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Health - Second Term Agenda

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

November 14, 1996

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala

As we prepare for a second term I wanted to lay out for you, in broad terms, a series of health policies that you might want to consider. These proposals build on the successes of the first term, reinforce commitments made during the recent campaign, and are consistent with your balanced budget commitments.

This proposed strategy should focus on achieving real, sustainable results through practical, incremental reforms. These are not proposals that will significantly increase Federal outlays or impose significant new costs on states and localities.

BUILDING A HEALTHIER, SAFER AMERICA

Consistent with your first term, your goal must be to continue to build a safer and healthier America. We have taken great strides toward protecting and improving the health of the people of our Nation. To build on those successes and continue to fulfill the commitments you have made, we would pursue a series of targeted initiatives to improve the health of Americans and the ability of all our citizens to obtain high-quality, affordable health care. Under the overall theme of "A Healthier, Safer America," I suggest four areas:

- **Protecting the health of senior citizens and people living with disabilities:** We would stabilize the short-term financing of the Medicare program in the context of the budget, and create a bipartisan commission to devise longer term strategies to address longer-term needs as the baby boom generation retires. Further, we would build on our successes in preserving Medicaid's guarantee of coverage with proposals to make Medicaid more flexible for states while maintaining federal-state accountability.

- **Protecting the health and safety of children:** We will reduce the number of uninsured children, aiming towards a long-term goal of no uninsured children. Our initial strategies would focus on pragmatic building blocks: fulfilling the promise of current Medicaid by reaching 3 million children who are eligible but not enrolled; working with states to address private coverage for "gap" children; and public health strategies--including anti-drug and tobacco efforts--to ensure a safer and healthier environment for children.

- **Protecting the health of working families:** We will pursue your workers between jobs initiative; extension of Medicaid waivers and buy-in options for working Americans; and your proposal for voluntary purchasing cooperatives to enhance the purchasing power of small employers.

- **Providing consumer and quality protections and a Safe America:** We will address concerns about consumer protections and quality of care in the rapidly changing health system through your new national Advisory Commission. We would provide enhanced public health initiatives for a Safer America. We are already well along in plans for two powerful new safety initiatives (modeled on your tobacco strategy)that will affect every American--food safety and injury prevention. These may be great candidates for your State of the Union Address.

Following are brief presentations on our first term accomplishments and on steps to take to address each of these four goals. I look forward to discussing them with you further.

Building a Healthier and Safer America in the First Term

In the last four years, we have taken great strides toward protecting and improving the health of the people of our nation. Moving in incremental steps we have:

- Expanded coverage for 2.2 million Americans through the approval of 15 statewide Medicaid waivers;
- Protected coverage for 25 million working Americans through enactment of the Kennedy-Kassebaum Law;
- Extended the solvency of the Medicare trust fund into the 21st century;
- Reduced the rate of growth in Medicaid spending by nearly 300 percent;
- Enhanced mental health parity in insurance coverage;
- Reduced the rates of teen pregnancy, infant mortality, homicide, and domestic violence to all-time lows;
- Increased the rates of childhood immunization and early prenatal care to historic highs; reduced many common childhood diseases (e.g., measles, mumps, and polio) to record lows;
- Expanded choice in both Medicare and Medicaid while adding important prevention benefits; and,
- Launched major initiatives in important public health areas such as tobacco, dietary guidelines, and physical activity.

Protecting the Health of Senior Citizens and the Disabled

A. Medicare

One of our first priorities must be to stabilize the short-term financing of the Medicare program while moving forward toward a long-term plan to address the problems created by the retirement of the baby boom generation.

1. Short-Term Plan

As part of the fiscal year 1998 budget, we should move early in 1997 to secure passage of a package of Medicare reforms that will extend the solvency of the HI trust fund. It is important to note that a comparison of our balanced budget plan and that of the Republicans indicate many areas of agreement that could form the basis of a bipartisan package. While the details of this plan will have to be tailored to fit the framework of your revised balanced budget plan, they should include:

- Modernizing the Medicare program by offering beneficiaries much greater choice of health care delivery models while protecting the essential right to exercise that choice without penalty;

- Expanding the array of benefits to include respite benefits for the families of Alzheimer's disease patients; diabetes education and screening; and annual mammograms;

- Reducing the rate of increase in payments to hospitals, physicians, durable medical equipment suppliers, and other providers;

- Reforming the way Medicare pays for graduate medical education;

- Reforming the physician payment target and update systems; and,

- Extending the Part B premium at 25% of program costs.

2. Long-Term Plan

There is clear bipartisan support to create a national commission to undertake the important task of studying the long-term needs of an aging society and its implications for the Medicare program and help devise a strategy to preserve the solvency of the program well into the 21st century. There are several options available to us and I will be forwarding a background memorandum on this topic shortly.

B. Medicaid

We won an important victory by preserving Medicaid and its Federal guarantee of eligibility for 37 million poor, disabled, and elderly Americans. The balanced budget plan included $54 billion in Medicaid savings. As we develop a revised budget plan, it is important to note that Medicaid's baseline has already been reduced by $46 billion since the presentation of the current budget.

At the same time, we must continue to vigorously pursue ways to make Medicaid more flexible for the states while maintaining national standards and equity through our important oversight responsibility. We have already expanded the number of beneficiaries in managed care by 140% over the past three years. And our 15 waivers are promoting innovation--including new approaches to managing chronic illnesses.

Protecting the Health and Safety of Children

Working with parents, schools, health professionals, and others we have vastly improved the chances of a child born in America today living a long and productive life. Increased prenatal care and immunization rates mean a generation of healthier children who will grow up to be healthier adults. With relatively modest investments, we can continue to extend the length and quality of people's lives by:

A. Expanding Health Coverage of Children

Nearly 10 million children -- one in seven -- are uninsured in America today. That number has been increasing as employers have been reducing dependent coverage. Our goal must be to incrementally reduce this number to zero. While some in Congress are proposing large-scale government subsidies, I believe this issue requires a multi-faceted strategy that involves a more pragmatic series of incremental steps by both Federal and State government as well as private employers. These steps include:

- Under current law, we will add an estimated 1 million children to Medicaid over the next four years under the scheduled phase-in of adolescents in families below the Federal poverty line. One option would be to encourage states to move more quickly -- perhaps by 1998.

- An estimated 3 million children currently are entitled to Medicaid coverage but are not enrolled. Working with the states we should seek to identify and enroll these children and, in many cases, their parents. This is particularly important as it relates to implementation of welfare reform.

- Most of the remaining uninsured children -- known as "Gap Kids"--fall between Medicaid eligibility and private coverage from their parents' employers. We will work with the States to develop models appropriate to their circumstances. Pennsylvania has been a leader in this area, developing a strong public-private partnership that makes private coverage for children affordable for their parents.

- Finally, we will maximize our growing investment in community health centers, which can be a tremendous resource of care for uninsured children and working families. By building and supporting primary care capacity in under-served communities we could help states provide coverage and services to many uninsured children.

B. Providing A Safe and Healthy Environment for Children

While we build a stronger insurance safety net for our children, we also must continue our work to protect the physical health and safety of those kids. Initiatives include:

- **Tobacco and Kids.** We are poised to implement your anti-tobacco policies. Keeping one million kids from smoking will reduce our medical bill by $12 billion.

- **Reducing Drug Use.** Drug use among young people is on the rise and more than 10 million people under 21 are now consuming alcohol. Aggressively reducing these rates will save countless lives.

- **Vaccinating Children.** Today we have record high immunization coverage of two year olds (approximately 76%), and record low incidence of vaccine preventable disease in children. We must continue to build on that success and work to increase our immunization coverage to 90% by the end of the century.

- **Infant Mortality.** We have seen a sharp decline in infant deaths -- down one-third since you took office -- thanks to increased prenatal care and the remarkable reduction in sudden infant death syndrome due to the "Back to Sleep" campaign that advises mothers to place their infants on their backs while they sleep. We are virtually certain to reach our current goal of further reducing the infant mortality rate by the year 2000.

Protecting the Health of Working Families

The number of uninsured Americans has grown slightly during the first term to approximately 40 million and an estimated 80% of those individuals are either workers or the dependents of workers. We can systematically seek to reduce this number in incremental steps without a major impact on the Federal budget. The steps follow naturally on the Kennedy-Kassebaum law, which provides protection for workers who have insurance and those who are self-employed and buy their own coverage. Initiatives include:

- **Workers Between Jobs.** As included in the balanced budget plan, we would provide states with funds to subsidize the purchase of insurance for up to six months for workers who are receiving unemployment compensation and who had employer-sponsored coverage while they were working. This is the logical next step to Kennedy-Kassebaum and would assist 3.1 million uninsured individuals a year including up to 700,000 children.

- **Medicaid Waivers.** By allowing for extension of the statewide Medicaid waivers, we would ensure the continuation of coverage for those who received insurance under these waivers.

- **Medicaid Buy-In Options.** States would be encouraged to extend coverage to working Americans by charging an income-related premium to buy into Medicaid. This has been a popular option among the waiver states.

- **Voluntary Insurance Cooperatives.** The balanced budget plan also includes grants totaling $25 million a year to assist in the creation of voluntary health insurance purchasing cooperatives as a means for small employers to negotiate lower prices for coverage for their workers.

Providing for Consumer Protections, Quality, and a Safe America

Our health initiatives must address the needs of all Americans for consumer protections and quality for themselves and their families in the health system, as well as public health measures to assure a safe, and healthier America.

A. Consumer Protection and Quality Assurance.

The new Advisory Commission on Consumer Protection and Quality in the Health Care Industry will develop options to protect consumers' rights and the quality of care delivered in our rapidly changing health care system.

B. Safer America

Disease prevention efforts have contributed to 70% of the gains in U.S. life expectancy since the turn of the century. In fact, the majority of premature death and preventable disability is directly related to behavior. In the last four years, we have made remarkable progress in improving the health and safety of the American people. Through investments in public health we have saved the lives of countless men, women, and children. We will continue this progress in the following areas:

- **Food Safety.** A Presidential food safety initiative will improve our surveillance of food-borne disease; strengthen our system of inspections; expand the use of preventive controls used for seafood, meat, and poultry to other high-risk food products; increase our research base in microbiological risk assessment; improve coordination among local, state, and Federal health and regulatory authorities; and boost public education in the handling of food.

- **Injury Prevention.** Unintentional injuries account for 150,000 deaths among children, youth, and young adults. We can prevent many injuries through things like bike helmets, safety seats, sobriety checks, and safe work stations.

- **Violence Prevention.** By fully implementing the Violence Against Women Act we can provide a safe refuge for battered women and their children and help prevent a leading cause of injuries in women. A model program to reduce youth violence

through the schools and community-based organizations will include a non-violence curriculum for students, a parenting education program for adults, and an after-school program.

- **HIV Prevention and Treatment.** While the number of new infections with HIV has declined sharply from the rates experienced in the 1980s (from 100,000 per year to 40,000 per year), there has been little progress made in the last five years. Increased funding of CDC's HIV prevention activities allows us to focus on high-risk populations -- youth, women, and substance abusers. In addition, HHS-funded and sponsored research into HIV treatment alternatives has led to a number of promising drug therapies. We will continue to support focused research on HIV treatment.

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

November 23, 1996

MEMORANDUM FOR BRUCE REED
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FROM: Nancy-Ann Min NAM

RE: Ideas for Second-Term Health Initiatives

As you requested, I'm forwarding some ideas for health initiatives the President might want to consider for the second term. Under the theme of "Building a Healthier America", I've grouped them into two categories: (1) first-term initiatives that should be refined, strengthened, and re-proposed; and (2) possible new initiatives. I hope the result is helpful.

I've been telegraphic in some instances and will be happy to offer more details if you need them.

First-Term Initiatives That Should Be Refined, Strengthened, and Re-Proposed

1. Preserving Medicare for the Future

- Extend Short-Term Solvency: The very first thing the Administration must do is extend the short-term solvency of the Medicare Hospital Insurance (HI) Trust Fund beyond its current projected insolvency date of January 2001. To do this, the budget the President will submit to the Congress on February 1 must contain substantial savings and reform proposals, similar to the proposals that Congress refused to enact from the President's FY 1996 and FY 1997 budgets. Because we have lost two years from our original Balanced Budget Plan, the FY 1998 budget may require deeper Medicare savings if we are to extend the solvency of the Trust Fund to 2006 (i.e., ten years from 1996, which is the standard the President set in June 1995).

  While our earlier submissions contained no "new" beneficiary savings proposals, we should strongly consider income-relating the Part B premium and dedicating the savings to extend the solvency of the HI Trust Fund. Every Medicare plan on the Hill last year except the Administration's contained some version of this policy; it has gained wide acceptance among provider groups and the elite media, and even most of the seniors'

advocates. A policy similar to the one we advocated in the Health Security Act would charge beneficiaries with more than $90,000 in income ($115,000 for couples) a higher premium, affecting less than 3% of beneficiaries and saving an estimated $10 billion over five years.

- Lead the Effort to Solve Medicare's Long-Term Financing Problem: In his State of the Union address, the President should also make clear that he intends to lead the fight to save Medicare for the future. While the Republicans' whining about a "Mediscare" campaign strategy is mostly sour grapes, the fact is that the public trusts this President to take care of Medicare. Tackling this problem is not only the right thing to do; it will bolster our political credibility as well. The President should announce that his next priority, after extending the short-term solvency of the HI Trust Fund, is to work with Congress to create a bipartisan commission to address Medicare's longer-term financing problems.

2. Strengthening Medicaid's Safety Net

- Improve Medicaid: We should also make clear our commitment to preserving Medicaid and reforming it to make it more flexible and more accountable. This time last year, many in Washington were predicting that Medicaid would not survive as an entitlement to health care coverage for poor, disabled, pregnant women, and elderly Americans. Our refusal to budge on the entitlement--coupled with our willingness to reform the program--anchored the debate in the middle and led to an important victory: a broad-based, bipartisan commitment to preserving the entitlement.

  Although Medicaid spending appears to have slowed slightly, projected per capita growth rates remain higher than GDP, and analysts believe that spending could shoot up again as states attempt to fill the hole in their budgets left by welfare reform. This could bring a renewed assault on the program. Therefore, we should re-propose our plan to preserve the entitlement but reduce the rate of spending through (1) a cap linking growth in spending per beneficiary to growth in nominal GDP, and (2) more stringent constraints on spending for so-called disproportionate share hospitals.

  It will be difficult to achieve the same level of Medicaid savings that we had in the FY 1997 budget because of reductions in baseline projections, but we can still get substantial savings from a sound policy that builds on last year's proposal. Ignoring Medicaid (viewed as a free program for low-income people) when we are proposing large cuts from Medicare (viewed, in contrast, as a program that middle class people earn the right to participate in) opens us to political attack.

- Allow States to Expand Medicaid: In our first term, we approved 15 statewide Medicaid waivers that were mostly designed to allow states to move Medicaid beneficiaries to managed care (prohibited by Medicaid law, which requires that beneficiaries have

"freedom of choice") and use the savings to cover more uninsured people, usually workers and their families. HHS estimates that more than 2 million Americans gained health coverage through these waivers.

We could build on this progress in a couple of ways: (1) review the waiver process to see if it could be streamlined beyond what we've already done; and/or (2) develop a template, drawing on our experience with the first 15 waiver states, that specifies some waiver designs that could be, in essence, "pre-approved" if they meet certain criteria. The second option would be very bold and I suspect that some in HHS (and probably my own staff at OMB) would object to it. But it offers a tremendous opportunity for the President to work with the states and show his leadership in an area he cares most about--providing health coverage to more Americans.

3. Helping Families Maintain Employer-Sponsored Coverage

- Challenge Congress to Enact Our Workers' Transition Initiative: Our FY 1996 and 1997 balanced budgets proposed a new capped entitlement providing states with funds to subsidize insurance for up to six months for workers and their families who are receiving unemployment compensation and who had employer-sponsored insurance while they were working. While insurance coverage is theoretically available to these people through COBRA, many of them cannot afford it. We estimate that this would cost around $2 billion a year and would assist as many as 3 million Americans. And in an age of job insecurity, it has broad demographic appeal.

  The President should call on Congress to enact this program this year, as the next logical step to the insurance reforms in the Kennedy-Kassebaum legislation.

4. Protect Consumers and Enhance Managed Care Quality

- Challenge Congress to Enact "Anti-Gag" Legislation : One of the most contested bills in the last Congress was the "Patient Right to Know Act," bipartisan legislation that responded to widespread concerns (manifested by cover stories in the newsweeklies) that health plans have been restricting physicians from advising patients about alternative treatments. It appeared that this legislation had a good chance of passing, but the managed care industry managed to slow it down at the last minute by getting the Catholic provider community agitated about possible abortion implications.

  More than fifteen states--including California, Georgia, Indiana, Tennessee, and Pennsylvania--have enacted similar legislation. In the statement issued by the White House following passage of the FY 1997 appropriations bill, we expressed regret that the "anti-gag" legislation was not enacted. The President could challenge Congress in his State of the Union address to enact this legislation.

- Highlight Advisory Commission: Of course, the new Advisory Commission on Consumer Protection and Quality in the Health Care Industry, created by Executive Order, will also be working to develop additional options to address other concerns about quality in managed care. Once it becomes clear where this is headed, we should consider staging hearings around the country to put a spotlight on the Administration's efforts to address consumers' concerns about being protected from the excesses of managed care.

Possible New Initiatives

1. Reverse the Trends in Youth Substance Abuse

- The Problem: Teen Drug Use Is Increasing--According to the Household Survey on Drug Abuse (August 1996), the rate of marijuana use among youths aged 12-17 has more than doubled from 1992-1996, from 3.4% to 8.2% (3.4% was an all-time low). There is also a strong correlation between tobacco use and other substance abuse--youths age 12-17 who smoke are about 8 times as likely to use illicit drugs and 11 times as likely to drink heavily as nonsmoking youths.

  Federal Role Is Unfocused--During the latter part of the campaign, charges that the Administration should be held responsible for the negative trend in youth substance abuse began to stick. While this is somewhat unfair (as General McCaffrey points out, the increase started before we arrived), it is true that things are getting worse on our watch. Further, while the Federal government is spending around $1.6 billion on anti-substance abuse activities (prevention and treatment), we don't have a great deal to show for it, partly because we have failed to adequately measure what the states are doing with the money we're giving them for prevention and treatment, mostly through block grants.

- A Solution: Go After a Clear, Achievable Goal--Goal #1 of our National Drug Control Strategy is to "motivate America's youth to reject illegal drugs and substance abuse." No wonder we haven't gotten beyond this fuzzy rhetoric. The President should articulate a clear objective--e.g., "Reverse the Trend toward Increasing Teen Substance Abuse" (i.e., by 2000, returning to the all-time low of a 3.4% rate of use among youths age 12-17, which would require us to achieve about a 1% reduction each year) and direct the Drug Council, led by General McCaffrey, to implement a strategy to achieve it.

  It will take a comprehensive strategy to make use of HHS' and other Federal resources to achieve this goal. It will require changing the national dialogue about illegal drugs and substance abuse, investing in more basic biomedical research on substance abuse, and targeted prevention and treatment initiatives throughout the agencies of the Public Health Service.

  Some of these efforts have already begun, and just need to be more effectively coordinated and highlighted, including:

- FDA Tobacco Regulation Implementation--History will undoubtedly show that this is the most important thing we did to improve the health of Americans;

- SAMHSA "Synar Rule" Implementation--This rule became final in early 1996, and it requires that states prove that they have reduced the percentage of children who buy cigarettes by about 10% per year or lose SAMHSA funds;

- CDC Tobacco Control Activities--Our FY 1998 budget recommendation will include a substantial increase in these funds, go to states to promote nonsmoking among youth;

- SAMHSA Prevention and Treatment Activities--Our FY 1998 budget recommendation will include funding for SAMHSA to identify and replicate successful community-developed prevention programs and to coordinate a large-scale effectiveness study.

In addition, the initiative would include important new components:

- Aggressive Media Campaign to Change the National Dialogue--The best thing we have going for us is the President's ability to use the bully pulpit. We should stage an aggressive media campaign, led by the President, the Vice President, General McCaffrey, and prominent athletes and celebrities. Among other things, the President could promote corporate responsibility by calling on the major networks to provide more, and more desirable, air time for anti-drug abuse messages. Studies indicate that the frequency of anti-drug messages on television has fallen sharply since the mid-1980's, and also that having these messages appear during prime time is extremely important to their effectiveness.

- Challenge States to Crack Down on Substance Abuse--By the State of the Union, the plan the President requested from General McCaffrey and Secretary Pena to encourage states to make obtaining a driver's license subject to passing a drug test should be completed. The President should also renew his challenge to every state to pass "zero tolerance" laws for teen drinking and driving. Only thirteen states have laws prohibiting anyone under 21 from driving with alcohol in their blood.

  We should also consider whether the President should call on states to lower the legal limit for blood alcohol for drivers to 0.08 from the more common 0.10. There is evidence that in all but one of the states that have undertaken this measure, it has reduced deaths from drunk driving.

  We should also consider whether the President should kick off the initiative by inviting the nation's Governors to a "drug summit" to highlight our partnership with them in combating youth substance abuse and get their "buy-in" on the goal

and our strategy.

- Invest in Research to Develop New Approaches to Substance Abuse Prevention and Treatment--This year, NIH will spend approximately $700 million on research on causes of and treatments for drug abuse. As a result of recent scientific breakthroughs, we have moved closer to a quantum improvement in our ability to understand, prevent, and treat drug abuse. Although there is no guarantee that more research funding will produce specific results, increasing the Federal investment in substance abuse research has the potential to build on recent scientific discoveries and yield promising new ones. Therefore, we should consider devoting an additional $100 million or so to substance abuse prevention and treatment research.

- Consider Increasing the Tobacco Tax to Fund Anti-Substance Abuse Activities--I've suggested that our effort to stop underage smoking is our single most important health care accomplishment. It might be time to reconsider increasing the tobacco tax to fund additional anti-substance abuse activities. In addition to generating needed revenues, such a policy would also deter smoking--indeed, research indicates that a marginal increase in the cost of cigarettes has its greatest impact on teens. Some of the funding from the tobacco tax could be devoted to a subsidy/training program to help tobacco farmers shift to other ways of earning a living.

  Recall that we proposed a slight increase in the tobacco tax (around $.50/pack) in the Health Security Act, producing revenues of around $67 billion over 6 years.

2. Targeted Disease Prevention Initiatives

- Prevention Saves Lives and Saves Money: This is a classic "common ground" initiative that everyone believes and no member of Congress could vote against. Speaker Gingrich has been using this as one of the main themes of his recent speeches.

  I'd recommend that we pick one or two diseases--e.g., breast cancer, prostate cancer, diabetes--and launch a big public awareness campaign to make sure that all Americans are getting appropriate screening for early detection and treatment. There are a number of steps we can take to ensure that beneficiaries of our public health programs--Medicare, Medicaid, Indian Health Service, etc--are taking advantage of these benefits. In addition, we could use the bully pulpit to shame employers and health plans into covering these preventive tests.

  Increased Funding for Screening: We could combine the public awareness campaign with additional funding for states to provide free or low-cost screening to people who aren't covered by Medicare, Medicaid or private insurance. For example, CDC provides funds

to states for breast and cervical cancer screening for low-income or uninsured women. That program has been increased substantially during our Administration and now is available in every state, but it is a formula grant and it does not meet all the need. We're spending around $175 million annually now and another $100 million would go a long way.

3. Require Immunizations as Condition of Federal Program Participation

- Build on Success of Comprehensive Immunizations Initiative: After a rough start, the Administration's immunizations initiative has been a major public health success, producing the highest immunizations levels of two year olds in history. But there are still pockets of children, including children receiving public assistance of some form, who are less likely to receive their immunizations. We've shown that immunizations are a public health priority by devoting more Federal funds to vaccine purchase and infrastructure, but we have not used our most significant leverage by requiring that all children who receive AFDC (now TANF), Food Stamps, WIC, Federal housing assistance, etc., be immunized.

  This idea has bipartisan support and was discussed early in our first term. Although Carol Rasco, Belle Sawhill, and I thought it was a good idea, HHS did not support it at that time. I have had conversations with the Secretary since then that lead me to think she might support the idea now, though she might be inclined to a "carrot" or incentive approach rather than requiring immunizations as a condition of receiving other benefits (i.e., giving mothers who get their kids immunized additional WIC vouchers rather than requiring them to show evidence of immunizations in order to continue participation in the program).

  A number of demonstrations of this concept have been conducted (notably in South Carolina and New York), and have shown that it increases immunization levels. It would also highlight the President's commitment to personal responsibility, consistent with our approach in welfare reform. We should require all states to adopt one of these strategies now. It is not, as some have argued, unfairly coercive: to believe that, you would have to believe that requiring children to be immunized to enter public schools, as all states do, is coercive.

4. Set a Goal of Developing an AIDS Vaccine by the Year 2000

- Vaccine is Possible: For some time now, AIDS researchers have been discouraging talk of an AIDS vaccine as something that could be achieved anytime in the near future. Recent informal discussions with NIH AIDS researchers suggest, however, that there is new optimism about the chances for an AIDS vaccine in the near term (say the next 5 years).

  We're spending approximately $1.5 billion annually on AIDS research at NIH. If there is real hope of developing and testing an AIDS vaccine on the horizon, we should consider a

substantial infusion of new resources devoted to that research, with the President setting forth a national goal of making an AIDS vaccine available to all Americans by the end of the century (or by a date certain that the scientists are willing to embrace as a goal).

All the polling information I've seen suggests that the American people strongly support Federal funding for biomedical research, and that they believe that finding a cure for AIDS should be a top priority..

5. Set a Goal of Providing Health Coverage for All Children

- Reduce Number of Uninsured Children: Of the estimated 40 million Americans who are uninsured, some 10 million are children. Reducing the number of kids who lack health coverage is a goal no one could disagree with; the question is how we get there. The following are some of the ideas on the table; they could be pursued independently or in combination.

  - Provide Subsidies for Kids' Coverage--Congressional Democrats are considering an initiative to provide health insurance subsidies for children up to age 12 whose family income is under 240% of poverty. Our latest estimate is that such an approach would cost around $20 billion over five years; it would cover about 3 million children who are currently uninsured.

    There are some problems with this policy, not least of which is that it may have the perverse effect of encouraging employers to drop dependent coverage. Creating a new entitlement at the same time we are saying that balancing the budget is our top priority is also problematic. If we decide to pursue this proposal, we should consider financing it with an increase in the tobacco tax.

  - Increase Medicaid Coverage: HHS estimates there are about three million children who are eligible for Medicaid coverage but who are not enrolled in the program, and Secretary Shalala has in mind an outreach program to reach and enroll these kids. This is a good idea but will have to be pursued carefully, given that bringing these beneficiaries onto the Medicaid rolls will increase both Federal and state spending.

    States could also be encouraged to speed up the pace at which they are complying with the mandate to cover adolescents below 100% of poverty (under current law, coverage of 18 year olds does not become mandatory until 2002). In order to do this, we would probably need to offer states some financial incentive such as a higher matching rate (FMAP) for the new population.

    States also want--and they should have--the flexibility to provide less

comprehensive benefits packages to children. Some governors have stated that they would gladly expand coverage to more children, but they want the option to design less expensive benefits packages rather than being mandated to offer the full array of current-law Medicaid benefits (organ transplants are often cited as an example of a mandated benefit that deters governors from extending coverage to optional children).

- Increase Funding for Community Health Centers and School-Based Clinics: We spend about $800 million annually on community and migrant health centers, which are supposed to serve primarily uninsured and low-income people. Presumably, a substantial percentage of the 10 million uninsured children live within a reasonable radius of a community health center. We should consider providing incentive grants to community health centers that serve the highest number of these children and/or develop the most innovative strategies to reach them.

Community health centers have a great deal of support in Congress, and usually receive an additional $50 million or so every year. Tying next year's increase to a measurable increase in the number of uninsured children served would be relatively simple.

We should also consider making a bigger investment in elementary school-based clinics (to avoid family planning issues) to provide uninsured children with basic primary care and prevention services. Funding could be provided through one of the education grant programs, with the design of the clinics to be decided on the local level.