Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. memo	Maria Echaveste to Distribution re: First Lady's Box (3 pages)	01/12/1998	b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Melanne Verveer
OA/Box Number: 20023

FOLDER TITLE:
Budget '99 [2]

2013-0534-S
rc1690

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Document No. _____

WHITE HOUSE STAFFING MEMORANDUM

Date: 1/12 ACTION / CONCURRENCE / COMMENT DUE BY: ASAP

Subject: First Lady's Box

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☑	☐	NASH	☐	☐
PODESTA	☑	☐	REED	☐	☐
ECHAVESTE	☐	☑	RUFF	☐	☐
RICCHETTI	☑	☐	SOSNIK	☑	☐
LEW	☐	☐	SPERLING	☐	☐
BEGALA	☑	☐	STEIN	☑	☐
BERGER	☐	☐	STERN	☐	☐
BLUMENTHAL	☐	☐	STREETT	☐	☐
FRAMPTON	☐	☐	TRAMONTANO	☑	☐
IBARRA	☐	☐	VERVEER →	☑	☐
KLAIN	☐	☐	WALDMAN	☑	☐
LANE	☐	☐	YELLEN	☐	☐
LEWIS	☑	☐	_____	☐	☐
LINDSEY	☐	☐	_____	☐	☐
LOCKHART	☐	☐	_____	☐	☐
MARSHALL	☐	☐	_____	☐	☐
MOORE	☐	☐			

REMARKS:

Please advise - Comments to Maria or Clara Shin

RESPONSE:

Withdrawal/Redaction Marker
Clinton Library

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501-0800

Marsha Scott
01/15/99 12:40:55 PM

Record Type: Record

To: Shirley S. Sagawa/WHO/EOP

cc:
Subject: NEH building

Please find out from Melanne if she has spoken to Bill Ferris at NEH about GSA wanting them to move in 2001. I know that she has spoken to Bill Ivey of NEA and he is willing to move. Bill Ferris feels VERY strongly about not moving and, instead, raising the money to preserve the building. There are all sorts of implications and issues involved with whatever is done. Dave Barram, Administrator of GSA, has spoken with Bill Ferris but wants to know where Melanne is on this issue and especially whether she has conveyed her sentiments to Bill Ferris. Please call me at 62109 or get back to me today if you can so I can get back to Dave. Dave and I plan to meet with Bill next week to try and get this settled in a way that everyone is comfortable.

re: SOTU —

I think the ACorps section is too self-serving — "I fought to create AmeriCorps ... It's the thing I am most proud of ..."

I challenge Congress to support ...

I think it should acknowledge bi-partisan support that created it, then as it was + still is.

ACorps is about bringing people together to solve community problems — shouldn't be divisive

Clinton wins polling

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D. C. 20201

FACSIMILE

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

DATE: 1/15/99

TIME: _____

TO : Melanne Verveer

COMPANY : WH

FAX NUMBER: 456-6244 TELEPHONE NUMBER _____

FROM: Donna E. Shalala

OFFICE OF THE SECRETARY
200 INDEPENDENCE AVENUE, S.W.
WASHINGTON, D.C. 20201
(202) 690-7000 FAX NO. (202) 690-7595

COMMENTS: _____

IMPROVING HEALTH CARE ACCESS FOR UNINSURED WORKERS

January 15, 1999

Overview: The Clinton Administration has taken a number of important steps since1993 to expand coverage and respond to rapid changes in the U.S. health care system. We have given states the flexibility to insure more low-income workers, allowed Americans to take their health care with them when they change jobs, expanded health coverage to the children of low-income families, and proposed both making Medicare available to Americans aged 55 to 65 and making Medicare and Medicaid available to disabled Americans who work.

This new initiative complements these strategies by addressing the need for health care delivery systems serving the 32 million adult Americans still without insurance. Many providers of free or low-cost health care services currently do not have the resources or technical capacity necessary to coordinate their efforts with other providers. This initiative, funded at $1 billion over 5 years, will help fill that gap. The bulk of the funding would provide federal grants to help community health clinics, public hospitals, academic health centers, and other providers of free or low cost health services to create networks that strengthen comprehensive care for the uninsured. This coordination of services will help uninsured workers receive more efficient and higher quality care and gain entry into a "seamless" system of care for low-income working families.

A key emphasis in the early years of the program will be assisting communities and providers in the development of the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured, reaching approximately 100 communities over five years. Although need will vary by community, the focus will be on expanding access to primary health care and ensuring that it is coordinated with other health care needs, including mental health and substance abuse services.

Millions of Americans still lack health insurance. In 1997, the number of Americans without health insurance stood at over 43 million. While the Children's Health Insurance Program and increased Medicaid outreach can potentially provide insurance coverage for about half of the approximately 11 million uninsured children, roughly 32 million adults between the ages of 19 and 64 remain uninsured. Among these uninsured adults, about 17 million have incomes below 200 percent of the poverty level. Many of them receive their care at community health clinics and local hospitals.

Many of these Americans suffer from multiple health problems and require access to a coordinated set of health care services. Yet data show that these needs are not being met. In 1997, 30% of uninsured adults did not receive needed medical care and 55% postponed needed medical care because they could not afford it. They were only about half as likely to receive a routine check-up as insured adults. Among those who

did have a regular source of care, uninsured adults were about five times more likely than insured adults to use the emergency room as their regular source of care.

Yet, health care providers that help uninsured Americans face many pressures. These providers consist of institutions, facilities, and individual health professionals that provide a significant volume of health care services, either without payment or on a reduced fee basis, to those who are uninsured. They face a number of challenges, such as increases in the number of uninsured workers, reduced Medicaid revenues due to the pressures of Medicaid managed care, and a growing need for mental health and substance abuse services.

The Clinton Administration proposes strengthening health services for uninsured workers. To respond to these needs, the President's FY 2000 budget will propose a competitive grant program that would provide $1 billion over five years to strengthen public and private entities in 100 communities, increasing the availability of comprehensive, coordinated health care for uninsured workers. The President will request $25 million for the first year of this initiative in his FY 2000 budget proposal, which will be sent to Congress on February 1, 1999. The intent of these grants is to establish patient-focused systems of care to serve low-income, uninsured workers with greater efficiency and improved quality of care.

Those who provide health care to the uninsured will get help to create the infrastructure they need to provide quality care. A key emphasis in the early years of the program will be assisting communities and providers to develop the infrastructure necessary to participate in networks or other coordinated care arrangements. Funds will be available for the development of the financial, information, and telecommunications systems needed to appropriately monitor and manage patient needs. This support will improve the ability of providers to track patient care needs and receipt of service over time; permit more clients to be served; and strengthen the financial standing of providers by enhancing their ability to compete for business from Medicaid and commercial managed care organizations. Once a coordinated system has been established within a community, uninsured workers will gain entry into a coordinated health care system that meets their individual needs.

Once health services are coordinated in a community, gaps in service can be identified and filled. The initiative will also target substantial funding toward service gaps that can be identified within coordinated systems of care for the uninsured. Although need will vary by community, the emphasis will be on expanding access to primary health care and insuring coordination with other health care needs, including mental health and substance abuse services.

There is a history of bipartisan support for coordinating health care for uninsured workers. In the last Congress, a bipartisan bill was supported by the conservative "Blue Dog" Democrats and House Republicans that would have created "telehealth networks" for linking rural health services. While the proposal is similar, our initiative would actually reach a greater number of uninsured workers, in both rural and urban areas. In

the 103rd Congress, Senator Dole introduced a bill that would have funded greater integration of services for the uninsured in a grant program similar to what we are now proposing. The history of coordinating community services for the uninsured has been bipartisan, and the Administration looks forward to building that kind of consensus around this new initiative.

The Clinton Administration builds on a strong record of extending health care services to more Americans. Since 1993, HHS has approved Medicaid demonstration programs to extend health insurance coverage to 2.2 million Americans who would otherwise be uninsured. In 1996, the President signed the Kassebaum-Kennedy act, which ensured that Americans could take their health care with them when they changed jobs. In 1997, under the Balanced Budget Act, the Administration successfully supported the Children's Health Insurance Program (CHIP). Since then, 49 states and territories have had their CHIP plan approved by the U.S. Department of Health and Human Services.

MEMORANDUM

TO: All Interested Parties

FR: Communications\Research

DATE: February 5, 1999

RE: President Clinton's Bold Plan to Save Social Security

Attached please find a document, signed off on by Gene, outlining how President Clinton proposed a bold, sweeping plan to save Social Security following Republican calls for him to take the first step. We have also included three newspaper clips with particularly strong headlines. Feel free to distribute this material.

Thanks

PRESIDENT CLINTON RESPONDED WITH BOLD PLAN TO REPUBLICAN CALLS FOR LEADERSHIP ON SOCIAL SECURITY

For months a number of Republicans have been saying that they were willing to work with President Clinton on saving Social Security if he would show leadership on the issue and take the first step by submitting a specific plan. On January 19, 1999, the President laid out a bold framework in his State of the Union that meets America's challenges -- ensuring the solvency of Social Security until 2055. Newspapers around the country referred to the President's plan as "bold" and called it "the most sweeping changes to Social Security ever proposed."

Republicans Said They Were "Willing to Work With The President" If He Would "Show Leadership" on Social Security

❒ **Senate Majority Leader Lott: "The President's Going to Have to Show Leadership"**
On the December 6, 1998 "Meet the Press," Senate Majority Trent Lott (R-MI) was asked "what must be done" to save Social Security. He responded, *"What must be done is the president's going to have to show leadership. He's going to have to show some courage. He's going to have to make a proposal. I'm willing to work with the president and the Democrats, but they've got to propose something."* [NBC's "Meet the Press," 12/6/98 (emphasis added)]

❒ **Ways & Means Chairman Archer Called on the President to "Grab the Bull by the Horns"**
In a December 2, 1998 letter to President Clinton, House Ways and Means Committee Chairman Bill Archer (R-TX) called on President Clinton to submit a specific plan to save Social Security. Archer wrote: *"If ever there was a need for strong Presidential leadership, the time is now. I respectfully submit that you need to 'grab the bull by the horns' before it is too late...We have a small window of opportunity in which Social Security can be saved. I urge you to seize this moment and I commit to work with you on a bipartisan basis to get the job done."* ["President Should 'Grab the Bull by the Horns' on Social Security, Says Chairman Archer Citing Growing Factionalism, Chairman Sends Letter to the President," Rep. Archer press release, 12/2/98, Archer web page (emphasis added)]

❒ **Senate Budget Committee Chairman Domenici Urged President to Announce His Plan**
In a November 21, 1998 article entitled "Domenici Wants Clinton Plan Soon," the *Albuquerque Journal* reported, "Sen. Pete Domenici is urging President Clinton to waste no time in announcing his plan to ensure the solvency of the nation's Social Security system."

> Senate Budget Committee Chairman Pete Domenici (R-AZ): *"The longer we wait in dealing with Social Security, the more we spend the surplus on other things...The sooner we get an approach as to how we're going to deal with Social Security, The sooner we can determine how much we have for tax cuts."* [Albuquerque Journal, 11/21/98]

❒ **House Social Security Subcommittee Chairman Clay Shaw: To Save Social Security, "Mr. President, You Need to Lead Our Nation"**

House Ways and Means Subcommittee on Social Security Chairman Rep. Clay Shaw (R-FL): *"To save and strengthen Social Security, Mr. President, you need to lead our nation. It's that simple. You need to submit to the Congress, a specific plan to save Social Security soon, or the job may not get done."* [The White House Bulletin, 12/8/98 (emphasis added)]

> In his December 5, 1998 Republican Response to the President's Radio Address, Rep Shaw said, *"Because the president is elected by all of the people, he alone is best positioned to build a bipartisan consensus to get the job done. I look forward to hearing from President Clinton at this historic summit. Together, and with the support of all Americans, we can and we will strengthen Social Security because it embodies what's best for all Americans."* ["Clay Shaw Delivers Republican Response to the President's Radio Address" (Federal Document Clearing House), 12/5/98 (emphasis added)]

❒ **Sen. Rick Santorum: "We Need You to Go Out and Lead This Debate"**

Co-Chair of the Senate Majority Leader's Task Force on Social Security Senator Rick Santorum (R-PA): *"We need this administration Mr. President, we need you to go out and lead this debate in the American public's eyes, to lead it here in the Congress, and together we can really have a secure Social Security."* [Pittsburgh Post-Gazette, 12/9/98 (emphasis added)]

❒ **Sen. Judd Gregg: If President Says "Where and When" Republicans "Will Be There"**

Senate Budget Committee member Senator Judd Gregg (R-NH): *"Mr. President, if you simply tell us where and when, Republicans will be there and will work with you."* [United Press International, 12/12/98]

> Gregg: *"What we need to hear from the president is which of the options that are out there he would be willing to consider.... [A]s long as he is functioning on a plane of the ethereal, we can't move."* [Associated Press, 11/19/98]

❒ **Rep. Jerry Weller: "We Need Leadership" from the President "to Get the Ball Rolling"**

In a November 19, 1998 press release, House Ways and Means Committee and Social Security Subcomittee member Rep. Jerry Weller (R-IL) said, *"I am prepared to help President Clinton enact Social Security reform legislation. The American people expect us to work together and we cannot allow Social Security reform to fall prey to politics. We need leadership and a specific plan from the President to get the ball rolling. To his credit the President has made Social Security reform his number one priority. I look forward to reviewing the President's plan for Social Security reform."* ["Weller Ready to Save Social Security," Rep. Weller press release, 11/19/98 (emphasis added)]

Newspapers Around the Country Called The President's Plan To Save Social Security "Bold" and "The Most Sweeping"

- ***Boston Globe*: "A Bold Plan" To Save Social Security**
  According to a *Boston Globe* news article, President Clinton "offered an ambitious agenda to save Social Security and improve education...[H]e offered a challenging array of ideas and programs for governing in the next two years, including a bold plan to commit a large share of the budget surplus to Social Security and invest part of it in the stock market." [Boston Globe, 1/20/99 (emphasis added)]

- ***Washington Post*: "The Most Sweeping Change to the Program Since Its Creation"**
  According to a *Washington Post* new article, "[President Clinton's] two-pronged proposal [to save Social Security] would represent the most sweeping change to the program since its creation in the depths of the Depression." [Washington Post, 1/21/99]

- ***Los Angeles Times* Headline: "Ambitious Plan"**
  The following is the headline of a January 20, 1998 *Los Angeles Times* page one news article "Clinton Addresses Nation; President Outlines Agenda; Speech lays out ambitious plan, calling for the shoring up of Social Security and for programs to protect Americans health" [Los Angeles Times, 1/20/99]

- ***Seattle Post-Intelligencer*: "Clinton Laid Out A Bold Proposal" To Save Social Security**
  According to a *Seattle Post-Intelligencer* news article, "Delivering his sixth annual address to a joint session of Congress, Clinton laid out a bold proposal to allow the government to invest a portion of the Social Security trust fund in stocks..." [Seattle Post-Intelligencer, 1/20/99 (emphasis added)]

- **New York *Daily News*: "The Most Sweeping Changes to Social Security Ever Proposed"**
  According to a news article in the New York *Daily News*, "President Clinton defiantly brushed aside his historic impeachment trial last night, presenting Congress with an ambitious agenda that ranged from the most sweeping changes to Social Security ever proposed, to more education and military spending. Urging 'a new hour of healing and hopefulness,' a confident and comfortable Clinton never mentioned the sex scandal that has threatened his presidency and shaken his legacy." [Daily News (New York), 1/20/99 (emphasis added)]

- ***The Plain Dealer* Headline: "Clinton's Bold Plan for Social Security"**
  The following is the headline of a January 20, 1998 *The Plain Dealer* page one news article: *"Clinton's Bold Plan for Social Security"* [The Plain Dealer (Cleveland), 1/20/99]

  Note: The article that appeared in *The Plain Dealer* under that headline was a reprint of a *New York Times* story.

- ***Buffalo News* Headline: "Message Offers Bold Plan To Save Social Security"**
  The following is the headline of a January 20, 1998 *Buffalo News* page one news article: *"Message Offers Bold Plan to Save Social Security and Medicare."* [Buffalo News, 1/20/99]

Los Angeles Times

Clinton Addresses Nation;

President Outlines Agenda;

January 20, 1999

Speech lays out ambitious plan, calling for the shoring up of Social Security and for programs to protect Americans' health.

By JAMES GERSTENZANG, TIMES STAFF WRITER

WASHINGTON—President Clinton proposed a rescue plan for the Social Security system Tuesday night, using his sixth State of the Union address to offer the most sweeping domestic agenda of his second term.

Eight hours after his lawyers began telling the Senate why he should not be removed from office, the president offered to the nation a road map of social programs intended to protect Americans' health and retirement.

Admonishing the nation not to become complacent at a time of continuous prosperity, Clinton declared: "How we fare as a nation far into the 21st century depends upon what we do as a nation today.

"With our budget surplus growing, our economy expanding, our confidence rising, now is the moment for this generation to meet our historic responsiblity to the 21st century," he said.

His program is built on a strict parceling of the anticipated budget surplus over the next 15 years. He would allocate 62%—more than $2.7 trillion—to Social Security, and the rest primarily to Medicare, a new retirement savings program dependant on private investment and military and education needs. The budget surplus is expected to be $4.4 trillion over that period.

Speaking at one of the more extraordinary junctures in the history of the presidency, Clinton made no reference to his impeachment by the House of Representatives and his trial now under way in the Senate.

Reflecting the divisions caused by the trial, six members of the House and one senator, all Republicans, said that they would boycott the address. Some Republicans had said that the president should postpone the speech. House Speaker J. Dennis Hastert

Please see UNION, A14

UNION: Clinton Has Ambitious Agenda for U.S.

Continued from A1

of Illinois reminded members of Congress earlier that they shouldgreet Clinton in a dignified manner.

An introductory plea for "civility and bipartisanship" was greeted with applause from both sides of the aisle, and the president was rewarded with the conventional cheering and standing ovation upon his arrival in the chamber where House members, one month ago to the day, voted to impeach him. But Republicans appeared noticeably restrained as Clinton, his face unlined but his hair grown noticeably more silver, outlined a program that would expand the federal government's role in an array of domestic arenas.

For Clinton, the speech represented his grandest opportunity to remind the nation of his strengths—those of a president focused on the domestic and economic issues that the public, in opinion surveys, lists time and again as its greatest concerns.

Taking advantage of that opportunity in the midst of the impeachment drama offered the president perhaps the most forceful defense he can present. If his Senate trial, as many political scientists think, is ultimately a political rather than judicial test, then maintaining strong poll ratings may be his ultimate weapon.

Perhaps more than those of his recent predecessors, Clinton's State of the Union speech—and the budget he will present on Feb. 1—offer the president what White House counselor Doug Sosnik called a "center of gravity" to project his most ambitious goals for the coming year. Tuesday's call for reform of Social Security was as dramatic as any program he has espoused since 1994, when he called for universal health insurance.

In a moment of drama, Clinton said that the Justice Department would sue the tobacco industry to recover the accumulated costs borne by federal taxpayers of treating people with smoking-related diseases. The suit would seek to recover hundreds of billions of dollars from the nation's five major tobacco companies.

At its heart, the program Clinton presented to the joint session of Congress this year was built around the need to tackle the most pressing problems facing the nation as it nears a new century and the opportunities presented by the extended period of economic growth that has marked the end of the decade and the first federal budget surplus since 1969.

"Our fiscal discipline gives us an unsurpassed opportunity to address a remarkable new challenge: the aging of America," Clinton said. "With the number of elderly Americans set to double by 2030, the baby boom will become a senior boom. So first and above all, we must save Social Security for the 21st century."

Appealing for bipartisan cooperation at a moment of sharp partisan division, the president said: "I reach out my hand to those of you of both parties in both houses and ask you to join me in saying: We will save Social Security now."

The goal is to extend the actuarial security of the retirement program to 2055. Without revisions, analysts have predicted that the demands of an aging population combined with lowered payroll taxes from a reduced workforce would deplete the fund in 2032.

In addition to transferring nearly two-thirds of the budget surplus to the Social Security fund over 15 years, Clinton would create a trust fund, overseen by private managers, to make equity investments—a course that has drawn deep skepticism from labor unions and others in the traditional Democratic constituency.

The plan, likely to run into sharp controversy in Congress, which must approve it before it could take effect, would limit the investment to no more than 15% of the Social Security fund.

As projected by the Office of Management and Budget, the use of the surplus largely to meet the demands imposed on the Social Security system by the baby boom generation would so sharply reduce the government's need to borrow that the publicly held debt would fall by two-thirds.

The test will be whether Clinton, if he remains in office, is able to fend off pressure coming largely from the narrow Republican majority in the House to use the surplus to pay for an across-the-board tax cut and from some Democrats and allied groups to produce even greater increases in spending for domestic programs.

Signaling what aides said was his intention to fulfill an activist role for the final two years of his second term, Clinton set out dozens of goals.

They included strengthening the nation's education system by stressing academic achievement, particularly in low-peforming schools, putting 100,000 more teachers in classrooms over the next seven years and toughening discipline and promotion requirements.

"While our fourth-graders outperform their peers in other countries in math and science, our eighth-graders are around average and our twelfth-graders rank near the bottom," the president said. "We must do better."

The president also proposed a $6.1-billion program to help families pay for long-term health care, a $2-billion plan to help potential workers with disabilities surmount barriers to finding jobs and a $1-billion effort to help 200,000 welfare recipients join the workforce.

By using the surplus to pay for Medicare and Social Security, rather than spending the surplus on other programs, administration officials argued that they would bring the publicly held national debt to a level, when compared with the gross domestic product, that would be lower than at any point since 1917.

It is currently about 45% of the gross domestic product, the value of the nation's economic output of goods and services, and it would fall to 10% in 2014 under the administration's projections, officials said. If borrowing is reduced, government interest payments would be lower and more capital would be left in private hands for investment elsewhere in the economy.

Under Clinton's plan, 15% of the surplus, or $650 billion to $700 billion, would be spent on Medicare, the federal program of medical insurance for the elderly. It would be intended to make sure that the program remains financially sound for 20 years.

The president also called for steps to expand insurance coverage of prescription drug costs for the elderly.

Another large part of the surplus, 11%, would go toward establishing what the administration is calling universal savings accounts. It would earmark $33 billion a year, or $500 billion over 15 years, to help individuals save privately for retirement.

As sketched by Gene Sperling, who heads Clinton's National Economic Council, the program would give Americans incentives to save, particularly those who are not participating in such retirement programs as a 401(k) plan.

As structured by the administration but subject to reworking by Congress, Sperling said, the program would be built around a distribution by the government of a specific amount to each worker, perhaps $200 or $300, so that every American could open a retirement savings account. If individuals chose to contribute more, the sums would be matched at progressive levels and up to a certain limit by the government. Those with lower incomes would receive larger matches—say $1 from the government for every $1 an individual set aside in the investment account.

Clinton also proposed initiating a new round of global trade talks intended to halt the flow of jobs to countries where production is cheap because wages are low and environmental concerns are ignored.

"We must tear down barriers, open markets and expand trade. at the same time, we must ensure that ordinary citizens in all countries benefit from trade—pressing for trade that promotes the dignity of work, the rights of workers, the protection of the environment," the president said.

Clinton is planning to seek a $12-billion increase beyond original plans in the Pentagon's budet for fiscal 2000, which begins on Oct. 1, 1999, and a $110-billion increase over six years. Most of the increase would be spent on weapons modernization and a 4.4% pay increase for personnel. Many servicemen are being lured by higher pay to the private sector.

"It is time to reverse the decline in defense spending that began in 1985," the president said.

Clinton also pointed proudly to what he described as administration diplomatic successes in Northern Ireland, Bosnia and the Middle East peace process. But he gave no hint of what he hoped to do this year to build on U.S. world leadership.

"No nation in history has had the opportunity and responsibility we now have to shape a world more peaceful, secure and free," Clinton said.

He called on the Senate to ratify the comprehensive nuclear test ban treaty, which has languished there for two years since Clinton signed it. And he urged Congress to pay almost $1 billion in back dues to the United Nations.

"America needs a strong and effective U.N.," he said. "I want to work with this new Congress to pay our dues and our debts."

He also called for an increase in research on vaccines to protect against chemical and biological weapons and the training of police, firefighters and medical personnel to counteract such weapons in major metropolitan areas.

Samuel R. Berger, the president's assistant for national security affairs, said that Clinton was seeking a 70% increase—to a five-year total of $4.2 billion—in the budget for programs aimed at preventing the economically pressed Russian government from trying to solve its cash problems by selling weapons of mass destruction inherited from the collapsed Soviet Union.

Times staff writers Norman Kempster, Sam Fulwood and Judy Lin contributed to this story.

THE PLAIN DEALER

EST NEWSPAPER 35¢ FINAL CLEVELAND, WEDNESDAY, JANUARY

January 20, 1999

Clinton's bold plan for Social Security

By JAMES BENNET
NEW YORK TIMES

WASHINGTON — President Clinton proposed last night that the federal government invest for the first time in the stock market to strengthen Social Security, as he delivered a confident report on the State of the Union to a Congress considering cutting short his presidency.

Appearing in the grand chamber of the House of Representative a month to the day after he was impeached there, Clinton also urged Congress to begin contributing $33 billion a year to a new system of retirement accounts for American workers.

Clinton also proposed that $2.7 trillion of a projected $4.4 trillion in surpluses in the next 15 years be reserved for Social Security.

In all, the administration proposed investing up to 25 percent of the new money for Social Security, or $700 billion, in stocks over the next 15 years. Gene Sperling, the director of the National Economic Council, said that under this plan, Social Security would never have more than 15 percent of its assets in the market, a level he called "far, far more conservative than any pension plan in the country does."

But Republicans signaled they had no interest in the president's suggestion. "Government-controlled investment in markets is contrary to free enterprise," said Bill Archer, the Texas Republican who is chairman of the House Ways and Means Committee.

The remainder of the surplus money Clinton hopes to reserve for Social Security — about $2 trillion — would, like the money he would set aside for Medicare, go to pay off the federal debt.

That would simultaneously reduce the amount of government debt and increase Social Security's financial reserves.

• The president's Social Security plan draws GOP's fire. 8-A

Clinton called for maintaining Social Security as a "defined benefit" plan, that is, one with a guaranteed payout. But last night he also proposed the system of personal savings accounts, which are similar to what Republicans are seeking as at least a partial replacement for Social Security. For the president, the new accounts would supplement Social Security, not replace it.

Each worker would receive some flat payment, say $100, to open an account, similar to a 401(k). If he or she then chose to deposit more money, administration officials said, the government would match a portion of it, perhaps in the form of a tax credit.

During his address last night, the president never mentioned the trial, steps away in the Senate, where lawyers began defending him just a few hours earlier, as he envisioned using the rest of his term to strengthen the nation's schools, military forces and programs for the elderly.

"America is working again," Clinton said. "The promise of our future is limitless. But we cannot realize that promise if we allow the hum of our prosperity to lull us into complacency."

He announced last night that the Justice Department was preparing to sue tobacco companies, opening a new front in a war that has repeatedly gained him political ground. He argued that federal programs like Medicare were due hundreds of billions of dollars for the costs of treating lung cancer and other diseases.

The president left it to his lawyers to attack the charges he broke the law to cover up his affair with Monica Lewinsky, the former intern.

SEE CLINTON/8-A

Clinton proposes spending billions on Social Security

CLINTON FROM 1-A

The president presented his legislative shopping list — from an initiative to ease traffic congestion to a $1 billion program to help people switch from welfare to work — to a Republican Congress with far different plans for spending the surpluses accumulating after decades of deficits.

Calling this time "a new dawn for America," he urged his listeners to "put aside our divisions" and find "a new hour of healing and hopefulness."

With the justices of the Supreme Court and his antagonists and allies in both houses of Congress before him, the president recognized several people in the galleries to underscore his points. Among them, he singled out his wife, Hillary Rodham Clinton, whose loyalty and advice have been key to his political stamina. He praised her for "for all she has done for our children" and for "advancing our ideals at home and abroad."

Illustrating the peculiar political dynamic unfolding here, Republican Senate leaders also seemed eager to play down the trial. They laid out their own legislative agenda in the morning, insisting that mulling the first removal ever of a sitting president would not divert them from what the Majority Leader, Trent Lott, called "the people's business."

Though the president called for sure-fire political initiatives like putting 50,000 more police officers on the street, he also used his speech to push beyond his short-term predicament. In urging a long-term fix for the Social Security system, according to his associates, he hopes he will shine through the historic blot of impeachment.

Clinton urged Congress in his State of the Union Message last year to "Save Social Security first."

But with the surpluses growing and a new politics of prosperity firing legislators' imaginations, Senate Republicans declared that they would seek a 10 percent cut this year in personal income tax rates.

Last night, Clinton argued that 62 percent of forthcoming federal surpluses should be earmarked to preserve Social Security, a program that was at the heart of the Democratic New Deal but that has since developed overwhelming popular support.

Another 15 percent of the surpluses, Clinton said, should go to protect the Medicare program, which assists the elderly with health care. The president would spend about 11 percent of the surpluses to create new retirement savings accounts, called "universal savings accounts."

The remainder of the surpluses — roughly another 11 percent, according to the administration — would go to defense and domestic initiatives.

The administration also hopes to amend the law governing aid to public schools to demand that states and school systems begin testing new teachers for competence, identify failing schools and shut them down if necessary, and end practices like "social promotion," or routinely moving children into the next grade even if they have not gained the necessary skills.

"Each year the government invests more than $15 billion in our public schools," Clinton said. "I believe we must change the way we invest that money, to support what works and to stop supporting what does not work."

The president also proposed a series of narrowly targeted tax credits, rather than the kind of broad-based tax cuts that Republicans favor. He said that he would seek a $1,000 credit to help families pay for long-term care and another $1,000 credit to help disabled peopled return to work.

Weather

Mostly cloudy: high around 40; Page A2

THE BUFFALO NEWS

SOUTH SUBURBAN EDITION

Savings on horizon

In Local, Gov. Pataki proposes trimming income tax rates. Page B1

Shoppers' paradise

In Business, area consumers enjoy the sales tax holiday. Page B7

College cage clash

In Sports, Bona outlasts UB in a Big 4 matchup. Page D1

40 PAGES WEDNESDAY, JANUARY 20, 1999

Message offers bold plan to save Social Security and Medicare

By ROBERT A. RANKIN

Knight-Ridder Newspapers

WASHINGTON — President Clinton's plan to save Social Security and Medicare is the biggest, boldest proposal he has made since his abortive 1993-94 health-care reform crusade, and may prove equally controversial.

Clinton proposes to spend $3.4 trillion over the next 15 years to solve the two biggest financial challenges facing the government for the next generation, to rescue both popular programs without the pain of raising taxes or reducing benefits.

Another part of the proposal would create a new type of individual savings program, devoting $500 billion from the federal surplus to give most working people seed money to open their own retirement accounts.

The government also would help match people's personal investments as they built up those accounts over time, giving more money to those with low incomes. This approach might satisfy GOP desires to rest more of the nation's retirement system on private savings accounts, though it would not go so far as to privatize the Social Security system itself.

Without reforms, Social Security will be able to pay only 72 cents of every dollar it promises retirees in pension benefits starting in 2032, according to the system's trust-

See Benefits Page A6

Benefits: GOP objects to lack of cuts in income tax

Continued from Page A1

ees. But Clinton's plan to channel $2.7 trillion into Social Security would cover all current benefit costs until 2055.

In addition, Medicare — which covers most medical expenses for the elderly — is projected to go bankrupt in 2008. But Clinton's proposal to give Medicare up to $700 billion extra over 15 years would pay for all current benefits through 2020.

Many Republicans objected to the mechanics of Clinton's plan. Some accept parts of it but prefer to devote more of the expected surplus to tax cuts.

"We didn't balance the budget so the government could grow," complained Senate Budget Committee Chairman Pete Domenici, R-N.M., who sharply criticized Clinton's seizure of the entire surplus, saying his plan would preclude any income-tax cuts "for the next 15 years. ... We think taxpayers should get that money."

But analysts of every stripe acknowledged that Clinton's bold proposals were a political masterstroke, certain to ignite a great national debate over how to spend the looming surplus funds — if the Senate finishes his impeachment trial reasonably soon.

Clinton thus posed an implicit choice to Congress and the country, between bogging down in impeachment or governing imaginatively for the future.

"My instinct is, if the Senate starts calling witnesses and the impeachment trial drags on into April, you can probably kiss any significant legislation goodbye," said Henry Aaron, an economist at the Brookings Institution, a centrist think tank, who liked the thrust of Clinton's plan.

"It really is big news, big in every sense of the term. ... I think he does have something for everyone. ... For the general public, he is saying, 'Look, we can do this without asking too much of people in terms of sacrifices.' Everything else will look like castor oil compared to this," said John Rother, chief lobbyist for AARP, the influential senior citizens lobby. He too was favorable toward Clinton's proposals.

One big question mark, however, is whether the expected $4.4 trillion surplus turns up.

"These surpluses apparently assume 15 more years of economic growth. We've always been worried about how realistic those surpluses are," said Craig Cheslog, spokesman for the Concord Coalition, a bipartisan pressure group devoted to fiscal discipline. Nevertheless, Cheslog stressed, "we think it's an interesting first step."

The most controversial element of Clinton's plan calls for creating a new government mechanism to oversee investment of hundreds of billions of dollars in the stock market.

The federal budget is projected to run the $4.4 trillion surplus over the next 15 years; Clinton proposes putting 62 percent of it into the Social Security trust funds. A new board would oversee investment of about 25 percent of that in stocks; the rest would be invested in Treasury bonds.

Conservatives fear that permitting government to invest so much directly in stocks could lead to federal pressure, through ownership power, on private corporations to follow politically directed policies rather than ones set purely on business interests.

"No, no, a thousand times, no," said Rep. Bill Archer, R-Texas, chairman of the House Ways and Means Committee, which oversees Social Security and taxes. Archer passionately wants to cut taxes as well as craft Social Security reforms this Congress.

"Government-controlled investment in markets is contrary to free enterprise. It will open the door to all kinds of mischief involving government dictates, favoritism and cronyism. If there is to be an investment in the stock market, it must be at the discretion of free individuals, not at the dictates of the federal government," Archer said.

THE WHITE HOUSE

WASHINGTON

November 24, 1998

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings, Jennifer Klein, Jeanne Lambrew

SUBJECT: Response to Questions about Coverage Expansions

cc: Melanne Verveer, Neera Tanden, Nicole Rabner

In a recent discussion of the uninsured, you asked about several coverage expansion proposals, including a 55 to 65 coverage option, a Medicaid buy-in, a Federal Employees Health Benefit Plan (FEHBP) buy-in, and a new health insurance option for young adults. This memo summarizes these proposals, discusses their rationale, and provides you with a budget and Congressional status update. As was discussed in the memo to the President on the uninsured, the absence of substantial subsidies and the omission of an individual or employer mandate significantly limits the number of Americans who will be newly insured as a result of these policies. Having said this, each of these options (or modifications to them) can improve access to needed health insurance and are being considered for the FY2000 budget.

Medicare Buy-In / Health Insurance Options for People Ages 55 to 65

Policy. In our FY 1999 budget, we proposed three policies: (1) a Medicare buy-in for people ages 62 to 65 that is fully self-financed through an unsubsidized, two-part premium (an up-front premium plus a smaller, post-65 premium to compensate for any risk selection); (2) a similar Medicare buy-in for displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) guaranteed access to former employers' insurance for retirees age 55 and over whose retiree health benefits have been ended. According to CBO, this entire initiative costs about $1.5 billion over 5 years (mostly a temporary cost until the participants begin contributing their post-65 premium) and would assist about 300,000 people.

Rationale. This initiative, according to the latest data, is needed more than ever. Although still low, the number of uninsured people ages 55 to 65 grew the fastest in 1997 -- and will grow exponentially in the future since the number of people in this age cohort is projected to rise by over 60 percent by 2010. Moreover, we have increasing evidence that the individual insurance market -- relied on by this age group more than any other -- is raising its rates dramatically. Kaiser Permanente, for example, will double its individual insurance premiums for its older enrollees on January 1. This initiative gives people in this age group options to purchase insurance that they might not otherwise have. It also would be the bare minimum policy needed if the age eligibility for Medicare were raised -- an idea seriously being contemplated by the Medicare Commission.

Issues. Despite the need, this initiative was victimized by conflicting "too much - too little" criticisms. Republicans (and some conservative Democrats) claimed that the buy-in creates a huge loophole in Medicare that will ultimately lead to large costs. In part, this reflects a disbelief in our technical ability to set premiums that are self-financing in the long run. But mostly, it results from a strong belief that, even if the premium estimates are accurate, we will eventually succumb to the pressure to subsidize these premiums to make them more affordable for the lower income uninsured. In contrast, a number of traditionally liberal advocates and academics criticized the policy for helping too few people to justify the political capital that would be necessary to expend to get the proposal any serious attention by the Republican Congress.

Regardless of its political viability in this Congress, this proposal addresses a population in need, remains generally popular outside the beltway, and will continue to be seriously considered for inclusion in the FY 2000 budget. It is unclear whether it will make the final cut, however. The short-term savings needed to finance this initiative are controversial and/or likely to be used for other priorities (such as for underwriting the costs of the Jeffords/Kennedy disability coverage expansion bill). Also, there is concern about putting this proposal out so close to the final report released by the Medicare Commission this March. No matter how we resolve the budget question, however, we expect Senators Moynihan and Daschle as well as Congressman Gephardt to introduce this bill at the beginning of the next Congress.

Medicaid Buy-In

Policy. A Medicaid buy-in would allow states to charge income-related premiums for people in optional eligibility groups with income above 150 percent of poverty (the level at which states may charge cost sharing under the Children's Health Insurance Program (CHIP)). This proposal could be broadened to allow all people below a fixed income level -- not just those in current optional eligibility groups -- to buy into Medicaid.

Currently, states cannot charge premiums to Medicaid beneficiaries. A lesser known fact is that Medicaid law limits who can be covered as well. Historically, adults were eligible for Medicaid only if they were: (a) single parents, or married but unemployed parents, who receive welfare; (b) low-income elderly or people with disabilities who receive SSI; or (c) nursing home residents. During this Administration, however, new Medicaid eligibility options have been created. Welfare reform gave states the option to cover higher income single parents and unemployed married parents. The exclusion of married employed parents -- which is anti-work and anti-family -- was changed last summer with "100-hour rule" regulation. This lets states define "unemployed" as working more than 100 hours a month -- meaning that they may cover parents working 40-hour weeks if they so choose. And, in the Balanced Budget Act, we created a Medicaid buy-in for people with disabilities with incomes below 250 percent of poverty.

Rationale. A Medicaid buy-in could be an incentive for states to expand coverage to working adults, since even small family contributions improve the acceptance of such expansions. It also gives all states the flexibility that we have permitted through Medicaid waivers and supported in CHIP, as well as in the Medicaid buy-in for workers with disabilities.

Issues. Despite its sound policy basis, the likelihood that a Medicaid buy-in will significantly reduce the uninsured is low. Since large subsidies are required to encourage low-income, uninsured people to purchase health insurance, states would have to charge the families low premiums and pay for most of the costs themselves in order to get meaningful participation. Moreover, only states that have already expanded coverage to 150 percent of poverty could charge premiums to all new participants. Unfortunately, states typically cover few adults with incomes above 50 percent of poverty. Thus, premiums collected through a Medicaid buy-in would not come close to offsetting the large Federal and state costs. Additionally, while allowing premium payments from beneficiaries may be attractive to states, Republicans, and moderate Democrats, it would be vehemently opposed by advocates and liberal Democrats who believe that this opens the door to high premiums for lower-income Medicaid beneficiaries.

One idea that could possibly address the financial limitations of this proposal is to link the Medicaid buy-in proposal to a tobacco recoupment bill. The recent state tobacco settlement will likely lead to legislation about whether and under what terms states may keep the Federal share of that settlement. In such legislation, we could make expansion through a Medicaid buy-in one of the uses (or the sole use) of the Federal share. Congressional Democrats and advocates have long argued that tobacco settlements should be directly linked to health care, health insurance expansions, and Medicaid. It is possible they would accept a buy-in in a recoupment bill that assures Medicaid expansions. States, obviously, do not want any strings on the uses of the Federal share of the settlement, but may have the hardest time arguing against Medicaid investments since the settlement itself is premised on Medicaid costs resulting from tobacco use. The clear downside to this option is that money spent on expansions would limit the money used for other priorities like child care. This issue will be debated in our budget process.

FEHBP Buy-In

Policy. Another proposal for expanding coverage is opening up the Federal Employees Health Benefits Plan (FEHBP) to various groups of people (e.g., workers in small businesses, people ages 55 to 65 years old). In order to participate in FEHBP, health plans would have to offer health insurance to the designated group of eligibles. There are two options for how premiums would be set: first, new participants could be charged the same premiums as Federal employees; second, new participants could be charged premiums separately, depending on their own costs.

Rationale. The FEHBP buy-in would give certain groups of uninsured people the benefit of accessing the health plan options, information and possibly premiums that Federal government negotiates for its employees. It also reinforces our support for group health insurance purchasing, plan choices, and adequate information with which to make such choices.

Issues. Depending on how premiums are set, the FEHBP buy-in would either be costly to new participants or affect the premiums and choices of all Federal employees. Because newly eligible people who wish to purchase insurance who are healthy can likely find individual insurance that is cheaper, the population that decides to go into FEHBP is likely to be sicker. This will increase premiums of all current Federal employees if they are charged the same premium. It could also reduce plans participating in FEHBP if their enrollees include more costly, new participants than

Federal employees (which could happen in rural areas). As a consequence, most FEBHP buy-in proposals assume a risk pool separate from that of Federal employees for setting premiums. But because this pool would be a smaller and include less healthy people, premiums would be more expensive than FEHBP. As a consequence, most analysts project a relatively small effect on coverage. The only way to address this would be subsidies which carry significant cost implications. These complexities explain why there have been few FEHBP buy-in bills.

Given concerns about its use as a source of coverage, FEHBP may be better used as a model for other coverage expansion proposals. What makes FEHBP successful -- purchasing power for a large group of people; consumer information; plan choices -- could be incorporated into small businesses purchasing coalitions. These coalitions, promoted in previous budgets, provide any small business in the area with a set of plan choices and more affordable premiums. This year, we are examining options to aggressively encourage their development. For example, FEHBP managers could provide technical assistance in establishing these coalitions. They could also be granted non-profit status to facilitate private foundation support.

Catastrophic Coverage for Young Adults

Proposal. You mentioned an interest in policy options that would provide catastrophic coverage for young adults. Medicare, Medicaid, and FEHBP all provide comprehensive coverage, although we could conceivably develop a special program for catastrophic coverage. It is also possible through regulation to require individual insurers to offer such coverage to young adults.

Rationale. Young adults are more likely than any other age group to be uninsured -- nearly one in three 18 to 24 year olds lacks insurance. In part, this problem results because young adults are usually healthy and do not think that their need justifies the cost of comprehensive coverage. Thus, catastrophic coverage may be the best option for young adults since it is cheaper and protects them from the real risk of illness or injury that can be financially devastating.

Issues. Catastrophic coverage options probably would not insure many young adults. Few young adults would purchase even the lowest-cost catastrophic coverage without significant subsidies. In fact, some analysts believe that only an individual mandate will make young adults pay any level of premium for health insurance. This is because they rarely recognize their financial risk (e.g., one in four young adults sustains major injuries in a year and one in 20 is hospitalized). Second, while catastrophic coverage makes economic sense, people interested in insurance do not appear to like it. The lack of interest in the medical savings account (MSA) demonstration has shown that people prefer lower cost sharing and coverage of primary care.

Recognizing these challenges, we continue to examine policies to allow young adults to buy into Medicaid. Some of the most needing of insurance in this age group are foster care children who have aged past their 18th birthday (and thus last year of Medicaid eligibility.) We are working with OMB to provide a new state option for those Governors interested in expanding Medicaid coverage to this population. We believe it will be affordable (about $50 million over 5), sound policy that a number of states will pick up. As of this writing, the chances of this proposal being included in the budget appear to be quite good.

THE WHITE HOUSE

WASHINGTON

November 13, 1998

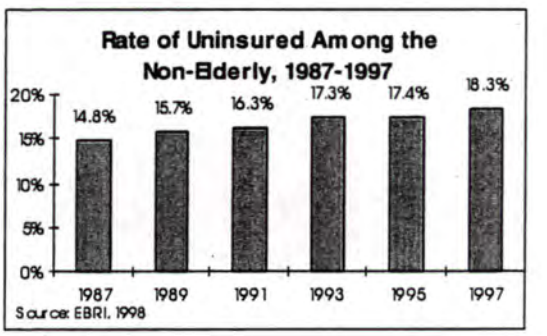
INFORMATIONAL MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings and Jeanne Lambrew

THROUGH: Bruce Reed, Gene Sperling

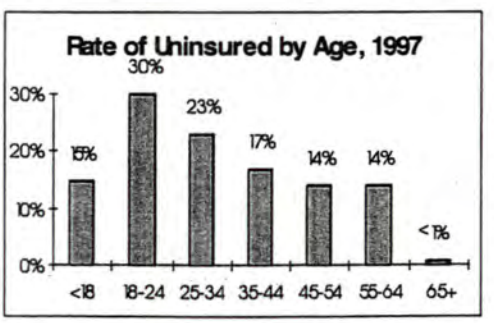
SUBJECT: Recent Uninsured Trends and Analyses

As you know, the Census Bureau recently estimated that 43.7 million Americans are uninsured -- an increase of 1.7 million from 1996 and nearly 5 million from 1992. Insurance coverage is one of the few social indicators that has not improved in the last several years. This contradicts the theory that a strong economy with low unemployment yields a high demand for workers, and thus better benefits like health insurance. It is even more disappointing given record-low health care cost growth in the last several years, which should make insurance more affordable and thus more common. This increase has important consequences since the uninsured are four times more likely to not receive needed health care, have hospitalization rates for preventable conditions that are 50 to 75 percent higher, and place growing uncompensated care burdens on the nation's providers.



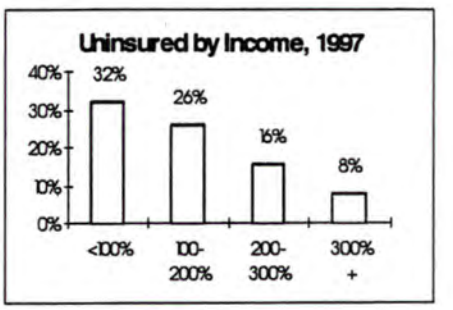
Because of the importance of this problem and your expressed interest in these data, we are providing you an analysis of the numbers and recent insurance coverage trends, as well as a summary of their policy implications.

Uninsured by age: Most of the uninsured in America are young; over 80 percent are under age 45 (35.2 million). These uninsured are disproportionately ages 18 to 24 -- 30 percent of whom are uninsured compared to 15 percent of children. The number of uninsured children did not increase in 1997, remaining at 10.7 million. This contrasts dramatically with last year's data that showed that 800,000 of the 1.1 million additional people who were uninsured were children. The change appears to be the result of the unprecedented focus on children's health in 1997. Beginning with the State of the Union and ending with the establishment of your Children's Health Insurance Program (CHIP), the Federal Government and the states started taking actions to address this serious problem. Next year, after Census' data reflects a full year's operation of CHIP, we would expect the number of uninsured children to fall.



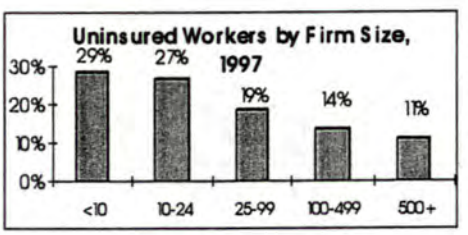
While the likelihood of being uninsured is higher among younger adults, the number of uninsured is growing faster among older adults. One million of the additional 1.7 million uninsured people in 1997 were age 35 or older. The increase is particularly concentrated among people ages 55 to 65; the number of uninsured people in this age group grew faster than all other age groups (7 percent growth). This trend is cause for concern because people ages 55 to 65 become more likely to develop a health problem and less likely to have employer insurance (because their spouses retire and join Medicare, they move to part-time or self-employment which typically does not offer insurance, or they retire). As a result, this age group is disproportionately relies on individual health insurance -- where premiums have been skyrocketing in recent years and underwriting practices remain prevalent. Because of the demographics, there is no doubt that the coverage problem will increase exponentially as the number of people in this age cohort is projected to rise by over 60 percent by 2010.

Uninsured by income: Not surprisingly, people with less income are less likely to have health insurance. Although only 13 percent of the U.S. population, poor Americans (with income less than $16,000 for a family of 4) represent 26 percent of the uninsured --, fully one-third have no insurance. However, reflecting the strong economy, the poverty rate continues to fall and the number of uninsured below 100 percent of poverty did not increase between 1996 and 1997.



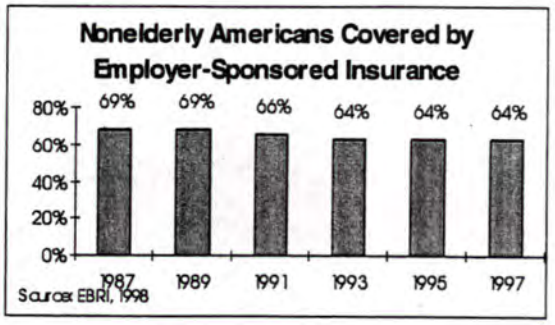
Despite the link between lack of insurance and low income, over 80 percent of the uninsured are in working families. The lack of insurance is growing among the middle class; all of last year's additional 1.7 million uninsured had income above the poverty level, with the greatest concentration of people between 100 and 200 percent of poverty. Inexplicably, although still small in number, the uninsured with income above 500 percent of poverty (over $80,000 for a family of 4) rose at an extraordinary 20 percent growth rate in 1997.

Job characteristics and the uninsured: Workers in small firms are less likely to have access to affordable, job-based health insurance. Nearly half of uninsured workers are in firms with fewer than 25 employees. Compared to over 95 percent of large firms, about half of firms with fewer than 10 employees and three-fourths of firms with 10 to 24 employees offer coverage. These facts underscore the need to find better ways for small businesses to pool resources and leverage to bargain for more affordable benefits.

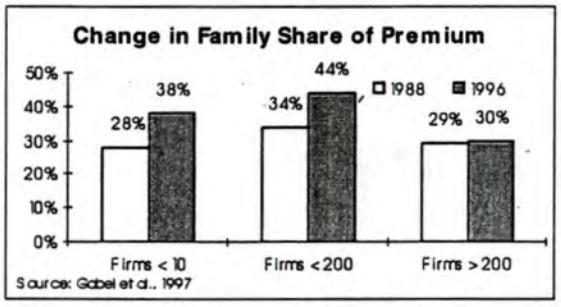


The rate of being uninsured is also high among people who work full time but only for part of the year, most likely due to job change or loss (27 percent). A recent Census study found that over 40 percent of workers with at least one job interruption had a gap in coverage. Because most people are insured through work, insurance coverage often ends with employment changes -- underscoring the importance of the Kassebaum-Kennedy portability and COBRA protections.

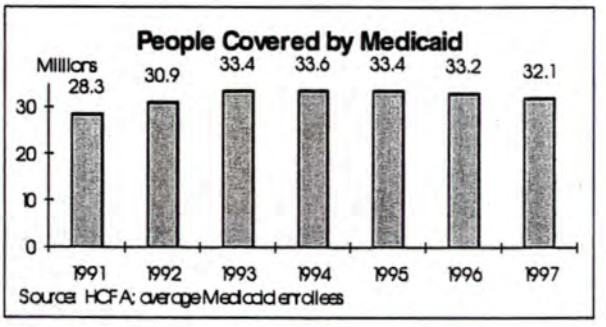
TRENDS IN EMPLOYER-SPONSORED INSURANCE. On the face of it, it does not appear that the increase in the uninsured is directly linked to a decline in employer-sponsored health insurance (ESI). The erosion that occurred in the late 1980s and early 1990s has ended. About 64 percent of nonelderly Americans had employer-based insurance in 1997, virtually unchanged from 1995 and 1996. In recent years, access to job-based health insurance has actually increased, even among small businesses. However, this has not translated into increased ESI coverage because a smaller proportion of people with access to ESI are purchasing it.



Even though more employers are offering health insurance, fewer employees are taking this coverage, primarily because they have to pay more of the premiums. The employee share of premiums has risen, especially in smaller firms. As a result, fewer employees are purchasing this coverage. For example, in 1987, 90 percent of workers in firms with fewer than 10 workers who had access to employer-based coverage took it, compared to 85 percent in 1996. These take-up rates drop as the share of the premium paid by the employee increases. This trend clearly affirms that health insurance affordability plays the most significant role in people's likelihood of buying health insurance.



TRENDS IN MEDICAID. The most notable drop in insurance coverage in 1997, reported by both the Census Bureau and HCFA, appears to come from the number of people covered by Medicaid. There are three possible explanations for this trend. The first and likely most significant factor is that, as the economy has strengthened, fewer people are eligible for Medicaid. This is supported by the fact that the poverty rate has declined, the number of poor covered by ESI has increased, and there was no increase in the number of uninsured children eligible for Medicaid (still 4.7 million). Second, there may be fewer people aware of their continuing Medicaid eligibility in the wake of state and Federal welfare reform. Third, it is becoming more likely that Medicaid beneficiaries misreport that they are covered by private insurance in the Census survey. States have been taking actions to "destigmatize" Medicaid by changing the name of their programs (e.g., TennCare, MinnesotaCare). Also, about 50 percent of Medicaid beneficiaries are enrolled in managed care plans, which are usually private plans. Thus, beneficiaries can easily mistake their coverage for private coverage.



FUTURE TRENDS IN THE UNINSURED. Given the complexity of these trends, it is unclear whether the rise in the number of uninsured will continue. Several compelling factors suggest that it will not and may actually decrease modestly. The Office of National Health Statistics projects that the proportion of Americans covered by employment-based insurance will rise as continued low unemployment will make employers more likely to use insurance to attract workers. Medicaid coverage may increase as well as additional low-income parents become eligible because of the "100-hour rule" welfare-to-work regulation you instituted this past summer and/or due to the states' continued use of Medicaid waivers, which have already covered over one million Americans. We also expect to see a decrease in the number of uninsured children beginning to showing up in next year's Census Report as the effects of CHIP take hold.

As the baby boom generation ages, however, more people will move into the 55 to 65 year old age bracket -- where the proportion of people with ESI is declining and uninsured is increasing. Furthermore, significant premium increases for next year, as some recent reports have projected, may make insurance unaffordable to greater numbers of Americans. While these conflicting trends make it extremely difficult to predict the future with any sense of confidence, it seems unlikely that we will see another significant increase in the uninsured next year.

IMPACT OF ECONOMIC AND EDUCATION SUCCESSES ON THE NATION'S HEALTH. This problem of the uninsured contrasts with tremendous improvements in other national health indicators. Your impressive economic accomplishments have had an impact on the costs of health insurance. For the first time in well over 30 years, health inflation was below general inflation in 1995 and 1996, thus actually reducing the real costs of health insurance. Moreover, gains in education, income and employment have contributed towards record high life expectancy (76.5 years for those born in 1997), a record low infant mortality rate (7.1 deaths per 1,000 live births), an AIDS death rate that is half of what it was in 1992, and a record-high immunization rates. And, historic increases in the investment in biomedical research during your Administration offer real hope for new (and hopefully cost-effective) treatments and cures for the diseases that will otherwise place unprecedented burdens on the nation's economy and health care system when the baby boom retires.

POLICY IMPLICATIONS. The uninsured in America remains one of the most challenging domestic social problems. Not only is the problem large in size, it is complex, crossing income, age and geographic boundaries. Despite its complexity, one fact is clear: making health insurance affordable is and always will be the key to significantly expanding coverage. Even for an employee whose employer pays for 80 percent of the premium, the family share of the premium is typically over $1,100 per year -- more than one out of every $10 of income for a minimum-wage worker. This cost is obviously much higher for people without access to employer-based insurance, especially if they have a history of illness. While traditional insurance regulation can help reduce insurance premium variation and discrimination, independent analysts will not project any substantial coverage expansions resulting from these interventions. In a non-mandate environment, they believe that only significant subsidies can induce a substantial reduction in the uninsured.

Ironically, our ability to propose policies to make insurance more affordable is limited by our success in reducing national health spending. In the last 5 years, hundreds of billions of dollars in excess Medicare and Medicaid spending have been squeezed out of these programs and used productively to help eliminate the deficit, finance children's health coverage, extend the life of the Medicare Trust Fund, and to make the Medicaid program a much more predictable and affordable safety net. However, substantial reductions in Medicare and Medicaid mean that these traditionally utilized funding sources cannot be relied on as offsets for major coverage expansions, let alone long-term Medicare reforms. With this in mind, outside funding sources from the tax code, tobacco, or elsewhere would be needed for a significant coverage expansion.

Administration & Republican coverage expansion ideas. The range of coverage options, currently being prepared through the traditional NEC/DPC/OMB budget process, will include some previous and new targeted coverage expansions. As this memo has documented, the most recent data validate the case for coverage expansions to the pre-65 and "workers-in between-jobs" populations. We also will continue to focus on administrative and possibly legislative outreach policies to encourage enrollment in CHIP and Medicaid to ensure your children's health initiative is a success. However, recognizing the questionable political and budgetary viability of these proposals, we are also reviewing options more likely to be well received in this Congress.

First, we are contemplating policies to encourage states to expand using existing options. With the 100-hour rule regulation, all states can now cover parents of children on Medicaid. Other states have used Medicaid 1115 waivers to cover all people up to certain income levels. Because this would likely require greater financial incentives, one option is making coverage expansions a priority on a short list of acceptable uses for the Federal share of state tobacco settlements.

As an alternative to coverage expansion options, we expect Secretary Shalala to advocate for a significant investment in public health infrastructure. This investment would be used to adapt the safety net to the rapidly changing health system. This idea would likely be better received than a coverage expansion by Republicans. However, if not a capped mandatory grant program, it would either require raising the discretionary caps or place a major strain on the current caps. Also, it would likely be perceived by some Democrats as giving up on coverage expansions.

Since there is bipartisan concern about small businesses' problem in accessing insurance, we are also considering enhancing our previously-proposed small business purchasing coalition grant initiative. We could more aggressively encourage these coalitions by directing OPM to provide technical advice for their establishment and operation, so that they more closely resemble FEHBP. We are also examining granting them non-profit status, to facilitate foundation support.

In 1999, Republicans, too, may consider small business group purchasing policies (although in the past, their versions have been significantly flawed). It is more likely, however, that, if Republicans decide to address the coverage issue at all, they will focus on the use of tax incentives for the purchase of individual health insurance. Encouraging individual insurance is intriguing because nation's reliance on voluntary, employer-based coverage has clearly not been an unqualified success. Moreover, if there is to be any significant investment in health care that the Republicans could possibly support, it would almost inevitably come from the tax code.

While acknowledging that tax credits are at least initially appealing, they are no panacea. They are extremely inefficient and expensive, as many of the assumed recipients would already have coverage. For independent experts to validate that the previously uninsured would take advantage of this policy, the credit would have to be quite large. In addition, if used for individual (rather than employer-based) insurance, they would require the type of major insurance reforms that have been historically opposed by Republicans. The individual market is the least regulated, most expensive, most "cherry-picked" and most unstable insurance market.

Notwithstanding legitimate concerns, we believe that tax credits may be the only health coverage expansion vehicle that could be produced by this Congress. As such, we are reviewing possible options for your consideration. For example, it might be possible to merge policies to promote small group purchasing coalitions with tax credits for participating employers or employees. Limiting the tax credit to such entities could further encourage a long-overdue expansion of small business coops. However, such approaches also raise equity concerns (e.g., why discriminate against an employee/employer who does not have access to, or does not want to be in, a purchasing coop) and political arguments (e.g., isn't this too similar to the Health Security Act). DPC, NEC, OMB, Treasury and HHS are reviewing this purchasing coalition/tax credit idea and other tax incentive approaches. We will keep you apprised of developments in this area, as well as other coverage options, as the budget process unfolds.

International Organizations and Programs
(IO&P)
($ in thousands)

	FY 1998 Acual	*FY 1999 Estimate*	*FY 2000 Request*
ECONOMIC PROSPERITY	***210,600***	***215,300***	***191,300***
Broad-based Growth	*210,500*	*215,000*	*191,000*
United Nations Development Program (UNDP)	98,000	100,000	80,000
United Nations Children's Fund (UNICEF)	100,000 /1	105,000 /1	101,000
United Nations Development Fund for Women (UNIFEM)	1,000	1,000	1,000
OAS Development Assistance Programs	6,500	6,500	6,500
International Fund for Agricultural Development (IFAD)	5,000 /2	2,500	2,500
Open Markets	*100*	*300*	*300*
International Civil Aviation Org. (ICAO) Aviation Programs	100	300	300
GLOBAL ISSUES	***74,500***	***64,200***	***90,700***
Protection of Global Environment	*49,500*	*64,200*	*65,700*
United Nations Environment Program (UNEP)	9,000	13,000	13,000
Montreal Protocol Multilateral Fund	28,000	34,450	34,450
International Conservation Programs	3,750	6,000	6,000
UNFCCC / IPCC	5,000	6,500	8,000
Int'l. Contributions for Scientific, Educational & Cultural Activities	2,250	2,250	2,250
World Meteorological Org./Voluntary Cooperation Program	1,500	2,000	2,000
Stabilization of World Population Growth	*25,000*	*0*	*25,000*
United Nations Population Fund (UNFPA)	25,000 /3	0 /4	25,000
DEMOCRACY AND HUMAN RIGHTS	***4,900***	***7,000***	***7,000***
UN Vol. Fund for Technical Coop. in Field of Human Rights	900	1,500	1,500
UN Voluntary Fund for Victims of Torture	1,500	3,000	3,000
OAS Fund for Strengthening Democracy	2,500	2,500	2,500
HUMANITARIAN ASSISTANCE	***4,500***	***5,500***	***4,000***
World Food Program (WFP)	4,000	5,000	3,500
Afghanistan Emergency Trust Fund	500	500	500
TOTAL	***294,500***	***292,000***	***293,000***

/1 Appropriated under Child Survival Programs
/2 Includes $2.5 million transferred from Development Assistance
/3 Does not reflect $5 million withheld for congressional prohibition of U.S. funding for UNFPA's China Program
/4 Funding for UNFPA is prohibited by the FY 1999 Omnibus Appropriations Act.

ARD M. KENNEDY
MASSACHUSETTS

United States Senate

WASHINGTON, DC 20510

December 18, 1998

MEMORANDUM FOR THE PRESIDENT

FROM SENATOR EDWARD M. KENNEDY

"PROPOSED DEMOCRATIC PRIORITIES FOR THE 106th CONGRESS"

The November elections reaffirmed the key Democratic priorities on which you have worked so effectively over the past two years. As a result, we are poised to move forward on a number of popular issues, especially:

-- The Patient's Bill of Rights;

-- The increase in the minimum wage;

-- Education reforms to reduce class size and facilitate school construction;

-- Aid for disabled Americans who are able to work and want to work;

-- Medicare "buy-in" for the near-elderly; and

-- Saving Social Security.

I encourage you to include in the Democratic agenda three new ideas that will help millions of Americans and expand our base of support for the year 2000.

1. Prescription Drug Coverage under Medicare:

We should help seniors by guaranteeing this coverage under Medicare. In 1965, when Medicare was enacted, most private insurance plans did not offer this coverage. Today, 99 percent of private insurers provide it -- but Medicare does not. Millions of senior citizens struggle to afford the expensive prescription drugs needed to maintain their health and avoid hospitalization.

In 1994 and 1996, Democrats received 48 percent of the senior citizen vote. This year, that support dropped slightly, to 44 percent. The elderly represent 28 percent of the voting public. We cannot afford as a party to lose this powerful and growing voting bloc. There is no better way to attract these voters than to fight for their health care. Providing prescription drug coverage is expensive -- which is why seniors are struggling so hard to afford it. But the need is

great, and the long-term benefit for the Democratic Party is great too.

2. A Well-Qualified Teacher in Every Classroom:

You deserve great credit for directing the national education debate to the all-important issues of quality and standards. Your two key proposals to reduce class size by funding 100,000 new teachers and to modernize schools have resonated throughout the country. To fill out the education picture, we must also assure that teachers are well-trained to meet high standards and raise student achievement.

You are already providing funds to hire new teachers. I propose that we help existing teachers, too. We need mentoring programs for novice teachers as they adjust to the classroom. We need more resources for teacher training, for professional development, and for appropriate recertification requirements -- while avoiding the divisive issue of teacher testing. With your leadership, we can assure parents and students that we are doing all we can to guarantee a well-trained teacher in every classroom in America.

3. Ready to Learn:

We must do a better job of enabling children to start school ready to learn. Experts agree that the attention given children in their formative years often determines their ability to learn and succeed over their lifetime. You have led the way on child care. We need to expand Headstart, Early Start, pre-K, and other programs with a proven record of preparing children for school, and we also need to focus these programs more effectively on early learning.

I believe that tobacco funding can provide the resources needed to pay for these initiatives, and that the iniatives will have widespread support from the American people and strengthen your hand in dealing with the tobacco companies.

For example, the governors could be permitted to keep the federal share of the state tobacco settlement, provided that the funds are used to prepare children to start school ready to learn.

In addition, the federal government should insist on compensation from the tobacco companies for the costs to the federal government of treating tobacco-related illnesses under Medicare, veterans' health programs, and other public health programs. The compensation could be pursued both in court and through legislation. To strengthen these approaches, we should earmark every cent collected from the tobacco companies for prescription drug coverage for our senior citizens under Medicare. I believe this linkage would receive broad support.

Thank you for your continued leadership on so many issues of vital importance to the nation. As always, I look forward to working with you to bring greater opportunities for working families.

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Thank you for your continued leadership on so many issues of vital importance to the nation. As always, I look forward to working with you to bring greater opportunities for working families.

TOBACCO TALKING POINTS -- DECEMBER 21, 1998

1) The Administration should renew its effort to substantially raise the federal tax on cigarettes. The budget should propose increasing the cigarette tax by at least 70 cents per pack. A majority of the Senate -- 58 members -- supported a $1.10 per pack increase in the last session. The cost of the state settlement is approximately 40 cents per pack. This leaves 70 cents per pack -- approximately $40 billion over five years -- to finance our initiatives.

2) Raising the price of cigarettes produces a double benefit -- it is an important deterrent to youth smoking and it produces badly needed revenue.

3) The federal government incurs enormous costs each year to provide health care for those suffering from tobacco-induced disease. Estimates place the federal cost at approximately $22 billion per year, of which roughly half is incurred in Medicare.

4) The successful state lawsuits already established the principle that the tobacco industry is liable for the costs which government incurs treating sick smokers. Whenever people ask me about tobacco issues, they want to know why the federal government has not filed suit.

5) The best way, probably the only way, to get Congress to enact a substantial cigarette tax increase is for the federal government to file suit against the industry. That is our leverage to bring the industry to the table and negotiate a strong legislative package.

6) I know you are hearing from the Justice Department that the federal government does not have a good case. Many of the foremost experts in the country disagree.

7) I (along with Senators Conrad and Bob Graham) have had several meetings about this issue with Attorney General Reno. She personally is very favorably disposed to bringing a suit, but the staff keeps raising obstacles to going forward.

8) At her invitation, I have put together a group of experts -- both legal academics and trial lawyers -- who believe the federal government has a strong case and who are willing to meet with the Attorney General and her staff on an ongoing basis to persuade them to file suit and to help them put the case together. It includes Larry Tribe, Robert Blakey (the RICO expert), Einer Elhauge (an anti-trust expert from Harvard), Mike Ciresi (the lead trial counsel in the Minnesota case) and Dick Scruggs (the lead counsel in the Mississippi case). We've already been meeting with them, and the first meeting with the Attorney General is scheduled for early in January.

9) They have identified four viable causes of action -- 1) civil RICO, 2) the Medical Care Recovery Act, 3) the federal common law of nuisance (used successfully in environmental cases prior to EPA), and 4) antitrust.

10) Such a lawsuit would clearly give us enormous leverage to negotiate strong tobacco legislation including a substantial price increase and FDA regulatory authority.

11) I believe we could further strengthen the legislative argument for a 70 cent per pack price increase by proposing that the money be spent to provide prescription drug benefits for seniors through Medicare. You know how popular that issue is, but we've never been able to fund it. Since much of the tobacco-related cost the federal government incurs is in Medicare, this would be a particularly appropriate use of the money. It is a much more potent message than spreading the money over a number of different programs.

12) I would try to use the federal share of the tobacco money which the states recovered in their Medicaid suits to address our child care and child development initiatives. We should only agree to waive the federal claim to those Medicaid dollars if the states agree to use the federal share for children's programs. The states are worried about losing that money, and an agreement along these lines can be negotiated.

THE WHITE HOUSE

WASHINGTON

February 24, 1999

TO: Gene S., Bruce R., Elena K., Larry S., Steve R.

FROM: Chris J. and Jeanne L.

RE: HCFA MEDICARE COMMISSION ANALYSIS

Last night, Senator Breaux released an analysis from the HCFA actuaries on the latest version of Senator Breaux's Medicare Commission reform packages. Senator Breaux's cover note suggests that premium support saves $347 to 372 billion over 10 years.

A closer reading of the analysis shows that premium support by itself saves about $75 to 100 billion over 10 years ($26 to 37 billion over 5 years). The $347 to 372 billion "savings" also includes about $100 billion in revenue from an income-related premium that is earmarked in its entirety for low-income protections and about $50 billion in reduced Medicare liability from transferring direct medical education out of the Medicare Trust Fund. As a consequence, almost one half -- about $150 of the $347 to 372 billion -- does not represent Federal savings.

The following is a brief description of the package and analysis:

SENATOR BREAUX'S PACKAGE

- **Premium support ($26 to 37 billion over 5, $75 to 102 billion over 10).** The actuaries estimated savings from Senator Breaux's "alternative" model that was described for the first time in a memo from the Commission on 2/17. The higher savings estimate assumes that there is no ability for private plans to vary their benefits. The lower savings estimate assumes a limited amount of variation. These savings are higher than expected because Senator Breaux has made important modifications in his proposal, specifically reducing the benefits flexibility, even in the more "flexible" model.

- **Income-related premium ($36 to 38 billion over 5, $95 to 96 billion over 10).** This plan would start increasing the Medicare premium for beneficiaries with income at $24,000 for singles, $30,000 for couples. These income thresholds are half as high as the 1997 Chafee-Breaux proposal, and would affect more than twice as many people -- about 30 percent of beneficiaries (about 12 million beneficiaries) would pay higher premiums. Assuming 1999 costs, this premium would be $125 a month each for an elderly couple with $50,000 annual income -- more than a 100 percent increase. All $38 billion in revenue from this income-related premium, according to the description, would be reinvested in a yet- to-be designed low-income protections and therefore would be budget neutral (no savings).

- **Raising the age eligibility ($2 billion over 5, $25 billion over 10).** The real savings from this proposal are in the long-run -- a separate analysis indicated that this policy alone would produce as much savings as premium support over the 30-year period. The analysis does not include any proposal to assist people losing Medicare eligibility in finding new sources of coverage (e.g., Medicare buy-in).

- **Cost sharing and Medigap changes ($14 billion over 5, $31 billion over 10).** This plan would make a number of changes to Medicare cost sharing which, in total, would increase the amount that beneficiaries pay out-of-pocket ($9 billion over 5, $20 billion over 10). This primarily results from a new 10 percent home health copay. The plan would also prohibiting Medigap from covering Medicare's deductible ($5 billion over 5, $11 billion over 10).

- **Fee-for-service reforms ($16 billion over 5, 79 billion over 10):** This includes extending most Balanced Budget Act proposals from 2003 to 2007 ($7 billion over 5, $57 billion over 10) (note: since the BBA expires in 2002, only 2003 and 2004 savings count toward the 5 year savings). The plan would also modernize Medicare fee-for-service by giving it additional flexibility used by private health plans ($9 billion over 5, $22 billion over 10). These savings are more than we expected, and probably are more than CBO would estimate.

- **Transferring direct medical education out of Medicare ($20 billion over 5, $46 billion over 10).** This proposal does not actually save the Federal government any money -- it simply moves DME spending from Medicare to some other, unnamed place in the budget.

WHAT IS NOT IN SENATOR BREAUX'S PACKAGE

- **Surplus:** The plan contains no revenue proposals.

- **Prescription drug benefit**: Under the more flexible benefits version of premium support, plans could offer a limited drug benefit and possibly receive a government subsidy for it if its premium is below average. People in traditional Medicare or without access to a low-cost private plan would have no drug option.

- **Defined benefit:** Despite improvements in their structure, both premium support options allow some flexibility around the core benefits (e.g., offer varying but actuarially equivalent levels of physician visit coverage, home health, outpatient care). The more flexible option allows plans to offer whatever additional benefits they desire, so long as the value of those benefits doesn't exceed a limit. Benefits variability not only reduces effective competition, but could cause risk selection and confusion among beneficiaries faced with a wide array of slightly different benefits options.

- **Medicare buy-in:** The proposal raises age eligibility without offering any options whatsoever for people who lose Medicare eligibility as a result of the change.

There are also unanswered questions, like whether beneficiaries choosing private plans will pay more or less depending on where they live. We will you posted as we learn more.

SENATOR BREAUX'S MEDICARE REFORM PROPOSALS

(Calendar years, dollars in billions)

	00-04	00-09
Premium Support		
Limited Flexible Benefits	-26	-75
No Flexible Benefits	-37	-102
Income Related Premium (Begins $24/30 ends $40/50)		
Limited Flexible Benefits	-36	-96
No Flexible Benefits	-38	-95
Raising Age Eligibility	-2	-25
Cost Sharing / Medigap Changes		
Cost sharing changes (including unlimited home health copay)	-9	-20
Medigap: Prohibiting coverage of deductible	-5	-11
Subtotal	**-14**	**-31**
Medicare Fee-For-Service Reforms		
BBA Extenders	-7	-57
Modernizing fee-for-service	-9	-22
Subtotal	**-16**	**-79**
Removing direct medical education from Medicare	-20	-46
Drug Coverage	Not Included	
Surplus	Not Included	
Interactions	1	6
MEDICARE SAVINGS		
Total Package Plus Premium Support #1	**-114**	**-346**
Total Package Plus Premium Support #2	**-126**	**-373**
FEDERAL SAVINGS (Minus Income-Related Premium; DME)		
Total Package Plus Premium Support #1	**-58**	**-204**
Total Package Plus Premium Support #2	**-69**	**-231**

Package 1—Draft Medicare legislative package introduced by Senator Breaux at January 26 Commission meeting[1]

Category	Provision	Comment
Fee-for-service:		
Cost sharing	Combined A & B deductible of $350 (indexed to CPI) 0% coinsurance on inpatient and preventive care; 10% coinsurance on home health care; present law OPD coinsurance; 20% coinsurance on all other services	
Modernization	Standard BCV package	
BBA extenders	NBCFM "temporary" package (through 2007) except: no M+C / no DSH	
Medical education	Remove DME funding from Medicare; no IME provision	
DSH	No provision	
Medigap reforms	Prohibit coverage of Medicare deductible(s)	
Premium support:		
Administration	Medicare Board would have considerable authority to negotiate premiums & benefit packages, enforce financial & quality standards, approve service areas, etc.	
Benefit packages	Option (1): Standardized "core" package required as minimum Additional benefits beyond core package are allowed Private plan packages must be ≥ government FFS plan Actuarial value of package may not exceed 110% of core value Peripheral benefits such as dental care, cosmetic surgery, vision care, OTC drugs, are not permitted Option (2): Standardized "core" package only; no benefit package flexibility	
Premium allocation	Gov't FFS plan must bid nationally, others may bid nationally or regionally Partial geographic adjustment of payments; full risk adjustment 2-bendpoint premium allocation formula; based on full plan bids: At or below 85% of WAP, 100% / 0% Medicare / beneficiary allocation At 100% of WAP, 88% / 12% Above 100% of WAP, gov't contrib = 88% of WAP	
Income related premium	Single bene's: 12% at $24,000 – 25% at $40,000+ Bene couples: 12% at $30,000 – 25% at $50,000+ Brackets indexed by CPI Revenue earmarked for improving low-income beneficiary coverage	No specific provision
FFS and PS:		
Eligibility age	Increase age of eligibility following OASDI schedule	
Voluntary coverage	No provision	
Drug coverage	No provision	
Budget surplus revenue	No provision	

[1] Specifications reflect clarifications and modifications received from Bobby Jindal, Daria Romito, and Sarah Lyons on 1-29-99, 2-11-99, 2-12-99, 2-17-99 and 2-22-99.

Office of the Actuary
February 23, 1999

Estimated costs (+) or savings (–) under two alternative versions of Medicare legislative package introduced by Senator Breaux at January 28 Commission meeting
(Calendar year estimates; amounts in billions)

—Option (1): Limited variation in benefit package—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total savings, nominal $ 2000-04	Total savings, nominal $ 2000-09	Total savings, % of PL expends 2000-04	Total savings, % of PL expends 2000-09	Total savings, % of PL expends 2000-10
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$11.3	-$6.5	-$8.9	-$11.0	-$11.9	-$12.2	-$7.1	-$57.1	-0.5%	-1.7%	-2.4%
Cost sharing changes	-1.8	-1.8	-1.9	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-9.2	-19.5	-0.7%	-0.6%	-0.7%
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-9.2	-21.8	-0.7%	-0.6%	-0.6%
Removal of DME	-3.8	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-20.1	-46.1	-1.4%	-1.3%	-0.9%
Premium support	-2.4	-3.9	-5.4	-6.7	-7.7	-8.3	-9.0	-9.7	-10.5	-11.4	-28.1	-74.9	-1.9%	-2.2%	-2.4%
Income-related premium	-6.6	-7.0	-7.5	-8.1	-8.8	-9.6	-10.5	-11.4	-12.5	-13.7	-38.1	-85.9	-2.7%	-2.5%	-3.1%
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-2.1	-25.2	-0.1%	-0.7%	-1.7%
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-5.2	-11.3	-0.4%	-0.3%	-0.2%
Interactions	0.1	0.1	0.1	0.3	0.4	0.5	0.7	0.9	1.0	1.1	1.0	5.2	0.1%	0.2%	0.2%
Total savings	-17.0	-19.2	-21.9	-26.8	-31.4	-36.0	-41.1	-46.5	-50.7	-56.0	-118.2	-346.6	-8.2%	-10.1%	-11.5%
Total present law expends	251	264	279	297	321	346	373	404	436	475	—	—	—	—	—
Savings as % of expends	-6.8%	-7.3%	-7.9%	-9.0%	-9.8%	-10.4%	-11.0%	-11.5%	-11.6%	-11.8%	—	—	—	—	—

Notes: 1. Refer to specification summaries for description of provisions.
2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.
3. "Savings" are defined as either expenditure reductions or increases in premium revenues.
4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

Estimated costs (+) or savings (–) under alternative versions of Medicare legislative package introduced by Senator Breaux at January 26 Commission meeting

(Calendar year estimates; amounts in billions)

—Option (2): No variation in benefit package—

Proposal	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	Total savings, nominal $ 2000-04	Total savings, nominal $ 2000-09	Total savings, % of PL expend's 2000-04	Total savings, % of PL expend's 2000-09	Total savings, % of PL expend's 2000-30
BBA extenders	$0.0	$0.0	-$0.4	-$2.4	-$4.3	-$6.5	-$8.8	-$11.0	-$11.5	-$12.2	-$7.1	-$57.1	-0.5%	-1.7%	-2.4%
Cost sharing changes	-1.8	-1.8	-1.8	-1.9	-1.9	-2.0	-2.0	-2.1	-2.1	-2.1	-9.2	-19.5	-0.7%	-0.6%	-0.1%
Modernization proposals	-1.7	-1.7	-1.8	-1.9	-2.1	-2.2	-2.3	-2.5	-2.7	-2.9	-8.2	-21.8	-0.7%	-0.6%	-0.6%
Removal of DME	-3.6	-3.8	-4.0	-4.2	-4.5	-4.7	-4.9	-5.2	-5.4	-5.7	-20.1	-46.1	-1.4%	-1.3%	-0.9%
Premium support	-4.1	-5.8	-7.6	-9.1	-10.3	-11.1	-11.8	-12.8	-14.0	-15.2	-36.9	-102.0	-2.8%	-3.0%	-3.2%
Income-related premium	-6.6	-7.0	-7.5	-8.1	-8.8	-9.6	-10.7	-11.4	-12.1	-13.6	-37.9	-95.5	-2.7%	-2.8%	-3.1%
Change in age of eligibility	0.0	0.0	0.0	-0.7	-1.4	-2.2	-3.0	-4.2	-5.8	-7.9	-2.1	-25.2	-0.1%	-0.7%	-1.7%
Medigap regulation changes	-1.0	-1.0	-1.0	-1.1	-1.1	-1.1	-1.2	-1.2	-1.3	-1.3	-5.2	-11.3	-0.4%	-0.3%	-0.2%
Interactions	0.1	0.1	0.2	0.3	0.5	0.7	0.8	1.0	1.2	1.4	1.2	6.3	0.1%	0.2%	0.2%
Total savings	-18.5	-21.0	-24.0	-29.0	-33.8	-38.8	-43.9	-49.5	-53.9	-59.5	-129.5	-372.0	-9.0%	-10.8%	-11.9%
Total present law expends	251	264	279	297	321	346	373	404	438	475	—	—	—	—	—
Savings as % of expends	-7.4%	-8.0%	-8.6%	-9.8%	-10.5%	-11.2%	-11.8%	-12.3%	-12.3%	-12.5%	—	—	—	—	—

Notes: 1. Refer to specification summaries for description of provisions.

2. Estimates shown for each provision are on a "stand alone" basis, that is, the financial impact of that provision only, relative to present law. Total savings for the package reflect interactions.

3. "Savings" are defined as either expenditure reductions or increases in premium revenues.

4. Estimates are preliminary and subject to change pending improved data and more refined methodologies. In particular, estimates of interactions among proposals are very rough.

The Administrator

United Nations Development Programme
Sustainable human development

11 February 1999

Dear Mrs. Clinton,

I would like to bring to your attention the very difficult position in which UNDP finds itself at this particular juncture. As you are aware, the Administration requested a very low figure, $80 million, (a dramatic drop of $25 million from last year's request) for UNDP for FY 2000. I hope to secure your help in rescuing UNDP from what is clearly a very negative signal being sent by the Administration to the United Nations, and most importantly, to the sustainable development work of the United Nations.

When I communicated this news to Melanne Verveer on the eve of the budget disclosure, she indicated that you would do whatever you could to help turn this situation around. It is most important that we support each agency at the highest possible level so that each may carry out its specific mandate, be it for children, health, population, environment or development. I would therefore like to request your personal support so that UNDP can reach a level of $113 million for FY 2000.

One possible avenue would be for the Administration to request supplemental funds that could be directed to UNDP. Our programme is hard at work both in Central America and in the West Bank and Gaza. Additional support is urgently required for our longer-term recovery and reconstruction initiatives in the aftermath of Hurricane Mitch. The recent Wye Accords underscore the need for our strengthened development efforts with the Palestinian people.

I think it is absolutely critical that we find a way to restore funding to UNDP, and I know I can count on your good offices to achieve this goal. I look forward to talking with you at your earliest convenience.

With best personal regards.

Yours sincerely,

James Gustave Speth

James Gustave Speth

First Lady Hillary Rodham Clinton
Office of the First Lady
The White House
Washington, DC 20500

President Clinton Continues to Fight to Improve the Health of Our Nation's Children

- **Children and Prescription Drug Testing.** Today's announcement requiring manufacturers to do studies on pediatric populations for new prescription drugs and those currently on the market builds on an impressive array of children's initiatives advocated by President Clinton.

- **Children and Insurance Coverage.** The President fought hard to ensure that the Balanced Budget Act included $24 billion -- the largest investment in children's health care since the passage of Medicaid in 1965 -- to provide meaningful health care coverage to as many as five million of our nation's uninsured children. He also fought to include revenue from a 20 cent tobacco tax which will not only further reduce the number of uninsured children, but it will also serve as a financial barrier to help prevent our children from starting to smoke in the first place.

- **Children and Tobacco.** The President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. Each day about three thousand children become regular smokers and 1,000 of them will die from a tobacco-related illness. According to former FDA Commissioner David Kessler, the possibility of a comprehensive, public health oriented settlement with the tobacco industry could not have come about without the President's leadership in this area.

- **Children and Insurance Reform.** By signing the Kassebaum-Kennedy bill into law last year, the President helped millions of American children keep their health care coverage when their parents lose or change jobs.

- **Children and Juvenile Diabetes.** The President fought to include $150 million ($30 million annually for five years) for research to help find the cure for diabetes. Americans with this disease often suffer severe consequences, such as blindness and kidney disease, even when they receive the best treatment and care. The HHS Secretary will have discretion to target the new funds toward the best scientific opportunities. This represents the largest single new investment in Juvenile Diabetes.

- **Children and Immunization.** As the President recently announced, over 90 percent of America's toddlers in 1996 received the most critical doses of each of the routinely recommended vaccines -- surpassing the goal set by the President in 1993.

- **Children and the Environment.** Earlier this year, the President signed an Executive Order to reduce environmental health and safety risks to children by requiring agencies to strengthen policies and improve research to protect children and ensure that new regulations consider special risks to children.

- **Children and Medicaid.** Throughout his Administration, the President has fought to preserve and strengthen the Medicaid program; its coverage of about 20 million children, makes it the largest single insurer of children. The Administration has partnered with states through Medicaid waivers to expand coverage to hundreds of thousands of children.

Draft

THE 1999 DEMOCRATIC AGENDA

Continue on the path of fiscal responsibility to keep our economy growing; Invest now to meet the challenges of the 21st century, including quality education for children and secure retirement and quality care for seniors; and enable families to meet their responsibilities at home and at work.

Invest the Surplus to save Social Security and Medicare and Pay Down the Debt

Save Social Security: Reserve 62 percent of the projected budget surpluses to save Social Security until 2055; Allow the trust fund to invest about one-fifth of the transferred surpluses in the private sector to achieve higher returns for Social Security just as any state or local government, or private pension does.

Strengthen Medicare for the 21st Century: Reserve 15 percent of the projected surpluses for Medicare, ensuring the Medicare Trust Fund is secure for 20 years, and achieve broader reforms -- including a covering prescription drugs.

Pay Down the Debt: Investing 77% of the surplus into Social Security and Medicare will reduce the national debt to the lowest level since 1917 and save taxpayers billions of dollars in interest charges.

Quality Education: Modernize Schools, Reduce Class Size and Provide Accountability

School Modernization: Federal tax credits will enable state and school districts to modernize and renovate 6,000 local public schools, to improve learning conditions, end overcrowding and make room for smaller classes.

Smaller Classes: Finish the job of hiring 100,000 new teachers over the next seven years to reduce class size in grades 1-3 to a national average of 18, making sure that every child gets a solid foundation in the basics.

Teacher Training and Recruitment: Increase support for teacher training in subject-matter knowledge and teaching expertise; new incentives to recruit highly qualified teachers.

Build Accountability Measures into federal support for education to ensure that school districts and states provide every student with a high quality education, building on proven reforms now being implemented in states and cities

Education Technology: Continue to provide schools with Internet capacity and resources for teacher training and integrating technology into the curricula; protect the e-

rate discount for schools and libraries and new teacher training

Secure Retirement and Quality Care for Seniors

Social Security: In addition to devoting 62% of the surplus to the Social Security system, we will work to enact further policies to strengthen the system, reduce poverty among elderly widows, and eliminate the earnings limit within the context of Social Security reform.

Medicare: Reserve 15% of the surplus to strengthen Medicare; work to enact further changes to strengthen and improve the Medicare program, including badly needed prescription drug benefit.

Protect Pensions

Expand Pension Benefit Coverage: Create a new plan that will make it easier for small businesses to start private pension plans that provide predictable and secure benefits, and for employees to save in IRAs through payroll deductions; Permit employees to rollover benefits from different types of retirement plans.

Strengthen Women's Retirement Security: Allow workers to count time taken under the Family and Medical Leave Act toward their retirement benefits. Call for pension plans to offer a 75 percent joint and survivor annuity option -- so that families can choose to reduce benefits while both are alive in order to guarantee that a surviving spouse would get higher benefits;

Targeted Tax Cuts for Retirement Savings, Child Care, and Long Term Care

Retirement Savings: Devote 12% of the surplus to USA Accounts, enabling working families to save for their own retirement in private accounts.

Child Care: Provide greater tax relief for working families who pay child care expenses in order to work, tax credit credits to businesses that provide child care services, and tax credits for stay at home parents.

Long Term Care: Provide $1,000 tax credits to families who provide care for elderly and disabled family members; support caregivers; and provide long term care insurance for federal employees.

Enable Families to Succeed at Home and at Work

Protecting Patients through a Strong, Enforceable Patients Bill of Rights: The Patients' Bill of Rights should contain a range of protections, including guaranteed access to needed specialists, access to emergency room services when and where the need arises, access to a meaningful independent and external appeals process for consumers to resolve

differences with their health plans, and the right to be compensated when a health plan's decision causes a patient to be harmed or die.

Continue to Expand Access to Quality, Affordable Health Care by enabling Americans age 62-65 and displaced and retired workers ages 55 to 65 to buy into Medicare if they lose coverage.

Ensure Opportunity for Americans with Disabilities by enabling workers with disabilities to buy into Medicaid and Medicare , a $1,000 tax credit and support for assistive technologies.

Targeted Tax Cuts for Retirement Savings, Child Care, and Long Term Care

Child Care: Improve the accessibility and safety of child care through expansion of the child care and development block grant to help working families meet costs and improve quality by increased training and support services for care givers.

After School Care: increase after school care to enable 1.1 million children each year to participate in after school and summer school programs by using public school facilities and existing resources.

50,000 More Cops with 21st Century Tools

More Police on the Streets: The 21st Century Policing Initiative builds on the successful COPS program by helping communities hire and redeploy up to 50,000 more law enforcement officers over five years, with an effort to target new police officers to crime "hot spots" and to help retain those officers recently hired.

Raise the Minimum Wage and Enforce Fair Pay

Raise the Minimum Wage: Recognize the value of work and support working families; give millions of Americans a pay raise by increasing the minimum wage.

Ensure Equal Pay: Help guarantee equal pay for women and men by stronger enforcement of equal pay laws, ending wage discrimination, and improving access to wage information for all workers.

Protect the Environment and Improve Livability

Protect Our Environment and our families' safety by ensuring clean air, clean water, and safe food; continue accelerated toxic waste clean up and make polluters pay; protect our national parks and other great places.

Improve our Parks and Help Communities Improve Livability: Expand federal efforts to save America's natural treasures. Provide new tools and resources to states and

local governments to help communities across America grow in ways that ensure a high quality of life and preserve green space for future generations.

Crackdown on Crimes Against Seniors

Give Law Enforcement Officials Additional Tools to prosecute criminals who target seniors, such as telemarketing fraud and health care, and strengthen penalties for criminal behavior that harms seniors physically and financially.

Reduce Unnecessary and Illegal Medicare Costs by cracking down on fraud and abuse in the Medicare system.

Privacy

Protect Individuals' most personal records by ensuring appropriate treatment for medical records, affording notice and opportunity for consent to sharing of financial information, and enhancing enforcement to prevent abuses.

THE WHITE HOUSE

WASHINGTON

March 15, 1999

TO: Steve R., Gene S., Bruce R., Larry S., Elena K., Jack L., Dan M. David B., Melanne V., Sarah B., Neera T., Janet M.

FROM: Chris J. and Jeanne L.

RE: BREAUX-THOMAS MEDICARE PLAN

Attached is the final Breaux-Thomas Medicare plan. They released it at a 5pm press conference. Highlights of the plan include:

- **No specific plan for Medicare financing**: The plan contains no options for raising new revenue for Medicare -- specifically it does not include the President's proposal to dedicate part of the surplus to Medicare. Instead, it states that once Medicare appears to be close to becoming insolvent (using a new definition), Congress would be notified. This would result in a Congressional debate on legislation to authorize any additional funding.

- **No meaningful prescription drug benefit**: The plan would require private managed care plans, Medigap, and possibly Medicare fee-for-service to offer a drug benefit, but only provides a subsidy for that coverage for people below 135 percent of poverty. This is troubling because it moves Medicare towards a means-tested, Medicaid-like program, and would probably result in large adverse selection in the unsubsidized Medicare fee-for-service option.

- **Age eligibility increase without a viable insurance alternative**: Although there is a suggestion that vulnerable sick people ages 65 to 67 would get Medicare, the proposal explicitly states that the Medicare buy-in would be unsubsidized and would not begin at 62 (which is truly conforming to Social Security). This plan would likely lead to an increase in the uninsured.

- **No income-related premium:** This was dropped since the last draft -- reportedly because some Republicans considered it too similar to a tax (since it is administered through Treasury).

There are probably other issues that we have not yet noticed; we will be working on a more complete memo of the issues for the morning.

Please call or page with questions.

SUMMARY OF BREAUX/THOMAS PROPOSAL

Medicare Board:
The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries premiums. Board would approve plan service areas and benefit package designs.

Benefits Package:
The standard benefits package is specified in law and would consist of all services covered under the existing Medicare statute. Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:
Private Plans
All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

Low-Income
The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty ($10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service
The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Medigap
All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:
Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower or 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:
The government-run fee-for-service plan would have a $400 combined deductible, indexed to the growth in Medicare costs. 10 percent coinsurance would be charged for home health, laboratory services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Special Payments:
Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. The proposal would also recommend exploring funding Indirect Medical Education (IME) and other non-insurance subsidies outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program. Any special payments remaining in Medicare would not be included in the calculation of premiums for the government-run fee-for-service plan or private plans.

Retirement Age:
The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. A non-subsidized buy-in would be available at age 65. Congress should develop a special category of eligibility based on specific needs-based criteria (i.e. ADLs) for individuals between 65 and the then-current eligibility age.

Long-Term Care:
Long-term care issues should be separated from Medicare (an acute care program), and long-term care improvements should be made through pension, Social Security, and investment reforms. The proposal would require a study of various long-term care issues.

Financing:
Part A and Part B trust funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare outlays, Congress would be required to authorize any additional contributions to the Medicare Trust Fund. This new test (40% of outlays) would probably not be reached until after 2005. Even if general revenue contributions were limited to 40% of program outlays, this proposal would extend solvency to 2013 (2017 under CBO's new baseline.)

Budgetary Impact:
Between 2000 and 2009, this proposal would save approximately $100 billion. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from $500 to $700 billion.

SUMMARY OF BREAUX/THOMAS PROPOSAL

Medicare Board:
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Benefits Package:
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All private plans would be required to offer a high option that includes at least the standard benefits package plus coverage for prescription drugs.

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The proposal would immediately extend coverage of prescription drugs for beneficiaries under 135 percent of poverty ($10,568/individual) under Medicaid with full federal funding of the additional cost. That coverage could be provided through high option plans when the premium support system was implemented.

Fee-For-Service
The government-run FFS plan could offer a high option plan which includes prescription drugs. The Medicare Board would approve the benefit package as it does for private plan offerings. HCFA would work with third-party contractors to offer its high option plan. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

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All Medigap plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

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Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. Only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower or 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

BUILDING A BETTER MEDICARE FOR TODAY AND TOMORROW

I. INTRODUCTION

This recommendation is in three parts:

- the design of a premium support system,
- improvements to the current Medicare program, and
- financing and solvency of the Medicare program.

We believe it is important to address the current program now because of the transition time necessary to implement this premium support system. We assume the enactment of this proposal in 1999 and that the premium support system would be fully operational in 2003.

We believe a premium support system is necessary to enable Medicare beneficiaries to obtain secure, dependable, comprehensive high quality health care coverage comparable to what most workers have today. We believe modeling a system on the one Members of Congress use to obtain health care coverage for themselves and their families is appropriate. This proposal, while based on that system, is different in several important ways in order to better meet the unique health care needs of seniors and individuals with disabilities. Our proposal would allow beneficiaries to choose from among competing comprehensive health plans in a system based on a blend of existing government protections and market-based competition. Unlike today's Medicare program, our proposal ensures that low income seniors would have comprehensive health care coverage.

Because the implementation of a premium support system will take a number of years, we recommend immediate improvements to the current Medicare program. In Section II we outline the incremental improvements to enhance the beneficiaries' security and quality of care now. We recommend immediate federal funding of pharmaceutical coverage through Medicaid for seniors up to 135% of poverty ($10,568 for an individual and $13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing.

In reviewing the three parts of this proposal, it is important to keep in mind the different government roles in the premium support system and in current law. We believe the guarantee our society makes to every senior is to ensure that they can obtain the highest quality health care, and that their health care coverage not be allowed to fall behind that available to people in their working years. We believe that our society's commitment to seniors, the Medicare entitlement, can be made ***more secure*** only by focusing the government's powers on ensuring comprehensive coverage at an affordable price rather than continuing the inefficiency, inequity, and inadequacy of the current Medicare program.

I. PREMIUM SUPPORT SYSTEM TO PROVIDE COMPREHENSIVE COVERAGE

The Medicare Board

A Medicare Board should be established to oversee and negotiate with private plans and the government-run fee-for-service plan. Some examples of the Board's role are: direct and oversee periodic open enrollment periods; provide comparative information to beneficiaries regarding the plans in their areas; transmit information about beneficiaries' plan selections and corresponding premium obligations to the Social Security Administration to permit premium collection as occurs today with Medicare Part B premiums; enforce financial and quality standards; review and approve benefit packages and service areas to ensure against the adverse selection that could be created through benefit design, delineation of service areas or other techniques; negotiate premiums with all health plans; and compute payments to plans (including risk and geographic adjustment).

This Board would operate under a government charter that would describe its responsibilities and operating standards including the ability to hire without regard to civil service requirements and salary restrictions.

Ensuring Plan Performance and Dependability

All plans (private plans and the government-run FFS plan) would compete in the premium support system; all plans would have Board-approved benefit designs and premiums. The Board would ensure that the benefits provided under all plans are self-funded and self-sustaining, determining whether plan premium submissions meet strict tests for actuarial soundness, assessing the adequacy of reserves, and monitoring their performance capacity.

Management of Government-run Fee-for-service in Premium Support

The government plan would have to be self-funded and self-sustaining and meet the same requirements applied to all private plans, including whether its premium submissions meet strict tests for actuarial soundness, the adequacy of reserves, and performance capacity.

Cost containment measures would be necessary. The provisions of the Balanced Budget Act of 1997 should be extended, or comparable savings achieved. In any region where the price control structure of the government run plan is not competitive, the government-run fee-for-service plan could operate on the basis of contracts negotiated with local providers on price and performance, just as is the case with private plans. The government plan would be run through contractors as it is today; contractors in one region would be able to bid in other regions; the Board should have powers to assure that the government-run plan would not distort local markets.

Benefits Package

A standard benefits package would be specified in law. This benefits package would consist of all services covered under the existing Medicare statute. Plans would be able to offer additional benefits beyond the core package and plans would be able to vary cost sharing, including copay and deductible levels, subject to Board approval. Benefits would be updated through the annual negotiations process between plans and the Board, although the Board would not have the power to expand the standard benefit package without Congressional approval. Health plans would establish rules and procedures to assure delivery of benefits in a manner consistent with prevailing private standards and procedures offered to employer groups and other major purchasers.

The Medicare Board would approve benefit offerings and could allow variation within a limited range, for example not more than 10% of the actuarial value of the standard package, provided the Board was satisfied that the overall valuation of the package would be consistent with statutory objectives and would not lead to adverse or unfavorable risk selection problems in the Medicare market.

New benefit to be instituted in the premium support system: Outpatient prescription drug coverage and stop-loss protection

In Private Plans:

Private plans would be required to offer a high option that includes at least Medicare covered services plus coverage for outpatient prescription drugs and stop-loss protection. Plans would be able to vary copay and deductible structures. Minimum drug benefits for high option plans would be based on an actuarial valuation. High option and standard option plans each would be required to be self-funded and self-sustaining.

In Government-run Fee-For-Service Plan:

The government-run fee-for-service plan would be required to offer high option (including outpatient prescription drugs and stop-loss) in addition to standard option plans. The Medicare Board approval process would be the same as for private plans. High option and standard option plans would be required to be separately self-funded and self-sustaining. Government contracts would be based on prices commonly available in the market, without recourse to price controls or rebates.

Comprehensive coverage for low-income beneficiaries:

Coverage would be provided through high option plans. The federal government would pay 100% of the premiums of the high option plans at or below 85% of the national weighted average premium of all high option plans for all eligible individuals up to 135% of poverty ($10,568 for an individual and $13,334 for a couple) on a fully federally funded basis. This financial support does not limit

these beneficiaries' choice of plans nor restrict plans' design with regard to cost-sharing or other flexibility authorized by the Board. State would maintain their current level of effort, but the federal government would pay 100% of additional costs for these individuals. In this context, Congress should review DSH payments to ensure that double payments do not occur.

Premium Formula Basics

On average, beneficiaries would be expected to pay 12 percent of the total cost of standard option plans. For plans that cost at or less than 85 percent of the national weighted average plan price, there would be no beneficiary premium. For plans with prices above the national weighted average, beneficiaries' premiums would include all costs above the national weighted average.

Only the cost of the standard package would count toward the computation of the national weighted average premium. Plans with a high option, whether private plans or government-run, would separately identify the incremental costs of benefits beyond the standard package in their submissions to the Board, and the government contribution would be calculated without regard to the costs of these additional benefits.

Premium for government-run fee-for-service plans

The government-run fee-for-service plan would be treated the same as private plans.

Government-run plan premium excludes costs of special subsidies in premium calculation

All non-insurance functions and special payments now in Medicare would not be included in calculation of premiums for the government-run FFS plan or private plans.

Guaranteed premium levels where competition develops more slowly

In areas where no competition to the government-run fee-for-service plan exists, beneficiaries' obligations would be no greater than 12 percent of the FFS premium or the national weighted average, whichever is lower. The Medicare Board should periodically review those areas with a fixed percentage premium to ensure that the fixed percentage premium is not anti-competitive.

Medicare's Special Payments in a Premium Support System

Congress should examine all non-insurance functions, special payments and subsidies to determine whether they should be funded through the Trust fund or from another source. For example, payments for Direct Medical Education (DME) would be financed and distributed independent of a Medicare premium support system. Since the Part A and Part B trust funds would be combined and the traditionally separate funding sources of payroll taxes and general revenues would be blurred, Congress should provide a separate mechanism for continued funding through either a mandatory entitlement or multi-year discretionary appropriation program. On the other hand, Indirect Medical Education (IME) presents a unique problem since it is difficult to identify the actual statistical difference in costs between teaching and non-teaching hospitals.

Therefore, for now Congress should continue to fund IME from the Trust Fund as an adjustment to hospital payments.

II. IMMEDIATE IMPROVEMENTS TO THE CURRENT MEDICARE PROGRAM AND OTHER ASPECTS OF SENIORS HEALTH CARE SPENDING

Provide Outpatient Prescription Drug Coverage for 3 million more low-income beneficiaries

Immediately provide federal funding for coverage of prescription drugs under Medicaid for beneficiaries up to 135 percent of poverty ($10,568 for an individual and $13,334 for a couple). This would also expand beneficiary participation in currently available subsidies for premiums and cost-sharing. All funding obligations related to the coverage under this provision would be federal.

Improve access to outpatient prescription drug coverage for seniors

Revise federal directives to National Association of Insurance Commissioners (NAIC) to develop new Medigap state model legislation immediately. All private supplemental plans would include basic coverage for prescription drugs. One plan would be a prescription drug-only plan.

Combine Parts A and B

Health care delivery changes have blurred the distinctions originally contemplated when Parts A and B of Medicare were enacted. Parts A and B should be combined in a single Medicare Trust Fund. (See Section III on Financing and Solvency.)

Lower deductible for 8 million beneficiaries

The current Medicare program subjects beneficiaries entering the hospital to extremely high costs just at a time when they face the many other expenses associated with serious illness. Virtually no private health plan imposes such costs. We propose to combine the current Part A ($768) deductible and B ($100) deductible, and replace it with a single deductible of $400, which should be indexed to growth in Medicare costs.

Improve utilization of health care services

A fee-for-service plan is best maintained by financial incentives, without which costs spiral out of control or freedom of choice must be restricted. To protect against unnecessary rises in beneficiary Part B premiums, 10% coinsurance would be established for all services except inpatient hospital stay and preventive care, and except where higher copays exist under current law.

Revise federal directives to NAIC to develop new state model legislation to conform to the changes proposed for Medicare cost-sharing. These directives should also be

designed to achieve more affordable and more efficient supplemental insurance and to minimize Medicare outlays. The new single Medicare deductible and coinsurance schedule would be insurable in part or in whole.

Eligibility Age

Medicare eligibility age should be conformed to that of Social Security. A non-subsidized buy-in should be available at age 65. In addition, Congress should develop a special category of eligibility based on specific needs-based criteria, for example selected activities of daily living, for individuals between age 65 and then-current eligibility age.

III. FINANCING AND SOLVENCY

The changes proposed in this document are intended to put Medicare on surer financial footing by creating savings due to competition, efficiency and other factors, and by slowing the growth in Medicare spending. In addition, these reforms would result in Medicare offering a benefit package that is more comparable to health care benefits offered in the private sector and would enhance our ability to meet our commitment to today's and future beneficiaries. Without these changes, quality of care could suffer, and significantly greater revenues and/or beneficiary sacrifices would be required. Beneficiaries and the taxpayers would not receive the greatest value for the total health dollars spent on seniors' behalf.

Medicare's financing needs would be dictated by the Medicare growth rate achieved under the premium support system. By moving to a premium support system, Medicare's growth rate would be reduced by 1 to 1.5 percentage points per year from the current long-term annual growth rate of 7.6 percent (Trustees Intermediate) or 8.6 (Commission's No Slowdown Baseline.) If this reduction in growth rate can be achieved, the fiscal integrity and Medicare would be significantly improved.

Even if the estimated reduction in growth rate is achieved, Medicare will require additional resources as the percent of population that is eligible for Medicare increases. As revenue is needed, how much should be funded through the payroll tax, through general revenue, and through beneficiary premiums?

The answer to this question is difficult because it would require knowing today the health care system of the future. We do not know what the future holds in terms of the evolution of the health care delivery system, or the impact that technology will have on health care costs.

At the Commission's first meeting, Federal Reserve Chairman Alan Greenspan said that "the trajectory of health spending in coming years will depend importantly on the course of technology which has been a key driver of per-person health costs" Yet he went on to underscore what could be the absurdity of attempting now to determine funding levels necessary decades into the future "technology cuts both ways with respect to both saving medical expenditures and

potentially expanding the possibilities in such a manner that even though unit costs may be falling, the absolute dollar amounts could be expanding at a very rapid pace. One of the major problems that everyone has had with technology--and I could allude to all sorts of forecasts over the most recent generations--one of the largest difficulties is in forecasting the pattern of technology. It is an extremely difficult activity."

Notwithstanding the magnitude of uncertainty contained in the task, the statute establishing the Commission directed us to recommend measures to attain the long-term "solvency" of the Medicare program. Because of recent history the meaning of "solvency" has come under question. We believe a new measure of solvency must be developed that couples the uncertainty inherent in the task with the real need for the public to evaluate the cost of Medicare and how we should choose to fund this program over time.

The solvency test that has been applied to Social Security is not an apt model for Medicare. Social Security Trust Funds are funded exclusively through payroll taxes; Medicare is paid for by a combination of payroll taxes, general revenue and beneficiary premiums. These ratios have changed over time such that a greater portion of program expenses is now paid by general revenues and a relatively smaller portion is paid by payroll taxes and beneficiary premiums.

In addition, the payroll tax supporting the OASDI Trust Funds is limited both by its rate and the wage base on which that rate is applied. No portion of Medicare's funding contains these limitations. In Medicare, there is no cap on the wage base; the Part A Trust Fund is funded by a payroll tax of 2.9% on all earnings, and pays only for the Part A benefits of Medicare. Medicare's Part B benefits are paid 75% by general revenues and 25% by beneficiaries.

Consequently, the historic concept of Medicare's solvency is one that has been partially and inappropriately borrowed from Social Security and has never fully reflected the fiscal integrity, or lack thereof, of the Medicare program. In Medicare, "solvency" has meant only whether the Part A Trust Fund outlays were poised to exceed Part A reserves and collections. That is all.

Recently even this partial proof of fiscal integrity has been shattered. The notion of Part A "solvency" or rather "insolvency" has been used to shift more program costs to the general fund. An act of Congress shifted major home health expenditures from Part A to Part B in 1997, thus extending the fiction of the Part A Trust Fund "solvency" from 2002 through 2008 by shifting obligations to the general fund. The general fund, in great part, became the source of Part A "solvency".

The ever increasing estimates of general fund exposure should be part of any definition of solvency. Absent reform, general fund exposure jumps from 37% of program funding in FY2000 to 43% in FY2005 and 49% in FY2010. General fund demand will increase from $92 billion in FY2000 to $156 billion in FY2005 to $261 billion in FY2010.

Consequently, the "solvency" of the Part A Trust Fund is not useful as a guide to policy making or even as a tool to educate the public on the security and financial condition of the Medicare program.

Therefore, Part A and Part B Trust Funds should be combined into a single Medicare Trust Fund and a new concept of solvency for Medicare should be developed. This concept should more accurately reflect the implications of the program's financing structure, i.e., the ratio of relative financing burdens on the general fund, the Hospital Insurance payroll tax, and the premiums beneficiaries pay. Because beneficiary premiums and the payroll tax rate can only be amended by law, and have proved very difficult to modify over time, the only meaningful solvency test of this entitlement program is one based on the amount of general revenues needed to fund program outlays. This could be referred to as a programmatic solvency test.

Congress should enact this revised definition of Medicare solvency so that decisions can be made in the context of competing demands for general revenue. Congress should require the Trustees to publish annual projections regarding the ratio in program financing. In any year in which the general fund contributions are projected to exceed 40% of annual total Medicare program outlays, the Trustees would be required to notify the Congress that the Medicare program is in danger of becoming programmatically insolvent. The Trustees Report should provide for necessary and important public debate leading to potential adjustments to the payroll tax and/or the beneficiary premium as well as any adjustment of the general fund devoted to Medicare. Congressional approval would be required to authorize any additional contributions to the Medicare Trust Fund.

With the reforms contemplated under this proposal, that new test would probably not activated until after 2005. Even if we limit general revenue contributions to 40% of program outlays, however, this proposal would extend the solvency of Medicare to 2013. This calculation, based on the most recent CBO baseline, would indicate that solvency under this test would extend to 2017 or beyond.

Long-term care

The Commission recognizes that its proposal is focused on acute care, and does not address the issue of long-term care. In 1995, Americans spent an estimated $91 billion on long-term care, with 60 percent coming from public sources. Despite these large public expenditures, the elderly face significant uncovered liabilities. The Commission recommends that the Institute of Medicine conduct a study to 1) estimate future demands for long-term care; and 2) analyze the long-term care financing options available to seniors, including long-term care insurance, tax policy and community-based, state and federal government programs.

To: Medicare Commission 3/14/99

From: Jeff Lemieux

Subject: Cost estimate of March 14 proposal

The attached estimate is based on the proposal specified below. The estimate is displayed in annual figures for the 10-year budget window used in the Senate (and slightly beyond). Long-term tables developed by the Modeling Task Force, which display the impact of the proposal using several different measures, are also included. In addition, a simulation of a combined trust fund is attached. The explanation of the basis of the estimate is limited to new items in the proposal. The February 17 estimate of the original Breaux proposal contains a general explanation of the premium support plan. Since the current proposal is similar to the nontraditional estimate on February 17, simulations of the impact on beneficiary premiums from that estimate continue to apply.

DESCRIPTION OF THE PROPOSAL

Medicare Board:

The Board would provide information to beneficiaries, negotiate with plans, compute payments to plans (including risk, geographic, and other adjustments), and compute beneficiaries' premiums (collected via Social Security system as with Part B premiums now). Board approval would be required for plan service areas and benefit package designs.

Benefits:

The standard benefits package specified in law would consist of all services covered under the existing Medicare statute (Medicare covered services). Plans could establish their own rules as to how the benefits would be provided. Board approval would be required for all benefit design offerings and the Board would allow variation only within a limited range as the risk adjusters were proven over time.

Prescription Drugs:

Private Plans

All private plans would be required to offer a high option that included at least the standard benefits package plus coverage for prescription drugs. The minimum drug benefit for high option plans would be based on an actuarial valuation, with standards and examples set by the Board.

Low-Income

The proposal would immediately extend coverage of prescription drugs to qualifying beneficiaries under 135 percent of poverty under Medicaid with full federal funding of the additional cost. That coverage

could be provided through high option plans when the premium support system was implemented. (A special premium support schedule could be used to combine premium and drug subsidies for low-income beneficiaries.)

Fee-For-Service
The Health Care Financing Administration (HCFA) would be allowed to contract with or enter joint marketing arrangements with private insurers offering prescription drug benefits. That would allow a public/private high option plan or plans, with HCFA providing coverage for Medicare covered services and its private partner(s) providing coverage for drugs. HCFA's share of the premium in a public/private high option plan would simply be the premium for its standard option plan. In the longer run, HCFA would be allowed to transition the government-run fee-for-service plan to a more private-managed basis overall, possibly with different alternatives available regionally.

Medigap
The National Association of Insurance Commissioners would develop new model plans immediately under a federal directive. All plans would include basic coverage for prescription drugs. One plan would be drug-only. Plans would vary regarding the degree Medicare coinsurance was covered.

Premium Formula Basics:

Beneficiaries would pay 12 percent of the premium for the standard benefits package on average, pay no premium for plans less than about 85 percent of national weighted average, and pay all of the additional premium for plan premiums above national weighted average. (An example of this type of premium schedule was included in the estimate from February 17.)

Although all plans would be available on the national premium schedule, only the cost of standard benefits (Medicare covered services) would count toward the computation of the national weighted average premium. Plans with only a high option would be required to separate out the cost of extra benefits in their submission to the Board for that purpose.

If early versions of the risk adjuster would otherwise fail to prevent excessive premium differences between high and standard option plans, the Board's actuaries could require that differences in premiums reflect the difference in value of benefits offered for private plans with multiple benefit options.

In areas where only the government-run fee-for-service plan operated, the beneficiary obligation would be limited to the lower of 12 percent of the fee-for-service premium or 12 percent of the national weighted average premium.

Fee-for-Service Benefits:

The government-run fee-for-service plan would have a $400 combined deductible, indexed to the growth in Medicare costs. Ten percent coinsurance would be charged for home health, laboratory

services, and certain other services not currently subject to coinsurance. No coinsurance would be charged for inpatient hospital stays and preventive care.

Management of the Government-Run Fee-for-Service Plan:

All plans, private plans and the government-run fee-for-service plan, would compete in the premium support system; all plans would have premiums and would be available on the national schedule. The fee-for-service plan would have a premium like any other plan–it would adjust its premium in subsequent years based on its cost experience.

The proposal recommends that efforts to contain costs in the fee-for-service plan continue. Toward that end, HCFA would be allowed to pursue competitive purchasing strategies in areas where its payments were not appropriate. The estimate assumes that the growth of fee-for-service spending would be moderated somewhat by a combination of HCFA and Congressional efforts. Without some such ongoing savings, the fee-for-service plan could gradually lose its competitive position with private plans.

Special Payments (Education, Disproportionate Share, Rural Subsidies):

Under the proposal, federal support for Direct Medical Education (DME) would be carved out of Medicare. DME funding would continue through either a mandatory entitlement or multi-year discretionary appropriation program separate from Medicare. Depending on the nature of the replacement program for DME, the federal budget as a whole might not be affected by the carve-out. The proposal would also recommend exploring funding disproportionate share hospitals (DSH) and Indirect Medical Education (IME) outside of the Medicare program and financing those items through a mandatory or multi-year discretionary appropriation program.

Any special payments remaining in Medicare would not be included in premiums for the government-run fee-for-service plan or private plans.

Retirement Age:

The normal age of eligibility would be gradually raised from 65 to 67 to conform with that of Social Security. Congress would develop an exemption process for affected beneficiaries with special needs, such as those unable to work and otherwise get health coverage. Eligibility requirements under that exemption process would not necessarily be the same as the requirements for eligibility based on disability for those under 65, although the waiting period for eligibility based on disability could also be waived or shortened for those affected by the change.

Long-Term Care:

The proposal indicates that long-term care issues should be separated from Medicare (an acute care program). The proposal would require a study of various long-term care issues. The cost estimate

does not include any impact on the budget from long-term care items.

Financing:

The proposal would implement a combined trust fund, with guaranteed general revenue funding to grow at the same rate as overall program costs if it otherwise would exceed 40 percent of the program's cost (without further Congressional approval). The initial balance in the combined fund would equal the balance in the Part A and Part B funds at the time of enactment.

BUDGETARY IMPACT

Table 1 lays out the estimate in the style of an annual Congressional cost estimate. The savings attributed to the individual policies result from a top-down ordering of the estimate. Premium support was estimated first, in the absence of any other policies. Then the subsequent policies were added one by one–the savings represent the incremental impact of that policy on Medicare spending. Because Medicare spending would be reduced compared with current law, premium collections from beneficiaries would be reduced as well. That is why the impact of the proposal on premiums is displayed as a cost item in the table–lower government premium collections reduce the budget surplus (or increase the deficit).

Excluding the optional items, the proposal would be approximately budget neutral in the 5-year budget window between 2000 and 2004. That is because the new assistance for low-income beneficiaries would begin immediately, while the savings provisions would not be implemented until 2003. Over the 10 years between 2000 and 2009, the proposal would save approximately $100 billion.

Tables 2-6 show the detailed cost estimate of the March 14 plan in the format developed by the Modeling Task Force. That format was designed to gauge the impact of proposals using many different measures. Because the Part A trust fund would be replaced by a combined fund, tables 2-6 do not show results for the Part A fund under the proposal. Over the longer term, the proposal would reduce the growth of Medicare spending by approximately 1 percent a year. Although the savings would accumulate slowly over time, by 2030 the annual budgetary savings would range from $500 to $700 billion.

Table 7 shows the projected impact of a combined trust fund under the proposal, with general revenue funding growing at the same rate as program costs overall. As noted in the February 17 estimate, the growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30-year baselines

used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short-run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in Table 7 should be extended by 3 or 4 years as well, to 2016 or 2017.

BASIS OF THE ESTIMATE AND DISCUSSION

Premium Support

The basic estimate of the premium support plan is largely unchanged from the February 17 estimate. Tying the national average to the cost of Medicare covered services reduces transition costs by a small amount, increasing slightly the savings attributed to premium support. The provision protecting beneficiaries in areas with only one plan from paying more than 12 percent of the cost of that plan or the national weighted average would add slightly to the cost of the proposal.

Requiring all plans to offer a high option plan and allowing the Board to maintain an appropriate price difference between plans' high and standard options until the risk adjuster was proven over time greatly reduces concerns about adverse selection in high option plans.

Low-Income Subsidies

Currently, state Medicaid programs cover drugs for only so-called dually-eligible Medicare beneficiaries, often limiting such coverage to those well under the poverty line. Medicaid covers Medicare premiums and cost sharing for those between the limit of Medicaid dual eligibility and the poverty line. Between 100 and 135 percent of poverty, Medicaid covers Medicare premiums only. The cost of such Medicaid coverage under current law is split between the states and the federal government. About 50 percent of beneficiaries between the limit of dual eligibility and the poverty line participate in premium and cost sharing subsidies; about 20 percent of beneficiaries between 100 and 135 percent of poverty participate.

This estimate assumes that the federal government would pay 100 percent of the cost of extending drug coverage to qualifying beneficiaries under 135 percent of poverty via the Medicaid program. (States would continue to be responsible for their share of the cost of drug coverage for dually-eligible beneficiaries.) In addition, the federal government would make grants to the states in amounts set to cover 100 percent of the cost of the extra participation in the current assistance programs (for premiums and cost sharing) that the new drug coverage would cause. The estimate assumes that the participation rate for those under 135 percent of poverty, but not dually eligible, would be 60 percent. Thus the federal government would effectively cover the cost of expanding participation for those not dually eligible but under poverty from 50 to 60 percent, and from 20 to 60 percent for those between 100 and 135 percent of poverty.

Management of the Fee-for-Service Plan

In the short run, the proposal would allow the government-run fee-for-service plan to partner with private plans to offer drug benefits under one high option premium. The estimate assumes that such partnerships would not involve HCFA regulation of that industry.

The estimate assumes that a combination of HCFA and Congressional initiatives would slow the growth of spending in the fee-for-service program somewhat. That slowdown was explained in the description of the nontraditional estimate of February 17. The estimated impact of the specified cost sharing changes in the fee-for-service plan is shown separately.

Financing

The Part A fund covers only part of Medicare spending, and an act of Congress recently aided the fund simply by transferring a portion of its spending out of Part A into Part B (which is funded mostly by general revenues). Current budget proposals would transfer additional funds from the general Treasury to the Part A fund in order to postpone its insolvency date. Because the Part A fund never covered all of Medicare, and because of the recent and proposed transfers of obligations and funds, the Part A fund no longer adequately summarizes the financial condition of the Medicare program. A combined fund could make it more clear who pays for Medicare and would allow a more transparent discussion of how to aid Medicare's finances.

Table 1. March 14 Proposal

(by calendar year)

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	00-04	00-09
	Cost (+) or Savings (-) in Billions of Dollars															
Premium Support	0	0	0	-2	-4	-6	-9	-11	-15	-19	-23	-29	-35	-42	-5	-65
Drug Coverage up to 135 Percent of Poverty \1	2	2	2	3	3	3	3	4	4	5	5	6	6	7	12	31
Extra Participation in Current Low-Inc. Programs \2	2	2	2	3	3	3	3	4	4	4	4	5	5	5	12	30
Cost sharing Changes and Medigap	0	0	0	-1	-2	-3	-3	-4	-5	-5	-6	-7	-8	-8	-4	-24
Removal of DME \3	0	0	0	-4	-5	-5	-5	-5	-6	-6	-6	-7	-7	-7	-9	-36
Age of Eligibility	0	0	0	-1	-1	-1	-1	-2	-2	-3	-4	-4	-5	-5	-1	-11
Slowdown of Growth in Gov't FFS plan \4	0	0	0	-1	-2	-4	-5	-7	-9	-10	-12	-14	-17	-19	-4	-39
Premiums	0	0	0	-2	-1	0	1	2	4	5	7	9	11	13	-4	9
Limit Enrollee Share to 12% in Areas Where There is no Alternative to the FFS Plan	0	0	0	0	0	0	0	0	1	1	1	1	1	1	0	3
Total	4	4	5	-6	-9	-11	-16	-20	-24	-29	-34	-41	-48	-55	-1	-102
Average Monthly Premium:																
Government-run FFS plan				$76	$80	$84	$89	$93	$98	$103	$108	$114	$119	$125		
Government-run plan in no alternative areas				$75	$79	$84	$88	$92	$96	$101	$106	$111	$116	$120		
Private plans				$75	$79	$82	$86	$90	$93	$97	$102	$106	$110	$114		
Average of all plans				$75	$79	$84	$88	$92	$96	$101	$106	$111	$116	$120		
Monthly Part B Premium under Current Law				$71	$77	$84	$91	$98	$106	$115	$123	$132	$141	$151		

Source: Medicare Commission Staff.

Notes: Stacking order is from top to bottom. Except for premium interaction, can peel off from bottom to top without affecting other items.
Estimate assumes enactment in 1999, with implementation of the premium support system and most other policies in 2003.
The estimate assumes that 30% of beneficiaries were in areas where FFS was the only alternative in 2003.
Over time, that percentage would gradually fall; if national private plans developed, it would fall to zero.
In this time period, the results are approximately the same using either of the Commission's baselines.
The premium support schedule is calibrated to Medicare spending after the home health transfer is fully phased in (2006).

\1 Assumes 100% federal funding with a state maintenance of effort for dually-eligible beneficiaries. Participation rate assumed to be about 60 percent.
\2 Assumes 100% federal funding for the cost of expanded participation in current assistance (premiums and cost sharing).
\3 Savings to Medicare, but not necessarily to the overall budget.
\4 Follows the method of the nontraditional estimate of Feb. 17, which assumed that the fee-for-service plan would compete to some extent.

Table 2. **March 14 Proposal** **DRAFT**

14-Mar-99

	Medicare Spending Growth Rate, 2000-		Medicare Spending as a Percent of GDP /1/2		Medicare as a Percent of Federal Revenues		Medicare Spending (in billions of dollars) /3		Part A or Combined Fund Insolvency /4	Premiums as a Percent of Beneficiaries' Income		Budgetary Costs (+) or Savings (-) (in billions) /5	
	2015	2030	2015	2030	2015	2030	2015	2030		2015	2030	2015	2030
Baselines													
Trustees Intermediate	8.2%	7.6%	4.4%	6.3%	19%	28%	801	2,212	2008	7%	7%	0	0
No Slowdown	8.3%	8.6%	4.5%	8.5%	19%	38%	817	2,972	2008	7%	10%	0	0
Viability Standard Based on Spending													
Slow Growth of Per Beneficiary Spending to that of Per Capita GDP													
Trustees Intermediate	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-182	-615
No Slowdown	6.0%	6.2%	3.2%	4.3%	14%	19%	591	1,501	~2028	5%	5%	-195	-1272
Preliminary Estimate													
March 14 Proposal													
Trustees Intermediate	6.9%	6.4%	3.7%	4.5%	16%	20%	676	1,596	~2013	5%	5%	-99	-514
No Slowdown	7.1%	7.4%	3.8%	5.9%	17%	27%	688	2,087	~2013	5%	6%	-101	-740

Policy: The Part B premium and the Medicare+Choice system for private plans would be replaced by a premium support with standard and high options under formula that allowed zero-premium plans. Normal age of eligibility would be gradually increased, but waiting period for eligibility for disabled would be waived or reduced for those affected. Low-income subsidies expanded with drug coverage for qualifying beneficiaries under 135 percent of poverty Benefits package change would include coinsurance for home health and lab services with combined deductible (indexed to program costs). Direct education carved out. HCFA can organize public/private fee-for-service plan, with standard and high option. Premium formula anchored to standard option/Medicare covered services.

SOURCE: Medicare Commission Staff.

1. In 2000, Medicare spending will be 3 percent of GDP and 12 percent of the federal budget (revenues). Total projected Medicare spending will be $247 billion in 2000.
2. Payroll is approximately half of GDP. For example, in 2015 under the Trustees Intermediate baseline, Medicare spending would be 9.0 percent of payroll.
3. All spending estimates after Part A fund insolvency are hypothetical.
4. Updated estimates from HCFA and CBO will probably extend insolvency date by 3 or 4 years under current law. This cost estimate does not include that update.
5. Medicare cost or savings in the year shown.

Table 3.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
Trustees Intermediate Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.4	5.0	5.7	6.3
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.7	4.0	4.3	4.5
Medicare Spending as a Percent of Payroll \1													
Trustees Intermediate Baseline	1	2	3	4	4	5	6	6	8	9	10	12	13
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	8	9	9
Medicare Spending as a Percent of the Federal Budget \2													
Trustees Intermediate Baseline	3	5	6	8	9	11	12	14	16	19	22	25	28
March 14 Proposal	3	5	6	8	9	11	12	13	14	16	18	19	20
Medicare Spending in Billions of Dollars													
Trustees Intermediate Baseline	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
Average Annual Growth in Spending from Previous Year Shown													
Trustees Intermediate Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.1	8.4	7.5	7.0	6.6
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.2	6.4	5.7	5.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
Trustees Intermediate Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.3	6.0	4.9	4.3	4.2
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	4.9	3.8	3.0	3.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) \3													
Trustees Intermediate Baseline						3	4	5	6	7	7	7	7
March 14 Proposal						3	4	5	5	5	5	5	5

Source: Medicare Commission Staff.

Note: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP .

Table 4.

DRAFT

14-Mar

Medicare Spending: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
Medicare Spending as a Percent of GDP													
No Slowdown Baseline	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.1	3.7	4.5	5.5	6.9	8.5
March 14 Proposal	0.7	1.0	1.3	1.7	1.9	2.5	2.7	3.0	3.3	3.8	4.4	5.1	5.9
Medicare Spending as a Percent of Payroll \1													
No Slowdown Baseline	1	2	3	4	4	5	6	6	8	9	11	14	17
March 14 Proposal	1	2	3	4	4	5	6	6	7	8	9	10	12
Medicare Spending as a Percent of the Federal Budget \2													
No Slowdown Baseline	3	5	6	8	9	11	12	14	16	19	24	30	38
March 14 Proposal	3	5	6	8	9	11	12	13	14	17	19	23	27
Medicare Spending in Billions of Dollars													
No Slowdown Baseline	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
Average Annual Growth in Spending from Previous Year Shown													
No Slowdown Baseline		16.7	18.1	14.5	9.0	10.8	6.5	8.0	8.2	8.7	9.0	9.2	8.8
March 14 Proposal		16.7	18.1	14.5	9.0	10.8	6.5	6.7	6.9	7.6	7.8	7.6	7.6
Average Annual Growth in Spending Above the Impact of Demographics (from Previous Year Shown)													
No Slowdown Baseline		8.2	14.7	11.8	6.8	8.5	4.8	6.4	6.4	6.4	6.4	6.4	6.4
March 14 Proposal		8.2	14.7	11.8	6.8	8.5	4.8	5.1	5.1	5.3	5.2	4.9	5.2
Memorandum: Monthly Part B Premium (as a percent of enrollees' average income) \3													
No Slowdown Baseline						3	4	5	6	7	8	9	10
March 14 Proposal						3	4	5	5	5	6	6	6

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

1. Total Medicare spending as a percent of wage and salary disbursements. Under current law, Part A of Medicare is funded by a 2.9 percent payroll tax.
2. Medicare spending net of premiums as a percent of federal receipts.
3. Assumes enrollees average income rises at the same rate as percapita GDP.

Table 5.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = Trustees Intermediate)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
						Billions of Dollars							
Trustees Intermediate Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	110	156	217	299
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	432	668	992	1,416
Total, Medicare Spending	7	15	36	70	108	180	247	363	536	801	1,148	1,611	2,212
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	84	114	150	196
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	333	484	666	902
Total, Medicare Spending	7	15	36	70	108	180	247	341	476	676	922	1,217	1,596
						Percent Distribution							
Trustees Intermediate Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	13
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	28	25	22
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	54	58	62	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	35	33	31
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	49	53	55	57
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
Trustees Intermediate Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	262	388	607	949	1,450
Net	1	1	1	5	13	-3	1	-10	-40	-109	-258	-517	-914
Balance	3	11	14	21	99	130	110	87	(49)	(438)	(1,388)	(3,411)	(7,090)

Source: Medicare Commission Staff.

Note: Trustees Intermediate scenario based on Congressional Budget Office (January 1998), using Trustees' Intermediate (1997) assumptions.

Part A estimates here computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical.
Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 6.

DRAFT

14-Mar

Medicare Financing: March 14 Proposal (Current Law Baseline = No Slowdown)
(by selected calendar year)

	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2020	2025	2030
							Billions of Dollars						
No Slowdown Baseline													
Medicare Premiums	1	2	2	3	8	17	25	43	69	112	171	263	401
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	156	261	445	763	1,285	2,073
Total, Medicare Spending	7	15	36	70	108	180	247	363	537	817	1,258	1,949	2,972
March 14 Proposal													
Medicare Premiums	1	2	2	3	8	17	25	43	59	85	124	179	257
Payroll Taxes	5	12	24	48	72	98	130	164	206	259	324	401	497
General Revenue or Other Funding Needed	1	2	10	19	28	65	92	135	211	344	555	868	1,333
Total, Medicare Spending	7	15	36	70	108	180	247	341	477	688	1,002	1,448	2,087
							Percent Distribution						
No Slowdown Baseline													
Medicare Premiums	12	12	5	5	8	9	10	12	13	14	14	13	14
Payroll Taxes	68	74	66	68	67	55	53	45	38	32	26	21	17
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	43	49	55	61	66	70
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
March 14 Proposal													
Medicare Premiums	12	12	5	5	8	9	10	12	12	12	12	12	12
Payroll Taxes	68	74	66	68	67	55	53	48	43	38	32	28	24
General Revenue or Other Funding Needed	20	14	29	28	26	36	37	40	44	50	55	60	64
Total, Medicare Spending	100	100	100	100	100	100	100	100	100	100	100	100	100
Memorandum: Part A Fund (in billions of dollars)													
No Slowdown Baseline													
Inflows	6	13	26	51	80	115	146	181	222	279	349	432	536
Outflows	5	12	26	48	67	118	146	192	263	397	669	1,159	1,969
Net	1	1	1	5	13	-3	1	-10	-41	-117	-320	-727	-1434
Balance	3	11	14	21	99	130	110	87	(49)	(457)	(1,581)	(4,308)	(9,872)

Source: Medicare Commission Staff.

Note: No Slowdown scenario created as an illustration by Commission staff. It assumes a constant rate of growth in Medicare spending above the impact of demographics. That rate of growth is roughly consistent with Medicare's spending performance over the last decade.

Part A estimates computed by Commission staff. All spending estimates after Part A Fund insolvency are hypothetical. Includes interest paid and received. (Interest is an intragovernmental transfer, which does not affect the budget surplus.)

Table 7. A Combined Trust Fund Under the March 14 Proposal

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
						Billions of Dollars					
Inflows											
Premiums	32	36	39	42	46	50	55	60	65	70	77
Payroll Taxes	149	156	164	171	180	188	197	206	216	226	237
General Revenues	117	128	140	150	161	172	184	198	212	228	245
Interest	9	9	9	9	9	8	7	5	3	0	0
Total, Inflows	307	329	352	373	395	418	443	469	496	525	559
Outflows											
Medicare Spending	307	329	352	376	402	431	461	494	530	570	613
Interest	0	0	0	0	0	0	0	0	0	0	3
Total, Outflows	307	329	352	376	402	431	461	494	530	570	617
Net	0	0	0	(3)	(7)	(13)	(18)	(25)	(34)	(45)	(57)
Balance	150	150	150	147	140	127	109	84	49	4	(53)
Memorandum:											
General Revenue Share of Medicare Financing	38%	39%	40%	40%	40%	40%	40%	40%	40%	40%	40%

Source: Medicare Commission Staff.

Note: The growth of Medicare spending slowed significantly in 1998, and will probably remain slow in 1999. Reasons for the slowdown include payment restraints enacted in the Balanced Budget Act of 1997 and efforts to ensure compliance with billing rules spurred by enactment of the Health Insurance Portability and Accessibility Act of 1996 and other laws.

Although those changes will reduce the projected path of Medicare spending in the next few years, they are not likely to slow the long-run growth of spending in the program. Therefore, the 30 year baselines used by the Commission remain appropriate. Because of interest payments, however, trust fund calculations can be greatly affected by short run changes in spending or revenues. Estimates of the expected life of the Part A fund under current law will probably be extended from 2008 or 2009 to 2012 or 2013 by CBO and HCFA in the coming months. To be consistent with the latest estimates, the insolvency date of the combined trust fund in this table should be extended by 3 or 4 years as well, to 2016 or 2017.

TO: Melanne
(gave copy to Neera)

THE WHITE HOUSE
WASHINGTON

March 1, 1999

TO: Steve R., Gene S., Bruce R., Larry S., Elena K.

FROM: Chris J. and Jeanne L.

RE: RESPONSE TO BREAUX PLAN BY ALTMAN AND TYSON

Today, Stuart Altman and Laura Tyson sent a list of suggested changes to Chairmen Breaux and Thomas on their reform plan. They have informed us that it is their belief that these changes are not negotiable but, rather, are what would be minimally acceptable for them to even consider voting to report out a Commission plan. Their recommendations are generally consistent with the principles for reform that the President outlined. For example, they suggest including the surplus or an analogous proposal, adding an optional prescription drug benefit accessible and affordable to all beneficiaries, ensuring guaranteed benefits, and allowing 62 to 64 year olds to buy into Medicare.

However, the list also includes controversial elements such as raising the age eligibility from 65 to 67 so long as there is a subsidized Medicare buy-in and adding an income-related premium beginning at $50,000 (which is twice as high as recommended by the Commission but much lower than most of the Democratic base would contemplate). Although consistent with their past statements, the document reiterates their openness to premium support that meets the goals that they outline (e.g., adequate government payment, defined benefits).

This paper was sent confidentially, but we would be surprised if it doesn't soon become public. If it does, Senator Daschle, Congressman Gephardt and others can be expected to be critical on both substantive and political grounds. They will be particularly upset that the President's appointees continue to negotiate with Senator Breaux and Congressman Thomas at a time when they feel they have disregarded Democratic concerns. Having said this, it is unlikely that Senator Breaux will be able to obtain Republican support for all of Stuart and Laura's recommendations. If this is the case, then the Commission will likely report out with 9 or 10 votes, not the supermajority (11 votes) needed. We will keep you posted on any news.

CONFIDENTIAL–NOT TO BE QUOTED

DRAFT 3/1/99

Recommended Changes to the Breaux Medicare Reform Plan

Stuart H. Altman
Laura Tyson

The Medicare program which began in 1965 has been among the most successful programs developed by the Federal government. It has allowed millions of Americans, mostly over age 65, to have access to the best health care our nation offers, and provided critically needed funding to enable the health care system to support its ever changing structure and the use of increasingly expensive technology. But, Medicare has problems, problems which will grow much worse in the years ahead. To greatly simplify these problems can be put into three categories:

A. Inadequate Benefits

Medicare currently covers about 53 percent of the health care spending of Americans 65 years of age and over. Among the benefits not covered the most important are outpatient prescription drugs and long-term care.

B. Future High Cost

The combination of Medicare spending on a per capita basis growing faster than the growth in GNP and the number of Medicare beneficiaries doubling over the next 30 years, every projection indicates that spending under the current Medicare program will consume an ever larger proportion of our national income. With that said, it should also be emphasized that Medicare will be required to cover a much larger proportion of the US population and that Medicare spending per capita must be related to the medical cost growth in the general economy or the program will cease to provide adequate coverage for "mainstream" medical care.

C. Inflexible Program

Medicare is a major federal program which is governed by the laws of Congress and administered by an agency of the federal government. As a result it is often restricted in its operation and the creation of new programs by political infighting within the Congress and between the Congress and the Administration. These political problems are compounded by the bureaucratic inertia of a large governmental program.

PROPOSED CHANGES TO BREAUX REFORM PLAN

To address the problems listed above and still maintain the integrity and valu.. this vital program requires that we not replace three of Medicare's critical underlyin; principles:

1. A government guarantee that a specified set of benefits will be covered b- ay approved and financed Medicare plan.

2. A sufficient government contribution such that adequate coverage will b available and affordable to all beneficiaries regardless of their income o. geographic location.

3. A premium and cost sharing structure that does not invalidate the social insurance aspects of Medicare such that it no longer is a preferred plan f all income groups.

A premium support plan with defined benefits and expanded coverage for outpatient prescription drug expenses that has limited income related premiu and/or co-payments can meet these requirements if it is designed correctly and adequately financed.

The specifics outlined by Senator Breaux could be the foundation for such a plan but, fails to include a number of important factors and includes other components which could undermine the basic integrity of Medicare as a social insurance program. We have summarized these issues below along with proposed changes we believe are necessary to make the reform plan adequate for the 21st century and meet the high goals originally established for the Medicare program.

1. **Lacks a specified and adequate set of benefits.**

In order for adequate benefits to be available and affordable to all Medicare beneficiaries they must be specified in law and available in all approved Medicare plans including the one administered by the federal government. They also must include sufficient payments to providers that they will in fact be available and sufficient funds from the Medicare program that they will be affordable to beneficiaries. To that end, we would propose the following additions to the Breaux plan.

A. All health insurers approved by Medicare including the program operated by the federal government must provide for beneficiaries to select as an option to basic coverage a plan which includes at least the following coverage outpatient prescription drug expenses.

-- Following a special drug benefit deductible of $500, the plan will pay 75 per cent of all outpatient drugs prescribed by an approved Medicare provider. After an individual reaches an out-of-pocket payment including the deductible of $2500 per year, the plan would pay all additional drug expenses. For a couple living together the spending limit would be $4000. For the basic Medicare plan, the federal government will contract with a limited number of private prescription drug benefit managers to administer the program. It is expected that such PBMs will use the same techniques developed by private health plans to help control spending including volume discounting, mail order dispensing and approved pharmacy formularies. The prescription drug option would require a special premium which would equal 50 percent of its expected costs. Beneficiaries would pay more or less than this average premium based on an income related schedule consistent with the design established for the basic Medicare plan. For low income beneficiaries, the deductible would vary from $0 up to 135% of poverty to the full $500 at 300% of poverty.

B. A detailed set of benefits covered under all Medicare plans must be specified in law. At a minimum, benefits would include all services covered under the existing Medicare program plus an option for outpatient prescription drugs. All plans, including the one administered by the federal government, can establish their own rules as to how these benefits will be provided. Also permitted will be small variations requested by plans from the exact magnitude of the benefits subscribed in law. The Board which will oversee the operation of the premium support plan must approve all benefit designs and develop sufficient oversight competence that it can assure the Congress and the President that all plans do in fact provide the approved benefits and comply with all other aspects of the relevant statutes.

2. **Income related payments could jeopardize social insurance aspects of Medicare**

A. Any income related aspects of the reform plan will not consider family income below $75,000 ($50,000 for an individual) to be subject to a higher than average payment amount. The income related schedule should also recognize that some government payment amount is appropriate even for the highest income groups as they are also the groups which pay the largest tax amounts. Furthermore, any individual whose annual income is equal to or less than 135% of the poverty level will not be required to pay any premium or co-payment amounts.

3. **Raising age could increase uninsured**

A. The age when an individual becomes eligible for the full Medicare program will gradually be raised from age 65 to age 67. In tandem with this change all otherwise eligible individuals could buy into the Medicare program at age 62. For those aged 65-67, the premium charged would be income related for the lowest income groups using the same schedule as discussed above.

4. **The core Medicare program must continue to be affordable to all**

A. The modernized Medicare plan operated by the federal government must continue to be primarily a fee-for-service plan open to all qualified and approved providers except for certain select high cost procedures and where clear quality differences are shown to exist. The basic Medicare plan should also be given the necessary authority to engage in the kinds of competitive bidding schemes used by private health plans for laboratory services, durable medical equipment and other similar services. Since this plan will retain much of its current character it should continue to have the power of federal government pricing and contracting authority.

B. The system used to allocate funds to different regions of the US and to price the national basic Medicare plan must not create a regional bias against particular regions or in favor of the non basic plan except where clear regional or plan inefficiencies exist. To this end, all extra legislated payments to providers beyond what the market for patient care requires should be calculated on a per patient basis (including both basic Medicare and private health plans) and paid by the government from the Medicare trust fund independent of the calculations used to determine beneficiary premiums and the regional payment to private health plans.]

Specifically, the extra payments for Indirect Teaching Costs and Disproportionate Share, or the special subsidies to rural providers should not be paid only by the Basic Medicare plan or required of patients of private plans who live in areas where such programs exist.

5. **Need an adequate financing plan**

A. The plan must include a detailed structure on how it will be financed. While the exact dollar amounts need not be included since predictions of future spending become increasing suspect beyond 10 years, the proportions required from the different sources of funds should be specified and in general how such funds will be generated. Specifically, while the Breaux plan includes a number of provisions which will increase beneficiary liabilities, it does not mention how the additional governmental funds will be raised. This is a serious omission since the legislation which established the Commission required that we develop plans to restore the solvency of the Federal Hospital

Insurance Trust Fund and maintain the financial integrity of the Supplemental Medical Insurance plan. In that connection, the plan should include either the proposal stated by the President to use a portion of the expected federal surplus to help fund Medicare in the future or indicate how the needed federal revenues will be generated. Most importantly, the plan should indicate what proportion of the expected costs of the program should come from beneficiaries and the federal government, and how much should come from reduced payment growth to providers.

6. **No discussion of Long-term care needs.**

A. No mention is made in the Breaux plan for how the aged will pay for the increasingly expensive costs of long-term care in the future. At a minium, recognizing the complex nature of this problem and its very high costs, the plan should contain some general statements about a preferred direction of future policy.

DISCUSSION OF COMPETITIVE APPROACHES TO MEDICARE

DRAFT: March 22, 1999

I. Concept of "Premium Support"

II. Issues and Alternatives

III. Policy Pros and Cons

IV. Political Pros and Cons

I. CONCEPT OF "PREMIUM SUPPORT"

- **Current Medicare Managed Care**:
  - Government payments: Medicare pays managed care plans based on a payment schedule. This schedule is set using the local costs of traditional Medicare. All plans in the area get paid the same rate. If a plan can offer Medicare benefits for less than the payment rate, it must use the excess payments to give beneficiaries extra benefits.
  - Beneficiary premiums: All Medicare beneficiaries pay the same premiums regardless of their plan choices or place of residence.
  - Enrollment: Today, about 16 percent or 6 million beneficiaries are enrolled in Medicare managed care. About 70 percent of beneficiaries live in areas where managed care plans operate. Over two-thirds of managed care enrollees receive prescription drug coverage, reduced cost sharing or other supplemental benefits.

- **The Concept of Premium Support**:
  - Government payments: Medicare would pay plans an amount per beneficiary up to a limit. This limit could be a percent up to a cap (e.g., the national average premium) or a regional average premium.
  - Beneficiary premiums: Beneficiaries' premium would vary based on their plan choices. In general, those choosing higher-cost plans would pay more, those choosing lower-cost plans would pay less. In most models, traditional Medicare's premiums would be included in the formula, and could be higher if Medicare is a high-cost plan.
  - Savings: Medicare costs would be reduced if (a) the new payment system pays managed care plans less than they are paid today; and (b) more beneficiaries enroll in private plans.

BREAUX-THOMAS PREMIUM SUPPORT PROPOSAL

- **Flexible Benefits:** Requires that private plans offer at least the same benefits as traditional Medicare, but allows flexibility in how benefits are delivered.

- **Government Payments: Percent to a cap**: Medicare's payments would be based on the national weighted average premium for all plans. The government would pay:

  - 100 percent of the premium if the plan's premium is less than 85 percent of the national average premium;

  - From 100 to 88 percent of the premium if the plan's premium is between 85 and 100 percent of the national average premium; and

  - No more than 88 percent of the national average premium if the plan's premium is above 100 percent of the national average premium.

- **Beneficiary payments**: Beneficiaries would pay the difference between the government payment and the plan's premium -- including all of the additional premium for plans above the national average premium.

EXAMPLE: HOW PLANS WOULD BE PAID

Total Premium		Gov't Payment		Beneficiary Payment	
$	% of Nat'l Average	$	% of Total	$	% of Total
$5,100	85%	$5,100	100%	0	0%
$5,500	92%	$5,180	94%	$320	6%
$6,000 Avg	**100%**	**$5,280**	**88%**	**$720**	**12%**
$6,100 FFS	102%	$5,280	87%	$820	13%
$6,500	108%	$5,280	81%	$1,320	20%

* If beneficiaries in fee-for-service pay 12% of costs, they would pay $732.

II. ISSUES AND ALTERNATIVES

MAJOR ISSUES

- **Most beneficiaries would pay more for traditional Medicare**: The Breaux-Thomas plan would result in Medicare premiums that are 10 to 20 percent above current law, according to the independent Medicare actuary. Although the plan limits the Medicare premium for beneficiaries with no private plan option, it does nothing for people with limited or unattractive plan options.

- **Competition based on benefits, not price**: The proposal would allow private plans to vary their benefits within some limits. This could result in adverse selection as plans tailor their benefits to attract the healthiest beneficiaries.

- **Beneficiaries would pay more or less for private plans, depending on where they live**: Although the final version of the plan included no reference to how it would adjust payments for geographic differences, the previous versions suggested that the government would only pay part of the local costs of care -- in an effort to constrain the current, wide variation in payments. However, the consequences of this approach are that plans will over- or under-charge for their benefits to compensate for the partial geographic adjustment. As a result, beneficiaries will pick up part of the local costs -- paying more in high-cost areas and less in low-cost areas for a typical plan.

- **Somewhat aggressive transition**: The Breaux-Thomas premium support plan would be implemented in 2003. HHS would probably be better able to transition to a change as large as this over a longer period of time.

ALTERNATIVE: MANAGED CARE PAYMENT REFORM

- **Guarantee defined benefits:** Clear, defined guaranteed benefits. Private plans could buy down Medicare's cost sharing, but could not offer extra benefits (note: assuming that prescription drug benefit is added).

- **Protecting the fee-for-service premium and improving adjustments:** Options include: (1) anchoring the Medicare's payments to the national fee-for-service premium (not the national weighted average premium) so that beneficiaries would always pay the same percent premium; or (2) exempting fee-for-service from the private plan payment system..

  The government would pay the full amount of risk adjustment and all (not part) of the geographic adjustment.

- **Lower savings**: Relative to the Breaux-Thomas plan, this approach will save much less money -- in large part, because it does not rely on higher fee-for-service premiums for its savings. It is not clear how much more efficient than current law this would be.

III. POLICY PROS AND CONS

PROS

- **Would likely reduce Medicare costs through competition.** Although there would not be significant savings from a well-designed model, this approach probably saves more than current managed care payment systems.

- **Better aligns Medicare with private health insurance.** Relies less on explicit changes to Medicare reimbursement levels to control program costs. Medicare spending growth would be affected by private plans' ability to achieve efficiency and attract beneficiaries, which should better align Medicare with private spending growth.

- **Gives beneficiaries lower-cost options.** Beneficiaries could lower their Medicare premiums by enrolling in low-cost plans.

CONS

- **Variable and less beneficiary premiums.** Unlike today, all beneficiaries would not pay the same premiums. The Medicare fee-for-service premium would likely be higher than that of private plans -- even if it is protected against being higher than current law. Also, beneficiaries choosing private plans could face premiums that vary considerably from year to year.

- **Could reduce extra benefits that current Medicare managed care enrollees receive.** Currently, Medicare managed care plans compete for enrollment by offering beneficiaries additional benefits such as lower cost sharing, preventive care, and outpatient prescription drugs. Under competitive approaches, a greater share of the efficiency accrues to the government, reducing the amount that can be provided as additional benefits.

- **Significant regulation would be required to avoid two-tiered Medicare.** To promote competition based on price and quality -- not enrollment of the healthiest beneficiaries -- significant new rules and oversight would be needed. Without such rules, or because of imperfect implementation, this policy could have the unintended effects of creating higher premiums for people who are sick and low-income.

IV. POLITICAL PROS AND CONS

PROS

- **Increases the likelihood of bipartisan agreement on Medicare -- and Social Security.** Without some variation of premium support, it is unlikely that Republicans will consider any type of Medicare legislation -- especially a bill that includes the surplus or a prescription drug benefit.

- **A drug benefit and the dedication of the surplus could be worth some version of premium support.** The complexity and controversy surrounding premium support will necessitate it being phased in and otherwise altered to make it more acceptable. However, it is possible that the drug benefit, the surplus transfer and other reforms would begin sooner and remain intact.

- **Confirms willingness to reform Medicare.** Most economist and elite media consider premium support "real" reform. An openness to it would end Republican criticism that we only want an election issue or only more revenues and benefits for Medicare.

CONS

- **Would alienate Democratic base, particularly in the House, who think that premium support undermines Medicare's guarantees.** Base Democrats generally think that the risk of something bad coming out of any negotiation with Republicans far exceeds any potential for a positive outcome -- even if that means a prescription drug benefit.

- **Even if accompanied by a drug benefit and the surplus, the fear of higher premiums and elderly dissatisfaction may outweigh benefits.** High costs and less certainty will always be much more threatening and politically volatile to the elderly than the promise of a new benefit. This is particularly the case given the low odds that a good drug benefit and premium support proposal could emerge from a Republican Congress.

- **Opposition to premium support could unify beneficiary and provider groups.**

BACKGROUND ON PRESCRIPTION DRUGS

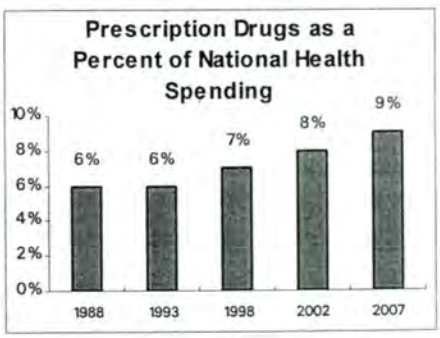
DRAFT: April 12, 1999

PRESCRIPTION DRUGS: A GROWING PART OF MODERN MEDICINE

- **Increasing reliance on drugs**. Prescription drugs have become an essential part of health care, and are expected to play an even greater role in the next century. They serve as complements to medical procedures (e.g., anti-coagulents with heart valve replacement surgery); substitutes for surgery and other interventions (e.g., lipid lowering drugs that lessen need for bypass surgery) and new treatments where there previously were none (e.g, drugs for HIV/AIDS). Some of the major advances in public health -- the near eradication of polio and measles and the decline in infectious diseases -- are largely the result of vaccines and antibiotics. And, as the understanding of genetics increases, the possibility for pharmaceutical and biotechnology interventions will multiply.

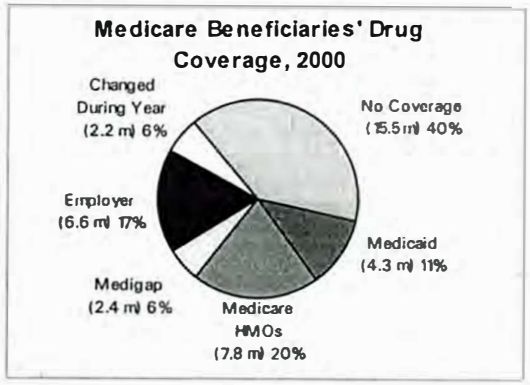
- **Elderly and people with disabilities rely more on prescription drugs**. Over 85 percent of Medicare beneficiaries use at least one prescription drug in the course of a year. Although the elderly comprise 12 percent of the U.S. population, they account for over one-third of all prescription drug spending. The elderly's per capita spending on drugs is over three times as high as that of non-elderly adults, and nearly 10 times that of children. This reflects the greater prevalence of chronic conditions like arthritis and high blood pressure that are best managed through medication.

- **Rising share of national health spending**. The increased importance of prescription drugs is reflected in national health spending trends. In the past 10 years, spending on prescription drugs has risen as a percent of total spending by 20 percent. In the next 10 years, its share of national health spending is projected to increase by nearly 30 percent. This means that nearly one in ten health care dollars will be spent on drugs.



- **Drugs may reduce need for other services**. Studies have found that elderly, ill Medicare beneficiaries whose Medicaid drug coverage was limited were twice as likely to enter nursing homes. The increased cost of institutionalization exceeded the savings from reduced drug utilization by 20 fold. And, stroke patients treated promptly with drugs to thin clots had lower health care costs.

DRUG COVERAGE AMONG MEDICARE BENEFICIARIES



- **Private supplemental drug coverage is low and declining:** Only 23 percent of Medicare beneficiaries are expected to have private insurance for drug coverage (retiree coverage or Medigap) in 2000 (according to the Medicare actuary) -- down from 38 percent in 1995. Both sources of coverage have been declining rapidly as the cost of coverage rises and therefore cannot be relied upon to provide needed insurance in the future.

  - ***Retiree health insurance***: Employer-sponsored retiree insurance, the most generous type of drug coverage for beneficiaries, is an important but eroding source of coverage. Between 1993 and 1997, the percent of large firms offering retiree health benefits for Medicare eligibles dropped about 20 percent. The Medicare actuaries project that, by 2000, only 17 percent of beneficiaries will have retiree drug coverage -- down from [28 percent] in 1995.

  - ***Medigap***: Medigap, the standardized private insurance supplement for Medicare, offers prescription drugs in some of its plans. Its drug benefit has a $250 deductible, 50 percent coinsurance, and a cap on benefits spending of $1,250 or $3,000. Medigap premiums are expensive and virtually always underwritten, meaning that premiums are based on the person's health. The median premium for a plan with prescription drug coverage is about $1,100 more than a Medigap plan without drug coverage ($2,073 v $913 in 1998). Medigap premiums have been rising at double-digit inflation. At the same time, Medigap coverage has been declining. The actuaries project that only 6 percent of beneficiaries will have Medigap drug coverage in 2000, down from 10 percent in 1995.

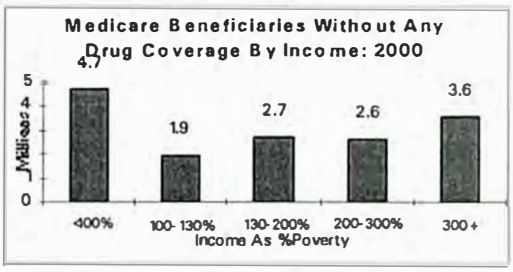
- **Public coverage exceeds private coverage:** More beneficiaries are projected to have public (30%) than private (23%) drug coverage -- suggesting that concerns about a new benefit "crowding out" private coverage are exaggerated.

  - ***Medicare managed care***: Over 90 percent of beneficiaries in Medicare HMOs have some type of drug coverage. Typical Medicare managed care plans have no deductibles and relatively low copayments, but limit the amount that they pay for benefits. In 1998, 42 percent of beneficiaries had coverage limited to $1,000 or less. Rising costs and lower Medicare payments could reduce benefits in the future.

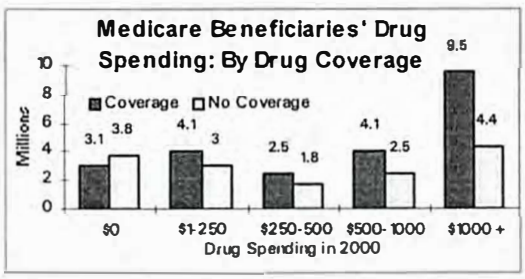
  - ***Medicaid***: Only about 4.3 million Medicare beneficiaries who are fully eligible for Medicaid (e.g., who receive Supplemental Security Income (SSI) or are medically needy) receive prescription drug coverage. This represents less than half of Medicare beneficiaries below poverty since Medicaid eligibility is typically only up to 75 percent of poverty. Moreover, even those beneficiaries who are eligible have low participation rates; only about 55 percent of beneficiaries eligible for SSI participate.

BENEFICIARIES WITHOUT DRUG COVERAGE: CHARACTERISTICS AND CONSEQUENCES

- **About 16 million beneficiaries (40%) are projected to have no drug coverage in 2000.** Lack of drug coverage is not just a problem for low-income beneficiaries; 40 percent of beneficiaries without drug coverage have income above 200 percent of poverty (about $17,000 for a single, $23,000 for a couple in 2000). Nearly one in three (30 percent) of nonelderly Medicare beneficiaries with disabilities does not have any coverage for prescription drugs. Older beneficiaries are less likely to have drug coverage, as are rural beneficiaries. Nearly half of rural beneficiaries have no insurance coverage for drugs.



- **Many beneficiaries with drug coverage have high drug spending.** According the Medicare actuaries' projections for 2000, beneficiaries with some type of insurance coverage (private or public) have higher spending and utilization than those with no insurance coverage for prescription drugs. Most research has found that lack of coverage reduced needed drug utilization. Despite this, nearly half of beneficiaries without any insurance coverage for prescription drugs have annual out-of-pocket spending of greater than $500.



- **Elderly without coverage pay higher prices.** Medicare beneficiaries without drug coverage pay higher prices than large HMOs, employers and the Veterans' Administration pay for the same drugs. Moreover, American senior citizens pay higher prices for drugs than citizens in other nations. For example, the average retail price for the top ten drugs for seniors are 72 percent higher in the U.S. versus Canada.

COMPARISON OF PRICES FOR DRUGS

Drug	Use	Price for Preferred Customers	Regular Price
Prilosec	Ulcers	$56.38	$111.94
Zocor	Cholesterol	$42.95	$104.80
Procardia	Heart	$67.35	$126.86
Zoloft	Depression	$123.88	$213.72

Source: Minority staff report to Committee on Gov't Reform

- **Larger financial burden**. Elderly with private insurance for drugs have about half the out-of-pocket financial burden for drugs than those without coverage. About 1 million beneficiaries without drug coverage have annual out-of-pocket expenses that exceed $3,000 – which more than 20 percent of income for at least half of these beneficiaries. Rural elderly have out-of-pocket costs that are 35 percent higher than urban elderly, and women have, on average, costs that are 20 percent higher than men, primarily because many are widowed and lower income.

ISSUES WITH RAISING THE AGE ELIGIBILITY FOR MEDICARE
DRAFT: April 12, 1999

PROPOSAL: Increase the Medicare age eligibility from 65 to 67, one month per year, parallel to Social Security. Some proposals include an unsubsidized Medicare buy-in proposal, similar to what the President has proposed for certain people ages 55 to 65.

ISSUES:

- **There has been no improvement in the availability or affordability of health insurance for people in their early 60s that would justify raising Medicare's eligibility age.**

  - **People ages 55 to 65 are the fastest growing group of uninsured.** The number of uninsured ages 55 to 65 increased by nearly 7 percent in 1998 -- as fast as people ages 35 to 45 and faster than all other age groups.

  - **Fewer have employer-based health insurance**. Compared to younger adults, people approaching retirement are less likely to have employer-sponsored health insurance -- which is the least expensive type of insurance. For example, about 73 percent of people ages 45 to 55 have employer-based health insurance, but this drops to 64 percent for all people ages 55 to 65 -- and only 54 percent of 64 year olds. In part, this reflects changes in employment as workers retire, cut down on hours, or take "bridge" jobs (e.g., consulting, new careers), forfeiting health insurance. It also results from younger spouses losing their health coverage when their older spouses retire and goes on Medicare.

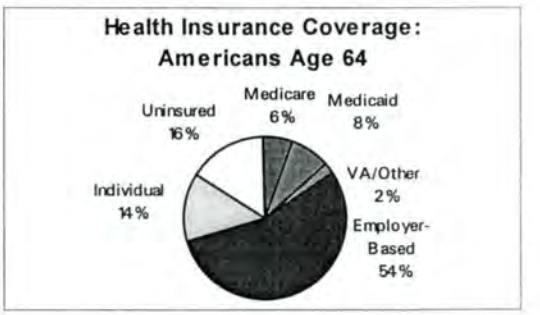
  - **More are forced to turn to expensive individual insurance or have no options at all.** People ages 55 to 65 are twice as likely as younger people to purchase individual private health insurance -- despite the fact that, in virtually all states, it is most expensive and inaccessible for older Americans. In 1998, 36 states allowed insurers to deny people individual insurance outright and many more allow insurers to charge more for older and/or sicker people.

  Thus, unlike Social Security, where the effects of gradually raising age eligibility to 67 are mitigated by the increased wealth and longer work lives of Americans, there is no comparable improvement in the health insurance system -- making it hard to extend it if the age eligibility for Medicare were raised.

- **More difficult to postpone health care needs than retirement**. Retirement is a fairly predictable event that most families plan for years in advance. Illness and disability, in contrast, are rarely foreseeable and are increasingly likely as people age. People ages 55 to 65 are twice as likely to experience health problems such as heart disease, emphysema, heart attack, stroke and cancer than those ages 45 to 55. The likelihood of developing health problems is even greater at ages 65 and 66. Thus, raising Medicare's eligibility age would take away guaranteed health insurance from people with the greatest risk of health problems and lowest probability of finding affordable private health insurance options.

- **Raising Medicare's age eligibility could have serious consequences**. Although the Federal government and Medicare Trust Fund would save from raising Medicare's eligibility age, it could create other costs and problems.

  - **Increase the uninsured**. In 1998, 16 percent of people age 64 were uninsured. If the 3.7 million people age 65 and 66 were to lose Medicare, it could be assumed that 16 percent of this group would also be uninsured -- nearly 600,000. This would likely be higher since more people in this age group have health problems and would be unable to access or afford private individual health insurance. Similarly, it is not clear that all of those who had employer-based insurance when they were 64 could maintain it until they are 67.



  - **Cost shift to employers**. About half of people age 64 have insurance through their employers. If Medicare's eligibility age were raised, these employers would have to continue coverage of these older workers. Costs would result not only from covering workers longer, but from higher premiums for all workers. This is because the older workers would raise the average costs of all employees. The Federal government would also incur costs since employer-based health coverage gets special tax treatment.

  - **Unfunded mandate to states**. State Medicaid programs would incur significant new costs from raising Medicare's eligibility age. Not only would states continue to be the primary payer for the 8 percent of the 64 year olds on Medicaid who turn 65, but Medicaid would become primary payer for the additional elderly who become eligible for Supplemental Security Income (SSI) at age 65.

- **No viable policy has been offered to prevent the elderly uninsured from increasing.**

  - **Medicare buy-in cannot replace Medicare**. Some proponents of raising the age eligibility of Medicare have suggested that the President's Medicare buy-in proposal as a health insurance alternative for people ages 66 and 67. It is true that, relative to the coverage options facing people ages 55 to 65, it is an affordable, attractive option, even without a subsidy. However, it is not designed to be a substitute for Medicare. According to the Congressional Budget Office, about 9 percent of the uninsured and 5 percent of the total eligible population ages 62 to 65 would participate in the buy-in. Applying these rates to the population age 65 to 67, this suggests that only about 185,000 of the 3.7 million who would lose Medicare would opt for coverage through the buy-in.

  - **Costs of subsidies for buy-in would reduce savings**. The Medicare buy-in proposal could be subsidized to encourage low-income people to participate. However, since about 35 percent of people ages 65 and 66 have income below 200 percent of poverty (about $18,000 for a single, $22,000 for a couple), the savings would be much lower.

ADDRESSING MEDICARE'S CHALLENGES

DRAFT

April, 1999

ADDRESSING MEDICARE'S CHALLENGES

I. Overview

- Importance of Medicare
- Challenges Facing Medicare

II. Medicare Commission

III. President's Plan for Strengthening Medicare

I. OVERVIEW
IMPORTANCE OF MEDICARE

- **Medicare now pays for health care for 39 million elderly and disabled Americans**: About 34 million elderly and 5 million people with disabilities receive Medicare.

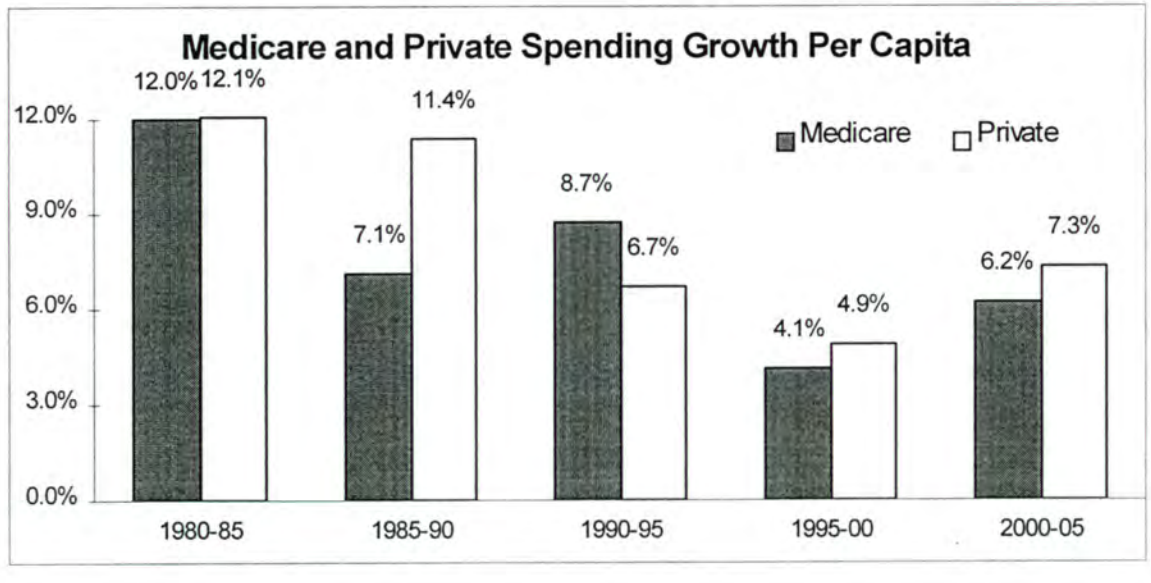
- **Helps those who would otherwise be uninsured**: Before Medicare, almost half (44 percent) of the elderly were uninsured. Given the recent rapid rise of the uninsured ages 55 to 65, this problem would inevitably be worse today.

- **Improves life expectancy, access to care and reduces poverty**: Since 1965:
  - Life expectancy of the elderly has increased by 20 percent (79 to 82 years)
  - Access to care has increased by one-third (elderly seeing doctors: 68 to 90%)
  - Poverty has declined by nearly two-thirds (29.0 to 10.5%)

RECENT SUCCESS IN SLOWING MEDICARE GROWTH

- In the early 1990s, Medicare spending growth outpaced private health insurance growth. However, due to the policy changes in 1993 and 1997, as well as aggressive efforts to reduce fraud, Medicare spending growth has slowed. In 1999, it is projected to be below inflation.

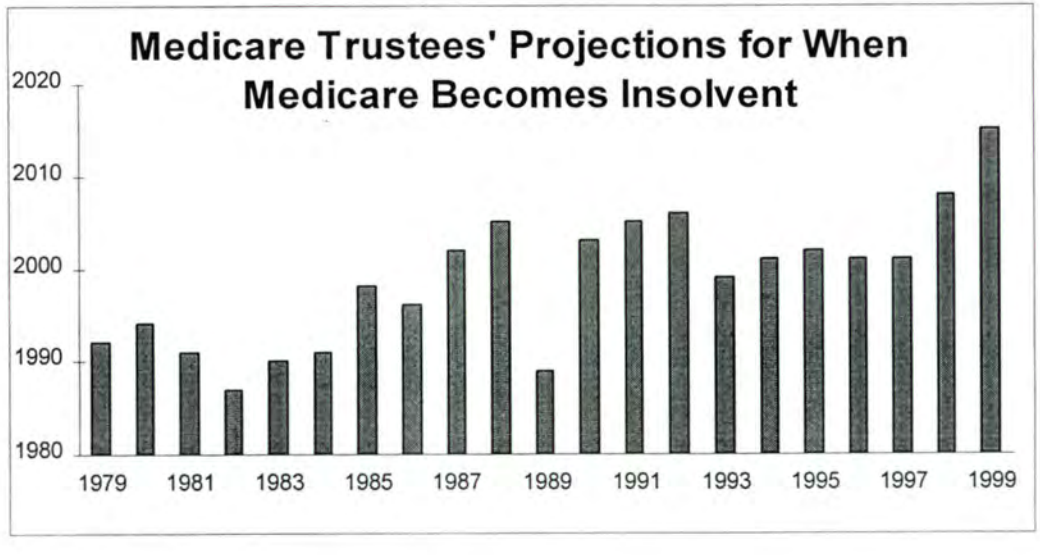
- The slow Medicare spending growth is expected to continue through 2002 -- at which point many of the policies in the Balanced Budget Act (BBA) of 1997 expire.



MEDICARE'S TRUST FUND STATUS HAS IMPROVED

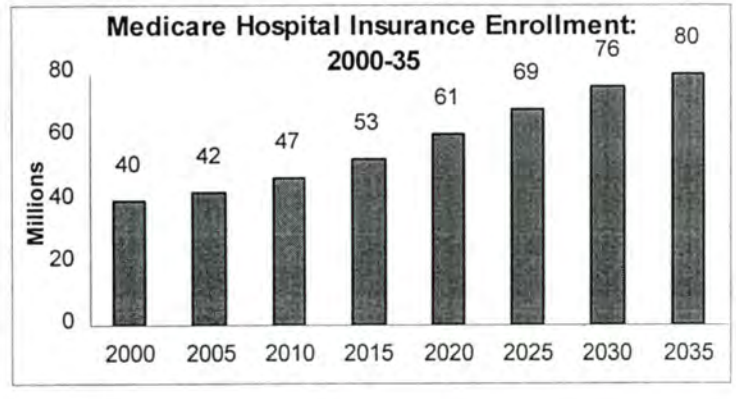
- In 1993, when President Clinton took office, the Hospital Insurance (HI) trust fund was projected to be exhausted in 1999.

- Through commitment to a strong economy, coupled with actions that improves Medicare benefits while constraining cost growth, the trust fund now is projected to be solvent until 2015. Its actuarial deficit (measure of long-run solvency) is the best that it has been since this measure has been reported.



CHALLENGES FACING MEDICARE: FINANCIAL STRAIN OF CHANGING DEMOGRAPHICS

- **More beneficiaries**: Enrollment in Medicare will climb when the baby boom generation retires: from 39 to 80 million by 2035 -- from 13 percent to about 20 percent of the population.



- **Fewer workers**: The ratio of workers who support Medicare to beneficiaries is expected to decline by 40 percent by 2030 (3.6 workers per beneficiary in 2010; 2.3 in 2030).

- **Cost growth will rise**: Although Medicare has recently reined in cost growth, as recent policy changes wear off, it is expected to rise to the level of private health growth.

- **Inadequate financing:** Medicare's Trust Fund will become insolvent in 2015 -- about 20 years earlier than Social Security and just as the baby boom generation starts to retire. Even with reforms that substantially slow cost growth, the revenues coming to the Medicare trust fund will not support this larger number of beneficiaries.

ADDITIONAL CHALLENGES FACING MEDICARE

- **Inadequate benefits**: Medicare's benefits are not very generous. In particular:
  - No prescription drug coverage: Even though pharmaceuticals are an increasingly important part of health care, Medicare does not pay for them. As a result, America's elderly pay the highest price for drugs -- either by buying them without discounts or by paying for expensive Medigap insurance.
  - High beneficiary payments for hospital care: Today, Medicare beneficiaries pay a $768 deductible for hospital care, and $192 per day after two months, when beneficiaries are the sickest.
  - Cost sharing for preventive care: Requiring beneficiary payments for preventive services (e.g., screening mammography) can discourage use.
  - Medigap insurance: Because of Medicare's sub-standard benefits, about one-third of beneficiaries pay for expensive and inefficient Medigap coverage.
- **Insufficient private tools for reducing costs**: Current law does not permit Medicare to adopt the most effective private sector tools to increase competition and save Medicare money.

II. MEDICARE COMMISSION
SUMMARY OF THE BREAUX-THOMAS PROPOSAL

- **Breaux-Thomas Proposal**: Its centerpiece is a "premium support" proposal which saves a net of $53 billion (Commission staff estimates) over 10 years. Most of the proposal's savings come from other policies, including:

  - Modernizing traditional Medicare
  - Extending the BBA savings proposals
  - Adding an unlimited home health copay
  - Raising Medicare's eligibility age to 67

- **Savings small relative to the size of Medicare's problem.** Commission staff claims $102 billion in net savings (including the $36 billion GME shift). These savings are less than:

  - One-third of BBA savings proposals and
  - One-third of amount from committing 15 percent of the surplus to Medicare.

SAVINGS UNDER THE BREAUX-THOMAS PROPOSAL
(Dollars in Billions, Commission estimates)

	00-04	00-09
Premium Support	-9	-56
Rural Adjustment	+0	+3
Modernizing Medicare Plus Extenders	-4	-39
Raising Age Eligibility	-1	-11
Cost Sharing Changes	-4	-24
Removing medical ed.*	-9	-36
Medicaid Drug Benefit, Increased Participation	+24	+61
MEDICARE SAVINGS	**-3**	**-102**
BUDGET SAVINGS*	***+6***	***-66***

* Graduate medical education would still be funded but not by Medicare; thus, not budget savings.

CONTRIBUTIONS OF THE MEDICARE COMMISSION

- **Focused attention on Medicare**: The year-long deliberations of the Medicare Commission, along with President's call for Medicare reform in the State of the Union, helped highlight the challenges facing the Medicare program.

- **The Breaux-Thomas proposal has advanced the debate.** The plan has recommended a number of ideas worth serious consideration, including:

  - ➛ Making Medicare's traditional plan more competitive: It recommends that Medicare adopt many of the competitive management tools that are used in the private sector.

  - ➛ Rationalizes Medicare's complicated, confusing cost sharing: It takes important steps like eliminating cost sharing for preventive services.

  - ➛ Recognizing the need for expanded coverage of prescription drugs: By expanding Medicaid drug coverage for beneficiaries with income below 135 percent of poverty, the Breaux-Thomas proposal takes a modest but positive step towards providing drug coverage to Medicare beneficiaries.

SHORTCOMINGS OF PREMIUM SUPPORT PROPOSAL

- **Increases premiums for millions of beneficiaries**: The Breaux-Thomas "premium support" proposal caps the government contribution at the national average, which would cause the premium for the traditional program to rise by 18 to 30 percent (or 10 to 20 percent if traditional program reforms were enacted), according to the independent Medicare actuary (2/24/99).

    - Although beneficiaries in an areas without private plan options are supposed to be protected against higher premiums in traditional Medicare, this protection ends if even one private plan becomes available. For these beneficiaries, traditional premiums would rise suddenly.

    - States would face a significant increase in costs since Medicaid pays for premiums for beneficiaries with income below 135 percent of poverty.

- **Unclear commitment to defined guarantee of benefits**: Allowing a board to approve benefit variations over time could erode Medicare's promise of a defined benefit package.

- **Creates regional inequities by failing to adequately adjust for regional cost differences**.
    - Urban Areas. Beneficiaries in urban areas would face higher premiums in both traditional Medicare and private plans, since the government would pay for only part of the local costs.

    - Rural Areas. Rural beneficiaries would face a dilemma. When no private plans are available, their premiums remain at current levels. If a private plan becomes available, they would face lower premiums for the private plan (because the government overpays plans in low-cost areas), but their premium for traditional Medicare would increase significantly.

OTHER SHORTCOMINGS OF THE BREAUX-THOMAS PLAN

- **Does not address Medicare's long-term solvency**: The Breaux-Thomas proposal ignores the need for new revenues to finance the care of the growing numbers of new beneficiaries. The plan's net Medicare savings of around $100 billion over 10 years are not nearly large enough to meaningfully address the long-term shortfall -- trust fund solvency will only be extended by several years. The lack of financing makes the problem much larger to solve in the future and shifts more of the burden to our nation's children.

- **Raises the age eligibility for Medicare**: The most rapidly growing group of the uninsured are ages of 55 to 65. Raising the Medicare eligibility age without a policy to prevent even more uninsured would exacerbate this problem.

- **Includes an unlimited home health copay**: Beneficiaries would be charged 10 percent coinsurance for all home health visits. For the over 1 million beneficiaries who have more than 60 visits in a year, this copay could represent a large financial burden.

- **Removes Direct Medical Education from Medicare:** Shifts funding for direct medical education from Medicare to an unspecified part of the budget. This policy does not produce Federal budget savings and does not assure that the nation's teaching hospitals are funded to continue their important mission.

INADEQUATE & INEFFICIENT PRESCRIPTION DRUG BENEFIT

- **Not a Medicare benefit**. One of Medicare's strengths is that it provides all beneficiaries, regardless of their residence, income or health status, with basic health services. The Breaux-Thomas proposal to extend Medicaid to beneficiaries with income below 135 percent of poverty (about $11,000 a year for a single senior) does not constitute a Medicare prescription drug benefit.

    - **Helps only a fraction of beneficiaries without drug coverage:** Nearly 60 percent of beneficiaries without drug coverage would not qualify. For example, a widow with $15,000 in income would not receive drug coverage.

    - **Fewer people enroll in Medicaid programs**: Experience with Medicare premium assistance programs shows that usually only about half of people eligible for Medicaid-run benefits enroll (barriers include the welfare stigma, administrative complexity, lack of knowledge of eligibility). In contrast, nearly 100 percent of beneficiaries enroll in the voluntary Part B program.

- **Medigap proposal is unworkable.** The Breaux-Thomas proposal would also require all Medigap insurance plans to include drug coverage. However, premiums would be high and rise rapidly since the heavy users would sign up first, driving up costs. Over time, insurers would likely stop offering coverage, leaving less access than before.

III. PRESIDENT'S PLAN TO STRENGTHEN MEDICARE

- **President's commitment to develop a plan to strengthen Medicare**: Neither the President nor his four appointees to the Commission could endorse all of aspects of the Breaux-Thomas proposal. However, the President is committed to working with Congress to develop and pass a plan this year to strengthen Medicare for the next century. To that end, he has instructed his advisors to develop a plan that conforms to the principles that he outlined in January:

  - Making Medicare more efficient and competitive;
  - Maintaining and improving Medicare's guaranteed benefits, including a prescription drug benefit; and
  - Assuring adequate financing by dedicating 15 percent of the surplus to Medicare.

MAKING MEDICARE MORE EFFICIENT AND COMPETITIVE

- **Providing private sector purchasing tools for traditional Medicare**: Medicare should be allowed to use the same, effective practices that private health insurers use to constrain costs, including:
  - Competitive pricing for services like medical supplies; and
  - Selectively contracting with lower-cost, high-quality providers.

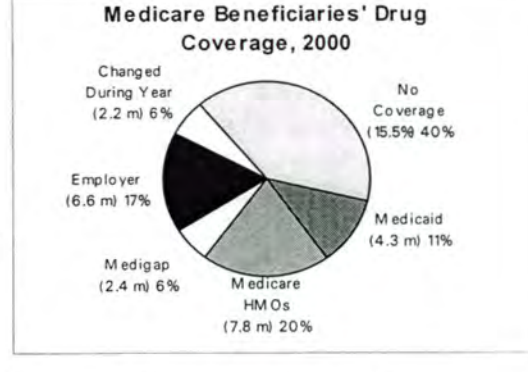
- **Examining other policies to reduce overpayment and increase competition**: The Administration will also examine specific options to reduce fraud, constrain costs and make both the traditional program and managed care payments more competitive and efficient.

MAINTAINING AND IMPROVING MEDICARE'S GUARANTEED BENEFITS

- **Ensuring that Medicare's guarantee is strong**: Medicare protects some of our most vulnerable citizens -- the elderly and people with disabilities -- from excessive health care costs. Proposal to strengthen Medicare must not do so at the expense of this guarantee to a defined set of benefits.

- **Providing a long-overdue prescription drug benefit**:
  - Critical to modern medicine: Nearly all Medicare beneficiaries use prescription drugs, and their costs are over three times as high as that of other adults, and nearly 10 times that of children.

  - Existing coverage is unstable and expensive: The few beneficiaries who have private coverage are vulnerable, since employers are dropping retiree coverage and Medigap is becoming more costly and less accessible.



  - Essential component of legislation to strengthen Medicare: Any proposal should provide prescription drug coverage that is available and affordable.

DEDICATING PART OF THE SURPLUS TO MEDICARE

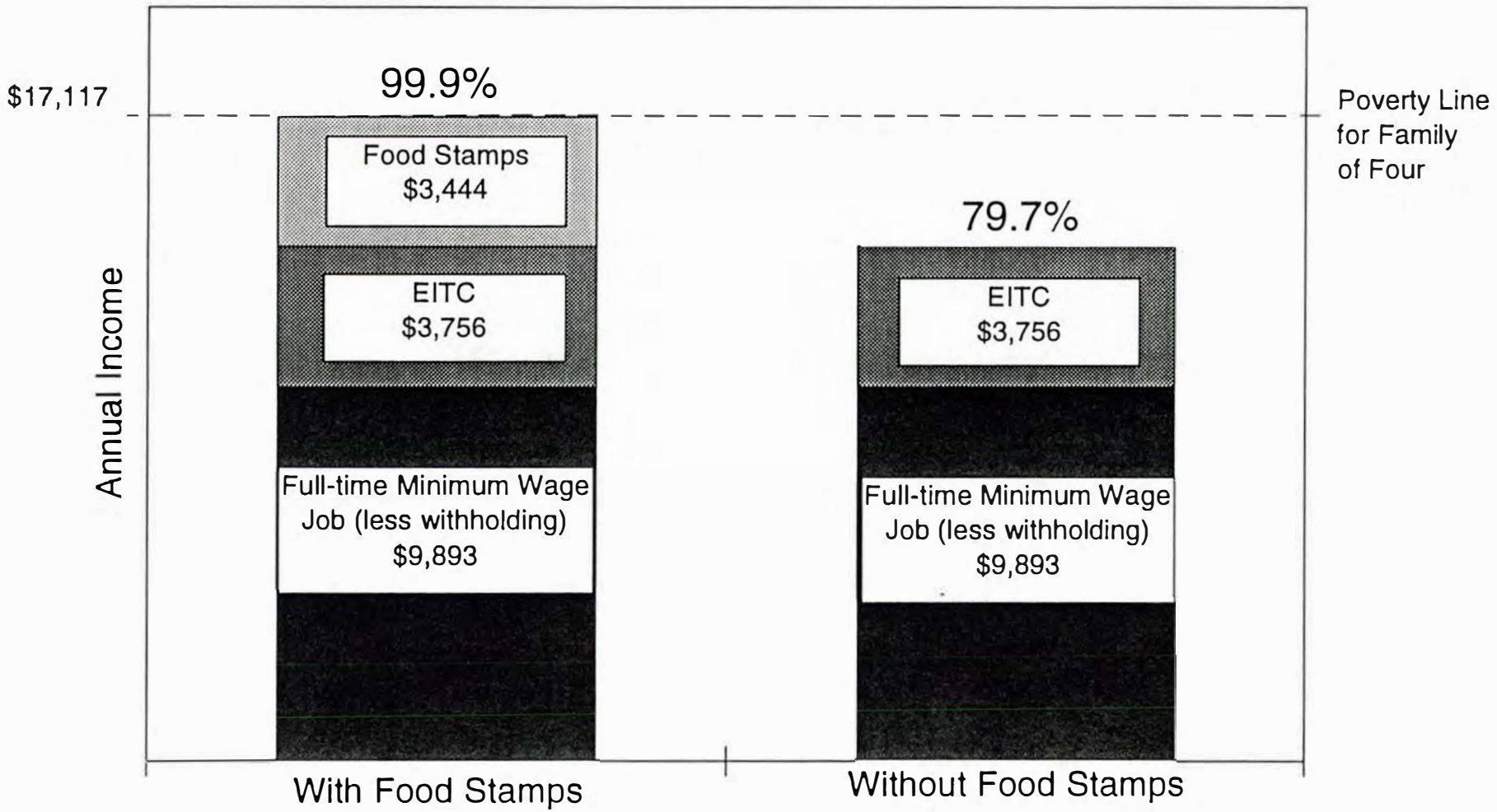
- **Providing new financing by dedicating part of the surplus to Medicare**: The President's proposal would transfer 15 percent of the projected unified budget surplus to the Medicare Hospital Insurance (HI) Trust Fund for the next 15 years. This amount would equal $686 billion over the period and extend the life of the trust fund for another decade.

    - Investing now prevents larger problem later. Even though the Medicare shortfall is projected to accumulate to over $1 trillion over the next quarter century, the President's $686 billion investment can fill this hole because it is done now -- allowing it to build interest and prevent borrowing later.

    - One-time, fixed contribution: The plan does not create an unlimited tap on general revenues. Instead, it invests a fixed proportion of the surplus in Medicare to cover the temporary but overwhelming influx of retirees.

    - Funded by the baby boom generation -- not tomorrow's workers: The surplus was largely created by the baby boom generation, and makes sense as a one-time funding source for Medicare. In contrast, waiting until future generations are faced with raising taxes to support Medicare would shift this burden to younger and low-income workers.

HELPING WORKING FAMILIES REACH THE POVERTY LINE, 1998



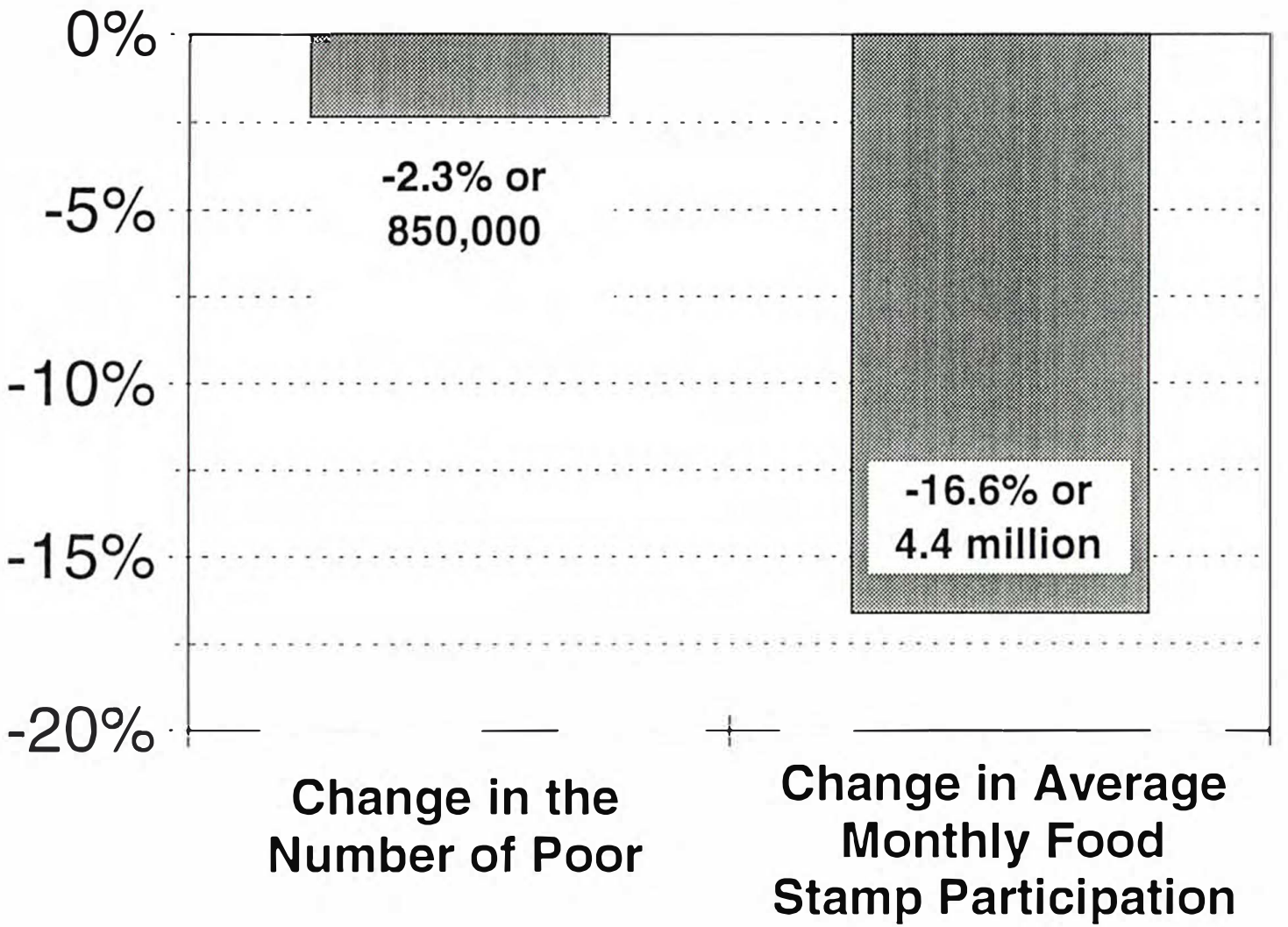
How Much Can Food Stamps Raise the Incomes of Low-Income Working Families

(Table assumes families spend $350 monthly for rent and utilities)

	Earnings		
	30 hours, minimum wage	**34 hours, $6.50 per hour**	**Full-time, $7.50 per hour**
Monthly take-home earnings:	$618	$884	$1,200
Food Stamps for a family of 3:	$253	$149	$57
% Increase in monthly take-home earnings:	41%	17%	5%

Note: "Take-home" earnings equals earnings minus federal payroll taxes and does not include the EITC or the effects of state taxes.

Changes in the Number of Poor People and Food Stamp Participation 1995-1997



Child Program Participants As a Percent of Children Poor After Receiving Social Insurance Benefits

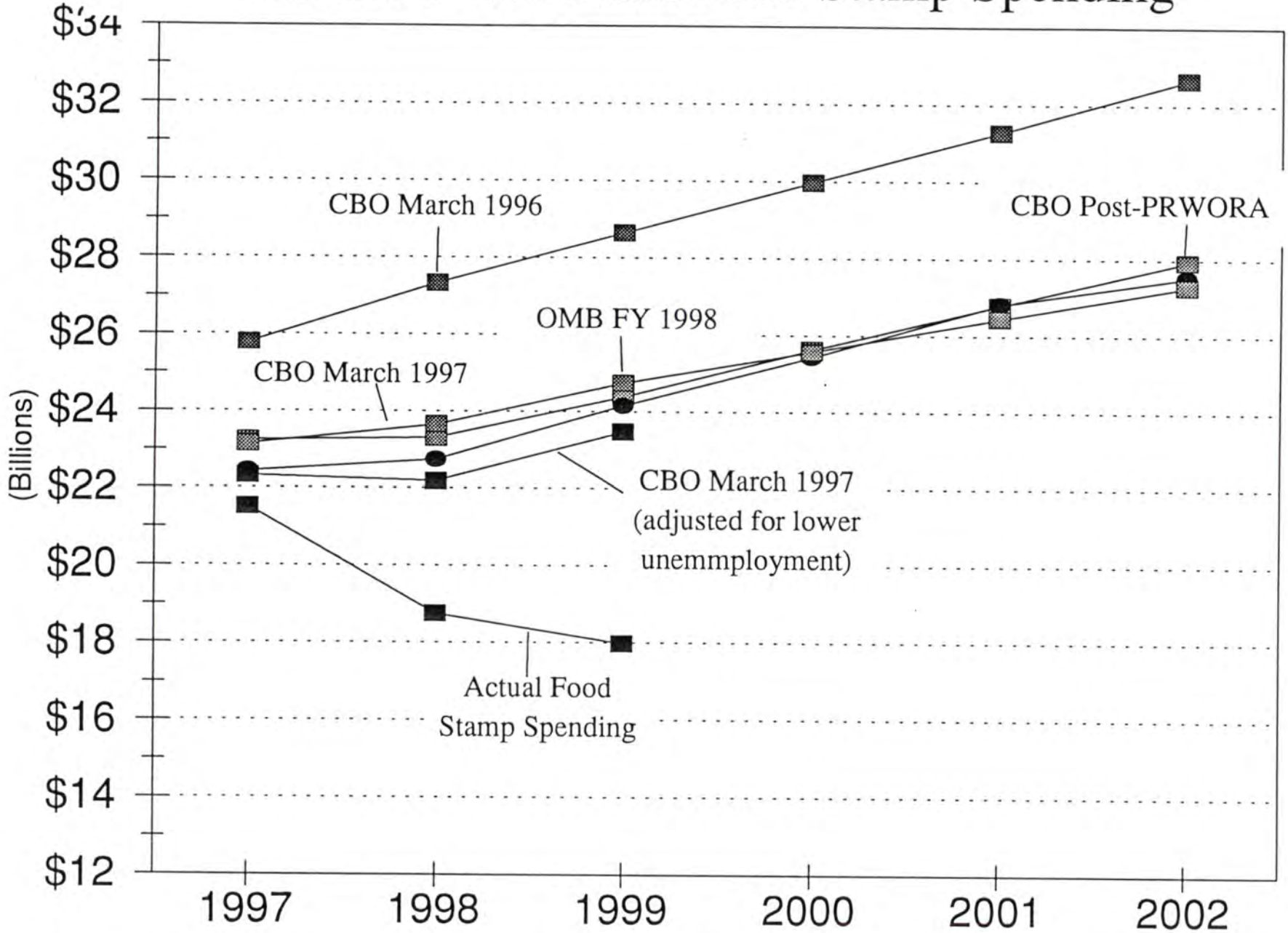
(in thousands)

	Number of Children Poor After Receiving Social Insurance	Number of Child Food Stamp Recipients	Percent of Poor Children Receiving Food Stamps	Number of Child AFDC Recipients	Percent of Poor Children Receiving AFDC
1994	16,324	14,391	88.2%	9,440	57.8%
1997	14,890	11,871	79.7%	7,527	50.6%
1998*	14,454	10,585	72.8%	6,898	47.4%
Change:					
'94 - '97	***-8.8%***	***-17.5%***	***-9.6%***	***-20.3%***	***-12.6%***
'94 - '98	***-11.5%***	***-26.4%***	***-17.5%***	***-26.9%***	***-18.0%***

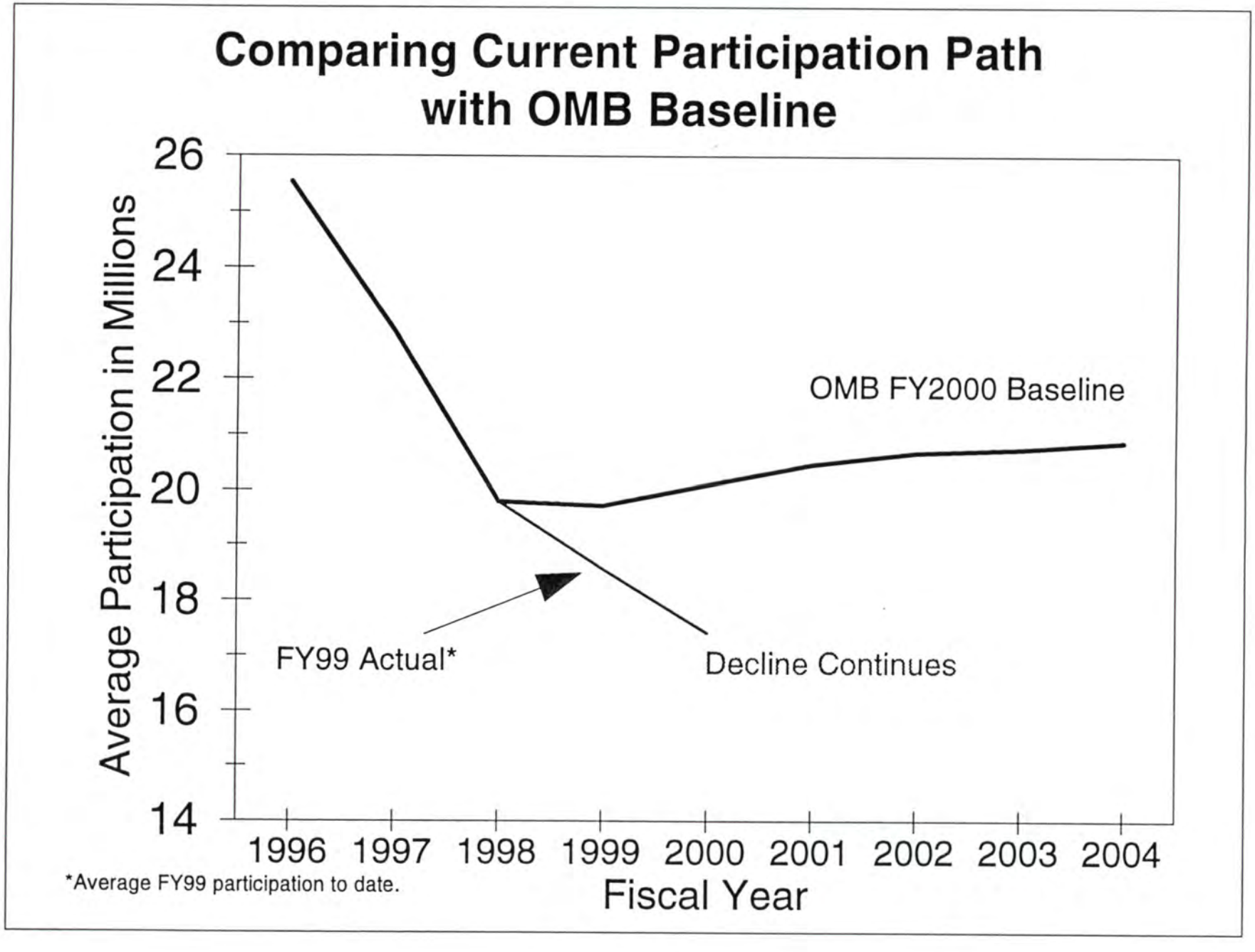
Source: CBPP calculations based on Census and HHS data

* Based upon decline in total recipients and average decline in poverty

Estimated vs. Actual Food Stamp Spending



*Projected from data for first five months of fiscal year.


Comparing Current Participation Path
with OMB Baseline
Average Participation in Millions
26
24
22
20
18
16
14
OMB FY2000 Baseline
FY99 Actual*
Decline Continues
1996 1997 1998 1999 2000 2001 2002 2003 2004
Fiscal Year
*Average FY99 participation to date.

Budget 1999

DRAFT--FY2001 BUDGET ROLLOUT ITEMS--DRAFT

(A/O 12/23/99)

POSSIBLE HOLIDAY SEASON ADVANCES:

NOTE: Rollout strategy should be coordinated with both the Office of the Vice President and the Office of the First Lady.

- **Expanding Charter Schools, Second-Chance Schools, and Public School Choice.** With a $30 million increase in the FY01 budget, from $145 to $175 million, the President will surpass his goal of creating 3,000 charter schools. We are also providing seed money for innovative public school choice projects, and are continuing to support universal public school choice for students in failing schools. At the same time, the Department of Education's 4th Year Charter School Report, which details the continued growth of charter schools, is ready for release. (Now planned for January 3).

- **Enhancing the Nation's Food Safety System.** CDC estimates that contaminated food kills up to 5,000 Americans and sickens 76 million more each year. This $35 million initiative will increase the number of imported and domestic food inspections by over 7,000, with a special emphasis on high-risk domestic foods such eggs and unpasteurized juice. It will also place an additional 100 inspection agents in the field. The FDA expects that this new investment will prevent over 100,000 illnesses per year.

- **120,000 New Housing Vouchers for America's Hard-Pressed Working Families.** The FY 01 budget will include $690 million for 120,000 additional rental assistance vouchers to meet the critical housing needs of America's low income families, including 18,000 vouchers for homeless families and 32,000 to help those moving from welfare to work. These vouchers will subsidize the rents of America's hard-pressed working families and enable families to move closer to economic opportunities. Families with such vouchers pay about a third of their income in rent, with the vouchers paying the remainder of the cost. This November, only because of the President's leadership, were 60,000 new vouchers added to the final budget after having been left out of both the House and Senate bills and last year, the President secured 50,000 vouchers, the first in four years. (Now planned December 29).

THE CHILD AND DEPENDENT CARE TAX CREDIT AND REFUNDABILITY
December 20, 1999

- Currently, the Child and Dependent Care Tax Credit (CDCTC) is not refundable, meaning that only families with incomes high enough to have a tax liability can benefit from it. For a single parent with 2 children, that would be $14,000. However, because of interactions with other refundable or partially-refundable tax credits (*e.g.* the EITC and the Child Tax Credit, which are claimed first), families do not actually benefit from the CDCTC unless they make roughly $21,000.

- While subsidies for child care are the most effective mechanism to help families with child care costs, we know that the Child Care and Development Block Grant (CCDBG) serves a fraction of the need. In 1998, the CCDBG served 1.5 of the 15 million children who are eligible under federal law. And, states set eligibility levels far below what is allowed by federal law.

- Therefore, there is a real gap in assisting working families with the high costs of child care. The CCDBG today effectively provides subsidies to the very lowest end of the income ladder. And, the CDCTC serves moderate to higher income families. Families between 100-200 percent of poverty, however, can receive no assistance with child care costs through either mechanism. Making the CDCTC refundable could help to close that gap and ensure that these working families can stay afloat and out of poverty.

JANUARY EVENT RECOMMENDATIONS:

NOTE: Rollout strategy should be coordinated with both the Office of the Vice President and the Office of the First Lady.

- **Federal Firearms Enforcement Budget Initiatives and Gun Violence Reduction Strategy.** This initiative puts an unprecedented level of resources into firearms enforcement, and includes: 1) 500 new ATF agents and inspectors, to investigate more gun trafficking cases and to bring the successful Youth Crime Gun Interdiction Initiative to more cities, and to crack down on unscrupulous dealers, manufacturers and distributors; 2) a comprehensive crime gun tracing package; 4) 1,000 new gun prosecutors and additional funds to help cities create community gun prosecutors; 5) a major expansion of existing ballistics testing systems; 6) funding for better Brady background checks; and 7) a new national notification system tied to NICS that speeds certain Brady denials (felons and other restricted persons) to local authorities. We could also release our gun violence reduction strategy, developed in response to the President's directive earlier this year. The report will also lay the groundwork for current and new legislative/budget proposals: more resources at the state/federal level, stronger gun laws, industry accountability, prevention and local partnerships. *NOTE: **This is our highest priority event**, and must be done before the January 21st Gun Industry Annual Trade Show.*

- **Medicare Fraud.** This new $30 million initiative will create a team of over 100 anti-fraud analysts to be placed in the offices of Medicare contractors nationwide to ensure a swift and coordinated response to suspected instances of fraud. In addition, it will invest new funds to implement new, financial management computer systems to accurately track and identify claims payments and prevent Medicare claims processors and auditors from defrauding the program. This initiative was developed in response to a critical GAO report detailing a myriad of abuses and a range of fraudulent activity by Medicare contractors. Any announcement on this front should be coordinated with the early January release of an HHS-DOJ report detailing our current success in fighting fraud, waste and abuse in Medicare.

- **Teacher Quality Initiatives.** The Teaching to High Standards block grant is a $1 billion initiative that includes: 1) a pay-for-performance and peer review program; 2) Troops to Teachers; 3) teacher recruitment proposal that would provide a down payment on the Vice President's 21st Century Teachers Corps (modeled after Teach for America), and an OMB initiative to recruit future teachers while they're still in high school; 4) principals initiative to fund independent School Leadership Centers to recruit nontraditional candidates and to focus on effective management, school design, technology, and district governance; and 5) a continuation of the President's class size reduction initiative. *The President could announce this budget initiative at the Department of Education's Teacher Quality Summit, January 10-12, which will include participation by university presidents,*

deans, professors, and teachers (approx. 800 participants).

- **Health Insurance Coverage.** This initiative to expand access to affordable health insurance to working Americans represents the most significant investment in health coverage in recent years. Its centerpiece is a proposal to give states financial incentives to cover uninsured parents of children eligible for Medicaid or the Children's Health Insurance Program (CHIP). The initiative could also help: (1) people without access to job-based insurance by offering a 15 percent tax credit towards individual health insurance; (2) people ages 55 to 65 buy into Medicare and offers them a new tax credit to make this option more affordable; (3) workers in small businesses by providing firms a 25 percent tax credit for small businesses that join purchasing coalitions; (4) workers between jobs by providing them and their former employers a tax credit towards COBRA coverage; and (5) legal immigrants by allowing states to cover them in Medicaid or CHIP at states' option. These policies to expand access to affordable insurance would be complemented by an investment of an additional $175 million in community-based efforts to strengthen the safety-net (e.g., community health centers, public hospitals). *This announcement could be timed to coincide with the January 13 release of a HIAA / Families USA / RWJ study on this issue.*

- **Preventing Medical Errors and Improving Health Care Quality.** This initiative will respond to the recent Institute of Medicine study and the President's request to develop new avenues for the prevention of medical errors. It will include new funding to increase medical errors prevention, patient safety research, information dissemination, and create a new Center for Patient Safety at HHS. It will also include new funds to strengthen FDA's post-market surveillance system for prescription drugs and its voluntary adverse event reporting system for health professionals and consumers, and to implement new requirements for the naming, labeling, and packaging of drugs designed to prevent medical errors. The FY 2001 budget will include steps to develop a consistent national architecture for health care information technology. This could be combined with patient safety regulatory actions at both the DVA and HCFA -- for instance, requiring hospitals participating in Medicare to implement error reduction programs. Any action we take on this front could be timed with an announcement that we are creating a private sector Task Force on this issue to complement ongoing Federal efforts. (This piece is currently being reviewed to ensure that it is not duplicative.)

- Tax Cut Radio Address (i.c., long-term care, faith-based) (DEFER TO NEC)

AVAILABLE FOR ADVANCES BEFORE STATE OF THE UNION:

NOTE: Rollout strategy should be coordinated with both the Office of the Vice President and the Office of the First Lady.

EDUCATION

- **SAT and ACT Test Preparation.** This program would support partnerships among high schools, proven providers of college test prep courses (such as Kaplan and Princeton Review), and community-based organizations to offer high-need students college test preparation and other services related to college admissions. *(Policy still in development.)*

- **AP Online.** This distance learning initiative aims to ensure that students in underserved areas get access to high-quality academic courses and ESL programs online. In order to ensure high-quality content, the proposal also calls for a partnership with leading course software developers like APEX, which would subsidize the cost of high quality Web-based course development in return for cut-rate prices for high poverty school districts.

- **Higher Education Initiatives** (DEFER TO NEC)

- **Special Education.**

HEALTH CARE

- **Internet Drug Sales Initiative.** This $10 million initiative would invest new funds in the investigation and prosecution of entities selling drugs illegally over the Internet. It would establish new Federal certification requirements for all Internet pharmacy sites to ensure that they meet all state and Federal requirements. It would also update the current penalty structure to create new civil money penalties of up to $500,000 for dispensing without a valid prescription over the internet or for selling drugs without Federal certification; give Federal agencies authority to require internet service providers to verify the identity and business location of domain name registrars; and provide FDA with new administrative subpoena authority in order to gather the information necessary to build a case against offenders.

- **Children's Health Insurance Program Outreach Initiative.** This initiative promotes school-based CHIP and Medicaid enrollment by: (1) allowing school lunch application information to be shared with Medicaid and CHIP for outreach; (2) letting enrollment in the school lunch program serve as a proxy for Medicaid or CHIP eligibility while formal applications are being processed; and (3) allowing additional

sites like child care referral centers and homeless programs to determine presumptive eligibility. The initiative would also simplify the enrollment process. Finally, it creates a $10 million competitive state grant program in Medicaid to coordinate programs and increase enrollment of homeless children and families in Medicaid, CHIP, and other social service programs. Its rollout could be combined with the release of a new report announcing that 2 million children have been enrolled in CHIP – a doubling in enrollment in the past year. This announcement could be timed to coincide with the January 4 release of a RWJ / Kaiser Family Foundation study on outreach and enrollment. Cost: TBD, about $1-1.5 billion/5 years.

- **Finishing The Job on Kennedy-Jeffords.** This proposal rounds out the Work Incentives Improvement Act by removing the arbitrary limit on Medicare coverage imposed in the final compromise. The final legislation limits Medicare coverage for people returning to work, postponing rather than eliminating the disincentive to work.

- **Announcing A Major Increase In The War On Emerging Infectious Diseases.** This $20 million initiative will dedicate new funds to further the development of a national electronic disease surveillance network to track newly emerging infectious diseases, such as West Nile-like encephalitis, new strains of influenza, and new hospital acquired infections, and provide essential information to public health clinics, hospitals, and health care providers. Funds will also be used to enhance local investigations, education, and focused disease monitoring nationwide, and promote the dissemination of new software for outbreak detection.

- **Determining The Environmental Causes Of Diseases, Including Breast And Prostate Cancer.** This initiative will invest $7.5 million to: evaluate the exposure of men, women, and children to toxic substances that cause cancer; assist state and local public health officials to ensure the thorough investigation of cancer clusters; and support local efforts to rapidly evaluate the impact of public health disasters, such as chemical spills and groundwater contamination, on local residents. It will also provide an additional $5 million for breast cancer screening programs at CDC.

- **Unveiling Major New Investment To Combat HIV And AIDS.** This initiative would invest an additional $50 million in domestic community based interventions to: help 150,000 individuals who are not aware of their infection learn their status and access prevention counseling and treatment services; expand community prevention planning, with a special emphasis on racial and ethnic minorities, women, injection drug users and their partners, and young gay men; and building a data infrastructure to assist local public health officials in targeting their prevention efforts. It will also invest an additional $40 million in efforts in activities to prevent AIDS worldwide, including: providing care for children who have been orphaned by AIDS; implementing workplace prevention programs through international labor unions; and providing treatment for the opportunistic infections associated with the disease. Finally, the new investment in Ryan White and ADAP would shorten the waiting time to access the comprehensive range of drugs needed to effectively treat

this disease. Total investment $225 million. (Note: Ryan White is up for reauthorization this year.)

- **Increasing Prevention And Treatment Services For Mental Illness And Substance Abuse.** This $170 million proposal would invest new funds in treatment for the severely mentally ill and establish a new local mental health enhancement program that would provide new prevention, early intervention, and treatment services for Americans with less severe mental illnesses. It would also provide new funds for substance abuse treatment services nationwide, with an emphasis on ethnic and racial minorities. (POTENTIAL MEG EVENT.)

- **Eradicating Polio Worldwide.** Medical and scientific experts estimate that we will be able to eradicate polio worldwide by the end of the year 2000. HHS believes that a $15 million increase will intensify current efforts to eradicate this disease, including: providing estimate 187 million doses of polio vaccine for use during worldwide National Immunization Days. In addition, funds will be used to develop permanent systems of disease surveillance, especially important for polio, where only one in 200 cases causes weakness or paralysis, thus allowing most polio infections to go undetected.

- **Improving Nursing Home Quality.** This $16.8 million initiative provides new funds to help states strengthen nursing home enforcement tools and increase Federal oversight of nursing home quality and safety standards. Funding will be provided for new enforcement provisions and increased surveys of repeat offenders and improve surveyor training, to address the backlog of nursing home appeals, and handle increased legal advice, litigation support, and hearings on nursing home enforcement cases. This initiative could be combined with new regulatory actions by HCFA to improve its survey and certification efforts.

- **Increasing Family Planning Efforts Nationwide.** These grants fund family planning clinics providing reproductive health services and clinical care to over 5 million low income women. These new funds ($35 million) will be used to prevent over a million unintended pregnancies year by improving the delivery of comprehensive reproductive health services, including STD and cancer screening and prevention, and HIV prevention, education and counseling; providing educational programs that encourage adolescents to postpone of sexual activity; increase the accessibility of contraceptive counseling and services; increasing efforts to provide effective contraceptives to those in need; and developing partnerships with other community based providers to conduct outreach to adolescents at risk.

4 • **Providing Education Funds To Children's Hospitals.** This initiative doubles to $80 million our funding level to provide freestanding children's hospitals with Federal financing for the cost of providing direct graduate medical education (GME) associated with the provision of care to Medicaid patients. While some states have funded GME through Medicaid, most

programs are ending as more states move to Medicaid managed care.

NON-BUDGET EVENTS:

- **Releasing Prescription Drug Cost Report.** In October, the President directed the Secretary Donna Shalala to produce the first-ever Health and Human Services (HHS) study of prescription drug costs and trends for Medicare beneficiaries with and without coverage. The study will investigate: price differences for the most commonly used drugs between people with and without coverage; drug spending by people of different ages, as a percentage of income and as a percentage of total health spending; and trends in drug expenditures by people of different ages, as a percentage of income and total health spending.

CHILDREN AND FAMILIES

- **Create a New Paid Leave Demonstration Program.** This is a new $18.5 million competitive grant fund to support innovative state efforts to provide partial wage replacement to workers on some form of family leave. States could use the Unemployment Insurance system (subject to final DOL rule-making), Temporary Disability Insurance programs, or some other vehicle.

CRIME

- **Smart Gun Technology**. (Anytime in January). We could highlight the $10 million that will be provided in the budget to fund smart gun and other personalized gun technology development at DOJ/National Institute for Justice.

- **Ex-Offenders Initiative.** We could highlight a new Justice-Labor initiative that funds a range of programs to prisoners after their release make the transition to work and community life -- and also creates police-social service partnerships to provide effective supervision of these ex-offenders. The budget will contain $60 million for a DoJ initiative to establish reentry partnerships and reentry courts, and $75 million for a complementary DoL initiative to connect ex-offenders to jobs skills training.

- **HUD Gun Initiative.** We could announce a new $30 million HUD gun violence reduction initiative to promote public education on gun safety, implement local gun violence reduction programs, and fund technology such as computer crime mapping to target gun crimes.

IMMIGRATION AND CIVIL RIGHTS

- **ESL/Civics Initiative.** This proposal funds English as a Second Language Programs that are

linked to civics and lifeskills instruction. In FY2000, the President requested $70 million and received $25.5 million. In FY2001 budget request is $75 million.

- **Naturalization Testing Process Streamlining.** This proposal would streamline and improve the current naturalization citizenship test process.

NATIVE AMERICANS INITIATIVE

- **Native American Initiative.** We could announce our over $1 billion Native American FY2001 budget initiative, which brings together all agencies to address the needs of Native American communities. Highlights include: increased funding for BIA school construction; initiatives to address the "digital divide" such as encouraging Native Americans to enter information technology fields; funding 500 new Native American school administrators; an over $200 million increase for the Indian Health Service, and over $100 million for new roads in Indian Country.

HOMELESSNESS

- **HUD Budget and Mainstream Homeless Initiative.** We could announce our FY2001 homelessness budget, which is over $1 billion in HUD funding and includes continuum of care and emergency shelter grants. We could also highlight a new initiative that would create, for the first time, a mechanism by which states are provided assistance in order to ensure that so-called "mainstream" programs – Medicaid, CHIP, TANF, Food Stamps, and the Mental Health and Substance Abuse Block Grant -- are accountable to the homeless.

ENVIRONMENT

- **Lands Legacy Initiative.** The POTUS would announce a major increase in funding to protect sensitive lands at all levels of government and would once again call for creation of a permanent trust to provide dedicated funding for this purpose in the future. The announcement could also be combined with a POTUS status on the possible creation of new national monuments.

- **Climate Change Initiative.** The POTUS would announce a major increase in support for climate activities. The announcement would have four major parts: (1) the next installment in the multi-year Climate Change Technology Initiative, including tax proposals; (2) a renewed call for the EPA's innovative Clean Air Partnership Fund; (3) vigorous implementation of the President's executive order on biofuels to promote renewable energy sources; (4) increased funding for the Global Environment Facility, the lead U.S. entity for promoting positive international action on climate change; and (5) a new international effort to promote clean U.S. technologies abroad.

- **Tropical Forest Conservation.** The proposal would expand AID's work on tropical forest, implement the Congressionally authorized Tropical Forest Conservation Act at Treasury, and provide technical assistance to struggling developing countries through USDA. The initiative would be designed in part to help the U.S. to respond to criticisms heard during the WTO process about the impacts of international trade on forests.

- **Salmon Recovery.** This proposal consists of a Salmon Recovery Fund, which funds state efforts in the Pacific NW and the implementation of the treaty with Canada, and Endangered Species Act money for NOAA. The FY 2001 proposal maintains FY 2000 proposed level of $160 million for the Fund.

SCIENCE & TECHNOLOGY

- **Research and Development Initiative** ($1.5 billion)
  -including restoration of balance between biomedical and other scientific research
  -clean energy

AGRICULTURE (DEFER TO NEC)

-Farm Safety Net
-AgNet Registry for Farmworkers

OTHER

- **Equal Pay Initiative.** We could rollout our joint Department of Labor and Equal Employment Opportunity Commission equal pay initiative. This rollout would include announcement of a new $10 million initiative (paid for by the fees from H1B visas) in order to provide training to women in nontraditional jobs in the high tech industry.

- **Supporting Youth-Driven Solutions to Community Problems through National Service** Three new initiatives to support the President's continuing commitment to community service and to respond to the growing need to empower youth in developing their own solutions to community problems. The budget for the Corporation for National Service includes: a $5 million Community Coaches initiative: $3 million for Youth Empowerment Fellowships; and $5 million to begin an AmeriCorps Reserves.

- **Philanthropy/Faith-Based Initiatives.** Among the possible announcements we can make are 1) steps to increase involvement of community- and faith-based groups in after-school and other important programs; and 2) new tax incentives to promote increased charitable giving by all taxpayers.

- **Hispanic Agenda Budget Items.**
  -Education Package
  -Welfare
  -Food Stamps
  -Immigration

- **Tobacco Penalty.**

TO BE HELD FOR STATE OF THE UNION:

NOTE: Rollout strategy should be coordinated with both the Office of the Vice President and the Office of the First Lady.

- **Universal After-School to Lift Standards in Failing Schools.** This package includes the following initiatives: 1) Universal After-School: by more than doubling after-school funding in the FY 2001 budget (from $453 million in FY 2000 to $1 billion in FY 2001), we can meet an urgent goal, which is to provide after-school and summer school to every student in a failing school; 2) Reward High Performance: from FY 2001-2003, states would receive awards for adopting statewide accountability systems -- including high school exit exams, teacher quality requirements, and school report cards -- ahead of the timetable called for in the President's ESEA proposal. After 2003, the Reward Fund would incorporate student performance measures as well; 3) Title I Accountability Fund: This year the President's budget will increase the set-aside for Title I accountability from $134 million to $250 million. This funding helps states and localities fix failing schools or shut them down.

- **School Construction: A New Initiative to Repair Existing Schools.** In addition to our existing plan which would leverage $20 billion in school construction over 5 years, this year we are proposing a discretionary initiative for FY2001 that would provide funds for immediate repairs. As part of the discretionary budget, this plan will make it more difficult for Congress to ignore school construction in the budget debate next fall.

- **A Small Schools Initiative to Reform the American High School.** This initiative would offer competitive grants to school districts for opening smaller schools (including charter schools), or for breaking up larger schools and using strategies such as schools-within-schools, career academics, or restructured school days.

- **Child Care Initiative.** (1) $818 million increase in the Child Care and Development Block Grant (discretionary) to serve 275,000 additional low-income children with child care subsidies; (2) Early Learning Fund (funding TBD) to help local communities promote early learning and improve child care quality, through a variety of allowable activities including licensing, accreditation, parent education, etc.; (3) Expansion of the Child and Dependent Care Tax Credit to provide low and moderate income families with greater tax relief for child care costs (cost/refundability TBD); (4) new tax credit for businesses that offer child care services to their workers; (5) increase in campus-based child care ($ TBD); and (6) new Early Childhood Professional Development Grants to provide grants to partnerships between universities, child care providers, and school districts to offer training and professional development to child care providers around language and literacy ($ TBD).

- **Dramatic increase in Head Start funding.** Announce $1 billion increase in Head Start funding for FY 01, the largest increase in the program's history. The $1 billion could provide

resources to reach nearly 1 million children with Head Start services (roughly 950,000).

- **Responsible Fatherhood Initiative:** Promoting responsible fatherhood is the critical next stage of welfare reform and one of the most important things we can do to reduce child poverty. We could a) announce new data showing the dramatic increases in child support collections made by this Administration and at the same time put forward a package of proposals to b) ensure every unemployed parent who owes child support goes to work and supports his children; c) collect more child support from parents who can afford to pay; d) revise outdated rules to ensure mothers and children receive more of the support the father pays; and e) promote efforts to ensure fathers returning from prison become responsible fathers and responsible members of society.

- **Digital Divide.** New initiatives: subsidized home Internet access for low-income families, and major boost for community technology centers. (NEC has more information).

- **Gun Initiatives.**

- **Universal Banking.** (NEC)

- **One of Several Possible Tax Cuts** (i.e., DCTC, faith-based, EITC) (NEC)