Health budget

DRAFT: HEALTH CARE
USES OF FUNDS FOR THE FY 2000 BUDGET

(Dollars in billions, fiscal years)

DISCRETIONARY	Requests	OMB Passback	HHS Appeal	WH Priorities	COMMENTS
	2000	2000	2000	2000	
Bioterrorism	0.370	0.152	+ 0.218	+ 0.090	High priority
Superbug	0.020	0.000		+ 0.010	High priority
AoA Caregiver Program	0.150	0.010	+ 0.140	+ 0.140	Needed for LTC initiative
Nursing Home Quality	0.100	0.035	+ 0.013	+ 0.100	GAO investigation underway/ need $
Medicare LTC Education	0.025	0.000		+ 0.025	Needed for LTC initiative
AIDS: Ryan White	0.100	0.072		+ 0.050	OMB funding only minimum
AIDS: CBC Initiative	0.100	0.000	+ 0.050	+ 0.050	Needed for CBC
Race & Health	0.080	0.000	+ 0.103	+ 0.050	High priority
Mental Health	0.100	0.000	+ 0.116	+ 0.100	VP priority
Asthma (only EPA funds)	0.025	0.000	+ 0.050	+ 0.025	Funded through EPA/maybe Medicaid
Medicaid de-institut. grant	0.050	0.000	+ 0.038		Other disability policies should be enough
Rural emergency services	0.050	0.000		+ 0.025	POTUS interest/possible mandatory
FDA, Food Safety	0.550	0.127	+ 0.263	+ 0.050	Need $50 m for food safety
Native Americans	0.500	0.175	+ 0.205		Probably OK
Children's GME	0.150	0.000		+ 0.040	FLOTUS priority
DoD Cancer, osteoporosis					Want $200 million of DoD increase
Biomedical Research	0.500	0.049	+ 1.500		Problem that won't go away
TOTAL	2.870	0.620	+ 2.696	+ 0.755	

MANDATORY	Requests	OMB Passback	Additions/ Priorities	
	2000-04	2000-04	2000-04	
Jeffords-Kennedy	1.200	1.200		
Medicare Buy-In	1.700	0.000	+ 1.700	POTUS interest
Cancer Clinical Trials	0.750	0.000	+ 0.750	VP priority
Medicaid disability option	0.110	0.110		Important to disability community
Medicaid for Foster Kids	0.050	0.050		FLOTUS priority
Legal Immigrant Kids	0.100	0.100		Last year's proposal
CHIP Territories	0.100	0.100		" "
QMB Low-Income Reforms	0.000	0.000		Depending on baseline, budget neutral
Kids' Outreach	0.000	0.000		" "
TOTAL	4.010	1.560	+ 2.450	

DRAFT: HEALTH CARE
SOURCES OF FUNDS: FY 2000 BUDGET OPTIONS

	OMB LIST		COMMENTS
	2000	5 Years	
For Discretionary Programs			
DRG Payments	0.084	0.420	Somewhat controversial
Single Fee for Surgery	0.140	0.760	Somewhat controversial
Lab Fees	0.030	0.190	Can only have 1 Lab policy (see below)
Hospice Double Payment	0.060	0.360	Very controversial
Reducing Prosthetics & Orthotics	0.090	0.470	Very controversial/contrary to disability init.
Reducing Enteral Nutrients	0.030	0.150	Very controversial
Subtotal	***0.434***	***2.350***	
MIP/ Flatlining Fraud **	0.090	0.990	Contrary to fraud efforts
Bad Debt Payment Reductions	0.160	1.490	Dropped from Omnibus: very controversial
Hospital Update Reduction	0.250	4.600	Viable but controversial/ should lower amt.
DSH Reduction or Medicaid Admin **	0.150	1.770	Not good policy
IME reform **	0.300	2.000	Ahead of Commission/ not for this year
Subtotal	***0.950***	***10.850***	
TOTAL	**1.384**	**13.200**	
For Mandatory Programs			
Cost Allocation			
With TANF Prohibition	0.295	1.900	Very controversial/bad policy
Without TANF Prohibition	0.050	1.000	Better but still difficult
Last Year's Program Integrity		2.300	OK
20% Lab Coinsurance for lower prevent. copays		0.300	Ahead of Commission/one 1 Lab policy
Medicaid Generics		0.100	Slightly controversial
Technical Fix to Medicare SGR (physicians)		0.300	OK
TOTAL		**5.900**	

** OMB may drop on its own.

Clinton Plans New Health Care Fight

On Eve of Election Year, a Proposal to Overhaul H.M.O. Rules

By ROBERT PEAR

WASHINGTON, Nov. 23 — President Clinton is preparing for another election-year battle over health care as he proposes sweeping new Federal regulations for insurance companies and health maintenance organizations to protect patients' rights.

A Presidential advisory panel recommended last week a bill of rights for patients. But in urging Congress to translate the rights into law, Mr. Clinton went beyond the recommendations of the 34-member panel, which reserved judgment on who should enforce the proposed standards.

In advocating regulation, Democrats believe that they have a winning issue that resonates with voters, many of whom have had frustrating experiences with health maintenance organizations. White House officials said they would welcome a fight over the issue, which they expect will unite Democrats and divide Republicans in the election season next year.

Health insurance has historically been regulated by the states. Democrats see a clear need for Federal laws and regulations to set standards for insurers and H.M.O.'s. More than a third of Congressional Republicans, including some conservatives, support such legislation, which would help consumers navigate a rapidly changing health system.

But the House Republicans' floor leader, Dick Armey of Texas, and the Senate Republican leader, Trent Lott of Mississippi, adamantly oppose a new regulatory regime, saying it would increase the cost of benefits. The higher costs, they say, would force employers to cut back health benefits, increasing the number of uninsured Americans and whetting the public appetite for new Government health programs.

On Thursday, Mr. Clinton enthusiastically endorsed the proposals, which would give consumers access to additional information about the quality of health plans, the right to appeal a denial of care or reimbursement and an assurance that medical records would be kept confidential. Similar proposals were in Mr. Clinton's ill-fated scheme to redesign the health care system in 1993 and 1994.

Mr. Clinton is no longer proposing universal insurance coverage, a standard package of benefits or a requirement for employers to provide such benefits. But the President made clear that the old impulses, the yearnings for health security for all, are just below the surface.

"There is," he said, "an emerging consensus that while people may not have wanted to bite the whole apple at once in 1994, almost the whole population wants to keep nibbling away at the apple until we actually have solved the problems of cost, accessibility and quality for all responsible American citizens."

Karen M. Ignagni, president of the American Association of Health Plans, the chief lobbyist for H.M.O.'s, spoke for many in the industry when she said, "It's beginning to feel a lot like 1993."

Some members of the President's advisory panel were stunned by the speed of his endorsement, which preempts much of the work they had been planning to carry out in the next four months.

> Democrats hope an issue of rights strikes a chord with voters.

The panel would never have achieved consensus if members had known that their recommendations would be the basis for new laws. Many members prefer using private accreditation agencies to insure compliance with the proposed standards.

One panel member, J. Randall MacDonald, executive vice president of the GTE Corporation, said, "These standards can be carried out voluntarily, without the need for Federal legislation."

GTE, which provides health coverage to 400,000 people, said it would voluntarily adopt the standards.

In its report to the President, the panel skirted the question of how to enforce and carry out the proposed rights.

"The rights enumerated in this report," the panel said, "can be achieved in several ways, including voluntary actions by health plans, purchasers, facilities and providers; the effects of market forces; accreditation processes, as well as state or Federal legislation or regulation."

The group promised to choose among the alternatives in its final report, due on March 30.

The question of enforcing patients' rights is more explosive than the substance of the guarantees.

Another commission member, Gail L. Warden, president of the Henry Ford Health System in Detroit, said, "It's premature to be proposing how the bill of rights should be implemented."

The prospect of new laws may discourage employers and health plans from "buying into what we're trying to accomplish," Mr. Warden said.

More than 200 House members, including 91 Republicans, are cosponsors of a comprehensive bill to set detailed standards for the operations of H.M.O.'s and health insurance companies. The bill, introduced by Representative Charlie Norwood, Republican of Georgia, is supported by some conservative Republicans.

Melody J. Harned, a lobbyist at the Health Insurance Association of America, said that on the issue of standards, "the far left and the far right are coalescing, it seems."

In a memorandum last month, Ms. Harned said, "The message we are getting from House and Senate leadership is that we are in a war and need to start fighting like we're in a war" over the Federal regulation of health insurance.

Vice President Al Gore took up the challenge. "If any special interests want to make this a war, it's one we're proud to fight in behalf of America's families."

Representative Marge Roukema, a moderate Republican from New Jersey, cautioned her party's leaders. "The handwriting is on the wall," Mrs. Roukema said. "We can't be practicing medicine on the floor of the House of Representatives. But we've got to have some national standards, because Americans are extremely concerned about the practices of H.M.O.'s. If the Republican Party hopes to remain a national majority party, it can't just stand there saying no, as it has in the past."

The New York Times

MONDAY, NOVEMBER 24, 1997

While Congress Is Away, Clinton Toys With Idea of an End Run

By JOHN M. BRODER

WASHINGTON, Nov. 21 — A constitutional power rooted in the muddy roads and farm rhythms of the 18th century may give President Clinton a chance to salvage — at least for a few months — the troubled nomination of Bill Lann Lee to head the civil rights division in the Justice Department.

Before leaving town last week on a 10-week recess, Senate Republicans made clear their opposition to Mr. Lee's being in the post because of his views on racial preferences. But Congress adjourned without acting on the nomination, presenting Mr. Clinton an opportunity to put Mr. Lee in office under a so-called recess appointment.

That would be a defiant move on the President's part, a thumb in the eye of the Senate Republican leadership and a challenge to the senatorial power of advice and consent. The President and his aides may be willing to risk a confrontation and Senate retaliation to make a point on affirmative action and to shore up support among minority-group voters.

Article II, Section 2 of the Constitution gives a President the authority to fill vacant positions "that may happen during the recess of the Senate." The appointee can hold the office until the end of the next Congressional session, unless a Senate vote explicitly rejects the officeholder.

The section was written when Congress met a few months a year, travel times were long and the Congressional calendar was set to accommodate planting schedules. Presidents often needed to fill Cabinet posts, judgeships and ambassadorial positions months before the Senate could convene.

In Mr. Lee's case, the use of a recess appointment would allow him to serve at least until the Senate adjourns next autumn. The Administration could continue to lobby to win his permanent confirmation and Democrats could filibuster to block any effort to vote him out of office.

But the political cost of such an act would be high, after Senate Republicans have unambiguously stated that Mr. Lee, a former top lawyer for the NAACP Legal Defense and Educational Fund Inc., is unacceptable.

Presidents since George Washington have used recess appointments in the gaps between Congressional sessions. The Senate has never looked kindly on the practice, but has seldom rejected recess appointees.

President Dwight D. Eisenhower put three Justices on the Supreme Court while the Senate was adjourned: Earl Warren, William J. Brennan Jr. and Potter Stewart. All were later confirmed.

President Ronald Reagan made liberal use of the power, naming 139 people to posts in his first term. The affront to senatorial privilege ultimately had its price for Mr. Reagan. He used a five-week recess in August 1985 to make eight appointments, none particularly controversial, but enough to move Senator Robert C. Byrd, the West Virginia Democrat who was Senate majority leader, to declare that he had had enough.

Mr. Byrd held up 5,871 pending nominations, including more than 5,000 military promotions, several appellate judgeships and two high-ranking United Nations nominees. He refused to relent until Mr. Reagan promised to notify the Senate before more recess appointments.

Mr. Clinton is aware of the bipartisan senatorial hostility to recess appointments, his aides say. He has used the power sparingly, exercising it 37 times in his first five years in office, many of those for part-time boards and commissions. All have been confirmed or served their terms without controversy.

Mr. Lee's case would be dramatically different, because Senate Republicans have already pronounced him unfit. Mr. Clinton is considering a recess appointment because he feels strongly that Mr. Lee is eminently qualified and because he does not want to give up on the appointment without a fight, aides said.

Installing Mr. Lee in the Justice Department as Congress is out of town and over the express opposition of Senator Orrin G. Hatch, the Republican of Utah who is chairman of the Judiciary Committee, would be a calculated gamble, certain to infuriate the Republican leadership and cause lasting damage in the relationship between the White House and Congress.

The White House appears to be on a collision course with the Senate. Erskine B. Bowles, Mr. Clinton's chief of staff, said last week that the refusal to vote on Mr. Lee's nomination was disgraceful. He threw down the gauntlet, saying, "I assure you he will be the next Assistant Attorney General for civil rights."

Mr. Hatch's advice to the President was to forget it. "If the President recess appoints him," Mr. Hatch said, "it would be an unfortunate elevation of politics above due respect for the Senate, its procedures and its constitutional responsibilities. It would serve as evidence, in my opinion, that this Administration does not wish to achieve consensus on the difficult issue of race but is instead intent on playing wedge politics."

Mr. Hatch stopped shy of threatening retaliation, saying he was above such pettiness. But he warned that a number of Republican members of Congress would seek to punish the White House on appointments or unrelated requests. "It would be taken very badly by Republicans on Capitol Hill," he said.

White House aides are sounding out Mr. Lee to see whether he is willing to abide the inconvenience of moving across the country for an uncertain tenure in a job that a majority of the Senate Judiciary Committee does not want him to have. If he is game, Administration officials indicated, they are leaning toward picking a fight in the Senate and are hoping to win in the court of public opinion.

Thomas E. Mann, an expert on Congress at the Brookings Institution, said Mr. Lee would find his freedom of action severely limited if he obtained his job in a recess appointment. He would face constant demands for testimony and second-guessing from the committee that oversees the budget and operations of the Justice Department.

On the other hand, Mr. Lee's appointment would carry significant political benefits for Mr. Clinton, who has a reputation for going squishy over controversial appointments, Mr. Mann said. The appointment would shore up Mr. Clinton's constituency on the left and among minority groups and cost him little among Republicans, who vehemently oppose him on affirmative action, anyway. "Why not take a stand, show your loyalty and your willingness to fight for a constituency that isn't very happy with you right now?" Mr. Mann asked, echoing current thinking in the White House.

But moral victories have their price, as many Presidents have learned. President Washington used a Senate recess in the summer of 1795 to appoint John Rutledge of South Carolina as Chief Justice of the United States, knowing that the majority Federalists were hostile because of Rutledge's support for the Jay Treaty on trade with England.

Rutledge presided over two cases as Chief Justice, but when the Senate returned in the fall it voted, 14 to 10, to reject his nomination, dealing a defeat to Washington and a humiliating blow to Rutledge.

"Rutledge, who had been depressed since the death of his wife in 1792, attempted suicide by jumping off a wharf into Charleston Bay," according to the Oxford History of the United States Supreme Court. "He spent most of the remainder of his life as a recluse."

The New York Times
MONDAY, NOVEMBER 24, 1997

10/22/98

Bruce,

Attached is the current edition of the health care budget ideas. As you know, these will be altered as new policy and budget information becomes available. However, they do represent the most likely priorities for the budget deliberations.

The tax incentive provisions and the spending initiatives from last years budget are in fairly good shape in terms of scoring. It will take more time to develop sound cost estimates for the new initiatives, but we have done our best to estimate expenditures where possible. Having reviewed the initial HHS budget submission and talked with OMB, we believe that the vast majority of these initiatives are viable.

We do expect there to be additional public health initiatives that we'd like to talk to you about. In addition, we are still working with Labor on a number of their health care initiatives.

We are also reviewing funding included in the omnibus bill that we may be able to highlight later this fall. As we discussed, we are looking to explore initiatives at CDC related to the superbug and other public health challenges.

If you need to talk with me about these initiatives prior to your meeting tomorrow, don't hesitate to contact me via SkyPage. Hope the information is helpful.

Chris

HEALTH BUDGET IDEAS (October 22, 1998)

1. Long-Term Care

- **Long-term care tax credit**. (new policy) Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major cost burden for the elderly and their families. Long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries. This proposal would give people with three or more limitations in activities of daily living (ADL) or their caregivers a tax credit of up to $1,000 to help pay for formal or informal long-term care. (Cost: About $4.6 billion over 5 years, offset by closing some tax loopholes; helps about 2.3 million people).

- **Offering private long-term care insurance to Federal employees.** (new policy) Since expanding Federal programs alone cannot address the next century's long-term care needs, the Federal government --as the nation's largest employer --could illustrate that a model employer should promote high-quality private long-term care insurance policies to its employees. Under this proposal, OPM would offer its employees the choice of buying differing types of high quality policies and use its market leverage to extract better prices for these policies. There would be no Federal contribution for this coverage. (Cost: Small administrative costs; OPM estimates about 300,000 participants).

- **Family Caregiver Support Program.** (new policy) About 50 million people provide some type of long-term care to family and friends. Families who have a relative who develops long-term care needs often do not know how to provide such care and where to turn for help. This proposal would give grants from the Administration on Aging to states to provide for a "one-stop-shop" access point to assist families who care for elderly relatives with 2 or more ADL limitations and/or severe cognitive impairment. This assistance would include providing information, counseling, training and arranging for respite services for caregivers. (Cost: About $500 -750 million over 5 years).

- **Nursing home quality initiative.** Last July, the President announced an initiative to dramatically improve the quality of nursing homes, by strengthening nursing home enforcement tools and improving Federal oversight. This past week, the Justice Department and HCFA held a conference to begin to develop other nursing home quality/anti-fraud and abuse initiatives with enforcement agencies across the nation. To respond to the critical need to improve quality of nursing homes, implementing the initiatives the President outlined in July or other new efforts could be included in the budget or as a freestanding initiative. These initiatives will no doubt include new enforcement provisions (e.g., increased penalties, etc.), as well as new funds to

conduct more frequent surveys of repeat offenders and improve surveyor training. We are also working with the Department to explore the possibility of establishing a Nursing Home Commission to oversee HCFA's efforts. (Costs:$750 million over 5 years).

- **Tax credit for work-related impairment expenses for people with disabilities**. (new policy) Almost 75 percent of people with significant disabilities are unemployed; many of those within the population cite the cost of employment support services/devices, as well as the potential to lose Medicaid or Medicare coverage, as the primary barriers to seeking and keeping employment. This proposal would give a 50 percent tax credit, up to $5,000, for impairment-related work expenses. This policy overlaps to some degree with the Jeffords-Kennedy Work Incentive proposal, described later, but has the advantage of helping people in all states irrespective of whether states take up optional coverage. (Cost: About $500 million over 5 years, offset by closing tax loopholes, and would help about 300,000 people).

2. Modernizing Medicare

- **Adopting private sector, competitive pricing strategies**. (FY 1998 budget) The President has consistently supported making Medicare more competitive by giving the Health Care Financing Administration the same tools to manage health care costs as are used by private sector plans. This includes competitive pricing for services like durable medical equipment and other supplies; expanding the competitive pricing demonstration for managed care; and adopting new payment methodologies like Centers of Excellence, among others. Although these ideas are being considered by the Medicare Commission, the President could take the lead on improving competition within Medicare since he has supported this approach in the past. (Savings: $0.1 to $0.5 billion, depending on the policies).

- **Prescription drug coverage for Medicare beneficiaries** (new policy). The lack of coverage for prescription drugs in Medicare is widely believed to be its most glaring shortcoming. Virtually every private health plan for the under-65 population has a drug benefit, in recognition of the medical community's reliance on prescriptions for the provision of much of the care provided to Americans. Lack of Medicare coverage of drugs results in high out-of-pocket beneficiary costs --which will only increase in the next century as most advances in health care interventions will be pharmacologically-based. Responding to this fact, Republicans and Democrats on the Medicare Commission, as well as almost every health care policy expert, are consistently stating that reforming Medicare without addressing the prescription drug coverage issue would be a mistake. We are developing a wide variety of options, including a means-tested Medicaid option, a managed care benefit only approach, a traditional benefit for all beneficiaries, and an unsubsidized purchasing mechanism that uses Medicare's size as leverage for drug discounts for beneficiaries. If desirable, a proposal could be included in the budget or coordinated with the March release of the Medicare Commission's recommendations. (Cost: Varies significantly depending on

proposal, but could be $1 to 20 billion a year; assumed offset would be Medicare savings, which might more easily be achieved in context of a broader reform proposal).

- **Protecting beneficiaries from HMO withdrawals from Medicare**. This year, a number of HMOs have pulled out of Medicare with only a few months notice, leaving 50,000 beneficiaries with no plan options in their areas. These withdrawals are causing beneficiaries unnecessary hardships as they rush to find alternative sources of coverage. The President has stated his determination to work with the Secretary of HHS and Congress to develop legislation to prevent this behavior in the future (e.g., limit the time between when a plan files to participate in Medicare and when enrollment begins, making it less necessary for plans to pull out at the last minute). (Cost: not clear that there will be costs).

- **Medigap reform for people with disabilities.** In 1997, the President endorsed bipartisan legislation from Rockefeller, Chafee and Nancy Johnson that makes Medigap supplemental insurance more accessible to beneficiaries. The Balanced Budget Act did include some of its important protections for seniors on Medicare, but essentially excluded beneficiaries with disabilities from this reform. This proposal would make all Medigap insurers provide Medigap to people with disabilities when they sign up for Medicare. It would also ensure that they get a guaranteed issue Medigap option when transitioning out of a Medicare managed care plan --including in the event that their HMO withdraws from Medicare. (Cost: not clear that there will be costs).

- **Cancer clinical trials demonstration** (FY 1999 budget; not passed). Less than three percent of cancer patients participate in clinical trials. Moreover, Americans over the age of 65 make up half of all cancer patients, and are 10 times more likely to get cancer than younger Americans. This proposed three-year demonstration, extremely popular with the cancer patient advocacy community, would cover the patient care costs associated with certain high-quality clinical trials. (Cost: $750 million over 3 years).

- **Redesigning and increasing enrollment in Medicare's premium assistance program** (extension of July executive action and new policy). Over 3 million low-income Medicare beneficiaries are eligible but do not receive Medicaid coverage of their Medicare premiums and cost sharing. Many more may not get enough assistance through the new BBA provision that is supposed to help higher income beneficiaries. We are developing a range of proposals that build on the President's actions in this area to better utilize Social Security Offices to educate beneficiaries about this program, to reduce administrative complexity for states and to give them incentives to engage in more aggressive outreach efforts. (Costs vary depending on policies; up to $500 million over 5 years).

- **Reducing Medicare fraud and overpayment**. (Some FY 1999 policies; some new

policies) Medicare fraud costs the program billions of dollars each year and many seniors believe it is the largest threat to the program. In every budget for the last 5 years, the President has proposed new initiatives to help combat excessive payments and provider fraud in Medicare. Last year alone, Medicare saved over $1 billion through these efforts. The President announced last January a 10-point plan for reducing fraud and overpayment, including provisions like reducing overpayments for drugs and ensuring Medicare does not pay for claims that ought to be paid by private insurers. HHS and the Department of Justice continue their efforts to enforce current policies, reintroduce those that did not pass, and develop new ones. (Savings: From $1 to 3 billion over 5 years, depending on the policies).

3. **Health Insurance Coverage Expansions.**

- **Providing new coverage options for people ages 55 to 65** (FY 1999 budget; not passed). Americans ages 55 to 65 have a greater risk of becoming sick; have a weakened connection to work-based health insurance, and face high premiums in the individual insurance market. This three-part initiative would: (1) allow Americans ages 62 to 65 to buy into Medicare, through a premium designed so that this policy is self-financed; (2) offer a similar Medicare buy-in to displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) give retirees 55 and over whose retiree health benefits have been ended access to their former employers' health insurance. A proposal such as this would be minimally necessary for any serious consideration of proposals to raise Medicare's eligibility age. (Cost: $1.5 billion over 5 years, which would assist about 300,000 people).

- **Jeffords-Kennedy Work Incentives Improvement Act**. (Congressional proposal; not passed). In the final budget negotiations, the Administration put the Jeffords-Kennedy bill on its list of top priorities for passage this year. This bill would enable people with disabilities to go back to work by providing an option to buy into Medicaid and Medicare, as well as other pro-work initiatives. Although it was rejected by Republicans, we received a great deal of credit from the disability community for advocating this policy and for sending a message that we will continue to fight to give people with disabilities the opportunity to work --including the critical health insurance that makes work possible. (Cost: About $1.2 billion over 5 years)

- **Health coverage for workers between jobs** (FY 1997 and 1998 budgets; not passed). Because most health insurance is employment based, job changes put families at risk of losing their health care coverage. Many families do not have access to affordable health insurance when they are between jobs because they work for firms that do not offer continuation coverage or cannot afford individual insurance. The proposal would provide temporary premium assistance for up to six months for workers between jobs who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own. (Costs depend on whether it is done as a demo (about $2.5 billion over 5 years, which would help about 600,000 people) or nationwide (about $10 billion over 5 years, which would cover

about 1.4 million persons).

- **Children's health insurance outreach** (FY 1999 budget; not passed and new policy). Only shortly after the first anniversary of CHIP, about 45 states have CHIP plans approved. These new expansions have great potential to help uninsured children, but not if families do not know or understand the need for insurance. Moreover, over 4 million uninsured children are eligible for Medicaid today but are not enrolled. Last year's budget included several policies to promote outreach, including allowing states to temporarily enroll uninsured children in Medicaid through cites such as child care referral centers, schools; and allowing States to access extra Federal funds for children's outreach campaigns. An additional proposal is to pay for a nationwide toll-free number that connects families with state eligibility workers. Such a line is essential for the nationwide media campaign that we are planning to launch in January with the NGA. However, NGA is sponsoring this line for one year only. (Cost: Between $400 and $1 billion over 5 years; could be funded through tobacco recoupment)

- **Medicaid options for older children/young adults** (new policy). Nearly one in three people ages 18 to 24 lack health insurance. Additionally, the parents of low-income children covered through Medicaid and CHIP are often left uninsured. One proposals would give states the flexibility to continue covering children who lose eligibility only because they turn 18 years old. This extension would be administratively simple, targeted, and help young people whose first jobs often lack health insurance. (Cost: Unknown at this point).

- **Voluntary purchasing cooperatives** (FY 1997, 1998, and 1999 budgets; not passed). Workers in small firms are most likely to be uninsured; over a quarter of workers in firms with fewer than 10 employees lack health insurance —almost twice the nationwide average. This results in large part because administrative costs are higher and that small businesses pay more for the same benefits as larger firms. This proposal would provide seed money for states to establish voluntary purchasing cooperatives. These cooperatives would allow small employers to pool their purchasing power to try to negotiate better rates for their employees. The Office of Personnel Management would provide technical assistance, so that this coops are modeled on the Federal Employees Health Benefits Program (FEHBP) (Cost: about $100 million over 5 years).

4. Paying for Health Education and Uncompensated Care

- **Providing needed education funds to children's hospitals.** Medicare has invested billions of dollars in graduate medical education to hospitals since 1966. However, because of its current formula, free-standing children's hospitals are forced to shoulder the majority of the cost of training pediatricians, placing them at a severe financial disadvantage. This proposal would modify the distribution formula to provide reimbursement for the training costs incurred by children's hospitals. Addressing

children's hospitals' education financing has bipartisan support, and Senator Frist has made this a priority for the Medicare Commission (Costs: depends on the proposal).

- **Improving the targeting of tax subsidies for hospitals providing uncompensated care**. About $7 billion in preferential tax treatment is granted each year to nonprofit hospitals to help offset the costs of providing care for uninsured and underinsured people. However, this tax preference is not well targeted: hospitals with a great burden often don't get enough help, while hospitals providing little care get too much. This proposal --which is very preliminary --would replace the preferential tax treatment of non-profit hospitals with a new uncompensated care pool. This pool would, through the tax system, provide assistance to hospitals that demonstrate that they provide a lot of uncompensated care. This proposal could be considered in tandem with proposals to reform the Medicare disproportionate share payment (DSH) system, which also intends to cover these costs. (Cost: none; budget neutral).

Public Health/Underserved Populations

- **Combating Resistance to Anti-biotics (Super Bug).** Recent reports have indicated that resistance to anti-biotics is becoming a major public health crisis. Some viruses, such as pneumonia and many hospital-based infections becoming resistant to even the strongest anti-biotics, causing prolonged illnesses and even death. For example, pneumonia, which impacts over 500,000 Americans per year, is becoming resistant to the strongest antibiotics. CDC believes that this critical public health problem is on track to affect more and more viruses as it is becoming more difficult to develop new effective antibiotics. However, this problem could be reduced if we knew more about which viruses are likely to become resistant and why and if drugs were prescribed and used more appropriately. For example, there are over 50 million inappropriate outpatient antibiotic prescriptions written annually. The budget could fund a major public health campaign that would: educate consumers and health providers to help assure appropriate use of antibiotics; assure awareness about appropriate guidelines, and improve surveillance and research efforts to understand which antibiotics are at risk for becoming ineffective and why. (Cost: up to $50 million).

- **Improving Access to Health Care in Underserved Rural Areas.** The 25 million Americans that live in rural areas frequently do not have access to adequate health care services. For example, the physician-to-patient ratio is more than 80 percent lower in rural communities and more rural Americans are uninsured and lack access to health care services. The budget could include an initiative that would help maintain and improve access to health care in rural communities by: giving grants to help develop creative emergency services to enable rural health facilities to remain operational and responsive to the needs of their populations; providing assistance to states to help take advantage of a Balanced Budget Act provision that provides higher Medicare payments to hospitals that revamp services to meet the specific needs of their communities; and increasing the number of health professionals in rural communities by providing loan repayments or scholarships to train rural Americans who are likely to stay in the communities to become nurse practitioners. (Cost: Unclear. Approximately $100 million).

- **Reauthorizing the Older Americans' Act.** The Older Americans' Act has played a critical role in responding to the diverse needs of our nation's seniors. For example, it provides 240 million meals to over one million vulnerable seniors each year through its meals-on-wheels program; finances and supports an ombudsman program that helps resolve tens of thousands of problems affecting nursing homes and other vulnerable populations, including abuse and neglect; and, in many communities, it provides the type of adult day care that gives families a much needed respite from caregiving responsibilities. Many in the aging community believe the fact that the Congress has not reauthorized this program in several years undermines this program and the critical services. We could propose a reauthorization of this program to enhance emphasis on ombudsman and other programs, while proposing an increase for many of these critical programs.

- **Improving Access to Emergency Room Care for Veterans.** As part of the President's request to bring Federal health programs into compliance with the patients' bill of rights, the issue of whether the VA provides veterans adequate access to emergency room services has been widely publicized. The VA currently only reimburses for VA emergency visits at VA hospitals, which is certainly not consistent with the patient protection to assure emergency services when and where the need arises. We expect Senator Daschle to offer a proposal to extend VA access to emergency room services, and it may well be advisable for us to address this issue so we are not perceived as falling short on our commitment to apply the patients' bill of rights where we can. (Cost: VA's current proposal costs $550 million per year. However, OMB has been working to dramatically reduce the costs of this proposal).

- **Enhancing Drug Approvals, Food Safety, and other FDA priorities.** The FDA has unprecedented new challenges, including: a surge in promising technologies and drugs that need approval; increasingly challenging diseases, such as AIDS and emerging pathogens; important public health issues such as food and blood safety; as well as major new statutory responsibilities from FDA reform. However, funding for this agency has not increased in several years. This has serious implications for the agency, as food inspections, organ banks, and drug companies are rarely inspected and it is more challenging to meet drug approval needs. Since Congress has been unwilling to fund user fees for FDA, it may be necessary to make it a priority to fund FDA at higher levels (Cost: $100 to $300 million).

- **Investing in Promising DoD Breast Cancer/Prostate Cancer Programs.** We have continually highlighted DoD's innovative, popular cancer research programs (most recently the President announced grants in the DoD prostate cancer research program in his Father's Day radio address). However, we have received increasing scrutiny as to why your budget never proposes funding for this critical program by advocates who question your commitment to this program and believe that the lack of an Administration proposal makes it much more difficult to lobby for this funding on the Hill. DoD is somewhat resistant to this concept as they believe that even though they have developed a model program in response to a Congressional mandate, cancer research is not within their military mission. (Cost: it is unclear what the Congress will propose for this year's funding (the Senate bill includes $250 million). If you chose to fund this area, we would need to at least match FY1999 funding and potentially increase this amount.

- **Continuing the President's Successful Race and Health Initiative.** The race and health initiative proposed in the President's FY1999 budget was extremely well received by the minority and public health communities. As part of this initiative designed to eliminate racial health disparities in six critical health areas, we committed to investing $400 million over five years. Therefore, it is important that the President's FY2000 budget include no less than the $80 million we promised for each year, and we may want to consider additional funding for this issue. (Cost: $80 million).

- **Investing in Promising Biomedical Research.** Your FY 1999 budget includes historic increases in the NIH, and the Congress has funded the NIH at even higher levels (a historic $2 billion increase this year), regardless of how much you propose in this area. Therefore, you could either continue to fund this research at historic levels or since Congress will likely anyway, you may want to propose less to make room for other priorities. (Cost: over $300 million to $1 billion).

- **Improving Access to Promising HIV/AIDS Drugs.** Since there has been so much progress in therapies for HIV/AIDS, the AIDS community has been pushing to expand access to these drugs. Their expectations were raised last year when the Vice President asked HCFA to look into the feasibility of a demo to expand Medicaid to patients with HIV at an earlier point in their disease. We may want to consider additional options, perhaps in the context of the Jeffords-Kennedy legislation, to help people with HIV/AIDS have better access to treatment. Last year, we proposed significant funding for the AIDS Drugs Assistance Programs (ADAP), but there may be other approaches. Regardless of status of Jeffords-Kennedy, we may receive a great deal of criticism from the community if we propose no increases for treatment and also for prevention and enhancing HIV surveillance efforts at the Centers for Disease Control (Cost: approximately $100 million).

- **Improving Health for Medically Underserved Native Americans.** Native Americans have particularly poor health status (as much as five times higher diabetes rates, and three to four times the rate for SIDS). It is widely recognized that the IHS, the main resource for Indian tribes who deliver health programs to their communities, is not sufficiently funded to address the needs of this population. We could develop a number of initiatives to help improve health for Native Americans, including: domestic violence, or alcoholism; or elder care, working with HCFA, to help develop home-and-community based care options for Native Americans. This would build on the President's efforts to elevate the Director of IHS to an Assistant Secretary position and your participation in the conference on "Building Economic Self-Determination in Indian Communities" and would compliment well the President's race and health initiative. (Cost: about $100 million).

THE POLICY SCIENCES CENTER, INC.
127 Wall Street, Room 322
P.O. Box 208215
New Haven, Connecticut 06520-8215, U.S.A.
Tel: (203) 432-1993 • Fax: (203) 432-7247

Please Reply to: DR. LLOYD ETHEREDGE
7106 Bells Mill Road
Bethesda, MD 20817
Tel: (301) 365-5241
Fax: (301) 657-4214
Internet: lloyd.etheredge@yale.edu

September 7, 1999

Mr. Tom Freedman
Domestic Policy Council
Old Executive Office Building - Room 204
17th & PA Ave., NW
Washington, DC 20502

Dear Tom:

A project supported by the Robert Wood Johnson Foundation is widely circulating the enclosed paper. There have been important evolutions in developing bipartisan formulas to underwrite health care benefits (e.g., tax credits, rather than government expenditures). The result is that - if the Clinton-Gore Administration wants to do it - extension of an affordable, basic health insurance package to 33 million adult workers (with equitable cost-sharing) probably can be enacted this fall within the tax cut legislation.

Combined with CHIP's (enacted) coverage of children, one of the legacies of the Clinton-Gore Administration would be to have achieved essentially universal health insurance coverage for working families.

Many people - including traditional Democratic constituencies - will be deeply grateful that, with our growing wealth, a bipartisan solution has been found to make fundamental progress. The plan gives us a basic fairness in the use of federal tax benefits for health insurance: the federal cost (via tax credits) for the working adults would be about $22 billion in 2000 - and in 1998 federal health insurance tax benefits for families with incomes over $100,000 averaged $2,357 and totalled $26.2 billion. The plan also creatively solves several technical problems in the use of tax credits, assures low-overhead administration, and coordination with state policies.

You might want to take a serious look at this: I have great confidence in the author's policy-analysis abilities and if the electoral/political benefits are persuasive to the Administration, I think it will be good for the country.

- On the global Internet projects, the State Department is still stumbling-about but the Reinventing Diplomacy group's recommendations have had an enthusiastic reception from the Secretary-General's senior staff. Ted Turner's $1 billion cannot be spent by the UN, so the new UN Foundation has asked the Secretary-General to forward ideas. The securing of global satellite links and 100,000 basic Internet terminals for health, science and education in UDCs also would help the UN to strengthen the NGO community, one of the key constituencies that the new UN leadership is trying to secure.

It would be hopeful if the State Department thought about US influence with other countries and NGOs as an analog to running for electoral office. But almost nobody in the foreign policy process has that background.

All the best,

Lloyd

(Dr.) Lloyd S. Etheredge, Trustee; Director
Government Learning Project