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002. memo	Mike Lux to Hillary Clinton Re: Health Care Policy and Politics (5 pages)	3/24/93	P5
003. memo w/attach	Chris Jennings to Hillary Clinton Re: Polling Data Analysis by Senator Kennedy's Office (14 pages)	12/12/94	P5
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Clinton Presidential Records
Domestic Policy Council
Chris Jennings (Health Security Act)
OA/Box Number: 23758

FOLDER TITLE:
HRC Memos-HSA [5]

gf131

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M E M O R A N D U M

TO: Hillary Rodham Clinton
FR: Chris Jennings
RE: Meeting with Chairman Brooks
cc: Melanne, Lorraine, Steve, Kim Tilley

March 16, 1993

Tomorrow you are scheduled to meet with Congressman Jack Brooks, Chairman of the Judiciary Committee. As you know, this legislative body may be one of the "sleeper" Committees during the health care reform debate. In attendance at this meeting will be the Chairman's General Counsel, Jon Yarowsky.

BACKGROUND

The importance of doing something on malpractice and anti-trust reform as a part of the reform initiative becomes more and more self-evident as we continue our meetings on Capitol Hill. Physicians and other health care providers will trade a great deal for malpractice reform. Even more importantly, as you have seen in your own meetings, this issue is of great importance to almost every Republican and many conservative to moderate Democrats. More recently, anti-trust roadblocks to health care facilities' efforts to coordinate purchasing and utilization of expensive medical equipment has been raised.

Of the two big issues that have Judiciary Committee jurisdiction, the anti-trust reform issue appears to be, far and away, the one of greatest interest and concern to the Chairman. For years now, Congressman Brooks has been attempting to limit the one industry (other than baseball) that has an exemption from anti-trust laws -- the insurance industry. (As you know, the McCarren Fergeson law provides this exemption; it has been cited by the Chairman and others as an example of the unanticipated problems that can emerge from poorly thought out anti-trust exemption laws).

At this point, the Chairman believes he is very close to passing his McCarren Fergeson limiting legislation. He is, therefore, very sensitive to talk about any legislation that goes in the exact opposite direction and could, in his opinion, undermine his efforts to limit abuses by the insurance industry. What he wants to hear is that you are aware of his legislation and that you and the President would like nothing less than to undercut his efforts in any way. In addition, he does not want you to broadly say that it is important to exempt hospitals and other purchasers from anti-trust laws.

The Chairman would accept, and be very open to, however, hearing that narrowly drafted anti-trust exemptions are necessary and important, as long as it is clear what any reform allows and, more importantly, what it does not allow. Legislation that follows that formula in another area and has been endorsed by the President (the Production Joint Venture initiative) was introduced last week by Congressman Brooks. He would love to hear you make an analogy between that bill and any anti-trust provisions that we would consider that would provide some room for legitimate coordination agreements with facilities.

On the medical malpractice front, he and his staff believes that there is very little empirical data to confirm that this issue is the problem that the health care industry and its advocates say it is. Having said this, they appear willing to work with you on this legislation (understanding that perception is reality and that so many Members are supportive of tort reform) as long as it is not overly broad. He will want you acknowledge that empirical limitations on this issue, but you should be honest about the political problem and about the need to have something that is perceived as "real." He will appreciate such candor.

Lastly, Chairman Brooks may raise the issue of the pharmaceutical industry's request to have a Justice Department ruling that grants them a private letter of approval to negotiate with the Administration on their voluntary price constraint proposal. On this issue, my advice is to just listen and ask him what he thinks about the need for such intervention by the Department. In addition, you may want to discuss what, if any other, anti-trust issues are relevant to cost containment initiatives.

CONCLUSION

The above mentioned issues are complex and controversial. To assist us in the front end (as well as hopefully after the bill is introduced), we have invited Congressman Brooks' staff to participate in the working groups. They have participated a great deal already on the medical malpractice reform working group and, starting later this week, they will be sending someone else to our discussions about anti-trust issues. You may wish to thank him for the use of his staff.

Lastly, attached for your information is some background information on the anti-trust and medical malpractice issues that were prepared by working group staff. The information is summarized, but we hope you will find it useful.

MEMORANDUM

CHC's - community-based system - Health-focus

TO: Hillary Rodham Clinton March 10, 1993
FR: Chris Jennings
RE: Rockefeller, Montgomery, Rowland Veterans Meeting
cc: Melanne, Steve R., Lorraine M., Kim Tilley

After your meeting with the Women Senators, you are scheduled to meet with the Senate and House Chairmen of the Veterans' Affairs Committees, Senator Jay Rockefeller and Congressman Sonny Montgomery. Also in attendance at the request of Congressman Montgomery will be Congressman J. Roy Rowland, who is on the House VA Committee and is a physician.

Attending this meeting with you will be Vick Raymond, Secretary Brown's right-hand policy guy. Vick is Secretary's staff designate to the Health Task Force and is participating in the Work Groups.

BACKGROUND

One extraordinarily important political goal of any health reform proposal is to design it in such a way that a vote against the Clinton health reform initiative is a vote against veterans. The veterans represent one of the strongest lobbying forces in Washington and we need them on our side.

In the past, having the veterans on your side in health reform meant that they had to be treated separate and apart from the rest of the system. Now, there is growing recognition within the VA advocates community that the very survival of special services for veterans depends on the ability of the VA system to play an important role within the context of entire system.

Having said the above, there is great nervousness that this means that the VA and its providers will have to be totally "integrated" into the system and that veterans may not receive the type of special care to which they have become accustomed. Moreover, there are still many interest groups within the veterans community who are viscerally opposed to any significant changes from the days of old.

Senator Rockefeller shares your belief that we must the veterans' groups forward on this issue. However, since he just became Chairman this year, he wants to make certain he has the time to build enough credibility with the groups BEFORE he pushes too hard publicly. He is working on building those relationships now. One that he apparently has been very successful with is the friendship he now has with Chairman Montgomery. They are very close.

Senator Rockefeller's staff has expressed some frustration that he has not been informed of the policy pronouncements that Secretary Brown has been making before he has made them. Although this is not a major problem and can likely be solved with a meeting between the new Chairman and the new Secretary (which is now being scheduled), it is somthing the Secretary may be well advised to be more sensitive to.

Vick Raymond reports that he thinks that the Secretary is open to even more innovative approaches to health reform than he has been discussing with the press. Like Senator Rockefeller in many ways, Vick believes that upside of the Secretary's statements is that they serve the useful purpose of building up credibility with these sometimes difficult groups. As Vick said, Richard Nixon could go to China; perhaps Secretary Brown will be able to later raise some difficult issues.

Vick prepared a short one page background on the Secretary's position on reform, as well as a three page summary of the Department. This information is attached for your review.

Chairman Montgomery, I believe, will be somewhat deferential to Senator Rockefeller. He will want to hear how important you feel that the VA and their advocates are part of the process. Since Vick used to work for the Chairman, he is very comfortable with who is at the table. As one of the few physicians in the Congress, Congressman Rowland probably can be counted on to raise the importance of having doctors in the process. Although you addressed this at your meeting with him at Energy and Commerce, he may well raise it again.

This meeting is very important, but I would guess that it will not be difficult at all. Senator Rockefeller will make sure it goes very smoothly.

M E M O R A N D U M

TO: Hillary Rodham Clinton/Kim Tilley March 8, 1993
FR: Chris Jennings
RE: Tuesday Meeting with Congressman McDermott
cc: Melanne

Following up on your meeting with the lead Senate sponsor (Senator Wellstone) of the single payer bill that most of the hard core advocates support, we thought it appropriate that you hold a similar meeting with the bill's lead House sponsor (Congressman McDermott). Tuesday, at 1:15, you are scheduled for just such a meeting. In attendance will be Barbara Smith (Congressman McDermott's health staff person).

Congressman McDermott and over 50 House cosponsors, along with Senator Wellstone in the House, introduced their single-payer legislation last Wednesday. As you may recall from the Wellstone memo, the 1995 new Federal costs required by this bill amounts to approximately $551 billion. It is payed for by increases in income taxes, payroll taxes, corporate taxes and other revenue raisers. By 1996, however, overall private/public spending will be less than what it would be under current projections. (Attached for your review is some background information on this bill).

Both McDermott and Wellstone stated in their press conference remarks that they have every intention of working closely with the Clinton Administration on health reform and suggested that they are open to alternative approaches that meet their basic (access, choice and affordability) principles. They said that they are comfortable taking this position because they believe that there is a great deal of common ground between the health reform principles and goals that have been outlined by the Clinton Administration and where their bill is.

It is important to the Congressman that everyone acknowledges that his bill is NOT the same bill as the old Russo, single-payer bill. He believes he moved the bill more to the center by providing much more state flexibility in his version. He believes these modifications came at the expense of relationships with some of the more "pure-minded" single-payer advocates. He (and particularly his staff, it seems) would like to hear some recognition of this "sacrifice."

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Tobacco #4

MEMORANDUM

TO: Pat G., Harold I., Ira M., Carol R., Distribution March 9, 1994
FR: Marion Berry and Chris Jennings
RE: Tobacco Issues and Health Security Act

Following up on a recent meeting with the First Lady, Carol Rasco, Ira Magaziner, Secretary Espy and others, Carol requested that Marion Berry, Agriculture Special Assistant to the President, and Chris Jennings work together to review Administration options dealing with concerns raised by Members of Congress about the Health Security Act's tobacco tax provisions. In the course of our review, we discovered that it is possible that the Administration may need to make a decision by March 31st on a very relevant tobacco tariff issue; this decision has significant implications for discussions with Members of Congress from tobacco states regarding health reform.

The tobacco issue has great potential to have an impact on early Committee actions on the Health Security Act, particularly during mark-ups at the Energy and Commerce Committee. Keeping this and the above-mentioned March 31st date in mind, we concluded that it would be highly advisable for a senior White House staff meeting to be held on this subject.

After reviewing all calendars, we have been able to secure a room (476 EOEB) and a time (4:00) for a meeting <u>today</u> that hopefully will serve to bring you up-to-date on this issue. We believe that it would be advisable to have a small group of representatives from the U.S.D.A., the U.S.T.A., and the Treasury Department to be on hand to provide historical and substantive perspective on this issue. Should any decision be contemplated that would alter our current position with regard to tobacco taxes, it will be critical for all three of these agencies to be involved in a coordinated strategy with the White House to send a consistent message to the Hill.

Attached is some background information on the tobacco issue prepared by Marion. If you have any questions you need answered prior to this meeting, please call Marion (at 6-6586) or Chris (at 6-2645) so that we can attempt to schedule a meeting at a mutually convenient time.

Distribution: John Hart, Jack Lew, Lynn Margherio, Janet Murguia, Steve Ricchetti, Melanne Verveer

INFORMATIONAL MEMORANDUM

FROM: **Marion Berry**

SUBJECT: **Tobacco Issues**

BACKGROUND:

The Southeastern United States contains many small farmers that are very dependent on the tobacco crop. Around 100,000 farmers grow tobacco, mainly in 6 states: North Carolina, Kentucky, Tennessee, South Carolina, Virginia and Georgia. Tobacco is the mainstay of the economy in many of these areas.

Tobacco producers have operated under the tobacco marketing quota and price support program for many years. The tobacco program is under pressure because high support prices are making U.S. tobacco less competitive in world markets and the program must operate at no net cost to the Government. Tobacco imports have grown significantly in recent years and U.S. producers have lost domestic market share.

The demand for U.S.-grown tobacco continues to decline. Large world leaf supplies at lower prices than in the United States are reducing exports of both tobacco leaf and cigarettes. Moreover, tax hikes in the United States, more stringent restrictions and outright bans on smoking in public places, and declining social acceptance of cigarette smoking are causing domestic tobacco consumption to fall at an increasing rate.

The so-called Ford Amendment to the budget reconciliation act of 1993 limits the content of cigarettes sold in this country to 25 percent foreign tobacco and requires certain assessments on imported tobacco. This domestic content requirement was intended to make the anticipated tobacco tax increase more palatable to tobacco growers and to reduce rapidly rising imports. This was understood to be a deal with the tobacco interest when it was included in the budget act in 1993. However, this requirement is clearly inconsistent with U.S. obligations under the General Agreement on Tariffs and Trade (GATT), and a GATT panel may so rule within 6-8 months.

With rising assessments to pay for the tobacco program and future marketing quota reductions, those concerned with tobacco grower interests feel a great sense of urgency to do something. They believe their most urgent need is to control imports of tobacco in order to maintain the domestic market share at current prices.

ALTERNATIVES TO DOMESTIC CONTENT REQUIREMENT:

Section 22

Under Section 22 of the Agricultural Adjustment Act of 1933, as amended, the President has the authority to implement emergency import quotas or tariffs if imports materially interfere with a commodity program. (The International Trade Commission would conduct an investigation and make recommendations to the President.) However, under the Uruguay Round GATT agreement, the United States has agreed to eliminate Section 22 when the GATT agreement is implemented in 1995. As a result, any Section 22 action at this late date would be of limited duration and would also be considered inconsistent by our trading partners with the policies we have been urging in the GATT negotiations.

GATT Article XXVIII

There is a GATT consistent way to limit tobacco imports. Under Article XXVIII.5 of GATT, the United States has reserved the right to renegotiate its tariff concessions at any time. Under this procedure, the United States would replace its tariffs with tariff-rate quotas as part of its offer for compensatory adjustment. Tariff-rate quotas would allow a fixed amount of tobacco to be imported at current tariffs with all other imports subject to much higher tariffs. We would have to negotiate with other GATT members who have Article XXVIII rights. If those members did not accept our offer, they could withdraw concessions of their own.

The negotiations would need to include not only the Uruguay Round offer, but the current tariff binding for the affected tobacco products. Once the agreement is negotiated for the withdrawal of the current tariff binding, there would have to be statutory implementation either through declaration of the tariff-rate quota in the Uruguay Round implementing legislation or through creation of authority for the President to proclaim a change in the tariff schedule to make the tobacco tariff-rate quota effective as soon as possible. This authority could be accompanied in the legislation by repeal of the Ford amendment.

There would be a significant advantage in initiating these Article XXVIII negotiations in Geneva immediately and reaching agreement prior to the signing of the Uruguay Round protocol on March 31st. Successful Article XXVIII negotiations would eliminate the embarrassment from an adverse GATT panel decision on the Ford amendment.

Tobacco quota buy out and price support reduction

There is increasing debate about assisting tobacco farmers to offset reduced income from
tobacco. One option would be to retire or buy out tobacco quotas. though it would not be a popular one with tobacco interest. These are tobacco farmers and they want to remain
tobacco farmers. There is no other crop that can replace tobacco in the cultural or economic
scope of their lives.

At a price of $2.50 per pound, the average payment would run $3,000 to $4,000 for burley quotas, and $25,000 to $35,000 for flue-cured quotas. Along with a legislated price-support reduction of around 25 percent, this option would provide a substantial incentive for participation in a buy out by less productive producers and help assure that the remaining producers would be more competitive.

If about one-half of the quota was purchased, a buy out would cost about $1.7 billion for direct payments to quota holders. Similar amounts might have to be provided for others, i.e., tenants, farm workers, warehouse operators, and local governments. The total cost of $3.5 billion would amount to 8-10 cents per pack of cigarettes for two years.

Any buy out would require congressional action. A buy out could retire some quota holders, lower prices, and permit the remaining industry to become stronger. It would compensate producers and minimize disruption of the economies in these regions.

Another alternative is assistance for growing alternative crops (tobacco is the most valuable crop grown on tobacco farms). However, because of lack of management skills and consistent and profitable markets, and competition from other regions, this provides only limited opportunity to offset losses from tobacco.

Alternative excise tax revenue

Raising the Federal excise tax on a package of cigarettes from $.24 to $1.00 would increase excise tax revenues. However, the precise effect of higher excise taxes on consumption, and therefore revenues, is uncertain. USDA estimates that cigarette consumption would decline by 18 percent and revenues would increase by about $14 billion annually. An increase in the excise tax to $.74 per package would increase federal revenues by an estimated $10 billion and reduce consumption by 12 percent. Current annual excise tax revenues are $6 billion.

Smokeless tobacco is approximately the equivalent of the cigarette excise tax.It is applied to a per weight basis and at one time was considerably less than cigarettes, but is now approximately the same.

The tobacco industry obviously feels mistreated because of the single nature of the above taxes. Other taxes have been discussed with the President and he rejected them at the time. Some of these are taxes on various forms of alcoholic beverages and soft drinks. They are still a possibility and would definitely soften the blow to the tobacco interest.

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January 27, 1995

MEMORANDUM FOR HILLARY RODHAM CLINTON

FROM: CHRIS JENNINGS
SUBJECT: Health Care/Budget Briefing
cc: Melanne V.

The following information was prepared as back-up for an oral briefing for the President on the implications of a Medicaid block grant or cap. Because of time constraints, the briefing was cancelled

Since the Medicaid subject is not likely to be raised at NGA this weekend, Carol decided it would not be wise to overwhelm him with paper at this time. I thought, however, that you would be interested in the enclosed. The Medicaid capping issue will be at the heart of the upcoming budget discussion and I believe this information may be quite helpful to you decide how we can best evaluate how to respond to the inevitable Republican initiatives in this area.

Attached you will find a 2-page document that provides a brief summary of the budget and political status of this proposal and an advantage/disadvantage summary. Behind this document is a much more detailed background memo which illustrates the serious implications of the block grant/capping idea and the reason why many of the Democratic Governors (and particularly the advocates) are nervous.

On an unrelated matter, I want you to know that I have started meeting with Drug Company reps on the regulatory review issue. Just last night, I had a productive discussion with Merck and Bill Schultz (the new FDA Deputy to David Kessler and a friend of mine). They had a number of ideas that sounded quite reasonable to both Bill and myself. Their particular gripe is with the section of FDA that reviews biotech drugs and their slow and unresponsive review process.

We are going to meet with at least two or three others companies (I will include American Home Products on that list) in the very near future to add to our now growing list of regulatory changes that will please the industry and that can be implemented without compromising safety. I would be happy to go over them if you have any desire to do so.

Lastly, I talked with Harkin's staff. They are sending me over everything they have been doing in their oversight work on HCFA. Their staff is very interested in working with us. I'll talk to you the moment I have some follow-up that comes close to being worthwhile.

MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

- **Congressional Republicans need hundreds of billions of dollars** to finance tax cut and deficit reduction pledges.

- **Medicaid is seen as major cash cow** because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

- **Speaker Gingrich discussing a 5% cap on Medicaid program growth,** which would yield $130 billion ($193 billion using CBO numbers) in Federal savings through 2002 and $375 billion ($500 billion using CBO) in Federal savings through 2005.

- **Republican Governors either supportive or staying quiet for now** because they philosophically support. Moderate Republicans from states with high growth rates are evaluating just how they could live with these reductions in Federal dollars.

- **Governor Dean sending signals he might be open to a cap, although most Democratic Governors appear to be extremely nervous about it.** Governor Chiles, for example, is very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of the Democrats, however, is the size of potential reductions in Federal support.

- **Not on NGA agenda for this weekend, although DGA meeting may discuss** to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget disucssions that may be raised at NGA meeting.

- **Any block grant deal on welfare reform will serve as precedence** and political cover for Republicans who need the Medicaid money.

- **Weak but vocal advocates are opposed and scared:** many of these are considered our traditional Democratic base.

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
  - Leaves States at risk during recessions.
  - Places States at risk for cost of aging population.
  - Makes States less able to expand coverage.
  - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
  - Increases number of uninsured.
  - Exacerbates cost shifting.

MEDICAID CAP/BLOCK GRANT BACKROUND INFORMATION

PURPOSE:

To review the implications for states and for coverage under the Medicaid program of NGA and likely Republican proposals to cap Medicaid spending.

BACKGROUND:

Although not on the formal agenda, it is possible that the topic of capping the Medicaid program may be raised at the upcoming meeting with the Governors. (In all likelihood, if it is raised, it would come up in the context of the balanced budget amendment discussion.)

NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. The NGA staff recognize this "choice" is a political and not a practical policy response to a desire by many Republican Governors to assure that a Medicaid cap/block grant proposal is on the table for consideration. Democratic Governors, like Governor Chiles, have made the point that such a choice would not work in the Congress or in the budget world since states could choose what is best for them financially; as a result, the primary incentive for enacting a cap -- saving Federal dollars -- would likely not be achieved in any significant way.

A number of Governors have been discussing a Medicaid block grant with the Republicans in Congress. Both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about $375 billion over ten years (over $500 billion under the CBO baseline). In recent days, however, Governor Dean and his office have made clear he has made no deal and does have concerns.

It is worth pointing out that a 5% cap means that the states (in aggregate) must reduce total program costs by the $375 billion before they can begin reducing their own spending levels. While there are some low growth with fairly large base levels who could save money in the short-term, it is unlikely they could do so over the long term without cut-backs in services or programs.

Obviously, the Governors are interested in block grants because they free states from federal requirements and oversight. Many Governors appear to be willing to consider reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, if the Administration can come up with proposals that are responsive to the flexibility requests of the States that do not include Federal caps, such an approach could well be more attractive. (Such approaches are discussed at end of the memo).

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. The following outlines these concerns.

Converting from Individual Entitlement to a Block Grant Raises State Concerns:

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.

- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by $130 billion between 1996 and 2002, and by about $375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over $500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rises to 35% (40% under CBO baseline). This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from some Republican Governors (and particularly Republicans from the Hill) that large reductions in the growth of federal payments are acceptable because managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings , the savings are not nearly enough to compensate for the very large reductions being discussed with the block grant proposals.

Given the rapid expansion of managed care that already is occurring in states, a significant portion of the potential savings are already being realized. Also, managed care is applied almost exclusively to the nonelderly, nondisabled population, who account for only about one third of Medicaid expenditures. Preliminary OMB estimates show that if all nondisabled, nonelderly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. However, some states may use managed care as a mechanism simply to make large cuts in provider payments. In reality, this is a cost shifting strategy rather than cost containment.

Under the current baseline, Medicaid enrollment is projected to grow at about 4% annually. Medicaid per capita spending actually is projected to grow at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline would appear to assume either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program (including cuts in eligibility) are acceptable. While some states may be able to adapt to such a large reduction in federal support for a few years, most probably cannot. Over a longer period, few states could respond to this level of reduction without significant program cuts.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks. Although a few states might increase spending in response to federal payment reductions, most would likely reduce eligibility, benefits or payment levels.

The following scenarios assume that states maintain (or in the first case, increase) the level of spending projected in the baseline. The state responses shown below merely offset the reductions in federal spending -- they do not produce any savings to states. If states were to reduce their spending below the projected levels in order to achieve savings in their own budgets, additional reductions would be needed.

- **Increase State Medicaid Spending**
  If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;
  - In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

  If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on average by 13.7%. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

  - In 1997, a 6% reduction in hospital payments would be needed;
  - In 2002, a 22.9% reduction in hospital payments would be needed;;
  - In 2005, a 32.8% reduction in hospital payments would be needed.

  These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

  States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

  States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. However, given the magnitude of the reduction in federal payments, even when states spread the cuts over several of these categories, the reductions in each category would still be quite large. For example, a 5% cap would reduce federal payments to states in 2005 by about $66.3 billion below baseline projections. If a state chose not to increase spending and were to allocate their portion of this reduction roughly equally to reductions in provider payments, benefits and eligibility, it could achieve approximately the necessary savings through:

- Reducing provider payments by 12 to 13%.
- Eliminating coverage for prescription drugs and EPSDT, and
- Eliminating coverage for noncash children and qualified and special Medicare beneficiaries (QMBs).

And, because federal payments would continue to decline, further reductions would be needed in each future year. Other options are, of course, possible. Chart 3 gives you a partial menu of how much the elimination of particular populations and services (on a nantional level) would save. Some would argue that states would be more likely to choose eliminate AFDC adults rather than noncash kids and QMBs.

Even under less extreme proposals, federal payment reductions can be significant over time. For example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- $ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSION

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put those served by Medicaid at some risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

  During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting**. One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

Alternative To Capping Federal Payments that States May Find Attractive.

The obvious question is how to be responsive to States' legitimate need and desire for more flexibility without imposing significant reductions in Federal support. We have reviewed the NGA's health policy position paper's recommendations and have conducted our own internal analyis, which included discussions with OMB and HHS, and have come up with some interesting possibilities -- there may be even more -- that Iwe believe would be welcomed by the Governors. (Since Medicaid is not scheduled to come up before the NGA meetings, we probably should discuss when would be the most strategic and opportune time to begin discussions with the Governors on this issue.)

Specific and preliminary options to Medicaid cap now include:

- **Agree to NGA's request to eliminate the 1915(b) waiver approval process for states implementing managed care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Consistent with NGA request, agree to eliminate the waiver approval process for states implementing home and community-based care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.

- **Agree to NGA's request to establish safe harbors under the Boren amendment for state hospital payments.**

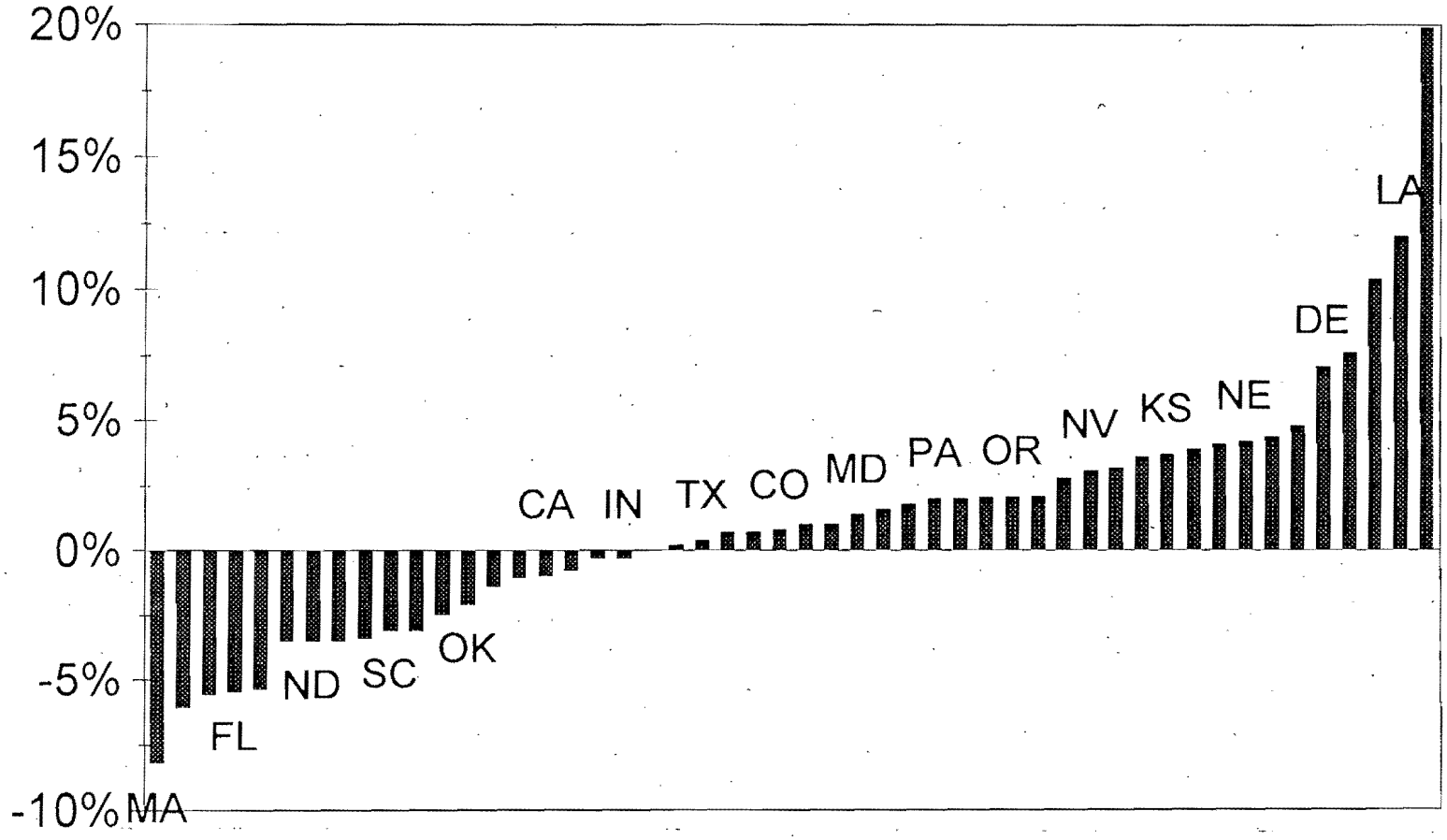
- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA's request for substantial modifications to the PASARR provisions under nursing home reform.** For example, agree that the annual resident review should be repealed.

- **Agree to NGA's request for the development of more demonstration programs that investigate the integration acute and long-term care services.**

Variation in State Medicaid Growth

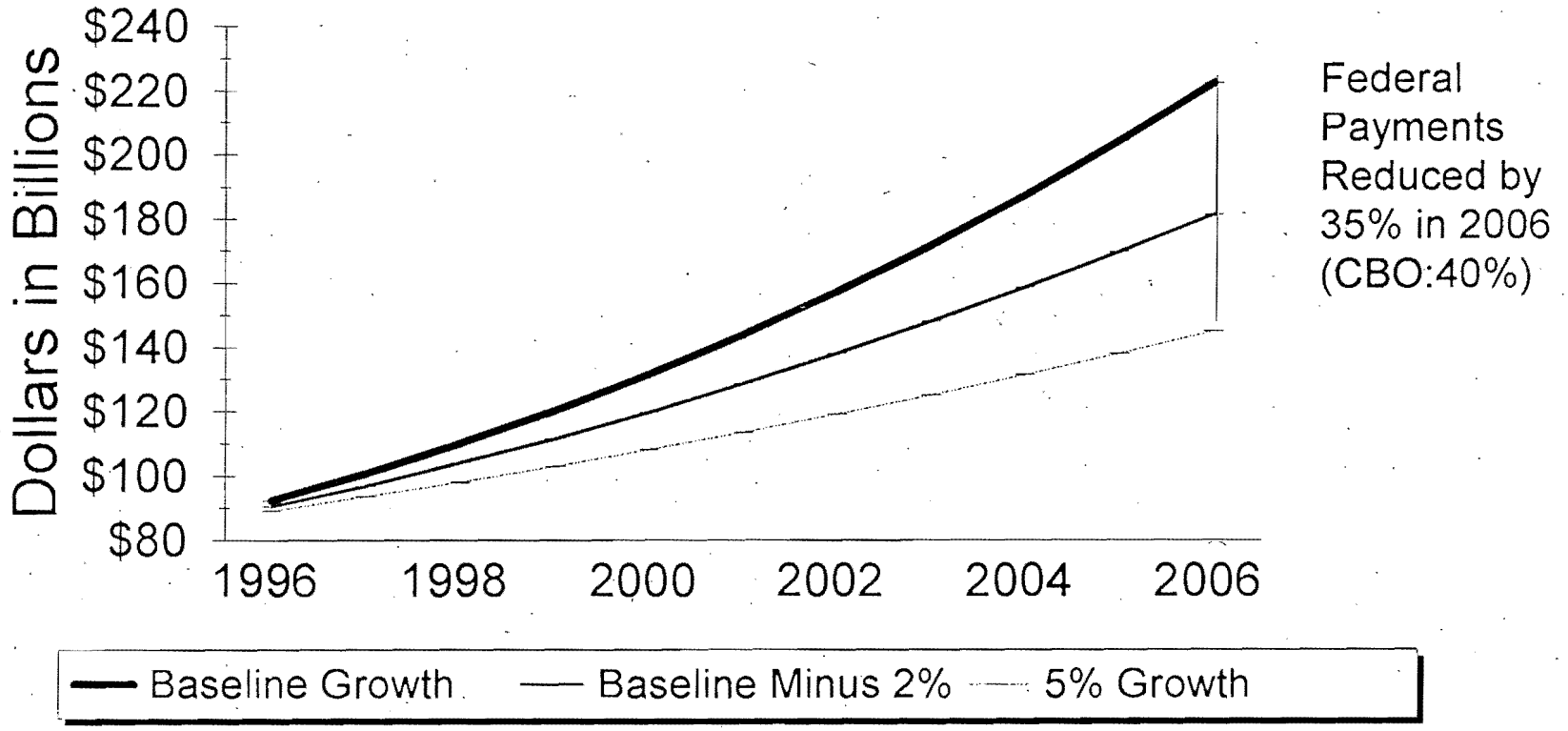
Difference from Average, 1990-1993



* Note: Average annual per capita growth rates, excluding Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Federal Medicaid Payments 1996-2006

Baseline & Capped Federal Payments



This wedge illustrates the cumulative effect of capped expenditures. Over time, the size of the federal payment reduction grows.

Potential Savings From Eliminating Selected Services or Recipient Categories

	1997 $ in billions	2005 $ in billions
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	1.9	3.9
Drugs	9.3	17.6
EPSDT	1.1	4.0
Home Health & Hospice	2.5	5.8
Medicare Premiums & Cost Sharing	4.7	10.8
Personal Care Services	3.8	7.1
Cost of Services for Recipients		
AFDC Adults	12.0	24.4
NonCash Kids (OBRA Expansion)	4.3	9.5
QMBs/SLMBs (1)	4.7	10.8
Medically Needy	22.1	38.8

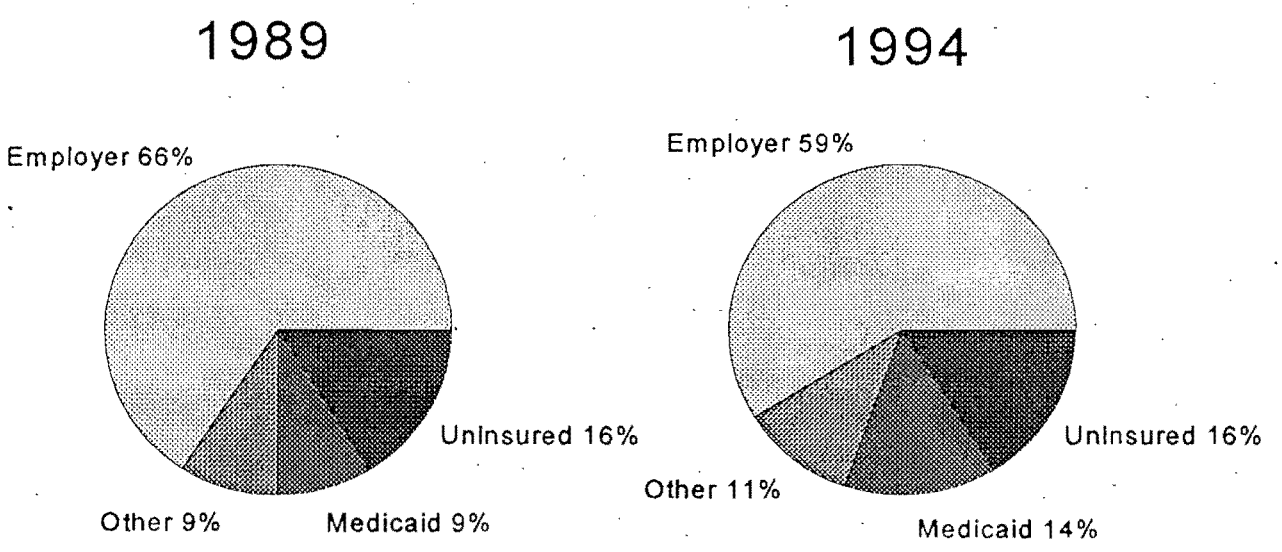
- The 1997 reductions will not be sufficient over time, because the size of the federal reduction would increase each year. For example, while eliminating dental benefits could achieve 28% of the required savings in 1997, in 2005 this service reduction would produce only 6% of the necessary savings.

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states, and overstate savings, because of interactions in the expenditure categories.

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.

~~CONFIDENTIAL~~ MEMORANDUM

DETERMINED TO BE AN
ADMINISTRATIVE MARKING
INITIALS: MF DATE: 8·23·05

TO: **Hillary Rodham Clinton**
RE: **Medicare/Medicaid and the budget**
DT: **12/14/94**
cc: **Melanne**

In this morning's budget discussion, Alice will lay out where we fall short in achieving the current goals of a tax cut (approximately $50 billion), a worker retraining initiative (approximately $25 billion), and avoiding a deficit problem. Apparently, we face a significant shortfall (particularly when you consider some of our possible assumed savings are unlikely to be politically viable), which will require painful decisions -- decisions that may bring back into play some significant cuts in Medicare and, possibly, Medicaid.

I believe one of the desires of this (and/or previous) meetings has been to come to closure on exactly what is the size/scope of the tax cut, so that the President can talk about it with some specificity on Thursday. The one point I think is important to emphasize is that publicizing a specific number may well signficantly constrain our budget options and may push us to look at significant cuts in the health entitlements for financing. **My primary point here is to suggest that, if finalizing a tax cut policy has the potential to drive other budget numbers, you may consider asking what implications any such decision has on health care savings proposals. For example, does this by definition tie our hands into any specific funding need from the health programs beyond the extenders and, if so, what are the specific implifications in terms of dollars necessary and impact on health policy politics (whether for our budget or in future negotiations on the Hill).**

It is now clear that, as far as Leon and OMB are concerned, both sets of Medicare extenders [$19 billion over 5 years and $125 over 10 years] that we have been talking about as possible health reform financing sources are already being assumed in the budget baseline. In other words, these Medicare savings are being used as funding sources for the non-health care spenders or to help reduce the deficit problem.

Because of the budget pressures, it does not come as a surprise that these extenders are apparently being assumed for non-health purposes in the budget baseline (although some of our supporters, including Senator Kennedy -- who just met with the President today, will be upset). What would create disproportionately greater problems is a move for significantly greater cuts from Medicare and possibly Medicaid to address real or perceived shortfalls.

Apparently Alice will be presenting a whole range of Medicare and Medicaid savings that may amount to over 85 billion dollars more OVER 5 years. I believe she is preparing this information because (1) she thinks we should be placing these on the table now so that we can define ourselves in terms of being willing to step up to the plate and show our desire to both reduce the deficit and have small investments in health reform; (2) she believes Leon and Bob are open to additional Medicare (particularly provider) cuts; (3) she has heard Laura talk about the possible need for an entitlement summit and possible implications of a small Medicare entitlement cap; and (4) she thinks we need money or at least more options on the table to make the numbers eventually work out.

The fears I have about Alice's presentation can be narrowed to one word: **LEAKS. If there is any public perception that we are talking about major Medicare/Medicaid cuts (particularly if they are not signficantly redirected for reform), we will hear a major outcry from our traditional base of consumer advocates and the elderly, the hospitals, and many other providers.** I would like to suggest that you emphasize this point.

You may also want to ask her when we will have the new Medicare/Medicaid baseline numbers incorporated into the baseline (which apparently will lower the deficit -- perhaps by tens of billions of dollars -- and thus hopefully reduce pressure on us to cut programs for deficit reduction). [She is pushing HHS for these numbers now, but their absence means that we will have to recalibrate our deficit numbers and proposed savings numbers in a very short period of time].

Lastly, it is possible that the subject of a Medicaid block grant or other Medicaid savings proposals may come up. There may be some political and policy appeal to these proposals. Because of the states strong desire for flexibility and the Governors ongoing discussions with the Republicans (and the President), the President may understandably be somewhat intrigued. As you know, however, there are tremendous implications with proposals such as these and I would only ask that we have an informed discussion on the matter preceeded by a DPC/NEC Map Group meeting to help us prepare.

In case the Medicaid blockgrant issue is raised, I am attaching some background information and some pros & cons on it for your use. (I do this although I understand from Melanne's intelligence that most of the budget participants -- other than Gene and perhaps the President -- are not seriously focusing on this proposal at this point).

I am sure I am giving you too much, but I thought this information might be helpful for both the morning budget meeting (if you go) and your afternoon meeting with Bob, Alice and Laura.

MEDICAID PROGRAM AND POSSIBLE BLOCK GRANT

Background on Medicaid

The Medicaid program provides acute health care and long term care services to low-income families, the disabled, and the elderly. The program is jointly funded by the federal government and the states, with the federal "match" varying from 50% to 78% depending on average income in a state.

Any low-income family receiving AFDC, or elderly or disabled person receiving SSI, is automatically eligible for Medicaid. Certain categorical groups not eligible for cash assistance -- including low-income pregnant women and children -- may also eligible for Medicaid, with income thresholds generally varying from state to state.

Certain services and eligibility levels are specified in federal law, while others are funded on a matched basis by the federal government at the option of states.

Where Medicaid Dollars Go

- Medicaid is a program that serves five groups of people:
  - Low income mothers
  - Children
  - Non-elderly disabled people get health insurance and long-term care.
  - Poor elderly people get Medigap-like insurance to supplement Medicare.
  - Disabled elderly get long-term care.

- A disproportionate share of Medicaid funds are spent on elderly and disabled people:
  - Low income kids and adults account for 73.1% of Medicaid enrollees, but consume only 32.8% of total Medicaid spending.
  - Nonelderly disabled people comprise only 15.5% of Medicaid enrollees, but account for 38.7% of spending.
  - Elderly people make up only 11.5% of Medicaid enrollees, but account for 28.4% of spending.

- The Medicaid program is projected to grow at about 10.5% annually through the end of the decade (this may change slightly with new baseline). About two-fifths of the growth is projected growth in enrollment.
  - The disabled population on Medicaid is projected to grow by 8.2% per year.
  - The welfare population is projected to grow by less than 2% per year.
  - Enrollment in Medicaid of non-welfare children under poverty is projected to grow at 4% per year.

- The increase in per capita spending for Medicaid beneficiaries is projected to be about 6.5% annually; about the same as the projected per capita increase for private health insurance.

A Medicaid Block Grant

The Republicans, as part of their budget proposal, are likely to propose significant cuts in the Medicaid program. To be better able to influence the debate on this issue, it has been argued that the administration needs to propose some cuts in Medicaid as part of its budget. One option that has been put forward is for the administration to propose a Medicaid block grant.

Under a Medicaid block grant, the program could remain an entitlement, but it would be an entitlement to states rather than to individuals. The block grant would grow each year at a defined rate; to produce federal savings, the rate of growth would have to be lower than current federal projections. States would likely have broad flexibility to determine what kinds of services to provide and who receives them.

Arguments For a Block Grant Proposal

- Would permit the Administration to propose significant reductions in federal Medicaid spending (by capping growth in total spending) without identifying specific cuts that would provoke significant opposition.

- Proposing some reductions in Medicaid demonstrates the administration's commitment to re-evaluating existing government programs and allows the administration to oppose more significant cuts without being perceived as defending the status quo.

- Would provide states with relief from unfunded mandates.

- Would give states greater flexibility to respond to local circumstances.

- States willing to increase spending would have broad flexibility under a block grant approach to pursue strategies to reform their health care systems.

- A block grant proposal may be popular with governors.

Arguments Against a Block Grant Proposal

- Significant reductions in Medicaid would very likely lead to reductions in coverage or services.

  Medicaid is growing faster than private health spending because of enrollment growth -- not program inefficiency. (The per capita growth in Medicaid is about the same the per capita growth in private health insurance). There is no reason to expect that the Medicaid program can contain costs more successfully than the private sector. As a result, capping the program to achieve significant savings (e.g., Medicaid population plus general CPI) would inevitably lead to reductions in coverage or services.

- Proposing a cap on Medicaid (with or without a block grant) would provoke vocal criticism from many groups that are part of the Democratic base. And, despite the welfare image of the program, 67% of all Medicaid spending is for the elderly, blind, and disabled. A block grant proposal could engender significant opposition from these groups.

- Some states may atempt to control costs through further cuts in provider payments, which could reduce access or shift costs to the private sector.

- The administration has criticized the Republicans for failure to be specific in many of their budget and tax proposals. We may be subject to the same charge if we go with something that looks like a cap.

- The process of determining how much each state gets, how much the block grant increases over time, whether DSH continues, and what strings may be attached will be controversial and will pit some states against others.

- Block grants eliminate the federal floor for Medicaid eligibility and services and encourage states to reduce their programs to avoid becoming magnets for the poor and sick.