NLWJC - Kagan

DPC - Box 028 - Folder 009

Health - Children's Coverage

Health - children's coverage

Karin Kullman 02/17/99 11:34:52 AM

Record Type: Record

To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP, Christopher C. Jennings/OPD/EOP

cc: Devorah R. Adler/OPD/EOP
Subject: CHIP Outreach Event

I just wanted to give you all a run down of the initial meeting yesterday on next week's CHIP Outreach Event.

The event will be in the East Room, probably starting around 1:30pm or 2:00pm.

Speaking Program:
FLOTUS
Sec. Shalala
Gov. Carper
Gov. Leavitt
POTUS

In the Ann Lewis meeting yesterday it was decided to keep the speaking program to these 5 people, and not add a "real person". Also, members of congress will be invited to attend, but no speaking roles will be offered/kept for them.

The President will introduce the First Lady's PSA (and possibly others from NBC or ABC), and the 1-800 number would be displayed on the tv monitors while not being used to show the PSA.

There will be an audience of about 150-170 people consisting of those people who have made commitments to the National Campaign, including media types, corporates, religious organizations, etc.

Please let me know if anyone has any questions about the event. Thanks!

Health - children's coverage

INSURE KIDS NOW CAMPAIGN
NEW COMMITMENTS
February 23, 1999

Today, the President and the First Lady, along with Governors Carper and Leavitt and Secretary Shalala, launched the nationwide Insure Kids Now campaign that aims to enroll every eligible but uninsured child in Medicaid and the new Children's Health Insurance Program (CHIP). About half of the over 10 million uninsured children qualify for these programs but remain unenrolled. To ensure that families know that their children may be eligible, the President has engaged a broad-based, bipartisan, public-private coalition to use every possible means to educate and assist families in insuring their children.

Public-Private Partnership. The Insure Kids Now campaign has three components: (1) a new television, radio, and print media campaign; (2) new efforts by private corporations and professional associations; (3) new outreach strategies designed by grassroots organizations serving millions of people; and (4) new proposals and actions from the President, all designed to educate families about the health insurance options available through Medicaid and CHIP. Teachers, volunteers, health care providers, ministers and rabbis will inform parents of the toll free number and the message will be reinforced through PSAs on the radio and television, as well as through the display of the new toll free number on restaurant tray liners, grocery bags, and diaper boxes.

Launching 1-877 KIDS NOW, a new, national toll-free number for children's health outreach. Today, the President and First Lady launched 1-877 KIDS NOW, a new toll free number developed by the National Governors Association in partnership with Bell Atlantic and the Administration, that provides information on Medicaid and CHIP to families nationwide. This number will provide families in all 50 States with State specific information about Medicaid and CHIP. Families calling the line will speak with an eligibility counselor who can provide information about their State's eligibility criteria, benefits, and how to apply for coverage. Beginning in October, HHS plans to assume responsibility for this line.

THE NATIONAL MEDIA MAKES AN UNPRECEDENTED COMMITMENT TO CHILDREN'S HEALTH INSURANCE OUTREACH. Today, the President unveiled new efforts by national media organizations to provide families across the country with information about the importance of health insurance and how to apply for Medicaid and CHIP, including:

TELEVISION

- **NBC's** "The More You Know" campaign will air a public service announcement on children's health insurance beginning on February 24, using NBC stars S. Epatha Merkerson and Benjamin Bratt, to provide information about the importance of health insurance for children and includes the Insure Kids Now number.

- **ABC** will air a PSA featuring the new Insure Kids Now number during their morning programming and evening programming for at least a year beginning on February 25 and will distribute it to their affiliates to air during local programming.

- **Viacom/Paramount** will air a PSA featuring the new Insure Kids Now number beginning March 1st. This PSA will air on 19 of their stations throughout the country .

- **Black Entertainment Television** will run the First Lady's PSA twice a day for the next several months.

- **Turner Broadcasting** will air a PSA featuring the First Lady and the Insure Kids Now number later this year.

- **Univision** will air a Spanish language PSA developed by the Department of Health and Human Services beginning on February 23. The PSA will air once a day (during the day or in prime time) over the next year. Over 25 percent of Hispanic children are uninsured, and Univision is watched by 90 percent of Hispanic households -- over 18 million people.

- **Martha Stewart Inc.** will produce a PSA featuring Martha Stewart and the Insure Kids Now number later this year.

- **National Association of Broadcasters** (NAB) will distribute a PSA featuring the new Insure Kids Now number. The NAB, the national trade association representing broadcast stations, will make the PSA available to all their member stations on Monday, February 22nd.

RADIO

- **Radio ads in 45 States.** Beginning on February 23, the Department of Health and Human Services will fund radio ads to be aired in 45 States and the District of Columbia. In each State, the spots will run for 4 weeks (15 per week). The spots will run in groups of 10-11 States at a time, beginning with California, Utah, Colorado, Alabama, Illinois, Ohio, Kentucky, North Carolina, New Jersey, Connecticut, and Maine.

- **Bonneville Communications** will run six public service announcements narrated by the First Lady and General Powell that will be aired in Chicago, Salt Lake City, San Francisco, Washington DC, and several other cities.

PRINT MEDIA

- **USA Today** will run an editorial on the importance of children's health insurance. USA Today has agreed to do a editorial in their weekend edition on the importance of health insurance for children and the new options available to families through Medicaid and CHIP. The editorial will feature the new Insure Kids Now number.

PRIVATE ORGANIZATIONS JOIN THE ADMINISTRATION'S NATIONAL EFFORT. Today, the First Lady and the President lauded the efforts of private sector companies to get the word out about the new free or low cost children's health insurance options available to families across the nation. The following is a list of the new commitments:

CORPORATIONS

- **American Medical Response** will include the Insure Kids Now number on ambulances and other transport vehicles, such as school buses, which transport over 2,000,000 students daily. In addition, they will provide information on Medicaid and CHIP to communities in 36 States through their 20,000 employees.

- **K-Mart Corporation** will dedicate two columns on children's health insurance in the K-Mart circular distributed to more than 70 million homes, and they will also put daily public service announcements on K-Mart in-store radio network and put the Insure Kids Now number on all K-Mart shopping bags during June and September of 1999. In addition, during the month of May, K-Mart will work with the March of Dimes to staff counter displays at 1,600 K-Mart pharmacies nationwide with brochures for the Insure Kids Now campaign.

- **McDonalds** will distribute information about Insure Kids Now to its millions of customers.

- **General Motors** will work with La Raza to affix labels with the Insure Kids Now number to child safety seats being donated to families in low-income communities across the country.

- **Ralphs Grocery** will place bag stuffers in shopping bags and air PSA announcements in their in-store radio network to promote the Insure Kids Now toll free number.

- **Kids Korner Gift Shops**, owner of the 1-800-KIDS NOW and 888- KIDS NOW numbers, will refer callers to the 1-877 KIDS NOW number. Kids Korner Gift Shops will also include Insure Kids Now materials in packets sent to thousands of schools nationwide.

- **Romano & Associates Inc.** will work with CHIP corporate partners to produce a television PSA to distribute on behalf of the campaign.

HEALTH INDUSTRY

- **Blue Cross & Blue Shield Association** will begin to educate local physicians, hospitals and state government partners about the new health insurance options for low income children next month by distributing posters, brochures, and other materials featuring the Insure Kids Now number. In addition, Blue Cross / Blue Shield's national association will produce and

distribute a radio public service announcement nationwide as well as print advertorials on the Insure Kids Now campaign in the April issues of Readers Digest and Time Magazine.

- **Pfizer, Inc** will incorporate the Insure Kids Now number onto their patient/parent resource publication, mailings to their pediatricians, and in their Pharmacy Assistance Program. In addition, Pfizer will distribute an outreach kit to 400 community health centers in the Spring.
- **Wyeth Lederle Vaccines** will distribute handbooks this March that include the Insure Kids Now number and information on how to educate families about health insurance options for their children to 1,500 local community based organizations and providers.

- **Schering-Plough** will provide information on the Insure Kids Now effort to the nation's 33,000 school nurses through their health education website later this year.

PROFESSIONAL ASSOCIATIONS

- **American Dental Hygienists' Association** will include the Insure Kids Now number on toothbrushes and on a tear out flyer in its Access magazine, which reaches 80,000 dental hygienists in each of the 50 states nationwide.

- **American Medical Association** will promote the Insure Kids Now toll free number to the nation's 600,000 physicians in its weekly newspaper, the American Medical News, and by posting information on AMA's website.

- **American Nurses Association** will distribute posters featuring the Insure Kids Now number and other materials to their 180,000 member nurses this spring. Information will also be posted on their new web site.

- **American College of Emergency Physicians** will send information to 20,000 members through their March newsletter, including how to download posters and access outreach materials through the internet.

- **American College of Physicians / American Society for Internal Medicine** will advertise the Insure Kids Now number through its national website, in its monthly publication, the Observer, and in its bi-monthly legislative newsletter. These materials are distributed to 110,000 physicians.

- **Association of State and Territorial Health Officials** will distribute outreach resource packets to publicize the Insure Kids Now number to state health departments leaders and staff in 57 states and territories.

- **American Maternal and Child Health Association** will devote the front page of their newsletter Updates, which is mailed to over 500 national, State, and local public health organizations and officials, to Insure Kids Now. They will also add an ad banner to their

website that will link to the Insure Kids Now website.

- **American Psychiatric Association** will develop a Medicaid/CHIP Tool Kit to educate doctors and patients about Medicaid and CHIP programs for use by its 42,000 members nationwide.

- **American Dental Association** will put the Insure Kids Now number on their website.

GRASSROOTS ORGANIZATIONS JOIN TOGETHER WITH PRIVATE SECTOR PARTNERS IN THIS BROAD BASED EFFORT. In addition, numerous groups representing health care providers, volunteers, children's advocates, educators, child care providers, and religious organizations come in contact with low-income and working families on a regular basis and can help educate them about Medicaid and CHIP.

COMMUNITY-BASED ORGANIZATIONS

- **Volunteers of America** will make information on Medicaid and CHIP available to low-income families through the distribution of outreach material to homeless shelters, low income housing, and childcare centers.

- **United Way of America**, together with the Department of Justice, will attempt to enroll 500,000 eligible children in CHIP and will mobilize select local United Ways (of which there are 1400 across the country) to partner with local organizations to coordinate training for outreach volunteers to pilot the program, then expanding to approximately 30-50 communities across the country.

- **Points of Light Foundation** will publicize the Insure Kids Now number by providing it to over 20 million people through the "Connect America" initiative. Information will also be provided to 450 communities and 200 corporate members through the Volunteer Centers of the Points of Light Foundation. In addition, over 2,000 members will receive information on the Insure Kids Now toll free number.

- **March of Dimes** will feature children's health insurance in a direct mail newsletter to be sent to 800,000 individual donors in September of 1999, In addition, they will promote the Insure Kids Now effort through the June issue of the local chapter and WalkAmerica newsletters which are sent to an additional 500,000 volunteers and 20,000 corporate supporters. They will also work with the Children's Defense Fund and K-Mart to staff display tables with information about Insure Kids Now.

- **HOPE for Kids** will make children's health insurance the primary focus of its national outreach event on April 17, 1999. Beginning this spring, it will also implement efforts to educate 400,000 people in 38 States about Medicaid and CHIP.

- **Veterans of Foreign Wars (VFW)** will distribute information about CHIP through its network of posts.

- **YMCA** will fax information on the Insure Kids Now campaign to over 4,000 YMCA staff and volunteers. They will also incorporate information on Insure Kids Now into the materials distributed for Healthy Kids Day (April 10) a national YMCA day that highlights kids health issues, and will disseminate the information at the YMCA City Agenda Conferences over the next nine months.

EDUCATION AND CHILDREN'S ADVOCATES

- **National Collaboration for Youth** will distribute the Insure Kids Now number to its 27 member organizations and 5 million volunteers, who collectively serve 40 million children aged 6 to 18. The collaboration includes Boys and Girls Clubs, Girls Inc., YMCA, YWCA, Big Brothers and Big Sisters, Campfire Boys and Girls, and the Salvation Army.

- **National Association of School Principals** will distribute the Insure Kids Now number to their members nationwide.

- **National Association of Elementary School Principals** will post the Insure Kids Now information on their website and put information on the campaign in their newsletter.

- **National Association of Secondary School Principals** will distribute information on the Insure Kids Now campaign to their members.

- **National Child Care Association** has agreed to distribute advertisements and posters promoting the Insure Kids Now number to 700,000 parents through the network beginning this spring.

- **Public Education Network** will provide information on Insure Kids Now to the 2,000 members participating in their listserve, and will display the Insure Kids Now number on their website. They will also send information on Insure Kids Now to the participants of the Comprehensive School Health Initiative.

RELIGIOUS ORGANIZATIONS

- **National Council of Churches of Christ** will distribute the Insure Kids Now number to their 33 member communions representing 52 million people.

- **Union of American Hebrew Congregations** will advertise CHIP and the Insure Kids Now number to all 875 Reform Jewish Congregations across the nation through a mass mailing this spring.

- **Catholic Charities/USA** will host 10 training events, together with the Catholic Charities, to help facilitate enrollment in Medicaid and other state insurance programs during 1999.

- **Catholic Health Association** will put the Insure Kids Now number on their website and in their newsletter, which reaches thousands of people. They are also hosting 10 training events together with the Catholic Charities.

- **International Union of Gospel Missions** will distribute the Insure Kids Now number to their missions located in 260 cities where they serve over 7 million homeless and needy people.

- **United Synagogue of Conservative Judaism** will publicize the Insure Kids Now number to their over 800 congregations across the country.

- **NETWORK MAGAZINE** will advertise the Insure Kids Now number in their magazine, which that reaches 10,000 people nationwide.

- **The Evangelical Lutheran Church in America, National Council of Catholic Women, Church Women United, Council of Jewish Federations, Unitarian Universalist Service Committee, United Methodist Church-General board of Church and Society, and Women's Missionary Union** will distribute the Insure Kids Now number to their members.

EXPANDING FEDERAL EFFORTS. Today, the President and First Lady unveiled the new steps Federal agencies are taking to identify and enroll uninsured children in free or low cost health insurance. These include:

- **HHS: Launching the "insurekidsnow.gov" website for outreach**. HHS has developed a website with State-specific information for families eligible to participate in the Medicaid and CHIP, including contact information, benefits, and eligibility information in a user friendly format for families, educators, advocates and other non-health professionals. It will also provide information on the Administration's public-private outreach campaign, including posters, hand-outs, and descriptions of the effort.

- **HHS: Distributing 145,000 posters advertising the toll free number to over 20,000 Federal grantees and field offices beginning March 1.** HHS developed posters advertising the Insure Kids Now number to be distributed to over 20,000 Federal grantees and field offices as part of their new and ongoing efforts to educate parents, health care providers, and other Federal employees about Medicaid and CHIP.

- **HHS: Development of a kit to teach other agencies about how to explain the Medicaid and CHIP programs to their employees and clients.** Today, HHS will distribute an outreach training kit that has been prepared for to Federal workers from all Departments participating in the "Insure Kids Now" campaign. The kit contains a presentation outline,

posters, and materials that can be used as handouts.

- **USDA: Sending 92,000 employees information about outreach.** On March 8, over 92,000 USDA employees will receive information on CHIP with the Insure Kids Now number on their Wage and Earnings Statements.

- **USDA: Reaching uninsured children through the Women, Infant and Children (WIC) program.** During February, over 115,000 Alabama WIC participants will receive a CHIP outreach message with the Al-Kids toll-free hotline number on their WIC food instruments. In the near future, over 90,000 Oklahoma WIC applicants and participants will receive assistance in completing CHIP applications during their WIC visit.

- **JUSTICE: Distributing information through Operation Weed and Seed.** The Department of Justice will work with Operation Weed and Seed, a crime prevention and community revitalization initiative that brings together the United States Attorney and 170 community leaders nationwide to distribute a letter with information on CHIP and Medicaid and posters advertising the new toll free number beginning in March of 1999.

- **JUSTICE: Hands on involvement in communities nationwide.** Beginning in March of 1999, the Department of Justice, together with the United Way and HOPE for Kids (a non-profit charitable organization), will hold community forums, distribute enrollment information, and provide application assistance to residents in 6 to 10 cities to identify and enroll uninsured children in Medicaid and CHIP.

- **EPA: Distributing information on Medicaid and CHIP through the Child Health Champion Campaign.** The Environmental Protection Agency will distribute information on Medicaid, CHIP, and the new Insure Kids Now number through the new Child Health Champion Campaign, which works with 200 communities nationwide to protect children from environmental hazards by providing information, technical assistance and other support.

THESE NEW ACTIVITIES BUILD ON THE COMMITMENTS MADE BY:

- **America's Promise** will secure committments from private coroporations who are willing to particpate in the Insure Kids Now effort.

- **National Association of Chain Drug Stores (NACDS)** will include the Insure Kids Now number and include outreach campaign materials with each prescription filled. Additionally, NACDS will display outreach posters and have brochures available in 30,000 chain pharmacies visited by over 5 million people daily.

- **Safeway** will print the Insure Kids Now toll free number on grocery bags used at their stores nationwide beginning later this year.

- **National Community Pharmacists Association** will distribute information on Insure Kids

Now to 50,000 pharmacists through their newsletter, journal, and satellite programs.

- **American Hospital Association** will include materials on the Insure Kids Now campaign in their "Campaign for Coverage" information, will reach over 6 million uninsured people.

- **Bell Atlantic** provided NGA with funding to implement the new Insure Kids Now number, the cornerstone of the President's new national effort.

- **Pampers** will include Insure Kids Now materials in their child birth education packages, which are given to 90 percent of first time mothers.

- **National Educational Association** will provide information on the Insure Kids Now number to the presidents of their 14,000 local affiliates beginning this month. In addition, NEA will feature an article about CHIP in the October issue of the organization's magazine, distributed to 2.4 million educational employees.

Health - children's coverage

THE WHITE HOUSE

WASHINGTON

February 22, 1999

CHILDREN'S HEALTH OUTREACH EVENT

DATE:	February 23, 1999
LOCATION:	East Room
TIME:	1:45pm - 2:10pm (Briefing)
	2:15pm - 2:30pm (Meet & Greet)
	2:30pm - 3:10pm (Event)
FROM:	Bruce Reed, Mary Beth Cahill

I. PURPOSE

To launch the nationwide "Insure Kids Now" campaign aimed at enrolling eligible but uninsured child in Medicaid and the new Children's Health Insurance Program. You will launch the National Governors' Association/White House/Bell Atlantic, toll-free phone number and preview both the First Lady's and *NBC*'s public service announcements. You also will commend various media, corporate, and grass-roots organizations for their commitment to the campaign to enroll uninsured children.

II. BACKGROUND

You and First Lady have made improving children's health a priority. Studies show that children without health insurance are more likely to be sick as newborns, less likely to be immunized as preschoolers, and less likely to receive medical treatment when they are injured.

- **Historic new options for children.** In 1997, you created the Children's Health Insurance Program (CHIP), which devotes $24 billion dollars over five years for health coverage for children. Today, 47 states have implemented CHIP; they expect to enroll over 2.5 million children through this program when fully operational.

- **The challenge of enrolling children.** Ensuring that all eligible children get enrolled in health insurance programs is a formidable challenge. Barriers like complicated applications, lack of coordination between programs, and misinformation about eligibility criteria prevent uninsured children from getting the coverage that they need. To remove these barriers, you have taken numerous actions to encourage states to streamline their application and enrollment processes, accept mail-in applications, and place eligibility workers in convenient

locations. You also ordered federal agencies to provide active assistance in enrolling children through their many programs serving working families.

New Nationwide "Insure Kids Now" Outreach Campaign

Building on last year's efforts, today you and First Lady will launch the "Insure Kids Now" public-private campaign. For the first time, major TV and radio networks, corporations, health care organizations, religious groups, and other community-based organizations will join federal agencies in disseminating information about children's health insurance.

- **Launching "1-877-KIDS NOW" Hotline.** Today, Governors Carper and Leavitt unveiled 1-877 KIDS NOW, a new toll free number developed by the National Governors Association in partnership with Bell Atlantic and the Administration, to provide state-specific information about Medicaid and CHIP to families in all 50 states. Families calling this number will receive information about eligibility criteria, benefits, and how to apply for coverage. Beginning in October, the Department of Health and Human Services (HHS) plans to assume responsibility for operating this toll-free line.

- **Running public service announcements on national television about Insure Kids Now.** Beginning tomorrow, NBC, ABC, Univision, Turner Entertainment, the National Association of Broadcasters, and Viacom/Paramount will air public service announcements providing information about the importance of health insurance and promoting the Insure Kids Now number.

- **Airing radio advertisements about Insure Kids Now.** Today, HHS will begin funding radio ads on Insure Kids Now in 45 States and the District of Columbia, starting with California, Utah, Colorado, Alabama, Arkansas, Illinois, Ohio, Kentucky, North Carolina, New Jersey, Connecticut, and Maine. Later this year, Radio Disney and Bonneville will run similar ads nationwide. Radio reaches 77 percent of consumers daily, making radio ads a highly effective way to reach the millions of families with children eligible for Medicaid or CHIP.

- **Publishing information about Insure Kids Now.** This spring, USA Today will publish an editorial and Blue Cross/Blue Shield will publish a full page advertisement in the April issue of Time Magazine on children's health insurance. In addition, Pfizer, the American College of Emergency Physicians, the American Nurses Association, the United Way, the American College of Physicians, the National Collaboration for Youth, the Association of State and Territorial Health Officials, Wyeth Lederle, Kaiser Permanente, Volunteers of America, the March of Dimes, the Points of Light Foundation, Hope for Kids, the Veterans of Foreign Wars, the National Education Association, and religious organizations from across the country have agreed to put information on Insure Kids Now in their product handbooks, circulars, and mass mailings, as well as to distribute posters featuring the Insure Kids Now number to their clients and constituents. Print media is an effective educational tool, especially when used together with other media, because it allows the reader to reread and thoroughly digest the information.

- **Printing the Insure Kids Now toll free number on commonly used products.** Building on a series of commitments made in 1998, K-Mart, General Motors, the American Dental Hygienists Association, and American Medical Response have pledged to put the new toll-free number on grocery bags, toothbrushes, diaper boxes, pharmaceutical products, child safety seats, and schoolbuses.

- **Expanding federal efforts to promote children's health insurance outreach.** Your FY 2000 budget includes over $1.2 billion to assist states to engage in children's health outreach activities. In addition, the Federal Task Force on children's health outreach has begun new outreach efforts, including launching the new "InsureKidsNow.Gov" website; distributing 145,000 posters to over 20,000 health centers, providers, and other grantees; providing 92,000 USDA employees with information about outreach, including the new toll-free number, on their wage and earning statements; and sending a letter and posters with the Insure Kids Now number to all 170 sites in the Department of Justice's Operation Weed and Seed program, a crime prevention and community revitalization initiative.

III. PARTICIPANTS

Briefing Participants
Secretary Donna Shalala
Bruce Reed
Mary Beth Cahill
Doug Sosnik
Mickey Ibarra
Chris Jennings
Jeanne Lambrew
Janet Murguia
Neera Tanden
Jordan Tamagni

Event Participants
The First Lady
Secretary Donna Shalala
Governor Thomas Carper (D-DE)
Governor Mike Leavitt (R-UT)

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

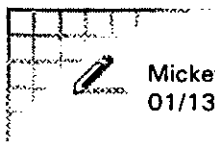
-You will be announced into the East Room, accompanied by the First Lady, Secretary Donna Shalala, Governor Thomas Carper, and Governor Michael Leavitt.

-The First Lady will make remarks and introduce Secretary Donna Shalala.
-Secretary Donna Shalala will make remarks and introduce Governor Michael Leavitt.
-Governor Michael Leavitt will make remarks and introduce Governor Thomas Carper.
-Governor Thomas Carper will make remarks and introduce you.
-You will make remarks and introduce both the First Lady's and *NBC*'s public service announcements.
-You will conclude your remarks, work a ropeline, and depart.

VI. REMARKS

To be provided by Speechwriting.

Health - children's coverage



Mickey Ibarra
01/13/99 09:47:01 PM

Record Type: Record

To: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP

cc:
Subject: Gov Patton

---------- Forwarded by Mickey Ibarra/WHO/EOP on 01/13/99 09:48 PM ----------

Fred Duval 01/13/99 09:43:45 PM

Record Type: Record

To: Ron Klain/OVP @ OVP

cc: See the distribution list at the bottom of this message
Subject: Gov Patton

I understand that you have been made aware that Gov Paul Patton is quite upset with the Administration over a number of recent events and policy announcements. His anger boiled over in a meeting today with Nancy Ann and the senior staff of HCFA where he angrily stormed out and then colorfully expressed his anger to me in the hall. It had been building over the past few months. A brief synopsis:

1. Kentucky CHIP. Kentucky recently had its state CHIP plan approved but the plan did not include coverage of the dependents of Kentucky state employees. The state originally believed it had been assured by HCFA that the children of state employees would receive coverage and had represented that widely in state legislative hearings when Kentucky passed its plan. When it was learned that this assumption was wrong, the Kentucky legislature and the Kentucky Teachers Assoc. went nuts. This is the pressure Patton is reacting to.

The federal law says that the federal govt. cannot cover the dependents of state employees where the state already does so or provides a benefit to the employee that can be used to cover their dependents. In Kentucky the state provides a cash stipend that is used by the employee to cover the cost of insurance. The weighted average cost of a state employees insurance package is $199 and the state employee subsidy is $203. (So the average net subsidy "benefit" is $4) All of the printed materials given to employees are drafted to assume this stipend covers only the employee. But, since it is possible for a state employee to opt for one of the less expensive plans and then have a cash/stipend balance which could be used for additional coverage for kids, HCFA concludes that a dependent benefit has been achieved and therefore the feds cannot cover the kids. The goal of the law was to prevent the states from using federal money to replace pre-existing state commitments.

Kentucky points out that only a small minority of the 160,000 state employees buy a smaller policy than what the stipend covers, and those that do usually first add spousal coverage not dependent coverage. So, if in fact their are cases where state money is being used by individual

employees to buy dependent coverage, it is very few and the dollars used to do so are tiny. Of particular frustration is that HCFA has approved two state plans (NC and Mississippi) which are similar except they provide their employees a plan itself rather than a subsidy to pay for the plan. The Governor sees HCFA as turning him - and the kids of Kentucky - down for coverage over the $4 difference.

The two obvious remedies are (1) Kentucky can change its state law, and (2) the Congress can change the federal law. Neither are likely to be achieved before Governor Patton's 1999 election date.

If you want more, Chris Jennings and I will come up and brief you.

2. Kentucky Locks. The Governor has asked for our commitment to allocate $20 million in FY 2000 for the replacement of the 60 year old lock on the Tennessee River at the Kentucky Dam which is the linchpin for Commerce moving between the Ohio River and the Tennessee River. In the last two years he made a similar request but we did not include this in our 98 or 99 budget. Sen. McConnell inserted approx. 8.4 million in last years budget and 4.2 mil in the 98 budget. Elgie Holstein informs us that this year we will include between 8 and 10 million for the lock. This is less than what the Gov is seeking, but is very helpful, and I suspect a smart hedge against another McConnell budget addition.

3. Transportation money. Last year, DOT awarded discretionary grants under section 1101 of the TEA-21 Act to all but three states. Kentucky was one of the 3 states. (I can give you DOT's individual justifications for each proposed project denial if you need them) Unfortunately this was more painful because Gov Patton was the lead Governor on Transportation and was very active in the lobbing for TEA 21. DOT is currently looking at the next batch of awards for next year.

4. EPA Air regs. As the Governor of a coal state, Patton lobbied hard against the recently promulgated rule on NOX emissions. He argued for less stringent standards, and was frustrated that the decision process did not permit him to make his case directly to the President. His industry feels as though he was unable to use his "clout" with the democratic administration to adequately convey the economic harm the new regs will do to his eneergy producers.

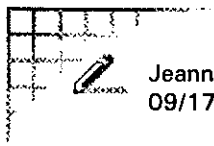
As you can see, we have had a string of bad luck. In addition, of course he hasn't been thrilled with much of our position on tobacco.

Now, all of this is not to say that we haven't had successes. We have worked with him successfully on federal funding for his home visitation project and early childhood development proposal, for his VINE program on sex offenders, Appalachian Regional Council (ARC) reform, etc. and he has been included in a number of high profile events at the White House. We have a warm personal relationship, and Audrey's joining MEGs staff has assured that good relations remain. But he is hoppin' mad on the "big" issues and is seeking our help.

Message Copied To:

John Podesta/WHO/EOP
Mickey Ibarra/WHO/EOP
Audrey T. Haynes/OVP @ OVP
Lynn G. Cutler/WHO/EOP
Christopher C. Jennings/OPD/EOP
William H. White Jr./WHO/EOP
Elwood Holstein/OMB/EOP
Minyon Moore/WHO/EOP
Linda L. Moore/WHO/EOP
Emory L. Mayfield/WHO/EOP
Jeanne Lambrew/OPD/EOP

Health - children's health



Jeanne Lambrew
09/17/98 10:05:16 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: Idea for Event on Kids' Outreach

Jen suggested that I write up some details of the idea of a POTUS kids' health outreach event that you discussed at the last Team Leaders' meeting. Here, specifically, is what we might do:

1. **Release first annual report on states' progress in implementing CHIP.** Expect to have 2.5 milliion kids covered by then; probably all but 5 to 8 states approved; will include in the report lots of local stories about what states are doing.

2. **Tentatively announce commitment by Americorps to help with children's health outreach.** Gene Sperling had suggested this and we are trying to figure this out now.

3. **Announce collaboration with NGA and America's Promise on public-private media campaign.** We are running paid radio ads, including one with the First Lady, in 9 states: Colorado, Delaware, Idaho, Indiana, Massachusetts, Ohio, Okalahoma, Pennsylvania, and Utah. This is beginning in early October and running through mid-November, as a ramp-up to a nationwide effort in January. We also have a TV spot with the First Lady that we could show at the event, although we are not airing it until January.

NGA definitely wants an event, but would rather have it in Delaware or Pennsylvania than DC. Tentatively think that they can get health co-chairs: Carper and Levitt. Not clear if Powell is interested in attending. This event would have to be between October 1 and the 6th or 7th, since the radio ads begin running around October 1.

Thanks, Jeanne

Message Sent To:

Bruce N. Reed/OPD/EOP
Elena Kagan/OPD/EOP
Christopher C. Jennings/OPD/EOP
Jennifer L. Klein/OPD/EOP
Neera Tanden/WHO/EOP
Christa Robinson/OPD/EOP

Health - children's coverage

THE CLINTON/GORE ADMINISTRATION: EXPANDING HEALTH COVERAGE FOR CHILDREN

September 1, 1998

"Every child's birth is a birth of hope, and no nation can achieve its full promise if unemployment is low, but child poverty is high, if interest rates are low, but malnutrition and disease rates are too high."

Vice President Al Gore
September 1, 1998

Today, Vice President Al Gore welcomes the Children's Health Fund's National Child Health Caravan to the White House where he will unveil new efforts to target and enroll uninsured children in health care programs. The Vice President will also announce the launch of new health outreach and enrollment efforts by departments within the federal government, and the approval of Children's Health Insurance Programs (CHIP) in three states, bringing the total number of states with plans to implement CHIP to thirty-three.

THE NEED TO REACH UNINSURED CHILDREN. There are over four million children who are currently eligible but not enrolled in Medicaid and the possibility that hundreds of thousands more children will be eligible but not signed up as states implement CHIP. Recent studies show that uninsured children are more likely to be sick as newborns, less likely to be immunized, and less likely to receive treatment for recurring illnesses. In addition, there are particular challenges to enrolling children in rural areas, where 2.5 million of the nation's uninsured children live.

NEW INITIATIVES TO IDENTIFY AND ENROLL UNINSURED CHILDREN. In response to the public-private outreach initiative the President announced earlier this year, pharmacies, grocery stores, and other private companies are launching efforts to reach out to families with uninsured children. In June, the President signed an executive memorandum directing eight federal agencies to help sign up millions of uninsured children. Today, the Vice President announces new steps that agencies are taking in response to that directive:

- **Encouraging States To Work With School Lunch Programs That Serve 15 Million Children.** The Department of Agriculture will distribute several model free and reduced price lunch application forms that states and schools may use to link families to state health insurance programs through school lunch programs that 15 million children -- many of whom are uninsured -- are enrolled in;

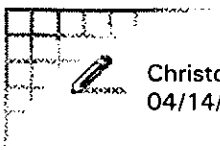
- **Encouraging Efforts To Reach 6 Million Families In Low-Income Housing Programs About Health Insurance.** The Department of Housing and Urban Development will send information about CHIP and how to identify and enroll families eligible for Medicaid or CHIP to housing authorities, owners and managers of multi-family properties, and others who provide assistance to 6 million low-income households nationwide;

- **Utilizing Employees Who Work With Earned Income Tax Credit And Other Low-Income Programs To Educate Families About CHIP and Medicaid.** Secretary of Treasury Robert Rubin is sending a memorandum to 158,000 employees encouraging their participation in efforts to target and enroll children in CHIP and Medicaid.

NEARLY TWO-THIRDS OF ALL STATES NOW HAVE APPROVED CHILDREN'S HEALTH INSURANCE PROGRAMS. The Vice President will announce that the Secretary of Health and Human Services approved three new states today -- Delaware, Iowa, and Kansas -- for CHIP, providing health coverage for tens of thousands of uninsured children. With these approvals, 33 states and Puerto Rico have approved plans that expect to cover over 2 million children when fully implemented.

RENEWING SUCCESSFUL RURAL HEALTH PROJECTS. Roughly 2.5 million uninsured children in America live in rural areas. Today, the Vice President will announce that HHS will renew projects that reach out to children in underserved rural areas. In addition, the Vice President will urge Congress to pass the President's Rural Outreach Initiative, which would provide resources to up to ten rural communities nationwide to train local citizens in providing outreach services to residents in hard-to-reach populations.

Health - children's coverage



Christopher C. Jennings
04/14/98 04:53:50 PM

Record Type: Record

To: Erskine B. Bowles/WHO/EOP

cc: See the distribution list at the bottom of this message

Subject: Call request to the CEO of Bell Atlantic to help asssure the successful implementation of their pledge to establish a 800 toll free number for children's health outreach

On February 18 of this year, the President and the First Lady held an event at D.C.'s Children Hospital outlining the Administration's commitment to ensuring that we work to sign up as many of the 4 million kids now eligible, but not enrolled in the Medicaid program. We also announced the first states being approved under the new Children's Health Insurance Program (CHIP). This event well illustrated our ongoing efforts to meeting the President and the First Lady's desire to provide insurance (whether it be through Medicaid or CHIP) to as many of the 11 million uninsured children as is possible.

At this event, Bell Atlantic pledged to set up an 800 toll free number to help us facilitate the enrollment of uninsured children. This number will be used to route calls from interested parties directly to the enrollment agencies that the states designate. It has become quite clear to us that it will be impossible to engage in an effective national oureach effort without this number because all of our partners -- whether they be the numerous Federal agencies that are making commitments to integrate information about children's health coverage with their programs OR the State and local governments who want to work with us on their outreach and enrollment campaigns OR the multitude of private sector actors (Pampers, Safeway, the pharmacists, possibly McDonalds, etc.) need to direct parents and other interested parties to a place where they can ask questions and start the process of enrollment.

We have been aiming for a May Presidential or First Lady event designed to announce the new 800 number, as well as a host of other public/private initiatives aimed at enrolling uninsured children. However, we are growing increasingly nervous that the 800 toll free number may not be operational in May or even June because of a seemingly slow follow-up by Bell Atlantic to get it tested and up and running. An unworkable, untimely and/or virus plagued toll free number would be embarassing to both the President and Bell Atlantic; something we both should obviously do everything possible to avoid.

We have been sending signals (through Maria's shop) about our nervousness, but are still not overly confident they have been heard -- certainly not enough to give us confidence that we will have a national, 50-state accessible, operational program by this summer. (To ensure this toll free number works will require careful testing and coordination with the states -- a process that probably generally takes weeks if not months.)

I am writing to inquire if you would be willing to call Raymond Smith, the CEO of Bell Atlantic, to expedite their work on this issue. The call would be designed to:

- Thank Mr. Smith for his company's extremely important commitment -- one that we think could make the difference between a successful or unsuccessful national outreach campaign to enroll millions of uninsured kids.

- To advise him about how excited the numerous federal agencies, states, and our private sector corporate partners are, on a bipartisan basis, to utilize the toll free number. (E.G., the National Governors' Association has already notified us about states who want to be the first to test this number out, the pharmacists and the grocers want to have it as soon as possible to give out directly to their customers.)
- To share with him our belief that this number needs to be up and running this summer to take advantage of the unprecedented interest of both private and public sectors in enrolling kids.
- To advise him about our nervousness, based on past experiences with multiple federal agencies, that the testing and administration of this toll free number needs to be done quickly and well to ensure a successful outreach program. If we do not succeed in implementing this number well (i.e., calls are made with no connection, are busy, or that no one answers or is trained to answer), we could face the type of criticism that none of us needs or wants.
- * To ask him for a status report AND to urge him to direct his people to do all that is humanly possible to get the number operational in a timely way AND to work more closely with us and the states to get the new number up and running.

We have been informed that Mr. Smith is supposed to be briefed this Thursday morning on the status of the implementation of their toll free number. I am requesting that you call him Thursday afternoon to give him the opportunity to brief you on developments, but mostly to highlight how important we believe Bell Atlantic's work is (and to subtly put the heat on to get moving on their work with us, the states, and are corporate and other private sector partners.)

Would you be willing to do this? If so, we will work with Maria's shop (Barbara Woolley) to put together a set of talking points (much like that above) and get
Carol the number to call.

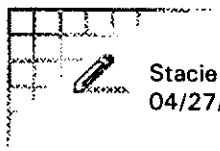
Thank you for considering this request.

cj

Message Copied To:

Maria Echaveste/WHO/EOP
Elena Kagan/OPD/EOP
Jeanne Lambrew/OPD/EOP
Barbara D. Woolley/WHO/EOP
Carole A. Parmelee/WHO/EOP
Jason S. Goldberg/WHO/EOP

Health - children's coverage



Stacie Spector
04/27/98 11:21:21 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Bruce N. Reed/OPD/EOP, Elena Kagan/OPD/EOP
Subject: FYI

HHS mentioned on the amplification call today that they are going to announce approved plans for Child Health implementation in Connecticut and New Jersey. Tomorrow they may announce Missouri and Idaho -- tbd.

Labor mentioned that later in the week (possibly Wed?) they will be releasing Welfare to Work grants in Delaware, Arkansas, Alabama, and Georgia.

Message Sent To:

Ann F. Lewis/WHO/EOP
Christa Robinson/OPD/EOP
Paul E. Begala/WHO/EOP
Sarah A. Bianchi/OPD/EOP
Michelle Crisci/WHO/EOP
Jennifer M. Palmieri/WHO/EOP
Stephanie S. Streett/WHO/EOP

health - children's coverage

THE CLINTON ADMINISTRATION: ENSURING HEALTH COVERAGE FOR CHILDREN

April 1, 1998

Today, on the sixth-month anniversary of the Children's Health Insurance Program (CHIP), Health and Human Services Secretary Donna Shalala, Domestic Policy Council Chair Bruce Reed, and National Economic Council Director Gene Sperling announce that New York and Illinois's children's health expansions have been approved. With these new additions to CHIP, eight states have approved plans that will, when fully implemented, cover over one million children.

AFTER ONLY 6 MONTHS, APPROVED PLANS WILL COVER ONE MILLION CHILDREN. Over 10 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. President Clinton is committed to ensuring coverage for these children. With the addition of New York and Illinois, eight states have approved CHIP plans. These approved state plans will provide health care coverage for an estimated one million children.

RAPIDLY IMPLEMENTING THE NEW CHILDREN'S HEALTH INSURANCE PROGRAM. An NEC/DPC Progress Report issued at today's event shows the successful implementation of the Children's Health Insurance Program. To date:

- **Eight states have approved plans to insure one million children**, including Alabama, California, Colorado, Florida, Illinois, New York, Ohio, and South Carolina. Together, these states estimate that they will provide health care coverage to over one million children;

- **Another fifteen states have submitted Child Health Plans for approval**, including Connecticut, Idaho, Massachusetts, Michigan, Missouri, New Jersey, Nevada, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Vermont, Wisconsin;

- **Almost all other states have processes in place to develop and submit plans to expand coverage to uninsured children**;

- **States are taking advantage of CHIP's flexibility to develop innovative programs that meet the unique needs of their populations**; for example, 12 states have proposed expanding coverage through Medicaid, 6 have proposed using block grants, and 5 have proposed a unique combination of the two.

CONTINUING WORK TO COVER UNINSURED CHILDREN. The rapid progress of the Children's Health Insurance Program will help millions of uninsured children get the health care coverage they need. However, this program will not reach all uninsured children. There are currently four million uninsured children that are eligible but not enrolled in Medicaid. Today, the Administration reiterated its commitment to finding ways to cover these children, by:

- Enrolling children in schools and child care sites. The President's budget proposes to allow states to enroll children in the places where they are --specifically schools and child care cites;

- Involving the private sector. Representatives of providers, children's health groups, foundations, and a host of private sector entities, such as pharmacies and grocery stores, have made new commitments to help find and enroll these kids.

Health - children's coverage

March 25, 1998

TO: Rahm E., Paul B., Ann L., Bruce R., Gene S., Elena K.

FROM: Chris Jennings

RE: **New Children's Health Law Breaks 1 Million Coverage Mark Next Wednesday**

Yesterday, HHS announced approval of California's children's health plan. Today, we received decent coverage of this announcement in the *LA Times* and the wires. Next Wednesday, however, we think we have the possibility of a larger announcement on the 6th month anniversary of the Children's Health Insurance Program (CHIP) which could:

- **Approve New York,** which will cover hundreds of thousands of uninsured children in one of the largest states in the nation;
- **Top the 1 million kids milestone,** with the approval of the first seven states (including New York);
- **Release a State-by-State Report Showing Dramatic Progress in Bringing New Programs on Line** since the October 1 implementation of the new law.

If you are interested in doing this, we need to tell HHS to hold off on final approval of New York until I'm not sure exactly who and how this would be announced, but the report is quite interesting and New York almost always generates news.

Health-children's coverage

February 18, 1998

MEMORANDUM FOR THE SECRETARY OF AGRICULTURE
THE SECRETARY OF EDUCATION
THE SECRETARY OF HEALTH AND HUMAN SERVICES
THE SECRETARY OF HOUSING AND URBAN DEVELOPMENT
THE SECRETARY OF LABOR
THE SECRETARY OF TREASURY
THE COMMISSIONER OF SOCIAL SECURITY

SUBJECT: Children's Health Insurance Outreach

Over 10 million children are currently uninsured and, as a consequence, often cannot afford much-needed health care services such as doctor visits, prescription drugs or, hospital care, when necessary. Last year, with bipartisan support, we took a major step toward solving this problem. The Balanced Budget Act I signed into law last summer enacted the largest single expansion of children's health insurance in 30 years. The new Children's Health Insurance Program (CHIP) provides $24 billion over 5 years for coverage of millions of uninsured children in working families. It builds on the Medicaid program, which currently covers nearly 20 million poor children across the country.

We now face the serious task of enrolling uninsured children in both Medicaid and state-administered children's health programs. We know that well over 3 million uninsured children are eligible but not enrolled in Medicaid. This is largely due to a lack of knowledge about Medicaid eligibility and the difficulty of the enrollment process. These same problems could limit the potential of the Children's Health Insurance Program to successfully enroll millions of uninsured children.

To ensure that both Medicaid and CHIP fulfil their potential, I am calling for a nationwide children's health outreach initiative involving both the private and public sectors. As illustrated by my announcement today, foundations, corporations, health care providers, consumer advocates and others in the private sector are already responding to our challenge to make every effort to enroll uninsured children in Medicaid or CHIP. In the public sector, the Administration's FY 1999 budget proposal includes policies to give States the flexibility and funding they need to conduct innovative outreach activities. I also have directed the Health Care Financing Administration (HCFA) and Health Resources and Services Administration (HRSA) to continue their focused effort to promote outreach through administrative actions.

There is clearly more that the Federal Government can do to help the States and the private sector achieve our mutual goal of targeting and providing coverage to uninsured children. Many children who lack health insurance are the same children who benefit from the programs your agency administers. Eligibility for Medicaid and CHIP is often similar to that for programs like WIC, Food Stamps, Head Start, tax programs, job training, welfare to work, Social Security programs, public housing sites and homeless initiatives. Thus, a coordinated effort across Federal agencies is critical to the success of the Administration and the States to provide health care coverage for children.

Therefore, to increase enrollment of uninsured children in Medicaid and CHIP, I hereby direct you to take the following actions consistent with the mission of your agency.

First, I direct you to identify all of the employees and grantees of your agency's programs who are likely to come in contact with low-income, uninsured children who may be eligible for Medicaid or CHIP.

Second, I direct you to develop and implement an educational strategy aimed to ensure that appropriate employees and grantees are fully informed about these programs' availability to our nation's children.

Third, I direct your agency to develop an agency-specific plan as part of an Administration-wide, intensive children's health outreach plan. This plan should include distributing information and educating families about their options; coordinating toll-free numbers and other sources of information on public programs; simplifying, coordinating and where possible unifying the application forms and process for related public programs; and working with State and local agencies on broadening the locations where families can apply for Medicaid and/or CHIP.

Fourth, I direct you to identify any statutory or regulatory impediments in your programs to conducting children's health outreach.

Finally, I direct the Department of Health and Human Services to serve as the coordinating agency to assist in the development and integration of agencies' plans and to report back to me on each agency's plan in 90 days with recommendations and a suggested implementation timetable. In so doing, I direct the Department to ensure that cross-Administration activities are complementary, aggressive and consistent with the overall initiative to cover uninsured children.

Health-children's coverage

THE WHITE HOUSE

WASHINGTON

February 18, 1998

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings, Jennifer Klein and Jeanne Lambrew

RE: Children's Health Implementation Update

CC: Melanne V., Bruce R., Gene S., Elena K.

This memo summarizes the activities related to the implementation of the Children's Health Insurance Program (CHIP) and our efforts to promote outreach for CHIP and Medicaid. There has been a tremendous amount of energy and activity surrounding the implementation of CHIP in the six short months since the Balanced Budget Act was signed. We expect the next six months to be even more intense, since States need to file their State Plans for CHIP by July 1 to access their 1998 funding allotment.

Tomorrow, you and the President are scheduled to participate with the President in an event announcing some of the first States coming on line in CHIP and highlighting a series of public and private initiatives aimed at enrolling eligible children in Medicaid and/or CHIP. This memo provides you background on what we have done to date in implementing CHIP and summarizes future initiatives to ensure success in enrolling uninsured children in Medicaid and CHIP.

IMPLEMENTATION ACTIVITIES TO DATE

The first phase of CHIP implementation consisted primarily of issuing Federal guidance on the new program. To date, there have been over 10 White House-approved, written communications from HHS to States that contain information necessary to implement the program. These and forthcoming communications include reporting forms and a host of technical but extremely important questions and answers. In the next two months, this policy guidance will be collapsed into regulations that will go through the ordinary public process. HHS has also been conducting regional conferences to assist States in the development of their plans.

Right now, we are at the beginning of the second, important phase of implementation: the State plan submissions. To date, we have received 17 State plans and have approved one. You

and the President will announce two more expansions tomorrow (Colorado and South Carolina). Interestingly, 8 States plan to expand coverage for children through Medicaid, 4 through non-Medicaid State programs, and 5 through a combination of the two. We approved the first plan for Alabama on January 30; the State simply expanded Medicaid to cover all poor children (the 14 to 18 year olds not already covered by the mandate). Because by law we have to either approve a State's plan within 90 days or "stop the clock" with a request for additional information, we had little choice in the timing of the Alabama approval.

Beyond the States that have already submitted their State plans, another 18 have some type of task force or work group assigned to identify children's health needs in the State and design the appropriate program. Preliminary reports suggest that another 6 States want to expand through Medicaid, 7 through a non-Medicaid program, and 5 through a combination of the two.

The White House has played a significant role in implementation. We run a weekly children's health implementation meeting, with HHS, OMB and Treasury. These meetings focus mostly on pressing policy issues and HHS's progress in meeting our aggressive implementation schedule. In addition, we run a weekly meeting with HHS staff that focuses on children's health outreach. This meeting serves to generate ideas and promote administrative actions to improve the enrollment of children.

ISSUES AND FUTURE ACTIVITIES

We can fairly say that implementation of the Children's Health Insurance Program, and the parallel focus on children's health outreach, has gone well to date. HHS has mobilized a large group of people to work on the State plan review, and we have had fewer than expected complaints from States and advocates.

That being said, our involvement has been necessary both to facilitate decisions being made and actions being taken by HHS. The Department tends to be divided on major policy issues and slow to resolve those divisions. In addition, we are beginning to get involved in what is sure to be myriad, difficult, State-specific issues. We are often put in this position because the Department does not like to take the hard-line stance with States, and even when they do, States often appeal to the White House. We already have several of these instances (Missouri, Maryland, Wisconsin). This has the effect of making children's health a major part of our daily work.

In addition to this oversight/policy making role, the most critically important activity that we can undertake is to engage in aggressive public-private outreach efforts to enroll eligible, uninsured children. To accomplish this, we need a short and long-term strategy. Tomorrow, you and the President will launch a national outreach campaign. The event will highlight Administration and State plans to enroll children in CHIP and Medicaid, outline the activities of private foundations, provider groups, children's groups, private businesses, and children themselves to help enroll uninsured children, and all members of the community to continue to

build on this important work.

This event, however, is just the first step in a long-term strategy. As you have noted, a sustained effort, both out in States and nationally, is essential to success in enrolling these uninsured children. There are a number of opportunities for you and the President to contribute in this effort, including:

- **Focus on the link between child care and health**: HHS will release in the next month a Medicaid manual for child workers. In addition, the Association for Child Care Resource and Referral Centers is planning a strategy to assist in outreach. We could highlight these activities in a State that works with such sites already (e.g., Philadelphia, rural Colorado).

- **Engaging schools**: NEA has already announced its intent to educate teachers. We could encourage principals, school coaches, school nurses, and others within schools to get involved as well. This could be done at one of the States coming on line with CHIP that intends to use schools (e.g., Connecticut, Pennsylvania, Florida).

- **AmeriCorps reauthorization**: The legislation to reauthorize AmeriCorps will be announced in the next few weeks. We could add to the legislation explicit encouragement of volunteers to engage in children's health outreach. Some volunteers (e.g., in Utica, NY) already do so.

- **Public Service Announcements**: Once the Bell Atlantic toll free phone number (that will be announced tomorrow) is established, we will work with the private sector on a public service announcement campaign.

- **Announcement of additional foundation or corporate contributions**: We expect that there will be great response to the President's challenge to foundations and the corporate community. We could organize events around such announcements.

- **Late May/early June announcement of Federal outreach plans**: The President will issue a directive tomorrow to Federal agencies to do outreach to the children who they serve in other programs. HHS will release a report in late May/early June describing all agency actions.

health - children's coverage

Christopher C. Jennings
02/09/98 11:34:08 PM

Record Type: Record

To: Bruce N. Reed/OPD/EOP

cc: See the distribution list at the bottom of this message
Subject: Re: carnahan

Gov. Carnahan is calling to urge us to expedite and approve his children's health waiver proposal. With one notable exception, we believe the waiver is acceptable and desirable. Unfortunately, the one exception deals with the state's desire to continue to rely on provider taxes, which were explicitly prohibited in the children's health insurance program enacted by the President last year. (Beyond this, Missouri's current Medicaid program appears to be severely out of compliance with current law as it relates to these provider taxes).

Recognizing their dependence on provider taxes that they know are at least vulnerable to interpretations by the Administration as being impermissable, the state wants to use the leverage of our desire to quickly implement new children's health programs as a vehicle for approving (or at least letting slide by) their reliance on this financing mechanism.

The Department, OMB, and I strongly believe that we should not and probably cannot comply with Missouri's wishes. We have made every effort to help Missouri by advocating legislation that would give the HHS Secretary the authority to waive past provider tax liabilities if the state comes into compliance prospectively. If the Secretary used this authority, it would provide a huge financial relief to Missouri. But Missouri believes that it can come up with no alternative financing mechanism and cannot financially survive without the crutch of a provider tax.

The reason why Gov Carnahan is calling Erskine and perhaps eventually the VP, is because he recognizes that he is unlikely to be successful in achieving approval of his provider tax proposal through the Department or through the normal OMB process. He will argue that his provider tax is or should be legal and moreover that his state has no way of providing an acceptable alternative revenue source.

Attached is some background inforamtion on this issue with some suggested talking points for your, Erskine's, or even the Vice President's use. Jeanne and I prepared this in case the Governor called.

Should the pressure from Gov Carnahan and his office significantly increase and we find our current talking points to be inadequate to appease the state, I would recommend holding an internal meeting with Jack Lew, Josh Gotbaum, Emily Bromberg, and us to determine the best way to respond to these concerns.

mo.209

MISSOURI CHILDREN'S HEALTH ISSUE

BACKGROUND

- **Governor Carnahan may call to express concern about HHS's consideration of Missouri's Children's Health Plan / Medicaid waiver proposal.** This proposal would expand coverage to both adults and children. The adults and some of the children would be fund through the Medicaid 1115 waiver and most children through the Children's Health Insurance Program.

- Missouri submitted an amendment on **August 25** to its 2-year-old 1115 waiver proposal, which was never approved by DHHS. The original waiver was not approved because the State and the Administration could not come to an agreement on how to treat the state's impermissible provider tax used to fund the program.

- The Governor met with Jack Lew, Mickey Ibarra and others on **September 23** to discuss this waiver. At that point, Jack encouraged the State to: (1) separate out their children's health application from the larger 1115 waiver since the children's part of the plan is less complicated that the adult part; and (2) not use the contentious provider taxes to fund the children's health piece. HHS repeated these requests to the State in subsequent meetings.

- On **February 6**, Missouri submitted a revision to their State plan and have requested that HHS give them comments by mid-week.

TALKING POINTS

- **Thank you for responding to our earlier request about your State Plan.** The February 6 plan does gives us the needed information to review your Child Health State plan, separate from your Medicaid waiver. We will encourage HHS staff to work on this at an accelerated pace, since this proposal has been pending for some time.

- **Remain concerned about provider tax issues.** As we discussed in September, Congress was quite clear about its prohibition of the use of provider taxes to fund the Children's Health Insurance Program. We have no option to approve State plans that use this funding source.

- **Support legislation for Medicaid.** However, as you know, we support legislation that allows us to work with you on some forgiveness of past liability in return for future compliance in your Medicaid program. We need your help in passing such legislation and encourage you to discuss this issue with the Committees of jurisdiction.

- **Look forward to approving your Plan.** We remain confident that the issues with your Child Health Plan can get worked out soon, so that you can begin your important, innovative expansion of coverage to many uninsured Missouri children.

BACKGROUND ON MISSOURI'S PROPOSAL

Proposed Expansion Populations

- **Children up to 300 percent of poverty.** The state intends to use the Children's Health Insurance Program (CHIP) to cover kids up to 200 percent FPL, then use the Medicaid waiver to cover kids from 200 to 300 percent of poverty.

- **Uninsured adults less than 300 percent of poverty** leaving welfare for work; certain uninsured poor parents; and some other groups like formerly pregnant women through the Medicaid waiver.

Benefits

- Children covered under both CHIP and Medicaid would receive the Medicaid benefit package. Both groups receive full EPSDT services. **The only exception is that the expansion populations would not receive non-emergency transportation benefits.**

- Most adults would receive the same benefit package as state employees. Formerly pregnant women who would lose Medicaid after 60 days postpartum receive "women's health" benefits only, for 2 years, regardless of income.

Financing

- **Missouri's original proposal provided almost no information about budget neutrality.** The original application states that HHS will have to "validate Missouri's current funding base and revenue sources" to implement the waiver -- meaning we have to resolve our long-standing disagreement with Missouri over the state's impermissible provider tax.

- Missouri's impermissible provider taxes (violating the hold harmless provision) are second only to NY in size (close to $1 billion). HCFA estimates Missouri continues to support its Medicaid program with approximately $200 million in impermissible provider taxes annually.

- Because Missouri's taxes violate the "hold harmless" provision of the provider tax law, they are not waivable. In October, we issued a letter stating our support for legislation that would allow HCFA to negotiate with the State (and others) on partial forgiveness for its ~~passed~~ past taxes in return for future compliance. Until such legislation passes, HCFA has no choice but to continue its process for enforcing current law.

health - children's coverage

THE WHITE HOUSE

WASHINGTON

February 17, 1998

CHILDREN'S HEALTH INSURANCE OUTREACH EVENT

DATE:	February 18, 1998
LOCATION:	Children's Hospital
EVENT TIME:	1:10 pm - 2:00 pm
FROM:	Bruce Reed/Chris Jennings

I. PURPOSE

To announce the first states to join the Children's Health Insurance Program and new efforts by the federal government and private sector to enroll millions of uninsured children into Medicaid or other state-based children's health programs.

II. BACKGROUND

Over 10 million children in America are uninsured, with 3 million of them eligible for but not enrolled in Medicaid. To address this problem, you fought for and signed into law the Children's Health Insurance Program (CHIP) last year, which provides funding for states to expand health care coverage to uninsured children. This event will provide you with an opportunity to highlight steps the Administration is taking to implement this initiative; to detail your 1999 budget proposal to improve children's health outreach; to announce executive actions complementing this legislative proposal; and call attention to significant private sector commitments to children's outreach.

At this event, you will make the following specific announcements:

- **COLORADO AND SOUTH CAROLINA HAVE JOINED ALABAMA AS THE FIRST COVERAGE EXPANSIONS UNDER THE NEW CHIP PROGRAM.** You will announce that Colorado and South Carolina join Alabama as the first states to come into the children's health program. In late January, Alabama received approval to expand its Medicaid program to children ages 14 to 18 up to 100 percent of poverty. South Carolina will expand its Medicaid program to provide coverage to all children up to 150 percent of poverty. And, Colorado builds upon its current non-Medicaid program to cover children up to 185 percent of poverty. You will also announce that many more States are well on their way to expanding coverage to more uninsured children. Currently, 14 states have submitted plans to HHS for approval,

and another 18 States have active working groups or task forces to design plans to address the needs of uninsured children.

- **A NEW PRESIDENTIAL DIRECTIVE TO LAUNCH A GOVERNMENT-WIDE EFFORT TO ENROLL UNINSURED CHILDREN.** At this event you will sign an executive memorandum to seven Federal agencies with jurisdiction over children's programs — the Departments of Agriculture, Interior, Education, HHS, HUD, Labor, and Treasury and the Social Security Administration -- that will direct the establishment of a multi-agency effort to enroll uninsured children. These agencies run programs such as WIC, Food Stamps, Head Start, and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. Your memorandum instructs these agencies: (1) to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; (2) to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and (3) to report back in 90 days on their plan to help enroll uninsured children.

- **NEW BUDGET PROPOSALS THAT PROVIDE MEDICAID ENROLLMENT INCENTIVES TO STATES.** Your FY 1999 budget invests $900 million over 5 years in children's health outreach policies, including the use of schools and child care centers to enroll children in Medicaid. The budget provides states with the option of automatically enrolling children in Medicaid even before having received all of the complicated eligibility and enrollment forms (a provision known as "presumptive eligibility"). It also expands the use of a Federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law.

- **A HISTORIC PRIVATE SECTOR COMMITMENT TO PROVIDE OUTREACH.** To complement the public outreach effort, you will announce unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

  - **A new toll-free number that directs families around the nation to their state enrollment centers.** You will announce that Bell Atlantic will establish and operate a toll-free number to help states enroll uninsured children. The number, which will be put in place during the upcoming months, will be used by the nation's Governors to help millions of families around the nation by directing them automatically to their local state Medicaid enrollment agency.

  -- **Over $23 million in commitments from private foundations across the country.** The Robert Wood Johnson Foundation will spend $13 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to $10 million over the next 5 years on studies to help understand why eligible

children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and the American Academy of Pediatrics, will mobilize corporations such as Smith Kline Beecham and Sheering Plough and local communities nationwide in children's health outreach efforts.

- **New initiatives from corporate and advocacy organizations to reach out to uninsured children.** Pampers has volunteered to include a letter in its child birth education packages, given to 90 percent of first-time mothers, giving families information about available health insurance options. Chain drug stores across the country will provide information about the new Bell Atlantic toll-free number to their customers. The National Education Association is launching an unprecedented effort to educate teachers on how they can inform children and their families about health insurance, through national newsletters, conferences, and special training sessions. The American Hospital Association's Campaign for Coverage will increase its nationwide initiative to engage hospitals in helping uninsured Americans, including children.

III. PARTICIPANTS

- The First Lady
- Secretary Shalala
- Ned Zechman, President and CEO of Children's Hospital
- Linda Haverson, parent whose son was recently enrolled in Medicaid because of a local outreach effort. Her son was able to have necessary ear surgery because of his coverage.

IV. PRESS PLAN

Open Press.

V. SEQUENCE OF EVENTS

- You will be announced onto the stage accompanied by the First Lady, Secretary Shalala, Ned Zechman, and Linda Haverson.
- Ned Zechman, President and CEO of Children's Hospital, will make welcoming remarks.
- Secretary Shalala will make remarks and introduce the First Lady.
- The First Lady will make remarks and introduce Linda Haverson.
- Linda Haverson will make remarks and introduce you.
- You will make remarks.
- You will sign the executive memorandum.
- You will work a ropeline and then depart to the holding room.
- You and the First Lady will briefly meet with private sector representatives who have made commitments to do children's health outreach. (Please see attached list.)

VI. REMARKS

Remarks provided by June Shih in Speechwriting.

health-children's coverage

PRESIDENT CLINTON ANNOUNCES A SERIES OF NEW EFFORTS TO ENROLL UNINSURED CHILDREN IN HEALTH INSURANCE PROGRAMS
February 18, 1998

Today, the President announced the first major state coverage expansions under the recently enacted Children's Health Insurance Program (CHIP) and released information showing that many States will soon follow. He also unveiled an unprecedented set of public/private initiatives designed to enroll the millions of uninsured children who are eligible but not enrolled in Medicaid and other state-based children's health programs. These initiatives have been designed in partnership with Governors, health care providers, children's health advocates, foundations, businesses and many others who are committed to providing health care coverage for the nation's uninsured children.

Over 10 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. Over 3 million of these uninsured children are already eligible for Medicaid. However, many families are not aware that their children are eligible for Medicaid, and others have difficulty filling out the application. Similar problems could undermine the new Children's Health Insurance Program's goal to enroll millions of uninsured children. With these challenges in mind, the President:

✔ **ANNOUNCED THAT COLORADO AND SOUTH CAROLINA HAVE JOINED ALABAMA AS THE FIRST COVERAGE EXPANSIONS UNDER THE NEW CHIP PROGRAM.** Today, the President announced that Colorado and South Carolina join Alabama as the first states to come into the children's health program. In late January, Alabama received approval to expand its Medicaid program to children ages 14 to 18 up to 100 percent of poverty. South Carolina will expand its Medicaid program to provide coverage to all children up to 150 percent of poverty. And, Colorado builds upon its current non-Medicaid program to cover children up to 185 percent of poverty. The President also announced that many more States are well on their way to expanding coverage to more uninsured children. Currently, 14 states have submitted plans to HHS for approval, and another 18 States have active working groups or task forces to design plans to address the needs of uninsured children.

✔ **RELEASED A NEW PRESIDENTIAL DIRECTIVE TO LAUNCH A GOVERNMENT-WIDE EFFORT TO ENROLL UNINSURED CHILDREN.** In an executive memorandum to seven Federal agencies with jurisdiction over children's programs — the Departments of Agriculture, Interior, Education, HHS, HUD, Labor, and Treasury and the Social Security Administration -- the President directed the establishment of a multi-agency effort to enroll uninsured children. These agencies run programs such as WIC, Food Stamps, Head Start, and public housing that cover many of the same children who are uninsured and eligible for Medicaid or other health insurance. The memorandum instructs these agencies: (1) to identify all their employees and grantees who might come into contact with these children and ensure that these individuals are aware of the health insurance programs available to children; (2) to develop an intensive children's outreach initiative, such as distributing information, coordinating toll-free numbers, and simplifying and coordinating application forms; and (3) to report back in 90 days on their plan to help enroll uninsured children.

✔ **HIGHLIGHTED BUDGET PROPOSALS THAT PROVIDE MEDICAID ENROLLMENT INCENTIVES TO STATES.** The President's FY 1999 budget invests $900 million over 5 years in children's health outreach policies, including the use of schools and child care centers to enroll children in Medicaid. The budget provides states with the option of automatically enrolling children in Medicaid even before having received all of the complicated eligibility and enrollment forms (a provision known as "presumptive eligibility"). It also expands the use of a Federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law.

✔ **ANNOUNCED A HISTORIC PRIVATE SECTOR COMMITMENT TO PROVIDE OUTREACH.** To complement the public outreach effort, the President announced unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

- **A new toll-free number that directs families around the nation to their state enrollment centers.** The President announced that Bell Atlantic will establish and operate a toll-free number to help states enroll uninsured children. The number, which will be put in place during the upcoming months, will be used by the nation's Governors to help millions of families around the nation by directing them automatically to their local state Medicaid enrollment agency.

-- **Over $23 million in commitments from private foundations across the country.** The Robert Wood Johnson Foundation will spend $13 million over the next 3 years to fund innovative state-local coalitions to design and conduct outreach initiatives, simplify enrollment processes, and coordinate existing coverage programs. The Kaiser Family Foundation will spend up to $10 million over the next 5 years on studies to help understand why eligible children do not enroll in existing programs and how best to provide insurance coverage for these children. America's Promise, with support from the Robert Wood Johnson Foundation and the American Academy of Pediatrics, will mobilize corporations such as SmithKline Beecham and Sheering Plough and local communities nationwide in children's health outreach efforts.

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✔ **ISSUED A CHALLENGE ACROSS AMERICA TO FIND NEW WAYS TO REACH OUT TO UNINSURED CHILDREN.** The President challenged every physician, nurse, health care provider, business, school, parent, grandparent, and community across the nation, to find new ways to ensure that uninsured children eligible for health insurance are enrolled in

Medicaid or CHIP. This national commitment should not stop until every eligible child across the country is enrolled in one of the existing health care programs.

health-children's coverage

'98 FEB 17 PM 8:11

PRESIDENT WILLIAM J. CLINTON
REMARKS ON CHILDREN'S HEALTH CARE INITIATIVE
WASHINGTON, D.C.
FEBRUARY 18, 1998

Acknowledgments: The First Lady, Sec. Shalala, [parent]

Last month, in my State of the Union, I asked the American people to strengthen our nation for the 21st century. It's a challenge for our government, our schools, and our families. And it is a challenge that is being met with no greater urgency than by the men and women of this hospital who work tirelessly to restore our most fragile children back to health, to give many of them second chances at life. This is a place where American medicine shines and miracles happen every day.

But it shouldn't take a miracle to ensure all children get the care and insurance they need to stay healthy. America's health care system is the finest in the world. But for millions of hard-working families, affording even the most basic health insurance has been nearly impossible. At the same time, millions of families who are already eligible still do not know they qualify for Medicaid.

Last summer's historic balanced budget agreement gave us an unprecedented opportunity to change this situation, to bring health insurance to more of our children and peace of mind to their parents. It's an opportunity we cannot afford to waste.

Our new children's health initiative is the remarkable product of a new vision of government. We recognized that if we were going to go strong into the next century, we had to put our fiscal house in order. But we also recognized that we had to do this in a way that didn't forsake our oldest values or weaken our families.

As a result, we have a balanced budget and made the most significant commitment to children's health care in over a generation. But these new laws will be just words on paper unless we act to bring the health care to our children. It would be a terrible tragedy if we were to allow ignorance about Medicaid eligibility to keep a child from getting the medical care she needed. All of us have an obligation -- an urgent duty -- to see to it that every single child who is eligible takes advantage of this unprecedented investment in their health and in their future.

I've come here to say that we -- the federal government -- will do our part. But states, businesses, and individual citizens must also step to the plate.

So today, I am launching an all-out effort to let every family know about the health insurance -- whether it's Medicaid or another program -- that is currently or soon will be available to their children. In a few minutes, I will sign an executive memorandum directing the seven Federal agencies who run children's programs to cooperate in a comprehensive effort to

make sure that every family gets the information they need to enroll their children -- whether it's from agency employees or pamphlets, toll-free numbers or simplified application forms.

And I call on Congress to pass the new funds I am requesting in my next balanced budget to help states publicize their new programs and enroll children in Medicaid automatically -- even as they wait for final approval of their applications.

Next, every state must take responsibility for ensuring that every eligible child within their borders gets insured. Medicaid is one of the best ways we can expand health insurance coverage to more children -- and it's a state-run program. I am pleased to announce that Colorado and South Carolina will join Alabama as the first states to insure children whose parents' incomes place them above the poverty level but are still too small to afford insurance. We must not rest until all 50 states have followed their lead.

Finally, the private sector must help us get the job done. Many businesses and private foundations have already joined our efforts. Bell Atlantic will establish and operate a new 800-number that will direct families to the state agencies in charge of Medicaid. Drug store chains have agreed to put the 800-number on their shopping bags. Pampers has agreed to include a letter in their birth education packages. I thank all of you for being exemplary corporate citizens.

And I want to thank the Kaiser Family Foundation, the Robert Wood Johnson Foundation, America's Promise, the American Academy of Pediatrics, the American Hospital Association and the Nation Education Association for devising their own outreach efforts and working with us to spread the word about the children's health initiative.

This is an extraordinary partnership to ensure that every child gets the health coverage he or she needs to have a fair and healthy start at life. But it is only a first step. I challenge every parent, grandparent, doctor, nurse, health care provider, teacher, business leader, and community across America to find new ways to reach children who can be covered by Medicaid or the new children's health insurance programs.

Hillary and I know from experience that nothing can weigh more heavily on a parent's mind than a child's illness. Even the slightest cough, the most minor accident on the playground, can cause a great deal of worry. I can't even imagine what it would be like to also have to worry about finding the money to pay for the medical care my child would need to get better. Too many parents live with these worries every day, live with the impossible choice of buying medicine for a sick child or putting food on the table for the rest of the family. Let us all work to make sure that these are dilemmas no family will ever have to face in the 21st Century.

Health - children's coverage

PRESIDENT CLINTON:
HEALTH CARE FOR KIDS

February 18, 1998

"It shouldn't take a miracle to ensure that all children get the care and insurance they need to stay healthy. America's health care system is the finest in the world. But for millions of hard-working families, affording even the most basic health insurance has been nearly impossible. At the same time, millions of families who are already eligible still do not know they qualify for Medicaid. Last summer's historic balanced budget agreement gave us an unprecedented opportunity to change this situation, to bring health insurance to more of our children and peace of mind to their parents."

President Bill Clinton

February 18, 1998

Today, President Clinton announces the first major state coverage expansions under the recently enacted Children's Health Insurance Program (CHIP) and released information showing that many States will soon follow. He also unveils an unprecedented set of public/private initiatives designed to enroll the millions of uninsured children who are eligible but not enrolled in Medicaid and other state-based children's health programs.

Over 10 million children in America are uninsured. Nearly 90 percent of these children have parents who work, but do not have access to or cannot afford health insurance. Over 3 million of these uninsured children are already eligible for Medicaid. However, many families are not aware that their children are eligible for Medicaid, and others have difficulty filling out the application. With these challenges in mind, the President:

ANNOUNCES THE FIRST COVERAGE EXPANSIONS UNDER THE NEW CHIP PROGRAM. Today, the President announces that Colorado and South Carolina join Alabama as the first states to come into the children's health program. The President also announces that many more States are well on their way to expanding coverage to more uninsured children. Currently, 14 states have submitted plans to HHS for approval, and another 18 States have active working groups or task forces to design plans to address the needs of uninsured children.

RELEASES A NEW PRESIDENTIAL DIRECTIVE TO ENROLL UNINSURED CHILDREN. In an executive memorandum to seven Federal agencies with jurisdiction over children's programs — the Departments of Agriculture, Interior, Education, HHS, HUD, Interior, Labor, and Treasury and the Social Security Administration -- the President directs the establishment of a multi-agency effort to enroll uninsured children.

HIGHLIGHTS BUDGET PROPOSALS THAT PROVIDE MEDICAID ENROLLMENT INCENTIVES. The President's FY 1999 budget invests $900 million over 5 years in children's health outreach policies, including the use of schools and child care centers to enroll children in Medicaid. It also expands the use of a federally-financed administrative fund so that it can underwrite the costs for all uninsured children — not just the limited population allowed under current law.

ANNOUNCES AN HISTORIC PRIVATE SECTOR COMMITMENT TO PROVIDE OUTREACH. To complement the public outreach effort, the President announces unprecedented new contributions from the private sector to help ensure that all children who are eligible for health insurance receive it, including:

- A new toll-free number that directs families around the nation to their state enrollment centers;
- Over $23 million in commitments from private foundations across the country;
- New initiatives from corporate and advocacy organizations to reach out to uninsured children.

ISSUES A CHALLENGE TO AMERICA TO FIND NEW WAYS TO REACH UNINSURED CHILDREN. The President challenged every physician, nurse, health care provider, business, school, parent, grandparent, and community

across the nation, to find new ways to ensure that uninsured children eligible for health insurance are enrolled in Medicaid or CHIP.

Health - children's coverage

Radio Address Option:
Announcement of First State Children's Health Insurance Program Plans

The radio address could:

- **Announce that Alabama, Colorado, and South Carolina are the first states to be approved for the President's Children's Health Insurance Program.** They will be able to access their share of the $24 billion for children's health.

- **Highlight that this is a bipartisan achievement.** Two of the three states have Republican governors.

- **Announce that almost all states are planning coverage expansions.** Another:

  14 states's applications are currently under review for final approval

  4 states have announced plans and will submit applications shortly

  11 states have formal task forces or committees planning their programs

- **Highlight the President's budget policies to promote children's health outreach.** These policies include encouraging enrollment of children in places like schools and child care centers and expanding fund options for outreach.

Health – children's coverage
and
Health – Medicare fraud
+ abuse

Here you go Elena.
Sorry for not getting this to you sooner

MEMORANDUM

January 15, 1997

TO: Rahm

FR: Chris

RE: Fraud and Children's Health

cc: Bruce and Gene

As per your request, here is an outline of the anti-fraud announcement that I think can be made next week. Also attached is the children's health announcements that we discussed that we can (and in my opinion) should make.

Anti-Fraud and Abuse Announcement. We could do this either as an event that Donna and Janet Reno do sometime earlier in the week (remember Melissa wants it as soon as possible) or we can wait for the Saturday radio address with the President. Regardless, any such announcement would release:

- The first Justice/HHS/IG report following the enactment of the Kennedy/Kassebaum law, which empowered and provided full funding for our ongoing anti-fraud and abuse enforcement activities. The report touts we have captured and returned to the Medicare Trust Fund $1 billion.

- A new regulation that requires medical equipment suppliers to purchase surety bonds to ensure the Trust Fund is protected when fraudulent suppliers go bankrupt and/or are caught cheating Medicare.

- A new requirement directing HHS to conduct on-site inspections for medical equipment suppliers to ensure that they are, and continue to be, legitimate providers of goods and services.

- (We could also release some or the rest of our anti-fraud and abuse initiatives that are currently in the budget to pay for the Medicare buy-in; most fall in the abuse, rather than the fraud categories, but it could be helpful in illustrating our ongoing commitment. If we can come up with any others, we can throw those in as well).

CHILDREN'S HEALTH IDEAS:

Leak Out Good News About Children's Outreach Initiative to NY TIMES for Monday, which responds directly to the President's concern about the 3 million uninsured children eligible, but not enrolled in Medicaid. Pear is extremely interested in this population and would doubtless love to do a piece on what we are doing administratively and in the budget for this population. I believe he would play up the story big for the POTUS and the FLOTUS, since these policies are popular state option proposals, which will get validation from Governors and children's groups. Pear will likely validate the policies because there is some money behind them, but the good news is it doesn't sound like big money -- less than $200 million a year.

Schedule Event in February With President and First Lady Announcing First States Taking Advantage of New Children's Health Provisions Included in the BBA. We have two, perhaps as many as four, states that are on the cusp of being approved as the first states coming on line for the new Children's Health Insurance Program (CHIP). Two states have Democratic Governors and two states have Republican Governors. We could do a great event in which Republicans and Democrats would have every reason to sing the praises of this new program and the kids it will cover.

And, by the way, we could set up additional such state-approval events with the First Lady in all sorts of positive settings -- like in child care programs and schools -- where our new outreach proposals will work toward signing up hundreds of thousands of children.

As always, these events need some time to prepare to do well. Please give us as much advance notice as possible. Clearly, it would extremely helpful if we could get closure on these issues sometime tomorrow.

Health - Children's Coverage

JAN 27 P4:3

THE WHITE HOUSE

WASHINGTON

January 21, 1998

MEMORANDUM FOR THE PRESIDENT

FROM: Chris Jennings CJ

SUBJECT: Waivers and the Children's Health Insurance Program

cc: Bruce Reed, Gene Sperling, Jack Lew, Josh Gotbaum, Elena Kagan

This memo seeks your guidance on how much, if any, additional flexibility should be given to states in the Children's Health Insurance Program (CHIP) through the use of §1115 waivers. Although waivers have been instrumental in modernizing and reforming welfare and Medicaid, questions have been raised about the feasibility and advisability of granting waivers for the new children's health care program so soon after its enactment.

Despite acknowledging the great amount of flexibility given to the states in the new CHIP grant program, the Governors asked — soon after the law's enactment — if additional flexibility would be given through waivers. HHS's interim response was that it would be difficult to review and evaluate the merits of waiver proposals until we had some experience with the implementation of the new law. Your advisors agreed that this was the appropriate, initial response, but we also underscored that this was not necessarily our final position.

The National Governors Association (NGA) immediately responded by formally requesting that we affirm states' ability to seek new CHIP grant program §1115 waivers. Since then, two other issues have been raised: (1) Will we approve new Medicaid §1115 waivers in the Medicaid option within CHIP, and (2) Will we allow states with current Medicaid §1115 waivers to expand those programs through CHIP (even though some have provisions below the CHIP minimums).

All of your advisors agree that the HHS Secretary does have the authority to grant waivers for CHIP, whether administered through a new non-Medicaid grant program or through Medicaid. They also generally agree that the CHIP waiver policy need not conform to existing waiver policy. However, they (HHS, OMB, Treasury, NEC/DPC) disagree on whether and under what circumstances HHS should approve waivers in CHIP.

Because HHS is holding state conferences this month on CHIP and the annual NGA conference is in February, it is important that we receive direction from you in short order on this issue. This memo, developed in collaboration with HHS and OMB, outlines these issues, provides policy options for your consideration, and summarizes where your advisors stand on these options.

BACKGROUND

Your Administration has given states unprecedented flexibility for their health care programs. Since 1993, we have granted 15 comprehensive Medicaid waivers that test approaches not allowed in Medicaid like experimenting with premiums and cost sharing for low-income populations, waiving benefits, and accelerating enrollment in managed care. States have also used waivers to expand coverage to millions of Americans. In addition, with the Administration's strong support, the Balanced Budget Act secured much greater administrative flexibility for the Medicaid program (e.g., eliminated the need for a waiver for a managed care program, repealed the Boren amendment, and reduced cost-based reimbursement requirements for community health centers). In so doing, we eliminated the need for many time-consuming waivers that we heretofore required from states.

The BBA also created CHIP, which has fewer Federal guidelines than any other health insurance program that the Government oversees. Unlike Medicaid, CHIP allows states that opt to expand through a new, non-Medicaid grant program to cap the number of children covered (i.e, no entitlement requirement); to limit programs to parts of the state; to not cover Medicaid's EPSDT (Early, Periodic, Screening, Detection and Treatment) benefit; and to charge beneficiaries long-sought-after (although limited) cost-sharing. Alternatively, states may expand using the enhanced Federal match through the now more flexible Medicaid program. However, states choosing this option must follow Medicaid rules (e.g., no benefits changes or cost sharing).

- Although extremely flexible, CHIP includes standards for accountability, benefits, and cost sharing limits; these were secured by you and Congressional Democrats. Accountability provisions include limits on the type of state contribution (e.g., no provider taxes and donations) and provisions to prevent "crowd out" (substitution of the new coverage for existing coverage). For the new non-Medicaid grant program, we developed a benefit standard that simultaneously ensures that it is valuable but provides great flexibility to states in benefits design. Cost-sharing is allowed in the grant program but limited to moderate premium and copayment schedules for those below 150 percent of poverty and to 5 percent of family income for those above 150 percent. As under current law, states electing the Medicaid option must follow Medicaid rules for benefits (including EPSDT) and cost sharing (for children, none is allowed).

Despite the flexibility in CHIP, some states have indicated that they want §1115 waivers. There are three types of waivers that states are seeking. First, several states want to waive provisions for non-Medicaid, CHIP grant programs (e.g., California wants to impose greater cost sharing above the CHIP limits). Second, others want to waive Medicaid provisions within CHIP's Medicaid option since states choosing the Medicaid option must use all Medicaid rules (e.g., Missouri wants to waive the Medicaid requirement to cover non-emergency transportation). Third, most states that already have Medicaid §1115 waivers want to expand those programs to more children to receive CHIP's higher matching rate — even though some include provisions that are significantly below the new CHIP minimums (e.g., Arkansas has higher cost sharing requirements than allowed in CHIP). It is important to note that the provisions that states want most to waive are the benefits and cost sharing minimums we worked to secure before signing off on the budget agreement.

CONSENSUS RECOMMENDATION: DEFERRING NON-MEDICAID CHIP WAIVERS

Your advisors have achieved consensus on one of the major issues. For CHIP non-Medicaid grant programs, we believe the Administration should consider waiver applications only after a state has had at least a year's worth of experience, followed by an evaluation of its children's health insurance program. As we gain experience with the new CHIP grant program, we will have a better understanding of what types of CHIP demonstrations are appropriate and will develop guidelines at that point.

We believe that deferring approvals for waivers of the already extremely flexible CHIP is advisable because this enables us to see how the program you signed into law last summer will work. Granting waivers now would place great pressure on us to weaken the accountability and benefits standards that we secured in the Balanced Budget negotiations that base Democrats and advocates think are too modest anyway. Having said this, waiver policy for CHIP may well be advisable after we have had time to learn about the program's strengths and weaknesses.

If you agree, we will inform Governors of this policy in a response to their letter. While we believe that Governors will be disappointed with this position, they will likely appreciate that our policy is temporary and that we open up the prospect for waivers soon after they implement their children's health programs.

Decision

_____Agree on deferring non-Medicaid grant program waivers until plans in place for one year

_____Let's discuss

ISSUE: POLICY FOR MEDICAID WAIVERS

The other types of waivers, about which there is disagreement amongst your advisors, concern the Medicaid option within CHIP. We all agree that our Medicaid waiver policy should be modified to acknowledge the fact that the Congress did pass legislation that explicitly outlines new guidance on balancing the need for greater flexibility with the need for accountability. However, we differ on how our policy should be modified to reflect this policy change and, more specifically, the extent to which we would hold Medicaid waivers to the CHIP standard.

There are two questions. The first is whether we grant new waivers to states that expand CHIP coverage through Medicaid. States have indicated that they are interested in expanding coverage through the Medicaid option, but since the law allows no flexibility from Medicaid rules, they want waivers, particularly in the area of cost sharing. The second question is whether we allow states that already have Medicaid §1115 waivers to expand those programs, without change, to get the CHIP allotment and higher match. The following are the options proposed by your advisors.

OPTION 1 (HHS): Defer new Medicaid CHIP waivers (with minor exceptions) and allow expansions of existing Medicaid waivers if consistent with CHIP standards for non-Medicaid grant programs. HHS recommends that we apply the same policy for new Medicaid and non-Medicaid, grant program waivers. It would hold off on approving any new Medicaid waiver under CHIP until we have at least a year's experience plus an evaluation. (The only exception would be for waivers for small, incidental provisions that have little or no effect on most children — like Missouri's desire to waive the Medicaid requirement for non-emergency transportation.) For states that have waivers already, HHS would allow them access to the new enhanced matching dollars only if they met CHIP's non-Medicaid grant program standards.

Although HHS/OMB have, in years past, approved a number of Medicaid waivers that have less generous benefits than even the new CHIP grant program, HHS believes the new law set a floor that we should not fall below. They fear that once we open the door to waivers, we will have a difficult time maintaining these standards. In addition, they are concerned that waiver negotiations will delay implementation of new programs in a number of states. Rapid implementation is one critical component to covering our target 5 million uninsured children.

If you choose this option, the Democrats and children's health advocates will applaud our decision to respect the rules enacted in the widely praised new health insurance program for children. However, Governors — who are hoping that we will allow some type of Medicaid waivers — will surely react strongly and negatively to this policy.

OPTION 2 (NEC/DPC): Allow Medicaid CHIP waivers (new or old) if <u>generally</u> consistent with CHIP standards for non-Medicaid grant programs. This option would allow new waivers through the Medicaid option of CHIP <u>if</u> those waivers were consistent with the standards provided under the new CHIP grant model. In other words, states choosing the Medicaid CHIP option could waive Medicaid rules as long as the benefits, cost-sharing and other accountability provisions are in line with the CHIP grant program standards. Existing (old) Medicaid §1115 waiver programs could also receive the higher matching rate, but they too would have to meet CHIP standards; in a number of cases, this would mean they would have to strengthen some of their benefits/cost-sharing protections to access these additional dollars. Although a few states would have to reduce cost sharing requirements to comply with CHIP, we believe that the higher matching rate available under CHIP would be sufficient to offset these costs.

DPC/NEC believes that this option strikes an appropriate balance by maintaining the integrity of the CHIP program and the Balanced Budget Act and giving the new standards time to be tested. It also removes an important disincentive for states to use the Medicaid option in CHIP. Many states would prefer to use their already-in-place Medicaid programs because it is administratively simple. Moreover, having a seamless Medicaid program serving both poor and children of working parents has obvious advantages. However, allowing any new Medicaid waivers through CHIP will be criticized by our base Congressional Democrats, some Republicans, and advocates. They believe that their support for the flexibility in the non-Medicaid CHIP program was conditional on no new flexibility in Medicaid. The Governors would like this approach better than the HHS option, but they could be counted on to say that it is still not flexible enough.

Within this option, NEC/DPC also recommends that the Secretary have the authority to approve Medicaid CHIP waivers that may be modestly below those standards provided for in the new CHIP grant program. While we strongly believe that the CHIP standards should be the guiding principle for Medicaid waivers, we also recognize that it is unwise and unrealistic to treat the new law's standards as "lines in the sand" that can never be crossed regardless of a waiver's merits. One good example is in the area of cost sharing.

In both previous Medicaid waivers and our internal policy positions, we have allowed limited cost sharing that exceeds the CHIP grant program standards. Such cost sharing can appropriately increase beneficiaries' cost sensitivity in using health services and decrease possible employer insurance dropping problems, since such a policy would more accurately mirror marketplace coverage. While we recommend providing this additional flexibility authority, we also believe that waivers of the CHIP grant standards for children not be granted below 133 percent of poverty -- the level your Administration advisors had previously concluded (during the balanced budget discussions) achieved the balance between appropriate and excessive cost-sharing.

While some might point out that it is inconsistent to allow flexibility below CHIP standards for Medicaid and not the grant option, we believe that the advantages of this approach far outweigh this criticism. First, the CHIP standards were designed for the grant program — not Medicaid. Second, Medicaid waivers are quite variable and have never been publicly held by Democrats and advocates to the same standards as legislated changes to public programs. And thirdly, as described above, having an additional incentive to administer the children's health program through Medicaid is desirable.

Giving HHS the authority to allow any cost sharing flexibility in Medicaid will likely anger base Congressional Democrats and some moderate Republicans. They will argue (as does HHS) that once we sanction higher cost sharing below 150 percent of poverty, decisions will be perceived as arbitrary, making it difficult to say no to states that demand even greater flexibility. We believe these are valid concerns and should be seriously considered. However, we are also well aware of states (such as Wisconsin) who will be requesting cost-sharing levels just under 150 percent (i.e., 143 percent of poverty) that we would find difficult to oppose on purely policy grounds.

OPTION 3 (OMB & TREASURY): Allow new CHIP Medicaid waivers if consistent with CHIP standards for non-Medicaid, grant programs, but allow existing Medicaid waivers to expand with no change. For states requesting *new* Medicaid waivers, OMB/Treasury agree with DPC/NEC option that the CHIP standards should guide approval of such waivers (also allowing for greater cost sharing for families no less than approximately 133 percent of poverty). This policy should be re-evaluated after states gain experience with their programs, at the same time the Administration is re-considering non-Medicaid, grant program waivers.

For states with waiver programs already approved (since the 1994 NGA waiver agreement), OMB and Treasury recommend that we recognize their history and different situation and not hold them to the CHIP standards. We anticipate that these 11 states will want to expand their current waiver programs under CHIP; OMB and Treasury think they should be permitted to do so with no changes. Although this option provides only a few more states with additional flexibility in cost-

sharing or benefits under CHIP than the DPC/NEC option, it helps these states avoid significant coordination problems by sanctioning CHIP programs consistent with approved waiver programs. In addition, lower income children in these states might pay more in premiums than the higher income children newly eligible under CHIP. Waiver states will consider the Administration to have reneged if we don't permit them to carry their waivers to CHIP. This option excludes pre-NGA agreement waivers (e.g., Tennessee) since states have been held to a higher standard since then.

Allowing existing Medicaid waivers into CHIP unchanged will surely be noticed and strongly opposed by base Democrats and children's advocates. They believe that some of the waivers that we have approved to date, such as Tennessee and Arkansas, have gone too far by allowing states to impose "excessive" cost sharing on low-income beneficiaries and waive EPSDT. Ironically, this policy may also be criticized by some Congressional Republicans, who think that many of our CHIP implementation decisions are steering states toward the Medicaid option. It would, however, be the most acceptable option to the NGA and the relevant (existing waiver) states.

Decisions

Medicaid Waivers

_____OPTION 1: Defer new Medicaid waivers in CHIP (with minor exceptions)
Allow existing waivers to expand through CHIP if consistent with CHIP standards for non-Medicaid, grant programs

_____OPTION 2: Allow new & existing Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs

_____OPTION 3: Allow new Medicaid waivers in CHIP if consistent with CHIP standards for non-Medicaid, grant programs
Allow existing waivers (post-NGA agreement) to expand through CHIP with no program changes even if they fall significantly below new CHIP grant standards

_____Let's discuss

Cost Sharing Flexibility

_____OPTION 1: Hold all Medicaid waivers to the cost sharing in CHIP for non-Medicaid, grant programs

_____OPTION 2: Authorize the Secretary to approve, within limits, Medicaid waivers in CHIP with cost sharing below CHIP standards for non-Medicaid, grant programs

_____Let's discuss

STATES WITH MEDICAID 1115 WAIVERS (Chronological Order)

STATE	Approved	Eligibility Limit	Benefits for New Eligibles	Cost Sharing: New Eligibles
Arizona	10/82	Existing eligibles	Medicaid benefits	None
Oregon	3/93	People < 100% PL	Prioritized benefits	Premiums: $6 to 28 No copays or deductibles
Hawaii	7/93	People < 300% PL, plus assets test	No long-term care	Premiums: $142 - 168 Copays: $5
Maryland	10/93 10/96	Children 133-185% PL Existing eligibles	No inpatient, outpatient, emergency room, some EPSDT; no long-term care Medicaid benefits	Copay: $5 None
Rhode Island	11/93	Children < 250% PL	Medicaid benefits	Premiums: From 185-250% PL: $1.50 - $10.75 No copays or deductibles
Tennessee	11/93	People up to 400% PL, with enrollment cap	Medicaid benefits	Premiums: $14.25 to 475 Deductibles: $250 / $500 Coinsurance: 2 to 10%
Florida	*9/94*	*People < 250% PL*	*Excludes some EPSDT, transportation, some long-term care and mental health*	*Premiums: $90 - 550 / mo* *Deductibles: Up to $500* *Copays: $10-200 or 20%*
Ohio	1/95	People < 100% PL	Medicaid benefits	None
Massachusetts	4/95	People < 200% PL	Medicaid benefits	Premiums: Variable Deductibles:$100 / $250 Copays: $5 / 10
Minnesota	4/95	Children < 275% PL	Medicaid benefits	Premiums: $4 to 104 / mo No copays or deductibles
Delaware	5/95	People < 100% PL	Medicaid w/ small changes	None
Vermont	7/95	People < 150% PL	No transportation, long-term care	Premiums: Above 25% PL: $5 to $20 every 6 months Copays: $3 for dental
Kentucky	*10/95*	*Existing eligibles*	*Medicaid benefits*	*None*
Oklahoma	10/95	Existing eligibles	Medicaid benefits	None
Illinois	*7/96*	*Existing eligibles*	*Medicaid benefits*	*None*
Alabama	12/96	Existing eligibles	Medicaid benefits	None
New York	7/97	Home relief pop.	Medicaid benefits	None
Arkansas	8/97	Children < 200% PL	No EPSDT, limited long-term care & mental health	Copays: $10 outpatient; 20% inpatient ; $5 for drugs

Italics indicated approved but not implemented. States above the line were approved prior to NGA 1994 agreement.

Health - children's coverage

Children's Health Outreach Initiative

New initiatives to increase enrollment of millions of uninsured children into Medicaid and the new Children's Health Insurance Program. These initiatives would help reach the President's goals of:

- Signing up the 3 million children currently eligible for Medicaid but not enrolled; and
- Helping ensure that we can reach the President's goal of insuring at least 5 million children through the new Children's Health Program.

Unprecedented Outreach Initiatives: These include policies that give states unprecedented new options for:

- Helping enroll thousands of new children by making it easier to sign up children in sites like child care referral centers and school, where children and their families are more likely to enroll; and
- Giving states incentives to sign up more uninsured children through new outreach initiatives, such as public service announcements, hotlines, and community-based programs. These programs educate and assist families in enrolling their uninsured children.

  States and Governors believe that these policies would be a major incentive for them to do more outreach and enrollment, and they cost only about $150 million per year.

Announcing the First State to Enter the New Children's Health Program:

- Colorado's and Alabama's children's health plan are currently pending approval at HCFA. We are currently trying to expedite approval so the President could announce the first two states to enter into the new children's health plan.

Making It Easier For Families to Enroll Families by:

- Unveiling a simplified application form for all children's health insurance programs. Current Medicaid eligibility forms are often more complicated than tax forms and discourage many families from signing their children up.

Highlighting Existing Model State Programs

The President could also highlight some examples of states that are already doing innovative outreach policies. The National Governors' Association could help unveil these model programs. We are also aware of some child care referral centers that currently do a good job enrolling children on Medicaid but their efforts would be greatly enhanced by our policies.

Health - children's ~~health~~ Coverage

CHILDREN'S HEALTH

Q: YOU SAID THAT YOU WOULD NOT SIGN A CHILDREN'S BILL THAT DID NOT ENSURE MEANINGFUL HEALTH BENEFITS, INCLUDING PRESCRIPTION DRUGS, VISION AND HEARING, AND MENTAL HEALTH SERVICES. YET THE PACKAGE THAT PASSED DOES NOT GUARANTEE THESE VERY BENEFITS. HOW CAN YOU VIEW THIS AS A WIN?

A: Without any doubt, this children's health bill is a win. Children will get benefits no less generous than those received by Federal and state employees or those families in the most popular HMO in the state. I would not settle for less. On top of that, these plans' prescription drugs, vision, hearing, and mental health coverage must be meaningful. These benefits are important to children's healthy development.

Beyond the benefits, our support for the increase in the tobacco tax raised the investment from $16 billion to $24 billion. The new tobacco tax will not only further reduce the number of uninsured children, but it will serve as a financial barrier to help prevent our children from starting smoking in the first place.

Q: DO YOU BELIEVE THAT THE CHILDREN'S HEALTH PACKAGE GIVES ENOUGH FLEXIBILITY TO THE STATES?

A: I believe that the children's health initiative has struck the appropriate balance between needed flexibility and accountability. In order to ensure success, there is no question that federal, state and local governments, consumer advocates, providers, insurance companies, and most of all, parents, will have to work together to get the job done. I will make certain that my administration does everything possible to carry its fair share of this burden, and we will do everything in our power to encourage all other parties to do the same.

Q: WILL THE CHILDREN'S INVESTMENT AGREED TO TODAY COVER FIVE MILLION CHILDREN?

A: This is the largest investment in children's health care since the passage of Medicaid over three decades ago. We believe that it is sufficient to provide coverage for up to five million American children. This $24 billion package has been carefully structured to provide meaningful coverage to as many uninsured children as possible. Moreover, it contains provisions to ensure that this investment supplements rather than replaces existing private or public spending on kid's health.

Q. THIS NEW CHILDREN'S HEALTH INITIATIVE IS SCHEDULED TO BEGIN OCTOBER 1. IS THIS FEASIBLE?

A. A number of states will be ready to go quickly, since over 30 states have experience with some type of expansion program for children. Others will require more time. However, the reactions to this initiative from our nation's governors, children's groups, providers, businesses and parents gives me confidence that most states will take advantage of this historic opportunity as quickly as possible.

Health — children's health

CHILDREN'S HEALTH

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Q: **A RECENT NEW YORK TIMES OP-ED PIECE SUGGESTED THAT THE CHILDREN'S INITIATIVE IS NOTHING MORE THAN A LARGE, INEFFICIENT PROGRAM THAT WILL CAUSE MASSIVE SUBSTITUTION OF PUBLIC COVERAGE FOR PRIVATE COVERAGE. IT ALSO SUGGESTS THAT THIS PROGRAM IS NOTHING MORE THAN A BACK-DOOR WAY TO NATIONAL HEALTH INSURANCE. DO YOU AGREE?**

A: Absolutely not. The article overlooked the many, important provisions designed to make this program efficient. There are strong walls between Medicaid, private coverage, and the new program so that funds are used only for uninsured children.

Eligibility is limited to children below 200 percent of poverty except in states that have already expanded to that level so higher income children cannot qualify for assistance. States have a great deal of experience in targeting coverage under 150 percent of poverty ($24,000 for a family of four) without undermining private sector coverage. And, for those over 150 percent of poverty, states may charge cost sharing which can be designed so that the plan's value does not exceed the value of coverage in the private sector. This would guard against any significant employer dropping.

And, finally, although I remain committed to step-by-step progress toward providing affordable coverage to all Americans, the new children's health initiative is not by any definition a take over of the health care system. It is a capped, targeted program that explicitly creates no entitlement and although the funds are unprecedented, they are limited to the dollar amounts written into law.

Health-medicare

MEDICARE

Q: DID YOU GIVE IN ON MEDICAL SAVINGS ACCOUNTS?

A: Not at all. I wanted to ensure that Medicare Medical Savings Accounts were a demonstration program and that is exactly what I got. I also fought to ensure that there are important consumer protections in the package that allow beneficiaries to get out of an MSA if they decide soon after that they made a mistake.

Q: WHY DID YOU AGREE ON INCLUDING A PRIVATE FEE-FOR-SERVICE OPTION IN THE FINAL PACKAGE?

A: While there is a private fee-for-service option in the final package, it is quite different than that passed by the Senate to which I objected. There are now a number of consumer protections, such as disclosure requirements and protections that prevent beneficiaries from excessive out-of-pocket costs. In particular, current balanced billing protections apply to doctors participating in this type of plan. Doctors would not be allowed to charge ~~over~~ more than fifteen percent ~~of~~ above the Medicare approved plan rates.

In fact, ~~reportedly~~ because of the new protections and other provisions in the package, the AARP has ~~apparently~~ stated that this package is acceptable.

Q: ARE YOU READY TO DO REAL MEDICARE REFORM IN A COMMISSION?

A: We actually just passed the largest, single reform of the Medicare program since it was created in 1965. We reformed the managed care payment system, so that beneficiaries have greater choices and we are not overpaying plans. We reigned in the cost of the remaining services the remaining fee-for-service providers such as home health agencies. We now offer beneficiaries a range of preventive benefits that save costs in the long run. And, we crack down on fraud and abuse in the program.

Despite this enormous accomplishment, we must take the needed, next steps to ensure Medicare's life well beyond the decade locked in by the budget bill just enacted. We look forward to working with Republicans on the bipartisan Medicare commission. This offers the opportunity to thoroughly examine this complex problem and its difficult solutions.

Q. WHO WILL BE ON THE COMMISSION? WHEN WILL YOU DECIDE?

A. This will be a critically important commission so I am not going to rush into any decisions or announcements at this time. In the coming weeks, I will be consulting with Congressional Republicans and Democrats to coordinate the set-up of this commission to ensure its successful commencement.

[NOTE: Do not discuss further details until we have information on personnel and timing options]

Q. CONGRESSMAN ARMEY SUGGESTED THAT SENATOR DOLE SHOULD CHAIR THE COMMISSION. DO YOU AGREE?

A. Senator Dole is among the most able leaders this country has seen. He is most capable of serving in this role. However, it is premature to discuss any commission members at this point.

Health - children's coverage

EFFECTIVENESS OF CHILDREN'S HEALTH INITIATIVES

Q. **TODAY'S *NEW YORK TIMES* REPORTED THAT NEITHER THE HOUSE NOR THE SENATE'S CHILDREN HEALTH INSURANCE PLANS WILL ACHIEVE MUCH COVERAGE. HOW DO YOU RESPOND?**

A. **We believe that CBO estimates are excessively low.** CBO assumes that states will prefer to use the money to offset existing spending -- not to expand coverage. We believe this lack of trust in the states is unwarranted and not backed up by recent experience. Specifically:

- **Most states have expanded Medicaid for children well above the minimum levels required under current law**. Over 30 states have taken up a Medicaid option to cover more children.

- **More expansions proposed.** This year alone, over 15 states will expand Medicaid or state programs for children.

- **Strong response to private initiatives.** Private foundations (such as Robert Wood Johnson) report that they are flooded with responses from states interested in expanding children's coverage. This interest exists even though states would have more "strings" and have to put up real money to receive the private funding.

- **Non-political career policy experts at the Department of Health and Human Services believe that a carefully structured initiative will increase the number of children with health insurance well beyond CBO estimates.**

CBO analysis does underscore the importance of ensuring tight targeting of funds and state accountability. Although flawed, the analysis does reinforce the President's belief that the investment should be used wisely to ensure that as many uninsured children as possible receive meaningful health coverage. This is why we support:

- **New coverage not existing coverage**. The President supports strong provisions (called maintenance of effort requirements) to prevent the new funds from replacing existing funds for children's health coverage. States should use the new investment to leverage not reduce their current spending.

- **Deletion of provisions that provide for services rather than insurance coverage.** The House bill would allow states to spend all of their money on one service or to offset the reductions to disproportionate share hospitals (DSH). This will not translate into meaningful coverage for children that protects their families from excessive cost sharing.

Health - Children's Coverage

CHILDREN'S HEALTH

Q: DO YOU BELIEVE THAT A CHILDREN'S HEALTH INITIATIVE CAN EMERGE FROM CONGRESS THAT YOU SUPPORT? DO YOU HAVE A PREFERENCE FOR HOUSE- OR SENATE-PASSED LEGISLATION?

A: Yes. We are working with the Congress to ensure that they produce a children's health initiative that provides meaningful health care coverage to millions of uninsured children. It is imperative that the single largest investment for children's health care since Medicaid was enacted in 1965 is efficiently spent to cover the most number of uninsured children.

I am committed to making sure that any investment in children's health care meets three principles: (1) that coverage is meaningful: from checkups to surgery -- children should get the care they need to grow up strong and healthy; (2) that coverage is targeted: through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and (3) that this investment supplements not supplants coverage: this investment should cover children who do not currently have insurance -- rather than new money to replace public or private money that already covers children.

I am optimistic that the House and certainly the Senate will improve their legislation. It is encouraging that Republicans and Democrats are working to ensure that the children's health package that is produced will ensure that benefits are meaningful and that low-income children are protected from excessive out-of-pocket costs. We will do everything that we can to work with these Members as the bill is debated on the House and Senate floor this week.

Q: WITH THE TOBACCO SETTLEMENT IN MIND, SENATOR LOTT RECENTLY IMPLIED THAT THE SETTLEMENT MIGHT UNDERMINE SUPPORT FOR THE TOBACCO TAX. DO YOU BELIEVE THAT THE CONGRESS SHOULD RESIST PASSING A TOBACCO TAX BEFORE THE FINAL TOBACCO AGREEMENT IS WORKED OUT?

A: No. The Finance Committee, on a bipartisan basis, passed out an increase in the tobacco tax to provide additional funding for children's health care coverage. The Congress should not alter its decisions based on an assumption that an acceptable tobacco settlement might be reached.

Q: DO YOU BELIEVE THAT RESOURCES FROM THE TOBACCO SETTLEMENT COULD COVER THE REST OF THE UNINSURED CHILDREN? HOW WOULD YOU RECOMMEND INVESTING THESE NEW DOLLARS?

A: We just heard the details of the tobacco settlement on Friday. Any final decisions about how any money from the potential settlement might be spent are obviously premature. The tobacco settlement could provide significant new funding for children's health and other public health initiatives. While we should be and are looking into possible options, we cannot count on any of these dollars. We should not let the possibility of additional revenue from a tobacco settlement undermine the investment for children that has already been agreed to in the balanced budget agreement.

Q: DO YOU SUPPORT THE TOBACCO TAX THAT WAS INCLUDED IN THE FINANCE COMMITTEE MARK-UP?

A: Yes. I do hope, however, that we can dedicate more of the savings from the revenue -- beyond the $8 billion -- to other children's priorities.

Q: WHY DID YOU OPPOSE THE HATCH-KENNEDY LEGISLATION? AND WHY DID YOU NOT OPPOSE THE ADDITIONAL $8 BILLION FOR CHILDREN'S HEALTH FROM TOBACCO REVENUE IN THE SENATE FINANCE MARK-UP. HOW DO YOU RECONCILE THIS INCONSISTENCY?

A: I have been supportive of using revenue raised from tobacco for health care since the beginning of his Administration. It was explicitly used as a revenue source for the Health Security Act.

I did not support adding the Hatch-Kennedy amendment in the context of the budget agreement because the Republican Leadership strongly asserted it would have undermined the budget deal and the $16 billion already allocated for children's health care. I have repeatedly said how difficult it was for me to oppose that legislation, which encompasses goals I clearly support.

In the recent Finance Committee mark-up, the Republican Leadership accepted a down-sized tobacco tax (20 cents) and allocated some of the savings ($8 billion) for children's health. Their support for this revenue source removes any barrier for me to support it.

Q. DO YOU BELIEVE THAT THE VOTE AGAINST THE CHAFEE-ROCKEFELLER CHILDREN'S AMENDMENT WAS A REJECTION OF THE YOUR HEALTH CARE PRIORITIES?

A. No. While we were disappointed that Chafee-Rockefeller amendment did not pass, the Senators made improvements that responded to a number of the concerns that I had raised about the Chairman's mark and the Commerce Committee bill.

Before the final compromise was reached, the original Finance legislation fell well short of assuring that the $16 billion for children's health care was being effectively targeted to ensure that the greatest number of children would be given a meaningful benefits package. For example, it would have permitted states to use the $16 billion for purposes other than expanding health insurance coverage to children, and it would have allowed states to offer health plans that would not have included many important benefits that children need.

I do, however, believe that we need to continue to work to ensure that the final bill includes provisions that guarantee that low-income children are not exposed to excessive cost sharing and to ensure that the benefit that is provided to children is meaningful.

I fought extremely hard to ensure that the $16 billion for children's health was in the Budget Agreement. I will continue to work to ensure that the final children's health legislation provides children with a meaningful benefits package and covers the most children possible.

Health-children's coverage

President Continues to Fight to Expand Health Care Coverage for Our Nation's Children

Today the President joined Kaiser Permanente in announcing that the health plan will give $100 million to provide health care coverage to up to 50,000 uninsured children in California. Kaiser is responding to the President's challenge at the Summit on Service, and their initiative complements the President's commitment to a national effort to extend health insurance.

This President will continue to fight hard to make sure that extending health care coverage to millions of uninsured children is a top priority in any balanced budget deal. The President fought hard to ensure that the balanced budget agreement included $16 billion to provide meaningful health care coverage to uninsured children. The President also supports the action by the Senate Finance Committee to raise a 20 cent tobacco tax to allocate additional Federal support for children's health.

The President outlined the principles he will use in evaluating children's health initiatives emerging from the Budget Agreement. The President is committed to making sure that any investment in children's health care meets three principles: **(1) that coverage is meaningful**: from checkups to surgery -- children should get the care they need to grow up strong and healthy; **(2) that coverage is targeted**: through grant programs and Medicaid, this investment should cover as many uninsured children as possible; and **(3) that this investment supplements not supplants coverage:** this investment should cover children who do not currently have insurance -- rather than replace public or private money that already covers children.

The Balanced Budget and the Kaiser announcement build on the President's previous successes in strengthening health care coverage for children.

- **Children and the Kassebaum-Kennedy Law.** By signing this bill into law, the President helped millions of Americans -- and their children -- keep their health care coverage when they change jobs.

- **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.

- **Children and the Environment.** 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 Tobacco.** The President has also taken action to limit children's access to tobacco. Each day about three million children become regular smokers and 1,000 of them will die from a tobacco-related illness. To reduce this trend, the President issued guidelines to eliminate easy access to tobacco products and to prohibit companies from advertising tobacco to kids. 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 Immunization.** During the Clinton Administration, childhood immunizations have reached a historic high. The President's childhood immunization initiative expands community-based educational efforts and makes vaccines more affordable. In 1995, fully 75 percent of two-year olds were immunized -- an historic high.

Health - Children's coverage

Major Improvements in the Senate Finance Children's Proposal

- The draft of the Senate Finance proposal (June 11, 1997) improved significantly by the time it passed. Major changes include:

	Before	After
Uses of Funds:	Health insurance or direct services (e.g., (clinics, transportation)	Health insurance only
Benefits:	Basic health insurance (e.g., no drugs)	Health insurance equivalent to Federal Employee Health Benefit, with HHS Secretary review
Financial Incentives:	Larger for grant (e.g., 75% matching rate which is higher than Medicaid option for 35 states)	Same for both Medicaid and grant
Qualifications for Funding:	None for grant; cover poor children up to 18 in Medicaid option	Cover poor children up to 18 in both options
Accountability:	No rules for state contribution	Medicaid rules for both options (no provider taxes and donations).

- Additionally, the grant is no longer run through the Maternal and Child Health (MCH) block grant.

June 18, 1997

Health - children's coverage

MEMORANDUM

June 17, 1997

TO: Distribution

FR: Chris Jennings

RE: Senate Finance Committee Markup and Children's Health Initiative

Attached is a copy of the letter the President sent up to Senator Roth indicating his support for amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch to the Senate Finance Committee markup on children's health. The President also referenced his support for this amendment at the conclusion of his remarks at the Title IX event this morning.

Also attached is a one-page background on this amendment and the concerns we have about the underlying provisions Chairman Roth has in his mark, as well as a set of Q & A's on possible issues that may be raised by the media on this issue. Lastly, you will find a copy of the letter Frank Raines sent to Chairman Roth this morning that outlines our concerns with all of the provisions in the mark that are either inconsistent with either the Budget Agreement or our policy priorities.

I hope you find this information useful. If you have any questions, please don't hesitate to call me.

THE WHITE HOUSE

WASHINGTON

June 17, 1997

Dear Mr. Chairman:

I urge the Senate Finance Committee to adopt the bipartisan children's health amendment proposed by Senators Chafee, Rockefeller, Jeffords, and Hatch. As you know, I am extremely committed to using the $16 billion for children's health to provide meaningful coverage for as many uninsured children as possible. The bipartisan amendment offers an opportunity to do just that.

It is critical that we continue to work together in this Congress to find ways to provide health care coverage for millions of uninsured children. As you know, over ten million children lack health care coverage -- and the impact on their families is profound. A recent study showed that nearly 40 percent of uninsured children go without the annual check-ups that all children need. One in four uninsured children do not have a regular doctor. And throughout the country, too many parents are living in fear that they may be forced to make the impossible choice between buying medicine for a sick child or food for an entire family.

Because of the importance of this problem, we need to work together to design the most effective way to invest the $16 billion. The bipartisan amendment takes a major step toward this goal. This plan rationalizes Medicaid so that children in the same family are eligible for the same coverage. Children under 6 years old and under 133% of poverty -- about $21,000 for a family of four -- are already eligible for Medicaid. The bipartisan plan provides incentives for states to cover older children up to this same income level. The plan also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. Resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program. In addition, this bipartisan plan offers meaningful coverage that protects vulnerable children from excessive costs.

The bipartisan initiative -- which balances protections for vulnerable children with flexibility to target middle-class children -- stands in sharp contrast to the Commerce Committee's proposal. The plan to simply put out a block grant, with few rules and no benefits requirements, will not result in meaningful coverage for many uninsured children. While your proposal improves

on the Commerce Committee's plan, the claim that it provides a choice between Medicaid and a grant approach is exaggerated. Given the incentives in the proposal, no rational state would choose Medicaid.

The bipartisan amendment merits strong and favorable support from the full Finance Committee. We should take advantage of this opportunity to significantly reduce the number of uninsured children. I look forward to working with you and others on the Finance Committee and in the Congress to achieve this end.

Sincerely,

Bill Clinton

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

PRESIDENT ANNOUNCES SUPPORT FOR BIPARTISAN CHILDREN'S PLAN

Today, the President announced his support for the Senate bipartisan amendment to provide meaningful health coverage to uninsured children. Senators Chafee, Rockefeller, Jeffords and Hatch have designed a consensus proposal on how to invest the $16 billion in the Balanced Budget Agreement. This proposal is consistent with the President's commitment to extending meaningful health coverage through the most cost-effective approach. This important legislation would result in the largest investment in children's health coverage since the enactment of Medicaid in 1965.

The bipartisan amendment protects vulnerable children while offering states flexibility. It:

- **Gives states incentives to rationalize Medicaid.** Today, Medicaid covers children under 6 years old with incomes up to 133% of poverty, or $21,000 for a family of four. The bipartisan plan provides incentives for states to cover all children, regardless of age, up to this income level.

- **Funds innovative state programs to target middle-class uninsured children.** Unlike low-income children, middle-class uninsured children are difficult to target with a single program. A grant program gives states the resources and flexibility to find and cover these children.

- **Offers meaningful coverage that protects vulnerable children from excessive costs.** Children have a wide range of health needs. The bipartisan amendment assures that children covered through the initiative receive meaningful benefits without unaffordable cost sharing.

The Roth proposal, in contrast, does not balance protection for vulnerable children with state flexibility.

- **False choice.** The Roth proposal asserts that states have the choice of expanding coverage to children through a block grant or Medicaid. However, it is a false choice. The rules for the block grant are designed so that no rational state would chose Medicaid, regardless of its merits.

- **Splits families.** The Roth proposal allows states to use the block grant for older, low-income children and Medicaid for younger children. It makes no sense to give a child below 6 years old one type of coverage and a child above 6 years old different coverage.

The President encourages the Senate Finance Committee and the full Congress to support this bipartisan approach. We should take full advantage of this opportunity to provide meaningful health coverage to a significant number of uninsured children.

Questions and Answers

Q: In Robert Pear's *New York Times* story today, the Governors -- who you applaud for their innovative efforts in this area -- are claiming that states will never expand coverage under a proposal with so many strings attached. How do you respond to this letter?

A: As a former Governor, the President well understands that states need flexibility to design programs that best meet the needs of their populations. However, if the taxpayers are going to invest $16 billion in children's health care, there needs to be some accountability for these dollars. We believe that this proposal contains important administrative and financial incentives that will help states expand their programs.

Q: Why don't you support Republican proposals that allow states to use all of the funding for grants?

A: We believe that we should build on the Medicaid program and encourage states to cover all children under 133 percent of poverty so that children in the same family -- whatever age -- are eligible for the same coverage. This approach offers meaningful coverage that protects vulnerable children from excessive costs. The Chafee-Rockefeller-Jeffords-Hatch amendment also gives states the option of choosing Medicaid or a more flexible grant approach for uninsured, middle-class children. We believe that resources and flexibility are needed because, unlike low-income children, middle class uninsured children are difficult to target with a single program.

Q: How can you criticize the Roth grant proposal when your benefit package is less prescriptive than his?

A: Our approach always assumes a strong Medicaid base program. The Roth proposal establishes incentives for states to allocate the entire $16 billion children's health investment to block grants, which would allow for less meaningful health insurance coverage. In so doing, it children 6 years of age and older at income levels less than 133 percent of poverty -- about $21,000 for a family of four -- would not have the same benefit as their younger siblings.

Q: Are you saying that you will veto any proposal that is less prescriptive than the Chafee-Rockefeller Amendment?

A: We will have to evaluate all proposals that come up. There may strengthening provisions that make some sense. But there is no question that relative to all proposals on the table, that the Chafee-Rockefeller-Jeffords-Hatch amendment is far preferable.

Elena - Health - children's coverage

FYI.

Jen

ROUTING SLIP
DATE: 5/27/97

FROM: Stephanie Streett
Deputy Assistant to the President and Director of Scheduling

SUBJECT: Satellite Appearance for Kaiser Permanente

Don Baer	✓	Katie McGinty	____
Sandy Berger	____	Mack McLarty	____
Erskine Bowles	____	John Podesta	____
Peg Cusack	____	Bruce Reed	✓
Rahm Emanuel	____	Dan Rosenthal	____
Maria Echaveste	____	Charles Ruff	____
Jack Gibbons	____	Peter Selfridge	✓
Laura Graham	✓	Patti Solis-Doyle	____
Marcia Hale	____	Craig Smith	____
Nancy Hernreich	____	Doug Sosnik	____
John Hilley	____	Gene Sperling	____
Kitty Higgins	____	Todd Stern	____
Ron Klain	____	Ann Stock	____
Ann Lewis	____	Kim Tilley	____
Bruce Lindsey	____	Jodie Torkelson	____
Sylvia Mathews	____	Melanne Verveer	____
Mike McCurry	✓	Michael Waldman	✓
		Jen Klein	✓

FILE: Accept

COMMENTS: Date TBD

ROUTING SLIP
DATE: 5/21/97

FROM: Stephanie Streett
Deputy Assistant to the President and Director of Scheduling

SUBJECT: Satellite Appearance for Kaiser Permanente

Don Baer	✓	Katie McGinty	
Sandy Berger		Mack McLarty	
Erskine Bowles		John Podesta	
Peg Cusack		Bruce Reed	✓
Rahm Emanuel		Dan Rosenthal	
Maria Echaveste		Charles Ruff	
Jack Gibbons		Peter Selfridge	✓
Laura Graham	✓	Patti Solis-Doyle	
Marcia Hale		Craig Smith	
Nancy Hernreich		Doug Sosnik	
John Hilley		Gene Sperling	
Kitty Higgins		Todd Stern	
Ron Klain		Ann Stock	
Ann Lewis		Kim Tilley	
Bruce Lindsey		Jodie Torkelson	
Sylvia Mathews		Melanne Verveer	
Mike McCurry	✓	Michael Waldman	✓
		Jon Klein	✓

FILE: Pending

COMMENTS:

SCHEDULE PROPOSAL 5/18/97

97 MAY 20 P12:50

____ ACCEPT ____ REGRET ✓ PENDING

TO: Stephanie Streett
Director of Scheduling

FROM: Bruce Reed

REQUEST: Satellite Appearance for Kaiser Permanente

PURPOSE: To highlight the President's leadership on children's health by participating in the launch of Kaiser Permanente's commitment to spend $100 million over five years to insure uninsured children in California.

BACKGROUND: We have been working with Kaiser on the development of their children's initiative for about two months and feel comfortable that their proposal complements the President's children's health initiative in the balanced budget. At our request, Kaiser did not include their commitment as part of the service summit and did not do an event with the First Lady during her recent visit to California because senior staff thought this would be a good opportunity for the President.

PREVIOUS PARTICIPATION: None.

DATE AND TIME: Suggested dates are June 16, 17, 19, 20 or 23 (during the President's visit to California). Other dates could also be considered.

DURATION: 15-20 minutes.

LOCATION: The White House or in California.

PARTICIPANTS: David Lawrence, CEO, Kaiser Permanente. Other participants not yet determined.

OUTLINE OF EVENTS:	President delivers remarks by satellite to event in California launching initiative.
REMARKS REQUIRED:	Prepared by speech writing.
MEDIA COVERAGE:	Open press. Kaiser expects significant television coverage in California.
FIRST LADY'S ATTENDANCE:	Not required.
VICE PRESIDENT'S ATTENDANCE:	Not required.
RECOMMENDED BY:	Bruce Reed, Rahm Emanuel, Ann Lewis, Chris Jennings.
CONTACT:	Jennifer Klein 456-2599
ORIGIN OF PROPOSAL:	White House Staff generated with input from Kaiser.
SECOND LADY'S ATTENDANCE:	Not required.
SOURCE OF PAYMENT:	Kaiser.

Health Children's Coverage

THE WHITE HOUSE
WASHINGTON

THE PRESIDENT HAS SEEN
3-10-97

February 21, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed and Gene Sperling

SUBJECT: Background Information on Uninsured Children

Following up your meeting with Erskine on Friday, we asked Chris Jennings to provide you with the attached detailed background memo on the status of uninsured children in the nation, a description of possible policy options to address the problem, and an overview of the budgetary and political environment that surrounds this issue. We have also asked him to give you a status report on TennCare and the possible lessons Governor McWherter's legislative success could teach us about the upcoming debate on children's coverage.

Both parties in Congress are considering a number of ways to expand coverage to children: tax incentives, grants to states, Medicaid reform, and vouchers. There is no consensus yet either on the most sensible policy or on the most politically viable approach.

Because we expect this issue to be a top priority in budget negotiations, we have begun a joint DPC-NEC process to review and analyze continually evolving options that are emerging from the Congress. We will use this process to provide you with updated information and to develop sound policy options as the budget debate progresses. We have scheduled a meeting with you on Monday to discuss this issue with you further.

THE WHITE HOUSE

WASHINGTON

February 21, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings CCJ

SUBJECT: Background Information on Uninsured Children

This memo responds to your request for background information about uninsured children. It includes:

(1) A summary of the problem and recent trends that define it;
(2) A description of who the uninsured children are and why;
(3) A brief description of the challenges of covering children;
(4) An overview of the major approaches to covering children; and
(5) An overview of the budgetary and political environment surrounding this issue.

In addition, there are two attachments, one that describes in detail our children's policies and a second on TennCare. Since you have indicated an interest in the status of TennCare, we have attached a three-page summary of the history and status of this innovative program. I asked Nancy-Ann Min to review and edit this document to make certain it provides you with a balanced and up-to-date portrayal of the TennCare experience.

UNINSURED CHILDREN: DESCRIPTION AND TRENDS

Number of Uninsured Children

- **In 1995, 10 million, or 14 percent, of all children lacked health insurance.** This proportion is higher than age groups over 45 years old (13 percent), but less than the 18 to 44 year old age group (about 25 percent). Despite major changes in the private health care coverage (outlined below), the proportion of uninsured children has hovered around 13-14 percent for almost a decade.

February 20, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Bruce Reed and Gene Sperling

SUBJECT: Background Information on Uninsured Children

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February 20, 1997

MEMORANDUM TO THE PRESIDENT

FROM: Chris Jennings

SUBJECT: Background Information on Uninsured Children

This memo responds to your request for background information about uninsured children. It includes:

(1) A summary of the problem and recent trends that define it;
(2) A description of who and why millions of children are uninsured;
(3) A brief description of the challenges of covering children;
(4) An overview of the major approaches to covering children; and
(5) An overview of the budgetary and political environment surrounding this issue.

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Trends

- **Employer coverage has declined.** While the proportion of uninsured kids is unchanged, it hides an underlying trend: coverage of children through employer plans has decreased (from 67 percent in 1987 to 59 percent in 1995). While some have asserted that this decrease stems from employers dropping dependent coverage, two facts challenge this theory. First, the proportion of adults as well as kids with employer coverage has declined, from 70 percent in 1988 to 64 percent in 1995. Second, about 80 percent of uninsured children have uninsured parents. This suggests that the decline in employer coverage is a family problem, not just a children's problem.

  One of the major reasons for the decline in employer-sponsored insurance has to do with the change in the U.S. labor market. Since the 1980s, industries have tended to outsource (subcontract with smaller firms) and hire more part-time workers; these workers are less likely to have health insurance. Additionally there has been a shift away from industries that are more likely to offer insurance, like manufacturing, to industries that often don't offer insurance, like retail. Finally, there has been an increase in workers in firms with less than 25 workers; about 30 percent of workers in firms with fewer than 25 employees lacked health insurance in 1995, relative to about 12 percent for workers in firms with 500 or more employees. In short, it is not that firms are dropping children's coverage so much as employment is shifting to firms less likely to offer insurance.

- **Medicaid coverage has increased, but is slowing.** The reason why the decline in employer coverage has not increased the number of uninsured children is Medicaid. In 1990, Federal law required states to begin phasing in coverage of poor children. As a result, the proportion of children covered by Medicaid increased from 16 percent in 1987 to 23 percent in 1995.

  Recent research suggests, however, that Medicaid did not necessarily help the children who lost their parents' employer coverage. Instead, it expanded coverage to families who did not have full-time workers, lowering the number of uninsured poor children at the same time as the employer trend increased the number of uninsured near poor children.

  While Medicaid has stabilized the proportion of the nation's children without insurance, its expansion is subsiding. In 1994 and 1995, the number of children covered by Medicaid barely increased. This is now reflected in lowered projections of the number of children covered by Medicaid in the future. The Congressional Budget Office (CBO) projects that the number of children covered by Medicaid will grow no faster than general population growth over the next 10 years.

- **Proportion of uninsured children may increase.** If recent trends continue (employer coverage continues to decline and Medicaid expansions continue to slow or stop), it is almost inevitable that the proportion of children without health insurance will rise.

WHO ARE UNINSURED CHILDREN

- **Most in working families.** Over 80 percent of uninsured children have a parent who works (about two-thirds of these children have a parent who works full year, full time).

- **Income varies.** There are large numbers of uninsured children across the income spectrum. In 1995, more than 3 million uninsured children were in families in each of the following income groups: poor, near poor (between 100 and 200 percent of poverty), and middle class (above 200 percent of poverty). Families just above poverty (between 100 and 150 percent of poverty) had the highest rate of uninsured children (24 percent), probably because they are above the Medicaid thresholds but have too little income to afford private coverage.

- **Concentrated in the south and southwest.** There is wide variation in the proportion of uninsured children across states. A disproportionate number of children reside in the south and southwest; in 1995, about 43 percent of all children but 55 percent of all uninsured children resided in these states. In part this reflects those states' Medicaid programs: southern states are less likely to have taken advantage of Medicaid options to expand coverage to children. This concentration also reflects these states' higher prevalence of low-income families, industries that don't provide health insurance, racial and ethnic groups less likely to be covered by insurance, and noncitizens.

WHY ARE CHILDREN UNINSURED

1. **Parents change jobs.** Because most children receive coverage through their parents' jobs, job changes disrupt the continuity of children's coverage. Nearly half of all children who lose health insurance do so because their parents lose or change jobs. About 30 percent of all children, regardless of income, spent at least one month without insurance between 1992 and 1994. In fact, when looking at workers with one or more job interruptions, they are over three times more likely to spend some time without insurance (42 percent relative to 13 percent of workers continuously employed). Thus, middle class children are at risk of losing insurance due to parents' job changes.

2. **Parents earn too much for Medicaid but too little for private coverage.** The highest rate of uninsured children is among families above poverty but below middle class. Low-wage workers are more likely to be employed by firms that do not offer health insurance; only 36 percent of workers earning less than $5 per hour in 1993 were employed by a firm sponsoring health insurance. Since the individual market for health insurance is volatile and costly, families without access to employer coverage may have few options. Even when these families are offered employer-sponsored insurance, they cannot always afford it. When job-related insurance loss is put to the side, the most important reason why children lose insurance is that it is too expensive for the family.

3. **Eligible but not enrolled in Medicaid.** Medicaid has not reached all of the children who qualify for it. An estimated 3 million uninsured children are eligible but not enrolled in Medicaid. Nonparticipation in Medicaid varies considerably across states; one report estimated that the proportion of these children ranged from a low of 7 percent in Vermont to 46 percent of eligibles not enrolled in Nevada. While there are no definitive studies on this problem, some reasons why this occurs include: lack of awareness of eligibility; the welfare stigma associated with Medicaid; cumbersome application processes; and availability of other coverage in the state (employer or state program).

CHALLENGES TO COVERING CHILDREN

Before summarizing policy options to cover children, it is important to understand the two most difficult challenges to developing viable policy: (1) substitution of Federal dollars for current employer and state contributions; and (2) administrative complexity.

- **Substitution or "crowd out".** Given that uninsured children are not a homogenous group, it is important to design policies that encourage the enrollment of uninsured children but discourage enrollment of already-insured children. Participation in any health insurance program depends both on the families' interest in health insurance and the attractiveness of the policy. While the former cannot be altered, the latter is determined by a policy's visibility, benefits, ease of application, and, most importantly, cost. The higher the premium subsidy, the greater the likelihood of participation.

  The goal of encouraging participation of the uninsured is often at odds with an equally strong desire to ensure that already-insured children do not drop their current coverage. Almost any new initiative risks substitution of Federal coverage for employer coverage, known as "crowd out". Generally, employer crowd out is a problem with policies that extend above 200 percent of poverty, since the number of children with employer coverage increases with income. A different type of crowd out happens when the new initiative replaces state or Medicaid coverage of children. Since most states have either used Medicaid options or have funded state-only programs for children, it is nearly impossible to design a policy that does not overlap with at least a few states' programs. Both types of crowd out are problematic because they increase Federal costs without increasing covered children.

- **Administration.** In any subsidy program, there is a conflict between the desire to target efficiently and to limit complexity and bureaucracy. Targeting requires sophisticated rules and protections against fraud and abuse. This creates a larger bureaucratic role. However, the organization charged with administering the program (probably states and / or the IRS) may not be willing or able to manage this complexity. Finding the appropriate administrative role is particularly important in children's initiatives given the greater potential for crowd out, described above.

OPTIONS FOR COVERING CHILDREN

Recognizing the complexity of the problem and the challenges in addressing it, proponents have considered four general approaches to increase health insurance coverage for children: tax credits, state grants, Medicaid expansions, and more traditional subsidy programs linked to a new entitlement (usually called vouchers). Clearly, there are other types of approaches, such as employer/individual mandates or a Medicare program for children. While such policies might well be more efficient to administer and more comprehensive in effect, they are unviable by any measure in today's economic and political environment. This section describes the four most considered approaches generally and discusses the major issues surrounding them.

1. **Child health tax credits.** Child tax credit proposals use a built-in system to give subsidies to families that have purchased coverage for their children. Usually this subsidy is granted either in a retrospective, annual refundable tax credit or as "advances", using changes in the withholding on payroll checks like in the earned income tax credit (EITC). While some proposals make the amount of the credit income-related, others have proposed flat credit amounts for all families. All rely on the IRS to administer and to some extent monitor the credit through tax withholdings, filings, refunds and audits.

   Proposals for tax credits for children's health coverage are almost intentionally poorly targeted since they aim to help all families — not just uninsured families — afford coverage. While this approach is equitable, it also is an expensive way to increase coverage since more money will go to families with insurance than without insurance. Additionally, the ability of the IRS to administer a child health tax credit is not proven. In 1991-1992, it oversaw a child health tax credit that was repealed in 1993 due to many problems, including problems that Treasury encountered in monitoring quality. These problems could be exacerbated if one of the coverage options is MSAs (as proposed by Senator Gramm).

2. **Grants to states.** A second option is to give states grant money to let them design their own programs. Today, most states sponsor non-Medicaid programs, often in partnership with the private sector. In Florida, for example, the Healthy Kids Program combines local, state and family contributions to cover low-income children through schools (we are considering having you visit one of these schools with Governor Chiles in early March on your trip to Florida). Grant programs use Federal money to either leverage these types of state programs or create new ones (like the workers between jobs initiative).

   States are probably the most efficient vehicle for administering a child health coverage initiative, since they already manage the health care coverage for 18 million children on Medicaid. However, the flip side of this advantage is that they have an incentive to use any new grant money to replace state spending. It is hard to design policy "walls" that prevent this from happening.

3. **Medicaid.** Given the central role that Medicaid already plays in covering children, expanding Medicaid is one of the simplest ways to increase kids' coverage. There are three ways that Medicaid could be changed to increase the number of children covered. First, the current program could be improved. As described earlier, Medicaid intends but does not succeed in covering all eligible children. Legislative and regulatory changes could be made to make Medicaid more accessible and last longer once the child is in the system (e.g., improve outreach, allow states to extend continuous coverage for 12 months). Second, states could be given either more flexibility or a financial incentive to expand optional coverage. For example, states could be allowed to charge premiums to children above the mandatory levels, as is done in several 1115 waiver states. Third, Federal law could be changed to require states to cover more children. However, concerns about unfunded mandates makes any Medicaid mandate extremely difficult to support.

   Medicaid options, like others, risk crowding out employer coverage, but the potential is usually low since they mostly focus on populations without access to employer insurance. This low employer crowd out, coupled with low state crowd out (since it builds on rather than replaces Medicaid), make Medicaid options among the most efficient. However, using Medicaid places administrative constraints on the option. It is hard to ask states to use Medicaid to administer a policy that is substantially different than Medicaid in terms of eligibility and benefits.

4. **Vouchers.** A fourth option is a 100 percent Federally funded entitlement program for children's health coverage. This approach allows for national standards for coverage and eligibility but usually relies on states to administer the program.

   This approach, like tax credits, is hard to target. Vouchers create a large financial incentive to substitute Federal for employer and / or state funding. Some options have developed complicated eligibility rules to minimize this risk (e.g., restricting eligibility to children who have not had coverage for a certain period of time). However, the more concerted the effort to keep insured children out of the program, the more administratively difficult it is to implement. And, since the Federal government does not have the state and regional offices equipped to determine eligibility and deliver subsidies, this administration would fall to states.

These approaches are not mutually exclusive and can be used in combination. For instance, a state grant program can be coupled with a tax credit to assist families in purchasing coverage. Alternatively, a grant program could be designed to begin where Medicaid coverage ends. Not only are these combinations possible; they may be needed since no single approach can cover the diverse group of uninsured children.

In fact, our children's health initiative uses multiple policies rather than a single, one-size-fits-all approach. We take on the three reasons why children lose coverage through: a grant program for

children losing coverage when their parents lose their job; a grant program for children with too much income to be eligible for Medicaid but too little to afford coverage; and a package of Medicaid improvements to target children who fall through the cracks. Using combinations of policies to effectively reach uninsured children is consistent with the general direction of Congressional proposals as well.

What remains at issue is which combination of approaches is both good policy and politically viable. One important fact is that most Congressional initiatives include at least some reliance on a tax incentive mechanism. This reflects Members' attempt at avoiding the appearance of a new Federal program. We did not include such a proposal in our children's health initiative because of concerns about crowd out and because the Department of Treasury believes such approaches are extremely difficult to administer. However, these problems may not be insurmountable and it may be the case that tax incentives in combination with some other type of approach (e.g., Medicaid buy in or state grant program) may yield both additional money for coverage and Republican support.

CONCLUSION: CURRENT BUDGETARY AND POLITICAL ENVIRONMENT

As described above, there are countless approaches to expanding coverage for children. And, there will inevitably be additional "unveilings" of proposals in the near future. That a consensus has not developed early in the debate is not surprising. In fact, it is a generally positive development for it gives Members the opportunity to be invested in whatever option can emerge from the Congress. It also gives us the ability to provide helpful technical advice that concurrently keeps us informed of Hill approaches and gives us the opportunity to steer policy options in appropriate directions.

Unfortunately, however, the opposition to our Medicaid per capita cap and DSH policies continues to complicate our ability to get a positive "lift" from our $18 billion investment in coverage expansion. The advocates and Governors — who should be our allies on a children's coverage initiative — are dedicating most of their time and resources to fighting our Medicaid policy. This is despite the fact that we are saving only $9 billion off an over $600 billion, 5-year Medicaid baseline. The disappointing consequence of the Governors' and advocates' lack of enthusiasm may well be that Republican Members and staff may start thinking that there is little price to pay for deleting coverage investments from the budget.

Having said this, there continues to be strong interest among the Democratic Leadership to include a significant health coverage expansion in any final balanced budget agreement. Succeeding in getting such a high priority item in the final budget might help us keep key Democrats on board in what will be an otherwise difficult vote.

The Blue Dogs are planning on releasing their budget proposal next week. Initial reports suggest that they are going to avoid significant tax cuts and investments at this point. This includes initiatives in the area of children's health coverage. However, Blue Dog staff have suggested

that they are taking this position for strategic reasons. They believe it enables their members to to bargain back votes using their excess savings, and have suggested that this could include investments in health care. Interestingly, the most conservative Members of this coalition (Condit and Hall) have expressed interest in policies to address workers between jobs.

Most interesting of late, however, has been a quiet movement among a number of Republicans (Gramm, Specter, Jeffords, Chafee, Archer and Bliley) to consider a major health coverage expansion investment for children. This obviously contrasts dramatically with the last Congress, which pushed the coverage issue off of any legislative priority list.

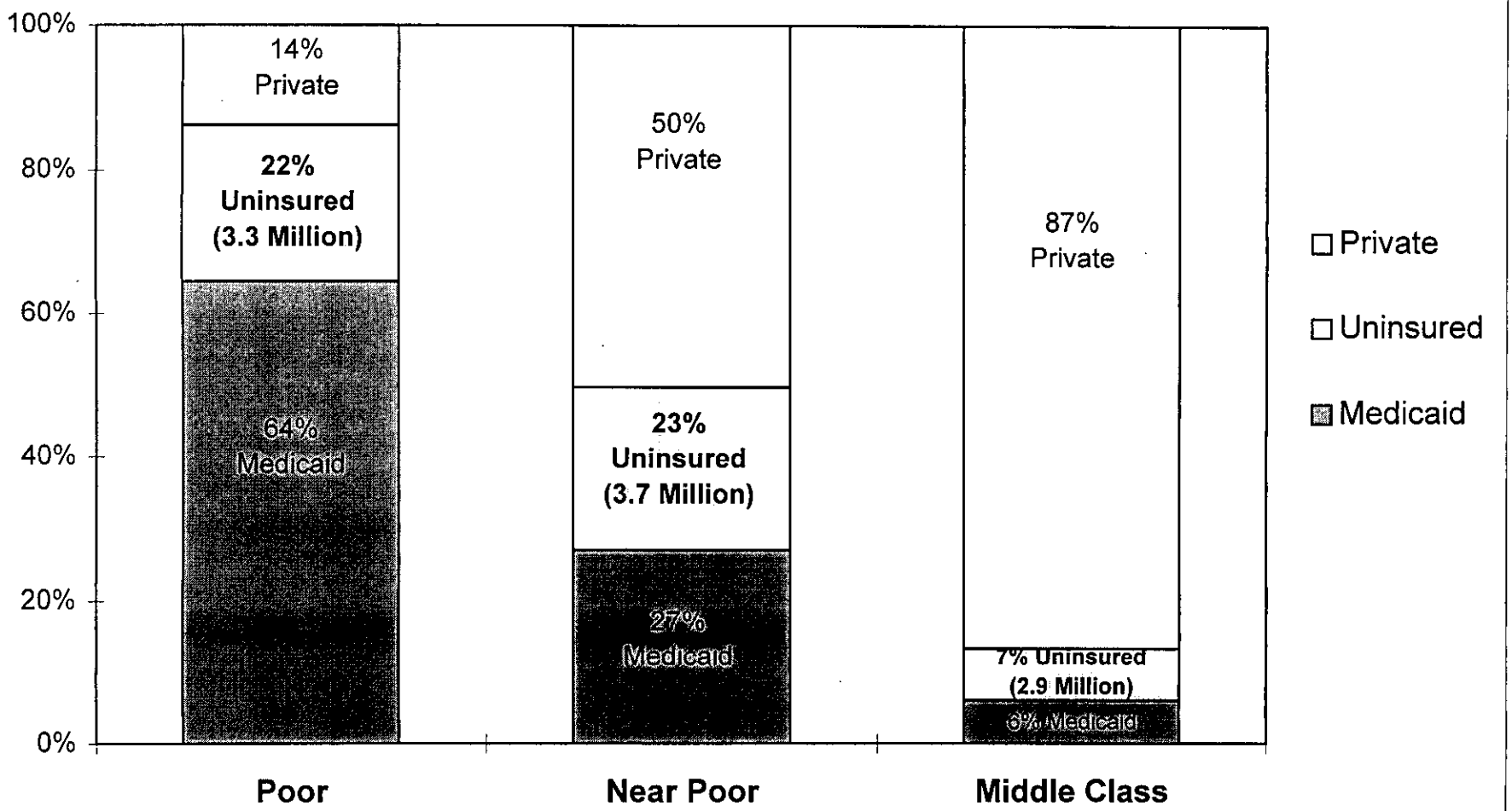
Despite this encouraging news, it remains unclear whether the interest in children's coverage, particularly among Republicans, will be retained after budgetary limitations and policy complexities are imposed on Members. In response, many Republicans may conclude that coverage expansions should be a low priority for them.

To keep a credible number of Republicans on board will require either major positive or negative incentives (or some combination of both). On the positive side, Republicans will have to believe that they will get at least some of the credit for the policy; they rightly think that Democrats — and particularly you — always get the lion's share of the credit for any health initiative. On the negative side, we will have to create an environment in which they feel they cannot reject a particular children's coverage policy without risking severe political consequences.

For the time being, our best strategy may well be to directly or indirectly continue to encourage Republicans to get out in front of this issue and introduce their own approaches. Even if we find ourselves disagreeing with their policies, we probably should keep these concerns very quiet. The most important goal for now is to get the Budget Committees to direct the Authorizing Committees to finance some coverage improvements. If they do, we still will have sufficient time to raise concerns at the Authorizing Committee level about particular approaches.

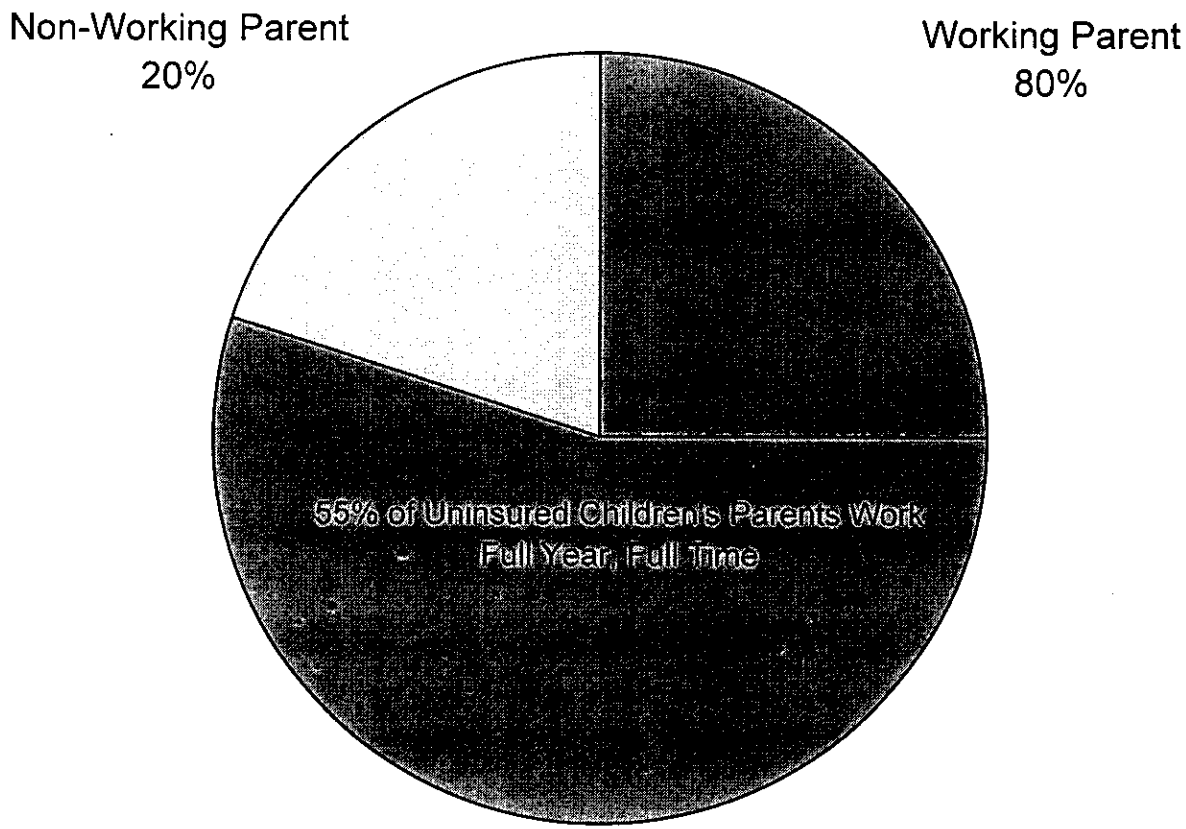
As Bruce and Gene mentioned in their memo, we are continuing our DPC-NEC policy review process to monitor legislative evolutions on the Hill and to determine whether we need to re-position our policy or modify our strategy. This process will enable us to evaluate new Hill proposals in great detail, provide you with Administration-wide opinion of them, and to make recommendations to you about legislative, communications and political strategy around children's health proposals.

Children's Health Coverage, 1995
Proportion of Children Covered by Different Sources



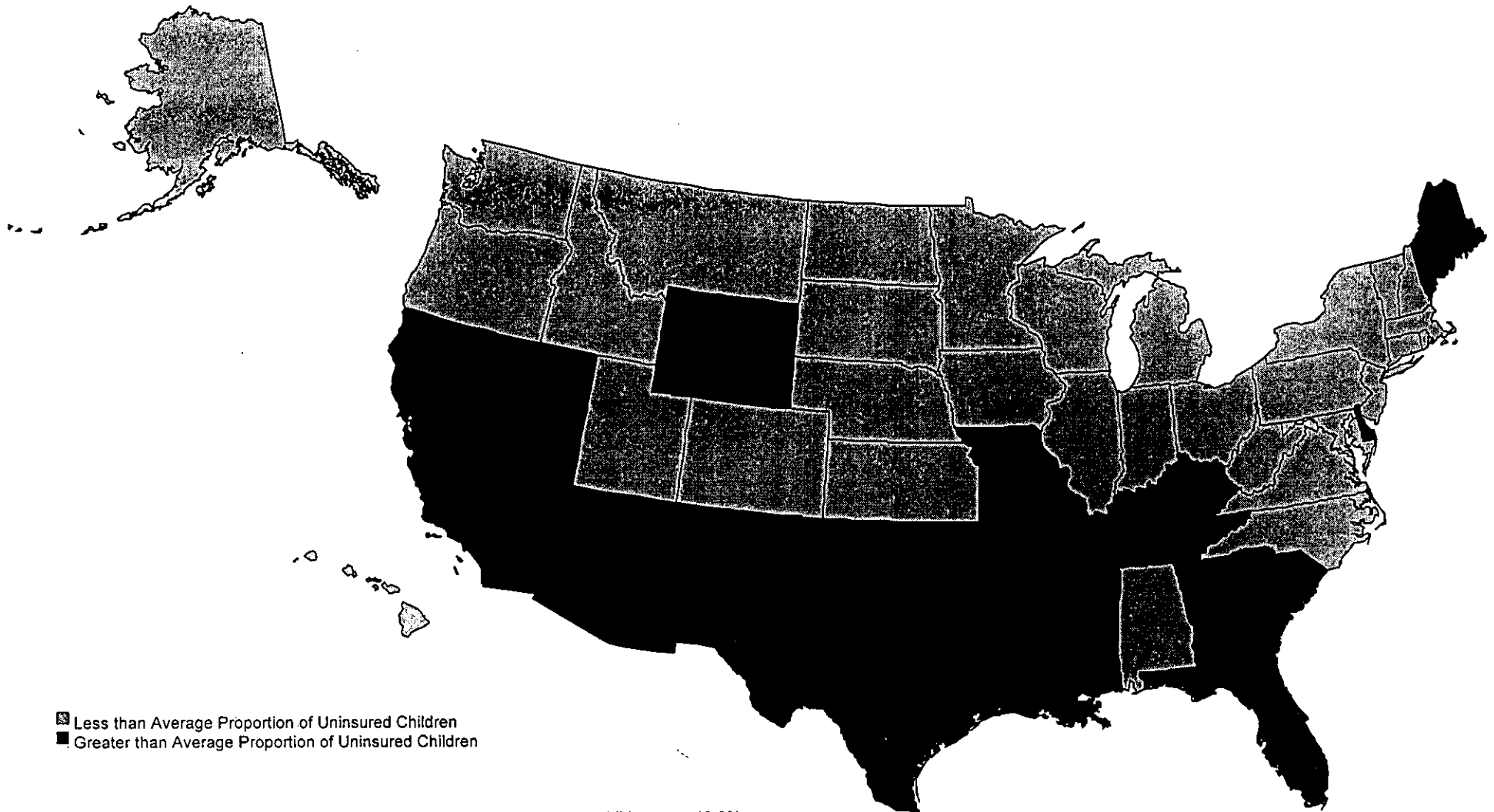
"Poor" means < 100% of poverty; "Near Poor" means 100-199% of poverty; "Middle Class" means > 200% of poverty. Source: EBRI, 1996

Most Uninsured Children Have a Parent Who Works



Source: EBRI, 1996

Uninsured Children, 1995



Source: EBRI, 1996. Note: In 1995, the national average proportion of uninsured children was 13.8%.

Experience in TennCare

- **What is TennCare?** In 1994, under a 1115 waiver granted by you, Tennessee converted its Medicaid program to a managed care program for virtually every one of its Medicaid recipients and also opened enrollment to all uninsured people in the state. It subsidized premiums for the uninsured, on a sliding scale basis, all the way up to 400 percent of poverty. (For example, families just above poverty paid $25 a month; families at 400 percent of poverty paid $366 a month; families above 400 percent of poverty paid $462 a month; and uninsurables -- families who have extremely sick individuals -- paid $562 a month). Due to a number of factors (explained below), enrollment of the uninsured ended after one year. However, the state plans to re-open enrollment to uninsured children in April 1997.

- **History of Tennessee's Waiver**. The idea for TennCare came from a need to avert a financial crisis facing Tennessee combined with a desire to expand coverage to the uninsured. In 1993, Tennessee and other states with large Medicaid disproportionate share hospital (DSH) programs were about to have their DSH funding limited by recently enacted laws. Tennessee's DSH spending was nearly 20 percent of the state's total Medicaid spending in 1992, among the highest in the nation. Governor McWherter, his Commissioner of Finance, and a small staff put together a plan that would capture the DSH funding through a "demonstration" or 1115 waiver program in which the state would use that money to expand coverage.

  In May 1993, Governor McWherter gained approval of a plan from the state legislature and set about the task of getting it Federally approved and implemented by January 1994, when the state legislature reconvened. During the summer and fall of 1993, he negotiated with the Administration and was granted the waiver in November; by January 1, 1994, the demonstration began.

- **Rapid Expansion in 1994**. In early 1994, TennCare not only switched virtually all of its Medicaid recipients to managed care, it increased its enrollment by nearly 50 percent to cover an additional 400,000 previously uninsured people. By January 1995, when Governor Sundquist took office, TennCare enrollment was at its peak of 1,259,895. This included about 450,000 previously uninsured people. The increase in the number of the uninsured pushed Tennessee's coverage numbers ahead of most states and ALL southern states in the nation; although statistics vary, the state was covering over 90 percent of its population -- an impressive achievement by any measure.

  However, the first year was marked by several problems. Many providers rebelled against the "cram down" policy in which the state would not contract with providers for state employees if the providers did not also treat TennCare patients. Additionally, both Medicaid and uninsured people were confused over how to enroll and had difficulty in determining whether their providers were in their network. Finally, there were reports of serious fraudulent marketing practices by managed health care health plans. Specifically, prisoners were illegally enrolled; homeless shelters were targeted to sign up people who would never receive services; young healthy white males were enrolled while anyone who looked ill was avoided; and people who were already covered by Medicaid were told they would lose their Medicaid if they didn't sign up for a particular new managed care plan.

- **Reduced TennCare enrollment in 1995 and 1996.** Due to first year implementation problems and state budget pressures, Governor Sundquist closed enrollment of new uninsured applicants (except for "uninsurables"), increased premiums and collection efforts, and implemented more stringent eligibility verification. As a result, there were 78,500 fewer enrollees as of December, 1995. In August of 1996, the TennCare Bureau announced that it would cut tens of thousands of additional names from the rolls, saying that it lacked current addresses and the enrollees failed to respond to mail inquiries about their eligibility. At the same time, Blue Cross, which covers nearly 50 percent of TennCare enrollees, announced that it would freeze enrollment of TennCare recipients. As a result of these reductions in enrollment, there were 1,148,148 people enrolled in TennCare, as of February 11, 1997.

- **Other challenges facing TennCare.** The provider community has consistently raised major quality, access, and payment concerns about TennCare. They threatened not to serve TennCare patients, but (other than a brief time of protest) most physicians are still serving the beneficiaries. The public hospitals who used to receive large DSH payments, like the "Med" in Memphis, have had a particularly hard time sustaining economic viability. However, with some financial and oversight assistance from the Federal Government, these problems and the marketing abuses outlined above, seem to be being addressed over time. For example, the state has commissioned a detailed study of access, cost and utilization to improve the operation of the program. Probably the most concerning development has been a recent rise in the infant mortality rate. This rate has not increased since 1987 and it happens to coincide with a time in which TennCare is covering over half of the state's live births.

- **Expanding to kids in 1997.** On January 13, 1997, the Governor announced that, for the first time in two years, enrollment in TennCare would be opened. It would extend coverage to poor children between 14 and 18, and would allow families with higher incomes to buy their children into TennCare. Governor Sundquist believes that they will be able to enroll 51,000 more children.

  Part of the reason for this initiative is the managed care plans' concerns about the risk selection without re-opening enrollment. According to John Ferguson, State Finance Commissioner, "the addition of uninsured enrollees is needed for the health of the program" since TennCare "has lost the healthier ones whose premiums help pay for the care of others." Tony Garr, head of the advocacy group, Tennessee Health Care Campaign, confirms this more pragmatic rationale: "opening enrollment is the only option for the state. They need to do it to preserve the integrity of the program...."

- **Does TennCare serve as a model for other states to expand coverage?** Given the experiences in this program, the jury is still out as to whether TennCare is a model program for other states to emulate. It is a major accomplishment that 450,000 Tennessee residents who would otherwise have been uninsured have benefited from this program. And, even though the number of uninsured has been increasing in recent years, there are at least 300,000 more people insured than there were prior to the implementation of TennCare. However, as mentioned above, there are persisting challenges, particularly in terms of risk selection and quality. Most importantly, however, because of the unique disproportionate share financing arrangement the Administration provided to Tennessee, the TennCare model would be extremely difficult to replicate in other states.

- **Why is TennCare difficult to replicate?** First, there are only a handful of states (NH and MO among them) that have enough DSH dollars and political will to divert that money from public hospitals toward new coverage. Second, the low-DSH Governors -- who represent the vast majority of the country -- would oppose such an approach both because they would not benefit and because they believe that those who would only could do so because they "gamed" the system in the first place. Third, DSH money available is being reduced in our balanced budget proposal; it is now contributing about $15 billion of our total $22 billion in gross Medicaid savings. Unfortunately, a reduction in DSH savings would require an increase in savings from the unpopular per capita cap.

- **Lessons of TennCare.**

  First, rapid movement from fee-for-service coverage to managed care achieves savings that can be invested back into coverage expansions. Unfortunately the savings may not be sustainable for long periods of time (TennCare plan premiums have seen some notable increases); moreover, since most states are already moving rapidly toward a greater use of managed care, future savings will be limited. Having said this, as we provide states with easier access to managed care (through the elimination of managed care waivers), we should strongly encourage them to reinvest their savings into coverage expansions.

  Second, outside financing sources (TennCare used their DSH dollars) will be necessary to have any major expansion of coverage. Your budget explicitly recognizes this point by reinvesting about $18 billion in support of increased access to insurance.

  Third, Governors will likely learn that it is extremely difficult to successfully exchange constraint in provider reimbursement for coverage expansion without utilizing a McWherter-type model that rushes the proposal through the legislative process. Unfortunately, providers are now better prepared to oppose this strategy specifically because of the TennCare experience.

  Fourth, the downside of legislative successes like TennCare is that they almost inevitably produce implementation problems (as has been the case in Tennessee) that are extremely challenging. Quality and access issues frequently arise because of rapid and confusing changes in the delivery system. Additionally, providers who oppose the changes are quick to point out -- in the most public ways possible -- any real and/or perceived problems.

  Finally, the TennCare experience supports the idea that efforts to significantly expand new coverage must be done in a way that covers the healthy as well as unhealthy populations to guard against adverse selection. The problem in a predominantly voluntary program is that it is extremely difficult to entice healthy uninsured people to join without high subsidies. This argues for carefully designed approaches to incremental reform. Expanding coverage to a group like kids, for example, might be a way to both limit the Federal dollars and get healthy people enrolled, since many parents want to cover their children regardless of their health.

Health Care Reforms

- As we constrain growth in the Medicare and Medicaid programs through long overdue payment and structural reforms, my budget also makes modest but important investments in improving the health care system.

- Specifically, the budget includes targeted and capped investments to expand coverage to two groups of deserving Americans: children and workers between jobs.

    - Almost 10 million children are uninsured. Because almost half of all children who become uninsured do so because their parent has lost or changed a job, these initiatives include a provision to provide premiums assistance for children and their parents who are in-between jobs. They are targeted and capped, and will also cover up to 5 million children and over 2 million adult workers (and their spouses).

- States can best identify and reach out to their citizens in need of health insurance. As such, all of our coverage expansions would be administered by the states.

- It is important that we can show the nation that we can work together to give working Americans the help they need to purchase health insurance. These initiatives aim to both reduce the unacceptable levels of people without insurance and make for a more health, stable workforce.

- **Avoid engaging on specific approaches to expanding coverage, particularly tax credits.**

    Child health tax credits: While the Republicans and the Democratic Leadership is interested in expanding coverage through tax deductions/credits, serious questions have been raised about whether they would be effective or administratively feasible. Many believe that they would simply give public dollars to people who are already paying for insurance, resulting in little new coverage. We are open, however, to thinking about how to combine a tax credit with other more effective options, like a Medicaid buy-in program or the grants to states.