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Health - Budget Proposal Generally

Preliminary Ideas for Mandatory Health Spending for the Budget

(Dollars in Billions, Fiscal Years; ALL PROPOSED OPTIONS' COST ESTIMATES ARE PRELIMINARY/UNOFFICIAL)

	FY 1998 BUDGET (AS PROPOSED)		FY 1999 BUDGET OPTIONS	
	Provision	**Savings / Cost**	**Provision**	**Savings / Cost**
MEDICARE: Savings	Traditional reductions & structural reforms	15-20 per yr 115 over 5 yrs	Income-related Part B premium	About 1 per yr 8 over 5 yrs
			Miscellaneous payment reductions & fraud prevention	0.3-0.7 per yr 1-2 over 5 yrs
Spending	Preventive benefits	1.5-2.0 per yr 8 over 5 yrs	Medicare buy-in for pre-65	0.5-1.0 per yr 3-4 over 5 yrs
	Respite benefit	0.5 per yr 2 over 5 yrs	Private long-term care insurance options	0.5-1.0 per yr 3-4 over 5 yrs
	Hospital outpatient coinsurance buy-down	1 per yr 5 over 5 yrs	Clinical cancer trial coverage	0.6 per yr 3.2 over 5 yrs
MEDICAID: Savings	Per capita cap and DSH reductions	2-3 per yr 16 over 5 yrs	Certain administrative matching reductions	0.1-0.2 per yr 0.5-1.0 over 5
Spending	State option to buy in disabled workers	10 m per yr 50 m over 5	Demonstration for people with disabilities (ADAPT)	0-0.5 per yr 0-2.5 over 5 yrs
COVERAGE	Temporarily unemployed health insurance program	2 per yr 10 over 4 yrs	Demonstration for families between jobs	0.5-1.0 per yr 3-4 over 5 yrs
	Children's health	1 per yr 10 over 5 yrs	Children's outreach: Medicaid incentive or presumptive eligibility	0.1-1.0 per yr 0.5-5.0 over yrs
	Voluntary purchasing cooperatives	20 m per yr 100 m over 5	Voluntary purchasing cooperatives	20 m per yr 100 m over 5

Health - Budget proposals generally

MEDICARE HIGH-INCOME PREMIUM

FACTS

- Medicare subsidizes 75 percent of the cost of Part B coverage for all elderly and disabled beneficiaries — including wealthy beneficiaries. Recent studies have shown that wealthier beneficiaries on average live longer and actually place a greater demand on the Medicare program for additional health care services during their longer life spans.

POLICY

- **Higher premiums for higher income:** Certain high-income Medicare beneficiaries would pay either 75 percent or 100 percent of the value of the Part B benefit.

- **Income thresholds for 1999**:

Single beneficiaries:	Beginning at $50,000 ($75,000) with full payment at $100,000
Couple:	Beginning at $65,000 ($90,000) with full payment at $115,000

  After 1999, eligibility thresholds would be indexed to inflation.

- **Administration:** This premium increase would be administered by the Treasury Department. Most eligible beneficiaries would fill out a Medicare Premiums Adjustment Form that is sent out with their annual tax returns. Beneficiaries would compare their income with a premium schedule and pay the extra premium amount in a check made out to the Medicare Trust Fund.

ADVANTAGES

- **No reason to wait**: Given Medicare's long-term problems, we should continue promoting structural reforms. The Commission is not an excuse for inaction.

- **Supports priority Medicare improvements**: Funding from the premium could be used for initiatives like a pre-65 Medicare buy-in, a long-term care pilot, and / or clinical cancer coverage.

DISADVANTAGES

- **Treasury administration may be problematic:** Both the controversy surrounding the IRS and the Republican opposition to using Treasury during the Balanced Budget debate may make Treasury administration more difficult.

- **Democratic base and aging groups would oppose.**

STATUS

- An interdepartmental working group has been refining the policy options since September. Will have discrete policy options in the next two weeks.

MEDICARE FRAUD AND OTHER SAVINGS

FACTS

POLICY

- [HHS is developing for the budget]
- EPO
- Managed care reimbursement
- Miscellaneous Medicaid administrative matching rates
- Cats and dogs

ADVANTAGES

DISADVANTAGES

STATUS

- Expecting HHS ideas in then next couple weeks.

MEDICARE BUY-IN FOR PRE-65 ELDERLY

FACTS

- Retiree health coverage for people less than 65 years old has declined precipitously. In 1985, 75 percent of employers offered such coverage but today it is about half.

- This lower access to employer-based coverage makes people aged 55 to 65 the largest proportionate purchasers if individual health insurance — the most unregulated type of insurance whose premiums are often too high for older and / or sicker people to afford.

POLICY

- **Medicare buy-in:** Allow certain uninsured people under 65 years old to buy into Medicare is a cost-effective way to reduce the uninsured in this age bracket.

- **Eligibility**: The age limits would be 62 through 65 years old. To limit "crowd out" of existing coverage, this option could require that Medicare is secondary payer to any employer plan and that people use 18 months of COBRA before enrolling. Enrollment could be capped and/or limited geographically.

- **Premiums**: The managed care payment rates would be age-rated and risk adjusted for this option. A selection add-on could be added to the Medicare premiums over the course of the person's lifetime.

- **Evaluation**: A built-in evaluation would answer questions like: how many / what type of people participate; does this option cause crowd out; what is the effect on Medicare?

ADVANTAGES

- **Expands coverage**: This offers an affordable option for people who might otherwise have few choices. As such, it fits with the overall agenda to improve health coverage.

- **Tests approach for broader use**: The idea of a Medicare buy-in has been widely discussed as a coverage option if the age eligibility for Medicare were postponed. However, testing the approach is critical to knowing it is sufficient and viable.

DISADVANTAGES

- **Leads to crowd out**: Any proposal for this age group risks affecting retirement decisions and switching from private to public insurance.

- **Adverse selection**: Since it is a voluntary program, it is likely that sicker, more expensive people will take this option, making it costly for the Medicare program.

STATUS

- An interdepartmental working group has met several times primarily to discuss the problem and insurance / work dynamics of this group. Beginning to discuss this option.

PRIVATE LONG-TERM CARE INSURANCE FOR MEDICARE BENEFICIARIES

FACTS

- The retirement of the Baby Boom generation will affect long-term care as well as Medicare. Today, one in four people over age 85 live in a nursing home. The proportion of elderly living to age 90 is projected to increase from 25 percent to 42 percent by 2050.

- Unlike acute care, long-term care is not primary financed by private insurance, which only pays 6 percent of its costs. Medicaid pays for 38 percent, Medicare pays for 16 percent, and families pay for one-third of the costs out of pocket.

- State Medicaid programs, which are the primary payer for two-thirds of nursing home residents, may not be able to sustain this role given the impending demographic change.

POLICY

- **Option 1: Medicare long-term care plan**: On a demonstration basis, develop a Medicare / private long-term care option. The plan would be a risk-sharing arrangement where Medicare would bear most of the catastrophic risk and the private plan would cover the front-end risk. Beneficiaries ages 45-65 years old would have the option to buy these plans which could be marketed with the Medicare Choice plans.

- **Option 2: Encourage private long-term care options:** Standardize long-term care options and add information on qualified private long-term care plans for Medicare beneficiaries to the Medicare Choice information brochures. An advisory council, similar to that in the Health Security Act, could develop the guidelines for plans that may be included in the Choice material.

ADVANTAGES

- **Affirms commitment to addressing a major, looming problem**: While the strain on the acute health care system due to the retirement of the Baby Boom generation will be addressed by the Medicare Commission, few are paying attention to the demographic change's consequences for long-term care. Although this initiative is modest, it helps develop long-term options.

- **Encourages development of private long-term care funding and improvement of private plans:** Today's long-term care insurance market suffers from lack of use and poor quality.

DISADVANTAGES

- **Could be perceived as adding another benefit to Medicare**: At a time when many are considering reducing Medicare's benefits, linking long-term care with Medicare may be misperceived as creating a large, new entitlement.

- **May not be popular**: A problem with private long-term care insurance is that people often are not interested in purchasing it before they need it; this may not be different.

STATUS

- Interagency work group has begun working on these options.

MEDICARE CLINICAL TRIAL COVERAGE

FACTS

- Medicare only covers treatments that are approved by the Food and Drug Administration (FDA).
- However, this policy limits both beneficiaries' choices of treatments and the understanding of how cancer treatments affect seniors, almost all of whom are Medicare beneficiaries.

POLICY

- **Medicare coverage of certain clinical trials**: Allow Medicare to cover patient care costs associated with certain cancer-treatment clinical trials that are of high quality, specifically:
  - Clinical trials that are sponsored by the National Cancer Institute;
  - Clinical trials that are sponsored by an organization that has a peer-review process that is comparable to that of NCI, as determined by the Secretary; and
  - Clinical trials that are approved under a review process determined by the National Cancer Policy Board.
- **Beneficiary protections**: Enrollment and choices for beneficiaries would be guaranteed.

ADVANTAGES

- **Access to important anti-cancer treatment**: The proposal would expand the choices of treatment that beneficiaries have by providing for Medicare coverage of high-quality cancer clinical trials. For those beneficiaries who are currently receiving care through a non-covered, qualified clinical trial, Medicare would now pay for the patient care costs associate with that trial.
- **Strong Congressional support**: Senators Rockefeller and Mack are strong proponents.

DISADVANTAGES

- **Costs could be high**: HCFA actuaries suggest that this costs $3.2 billion over 5 years; CBO scored a more generous provision at $2 billion over five years.

STATUS

- HHS is working on ideas to constrain the costs of this proposal.

MEDICAID DEMONSTRATION FOR PEOPLE WITH DISABILITIES

FACTS

- Medicaid is a major source of coverage for people with disabilities. In 1996, about one-third of Medicaid expenditures were for the 6 million people with disabilities covered by Medicaid.

- Part of the high cost of Medicaid for people with disabilities is the use of institutional care. Although necessary in many cases, in others it is both more cost-effective and preferable to use home and community-based care.

- Medicaid covers personal care, home care and allows for waivers to cover home and community-based care where it is budget neutral. Although there are currently over 200 home and community-based waivers in nearly all states, they may not be sufficient to overcome the institutional bias in Medicaid payment rates.

POLICY

- **Demonstration to support community assisted living**: Building on the home and community-based care waiver model, develop a demonstration that allows for innovative programs such as providing vouchers for certain personal care services or financing services like medication reminders or transportation that makes community living possible for people with disabilities. NOTE: A HCFA working group has been working both on budget-neutral demonstrations and demonstrations that cost.

ADVANTAGES

- **Tests ideas that may save Medicaid money and improve the standard of living for some people with disabilities**: There is controversy about whether ideas like these are indeed cost effective. Given a strong research component, this demonstration could come to conclusions.

- **Widespread support**: The group ADAPT has encouraged the Administration to look at a much broader version of this proposal, called "Community Attendant Services Act (CASA). They met with both the President and Congressman Gingrich and received support.

DISADVANTAGES

- **May not be enough for advocates**: ADAPT is quite aggressive and may view this as a watered down compromise, especially if Gingrich carries through on his support.

- **Could be costly**: HCFA has looked at ideas like this for years and has always been concerned that they could be too costly in the long-run.

STATUS

- HCFA promised at the September 10 meeting with the President to look into the idea of a demonstration; an interagency group is working on a proposal.

DEMONSTRATION FOR FAMILIES BETWEEN JOBS

FACTS

- More than half of the uninsured became uninsured because of job change or loss.
- These breaks in health coverage may not last long, but are very common. One in three Americans spends at least one month without insurance over a three year period.

POLICY

- **Provide limited Federal subsidies for the purchase of transitional health insurance coverage**: To ensure that people can maintain continuity of health coverage, provide about $1 billion in Federal funding for time-limited (6 months) premium assistance to uninsured, low-income families (less than 200 percent of poverty) in several states, to test the approach for general use. Eligibility rules and subsidy amounts would be the same across states.
- **State-run test of different approaches**: States would submit applications for the Federal funds and propose their own unique approach. We would chose states to receive funds on both the merits and diversity of their approaches. For example, we could choose some states that use COBRA, use Medicaid, and subsidize parents of children enrolled in CHIP.

ADVANTAGES

- **Makes continuity of health insurance coverage affordable**: While the Kassebaum-Kennedy makes health insurance portable from one job to the next, it may not make it affordable. Many families may not be able to afford health insurance between jobs or during a waiting period.
- **State option: Can compare approaches:** Delivery approaches can be compared for broader use. This could also be used to cover some parents of children receiving CHIP coverage.

DISADVANTAGES

- **Political support may be difficult to generate**: There were surprisingly few proponents of the Temporarily Unemployed program last year. The states may not want another administrative burden as they implement welfare reform and the children's health insurance program. Limiting assistance to several states may also be problematic given our funds for all states last year.

STATUS

- PRELIMINARY / no interagency discussion yet.

CHILDREN'S HEALTH OUTREACH

FACTS

- About 3 million uninsured children are eligible for Medicaid — but not eligible for the new Children's Health Insurance Program (CHIP). Although we anticipate that there will be a "carry-over" effect on Medicaid of outreach for the new program, it may not be enough.

POLICY

- **Option 1: Bonus for outreach**: States would receive a "bonus" for enrolling new children in Medicaid — an extra matching amount for each additional child enrolled in Medicaid. This amount would be based on the states' increase in covered children, costs per child, and new matching rate under the Children's Health Insurance Program (CHIP). Successful states would get this amount at the end of the year based on their performance.

- **Option 2: Financial incentives for eligibility simplification**: A series of policy changes could facilitate enrollment in Medicaid and CHIP. First, states could access the 90 percent matching rate for the TANF $500 million set-aside for outreach for all children (not just children loosing AFDC/Medicaid). Second, we could expand the "presumptive eligibility" provision in the BBA so it (a) more types of people/sites could give children temporary Medicaid coverage and (b) the expenditures for such children are not subject to the $24 billion Federal allotment limit. Third, we could simplify Medicaid eligibility rules for children to make it easier for states to use a single application for both Medicaid and CHIP.

ADVANTAGES

- **Removes differences between Medicaid and CHIP to ease coordination**: These policy changes would make the two programs align better both financially and administratively.

- **"Bonus" rewards strategies that work**: Rather than simply increasing funding for outreach campaigns that may or may not work, this approach offers a financial reward based on proven success in enrolling uninsured children in Medicaid. It also evens out the matching rate, so it is the same for a child enrolled in Medicaid and CHIP.

- **Cost effective**: About two-thirds of children eligible but not enrolled in Medicaid are uninsured, meaning that the risk of "crowding out" private coverage is very low.

DISADVANTAGES

- **7 or 8 million children covered**: Given the focus on the claimed 5 million children covered by the budget, we would have to justify how many more children we could cover with this initiative.

- **Paying for what states should be doing anyway**: There was some Congressional opposition to the idea of outreach bonuses due to concern that there is already significant Medicaid matching for these children.

STATUS

- These ideas have been discussed in the budget debate and informally among staff.

SMALL BUSINESS INSURANCE OPTIONS

FACTS

- Workers in small firms are most likely to be uninsured. About one-third of workers in firms with fewer than 10 employees lack health insurance — more than twice the nationwide average.

- In part, this results from the greater difficulties that smaller employer have in purchasing insurance. Studies have shown that administrative costs are higher and that small businesses pay more for the same benefits as larger firms.

POLICY

- **Encourage responsible association plan**: [Still working on this]

- **Voluntary purchasing cooperatives**: To give small businesses the same negotiating power as large businesses, encourage them to band together in purchasing cooperatives. Offer $25 million per year in grants to cover the start-up costs for such cooperatives.

- **Link Children's Health Insurance Program (CHIP) with small insurance group purchasing cooperatives**: Under CHIP, states may get a waiver to buy children into group coverage. We could make waiver approval automatic if the state purchases group coverage through a cooperative. We could also increase the amount of the grant for start-up costs for such cooperatives if they linked them with their CHIP program.

ADVANTAGES

- **Addresses an important problem**: The increase in the number of people working in small businesses implies that the deterioration of employer-based health insurance will continue. This initiative attempts to address this.

- **Builds on momentum in Congress**: Both the House and Senate have been considering legislation to help small businesses purchase coverage; this contributes to that effort.

DISADVANTAGES

- **Not the type of reform that small businesses want**: Small businesses may only be interested in association plan-type arrangements that are self-funded and thus exempt from state insurance regulation. They are unlikely to support the voluntary purchasing cooperatives.

- **Too little**: This initiative has not generated widespread support in the past because it is considered too small to make a dent in this important problem.

STATUS

- HHS and DOL have been working on options.

Health-Budget proposal generally

MAJOR HEALTH CARE ISSUES IN BUDGET RECONCILIATION

MEDICARE

- Home health reallocation (House and Senate)
- Higher Medicare eligibility age (Senate)
- Home health copayment (Senate)
- Income-related Part B premium (Senate)
- Balance billing (Senate)
- MSAs (House and Senate)
- Medical malpractice (House)
- Medicare commission (House and Senate)

MEDICAID

- Coverage for certain disabled children (House and Senate)
- Medicaid investments in DC, territories (House and Senate)
- Low-income Medicare beneficiary premium assistance (House and Senate)
- Cost sharing provisions (Senate)
- DSH allocation to states and targeting to hospitals (House and Senate)

EXPANSION OF HYDE AMENDMENT (House and Senate)

CHILDREN

- Tobacco tax sunset (Senate)
- Meaningful benefits and cost sharing protections (House)
- Accountability (House and Senate)

MEWAs (House)

This has not gone in yet

Health - budget proposals generally

THE WHITE HOUSE

WASHINGTON

July 4, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Gene Sperling and Chris Jennings

cc. John Hilley, Frank Raines, Jack Lew and Bruce Reed

SUBJECT: Major Medicare Issues for Conference

Attached is a quick summary of the three highest profile Medicare issues in the House / Senate conference: the high-income premium, changing the age eligibility for Medicare, and the home health copayment. The summary includes a brief description, an analysis of policy concerns, how the policies could be modified for possible consideration, and the degree of difficulty to make these changes.

As we have discussed, we have sent strong signals of opposition to including the age eligibility change and the home health copayment in the context of the budget agreement. John Hilley strongly believes that opening up discussion of these two issues will rupture the House Democratic Caucus and would force Senator Daschle to oppose the budget in the Senate (the Senator explicitly has pointed to these provisions as reasons why he voted against the Senate-passed bill). However, in expressing our opposition to inclusion of these provision in the budget agreement, the communications from OMB have been careful not in any way to rule out possibility of improving and passing improved versions of these ideas in another context. In the OMB letter and in other communications with the Leadership, we have left the door open to the consideration of the high-income premium provision within the budget agreement. As you will note from the attached, there are a number of political and policy concerns that need to be carefully considered should we move in this direction.

HIGH-PROFILE MEDICARE ISSUES

HIGH-INCOME PREMIUM. Increases the Medicare Part B premium for high-income beneficiaries, administered by Health and Human Services (HHS) or Social Security (SSA):

Single beneficiaries:	Begins at $50,000 with full payment at $100,000
Couple:	Begins at $75,000 with full payment at $125,000

In 2002, the 25% premium would be about $67 per month; under this policy, the highest income beneficiaries would pay an extra $200 per month, $2,400 per year.

Concern: **Creates complex new bureaucracy.** Duplicates the IRS. HHS or SSA would have to use tax returns, ask beneficiaries their income, and bill and collect premiums. Having another agency have access to income data has potential to raise unforseen and major privacy concerns. Could take as long as 2001 to reconcile premiums for 1998. Would also require recovery of premium payments from deceased beneficiaries' spouses. AARP cites HHS administration as a primary reason why they oppose this policy.

CBO assumes that more than half the premium revenue would be lost in its first 5 years due to inefficiency. If administered by IRS, only about 5% would be lost.

Could encourage seniors to leave Medicare. The policy to completely eliminate any premium subsidy could cause high-income beneficiaries to drop out of Medicare Part B, leaving traditional Medicare with the sicker, more expensive beneficiaries. The HCFA actuaries assume that twice as many beneficiaries will drop out of Medicare if they must pay the full cost of the premium rather than 75% of the premium.

Trust Fund effect is 1 year at most.

Necessary Policy Modification:

Administer through the IRS; phase out the high-income premium at 75%, not 100% of the subsidy. This would reduce the annual maximum premiums to $1,600 for singles and would be paid quarterly (as estimated taxes) or annually. Some would label this as a "tax". Changing the phase-out loses some revenue but this is more than offset by efficiency gains from IRS administration. Saves approximately $7.8 relative to $3.9 billion through HHS. Could raise the income threshold to address concerns that too many beneficiaries would be affected or that too much revenue is being raised.

Degree of Difficulty to Fix:

From a political perspective, this may be the easiest option since we are viewed to be relatively down the road on this issue. From a policy perspective, the administration of the policy would impose yet another burden on an already understaffed IRS which would need additional resources to carry out such a significant task. IRS administration would allay the privacy concerns.

POSTPONE MEDICARE ELIGIBILITY: Extends the eligibility age for Medicare from 65 years old to 67 years old. Phased in one month at time, with full implemented in the year 2027.

Concern: **Increases the number of uninsured**. In 1997, an estimated 1.75 million beneficiaries aged 65 to 67 have income below $25,000. These Medicare beneficiaries may not be able to afford private insurance, possibly increasing the proportion of Americans without insurance by 5 percent, according to a preliminary Urban Institute analysis.

No partial benefit or insurance alternatives. Social Security gives people who retire early a portion of their benefits; Medicare offers nothing to such beneficiaries.

Trust Fund effect is less than 1 year.

Necessary Policy Modification:

Create Medicare buy-in or premium assistance for COBRA; alternatively, could specify that the Secretary must develop policy options by 2000. Note: These options may be expensive. The Medicare spending per enrollee — even after the budget agreement — is $7,300 in 2003 when the postponed eligibility begins. We would need to find a way to means-test the buy-in so that lower-income 65 year olds could afford coverage.

Degree of Difficulty to Fix:

On a policy basis, we could probably modify this in a way that addresses our primary concern -- continued, affordable access to insurance for the elderly. From a political perspective, it will be much more difficult because both the business and labor communities are focusing their opposition to this policy, fearing a direct cost shift.

HOME HEALTH COPAYMENT. Adds a new $5 payment per Part B home health visit, with an annual limit on the copayments equal to the hospital deductible ($760 in 1997).

Concern: **Unlikely to change utilization significantly**. Over three-fourths of Medicare beneficiaries have Medigap or Medicaid and would not directly pay for the visit.

Severe impact on low-income beneficiaries. For the 15 percent of beneficiaries without Medigap or Medicaid, these costs could be high and might reduce access to needed care.

- Over 60 percent of Medicare's home health users without Medigap have incomes below $10,000. Fully 87 percent have incomes below $20,000.

- Poor home health users without Medigap protection are more likely to have more than 150 visits per year than less.

Unfunded mandate to states. Medicaid covers cost sharing for millions of low-income Medicare beneficiaries. CBO estimates that states' costs could rise by $700 million.

Necessary Policy Modification:

Extend low-income beneficiary protections; make major changes to current Medigap policies prohibiting coverage of the home health copayments below a certain threshold

Degree of Difficulty to Fix:

Although not as visible as the first two proposals, this reform may be the most difficult from both policy and political perspective. From a political perspective, both the aging advocates as well as the National Association of Home Care (Val Halamandaris) are lobbying hard to eliminate this provision

Health-budget proposal generally cc Elena + return

Reconciliation Action as of 6/13/97: MEDICARE

Major Issues	Budget Agreement	Committee Action
Home Health Reallocation	Extend solvency of the Part A Trust Fund for at least 10 years through a combination of savings and structural reforms (including home health reallocation). Maintain Part B premium at 25% of program costs and phase in over seven years the inclusion in the calculation of the part B premium the portion of home health expenditures reallocated to Part B.	*Ways & Means* -- Shifts home health spending from Part A to Part B over seven years. *Commerce* -- Adopted Administration's proposal (i.e., shift the spending from Part A to Part B immediately and phase in the impact of the shift on the Part B premium over 7 years). *Finance* -- Includes proposal similar to Ways & Means.
MSAs	Agreement is silent on this issue.	*Ways & Means* -- Provides for a 4-year demonstration with 500,000 participants and does not protect beneficiaries from balance billing. *Commerce* -- Provides for a 5-year demonstration with 500,000 participants and does not protect beneficiaries from balance billing. *Finance* -- Same design as Ways & Means. We believe that the demonstration would not protect beneficiaries from balance billing.
Medical Malpractice	Agreement is silent on this issue.	*Ways & Means* -- Contains objectional provisions from the House balanced budget act (1995) and Kennedy Kassebaum (e.g., cap on non-economic damages, statute of limitations). *Commerce* -- Same as Ways and Means. *Finance* -- No provision.
Preventive Benefits-- Co-payments for Mammograms	Funding for new health benefits including expanded mammography coverage.	*Ways & Means* -- Includes most preventive benefits contained in the Administration's proposal, but fails to waive coinsurance for mammograms. *Commerce* -- Includes most preventive benefits contained in the Administration's proposal, but fails to waive coinsurance for mammograms.

Reconciliation Action as of 6/13/97: MEDICARE

Major Issues	Budget Agreement	Committee Action
Medical Education/ Disproportionate Share (DSH) Carve-out	Agreement is silent on this issue.	*Ways & Means* -- Does not include the policy to move medical education and DSH adjustments out of managed care payment rates and redirect the funds to hospitals that provide services to Medicare managed care enrollees. *Commerce* -- Includes the carve-out proposal, with a 5-year transition period (i.e., removes 20% of IME/GME/DSH in 1998, 40% in 1999, 60% in 2000, 80% in 2001, and 100% in 2002). *Finance* -- Similar to Commerce proposal, but includes a 4-year transition period.
Prudent Purchasing	Agreement is silent on this issue.	*Ways & Means* -- Adopted the Administration's "Centers of Excellence" proposal, but fails to adopt the other proposals (e.g., global purchasing, competitive bidding for DME) which would allow Medicare to take advantage of lower rates providers offer to other payers. *Commerce* -- Same as Ways and Means, but also added a durable medical equipment competitive billing demonstration. *Finance* -- Fails to adopt all the prudent purchasing proposals.
Commission	Agreement is silent on this issue.	*Ways & Means* -- Would establish a Medicare commission. *Commerce* -- Would establish a Medicare commission.
Private Fee-For-Service Plans in Medicare Choice	Structural reforms will include provisions to give beneficiaries more choices among competing health plans, such as provider sponsored organizations and preferred provider organizations.	*Finance* -- Available language indicates that the Finance Committee will allow private fee-for-service plans in Medicare Choice with no restrictions on balance billing.

Reconciliation Action as of 6/13/97: MEDICARE

Major Issues	Budget Agreement	Committee Action
Home Health Co-pay	Agreement is silent on this issue.	*Ways & Means* -- No provision. *Commerce* -- No provision. *Finance* -- Impose a Part B home health co-payment of $5 per visit, capped at an amount equal to the annual hospital deductible.
Raise in Eligibility Age	Agreement is silent on this issue.	*Ways & Means* -- No provision. *Commerce* -- No provision. *Finance* -- Conform the Medicare eligibility age to the eligibility age for Social Security (i.e., 67).
HI Tax for All State and Local Workers	Agreement is silent on this issue.	*Ways & Means* -- No provision. *Commerce* -- No provision. *Finance* -- Extend the HI tax to States and local government employees.

Reconciliation Action as of 6/13/97: MEDICAID[1]

Major Issues	Budget Agreement	Committee Action
Investments	Net Medicaid savings include a higher match for D.C., and an adjustment for programs in Puerto Rico and other territories	Commerce----- Committee bill did not include the following investments that were specified in the Agreement: a higher FMAP for the District of Columbia and adjustments for the Medicaid programs in Puerto Rico and the territories. At full committee, Chairman Bliley stated that he would work to include these provisions at a later point in the process. Finance----- Committee bill includes a 60 percent FMAP for D.C. that sunsets in 2000. Funding for Puerto Rico and the territories appears lower than in the President's Budget.
Low-Income Beneficiary Protections	Net Medicaid savings include $1.5 billion in spending over five years to ease the impact of increasing Medicare premiums on low-income beneficiaries.	Commerce----- Committee bill included only $600 million for protections for low-income Medicare beneficiaries from the increasing Medicare premiums, while the Agreement specified that $1.5 billion should be invested for these protections. Rather than cover the entire Part B premium for people between 120 and 150 percent of poverty, as was intended by the agreement, the Committee bill would cover only the increment in the premium increase due to the home health reallocation. Finance------ The Finance Committee mark includes no provision to expand protections for low-income Medicare beneficiaries.

[1]As of June 13th, Commerce favorably reported their Medicare reconciliation legislation. Commerce reported out June 12th. Senate Finance is expected to take up the bill June 16th.

Major Issues	Budget Agreement	Committee Action
Disproportionate Share Hospital Savings	Savings derived from reduced disproportionate share payments and flexibility provisions	Commerce----- The Committee bill allocates the greatest proportion of DSH cuts to 'high-DSH' states. The Committee does not include re-targeting of DSH funds. Finance---- DSH allotments are reduced by imposing freezes, making graduated proportional reductions and reducing payments by amounts claimed for mental health services.
SSI Disabled Children	Restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility.	Commerce--------- Full committee amendment eliminates the continuation of Medicaid eligibility for current disabled children who lose SSI benefits due to the new, more strict definition of childhood disability. Finance ----Chairman's mark does not include a provision to restore Medicaid benefits to current disabled children.

Reconciliation Action as of 6/13/97:
CHILDREN'S HEALTH[1]

Major Issues	Budget Agreement	Committee Action
Direct Services/ Use of $16 billion Investment	Spend $16 billion over 5 years (to provide up to 5 million additional children with health insurance coverage by 2002)	Commerce----- Subcommittee bill provides a direct services option to states (i.e., payment for services rather than insurance for children). Finance -- Still working out the details of a capped grant and Medicaid option for States
Cost-effective Use of Resources	Resources will be used in the most cost-effective manner possible to expand coverage and services for low-income and uninsured children with a goal of up to 5 million currently uninsured children being served.	Commerce-------- Subcommittee bill includes both a Medicaid and a grant option.
Limit on Access to Abortion	Agreement is silent on this issue.	Commerce-------- Subcommittee bill includes Hyde language limiting access to medically necessary benefits, including abortion services.

[1]As of June 13th, Commerce favorably reported their Children's Health reconciliation legislation. Commerce reported out June 12th. Senate Finance is expected to take up the bill June 16th.

Reconciliation Action as of 6/13/97:
HEALTH CARE REFORM[1]

Major Issues	Budget Agreement	Committee Action
Multiple Employer Welfare Associations (MEWAs)	Agreement is silent on this issue.	Education and Workforce -- Includes Rep. Fawell's Expansion of Portability and Health Insurance Coverage Act. This bill would enable small firms and individuals to buy health insurance through Association Health Plans. These AHPs would not be subject to state insurance laws.

[1]As of June 13th, both Ways & Means and Commerce favorably reported their Medicare reconciliation legislation. Ways & Means reported out June 9th and Commerce reported out June 12th. Senate Finance is expected to take up the bill June 16th.

Health – budget proposal generally

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

THE DIRECTOR

June 17, 1997

The Honorable William V. Roth, Jr.
Chairman
Committee on Finance
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing to express the views of the Administration on the Medicare, Medicaid, and children's health provisions under consideration by the Finance Committee, for inclusion in the FY 1998 budget reconciliation bill. The Administration's views on the other provisions in the Chairman's mark, including Welfare-to-Work, benefits for immigrants and unemployment insurance, will be provided separately.

Overall, the Administration finds much to support in the mark. It incorporates many of the proposals from the FY 1998 President's budget and is generally consistent with the Bipartisan Budget Agreement. It proposes Medicare structural reforms that constrain growth, extend the life of the Hospital Insurance (HI) Trust Fund for at least a decade, and improve preventive care benefits. In addition, the Committee's mark assures that hospitals will receive all of the funding to which they are entitled for graduate medical education and uncompensated care. All of these changes will help strengthen and modernize Medicare for the 21st century. It also allocates the full $16 billion for children's coverage policies without dedicating any of this important investment to an inefficient tax approach.

Medicaid

In a number of areas related to Medicaid, however, the Administration has serious concerns with provisions that do not reflect the budget agreement. If the Committee were to proceed with its legislation in this form, we would be compelled to invoke the provisions of the agreement that call on the Administration and the bipartisan leadership to undertake remedial efforts to ensure that reconciliation legislation is consistent with the agreement.

Investments. After extended negotiations that preceded the budget agreement, the Administration and the Congressional leadership agreed to specified savings and investments in the Medicaid program over five years. Recognizing that premiums represent a significant burden on low-income beneficiaries, the agreement allocated $1.5 billion to ease the impact of increasing Medicare premiums on this population. The Finance Committee mark failed to include this proposal. We strongly urge the Committee to include this proposal.

We are pleased that the Committee mark includes a higher matching payment for the Medicaid program in the District of Columbia and inflation adjustments for the Medicaid programs in Puerto Rico and the territories, but we are concerned that the increases are not sufficient. The matching rate proposed in the mark for the District of Columbia sunsets at the end of FY 2000 and is 10 percentage points lower than the matching rate of 70 percent proposed in the FY 1998 President's budget. It appears that the five-year spending associated with the inflation adjustments for Puerto Rico and the territories proposed in the mark is lower than the level proposed in the President's budget. We strongly urge the Committee to include these provisions at the level proposed in the President's budget.

Restoring Medicaid Benefits for Disabled Children. The budget agreement clearly includes the proposal to restore Medicaid for current disabled children losing SSI because of the new, more strict definition of childhood eligibility. The Finance Committee mark failed to include this proposal. We strongly urge the Committee to include this provision and retain Medicaid benefits for approximately 30,000 children who could lose their health care coverage in FY 1998.

The Committee mark also includes a number of provisions that were not specifically addressed in the budget agreement, and about which the Administration has serious concerns. They include the following:

Disproportionate Share Hospital Savings. We have concerns about the details of the allocation of the disproportionate share hospital (DSH) payment reductions among States included in the mark. The Finance Committee mark may have unintended distributional effects among States. We recommend that the Committee revisit the FY 1998 President's budget proposal, which achieves savings by taking an equal percentage reduction off of states' total DSH spending, up to an "upper limit."

We are very concerned that the Finance Committee mark does not include any retargeting of DSH funds. As the Administration has stated previously, we believe that significant savings from DSH payments should be linked to an appropriate targeting mechanism. It is for this reason that we support proposals to assure that some DSH funds are directed to hospitals that serve a high proportion of low-income and uninsured patients.

Privatization. The Chairman's mark would allow the eligibility and enrollment determination functions of Federal and State health and human services benefits programs -- including Medicaid, WIC, and Food Stamps -- in ten States to be privatized and deems approved such a proposal from the State of Texas. While certain program functions, such as computer systems, can currently be contracted out to private entities, the certification of eligibility for benefits and related operations (such as obtaining and verifying information about income and other eligibility factors) should remain public functions. The Administration believes that changes to current law would not be in the best interest of program beneficiaries and strongly opposes this provision.

Medicaid Cost Sharing. The mark would allow States to require limited cost sharing for optional benefits. We are concerned that this proposal may compromise beneficiary access to quality care. Low-income Medicaid beneficiaries may forgo needed services if they cannot afford the copayments. We urge the Committee to revisit the FY 1998 President's budget proposal, which would allow nominal copayments only for HMO enrollees. This proposal grants States some flexibility and would allow HMOs to treat Medicaid enrollees in a manner similar to non-Medicaid enrollees, without compromising access to care.

Criminal Penalties for Asset Divestiture. The Finance Committee mark would amend Section 217 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to provide sanctions only against those who assist people to dispose of assets in order to qualify for Medicaid. We believe the better solution to the issues that the HIPAA provision created would be to repeal this section altogether.

Children's Health

The Chairman's mark does not include detailed specifics on the children's health provisions. However, we are encouraged by reports that a bipartisan group of Senators are proposing to use this investment to build on Medicaid for low-income children and offer States grants to give children in working families meaningful coverage.

We believe that the $16 billion investment in children's health should be used for health insurance coverage. It is for this reason that the Administration supports proposals that only allow funds to be used for insurance, through Medicaid or a capped grant, and does not allow funds to be used for direct services. Under a direct services option, we are concerned that a State could spend all of its money on one benefit or to offset the effects of the DSH cuts on certain hospitals, and children would not necessarily get meaningful coverage.

We urge the Committee to use the funds in the most cost-effective manner possible to expand coverage to children, as required by the agreement. The Chairman's mark includes both a Medicaid and a grant option; however, the mark should not discourage States from choosing the Medicaid option. We believe that Medicaid is a cost-effective approach to covering low-income children, and would like to work with you on strengthening this option. We also believe that the grant program should be designed to be as efficient as possible. The mark should provide appropriate details to assure that funds are used solely for the purposes intended by the agreement and not used to offset States' share of Medicaid.

It is our understanding that the alternative children's health coverage approach that is being developed by the bipartisan coalition of Senators includes provisions that address many, if not all, of these concerns. We look forward to working with the bipartisan coalition and the Committee on this high priority issue for the President and the Congress.

Medicare

Home Health Reallocation. It is our view that the home health reallocation in the budget agreement is not properly reflected in the Committee's mark. During the negotiations, we discussed at great length the shift of home health expenditures to Part B, and it was always understood to be immediate. The Committee's phase-in of the shift means a loss of two years of solvency on the Part A trust fund, two years which we can ill afford to lose. In addition, a phased-in reallocation would cause significant administrative problems regarding claims processing, appeals, and medical review for Medicare contractors. We urge the Committee to incorporate the same provision that was included in last week's House Commerce Committee bill.

Balance Billing Protections in Medicare Choice. While the Administration supports the introduction of new plan options for Medicare beneficiaries, we believe that any new options must be accompanied by appropriate beneficiary protections. We believe that inclusion of private fee-for-service plans in Medicare Choice without balance billing protections is unnecessary. Beneficiaries should not be exposed to billing in excess of current law protections. Also, we are concerned that this option will attract primarily healthy and wealthy beneficiaries and leave sicker and poorer beneficiaries in the more expensive, traditional Medicare program.

Medical Savings Accounts. While we have agreed to work to develop a demonstration of this concept for the Medicare population, we have concerns about the size and scale of the demonstration in the mark. The Committee's mark provides for a demonstration with 500,000 participants at a cost of approximately $2 billion over five years, which is many times larger than any other Medicare demonstration. We believe the demonstration should be limited geographically for a trial period, which will enable us to design the demonstration to answer key policy questions. We have suggested limiting the demonstration to two states for a three-year period. Further, we strongly believe that the current law limits on balance billing should also be applied to this demonstration to protect beneficiaries from being subjected to unlimited additional charges.

Preventive Benefits. While the preventive benefits are largely the same as those advanced in the President's budget, we bring to your attention the proposal to waive coinsurance for mammograms. As you know, mammography saves lives, yet many Medicare beneficiaries fail to use this benefit. Research has found that copayments hinder women from fully taking advantage of this benefit. Thus, we continue to support waiving copayments for mammograms.

Home Health Copayments. We note that the Committee's mark would impose a Part B home health copayment of $5 per visit, capped at an amount equal to the annual hospital deductible. Medicare beneficiaries who use home health services tend to be in poorer health than other Medicare beneficiaries. Two-thirds are women, and one-third live alone. Forty-three percent have incomes under $10,000 per year. We are concerned that a copayment could limit beneficiary access to the benefit. Imposing a home health copay is not necessary to balance the

budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare.

Medicare Eligibility Age. Raising the eligibility age for Medicare is not necessary to balance the budget, and any further consideration of this policy should be part of a bipartisan process to address the long-term financing challenges facing Medicare. Moreover, this proposal does not contain provisions to address the fact that early retirees between the ages of 65-67 may not be able to obtain affordable insurance in the private market.

Prudent Purchasing. As you know, the Medicare program is governed by a strict set of provider payment rules that limit the ability of the Federal government to secure the most competitive terms available to other payers in the marketplace. We have advanced a set of proposals to allow Medicare, the nation's largest health insurer, to also take advantage of lower rates providers offer to other payers. At a time when we all agree that Medicare spending has been growing too quickly and the Federal budget faces increasing pressures for scarce resources, we do not understand why the Committee would miss the opportunity to take advantage of all these proposals to allow Medicare to be a more prudent purchaser. We propose adopting practices that work in the private sector. We should let them work in the public sector as well. These practices can work well to save taxpayers money and promote quality. We urge the Committee to include the President's proposals.

HI Tax for State and Local Workers. We note that the Committee's mark includes a proposal to extend the HI tax for State and local government employees. This proposal was not discussed in the negotiations surrounding the development of the budget agreement.

Commission. We note that the Committee's mark includes a Medicare commission. Establishing a bipartisan process that is mutually agreeable is essential to successfully address the challenges facing Medicare. We look forward to working with you on the development of the best possible bipartisan process to address the long-term financing challenges facing Medicare while simultaneously ensuring the sound restructuring of the program to provide high-quality care for our nation's senior citizens.

Cost Allocation Amendment

We understand that amendments may be offered during Committee consideration to prevent costs from increasing in Food Stamps and Medicaid due to cost-shifting for common functions from the TANF block grant, which places a cap on TANF administrative costs. We understand that the CBO baseline includes costs of over $5 billion in FYs 98-02 because CBO assumes administrative cost-shifting from TANF to Food Stamps and Medicaid. This proposal seeks to reduce the extent of the cost-shift to Food Stamps and Medicaid, which could yield substantial savings against CBO's baseline.

While the Administration is generally supportive of this effort -- to prevent States from changing cost allocation plans in order to shift greater administrative costs from the capped TANF block grant to open-ended Food Stamp and Medicaid administrative costs that are matched by the Federal government -- we would need to carefully review the specific mechanism proposed. Furthermore, we would have very serious reservations about proposals that would cap Food Stamps and Medicaid administrative costs and would oppose a cap that would limit the ability of a State to manage its programs.

The budget negotiators discussed changes to the Food Stamp and Medicaid programs at considerable length. Any further savings in this area would require mutual agreement, as would the allocation of those savings either to deficit reduction or to new spending.

The budget agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. It is critical that we do so on a bipartisan basis.

I look forward to working with you to implement this historic agreement.

Sincerely,

Franklin D. Raines
Director

Identical letter sent to the Honorable Daniel Patrick Moynihan

Addendum

Medicare Choice. We would prefer to link the growth in payments for Medicare Choice plans to growth in the fee-for-service sector of Medicare, rather than having two separate growth targets. To do so may lead over time to an erosion of the value of the Medicare Choice benefit package and expose beneficiaries to increased premiums.

Medigap Reforms. The President's bill advanced a number of important Medigap reforms including annual open enrollment (as well as including information about Medigap plans in the annual open enrollment season informational materials), community rating, open enrollment for disabled and ESRD beneficiaries when they become entitled to Medicare, and portability protections similar to those enacted last year in HIPAA for the under-65 population. Many of these important protections were also advanced by bipartisan bills including those sponsored by Senators Chafee and Rockefeller. We urge your reconsideration of the merits of these proposals. They ensure that Medicare beneficiaries are able to purchase affordable Medigap policies to fill in the many areas not covered by Medicare. Medicare beneficiaries should be able to choose which Medigap plans to purchase, or Medicare Choice plans to enroll in, without artificial constraints.

Survey and Certification User Fee Proposal. The Committee mark does not contain a provision allowing HCFA to require state survey agencies to impose fees on health care providers for initial surveys required as a condition of participation in the Medicare program. This provision would authorize states to collect and retain fees from health care providers to cover the cost of initial surveys. Under the budget agreement, the discretionary funding level for HCFA Program Management assumes enactment of this mandatory, government receipt fee proposal. Adequate funding for survey and certification activities is essential to program integrity.

Hospital Capital Property Tax. We are concerned about the inclusion of this provision on the grounds that it results in an inequitable redistribution of inpatient hospital PPS funding among proprietary and not-for-profit hospitals.

Creation of Duplicative Managed Care Bureaucracy. We understand that an amendment may be offered that would establish a new bureaucracy in HHS to administer the managed care reforms in the mark. We would strongly oppose such an amendment. The implications for beneficiary services are serious: one agency is in a much better position to coordinate programs and policies that will permit the 38 million Medicare beneficiaries to make informed choices of the whole new array of plan options under the mark. In addition, at a time when we are trying to reduce the size of the Federal bureaucracy, it seems counter-productive to divide Federal administration of Medicare into two separate, largely duplicative agencies.

Health-budget issues generally

HEALTH CARE: BUDGET STRATEGY

MEDICARE

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

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

HEALTH CARE: BUDGET STRATEGY

MEDICAID

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

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

HEALTH CARE: BUDGET STRATEGY

CHILDREN'S HEALTH

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