HRC
HC CORR 95-I,J

PERSONAL
&
~~CONFIDENTIAL~~

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: 408 DATE: 12-5-13

PHOTOCOPY
PRESERVATION

R.L

M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris J.
RE: POTUS MEMO on Medicaid/Welfare Swap
cc: Melanne

February 13, 1995

When the Governors were in town, the President frequently referenced his interest in Senator Kassebaum's Medicaid/Welfare swap proposal. Carol asked me to draft the enclosed memo on the substance and Congressional status of this proposal. It is being sent to Staff Secretary this morning.

In short, the memo informs the President that the Kassebaum proposal does not appear to be going anywhere at this time. The primary reason is the same as it was when we discussed it over a month ago: It seems impossible to draft the proposal to meet the dual criteria of saving Federal dollars (the Republicans' number one priority with regard to Medicaid) while maintaining the States' support. Moreover, since Senator Kassebaum's Labor Committee has no jurisdiction over Medicaid and Senator Packwood (and his Finance Committee) apparently has no interest in the proposal, the likelihood of movement on this front seems dubious at best.

We will be forwarding the President two additional memos this week on the general status of Medicaid block grant/capping discussions as well as an update on the ERISA issue. (Apparently Governor Lowry gave an impassioned speech before the President on the importance of providing flexibility on the ERISA front.) I will of course make sure you get copies of these status (not recommendation) memos.

Lastly, today we are sending Senator Wofford the first big batch of articles he has requested. (I had a good conversation with him immediately after I talked with you.) I am enclosing a copy of that "Social Darwinism" article you referenced, as well as the responses to it. The Senator is coming to town soon and we are planning to get together to discuss how else we can be helpful.

Jen and I are going to set up a pre-map room meeting with you to brief you on the current set of numbers that go along with his policy priorities, as well as to bring you up-to-date on everything else we are doing (reg reform, etc.) Talk to you soon.

f

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.

January 27, 1995

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: CHRIS JENNINGS
SUBJECT: Health Care/Budget Briefing
cc: Melanne V.

The following information was prepared as back-up for an oral briefing for the President on the implications of a Medicaid block grant or cap. Because of time constraints, the briefing was cancelled

Since the Medicaid subject is not likely to be raised at NGA this weekend, Carol decided it would not be wise to overwhelm him with paper at this time. I thought, however, that you would be interested in the enclosed. The Medicaid capping issue will be at the heart of the upcoming budget discussion and I believe this information may be quite helpful to you decide how we can best evaluate how to respond to the inevitable Republican initiatives in this area.

Attached you will find a 2-page document that provides a brief summary of the budget and political status of this proposal and an advantage/disadvantage summary. Behind this document is a much more detailed background memo which illustrates the serious implications of the block grant/capping idea and the reason why many of the Democratic Governors (and particularly the advocates) are nervous.

On an unrelated matter, I want you to know that I have started meeting with Drug Company reps on the regulatory review issue. Just last night, I had a productive discussion with Merck and Bill Schultz (the new FDA Deputy to David Kessler and a friend of mine). They had a number of ideas that sounded quite reasonable to both Bill and myself. Their particular gripe is with the section of FDA that reviews biotech drugs and their slow and unresponsive review process.

We are going to meet with at least two or three others companies (I will include American Home Products on that list) in the very near future to add to our now growing list of regulatory changes that will please the industry and that can be implemented without compromising safety. I would be happy to go over them if you have any desire to do so.

Lastly, I talked with Harkin's staff. They are sending me over everything they have been doing in their oversight work on HCFA. Their staff is very interested in working with us. I'll talk to you the moment I have some follow-up that comes close to being worthwhile.

MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

- **Congressional Republicans need hundreds of billions of dollars** to finance tax cut and deficit reduction pledges.

- **Medicaid is seen as major cash cow** because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

- **Speaker Gingrich discussing a 5% cap on Medicaid program growth,** which would yield $130 billion ($193 billion using CBO numbers) in Federal savings through 2002 and $375 billion ($500 billion using CBO) in Federal savings through 2005.

- **Republican Governors either supportive or staying quiet for now** because they philosophically support. Moderate Republicans from states with high growth rates are evaluating just how they could live with these reductions in Federal dollars.

- **Governor Dean sending signals he might be open to a cap, although most Democratic Governors appear to be extremely nervous about it.** Governor Chiles, for example, is very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of the Democrats, however, is the size of potential reductions in Federal support.

- **Not on NGA agenda for this weekend, although DGA meeting may discuss** to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget disucssions that may be raised at NGA meeting.

- **Any block grant deal on welfare reform will serve as precedence** and political cover for Republicans who need the Medicaid money.

- **Weak but vocal advocates are opposed and scared:** many of these are considered our traditional Democratic base.

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
    - Leaves States at risk during recessions.
    - Places States at risk for cost of aging population.
    - Makes States less able to expand coverage.
    - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
    - Increases number of uninsured.
    - Exacerbates cost shifting.

MEDICAID CAP/BLOCK GRANT BACKROUND INFORMATION

PURPOSE:

To review the implications for states and for coverage under the Medicaid program of NGA and likely Republican proposals to cap Medicaid spending.

BACKGROUND:

Although not on the formal agenda, it is possible that the topic of capping the Medicaid program may be raised at the upcoming meeting with the Governors. (In all likelihood, if it is raised, it would come up in the context of the balanced budget amendment discussion.)

NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. The NGA staff recognize this "choice" is a political and not a practical policy response to a desire by many Republican Governors to assure that a Medicaid cap/block grant proposal is on the table for consideration. Democratic Governors, like Governor Chiles, have made the point that such a choice would not work in the Congress or in the budget world since states could choose what is best for them financially; as a result, the primary incentive for enacting a cap -- saving Federal dollars -- would likely not be achieved in any significant way.

A number of Governors have been discussing a Medicaid block grant with the Republicans in Congress. Both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about $375 billion over ten years (over $500 billion under the CBO baseline). In recent days, however, Governor Dean and his office have made clear he has made no deal and does have concerns.

It is worth pointing out that a 5% cap means that the states (in aggregate) must reduce total program costs by the $375 billion before they can begin reducing their own spending levels. While there are some low growth with fairly large base levels who could save money in the short-term, it is unlikely they could do so over the long term without cut-backs in services or programs.

Obviously, the Governors are interested in block grants because they free states from federal requirements and oversight. Many Governors appear to be willing to consider reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, if the Administration can come up with proposals that are responsive to the flexibility requests of the States that do not include Federal caps, such an approach could well be more attractive. (Such approaches are discussed at end of the memo).

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. The following outlines these concerns.

Converting from Individual Entitlement to a Block Grant Raises State Concerns:

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.

- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by $130 billion between 1996 and 2002, and by about $375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over $500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rises to 35% (40% under CBO baseline). This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from some Republican Governors (and particularly Republicans from the Hill) that large reductions in the growth of federal payments are acceptable because managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings , the savings are not nearly enough to compensate for the very large reductions being discussed with the block grant proposals.

Given the rapid expansion of managed care that already is occurring in states, a significant portion of the potential savings are already being realized. Also, managed care is applied almost exclusively to the nonelderly, nondisabled population, who account for only about one third of Medicaid expenditures. Preliminary OMB estimates show that if all nondisabled, nonelderly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. However, some states may use managed care as a mechanism simply to make large cuts in provider payments. In reality, this is a cost shifting strategy rather than cost containment.

Under the current baseline, Medicaid enrollment is projected to grow at about 4% annually. Medicaid per capita spending actually is projected to grow at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline would appear to assume either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program (including cuts in eligibility) are acceptable. While some states may be able to adapt to such a large reduction in federal support for a few years, most probably cannot. Over a longer period, few states could respond to this level of reduction without significant program cuts.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks. Although a few states might increase spending in response to federal payment reductions, most would likely reduce eligibility, benefits or payment levels.

The following scenarios assume that states maintain (or in the first case, increase) the level of spending projected in the baseline. The state responses shown below merely offset the reductions in federal spending -- they do not produce any savings to states. If states were to reduce their spending below the projected levels in order to achieve savings in their own budgets, additional reductions would be needed.

- **Increase State Medicaid Spending**
  If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;
  - In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

  If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on average by 13.7%. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

  - In 1997, a 6% reduction in hospital payments would be needed;
  - In 2002, a 22.9% reduction in hospital payments would be needed;;
  - In 2005, a 32.8% reduction in hospital payments would be needed.

  These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

  States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

  States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. However, given the magnitude of the reduction in federal payments, even when states spread the cuts over several of these categories, the reductions in each category would still be quite large. For example, a 5% cap would reduce federal payments to states in 2005 by about $66.3 billion below baseline projections. If a state chose not to increase spending and were to allocate their portion of this reduction roughly equally to reductions in provider payments, benefits and eligibility, it could achieve approximately the necessary savings through:

- Reducing provider payments by 12 to 13%.
- Eliminating coverage for prescription drugs and EPSDT, and
- Eliminating coverage for noncash children and qualified and special Medicare beneficiaries (QMBs).

And, because federal payments would continue to decline, further reductions would be needed in each future year. Other options are, of course, possible. Chart 3 gives you a partial menu of how much the elimination of particular populations and services (on a nantional level) would save. Some would argue that states would be more likely to choose eliminate AFDC adults rather than noncash kids and QMBs.

Even under less extreme proposals, federal payment reductions can be significant over time. For example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- $ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSION

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put those served by Medicaid at some risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

  During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting**. One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

Alternative To Capping Federal Payments that States May Find Attractive.

The obvious question is how to be responsive to States' legitimate need and desire for more flexibility without imposing significant reductions in Federal support. We have reviewed the NGA's health policy position paper's recommendations and have conducted our own internal analyis, which included discussions with OMB and HHS, and have come up with some interesting possibilities -- there may be even more -- that Iwe believe would be welcomed by the Governors. (Since Medicaid is not scheduled to come up before the NGA meetings, we probably should discuss when would be the most strategic and opportune time to begin discussions with the Governors on this issue.)

Specific and preliminary options to Medicaid cap now include:

- **Agree to NGA's request to eliminate the 1915(b) waiver approval process for states implementing managed care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Consistent with NGA request, agree to eliminate the waiver approval process for states implementing home and community-based care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.

- **Agree to NGA's request to establish safe harbors under the Boren amendment for state hospital payments.**

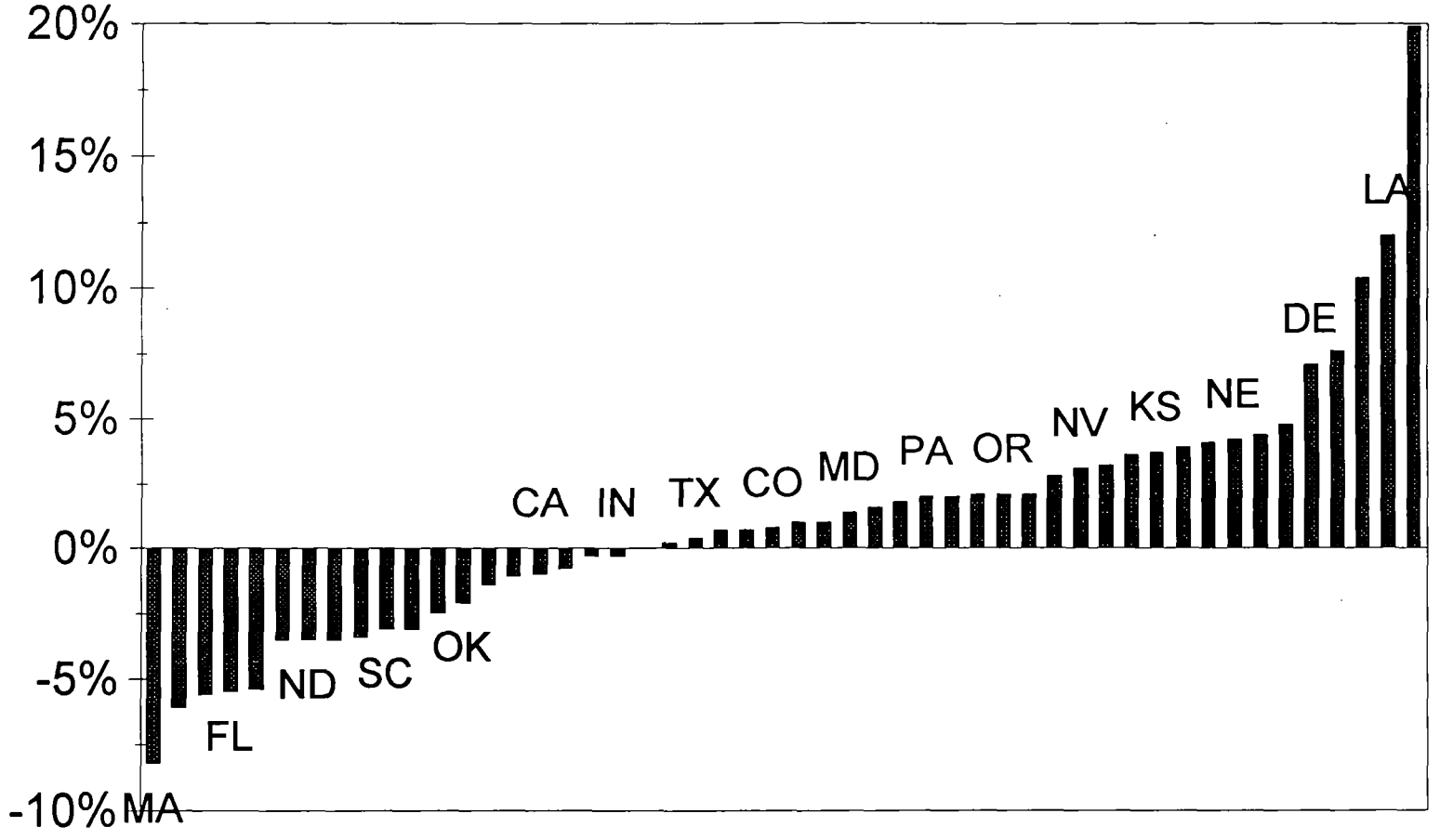
- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA's request for substantial modifications to the PASARR provisions under nursing home reform**. For example, agree that the annual resident review should be repealed.

- **Agree to NGA's request for the development of more demonstration programs that investigate the integration acute and long-term care services.**

Variation in State Medicaid Growth

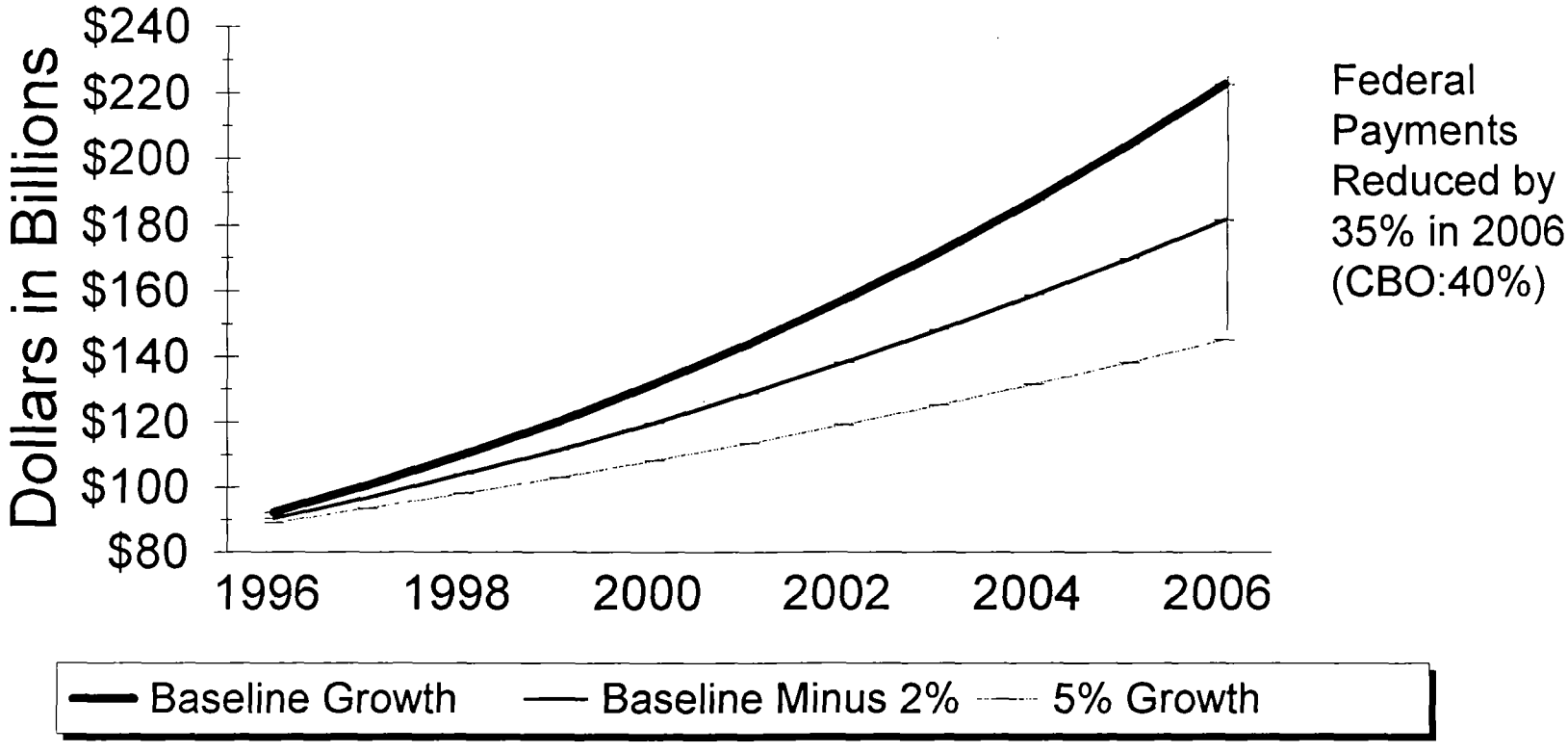
Difference from Average, 1990-1993



* Note: Average annual per capita growth rates, excluding Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Federal Medicaid Payments 1996-2006

Baseline & Capped Federal Payments



This wedge Illustrates the cumulative effect of capped expenditures. Over time, the size of the federal payment reduction grows.

Potential Savings From Eliminating Selected Services or Recipient Categories

	1997 $ in billions	2005 $ in billions
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	1.9	3.9
Drugs	9.3	17.6
EPSDT	1.1	4.0
Home Health & Hospice	2.5	5.8
Medicare Premiums & Cost Sharing	4.7	10.8
Personal Care Services	3.8	7.1
Cost of Services for Recipients		
AFDC Adults	12.0	24.4
NonCash Kids (OBRA Expansion)	4.3	9.5
QMBs/SLMBs (1)	4.7	10.8
Medically Needy	22.1	38.8

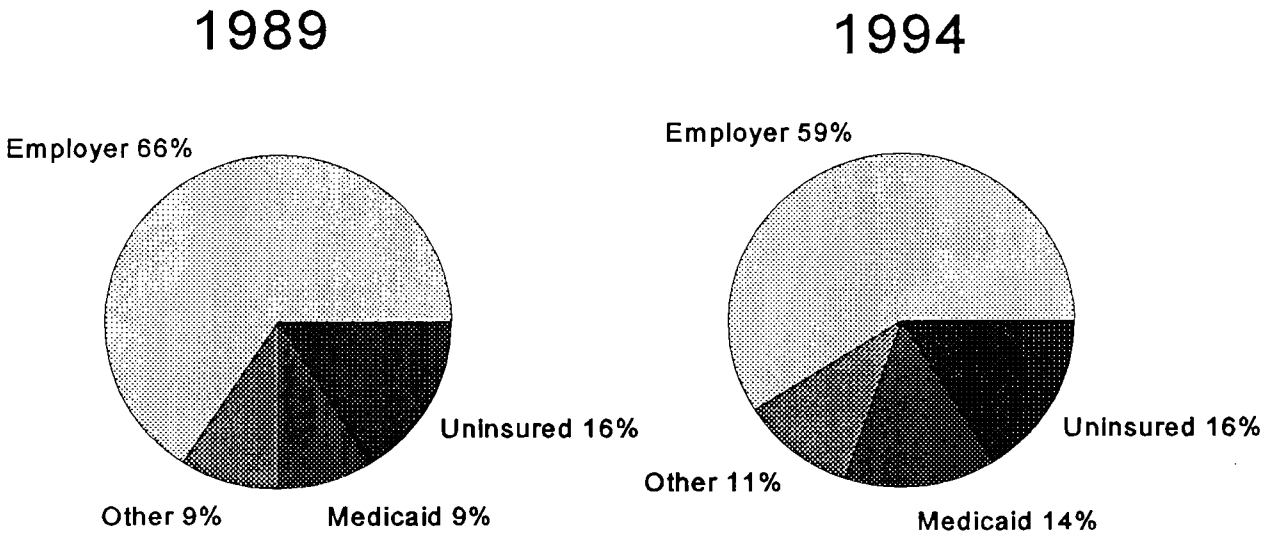
- The 1997 reductions will not be sufficient over time, because the size of the federal reduction would increase each year. For example, while eliminating dental benefits could achieve 28% of the required savings in 1997, in 2005 this service reduction would produce only 6% of the necessary savings.

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states, and overstate savings, because of interactions in the expenditure categories.

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.

Mc Fil

February 3, 1995

MEMORANDUM TO: MAP GROUP PARTICIPANTS

FROM: CHRIS JENNINGS
JENNIFER KLEIN

SUBJECT: Health Care Qs & As

Attached please find the most recent health care questions and answers. Also attached is a one-page final draft of the Medicare baseline document prepared by the Department of Health and Human Services. Lastly, you will find an excerpt from the President's December letter to the Congressional Leadership as well excerpts from his State of the Union speech relating to health care.

We hope that you will find this information useful for the budget roll out as well as to help prepare for upcoming testimony and other events on and off the Hill.

Please feel free to contact Chris (6-5560) or Jennifer (6-2599) if you would like any additional information.

Health Care Questions and Answers - February 3, 1995

HEALTH REFORM

Q. Why isn't health care in the budget? Doesn't this illustrate that the President is no longer committed to health reform?

In the President's State of the Union and in his December letter to the Congressional Leadership, the President strongly reiterated his fervent commitment to reform the nation's health care system. He indicated his willingness to tackle this task in a step by step manner, outlined his broad vision of what he felt could reasonably be achieved in this Congress, and stressed his desire to do so on a bipartisan basis.

Incorporating a specific health reform initiative within the budget would not enable the Congress to work jointly with the President to respond to the health care problems that confront this nation.

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.

The President believes Congress can and should:

- Reform the insurance market.
- 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.

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. What will the President do if the Congress does not act on health reform?

Because their constituents are demanding action, the President is confident that the Congress will be responsive. Republicans and Democrats have already begun to respond to the President's challenge though numerous statements and the introduction of bills. The President looks forward to reviewing their specific ideas and working together to address the health care needs of Americans.

Q. Will the President support any initiative labeled health reform?

The President has said that he will evaluate any health reform proposal in the context of whether it takes constructive steps forward toward his ultimate goal of providing affordable health insurance to every American. Using deep and destructive Medicare cuts as the cash cow for tax cuts is NOT health reform. He will not support new Medicare cuts outside the context of meaningful and needed health reform.

MEDICARE

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. The President opposes Medicare cuts to finance tax cuts. Is the President willing to support Medicare cuts for deficit reduction -- if it is in the context of "reform?"

The President has always said that an important component and outgrowth of meaningful health reform is long-term deficit reduction. Again, however, he opposes using Medicare as a cash cow for tax cuts or deficit reduction outside the context of reform.

Q. What is the harm of cutting the Medicare program outside the context of health care reform?

In order to achieve a balanced budget by 2002 (as called for in the balanced budget amendment), some in Congress are talking about capping growth of Federal programs at 5% or 3%. A 5% cap would require the Congress to come up with over $300 billion in Medicare cuts; a 3% cap would require over $400 billion in Medicare cuts over the 7 year budget window.

Cuts of this magnitude would simply mean that public programs would cost-shift onto the private sector -- particularly to small businesses that have been burdened by the highest insurance premiums for years. Cost-shifting could also result in unfunded mandates to the states, as public hospitals bear the burden of reduced Medicare payments. Lastly, cuts of this size might make health care providers less willing to see Medicare beneficiaries.

Q. What is your response to Newt Gingrich's and Bob Dole's comments about Medicare and their suggestion that the program needs to be restructured? What is the Administration's position on managed care?

We have always welcomed ideas that strengthen the Medicare program and provide more choices to beneficiaries. In fact, under our watch, the Medicare HMO (managed care) program has expanded at unprecedented rates. We think we can build on this success and, working with the Congress, further improve this part of Medicare with additional reforms.

We therefore look forward to reviewing any specific ideas the Speaker has. We sincerely hope, however, that terms like "restructuring" and "managed care" are not simply code words for deep and destructive Medicare cuts.

HEALTH CARE BASELINE

Q. The good news in your deficit reduction line seems to come less from new policies and more from just lowering your estimates of the Medicare and Medicaid baselines. The Administration has in the past bragged about using conservative numbers but now your health care estimates are so much more optimistic than CBO's. How can you call this conservative?

We believe that our numbers are conservative. Health care costs are slowing, the economy keeps improving, the Administration has increased efficiency in both Medicare and Medicare. The HCFA actuaries -- career staffers at HHS who estimate the baseline every year -- just took these new developments into account when doing

their baseline this winter. Their numbers are as conservative as they have always been.

Our difference with CBO over 5 years is only 4 percent of total spending for Medicare and Medicaid -- a pretty small variation when you're estimating the costs of programs that total $1.75 trillion over the 5 year budget window. It is not uncommon for the Administration and CBO to differ by about this much. In fact, the size of this year's difference is about average.

Q. **How can you explain why the baseline has come down so much? Doesn't this contradict the Administration's past statements that Federal health care costs could only come down through comprehensive health care reform?**

There are a number of reasons why the Medicare and Medicaid baselines continue to come down: first, the President's deficit reduction package and economic program have improved the economy and brought down inflation; second, there have been programmatic changes to both Medicare and Medicaid that have improved efficiency and brought down costs in the programs; and third, new data and empirical evidence have given the HCFA actuaries -- the career staffers at HHS who estimate the baseline every year -- a better picture of what's going on out there. As better information shows that Medicare and Medicaid costs are rising more slowly than was previously projected, the HCFA actuaries reflect these changes in their baseline estimates.

Growth in these programs is still too high. As we have stated in the past, cuts in the Medicare and Medicaid programs need to take place in the context of comprehensive health care reform in order to avoid cost-shifting to the private sector, particularly to small businesses. That is why the Administration remains committed to expanding coverage -- and has asked this Congress to take the first steps by covering children and helping workers who lose their jobs keep their health insurance.

MEDICARE AND MEDICAID SPENDING SLOWS UNDER THE CLINTON ADMINISTRATION

The Administration expects future costs of the Medicare and Medicaid programs to be significantly lower than projected just two years ago. The new price tag for these programs will cost $212 billion less for the years 1994 to 1998. The anticipated annual rate of growth for the two health programs combined fell from 12.7 percent a year to 9.5 percent, the first time this combined rate will drop below double digits since 1988.

Under the Clinton Administration, projected spending has dropped by $79 billion for Medicare and $133 billion for Medicaid. In fact, the growth rate for Medicaid spending is expected to slow from 13.9 percent per year to 8.7 percent. The anticipated growth rate in Medicare is reduced from an 11.9 percent rate of growth on average to 9.9 percent for the years 1994 to 1998.

The President's successful economic program, which curbed both general and health care inflation, provided the foundation for the improved future spending path.

- In the President's FY 96 Budget, announced today, the main contribution to lower Medicare spending is slower growth in Hospital Insurance (Part A) spending, driven primarily by a decline in forecasted hospital cost inflation.

- Lower estimates for Medicaid spending stem from the successful implementation of a 1991 law proposed by President Bush to limit States' use of inappropriate financing mechanisms (the bipartisan Provider Taxes and Donation Law) as well as from lower actual State spending, improved economic conditions, and fewer Supplemental Security Income (SSI) recipients.

In addition, the Clinton Administration has improved management of the Medicare and Medicaid programs by redoubling efforts to fight fraud and abuse, replacing contractors who performed poorly in accurately paying Medicare bills, promoting state flexibility through the Medicaid waiver program, and offering increased choice for Medicare beneficiaries. These endeavors will continue to help improve program efficiency and improve services to beneficiaries.

While we are encouraged by the slowdown in Medicare and Medicaid growth rates, health care costs for both private and public payers alike are still growing too quickly. We intend to work with the Congress in the years ahead to find ways that continue to strengthen the programs for beneficiaries by improving both service and cost-effectiveness.

PRESIDENT'S STATEMENTS ON HEALTH CARE

Excerpt from December 27, 1994, Letter to the Congressional Leadership

"While we could not achieve broad-based agreement on a health reform initiative last year, there can be little disagreement that **we still face the enormous problems of increasing health care costs and decreasing coverage. We need to confront these problems on a bipartisan basis and address the insecurities that too many Americans have about their health care.** I am writing to reiterate my strong desire to work with you in this regard.

I remain firmly committed to providing insurance coverage for every American and containing health care costs for families, businesses, and Federal, State, and local governments. **In the upcoming session of Congress, we can and should work together to take the first steps toward achieving these goals. We can pass legislation that includes measures to address the unfairness in the insurance market, make coverage more affordable for working families and children, assure quality and efficiency in the Medicare and Medicaid programs, and reduce the long-term Federal deficit."**

Excerpts from the State of the Union

"Now, my budget cuts a lot. But it protects education, veterans, Social Security and Medicare and I hope you will do the same thing. You should, and I hope you will."

"My budget pays for the Middle Class Bill of Rights without any cuts in Medicare. And I will oppose any attempts to pay for tax cuts with Medicare cuts. That's not the right thing to do."

Now, I still believe that our country has got to move toward providing health security for every American family. But I know that last year, as the evidence indicates, we bit off more than we could chew. So I'm asking you that we work together. **Let's do it step by step. Let's do whatever we have to do to get something done. Let's at least pass meaningful insurance reform so that no American risks losing coverage for facing skyrocketing prices. That nobody loses their coverage because they face high prices or unavailable insurance, when they change jobs and lose a job, or a family member gets sick.**

We ought to make sure that self-employed people in small businesses can buy insurance at more affordable rates through voluntary purchasing pools. We ought to help families provide long-term care for a sick parent or a disabled child. We can work to help workers who lose their jobs at least keep their health insurance coverage for a year while they look for work. And we can find a way -- it may take some time, but we can find a way -- to make sure that our children have health care."

H - CONGRESS P

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