NLWJC - Kagan
DPC - Box 004 - Folder 009

Budget Materials - Appropriations Riders 1999: Health

New file

Budget - appropriations riders 1999 - health

Jeffords-Kennedy "Work Incentive" Disability Bill

One of our top priorities in the final negotiations of the Appropriations process has been to work to pass the Jeffords-Kennedy "Work Incentive Improvement Act of 1998." This legislation enables people with disabilities to go back to work by helping provide an option to buy into Medicaid and Medicare, as well as other pro-work initiatives. CBO estimates this bill costs about $250 million a year when fully implemented (for a five year cost of $1.2 billion.) The costs of this bill are offset by savings that were included in our 55-65 Medicare buy-in proposal.

Democrats on the authorizing and appropriations committees are supportive of the Jeffords/Kennedy bill. In addition, Senator Jeffords' office informs us that Republican support for this bill is quite impressive as well. (Senator Lott's office has also quietly indicated interest as well.) The Republican authorizers (Roth of Senate Finance; Bliley of House Commerce) are reportedly opposing moving this bill this year. Roth apparently does not object to the policy, but has concerns about the offsets. Bliley is feeling "jammed" by a bill that never went through his Committee. It is important to note that the Administration (and the disability community) does not support passage of the House version of this bill (Bunning-Kennelly) this year unless the critical health care buy-in proposals in Jeffords-Kennedy are added on to this otherwise similar legislation.

Talking Points

- We all want to provide work incentives for anyone willing and able to work. The Jeffords-Kennedy legislation does just that by helping to remove one of the primary barriers for people with disabilities to go to work -- the fear of losing health insurance. We believe the bipartisan support this bill has received reflects how non-partisan this issue really is.

- This initiative allows people with disabilities to buy into the Medicaid and Medicare programs, helping people with disabilities to keep their health insurance when they return to work. It also includes the so-called "ticket" proposal that enables people to get public or private vocational rehabilitation, which was included in the Bunning-Kennelly bill.

- This bill is hardly radical or new. The new health provisions are all of 20 pages long. The Senate bill is simply the companion legislation to the Bunning-Kennelly bill. The major difference in the two bills, the Medicaid buy-in, simply builds on an initiative, which received bipartisan support, that was included in last year's BBA.

- The Senate bill simply improves on the BBA provision by giving more financial incentives and flexibility for states to take advantage of this <u>option</u>. It is not a mandate; states can limit costs; and it helps people work. This helps why it is so attractive to Republicans like Senator Dole, as well as Senators Grassley, Bond, McCain, DeWine, Snowe, Collins, and Specter.

- This is a priority to the disability community and to us. Let's work to get this "back-to-work" provision done.

Staff Contact: Chris J./6-5560

BACKGROUND

The disability community is extremely excited about the prospects of passing the Jeffords-Kennedy "Work Incentive Improvement Act of 1998," which the President endorsed in July and the Administration has been working on since this past spring. (You will recall your meeting with Tony Coehlo and Alexis Herman earlier this year on this subject in preparation for the President's meeting with the disability community.) The disability groups are hoping that it could be added to the omnibus budget bill prior to adjournment and are pressing us to be supportive. DPC, NEC, and OMB believe this is a very strong bill and merits making it one of our priorities. If it does not make it into the final bill, however, it is essential that it is clear that its omission was due to Republican opposition and not our lack of support.

Summary of Jeffords-Kennedy "Work Incentive" Disability Bill. This bill provides people with disabilities the ability to buy into the Medicaid and Medicare programs. Because the lack of health insurance is the number one barrier cited by disability community to return to work, this option is extremely important. This bill also provides for a so-called "ticket" to allow for public or private vocational rehabilitation. The disability groups cite this legislation as potentially the most significant initiative since the enactment of the Americans with Disabilities Act (ADA).

Cost Estimate and Offsets. CBO estimates this bill costs $77 million in FY 99 and about $250 million a year when fully implemented (for a five year cost of $1.2 billion.) We have proposed that the Congress use the Medicare savings offsets we originally dedicated to the 55-65 Medicare buy-in proposal, which clearly is not going anywhere this year. The offsets include a reduction in mark-ups that physicians bill Medicare for certain drugs, stronger enforcement of a provision requiring Medicare to be the secondary payer for beneficiaries who have private coverage, an expansion of a Medicare reform demo that contracts out with specific "Centers of Excellence" to provide certain services, and two Social Security Administration fraud and abuse provisions.

Hill Support. Democrats on the authorizing (Moynihan and Dingell) and appropriations committees are supportive of the Jeffords/Kennedy bill. We are informed that Senator Byrd, Senator Harkin, and Congressman Obey are carrying this bill on their priorities list. Senators Jeffords' staff has informed us that a number of Republicans (Grassley, Bond, McCain, DeWine, Snowe, Collins, and Specter) are supporting this proposal. Senator reportedly supports the policy, but has suggested that some of his Finance Committee Members might have problems with the offsets. The House Republican authorizers are apparently much more problematic, saying that they feel that they are being "jammed" with a policy that they never had an opportunity to review.

Politics. The House counterpart to the Work Incentive Improvement Act is H.R. 3433, a bill introduced by Representatives' Bunning and Kennelly. However, H.R. 3433 does not include the Medicaid/Medicare buy-in proposals. Although the disability community supports the provisions in H.R. 3433, they are opposing its passage this year UNLESS the Jeffords/Kennedy health add-ons are included. This should strengthen our hand to oppose Bunning/Kennelly UNLESS we get the health provisions we and the Democrats are seeking.

Bunning-Kennelly Background and Talking Points

The Bunning-Kennelly work incentives legislation is a positive bill, which the Administration explicitly supported when it passed the House. It provides people with disabilities a "ticket" to purchase publicly or privately-provided vocational services that help these Americans return to work. It does not address the barrier most often cited by people with disabilities as the reason they do not return to work -- the fear of losing desperately needed and affordable health insurance. The Jeffords-Kennedy bill, the companion to Bunning-Kennelly, was designed to respond to this shortcoming, while including all of the provisions included in the House bill.

While we support the provisions in Bunning-Kennelly, we are taking the position that it would be imprudent to pass and enact this legislation in the absence of also including the Jeffords-Kennedy provisions. We agree with the disability community -- see attached letters -- that picking off individual provisions has the potential to raise false expectations. Moreover, the absence of support from the community for passing Bunning-Kennelly as a stand-alone raises questions about the political viability of supporting such legislation at this time -- for either party.

Talking Points.

- We believe the Bunning-Kennelly legislation includes some important provisions that we continue to support. However, in the absence of the important health provisions included in the Jeffords-Kennedy bill, we believe it has the potential to raise false expectations and give the impression that we are removing the most important work barrier -- health care.

- We have taken this position only after careful consultation with the disability community. They have indicated quite strongly that the Bunning-Kennelly bill as a stand alone is not acceptable because "the 'ticket' alone, without health care... will result in a broken promise to Americans with disabilities."

- We believe this situation can be easily rectified by including the health provisions of the Jeffords-Kennedy bill. This bill is hardly radical or new. The new health provisions are all of 20 pages long. The Senate bill is simply the companion legislation to the Bunning-Kennelly bill. The major difference in the two bills, the Medicaid buy-in, simply builds on an initiative, which received bipartisan support, that was included in last year's BBA.

- The Senate bill simply improves on the BBA provision by giving more financial incentives and flexibility for states to take advantage of this <u>option</u>. It is not a mandate; states can limit costs; and it helps people work. This helps why it is so attractive to Republicans like Senator Dole, as well as Senators Grassley, Bond, McCain, DeWine, Snowe, Collins, and Specter.

- This is a priority to the disability community and to us. Let's work to get this "back-to-work" provision done.

Staff Contact: Chris J./6-5560

CONSORTIUM FOR CITIZENS WITH DISABILITIES

October 9, 1998

President William Jefferson Clinton
The White House
Washington, DC 20505

Dear President Clinton:

The undersigned national organizations of the Consortium for Citizens with Disabilities, along with the undersigned affiliated organizations, strongly urge you to locate sources of money that can be used as offsets in order to enact this year the *Work Incentives Improvement Act of 1998* as a substitute for H.R. 3433, the *Ticket to Work and Self-Sufficiency Act of 1998* which passed the House 410-1 in June.

The disability community extends its thanks to you and your domestic policy staff for the magnificent efforts made on our behalf that have made it possible to include vitally needed health care coverage with the return to work ticket legislation passed by the House. The *Work Incentives Improvement Act of 1998* extends the work begun by the House when it passed H.R. 3433, the Bunning/Kennelly "Ticket to Work and Self-Sufficiency Act". All of the provisions in H.R. 3433 were incorporated, some with modifications, into the Senate substitute bill. However, the Senate bill covers some of the issues raised in the House Committee Report but not addressed in the House bill.

The Senate bill incorporates critically important provisions which would extend health care coverage for SSI and SSDI beneficiaries who return to work. During the hearing conducted by the House Ways and Means Committee, extended health care coverage was identified as the number one barrier to employment for SSI and SSDI beneficiaries who want to work but are unable to affordable health care. Today, 7.5 million Americans with disabilities depend on assistance from the Social Security Administration. GAO has estimated that if 75,000 of these individuals, just one percent, become successfully employed, the savings in cash assistance alone could reach as high as $3.5 billion.

The current work incentives programs do not adequately remove barriers to work. Numerous studies and personal interviews of individuals with disabilities who want to work consistently report that barriers to employment include the loss of health coverage, the complexity of the work incentives, and the lack of choice in employment service providers. They also consistently say that all of these problems must be solved in order for them to work. The *Work Incentives Improvement Act of 1998* incorporates all of these solutions through the ticket to work, the work incentives planners, a strong advisory committee, protection and advocacy services, an extension of premium-free Medicare, and a state option in Medicaid that supports working people with disabilities.

People with disabilities do want to work and reduce their dependency on cash assistance. They need both the *ticket to work* AND *health care provisions* in order to work. The ticket alone, without health care, work incentives planners, protection and advocacy, and a strong advisory committee will result in a broken promise to Americans with disabilities, a failure in the design of state of the art public policy, and will fall far short of the goal of assisting people with disabilities to work. This bill is good public policy and must be enacted this year! We will not, however, be able to support the Ticket without the health care and work incentives provisions in the Jeffords/Kennedy legislation.

Sincerely, (See reverse side for signatories)

Marty Ford	Tony Young	Paul Seifert	Michael Losow
Marty Ford	Tony Young	Paul Seifert	Michael Losow
The Arc of the US	UCP	IAPSRS	NISH

Co-Chairs, CCD Task Force on Social Security

Signatory Organizations

American Counseling Association
American Association of University Affiliated Programs
Alliance for Rehabilitation Counseling (NRCA/ARCA)
American Network of Community Options and Resources
Association of Persons in Supported Employment
Autism Society of America
Bazelon Center For Mental Health Law
Bethpage
Center on Disability and Health
Council for Exceptional Children
Consortium of Developmental Disabilities Councils
Goodwill Industries International, Inc.
Disability Rights Education & Defense Fund
Easter Seals
Epilepsy Foundation of America
International Association of Psychosocial Rehabilitation Services
Inter-National Association of Business, Industry, and Rehabilitation
Learning Disabilities Association of America
National Alliance for the Mentally Ill
National Association of the Deaf
National Association of Developmental Disabilities Councils
National Association of People with Aids
National Association of Protection and Advocacy Systems
National Association of State Directors of Developmental Disabilities Services
National Association of State Mental Health Program Directors
National Council for Community Behavioral Healthcare
National Mental Health Association
National Parent Network on Disabilities
National Rehabilitation Counseling Association
NISH (formerly National Industries for the Severely Handicapped)
The Arc of the United States
Paralyzed Veterans of America
United Cerebral Palsy Associations
World Institute on Disability

Other signatory organizations:

AIDS Action
AIDS Legal Referral Panel
American Association for World Health
American Friends Service Committee

American Nurses Association
Association of Nurses in AIDS Care
Center for Women Policy Studies
Cities Advocating Emergency AIDS Relief
Coalition for the Homeless
Committee for Children
Human Rights Campaign
Legal Action Center
National Association of Public Hospitals and Health Systems
National Gay and Lesbian Task Force
National Health law Program
National Native American AIDS Prevention Center
National Rural Health Association
Oncology Nursing Society
Project Inform
Therapeutic Communities of America
United Jewish Appeal Federation of New York
Women's AIDS Network

National Parent Network on Disabilities, Inc.
1130 17th Street N.W., Suite 400
Washington, D.C. 20036
Phone: 202.463.2299
Fax: 202.463.9403

President Bill Clinton
White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton,

The National Parent Network on Disabilities (NPND) is a national organization committed to serving parents and family members of the over 5.5 million children with special needs and disabilities. We provide information on ALL disabilities and services to families in every state and U.S. Territory.

Mr. President we would like to thank you for the work your Administration has put forth to ensure that individuals with disabilities will have health care when the enter the work force. Your support has been recognized by NPND and many other family organizations.

NPND, and our members, have worked very hard on the bipartisan Work Incentive Improvement Act of 1998. Parents work too hard for their children to allow job opportunities to not be a reality for them as adults. We will not, however, be able to support the "ticket" without the health care and work incentive provisions in the Kennedy / Jeffords substitute legislation.

Please continue to support this important legislation, in its entirety, for individuals with disabilities want the opportunity to exercise their right to work.

Sincerely,
Patricia M. Smith

Patricia M. Smith
Executive Director,
National Parent Network on Disabilities, Inc.

National Council on Independent Living
1916 Wilson Blvd., Suite 209
Arlington, VA 22201
Voice (703) 525-3406
TTY (703) 525-4153
FAX (703) 525-3409
E-Mail ncil@tsbbs08.tnet.com

Executive Director
Anne-Marie Hughey

October 9, 1998

President Bill Clinton
White House
Washington, D.C.

Dear President Clinton:

On behalf of the individuals with disabilities and centers for independent living that make up the National Council on Independent Living, we want to thank you for your continuing efforts to increase the numbers of people with disabilities who start, or return to, work.

Most recently those efforts include your creation of the Task Force on the Employment of People with Disabilities and your proclamation that October is National Disability Employment Awareness Month. In addition, we also want to thank your staff, Chris Jennings and Jeanne Lambrew, who have spent many hours working with us in the last few months on the Work Incentives Improvement Act (S. 1858), introduced by Senators Jim Jeffords and Ted Kennedy.

Tonight S. 1858 is in trouble. Many of the cost offsets that were part of the bill are now gone, attached to another bill, with no replacement "pay-fors" in sight. In addition, there are efforts to kill this bill and instead pass H.R. 3433, The Ticket to Work and Self-Sufficiency Act, as introduced by Representative Jim Bunning and Barbara Kennelly.

NCIL strongly supported H.R. 3433 when it was introduced. It is, in many ways, a good bill. But the Senate took this good bill and made it even better. S. 1858 adds provisions to the ticket to work that continue health care coverage when a person with a disability starts, or returns to, work. Many of us are unable to go to work because if we do we will lose our Medicaid and Medicare. And that is a risk we cannot take. Our very lives depend on the prescriptions, the personal assistance, the assistive technology, the therapy, and the medical care we receive through our health care coverage.

The Work Incentives Improvement Act includes all of the House ticket to work provisions, and then builds on them. It responds to what our members have been telling Congress and the Administration for the last two years: You have to address the barriers to employment in a way that is comprehensive. The barriers are interrelated. They do not fall into tidy categories based on congressional committee jurisdiction. If I can choose the employment services provider that I want, but know that I will lose my health insurance if I go back to work, and know that I will not be able to earn enough to pay my personal assistant, my prescription costs, and my doctor, what difference does this choice make? The ticket works only if the health care barriers I face are also addressed.

We need health care coverage when we go to work, we need a real choice of providers, we need to have some say in the work incentives rules that affect our lives, and we need assistance navigating the complex maze of rules that are intended to help us but often stand in our way. And we need to begin to find a way to gradually get off benefits as our work earnings increase, not fall off the current "cash cliff" back into poverty. S. 1858 does all those things.

We urgently need your help. Help us find the new cost offsets this bill now needs, and help us convince this Congress that S. 1858, with both the ticket to work and health care provisions, is a bill they must pass. **Together** health care and increased choice through the ticket to work can ensure that our efforts to start, and return to, work will be successful. And that's good for our lives, our communities, and for this country's economy. Please work with us to get this bill passed before Congress adjourns -- then we can truly celebrate October as National Disability Employment Awareness Month.

Sincerely,

Paul Spooner
Vice-President

cc: Erskine Bowles, Chief of Staff to the President
Bruce Reed, Assistant to the President for Domestic Policy
Chris Jennings, Deputy Assistant for Health Policy Development
Jeanne Lambrew, Senior Health Policy Analyst
Jonathan Young, White House Office of Public Liaison

Assisted Suicide -- Priority of Senator Nickles and Congressman Hyde

The Republican Leadership has indicated that it may push for a version of the Nickles' assisted suicide legislation (S. 2151, the Lethal Drug Abuse Prevention Act), which would direct the Drug Enforcement Agency (DEA) to use the Controlled Substances Act (CSA) to apply penalties to physicians who used pain killer medications to assist in a suicide. This legislation was drafted to, in effect, preempt an Oregon state law that permits assisted suicide. Although (like the President), Senator Wyden opposes assisted suicide, he STRONGLY opposes any use of Federal law to preempt a law supported via referendum by the citizens of Oregon.

Because of the serious concerns medical groups like the AMA (who also oppose assisted suicide) have about the likely intimidating impact S. 2151 could have on physicians prescribing pain management medications for terminally ill patients, the AMA, the American Nurses Association, the American College of Physicians and numerous other national health care organizations strongly oppose the Nickles/Hatch/Hyde bill. They believe such legislation would exacerbate a long-documented problem of physicians under prescribing pain medications for the appropriate management of terminally ill patients. While we have repeatedly underscored the President's longstanding position against assisted suicide and our willingness to work on this legislation in the future (see attached letter to Judiciary Chairman Hatch), we have advised the Committee that their current bill is flawed and premature because it does not adequately address health care professionals' legitimate concerns in this area.

Senator Nickles' may be pushing for an alternative to his original bill or his most recent amendment, which attempted to codify a DEA letter on this issue that indicated DEA had the authority to this under current law -- a position which DoJ subsequently rejected. The latest rumor is that he has an alternative that DPC, White House Counsel, and DoJ has never seen. Altering our position on this issue would be vehemently attacked by Senator Wyden, the health care interest groups we have worked with for years, and the media elite who have consistently chastised the Nickles' approach.

Suggested Talking Points:

- As you know, the President strongly opposes assisted suicide. He reiterated this position when he signed the Assisted Suicide Funding Restriction Act just last year.

- However, as the Justice Department made clear in a letter to the Senate Judiciary Committee less than a month ago, we cannot support the Nickles/Hatch/Hyde bill -- or something that resembles it -- because we believe it has great potential to exacerbate the current problem of under prescribing pain medications designed to <u>appropriately</u> alleviate the suffering of the terminally ill.

- Our opposition to this bill is shared by many respected national health organizations, many of which also oppose assisted suicide, including the AMA, the Nurses Association, the American College of Physicians and numerous other national health care groups.

- As we have repeatedly said, we are willing to spend the time necessary to determine if appropriate legislation or other interventions can be designed. But this is the wrong policy, on the wrong vehicle, at the wrong time.

• Staff Contact: Chris J./6-5560

U.S. Department of Justice
Office of Legislative Affairs

Office of the Assistant Attorney General
Washington, D.C. 20530

September 16, 1998

The Honorable Orrin G. Hatch
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510-6275

Dear Mr. Chairman:

We are responding to your letter of September 9, 1998, to Mr. Joseph Onek, Principal Deputy Associate Attorney General, regarding S. 2151, the "Lethal Drug Abuse Prevention Act of 1998." We regret the delay in responding.

The President is committed to working with you, Senator Leahy, and Members on and off the Judiciary Committee to help develop approaches to curtail assisted suicide. As you know, this position is consistent with his longstanding opposition to assisted suicide and his support for the Assisted Suicide Funding Restriction Act last year. As such, he has requested that the Justice Department and the Department of Health and Human Services work collaboratively with you and other Members of Congress on this issue.

The President, however, is concerned that S. 2151 will have unintended adverse consequences, which cannot adequately be remedied in the limited time remaining in this Congress. The negative impact S. 2151 could have on the provision of pain relief medications for our nation's terminally ill is of particular concern to the Administration, as it is to virtually every major medical organization in the nation. These organizations share the President's abhorrence and opposition to assisted suicide, but, with very few exceptions, oppose the Lethal Drug Abuse Prevention Act.

There is broad consensus that the American medical system does a poor job of providing palliative care to terminally ill patients and, in particular, that it fails to provide effective pain management. As a result, many patients unnecessarily suffer excruciating pain and some patients – in pain or fearing future pain -- seriously consider suicide (physician assisted or otherwise).

Health care experts in this field strongly believe that S. 2151 exacerbates this problem. The legislation authorizes the DEA to impose serious civil penalties against physicians who dispense controlled substances to assist a patient suicide. The legislation may also authorize the imposition of criminal penalties on such physicians. Virtually all potent pain medications are controlled substances. Thus, physicians who dispense these medications to ease the pain of terminally ill patients could well fear that they could be the subject of a DEA investigation whenever a patient's death can be linked to the use of a controlled substance.

The Lethal Drug Abuse Prevention Act is designed to address physicians' fears by prohibiting sanctions as long as physicians do not dispense the controlled substance with the intent of causing death. However, the issue of intent would not necessarily be resolved simply by asking physicians about their intent. To establish intent, the DEA might also need to investigate the details of the physician's prescribing practices and of the physician's relationships with the patient and the patient's family.

It is precisely the fear of a DEA investigation that creates the potential to inhibit physicians from providing adequate pain medication to terminally ill patients. In response, physicians may undermedicate patients, patients may suffer unnecessary pain and, as a result of increased incidence of great pain amongst the terminally ill, patient suicides – physician assisted or not – may increase. Such an outcome would be far more than ironic; it would be tragic. Understanding this, the American Medical Association, the American Nurses Association, the National Hospice Organization and many other respected national health organizations strongly oppose S. 2151.

We believe that the better way to avoid assisted suicides is to develop consensus guidelines on the appropriate use of controlled substances for terminally ill patients. Such guidelines would be designed to be sufficiently clear that a physician who followed them would be free from any fear of sanctions. The board charged with developing these guidelines would have representatives of doctors, nurses, consumers, theologians, ethicists, and law enforcement officials and would report back to the Congress and the Administration in a specified period of time. The board also could provide recommendations on the most appropriate entity to enforce these guidelines, as well as the authority and responsibility such an entity should have.

Clearly, any board charged with developing guidelines for this area should be carefully chosen. If we pursued this approach, we would want to determine a mutually acceptable appointment process. If you find this advisory board concept acceptable, which would be one way of coming closer to a consensus approach, we would be pleased to work with you to establish -- through legislation or, if legal and appropriate, by Executive Action -- any such entity.

The Administration believes that working together we can develop an appropriate way to address this important issue. We look forward to working with you in the future. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's program to the presentation of this report. If we may be of additional assistance, we trust that you will not hesitate to call upon us.

Sincerely,

L. Anthony

L. Anthony Sutin
Acting Assistant Attorney General

cc: The Honorable Patrick J. Leahy
Ranking Minority Member

ORGAN DONATION

Subcommittee: Labor/HHS/Education

Ranking: High X Medium ___ Low ___

1999 Budget Policy: Organ donation was not addressed in the *Budget's* appropriations language since these organ donation policy issues were addressed in regulations.

Latest House Action: Section 213 of the House-committee-passed bill includes new language that would suspend or prevent enforcement of two HHS rules pertaining to organ donation:

(1). An August 1998 Health Care Financing Administration (HCFA) rule that seeks to expand the number of organs available for donation through more vigorous recruitment efforts; and

(2). A March 1998 Health Resources and Services Administration (HRSA) rule that would require the national organ transplant network to develop policies that would allocate organs based on patient's medical need, not their geographic location. ✓

Latest Senate Action: The Senate committee report mentions the debate regarding the appropriate method of distribution for scarce organs, but the bill does not do anything in appropriations language. Rather, the committee suggests that a "concerted effort" to increase the availability of organs from potential donors be undertaken. This effort includes funds to be used for education of the public and health professionals about organ donations and transplants, and to support agency staff providing clearinghouse and technical assistance functions. **Senators Lott, Hollings, and Torricelli have voiced opposition to the HRSA rule, which indicates possible legislative action will occur when the bill comes to the Senate floor.**

Overall: **The HCFA rule is non-controversial, but roughly 60% to 70% of congressional members oppose the HRSA regulation. Rep. Livingston and Rep. Obey have been most vocal in their opposition. We are attempting to forge a compromise, but both sides are deeply wedded to their convictions. The debate over the reg is a money/constituency issue, rather than a political issue.**

Solution/Options: The Secretary strongly opposes the House's new language. **Strike the language that postpones the effective date of the rule.**

Justification: The House Floor SAP objected to both provisions, based on the following:

(1). The HCFA rule: The HCFA rule requires that hospitals report all deaths to area Organ Procurement Organizations (OPOs) which will determine whether the patient is a good candidate for organ donation and will advise the patient's family on the possibility of organ donation. Recent research indicates that organ donations increase when hospitals are required to report all deaths and when non-hospital staff advise the patient's family.

(2). The HRSA rule: Despite technological advances in preserving organs, the system for allocating scarce organs remains weighted to local allocation, instead of broader regional or national allocation according to medical need. A patient who is less ill in one geographic area with a short waiting list may get a matching organ before a patient whose condition is more medically urgent in another area with a longer waiting time. Patients should have an equal chance to receive an organ based on their medical need, not the accident of geography.

FY 1998 Appropriations Action: N/A

Prepared By/Date: Jen Forshey (5-7788), Jonathan Blum (5-7844), 10/1/98

Remember conversation about OMB idea to reward states that do a great job of harvesting organs.

NEEDLE EXCHANGE

Subcommittee: Labor/HHS/Education

Ranking: High ___ Medium X Low ___

1999 Budget Policy: FY 1999 Budget language proposes returning to the FY 1997 and previous years' enacted language that allows for the Federal funding of needle exchange programs if the HHS Secretary certifies that such programs are effective at preventing the spread of HIV without encouraging the use of illegal drugs. Current law is similar, but it also stipulates that such a certification may be made by the Secretary only after March 31, 1998, and that such a program must be operated in accordance with criteria established by the Secretary.

In April of this year, Secretary Shalala endorsed needle exchanges as being effective at preventing HIV transmission without encouraging illegal drug use. This led to a politically-charged debate among Administration officials (including the drug and AIDS czars) which ultimately led the Administration to allow local communities choosing to implement needle exchange programs to use their own dollars to fund them.

Latest House Action: **Section 5 of** ~~T~~the House Committee bill includes language which flatly prohibits the use of any Federal funds for needle exchange programs.

Latest Senate Action: The Senate Committee bill includes language similar to current law, but does not specify a date after which the following two conditions would apply: 1) the Secretary must certify the effectiveness of needle exchange programs, and 2) that such programs are operated in accordance with criteria established by the Secretary.

Solution/Options: Repeat the language from the FY 1999 President's Budget. The Senate Committee language would also be an acceptable alternative to the House language.

Justification: The SAP states a preference for language similar to that in the FY 1999 President's Budget, which does not include an outright ban on Federal funding for needle exchange, but rather, allows for the discretion of the HHS Secretary in instituting a needle exchange program.

FY 1998 Appropriations Action: Similar objectionable language was included in the House-passed version of the FY 1998 bill, while the Senate version of the bill included the same language as appears in the FY 1999 Budget. As described above, the enacted bill stipulated that Federal funding could be used for needle exchange after March 31, 1998, only if certified by the Secretary as being successful at preventing the spread of HIV without encouraging the use of illegal drugs.

NEEDLE EXCHANGE

Subcommittee: District of Columbia

Ranking: High X Medium ___ Low ___

1999 Budget Policy: FY 1999 Budget language in the Labor/HHS bill would make the use of Federal funds for needle exchange conditional upon the certification of the Secretary of Health and Human Services that needle exchange programs are effective at preventing the spread of HIV without encouraging the use of illegal drugs. Current law is similar, except that it stipulates that such a certification could be made by the Secretary only after March 31, 1998. Although the Secretary actually endorsed the programs in April 1998, the Administration decided to allow local communities choosing to implement needle exchange programs to use their own dollars to fund them.

Latest Conference Action: Preliminary conference bill contains this objectionable language **(Section 168).**

Latest House Action: **Section 152 of** The House bill **(H.R. 4380)** includes language which prohibits the use of Federal and local funds for needle exchange programs in the District and which would prohibit any individual or entity that receives Federal or local funds from supporting needle exchange programs (even if the funds used for the needle exchange programs are their own).

Latest Senate Action: The Senate bill contains no similar provision.

Solution/Options: Remove the objectionable House language. **Or substitute language would only prohibit the use of Federal funds to support needle exchange programs.**

or certif?

Justification: The Administration objects to this provision as an unwarranted intrusion into local affairs. It is also inconsistent with current law nationwide and Administration policy on this issue. The House SAP explained that if such language were included in the bill presented to the President, his senior advisers would recommend that the President veto the bill.

FY 1998 Appropriations Action: No such language was included in last year's bill, although the enacted Labor/HHS bill stipulated that Federal funding could be used for needle exchange after March 31, 1998, only if certified by the Secretary as being successful at preventing the spread of HIV without encouraging the use of illegal drugs.

VIAGRA MEDICAID REIMBURSEMENT

Now Out

Subcommittee: Labor/HHS/Education

Ranking: High ___ Medium _X_ Low ___

ISSUE RESOLVED. Per 10/6/98 nightly appropriations report: "During discussions this evening, the conferees agreed to drop several objectionable language issues, including ... the House Viagra language."

1999 Budget Policy: No explicit assumptions. The FDA approved Viagra in March and HCFA clarified in July that the drug was required to be covered by States in Medicaid for its medically accepted indications.

Latest House Action: An amendment to the Committee bill includes language prohibiting HCFA from paying for a specific pharmaceutical agent -- Viagra -- under Medicaid, except for post-surgical treatment. A related amendment also prohibits HCFA from taking action against States that do not cover Viagra in Medicaid. The Statement of Administration Policy on the Labor/HHS bill opposed the amendments. CBO would score BA and outlay savings of $40 million from the proposal, but OMB, based on BRD, OGC staff, and RMO review, would score no savings because the Budget included no specific assumptions about Viagra in the baseline.

Latest Senate Action: The Senate Committee bill does not include this provision.

Solution/Options: Remove the language from the House bill. Other compromises are possible. The Secretary could evaluate Viagra prescription and use practices and report to Congress in one or two years on whether the drug is utilized appropriately. Based on the report, Congress could then decide whether to place Viagra on the list of drugs that are excluded or restricted from coverage in Medicaid.

Justification:

- We oppose the use of the appropriations process to make selective drug coverage determinations and judgments regarding how best to treat specific medical problems.

- The amendment sets a dangerous precedent for the selective choosing of drugs that can be covered by Medicaid. For instance, States may try to extend such language to exclude coverage of protease inhibitors for AIDS treatment. Many States were initially hesitant to cover this drug because of its costs.

- The provision is unnecessary because the Secretary already has the authority to limit coverage for pharmaceutical agents if they are prescribed inappropriately.

  - In fact, HCFA is acting to rigorously monitor the use of Viagra already. To ensure appropriate coverage, HCFA is working with States to review Viagra usage patterns and assure consistent data collection to determine if the drug is being clinically abused or inappropriately used. If such evidence is found, the Secretary can place Viagra on the list of allowable exclusions or restrictions.

- In addition, States already have broad latitude to limit the use of drugs under Federal law though drug utilization review and prior authorization programs. HCFA will shortly issue a letter to States strongly urging them to take measures to prevent abuse and misuse of

Viagra and to ensure appropriate use and cost efficiencies.

FY 1998 Appropriations Action: There was no appropriations action on this issue in FY98 (Viagra was approved by the FDA several months after the enactment of FY98 appropriations).

Prepared By/Date: Jeff Farkas (x5-7756), 10/6/98, L_VIAGR2.WPD

Call CJ if comes up

MEDICARE HOME HEALTH INTERIM PAYMENT SYSTEM -- NEW ISSUE

we need to act supportive of something

Subcommittee: Senate Finance; House Ways & Means; House Commerce (Possible amendment to an appropriations bill)

Ranking: High _X_ Medium ____ Low ____

1999 Budget Policy: The Balanced Budget Act of 1997 (BBA) implements a prospective payment system (PPS) for Medicare home health, beginning in FY 2000. Prior to the implementation of PPS, the BBA modified the existing payment methodology for home health (the "interim payment system," or IPS) -- i.e., the per visit cost limits were reduced from 112 percent of the mean to 105 percent of the median, and a new, average annual per-beneficiary limit (a blend of agency-specific and regional data) was added. The BBA did not cap the number of visits an agency can provide, nor did it limit the number beneficiaries an agency may treat.

The home health industry has raised concerns that the IPS has caused some home health agencies to close and has decreased access to home care for beneficiaries with high cost needs. The industry argues that they were hard hit by the BBA (CBO estimated five-year savings of $16.2 billion from home health) and that spending growth has slowed dramatically. As a result of these concerns, there has been strong interest among members of Congress to revise the IPS in light of the fact that HCFA will not be able to implement PPS on schedule (due to the Year 2000 problem).

Congress (particularly the House) appears to prefer to add money to the IPS, rather than create clear winners and losers by re-allocating existing funds in a budget-neutral manner. To offset the costs of any proposal, Congress would either have to spend part of the surplus or reduce spending in another area (potentially from other Medicare providers or the beneficiaries).

Latest House Action: The Ways & Means Committee has reported out a bill that would revise the IPS by increasing the per visit limits to 108 percent of the national median and by changing the blend used to calculate the per beneficiary limits. CBO estimates this proposal would cost ~~$1.4~~ **1.3** billion over five years. No offsets have been proposed. Instead, Chairman Archer referred the bill to the Commerce Committee (which shares jurisdiction over home health) and stated that Commerce and Ways & Means staff should work together to develop acceptable offsets.

Latest Senate Action: None to date.

Solution/Options: The Administration has stated that it is committed to working with the Congress on any proposal that has bipartisan support, is budget-neutral (or offset by specifically defined provisions), protects vulnerable beneficiaries and is administratively feasible. Note: proposals used to offset the costs of a change to the IPS cannot be used for other Administration priorities or appropriations bills.

HCFA has indicated that they could implement the Ways & Means-passed bill.

Justification:

- Any change in the IPS has the potential to be very expensive and should be offset.
- This proposal would set a poor precedent by inviting other Medicare providers who are unhappy with their post-BBA payment rates to request an increase in their Medicare payments.
- Prior to the BBA, home health had been one of the fastest growing Medicare benefits. In 1990, Medicare spent $4.7 billion (or about 3 percent of all Medicare payments) on home health care. By 1997, home health payments had grown to $17.2 billion (or about 9 percent of all Medicare expenditures). The GAO and HHS IG have also found increasing evidence of waste, fraud and abuse within the home health benefit.
- In a recent study, the GAO concluded that home health agency closures and the recent slowdown in home health spending could not necessarily be attributed to the IPS.

FY 1998 Appropriations Action: N/A.

Prepared By/Date: Caroline Davis (5-7842), 10/7/98, L_MHHIPS.WPD

Jonathan Blum

10/06/98 07:04:02 PM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP@EOP

cc: Barry T. Clendenin/OMB/EOP@EOP, Mark E. Miller/OMB/EOP@EOP, Caroline B. Davis/OMB/EOP@EOP, Gina C. Mooers/OMB/EOP@EOP

Subject: Home Health IPS--Current State of Play

One more point to note:

If introduced, Treasury policy officials would "vigorously" oppose the Roth IRA tax offset. The current income limit of $100,000 was negotiated during the BBA. The provision would be interpreted by Treasury as breaking a BBA-negotiated deal between the Administration and the Congress. They would also oppose the provision on the grounds that it would shift taxes away from upper-income individuals.

---------------------- Forwarded by Jonathan Blum/OMB/EOP on 10/06/98 06:59 PM ---------------------------

Jonathan Blum

10/06/98 04:06:07 PM

Record Type: Record

To: Daniel N. Mendelson/OMB/EOP@EOP

cc: Barry T. Clendenin/OMB/EOP@EOP, Mark E. Miller/OMB/EOP@EOP, Caroline B. Davis/OMB/EOP@EOP, Gina C. Mooers/OMB/EOP@EOP

Subject: Home Health IPS--Current State of Play

We have heard that House W&M and House Commerce Committees may have reached agreement to introduce an IPS reform bill as an amendment to the Omnibus Appropriations bill or to a possible continuing resolution. This email summarizes what we have heard so far. Please let us know if you have any questions or would like any additional information.

Tentative Agreement. Last night, W&M and Commerce Committee reached a tentative agreement on an IPS bill to include in Omnibus Appropriations bill or in a possible continuing resolution.. The bill would be possibly modeled on the Thomas bill that cleared the W&M Committee except additional funds would be given to home health agencies in the South. It is also possible, that a Medicare Subvention bill would be included as well. Minority staff described the agreement as "shaky" and may collapse if the Administration were to oppose the amendment. During off-line conversations, minority staff stated that if the Administration were to reiterate its commitment to a budget-neutral IPS solution the W&M/Commerce deal would fall apart.

Scoring and Offset. The bill is likely to have a five-year cost of $1.5 billion. To pay for the bill, the Committees would like to use a tax-increasing provision that is described as closing a loop-hole in the Roth IRA tax provision. Currently, IRA holders below a certain income limit may roll their regular IRA into a Roth IRA. When the IRA is rolled-over, individuals are charged a penalty but achieve tax savings in the future. The offset provision would increase the income limit to be able to roll-over, i.e., more IRA-holders will be able to roll-over to a Roth IRA. The provision would produce revenue in the early years, but would decrease revenue in the outyears. The net effect may be to decrease total revenue.

Scoring Implications: If the tax offset provision were amended to an appropriations bill or continuing resolution, OMB would score the increased revenue against the caps, thereby producing available funds to pay for the costs of the IPS bill. However, CBO would not score the tax bill against the caps. That is, the additional revenue, under CBO scoring rules, would not give the Appropriations Committee any room under the caps to include the IPS bill. CBO would score the additional revenue against the PAYGO scorecard.

MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM -- NEW ISSUE

Big deal to Harkin & Daschle, we're working on budget neutral alternative

Subcommittee: N/A (Possible amendment to an appropriations bill)

Ranking: High X Medium ____ Low ____

1999 Budget Policy: The Balanced Budget Act of 1997 (BBA) required the implementation of a prospective payment system (PPS) for Medicare skilled nursing facilities (SNFs), beginning July 1, 1998. The PPS rates cover all three categories of SNF payment: routine care (i.e., room, board and nursing costs), capital, and ancillary services (e.g., therapies, labs, medical supplies).

Some members of the SNF industry (particularly, the "sub-acute care" providers) have raised concerns that the PPS rates do not compensate them adequately for the costs of providing non-therapy ancillary services. As a result, Senators Daschle, Harkin, and Breaux are developing a proposal that would essentially allow SNFs to pass-through the costs of these services, rather than be constrained by the PPS, **for the first year of the PPS**. They argue that this could be done in a budget-neutral manner by re-allocating payments attributable to non-therapy ancillaries among SNFs (e.g., by increasing payments to sub-acute care providers and decreasing payments to all other SNFs), thereby creating clear winners and losers.

Latest House Action: None to date.

Latest Senate Action: Senators Daschle, Harkin, and Breaux and their staffs have been meeting with Nancy-Ann Min DeParle and HCFA staff to discuss the proposal.

Solution/Options:

Option #1: Do not include proposal. HCFA is strongly opposed to this proposal.

Option #2. **Rather than allowing SNFs to pass-through the costs of these services, allow all SNFs to choose whether to transition to the fully Federal PPS rate (as required under current law) or to by-pass the transition and receive the full Federal rate immediately. HCFA estimates that this option would cost approximately $1.0 billion over three years (the length of the transition period specified in the BBA). CBO could score the cost of this proposal higher than OMB. Note: This proposal has not been officially cleared with HHS, although some HHS staff are aware of it.**

Option #3. **Rather than allowing SNFs to pass-through the costs of these services, allow only those SNFs that can prove that their case-mix has changed significantly since 1995 (the base year used to set the PPS rates) to choose to by-pass the transition to the fully Federal rates (as required under current law) and receive the full Federal rate immediately. HCFA estimates that this option would cost approximately $0.5 billion over three years (the length of the transition period specified in the BBA). CBO could score the cost of this proposal higher than OMB. Note: This proposal has not been officially cleared with HHS, although some HHS staff are aware of it.**

Justification

Option #1:

- Carving-out one category of SNF expenditures from the PPS would substantially reduce the efficiencies gained from moving to a PPS. SNFs would have the incentive to inflate their non-therapy ancillary costs to recoup the payment reductions inherent in the PPS (CBO estimated five-year savings of $9.5 billion from SNF PPS).
- This proposal would set a poor precedent by inviting other Medicare providers unhappy with their post-BBA payment rates to request an increase in their Medicare payments.
- Implementing the Senate proposal would be administratively difficult and may not be possible, given the Year 2000 problem.

- To maintain budget neutrality, Medicare would have to shift money toward the sub-acute providers and away from all other SNFs. Again, this would create clear winners and losers within the SNF industry. **In particular, the nursing home advocate groups would be likely to oppose such a change. A non-budget neutral solution is likely to be costly.**

- Because this is the first year of the PPS, no data exists showing that the rates are not appropriate for SNFs that provide care to higher-intensity patients. In fact, the costs of non-therapy ancillary services are included in the prospective rates (which are based on 1995 cost data). Furthermore, these services (e.g., IV medications, IV therapy) are captured in the case-mix methodology and result in higher payments for SNFs.

- We believe that the current rates provide sufficient cushion to provide needed services to beneficiaries. The GAO (in recent Hill testimony) and HHS IG (in a report on SNF PPS) have argued that the amounts included in the PPS base rates are inflated and should be reduced sharply -- especially in the area of ancillary services.

We understand that the fix is motivated by the interests of one nursing home chain.

- According to HCFA, inpatient hospitals voiced similar concerns when the hospital PPS was implemented in 1983. However, the hospital industry soon learned to cope and attained substantial profitability.

Options #2 and #3:

Any SNFs that have changed their care delivery practice (i.e., moved from traditional SNF care to more costly sub-acute care) since 1995 are penalized by the PPS rates during the transition period (since the rates are a blend of agency-specific costs and the national average costs). This proposal would remove the agency-specific component of the rates for these SNFs.

HCFA could implement either of these options.

FY 1998 Appropriations Action: N/A.

Prepared By/Date: Caroline Davis (5-7842), 10/7/98, L_SNFPPS.WPD

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM -- NEW ISSUE

Subcommittee:

Ranking: High ___ Medium _X_ Low ___

1999 Budget Policy: The Balanced Budget Act of 1997 (BBA) required the implementation of a prospective payment system (PPS) for outpatient departments (OPD), beginning January 1, 1999. Implementation of the OPD PPS has been delayed due to Y2K until after January 1, 2000.

Under the OPD PPS, Medicare beneficiaries save money because copayment amounts will be lower. Beneficiary coinsurance for OPD services is currently based on 20 percent of a hospital's charges. Under the OPD PPS, coinsurance will no longer be based on charges. Instead, base copayment amounts will be established for each group of services based on the national median of charges for services in the group in 1996 and updated to 1999. These copayment amounts will be frozen until such time as coinsurance represents 20 percent of the total fee schedule amount. If the OPD PPS were implemented in 1999, calculation of the copayment amounts in such a fashion would result in coinsurance savings of $460 million for beneficiaries (not to the Medicare program) in 1999. Note that the beneficiaries are not paying more due to the delay of the OPD PPS. There was an expectation that their copays would decrease beginning January 1, 1999. This will not happen due to the delay.

Senator Dodd (D-CT) has requested a proposal which would save beneficiaries the same amount of money in 1999 that would have been saved if the PPS had been implemented. -

Latest House Action: None to date.

We think we're working this one out.

Latest Senate Action: None to date.

Solution/Options:

Option #1: Accept the following proposal for Senator Dodd. The following proposal would save beneficiaries $460 million in 1999. This is currently the preferred option, assuming that CBO does not score a large expense to the provision.

Beginning on January 1, 1999 and until such time as the OPD PPS is implemented, coinsurance would be based on a specified percentage of charges, which will be lower than 20 percent. The specified percentage (e.g., 18% or 17.5%) would be calculated by the Secretary and specified in law so that the beneficiaries, in aggregate, would achieve coinsurance savings equal to $460 million in 1999.

The Medicare payment, however, would continue to be calculated as if coinsurance were still based on 20 percent of charges. In so doing, the beneficiary coinsurance savings are not passed on to the Medicare program as a cost. Instead, the loss will be absorbed by hospitals, which is the same outcome that would have occurred in 1999 under the OPD PPS.

Under this proposal, hospitals would not be able to recoup their losses by increasing their charges. In fact, increasing their charges would result in a further loss. This is because higher charges cause an increase in coinsurance but an offsetting reduction in the Medicare payment since coinsurance is subtracted out in order to determine the Medicare payment.

Option #2: Reject the proposal. If nothing is done, beneficiaries will continue to pay coinsurance amounts equal to what they pay under current law for approximately one year; until the OPD PPS is implemented.

Justification:

Option #1: This proposal would save beneficiaries money while not imposing a significant cost on the Medicare program.

Option #2: This proposal would require a slight systems change and may have Y2K implications. HCFA may be accused of making certain systems changes which benefit them while using systems as an excuse not to make other changes.

There is a possibility of hospitals decreasing their charges in order to game the system. If this happened there would be a cost to Medicare. Although we have not spoken to CBO staff, we believe they may score this cost.

FY 1998 Appropriations Action: N/A

Prepared By/Date: Yvette Shenouda (5-7843), 10-2-98, L_OPDPPS.WPD

CHIP ALLOTMENTS -- NEW ISSUE

Probably won't make final cut, but is most likely of CHIP related issues

Subcommittee: Senate Finance; House Commerce

Ranking: High _X_ Medium___ Low___

Background: Section 2104 of the CHIP statute specifies the formula and data that is to be used in determining annual CHIP allotments. Annual allotments to states are based on a three-year average of the number of low-income, uninsured children in the state, as reported by the CPS, and a state cost factor. Although the total annual amount of CHIP funding is appropriated in statute and remains the same for the first few years of the program, there is substantial variation for some states between their FY 1998 and FY 1999 allotments. This variation is largely due to fluctuations in the CPS data that result from small sample sizes at the state level for this population.

Latest House/Senate Action: Nothing has been introduced yet, but there may be some interest in Commerce and Finance in changing the statute to prevent large year-to-year swings in CHIP funding among the states.

Solutions/Options: A statutory change could be made to mitigate the impact of the new CPS data on the allotment formula. Possible options include: freezing the allotments at FY 1998 levels; establishing floors and ceilings; increasing the number of years of CPS data used; and decreasing the formula's reliance on the number of uninsured poor children in favor of the number of poor children.

Justification:

- All states would have a greater ability to plan from year-to-year if the level of funding were stabilized.
- States that would lose a significant amount of FY 1999 funding due to the updated CPS data would welcome a legislative change that reduced the impact of the new data.
- States that would gain from the new CPS data in FY 1999 would oppose a stabilization measure, which could lead to a fight over the formula.
- Failure to oppose such a change in the statute could open the door for other statutory changes (e.g. CHIP rescission) that the Administration would oppose.

FY 1998 Appropriations Action: n/a

Prepared By/Date: Kate Kirchgraber (5-7815), 10/5/98, L_CHIPAL.WPD

CHIP - WISCONSIN WAIVER APPROVAL - - NEW ISSUE

Major problem

Subcommittee: n/a

Ranking: High _X_ Medium___ Low___

Background: On January 23, 1998, Wisconsin submitted a section 1115 proposal to cover families up to 185 percent of the federal poverty level (FPL). As submitted, Wisconsin's BadgerCare program would be comprised of a Medicaid section 1115 waiver and a non-Medicaid CHIP plan. All children would be covered under the CHIP plan; adults with children below 150% FPL also would be covered under CHIP using the family coverage variance. Adults with children over 150% FPL would be covered under a section 1115 Medicaid expansion.

The proposal that the state submitted did not meet the budget neutrality test required for section 1115 waivers. In order for a program to be budget neutral, it cannot cost more over the duration of the demonstration than the Medicaid program would have spent in the absence of that demonstration. Because Wisconsin cannot generate enough savings under its existing Medicaid program to pay for the expansion of Medicaid to the parents of children enrolled in the non-Medicaid CHIP program, the state's proposal is not budget neutral and therefore cannot be approved. According to Wisconsin's estimates, approximately 22,000 children and 28,000 adults would eventually be covered.

HHS approved Phase I of Wisconsin's CHIP plan, a Medicaid expansion to cover children ages 6 through 18 up to 100% of poverty, on May 14th. BadgerCare - Phase II of the State's CHIP plan - is actually a section 1115 Medicaid waiver proposal and is not required to be approved within any specific time frame.

Latest House/Senate Action: Sen. Kohl has written bill language which would deem Wisconsin's waiver proposal approved as it was submitted. No action has been taken on this language yet.

Solutions/Options: We strongly oppose this language. HHS has informed the state that the best, and perhaps *only* (ie. meets legal requirements), method to cover families under BadgerCare would be to adopt a Medicaid expansion under CHIP, rather than a separate, non-Medicaid program. Because adults must be "attached" to Medicaid-enrolled dependent children in order to be eligible for Medicaid themselves, this is the only approach that would enable Wisconsin to extend coverage to low-income parents. In this instance, the state would want to cap enrollment to contain Medicaid costs, however, such caps in Medicaid have been a "hot button" issue for the Administration. (See below.) Another option presented to the state would be to use Title XXI CHIP funds to purchase employer-sponsored insurance for those families that have access to it and for whom it is cost-effective.

Justification:

- States are allowed to use Title XXI CHIP funds to cover children and adults in very limited circumstances, provided that they are able to demonstrate that coverage to the entire family is cost-effective (i.e. the cost to CHIP of providing coverage to an entire family must not exceed the cost of covering only the uninsured children in the family.) This test prevents states from using CHIP dollars to cover adults at the expense of covering children.

- If Wisconsin chooses to use Title XXI CHIP funds to expand its Medicaid program, the state would receive virtually all of the federal matching that it is now seeking. The state would receive an enhanced match under CHIP for all BadgerCare children and, when the cost-effectiveness test can be met, for whole families. For parents covered by Medicaid, the state will receive the regular Federal matching rate. Although the Medicaid matching rate is lower than the CHIP enhanced match, the state, based on its own estimates, would see a reduction of *less than one percent* over five years. As a result, this option would not impose a fiscal burden on the state

- Wisconsin's request to impose an enrollment cap in Medicaid reflects the state's concern that the entitlement will impose uncontrolled costs. Adoption of the Medicaid option under CHIP entails a commitment to maintain the entitlement to eligibility that is fundamental to Medicaid, even after the state exhausts its CHIP allotment. The Administration has strongly opposed enrollment caps and the continued availability of Federal match under this scenario (at the regular Medicaid rate), as authorized by Congress, fully supports this view.

- To cap the number of children would mean that some eligible Medicaid children would not receive the health care coverage entitlement. Instead of implementing an enrollment cap, the state could choose to increase eligibility levels incrementally. The state could start its program at, for example, 170% of poverty instead of their proposed 185%. By doing this, the state could get a sense of how many children would enroll in the program, and if it looks like funds will be available, the state could increase eligibility in the future.

FY 1998 Appropriations Action: n/a

Prepared By/Date: Kate Kirchgraber (5-7815), 10/5/98, L_CHIPWI.WPD

CHIP - WASHINGTON STATE - NEW ISSUE

Like but – might open door. WH position

Subcommittee: n/a

Ranking: High _X_ Medium___ Low___

Background: When the Children's Health Insurance Program was established in August 1997, Washington State was already covering children under Medicaid up to 200% of poverty. Since the state has 90,000 children who are eligible for Medicaid but are not enrolled in the program, the state is seeking to use CHIP funds to pay for services provided to this population. The CHIP statute, however, does not allow states to collect the enhanced federal match for children who were eligible for Medicaid as of March 31, 1997, so states are only able to access CHIP funds by increasing income eligibility levels.

Latest House/Senate Action: Sen. Gorton has introduced a bill that would allow states now covering children at or above 200 percent of poverty to use Title XXI CHIP funding to cover, under Medicaid, children in families whose income is above the mandatory Medicaid income level for children. Funds would be used for new Medicaid enrollees only and states would be prevented from supplanting state funding currently being used to cover children in the Medicaid program. The bill would affect four states: Washington, Vermont, Hawaii and Minnesota

Solutions/Options: 1) Reject the proposal because it undermines the Administration's objective to insure more children. It opens the door to other states requesting enhanced CHIP maching for Medicaid eligible children. 2) While we have major policy concerns, as elaborated below, DPC believes there could be some political value in accepting this proposal.

Justification:

- The Administration could choose not to object to this proposal because it would help states that have already "done the right thing" by extending the enhanced match to children eligible, but not enrolled in Medicaid. In addition, this proposal would enable states to cover lower income children, rather than raising income eligibility levels and risking crowd out. The proposal would result in no new costs, since it would only allow states to access their existing CHIP allotments.

- The Administration could choose to oppose this proposal on the grounds that it would be difficult to limit this exception to states with a Medicaid eligibility level at or above 200% of poverty. Other states with large numbers of children who are eligible for Medicaid but not enrolled could push for a lowering of the threshold. It would also be difficult to establish a baseline enrollment measure so that we could be sure that the enhanced match is paying for children who were previously unenrolled. Without a baseline measure, this proposal is likely to undermine CHIP's efforts to reduce the number of uninsured children, as it could enable states to "buy out the base" of children they are already covering.

FY 1998 Appropriations Action: n/a

Prepared By/Date: Kate Kirchgraber (5-7815), 10/5/98, L_CHIPWA.WPD

MEDICARE DSH PAYMENTS IN PENNSYLVANIA--NEW ISSUE

Subcommittee: N/A (Possible amendment to an appropriations bill)

Ranking: High X Medium__ Low__

1999 Budget Policy: HCFA issued a program memorandum to its fiscal intermediaries in February 1997 clarifying its policy for making Medicare disproportionate share (DSH) hospital payments. The memorandum clarified that hospitals may not include state-funded General Assistance (days of medical care not eligible for Federal match) in their cost-reports to determine qualification for DSH payments.

For the past 12 years, hospitals in Pennsylvania have included General Assistance days in their cost reports, leading to Medicare overpayments to these hospitals. Pennsylvania hospitals that qualify for Medicare DSH payments have requested that HCFA and its fiscal intermediary not recoup the overpayments and to allow inclusion of these days in future cost reports. These hospitals argue that recoupment and exclusion of these days will lead to dramatic reductions in their Medicare payments. The hospitals urge HCFA to delay action until Congress addresses comprehensive Medicare DSH payment reform next year. HCFA would need legislative authority to delay action.

Nancy-Ann Min DeParle sent a letter to the Pennsylvania delegation indicating that HCFA did not have the authority to address the issue.

Latest House Action: Pennsylvania House delegation has contacted HCFA seeking a solution to this issue. Members of the House delagation including representatives Murtha (D-PA), Coyne (D-PA) have contacted the West Wing urging support for a legislative fix.

Latest Senate Action: Pennsylvania Senate delegation has contacted HCFA seeking a solution to this issue. Senator Specter's staff has requested HCFA's technical assistance to draft a possible amendment to an appropriations bill. In a letter to the Pennsylvania delegation, Nancy-Ann Min DeParle promised technical assistance to address this issue. Senator Specter may also contact the West Wing urging support for a legislative fix.

Solutions/Options:

(1) Trade the amendment for other Administration priorities (a $300 million offset will be needed).

(2) Force HCFA to re-visit the legal basis that adminsitrative action cannot be taken to address the issue (OMB staff not optimistic that HCFA will determine administrative authority)

(3) Do not include the amendment (expect strong political opposition).

Justification:

- CBO estimates the cost of the provision to Medicare at $300 million in FY1999 if the provision only prevented recoupment of the over payments. CBO would score an additional $100 million/year if Pennsylvania hospitals were allowed to continue to include General Assistance days. CBO's cost estimate of the provision would be much higher if other states were included. If not offset, including the provision in an appropriations bill would decrease the discretionary caps for FY1999 and possibly in the outyears depending on the provision's language.

- HCFA has been strongly criticized in the past for failing to recoup erroneous overpayments. The most recent HHS IG Financial Audited Statement for FY1997 found HCFA improperly overpaid Medicare providers an average of 11 percent ($20 billion) each year. Including the provision may invite further criticism that the Federal government is not serious about recouping Medicare overpayments.

- It is possible that other states may also include state-funded General Assistance days in their cost reports. These states may seek Congressional action to prevent recoupment of DSH payments and exclusion of these days in hospitals' cost reports.

- Other provider groups may seek similar Congressional action to prevent HCFA and their fiscal intermediary to prevent re-opening settled cost reports to recoup erroneous Medicare overpayments.

FY 1998 Appropriations Action: N/A

Prepared By/Date: Jonathan Blum (5-7844), 10/2/98, L_PADSH.WPD

RACE AND HEALTH INITIATIVE FUNDING LEVEL (INDIAN HEALTH SERVICE)

(BA in millions of dollars)

FY 1998	FY 1999 Req.	House	Senate	Likely Conference	Proposed Final Level
n/a	10	0	0	0	10

Subcommittee: Interior

1999 Budget Policy: The IHS portion of the Race and Health initiative is $10 million, of which $5 million is requested for alcohol and substance abuse treatment and prevention activities and another $5 million is requested for breast and cervical cancer screening for Native Americans and Alaska Natives. The IHS request is a part of the President's overall $80 million effort to address health disparities among minority groups. The other $70 million is requested under the L/HHS/Ed bill.

Latest House Action: Despite a higher overall funding increase above the FY 1999 President's Budget for IHS (+128 million), the House-passed bill failed to fund at $10 million the IHS component of the Race and Health Initiative. The House Interior Report language strongly stated the Committee's view that a great deal of funding in the hospitals and clinics area is already used to treat alcohol and substance abuse-related health problems. Administration concerns have been communicated by SAPs.

Latest Senate Action: While the overall funding for IHS is higher than the FY 1999 President's Budget (+ 18 million), the Senate bill failed to fund the IHS portion ($10 million) of the Race and Health initiative. Administrative concerns have been communicated by SAPs.

Solution/Potential Offsets:

Justification: The FY 1999 Budget initiative to address some of the disparities among racial groups is one of the Administration's priorities. It is critical that IHS receive specific funding to provide health care programs and services that target health disparities among Native Americans, who continue to suffer disproportionally from illness and diseases, such as alcoholism, substance abuse, and certain types of cancer.

FY 1998 Appropriations Action: This is a new initiative for FY 1999 and therefore has no previous appropriations history.

We need $30 million!!!

RACE AND HEALTH INITIATIVE FUNDING LEVEL (HRSA/CDC)

(BA in millions of dollars)

FY 1998	FY 1999 Req.	House	Senate	Likely Conference	Proposed Final Level
N/A	$70	$125	$49	$87	$70

Subcommittee: Labor/HHS/Education

1999 Budget Policy: Despite improvements in the Nation's overall health, continuing disparities remain in the burden of death and illness that certain minority groups experience. The request is $70 million for an initiative to address health disparities among racial minorities. An additional $10 million for this initiative is requested for the IHS in the Interior Appropriations bill. This initiative would provide $55 million for the CDC to support new demonstration programs to address racial disparities in health ($30 million) and to enhance existing CDC programs ($25 million) that could help address such disparities (e.g., diabetes, STD/HIV prevention programs). Community Health Centers (CHCs) in HRSA would receive $15 million under this initiative.

Latest House Action: The House Committee funds the existing CDC programs at the requested level of $25 million, but does not provide funding for the new demonstration programs citing a lack of performance and outcome measures for these programs. The House Committee funds the CHCs at a higher level than requested ($100 million vs. the $15 million requested). Administration concerns about the lack of funding for CDC's demonstration programs have been included in letters and SAPs.

Latest Senate Action: The Senate provides $10 million out of the $30 million requested for the CDC demonstration grants and $24 million out of the $25 million requested for existing CDC programs. The Senate also funds CHCs at the requested level of $15 million.

Solution/Potential Offsets: Seek both the level and mix of funding in the President's Budget, i.e., $70 million in total including $30 million CDC demonstration grants.

Justification: While the House Committee provides $55 million more than requested for this initiative overall, it did not fund CDC's important new demonstration grants (+$30 million) and over-funded HHS' request for CHCs (+$100 million instead of +$15 million). The Senate provided less than requested for the demonstration grants and for existing programs within CDC. The Administration seeks full funding for the $30 million in demonstration grants and the existing programs so that the initiative will have an appropriate balance between research (CDC's demonstrations) and services (including CHCs).

FY 1998 Appropriations Action: This is a new initiative for FY 1999 and therefore has no previous appropriations history.

FAMILY PLANNING

(BA in millions of dollars)

FY 1998	FY 1999 Req.	House	Senate	Likely Conference	Proposed Final Level
203	218	203	215	209	218

Subcommittee: Labor/HHS/Education

1999 Budget Policy: The request is $218 million, a $15 million increase over last year to provide family planning services to an additional 390,000 women for a total of 4.95 million women who are neither Medicaid eligible nor have private insurance.

Latest House Action: The House committee bill would fund Title X Family Planning at the FY 1998 level.

Latest Senate Action: The Senate committee bill would fund Title X Family Planning at $215 million. This is $3 million below the administration request and $12 million above the 1998 level.
Solution/Potential Offsets: Seek the $15 million increase requested in the Budget.

Justification: Making family planning services more widely available will lead to a reduced need for abortions and fewer unintended pregnancies. Under the President's proposal, 4,700 family planning clinics nationwide would provide comprehensive services including contraceptive services, pregnancy testing, sexually transmitted disease screening and treatment, and education and outreach.

FY 1998 Appropriations Action: Last year, the President requested a $5 million increase. The House recommended a $4 million decrease, while the Senate recommended a $10 million increase. The Conference Committee settled on a $5 million increase, the same as the requested level.

Prepared By/Date: Jen Forshey (5-7788), 9/8/98, F_FAMPLN.WPD

FOOD SAFETY INITIATIVE* FUNDING LEVEL
(BA in millions of dollars)

	FY 1998	FY 1999 Req.	House	Senate	Final Level
USDA	66	112	76	98	112
HHS/FDA	125	175	132	162	175
TOTAL	191	287	208	260	287

* Does not include funding for the CDC provided in the Labor/HHS Subcommittee.

Subcommittee: Agriculture/Rural Development

1999 Budget Policy: The request was an additional $96 million over the FY 98 enacted level for the Food Safety Initiative -- +$46 million for USDA and +$50 million for FDA. (The request also includes an additional $5 million for the Centers for Disease Control to expand the National Early Warning System and make other foodborne disease surveillance improvements, funded through the Labor/HHS bill, bringing the total Initiative to +$101 million.)

Latest House Action: The House allocated +$7 million for FDA food safety inspection and +$10 million for USDA activities (education, research, and risk assessment).

Latest Senate Action: A floor amendment by Sen. Harkin increased funding by $66 million -- +$29 million to USDA and +$37 million to FDA -- for a new Senate total of $69 million, $27 million less than requested. The offset for this amendment includes a provision requiring tobacco companies to partially reimburse USDA for its costs of administering tobacco-related programs, such as crop insurance for tobacco. The tobacco offset saved $40 million. However, Rep. Archer recently stated the $40 million offset could be unconstitutional because it may qualify as a tax and did not originate in the House. In early August, before the chief of staff met with a group of tobacco farmers and Democratic Representatives from North Carolina, he said he would call Rep. Archer to argue the tobacco company fee should not be dropped from the bill, because in subsequent years it would also benefit tobacco farmers by shifting an existing fee from them to companies.

Solution/Potential Offsets: The Senate level for the initiative is probably the best we can hope for. If the tobacco company user fee drops out in conference, an alternative offset would be necessary. OMB is discussing fallback offset options with Sen. Harkin's and Subcommittee staff. Maintaining the tobacco offset in the Senate bill is the preferred offset, but follow-up with the Chief of Staff's office is necessary to find out what he has heard from Rep. Archer.

Justification: Funding of the President's Food Safety Initiative in FY 1999 will go toward-

- providing additional resources for enhancing the safety of imported and domestic fruits and vegetables;
- increasing food safety education efforts targeted to high-risk populations, such as the elderly and school lunch preparation personnel;
- expanding research to develop tools to address a broad range of food safety hazards; and,
- improving coordination on food safety activities between USDA and HHS.

FY 1998 Appropriations Action: The House and Senate Appropriations Committees fully funded the FDA request of $24 million, for a total food safety activity level of $125 million, while only partially funding the USDA request for $9 million. The final conference action fully funded the food safety request for FDA and USDA.

Prepared By/Date: Amandeep Matharu/JimEsquea/Ruth Saunders (5-7792/5-7841/5-3448), 8/19/98, F_FOOD.WPD

Attachment to Country of Origin Labeling/Language One Pager -- FY 1999 Agriculture Appropriations Bill

Background

- The Senate-passed Agriculture Appropriations bill contains a "country of origin labeling provision" requiring that retailers of imported fruits and vegetables provide consumers, at the point of sale, information as to the country of origin of fruits and vegetables, e.g., individual packages of raspberries from Guatemala would clearly state that these are imported Guatemalan raspberries.

- This information could be provided to consumers as a label, stamp, or placard on the imported fruit or vegetable or on the package, display, or holding unit containing the fruits and vegetables. The USDA Secretary could assess a fine to retailers who fail to indicate country of origin.

Key Congressional Support

- This provision, section 765 of the Senate bill, was proposed by Senator Cochran (R-MS) for Senator Graham (D-FL) on the Senate floor and adopted by voice vote. The House-passed Agriculture Appropriations bill does not contain this provision.

- A similar labeling provision, but for beef and lamb, not fruits and vegetables was included in Senators' Daschle (D-SD) and Harkin (D-IA) agricultural disaster spending package, which they were proposing as an amendment to the Interior Appropriations bill. On September 14, a Senator Lugar (R-IN) amendment to table the entire amendment was adopted by a vote of 53-41.

- Senator Tim Johnson (D-SD) is also a major supporter of the country of origin labeling provisions for beef and lamb.

Several Problems -- Funding and Trade Implications

Funding -- Estimates Range from $5 million to $190 million

- The provision raises some questions and problems given that it is unclear who has primary responsibility for enforcing the labeling requirement (it could be USDA as the provision implies or the Food and Drug Administration which has primary responsibility for the safety of fruits and vegetables under current law) and what would be the cost of enforcing it.

- Preliminary agency enforcement cost estimates range from as low as $5 million to as high as $190 million depending on the chosen method of enforcement, e.g. the frequency of inspections (inspecting every retailer vs. random compliance checks similar to the FDA tobacco retailer inspection model).

- OMB staff are working with HHS and USDA to determine who might be responsible for enforcing the provision and what the scope and cost of the enforcement regime could be.

- The Senate bill, however, does not provide any additional funds to implement the provision and the agencies are concerned that they will have to absorb the cost.

Trade -- Concerns About Retaliation

- The provision also has international trade implications and would be of concern to the US Trade Representative.

- In an April 4, 1997 letter to Congressman Sonny Bono, registering her concern about the "Imported Labeling Act of 1997," US Trade Representative Charlene Barshefsky stated that imposing a labeling requirement may encourage other countries to do the same for American produce sold abroad, raising the cost of US exports and potentially being used as "unjustified barriers to trade."

- HMOs - bipartisan notification/initiation

Patients' BofR - [illegible] writing death articles
Ask Rahm - does he want
to do quote - law) [illegible]
"seem" etc
or other high-ranking

Nursing home
lib. Dems pushing for fix -
higher rates for cert instit
we don't have legal auth/ Dems disagree
(Harkin/Daschle/Kennedy)
Asked: help do budget-neutral fix
We do have approach.
OK to go up tomorrow?

before noon

Leak to Pear -
need 1st thing in
morning

Q: anyone?