent because this debate highlights the trends of both parties in terms of policies and values. It continues the Republican trend of the 80's -- sticking it to the middle-class -- the strategy that lost the 1992 election. It continues the Democratic trend of the 1990's -- rewarding work and helping the middle-class.



Source: NBC News.WSJ
People were read descriptions of plans which were not named and asked for how much the plans appealed to them

We win on the merits and on the politics. But we must remind members and candidates of the results of the March Wall Street Journal survey, presented in the article "Many Don't Realize It's Clinton Plan They Like." This poll -- which offered descriptions of the competing reform proposals without identifying them as Clinton, Chafee, etc. -- reported a 76% approval rating for Clinton's bill, 48% for Chafee's, 34% for Cooper's, 42% for Gramm's, and 31% for single-payer. In other words, support for a universal, employer mandate reform is still overwhelming. **The only way for Democrats to lose on health care is to shy away.**

December 21, 1994

MEMORANDUM FOR THE PRESIDENT

FROM: Carol Rasco and Robert Rubin

SUBJECT: Health Care/Budget Briefing

The purpose of this memorandum is to provide a description of the budget oriented health reform policy options that we plan to discuss with you at a meeting at 8:30 tomorrow morning. We will present: (1) the new deficit line that reflects changes to the Medicare/Medicaid baseline; (2) potential sources of financing for coverage expansions and/or deficit reduction; (3) possible options for coverage expansions; and (4) illustrative packages that pair financing sources with options for coverage expansion and deficit reduction.

THE NEW DEFICIT LINE

While OMB and HHS are currently discussing the magnitude of the reduction in the Medicare and Medicaid baseline that will be presented to you tomorrow, the changes will reduce the deficit by tens of billions of dollars over the five year budget period.

LIKELY SOURCES OF FINANCING

Background

Many health reform initiatives that were introduced in the last Congress by the Administration as well as by Members of Congress (e.g. Health Security Act, Mitchell's bill, Gephardt's bill, Dole's bill and Chafee's bill) were financed primarily by savings in Medicare and Medicaid.

In this Congress, the Republicans will be under pressure to use Medicare and Medicaid savings to pay for their commitments in the Contract with America. (This is why many in our base group and Hill health reform coalition are nervous that any cuts we put on the table will be used not for health investments, but to pay instead for the Republican Contract.)

The political and policy question is how best to achieve public sector cost containment through more efficient management of federal health programs while: (1) avoiding the charge that we are backing away from promises to preserve Medicare, (2) protecting the Medicare and Medicaid programs and their recipients from overly harsh cuts, and (3) preserving some of the savings for coverage expansion or program improvement.

Specific Sources of Funding on Options List

After long discussions about likely financing sources for health care, the NEC/DPC health policy working group has concluded that the current political environment limits the consideration of financing options to three (if unoriginal) sources: (1) Medicare, (2) Medicaid, and (3) tobacco taxes. Specific options include:

(1) Medicare

Medicare savings were, by far, the primary source of funding for all health care proposals in the last Congress. Even the Dole bill had $42 billion in Medicare savings over 5 years. While Medicare savings will likely remain a targeted source of funds for either deficit reduction or health care reform in the new political environment, the reality of our promises to cut Medicare only in the context of health care reform limit our flexibility on this issue.

The two major categories of Medicare savings proposals are "extenders" and "other savings proposals." Because of the extreme sensitivity to Medicare cuts and the potential for Hill Democrats to dispute our characterization of our Medicare savings, it is essential to define these categories as well as the areas of disagreement.

(a) **Medicare Extenders ($19 billion over 5 years).** We list $19 billion of Medicare savings as "extenders" in our budget tables. "Extenders" have been categorized in two ways by OMB (Alice Rivlin recently sent you a memo on this issue): (1) proposals that continue savings that would disappear from the Medicare spending baseline as a provision of current law sunsets; and (2) proposals that repeat a Medicare payment reduction policy that generated permanent savings, and in so doing achieve additional savings during the five-year budget window as well as in all future years.

Although the categories described above are reasonable, others have raised additional concerns about the use of extenders. For example, some within the White House argue that the close scrutiny of the media will make it virtually impossible for us to win a message argument that a Medicare extender is not an explicit "Medicare cut," particularly if the extender is not used in context of health reform.

Historically, policies are labeled extenders to avoid or limit any real or perceived pain associated with a usually non-controversial Medicare savings proposal. Thus, classification of an extender usually comes down to this: If provider groups or if the Hill take issue with the definition of extenders, the protective label of "extenders" quickly wears off. As you will recall, Senator Kennedy among others have red flagged this issue to you, suggesting that these relatively modest extenders could come back to haunt the Administration.

Although it varies, most Democratic policy experts on the Hill believe we have anywhere between $10 and $13.7 billion dollars in these traditional "extenders." The staff of the Ways and Means Committee would accept a definition that netted $13.7 billion; the Finance Committee would likely be closer to $10 billion. Republicans are not at all likely to be critical of anything we include in our extenders category; to them, the more the better.

(b) **Other Medicare Savings Proposals. ($39.3 Billion over 5 years).** HHS and OMB produced a list of additional Medicare savings proposals that they believe are defensible, particularly in the context of health care reform reinvestment. Of the $39.3 billion, HHS believes that about one-third of the changes ($12.5 billion) could be categorized as "desirable programmatic changes." In other words, if you are trying to run an efficient Medicare program, these cuts (such as competitively bidding out for lab services) should be implemented and would require statutory changes. OMB believes that there are a greater number of desirable programmatic changes.

The $39.3 billion in cuts come from providers, beneficiaries and state and local workers and their employers. The provider cuts account for over 50% of the total savings, the beneficiary cuts produce 31% of the savings, and the state and local workers/employers contribute the additional 19%. Of particular note, the hospitals are targeted for almost 80% of the total provider cuts and, if history is any judge, they will be certain to raise very loud objections. The beneficiaries are targeted with cuts that target the high income elderly and people who are recipients of home health services through a 10% copayment on services.

(2) Medicaid

A major source of possible funds for health care investments or deficit reduction would be reducing the growth in Medicaid. It is almost a certainty that even with the "dynamic scoring", the extremism of the Republic Contract will require a serious assault on Medicaid. The benefits of us affirmatively calling for savings from Medicaid are: 1) it is a serious source of savings that the Republicans will be calling for anyway; 2) the growth and perceived generosity of Medicaid may seem indefensible when raised to a high national profile, and if we do not propose savings, we may be seen as the defenders of the "status quo". This could actually make it harder for us to draw the line against draconian cuts.

The downside of taking savings from Medicaid are: (1) there is a chance that we would actually make it easier for Republicans to cut Medicaid in a way that hurts poor children and (2) on political grounds, if we propose Medicaid cuts, we may take away political heat that the Republicans would have to take. If our cuts were major, we could alienate our base, or be accused of taking steps that would reduce coverage -- working against our expanding coverage goal.

Clearly, the negatives would be blunted if the savings were moderate or if they were done in combination with some plan to expand coverage.

(a) **Freeze federal DSH payments at FY 1995 level ($17.4 billion over 5).** The savings policy that would appear least connected to benefit cuts and could be solidly justified on policy grounds is freezing current DSH payments. This proposal would save $17.4 billion. It would be more easily justified if we could argue that we were expanding coverage -- and thus uncompensated care. The main issue is going to be the reaction of Governors -- who will object. This $17.4 billion cut, however, will likely be far less than what Republicans will eventually be forced to propose.

(b) **Mandatory Managed Care for AFDC Populations (Current scoring: Costs $1 billion over 5 years; saves $4.7 over 10 years).** The concept of finding savings through managed care is an attractive one, because the claim can be made that savings are coming through the benefits of managed care and not a reduction in benefits. Furthermore, advocates of this proposal claim that beneficiaries would be better off if they came from a consistent provider, as they would in a managed plan. House Republicans (Kasich) make precisely this case when they advocate this proposal and claim $10 billion in savings over five years. Our preliminary analysis, however, shows that this proposal may actually cost $1 billion over five years (although it would save $4.7 billion over 10 years). Nonetheless, this proposal, together with a proposal under review to eliminate all waiver approval processes for states wanting to move ahead on managed care, could prove an attractive option to states.

One of the reasons why OMB has scored less savings for the mandatory managed care option is that they already assume in the baseline that 50% of recipients will eventually be in some form of managed care. As to whether Tennessee can serve as a model for reform, two caveats should be noted. First, the federal government let Tennessee lock-in its projected baseline growth at a maintenance of effort level -- and, given the recent significant reductions in the Medicaid baseline, they will be getting more federal aid, than they otherwise would have. Furthermore, Tennessee was better able than most states to make a transition to managed care because they had a strong managed care system already in place, and were in a position to reduce provider payments -- a situation that several states are not in.

(c) **Mandatory Managed Care - A Small Percentage 0.5%.**
One option would be to require states to place all Medicaid beneficiaries in managed care, with a slight reduction ($10 billion) in Medicaid over five years as an incentive for states to move quickly to more efficient care. If this is accomplished as a capped entitlement it would be scorable and could be seen as accepting Kasich's proposal -- while drawing the line on further cuts. Like the larger cap proposal, however, an argument against this approach might be that states which happen to have higher growth rates than others would be locked in a cap that disproportionately hurt them; this would be particularly troublesome to those states that did not have the capacity to establish managed care systems. Lastly, some would argue that this approach opens the door on capped entitlement for the gain of only a small amount of savings.

(d) **Total block grant-like cap on total program growth -- Medicaid population plus CPI; in other words, Medicaid current funding plus 8 percent ($43.6 billion over 5 years).** Under this proposal, states would assume full control of Medicaid. One idea would be to give states a capped entitlement that would grow at perhaps 8%. By doing so, we could save $43 billion if the cap started in FY 1997 -- or $70 billion if the 8% cap was in place by 1996.

The advantages of this strategy are the following: First, it is a significant source of funds. Second, it would be quite hard for Governors to oppose this proposal. To do so, they would have to claim that they could not manage Medicaid even with a 8-9% increase per year. Three, by giving this offer to the Governors, we give them "ownership" of the Medicaid baseline. They either accept it or they are the defenders of the status quo baseline.

The downsides of this approach, however, are considerable from a policy standpoint. The Governors will ask for considerable flexibility, which could lead to reductions in benefits or coverage -- though that decision would be the responsibility of the states. The real policy question, however, is whether this

proposal will blunt the Republicans' Medicaid assault (by calling their bluff) or whether it will make things worse. We must consider whether we end up taking the blame for a Medicaid cut that would have been proposed by the Republicans anyway and legitimizing the block grant approach.

COVERAGE OPTIONS

For the purpose of selecting options for coverage expansions, the NEC/DPC working group assumed that all options should be:

(1) **Modest.** Given the new political environment and the limitations on potential sources of funding, the options on the table are greatly scaled back from those on the table in the last Congress.

(2) **Middle-Class Oriented.** We focused on investments that either directly benefit the middle class or at least appeal to them politically.

(3) **Privately Administered.** To extent possible, the policies are administered privately to avoid the big government label.

The options for coverage expansions that best met these requirements were:

(a) **Kids Coverage. ($20-$25 billion over 5 years).** Children who have been uninsured for at least six months would be eligible for subsidies to purchase an insurance package similar to the Blue Cross/Blue Shield package offered to Federal employees. Since low-income children are already covered by Medicaid, the subsidies are targeted to higher income families: one option would reach children whose families have income up to 300% of poverty ($44,400 for a family of four) and the other would reach children up to 240% of poverty ($35,520 for a family of four).

(b) **Temporary Unemployed Coverage. ($16.6 billion over 5 years).** Individuals who are eligible for unemployment compensation and who are uninsured would be eligible to receive an insurance package similar to the Blue Cross package. The subsidy would be phased out at 250% of poverty ($37,000 for a family of four), but -- since eligibility would be determined on a monthly basis -- it is likely that Americans with annual incomes that are higher than $37,000 would be eligible.

(c) **Welfare to Work. ($6.2 billion over 5 years).** Consistent with the Administration's welfare reform initiative, people leaving welfare for work would be eligible to continue receiving Medicaid for two years. (Under current law, only one year of continued Medicaid is available.)

(d) **Self-Employed Tax Deduction -- 25%/100%. ($3.8-$7.5 billion over 5 years).** It is likely that any Republican or Democratic health reform bill will include an extension or expansion of the self-employed tax deduction. Treasury estimated a number of versions. We chose two to illustrate the policy. The first permanently extends the 25% deduction. The second phases-in the 100% deduction by 1998.

(e) **Long-Term Care Program. ($6.2 -$8.3 billion over 5 years).** If we consider significant Medicare cuts, you may want to reinvest some of the savings for the elderly. (The drug benefit is cost prohibitive.) This policy option is a moderate investment in state-administered home- and community-based long-term care program. (This investment is much less than what was contemplated in the Health Security Act).

(f) **Long-Term Care Tax Incentives. ($2.8 billion over 5 years).** These proposals include: (1) tax clarifications for long-term care private insurance policies and (2) a tax credit for personal assistance services for the disabled. If the Republicans do any significant Medicare cuts, they are likely to propose these incentives to illustrate their commitment to long-term care. (These policies were included in the Contract with America.)

(g) **Public Health Investment. ($1 billion over 5 years).** Since all Republican sponsored health reform initiatives that have invested in public health -- generally by expanding funding for community health centers -- we may want to propose a small investment in order to get credit for this type of proposal.

ILLUSTRATIVE EXAMPLES

During the presentation, you will have before you the attached tables on sources of financing and uses of funds to enable you and the other participants the opportunity to mix and match packages. However, to help focus the discussion, we also have prepared several package examples (e.g. one package includes rewarding workers through subsidies for the temporarily unemployed, extending Medicaid for individuals leaving welfare, and increasing and permanently extending the self-employed tax deduction). They are attached for your review.

CONCLUSION

We have limited this discussion to issues that must be resolved as part of the budget process. Subsequent memoranda will describe insurance reform and other issues that have been discussed by the working group.

POSSIBLE SOURCES OF FUNDING

Fiscal Years, Billions of Dollars

		1996	1997	1998	1999	2000	1996–2000
Medicare Savings Options							
Extensions of OBRA 1993 Baseline Savings	1/	-0.1	-0.4	-0.6	-3.1	-6.0	-10.2
Extensions of OBRA 1993 Savings Polices	1/	-1.0	-1.1	-1.5	-2.2	-2.8	-8.7
Additional OMB/HHS Medicare Savings and Receipt Proposals	1/	-2.9	-6.4	-7.0	-9.5	-11.7	-38.6
Medicaid Savings Options							
Managed Care AFDC/NC Kids, 5% One-tiem Reduction	2/	0.0	0.8	0.4	0.5	-0.7	1.0
Potential Republican Caps							
Total Program Growth (Medicaid Population + CPI)	3/		-3.3	-8.1	-13.1	-19.1	-43.6
Target DSH Offsets for Coverage Expansions							
Freeze Federal DSH Payments at FY 1995 Level	4/	-1.1	-2.2	-3.4	-4.6	-6.0	-17.4
Tobacco Tax							
$0.45 Phased Increase	5/	-1.9	-3.5	-4.9	-6.2	-6.6	-23.1
$0.75 Phased Increase		-8.2	-10.4	-10.3	-10.3	-10.2	-49.4
$1.00 Phased Increase		-10.2	-13.0	-12.9	-12.9	-12.8	-61.8
Medicare Savings from Health Care Reform Bills							
Dole	6/	-1.8	-3.5	-7.4	-12.2	-17.0	-41.9
Mainstream		-4.0	-8.2	-14.1	-21.1	-28.3	-75.7

NOTES

All estimates are preliminary. Totals may not add due to rounding. Baseline re-estimates for FY 1996 President's Budget will affect all savings estimates.

1/ Estimates from HCFA and OMB/HFB.

2/ Estimates from HCFA and OMB/HFB.

3/ Estimates from OMB/HFB.

4/ Estimates from OMB/HFB. A large downward re-estimation of the FY 1996 President's Budget baseline may significantly reduce estimates of DSH expenditures relative to the rest of the program.

5/ Estimates from Department of the Treasury.

6/ Estimates from HCFA.

DRAFT

Possible Uses of Funds

Fiscal Years, Billions of Dollars

	1995	1996	1997	1998	1999	2000	Total 1996-2000
OUTLAYS							
Kids' Program (1,2)							
Free to 133%, Phase-Out to 240%	0.0	0.0	3.8	5.2	5.4	5.6	20.0
Free to 133%, Phase-Out to 300%	0.0	0.0	4.7	6.5	6.8	7.1	25.1
Temporarily Unemployed (3)	0.0	0.0	3.0	4.2	4.5	4.9	16.6
Welfare to Work	0.0	0.0	1.4	1.5	1.6	1.7	6.2
Kids + Temporarily Unemployed (2,3)							
Free to 133%, Phase-Out to 240%	0.0	0.0	6.2	8.6	8.9	9.4	33.1
Free to 133%, Phase-Out to 300%	0.0	0.0	7.2	9.9	10.4	10.9	38.3
Kids + Temporarily Unemployed + Welfare to Work (2,3)							
Free to 133%, Phase-Out to 240%	0.0	0.0	7.2	9.7	10.1	10.7	37.7
Free to 133%, Phase-Out to 300%	0.0	0.0	8.2	11.0	11.6	12.2	42.9
Public Health/ FQHC	0.1	0.2	0.2	0.2	0.2	0.2	0.9
Long Term Care Program							
Expand Home & Community Based Services							
Low Option	0.0	0.0	1.5	1.5	1.6	1.6	6.2
High Option	0.0	0.0	0.0	1.8	2.9	3.6	8.3
REVENUES (4)							
Self-Employed Deduction (5)							
Extend 25% deduction	-0.6	-0.5	-0.6	-0.6	-0.7	-0.8	-3.8
100% deduction in 1995	-0.9	-2.2	-2.4	-2.7	-2.9	-3.2	-14.3
100% Deduction Phased In (6)	-0.5	-0.5	-0.9	-1.4	-2.0	-2.2	-7.5
Long Term Care							
Long-Term Care Insurance Tax Incentives	0.0	-0.2	-0.4	-0.5	-0.6	-0.7	-2.4
Personal Assistance Services Tax Credit	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.4

(1) Eligibility based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.
Note: Changing these estimates to an annual AGI saves approximately 20%.

(2) These estimates assume employer or employee dropping of insurance, which would result in increased tax revenues of approximately $2.2 billion between FY 1997 and FY 2000 and $5 8 billion between FY 1997 and FY 2005.

(3) Assumes that unemployment compensation is included in income determinations.

(4) These estimates are effects on revenue, not outlays. Thus, the negative numbers indicate decreases in revenue

(5) These totals include FY 1995 losses in revenue.

(6) Phase in. 25% in 1994, 25% in 1995, 50% in 1996, and 75% in 1997 and 100% in 1998.

FOR ILLUSTRATIVE PURPOSES ONLY

"KIDS FIRST"*

Initiatives

KIDS (UP TO 300% OF POVERTY)

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

$0.75 TOBACCO TAX

	1996–2000
Kids, up to 300% of poverty	28.1
Self-Employed phased-in to 100%	7.5
TOTAL COSTS:*	$35.6 billion
$0.75 Tobacco Tax	49.4
TOTAL FINANCING:*	$49.4 billion

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKERS"*

Initiatives

TEMPORARILY UNEMPLOYED

WELFARE TO WORK

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

$0.45 TOBACCO TAX

MEDICAID DSH

	1996-2000
Temporarily Unemployed	16.6
Self-Employed, phased-in to 100%	7.5
Welfare to Work	6.2
TOTAL COSTS:*	$30.3 billion
$0.45 Tobacco Tax	23.1
Medicaid DSH	17.4
TOTAL FINANCING:*	$30.5 billion

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"REWARDING WORKING FAMILIES"*

Initiatives

KIDS (UP TO 300% OF POVERTY)

TEMPORARILY UNEMPLOYED

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

Sources of Funds

MEDICAID DSH

PROVIDER MEDICARE SAVINGS

	1996-2000
Kids up to 300% of Poverty	25.1
Temporarily Unemployed	16.6
Self-Employed, phased to 100%	7.5
TOTAL COSTS:*	$49.2 billion
Medicaid DSH	17.4
Provider Medicare Savings	43.5
TOTAL FINANCING:*	$60.9 billion

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included

FOR ILLUSTRATIVE PURPOSES ONLY

"BUILDING THE FOUNDATION FOR UNIVERSAL COVERAGE"*

Initiatives

KIDS (UP TO 300% OF POVERTY)

TEMPORARILY UNEMPLOYED

WELFARE TO WORK

SELF EMPLOYED TAX DEDUCTION PHASED-IN TO 100%

LONG TERM CARE

PUBLIC HEALTH SERVICES

Sources of Funds

$0.75 TOBACCO TAX

MEDICAID DSH

PROVIDER MEDICARE SAVINGS

	1996–2000	
Kids up to 300% + Temporarily Unemployed + Welfare to Work (Combined)	42.9	
Self-Employed, phased-in to 100%	7.5	
Long Term Care	9.0	
Public Health Services	0.9	
TOTAL COSTS:*		$60.3 billion
$0.75 Tobacco Tax	49.4	
Medicaid DSH	17.4	
Provider Medicare Savings	43.5	
TOTAL FINANCING:*		$110.3 billion

* FOR DISCUSSION PURPOSES ONLY
Cost and Savings Estimates Not Prepared by OMB, HHS, Treasury
Revenue Estimates Not Prepared by Treasury
Interactive Effects of Proposals Not Included