HEALTH CARE: BUDGET STRATEGY

MEDICARE

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
Medical Savings Accounts (MSAs)	House Republicans will include program-wide MSA option, similar to what was included in the BBA. Rules governing MSA are currently unclear -- as is CBO scoring. House Dems will likely try to strike/alter provision.	Since Senate Finance may not have MSAs, taking an immediate position on a demo may be premature. NEC/DPC policy process reviewing acceptable demonstration options. Options will be available for Principal's sign-off as early as June 6th. In the interim, POTUS should raise major concerns with Members.	Eliminate the provision altogether or, if necessary to finalize an agreement on Medicare, develop an acceptable demo.
Medical Malpractice	Republicans will include a BBA-like provision in House mark-up. It will likely cap punitive and non-economic damages at $250,000.	No policy development options underway or likely necessary, since Senate will not include in their version and will strongly oppose in conference.	Eliminate provision through a strategy designed to ensure that conferees recede to Senate.
Academic Health Center "Carve-Out"	The House Mark will not include our proposal to "carve out" the portion of managed care payments being credited to plans for their costs of contracting out with teaching and DSH facilities.	Not many policy options other than to either keep or eliminate the "carve-out." The Senate Mark will likely retain the President's provision. (High priority for Moynihan.) POTUS may want to stress as priority with Members.	Work to get conferees to recede to likely Senate provision.
Home Health Reallocation	House and Senate Republicans (with exception of Commerce Committee) will change our policy to phase in not only the premium increase, but also the actual transfer of home health expenditures. Change will reduce the life of the Trust Fund by about 2 years and undermine our policy rationale for the transfer.	Should continue to argue for our original policy and clear (through OMB and normal NEC/DPC process) strong position for HHS to take during Mark-Ups. NOTE: It certainly could be argued that Republican position is explicitly inconsistent with balanced budget agreement addendum.	Strongly push the Republicans to accept our current policy. If unsuccessful, use this as leverage for other issues. (The Republican approach will still probably extend the life of the trust fund until at least 2007).

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
Prudent Purchasing Reforms	Republicans (and probably a number of Democrats) will likely reject the President's proposals to enhance Administration's ability to utilize market-oriented purchasing techniques (e.g., competitive bidding).	These provisions are a high priority to OMB, HHS, and have Administration-wide support. They illustrate our commitment to business-oriented mechanisms to purchase medical devices, lab services, etc. HHS should be empowered to continue to advocate for them, even though it will be very difficult to get Congress to respond. The meeting with the Members might be a good opportunity for the POTUS to push this initiative.	Although will be difficult to achieve, attempt to integrate all or most of the Administration's prudent purchasing provisions in the final bill. In so doing, secure "elite" validation that the Administration is committed to true structural reforms.
Medicare Commission	Republicans or Democrats may include language in the Mark or in subsequent amendments for the establishment of a bipartisan Commission to address long-term Medicare financing challenges.	NEC process that had been discussing these issues is being reconvened by Gene to consider options for both Medicare and Social Security, as well as how best to respond to Hill pressures.	Get out in front of the issue so that the President -- not the Congress -- has greater influence over the structure of any Commission. Ensure nothing gets passed on this issue that we cannot fully support. Preferably work out an agreement on the handling of this issue outside of the budget agreement.

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MEDICAID

Issues in Disagreement	Mark-Up Status	Policy Options	Final Policy Goal
Disproportion-ate Share Hospital (DSH) Payment Reductions	$15 billion in scorable DSH savings (roughly the amount we assumed) will require $20 billion in dedicated cuts b/c of CBO 25% leakage assumption. Committees -- responding to heavy lobbying from the Governors and hospitals -- are reducing DSH cut to about $9 billion by downsizing (non-kid) investments (see below) and increasing savings from flexibility provisions. Reportedly, allocation of remaining savings hits high DSH states quite hard.	NEC/DPC process reviewing all possible ways to reduce DSH cut without reducing any investments. This means we are focusing on additional flexibility options that CBO would score. Beyond the flexibility options we already assumed, our only other real option is to save $5 billion by allowing states to use Medicaid rates (rather than Medicare rates) for dual eligibles. Problems include (1) Negative impacts on providers (and possibly beneficiaries) AND (2) A $4.4 billion offset from Medicare.	Point out that the states won a big victory with the elimination of the per capita cap and push for all or most of the $15-16 billion in DSH savings assumed in the budget agreement. Link these savings to need for better DSH targeting (outlined below) and the need to protect invest-ments (also outlined below.)
DSH Targeting	Our rationale for relatively significant DSH savings was linked directly to our ability to better target the state spending of these dollars on those institutions that really did disproportionately serve the uninsured. Last night, we learned that the House Commerce Mark may have a modest targeting provision. (This is news, since we thought they would have none as a result of opposition from the Governors.)	HHS, OMB, DPC and NEC will review House targeting language as soon as available to determine adequacy. (Their provisions will likely be insufficient to respond to the concerns raised by the public hospitals, the children's hospitals, and the unions). We are in the process of developing alternatives. More likely, though, we will build off whatever the Hill starts with -- this is a major provider/union/state issue that is extremely complicated and formula driven.	To achieve the best possible agreement on targeting, most likely by pursuing a conference strategy. Final policy will likely not emerge until the very end.

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Medicaid investments	In order to reduce the size of the DSH cut, the House Republicans are reportedly planning on dropping **$2.7 billion** in Medicaid investments for: -- D.C.($900 million), -- Puerto Rico ($300 million), and -- Low income Medicare beneficiary protections ($1.5 billion) that were called for in the budget agreement. So far, the Republicans have not reduced the dollars allocated for children's health (or other "below the line investments") to take care of their DSH problem. The House Republicans are planning to show the Governors budget tables that illustrate that with a new block granted children's program (with virtually no strings attached) they will have the same or more resources than they would have had with their DSH payments.	If the weekend reports are true, the House Republican Medicaid budget would be in clear violation of the budget agreement. Until the NEC/DPC process can meet to review the implications of these provisions (not until later this week), we of course would maintain our budget agreement position. The question is what, if anything, should the President say in his meeting with the Members on this subject? It is worth noting that both the Democratic and Republican staff on the Commerce Committee are asking us to consider using Medicare savings to offset the $1.5 billion low income beneficiary protections cost. (This illustrates how difficult everyone is finding it to get savings from DSH.) If the Republicans include an MSA in their Mark-Up, one idea might be to use the savings from the elimination of the MSA to pay for this investment.	Protect most if not all the investments we won in the balanced budget agreement discussions.

HEALTH CARE: BUDGET STRATEGY

CHILDREN'S HEALTH

Issues in Disagreement	Mark-Up Status	Policy Options and Process	Final Policy Goal
Tax Deductions as Use for Some of the $16 Billion Investment for Children	Despite the fact that CBO and other outside, independent validators have concluded that tax incentives are clearly not the most efficient policy option to insure children, the House Ways and Means Committee (Mr. Thomas) and the Finance Subcommittee on Health Chairman (Senator Gramm) seem intent on allocating between $3-6 billion on tax deductions (including MSAs, under the Gramm approach) aimed at providing insurance for children.	The Thomas/Gramm approach is inconsistent with the budget agreement unless we explicitly alter our current NEC/DPC-cleared position against it. Our first priority is to ensure that we push the Committees back to the Medicaid and/or Capped-Mandatory approach that was outlined in the budget agreement. Tuesday's meeting would be a good time for the POTUS to say that tax approaches should be taken from the tax cut allotment (if used at all), rather than from the $16 billion set-aside for kids.	Limit investment to either/or Medicaid or a new capped mandatory program, unless the funding for the tax incentive alternatives does not come from the $16 billion children's health investment (and the alternatives are policy defensible).
Allocation of Investment and Optimal Children's Health Policy	Because Mark-Up is not until next week, we do not know exactly how the Committees of jurisdiction will allocate their dollars between Medicaid and a new grant program. It seems clear that Finance Committee will spend much more on Medicaid than on grants, and the Commerce Committee will do just the opposite. It also looks likely that the Finance Committee will place much greater accountability on the Governors to assure that dollars are used to pay for uninsured children (and not current state liabilities) and that they are spent on a "meaningful" benefit.	The NEC/DPC process is developing policy options for consideration by the Principals. We believe a policy that expands Medicaid to a certain, relatively low percentage of poverty, supplemented by a new capped grant program for children in higher incomes, seems to represent the most advisable policy. The NEC/DPC Deputy's policy team is reviewing options on targeting, state accountability, protection against state or employer substitution, benefits, etc. that could be ready for the Principals early next week.	To pass legislation that most efficiently and successfully provides a "meaningful" insurance benefit to the largest number of uninsured children.