DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

Memorandum to Chris Jennings

From: Mary Beth Donahue MBD
Chief of Staff

Subject: Addendum to the 1999 State of the Union proposals

The Department of Health and Human Services (HHS) provided a memorandum to you on November 20 outlining proposed thematic ideas for the 1999 State of the Union address. I am writing as a follow-up to that memorandum to request that an addendum to this document be considered.

Please find attached, a paragraph regarding *Enacting Federal Privacy Legislation.* We propose that this paragraph should be included in the November 20 document within the section entitled, "**Improving the Health of All Americans**". You will note that within this section we highlight concrete steps that the Administration can take to improve the health care system. We suggest that the addendum be inserted following the paragraph on *Enacting a Patients Bill of Rights.*

For your reference, I have attached a copy of the comprehensive memorandum forwarded to you on November 20.

Thank you for taking the time to consider this request. If you have any questions, please feel free to contact me at 202-690-7431.

ATTACHMENTS

- Addendum to November 20 document
- Copy of the November 20 document

Add to Section II, page 4, just after the "Enact a patients Bill of Rights" section:

Enact Federal Privacy Legislation: The American people expect, and are entitled to, confidential, fair, and respectful treatment of their health information. Over a year ago, Secretary Shalala sent a Report to the Congress recommending that the Congress enact legislation requiring that treatment. Since then, progress in crafting such legislation has been made by both Republicans and Democrats. Now its time to get serious about protecting the privacy that we in the United States cherish as essential to personal freedom and well-being. The need for such legislation is found in the rapid changes in the ways that health care is provided, documented, and paid for in the United States. These changes pose a challenge to American values that are both complementary and competing. On the one hand, patients have a legitimate need for confidentiality so that they can be frank with their physicians about their health conditions and behavior. That assurance is fundamental to effective diagnosis, treatment and healing. On the other hand, participants in the health care system -- insurers, governments at all levels, managed care organizations -- have legitimate needs for access to health records in serving patients and performing their roles in the system. Our challenge is to work together to balance these competing values.

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

NOV 20 1998

MEMORANDUM TO BRUCE REED AND GENE SPERLING

FROM: Donna E. Shalala
Secretary of Health and Human Services

As you begin to prepare for the 1999 State of the Union Address, I want to share with you some thematic ideas to stress the accomplishments of the Administration and its agenda for further improving the health and welfare of the American people. I strongly believe that these issues have wide public support and can form the basis for some bipartisan progress in Congress. They build on our past accomplishments and will help to ensure a long-lasting legacy for the Administration in the area of improving the quality of life for the American family. My staff will be happy to work further with you and other White House staff on the details of these proposals.

In the President's speech in Poland, he quoted an ancient Irish proverb: "May you live a hundred years." In the 20th Century, medical, scientific and public health breakthroughs have added 20 years to the average life expectancy of the American people. The President should declare a national goal of meeting or exceeding this accomplishment in the new century to come so that by the end of the 21st Century, the average life expectancy of an American can be nearly 100 years. Imagine what such an accomplishment will mean to the productivity and creativity of our people and our nation.

In that light, this memorandum lays out four major themes for the President's address:

Helping Working Families Help Themselves: This includes renewed efforts to improve child care and support working families and new initiatives in the area of long-term care.

Improving the Health of All Americans: This includes enacting a Patients' Bill of Rights and continuing our efforts to eliminate historical racial and ethnic disparities in health status, particularly those disparities affecting American Indians.

Making the World Safer for Children: This includes a renewed effort to combat tobacco use by children as well as new initiatives to reduce the number of accidental injuries and a new effort to combat the rising prevalence of asthma in children.

Improving Public Health Capacity: This includes continuing efforts to protect the safety of our food supply, countering the threat of bioterrorism, and ensuring the safety of drugs, medical devices, and the blood supply.

The following pages of this memorandum discuss each of these themes in greater depth and offer rhetorical language that might fit within the context of the State of the Union Address.

I. Helping Working Families Help Themselves

The American family is stronger and more able to deal with the unexpected today thanks to the far-sighted policies we have adopted during these last six years. The Family and Medical Leave Act allows working parents to spend the time they need with a newborn or sick child. A higher minimum wage, the expanded Earned Income Tax Credit, and the $500 child care credit have helped to lift working families out of poverty. Parents can move from job to job without worrying that their health insurance won't move with them. More pre-school children are fully immunized than at any time in our history. And more than two million additional children have health insurance that will help them to grow up healthy and strong.

But our work is far from complete. Today, too many parents still must worry that they cannot afford quality child care for their children. Too many families are adversely affected by substance abuse problems. And too many families worry that the cost of long-term care could wipe out a lifetime of savings. That is why I am so pleased to announce that my fiscal 2000 budget includes a series of initiatives designed to help working families help themselves.

Quality Child Care: We must make child care more affordable, more accessible, and of consistently high quality. We know that 70 percent of today's mothers depend on child care professionals to help them care for and educate their children. Currently, only one in ten families eligible to receive assistance for child care do so. And in three-quarters of our states, families living in poverty are ineligible for child care assistance. Last year, the First Lady and I hosted the historic White House Conference on Child Care. We know that the early years of life are critical to the development of children's brains and their ability to enter school ready to learn. We also know that the experiences that older children have in non-school hours are critical to their positive development and education. There is no better investment of our resources than assuring that our children grow up in safe and healthy learning environments. We need to make sure that mothers and fathers who hold jobs outside the home are secure in the knowledge that their children are being cared for in high-quality child care facilities. So let's finish the job and enact a child care bill that helps parents get their kids off to the right start.

Working Families Initiative: In the two years since I signed the welfare reform law we have made remarkable progress in helping families move from welfare to work and in supporting working families. The welfare rolls are at an historic low and our employment rates are at an all-time high. But it is clearly not enough to just help families find jobs. We must keep them out of poverty by again raising the minimum wage. We need to build secure and reliable supports for work, such as Food Stamps, child care, health care, housing, and transportation. And we must help them improve their education and skill development.

Substance Abuse: We must strengthen our efforts to assist families whose substance abuse problems threaten their ability to lead healthy and productive lives. More than 8 million children in our nation are now living in families where at least one parent has a serious alcohol or drug problem, and drug use rates among our young have recently been rising. Indeed, research tells us

that the children of substance abusers are at higher risk of developing such problems themselves. Under the leadership of General Barry McCaffrey, the Office of National Drug Control Policy has developed a comprehensive, long-term drug control strategy for our nation. This strategy lays out a road map for making treatment and prevention services more available to parents and their children. You have all seen the ads on TV. These are the first steps in raising awareness, changing attitudes, and getting families and children to take action. Through the budget process we are also moving to reduce the treatment gap, so that families will be able to get the treatment they need. Through these efforts, we are providing the tools that working families need so that they can address their alcohol and drug problems and provide healthy family environments for their children.

Long Term Care: Last year's budget made an unprecedented investment in medical research and my budget for this year keeps us on a path of doubling the NIH budget in five years. These investments will help us to unlock the mysteries of the human body and help to extend the length and quality of every human life. But we also must recognize that longer lives will increase our need for innovative ways to care for our parents and our grandparents. Every year over 50 million Americans spend time caring for sick and disabled family members and friends. They struggle to keep their loved ones at home for as long as possible. Yet they get remarkably little help in doing so. That is why I am proposing to establish a National Family Caregiver Program to help these heroic men and women care for their loved ones and why I am also proposing a new Bridge to Independence Initiative that will work to expand the availability of home and community-based care for the elderly and the disabled.

Today, more than four million Americans are living with Alzheimer's disease, including President Reagan. That number is projected to quadruple in the next 40 years. That is why my budget also includes funding for Alzheimer's disease research.

II. Improving the Health of All Americans

Our nation has the best health care system in the world. We have the best doctors, the most advanced technology, and the most exciting research. But we can make the American health care system even better.

Enact a Patients Bill of Rights: Quality health care should not be a partisan issue. Quality health care is a practical issue for patients and their families. The first task of this new Congress must be to finish the work we began last year and enact a Patients' Bill of Rights that will guarantee high-quality care for all Americans. Virtually every member of this body sponsored legislation to provide Americans with a Patients Bill of Rights. There were many very real issues that divided us in 1998, but these are not issues that should stop us from acting. We must provide Americans with a real choice of doctors, with real access to specialists, and with real emergency care when and where they need it. They must be able to take their disputes with their health plans to independent, external experts for a binding final decision. They must know that their medical records are secure. And they must be able to have recourse against health plans

that injure them or their loved ones.

Eliminate Racial Disparities in Health Status: For too long our nation has seen shocking gaps between the health of white Americans and that of African Americans, Hispanics, Asian Americans, American Indians and other racial and ethnic minorities. Last year, we began a national initiative with the bold goal of eliminating these shameful disparities by the year 2010 in six critical areas of health status: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS infections, and child and adult immunizations. We also launched a national effort to deal with the crisis that HIV and AIDS present to minority communities. I propose doubling our efforts in these areas so that the health of any American does not depend on the color of their skin.

Improve the Health of American Indians and Alaska Natives: While we work to improve the health of communities of color we must pay particular attention to the needs of the oldest American communities – American Indians. For far too long, these Native Americans have been accorded second-class status. We must enter the next millennium by making a national commitment to meet our legal and moral obligations to these citizens. We must provide health, education, and economic opportunities that will make the first Americans as economically productive, educationally competitive, and as healthy as those who followed them to these shores. We have begun by assisting tribal nations to develop innovative approaches that encourage community-based solutions for health status disparities effecting Indian families and communities.

III. Making the World Safer for Children

If parents are to have the opportunity to raise healthy children, we have the obligation to make the world around them as safe as possible. Every day, parents struggle to raise their children in an environment that nurtures their bodies and their souls. We can't do that job for them, but we can make it easier for them to do it successfully.

Reducing Tobacco Use: We have fundamentally changed our understanding of smoking. There can be no debate that the nicotine in cigarettes is addictive. We know that smoking is a pediatric disease. Three thousand young people become regular smokers each day and nearly one thousand of them will die prematurely. No legal obfuscation by the industry, nor slick TV ads can fool the American people. They know the truth – often from the industry's own data. If Congress wants to act, we will work with them. Science and common sense lead to the conclusion that a strong, comprehensive approach to the problem is best. But we will not wait on Congress. Any state, any community that wants to act on the knowledge and facts of this public health threat will have this Administration's full support.

Reducing the Incidence of Injuries: More than 400 Americans – including 50 children – die every day from preventable injuries and thousands more are injured every year, suffering permanent disabilities. Such injuries cost our society $224 billion a year in lost productivity,

health care and rehabilitation costs. Yet every dollar we invest in preventing injuries saves us millions. For example, smoke alarms save $69 for every $1 spent, bicycle helmets save $29 for every $1, and child safety seats save $32 for every $1. We need to make Americans safe at home, safe at school, safe at work, and safe as they move about in their communities. That is why my budget includes money to help protect our children by creating a safer environment in which they can grow and mature.

Fighting Asthma: Over the last 15 years, the number of Americans afflicted with asthma has doubled to more than 15 million and the largest increases have been among children. In fact, asthma is one of the leading causes of school absenteeism and a major reason for emergency room visits by parents and young children. Our investment in asthma research has increased our understanding of the root causes of this condition. Now it is time to invest in getting that information in the hands of doctors and their patients. My budget will help prevent the onset of asthma, help parents manage asthma in their kids, and improve the treatment of this manageable disease.

IV. Improving Public Health Capacity

If we are to protect our nation and our planet against disease in the new century, we must continue to build our public health infrastructure. Without a solid and stable system of public health, we cannot fight the threats we know and we cannot be prepared for those that we don't know. Working in partnership with the states, we must develop and maintain a rapid response approach to contain the outbreaks of the future. This investment will enable us to increase the number of trained scientists and public health professionals in our communities.

Food Safety: With bipartisan support we have made major progress toward making our nation's food supply as safe as possible. The CDC has established a nationwide surveillance network that alerts us to any threats to the food supply. This allows us to quickly identify and act on foodborne outbreaks anywhere in the country. We have instituted new agricultural practices designed to detect and prevent contamination of fruits and vegetables. And we are taking measures to reduce the potential for bacteria contamination by applying new scientific approaches to assure the safety of fruit juices. To make all of this work, I have directed that a national food safety council be established to monitor food safety and help us maintain a safe national food supply.

Drug Safety: By assuring the quality of the drugs we take, the medical devices we need, and the blood supply upon which we rely, we relieve a major source of concern for the people of this nation and others. Our new FDA Commissioner Jane Henney will work closely with you to implement the bipartisan FDA reform bill that I signed in the last Congress.

Fighting Bioterrorism: Ensuring the health and well-being of our citizens requires thinking the unthinkable and preparing accordingly. That is why I am requesting $370 million to enhance our ability to protect the American people against terrorism involving infectious

microorganisms. We will help state and local health departments and the Centers for Disease Control and Prevention improve their capabilities to detect unusual infectious-disease outbreaks that might be caused by terrorists. We will also strengthen local, state, and national capabilities to mount rapid medical responses to such incidents. Our overarching goals will be to prevent bioterrorism whenever we can and, when we can't, to limit the toll of death and suffering that those heinous crimes can inflict upon our communities.

Attachment
Tab A - Background Information on the Health Status of American Indians and Alaska Natives

Focus on the Tools of Opportunity. Develop economic opportunities in Indian communities, raise the health status of Indian people and their communities, and improve their educational status.

Health Status. American Indians and Alaska Natives have the lowest life expectancy of any group in the nation and disproportionately higher morbidity/mortality rates than the total population, as shown below.

Alcoholism	579% greater
Tuberculosis	475% greater
Diabetes	231% greater
Unintentional Injury	212% greater
Suicide	70% greater
Pneumonia and Influenza	61% greater
Homicide	41% greater
Gastrointestinal Disease	23% greater
Heart Disease	8% greater

The health of Indian people is measurably different than other Americans at all life stages. Indian infants die from sudden infant death syndrome at a rate 1.8 times the U.S. All Races infants rate of 2.1. Indian children, 5-14 years, die of traumatic injuries at twice the U.S. All Races rate, and suicide among Indian children, 15-24 years, is 2.7 times the U.S. All Races rate. The alcoholism death rate for Indian youth, 5-14 years, is over 17 times the rate for U.S. All Races. One in three adult Indians suffer from diabetes -- nearly twice the rate of U.S. All Races. Indian elders still die earlier than their U.S. All Races counterparts. American Indian and Alaska Native homes lack safe water and sanitary means of waste disposal 7.5 times that of homes of U.S. All Races.

Eliminate Health Disparities for Six Target Areas. The Administration's Initiative to Eliminate Racial and Ethnic Disparities in Health targets six areas: diabetes, heart disease, cancer screening and management, HIV/AIDS, infant mortality, and immunization.

Develop Economic Opportunity. Disparities exist in other programs aimed at improving the social and economic status of low-income and disadvantaged populations, including TANF and other ACF programs and Medicaid/CHIP outreach. This is the case for both reservation-based and urban-based American Indians and

Alaska Natives. This is not just a reservation issue. Sixty-five percent of Indian people live in urban or suburban areas. Indian people are the most disadvantaged population in the nation. Their median household income (1989) was $19,897 compared with $31,435 for Whites, $19,758 for Blacks, and $24,156 for Hispanics.

Living Below the Poverty Level	31.6%
Males 16 & Over Unemployed	16.2%
Bachelor's Degree or Higher, Ages 25 and older	8.9%

Improve the Academic Performance of American Indians and Alaska Native Students. Census data show that the Indian population has increased in the last three decades. Of the total Indian population, the age group 10-19 years represents a significant concentration. There are approximately 600,000 American Indian and Alaska Native children in the United States -- less than 1% of all school-aged children. They have the highest dropout rate in the nation. Thirty-six percent of American Indian and Alaska Native tenth graders drop out of school, more than twice the national percentage for white students. Thirty-two percent of American Indian and Alaska Native students showed a "below basic" level of performance in math, which represents twice that for white students (15.5%). Twenty-two percent of white students showed an "advanced" level of performance in math, which is almost five times that for Indian students (4.8%). The Bureau of Indian Affairs funds a K-12 educational program for 51,000 Native Americans in 185 school systems in 23 states. Of the 3,000 facilities in the BIA school system, 25 percent are more than 50 years old, 50 percent are more than 30 years old, and 3 percent are more than 100 years old. Twenty thousand American Indian and Alaska Native students attend classes in portable classrooms. The conditions of these facilities reflect significant operational and new school construction needs. The turnover rate for BIA teachers is 35%.

The White House Domestic Policy Council Working Group on American Indians and Alaska Natives approved a Policy Initiative for Indian Children and Adolescents as proposed by the IHS in 1997. The Policy Initiative focuses on directing resources from a number of Federal agencies and private sources. The Policy Initiative's intent is to improve the conditions and quality of life for American Indian and Alaska Native children and adolescents and help them become healthy adults. The IHS will continue to work with the Domestic Policy Council by providing additional information about the potential outcomes of the Initiative and other basic information on the status of Indian children and youth. The IHS will continue to pursue a potential presidential Executive Order or other administrative policy

statement in support of Indian children and youth. In addition, the IHS is planning the development of a major campaign in 1999 that will address the need for establishing healthy lifestyle programs for Indian youth. Tribal consultation will be a cornerstone of this campaign.

Continue the Momentum of Past Progress. The Administration has made progress on American Indian and Alaska Native health issues even though significant disparities remain. Mortality rates for American Indians and Alaska Natives have decreased significantly in many areas since 1973, as shown below, showing that investing in Indian health works!

Tuberculosis	79% reduction
Gastrointestinal Disease	76% reduction
Maternal Deaths	68% reduction
Infant Deaths	58% reduction
Unintentional Injury	56% reduction
Pneumonia and Influenza	52% reduction
Homicide	40% reduction
Alcoholism	37% reduction
Suicide	23% reduction

Public Health/Underserved Populations

- **Combating Resistance to Antibiotics (Super Bug).** Recent reports have indicated that resistance to antibiotics is increasingly becoming a public health crisis, causing prolonged illnesses and even death. For example, 500,000 Americans per year are infected with Staph (*Staphylococcus aureas)*, a commonly- acquired, potentially lethal, hospital-based infection. The bacteria now only responds to vancomycin and CDC has recently documented the first cases of resistance to this last resort drug. The hospital costs alone associated with treating antibiotic resistance total over $600 million per year. This new initiative could address this critical emerging problem through: (1) a major outreach initiative that will help reduce the vast overuse of antibiotics, making diseases less likely to become resistant. This could include creating a network of hospitals, health professionals, and managed care organizations to disseminate information; (2) new research and surveillance efforts to understand where and why antibiotic resistance occurs and develop effective responses; and (3) community-based efforts to test effective strategies to combat antibiotic resistance. (Cost: $40 million per year).

outside experts going in. vaccine development.

- **Assuring Ability to Detect and Manage Bioterrorism.** Bioterrorism is becoming an increasing threat that has the potential to injure or kill millions of Americans through deadly diseases, such as smallpox. While law enforcement and intelligence agencies seek to thwart these kinds of attacks, when prevention fails, we need a system in place that is prepared to manage and minimize the public health consequences. Unfortunately, unlike many types of attacks, bioterrorist threats could go for days or even weeks without being detected as they could be noticed only when clusters of deaths or a series of illnesses begin to emerge. Therefore, it is critical that the nation's public health system is equipped to both detect and respond to this potential problem. This initiative would: pay for training of epidemic intelligence officers who can coordinate with state health departments and other intelligence officers to identify and respond to attacks; develop a Metropolitan Medical Response System, a mass casualty emergency response system, that includes primary care, emergency transportation, and decontamination abilities that will be critical to save lives in the event of an attack; creating and maintaining a stockpile of pharmaceuticals and others drugs necessary for civilians; and improving research for new vaccines and antibiotics. ($100 to $300 million per year).

Pat Ruggles @ ASPE

- **Investing in Promising Biomedical Research.** We are now poised to make revolutionary advances that could dramatically alter and improve the way we treat diseases. To help realize these new possibilities, the President's FY1999 budget included a historic multi-year investment in biomedical research and Congress funded NIH at even higher levels (a $2 billion increase this year). The budget could either fund this research at historic levels or propose less as we expect that Congress will likely outspend the Administration in this area regardless. (Cost: $500 million to $1 billion).

- **Improving Access to Promising HIV/AIDS Drugs.** With progress in lifesaving HIV/AIDS therapies, the AIDS community has made it a top priority to extend these state-of-the-art treatments to Americans in need. In addition, other increases in HIV/AIDS will be important for the community, including investments in the AIDS Drugs Assistance Program (ADAP) that helps people with HIV pay for therapies they could not otherwise afford, with costs running as high as $15,000 per year, as well as increased prevention efforts. (Cost: approximately $100 million per year).

- **New Initiative to Prevent Heart Disease, the Nation's Leading Killer.** While diseases, such as cancer and HIV/AIDS receive far more media attention, heart disease is the leading killer of women and men across nearly all racial and ethnic groups. More than 960,000 Americans die of heart disease each year, accounting for more than 40 percent of all deaths. Moreover 58 million Americans live with some form of this disease. This disease can be markedly reduced by: preventing smoking which causes one-fifth of all cardiovascular deaths; improving physical activity, as Americans who are not physically active are at twice the risk of heart disease; and improving nutrition. This initiative could include: launching a new partnership with aging networks to evaluate and improve nutrition in public-private programs and to initiate awareness about nutrition and exercise through Older Americans' Act programs; measuring successful community prevention approaches and replicating them nationwide; and creating a network of, educators, churches, minority-based organizations to launch nationwide awareness campaign about prevention. ($40 million per year supplemented by NIH funding in this area).

- **Continuing the President's Successful Race and Health Initiative.** The President's race and health initiative, designed to eliminate the startling racial health disparities in six critical health areas, including cancer, diabetes, heart disease, immunizations, and HIV/AIDS, has been extremely well received by the minority and public health communities. When launching this program last year, we committed to investing $400 million over five years, and this budget should include no less than the $80 million promised for each year. This initiative could fund: (1) new incentives to public health programs to target disparities, including creating incentives for communities to develop effective private-public cardiovascular outreach campaigns and developing new network with managed care, minority-based organizations through the National Diabetes Education Program to implement treatment guidelines, (2) a $30 million grant program to test innovative community approaches to addressing these disparities replicating these programs nationwide; and (3) investments to build on this year's historic prevention and treatment efforts to address the ongoing health crisis of HIV/AIDS in the minority community. These investments could be supplemented by new efforts at NIH to better understand these disparities and develop new approaches to disseminate the most up-to-date information. ($80 million - $110 million per year).

- **Improving Health for Medically Underserved Native Americans.** Native Americans have disproportionately high rates of chronic and acute diseases (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 health care resource for Native Americans living on reservations, does not have sufficient funding to address the needs of this population. We could develop a number of initiatives to improve health for Native Americans, including: domestic violence prevention, alcoholism counseling programs; new 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 his participation in the conference on "Building Economic Self-Determination in Indian Communities" It would compliment well his race and health initiative. (Cost: about $100 million).

kids stat. guidance & to public prog.

- **New Comprehensive Initiative To Reduce Asthma.** Currently, 15 million Americans have asthma, nearly an 100 percent increase in the last 15 years, with the highest rate of increases for children under the age of five. This initiative includes new efforts in biomedical research to better understand increasing number of Americans suffering from asthma and to test effective interventions. It also will include implement a comprehensive new public health approach to use new guidelines to diagnose and manage this disease. (Cost: $40 million). CHIP & outreach — complement ongoing

- **Improving Mental Health Prevention and Treatment.** Important progress in treatments has given great new potential to improve the quality of life for people with mental illnesses. In addition, the recent startling outbreaks in school violence, underscore the need for new innovative approaches to address mental health prevention and treatment. The mental health block grant enables states to provide mental health services and treatments to millions of Americans, including assuring homeless shelters identify and treat mental illnesses, enhancing access to new treatments, and assuring elderly outreach programs have an anti-depression component. New investments could be targeted to implement new violence prevention strategies, to improve the availability of state-of-the-art treatments, to provide new incentives to communities who have implemented effective mental health programs, including homeless programs that effectively address mental illness (Up to $100 million per year).

- **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 question of whether the VA provides veterans adequate access to emergency room services has been widely publicized. The VA currently only pays costs associated with emergency services provided to veterans at VA hospitals, which is not entirely consistent with the patient protection to assure emergency services when and where the need arises. We expect Senator Daschle will offer a proposal to extend veterans access to emergency room at non-VA facilities, and it will be advisable for us to address this issue so we are not perceived as reneging 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).

NEW FIRST, ASTHMA, PH.

low priority.

- **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 services are often extremely fragmented which undermines quality care. The budget could include an initiative that would help maintain and improve access to health care in rural communities by: allowing communities to provide for grants to better integrate emergency medical providers into the primary health care system so they can refer to local providers when possible and train volunteers on emergency care. It could also provide 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. (Cost: Approximately $100 million per year).

Who will validate.

- **Investing in Promising DoD Breast Cancer/Prostate Cancer Research 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 been increasingly criticized by advocates who question the Administration's commitment to this program because the President's budget has never proposed any funding for this critical program. Advocates believe that the lack of an Administration proposal makes it much more difficult to lobby for funding on the Hill. DoD is somewhat resistant to this concept as they believe that although they have developed a model program in response to a Congressional mandate, cancer research is not within their military mission. If you chose to fund this area, we would need to at least match FY1999 funding and potentially increase this amount.(About $250 million per year). Bob Weyle

more detail of pick.

- **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 per year).

OMB this priority.

NIH FUNDING
small increase of $49 million; returns NIH to funding path of a 50% increase in 5 years

ASTHMA
can't find, but Dan says not funded; EPA got funds

RACE AND HEALTH
$50 million earmark from CHC funding (although they are level funded)

SAMHSA FUNDING
PATH increase of 4 million over 99
block grant flat funded
mental health KDG reduced by 20 million (77 million) from 1999

RYAN WHITE FUNDING
total increase 72.2 million; total ADAP increase 25 million

HEART DISEASE INITIATIVE
don't know

DOD INITIATIVE
don't know

RURAL HEALTH INITIATIVE
not funded

FDA ENHANCEMENTS
PMA approvals 20 milion
food safety flatline

IHS
$175 million increase

PASSBACK STATUS OF DISCRETIONARY PROGRAMS

AOA
can't find

NURSING HOME QUALITY INITIATIVE
18.1 million (HCFA) survey and certification - $7 million funded in base
6.9 million (OS) federal administration - 5.5 million funded in base
9.5 million (OS) increased legal work
total: 34.5 million

partially funded through user fees (intial certification fees and recertification fees)

funding level also includes certification funds for other long term care facilities

EDUCATING MEDICARE BENEFICIARIES ABOUT LONG TERM CARE
can't find

FUNDS FOR MEDICAID DEINSTITUTIONALIZATION DEMO
unfunded -- OMB states that HCFA's research agenda should be focused on projects that generate savings for Medicaid and Medicare; disease management projects

GME FOR CHILDREN'S HOSPITALS
OMB rejected

FIGHTING BIOTERRORISM
total 152.262 million
101 million (CDC); redistributed $20 million internal funds for tracking as part of larger system
20.522 (OEP)
$0 (OS) 4.850 less than 1999
$24.340 (NIH) flatline from 1999

SUPERBUG
subsumed in larger tracking initiative -- $30 (+10 in state match) for entire initative

adjust

STATUS OF HEALTH BUDGET IDEAS IN PASSBACK, 11/23/98

(Italics indicate discretionary funding)

NEW IDEAS	PASSBACK STATUS	REMARKS
1. LONG-TERM CARE		
Long-term care tax credit	NA	
Offering private long-term care insurance to Federal employees	NA	
Family Caregiver Support Program (new Administration on Aging grants)	*Will fund this new program but only at $10 million -- much lower than the requested $150 million*	*Necessary to attract aging network to support our long-term care policies. Without full funding cannot support programs in all states. VP will be ally.*
Nursing home quality initiative (HHS has asked for $100 million)	*Will fund at a lower level, partially through politically problematic user fees* ($1.5)	*May need more money to attract validators. Ask if user fees are really viable.*
Educating Medicare beneficiaries about long-term care alternatives	*Support idea but not sure about any funding (asking $25 million)*	*Low-cost activity worth the effort; shows we are not counting on Medicare to expand.*
2. DISABILITY		
Jeffords-Kennedy Work Incentives Improvement Act	Included in passback	
Tax credit for people with disabilities	NA	
Medigap reform for people with disabilities	No cost / included in passback	
Funds for Medicaid de-institutionalization demonstration ($50 million)	*Rejected by OMB*	*Issue is major priority for activists but might not be worth the fight since they may well think our base proposal is too modest, let alone any compromise with OMB*
3. MODERNIZING MEDICARE		
Adopting private sector, competitive pricing strategies	Included in passback	
Reducing Medicare fraud and overpayment	Included in passback	
Prescription drug coverage for Medicare beneficiaries	OMB is considering some type of limited state grant proposal	Worth considering, but may expose us to criticism that we gave up on a real Medicare drug benefit and are undermining those that want one

input

Jeanne: transitioning by being vague.

Senate side day one; hold off
win over budget if they new.

don't complicate —
put — physically. we don't even need lang —

BRIDGE #150 M/ 1 year
we want it separate the extent that we want to do it.

① Build it up
② Refund what's there 1.2 B now
③ Sweeten it?

demo & JK for enhanced

#300 M demo.
2nd line for BRIDGE

Community would say demo RATHER than BRIDGES.

most want direct receipt

NEW IDEAS	PASSBACK STATUS	REMARKS
Protecting Medicare beneficiaries from HMO withdrawals	No cost / included in passback	
Redesigning and increasing enrollment in Medicare's premium assistance program	No cost / likely to included in passback	
Cancer clinical trials demonstration	Rejected unless funded by tobacco.	VP priority. He'll need to fight to get in budget.
Bringing children's hospitals into parity with all other hospitals training future doctors (could be discretionary or capped mandatory)	*Rejected*	*FLOTUS priority, need to fight to get in budget. Because of financial well-being of children's hospitals, OMB opposes. There is a viable equity argument here.*
4. HEALTH INSURANCE COVERAGE EXPANSIONS		
Grants and/or tax incentives for small business purchasing coalitions	Do not know status; hoping for at least $50 million	Please check status.
Children's health insurance outreach	Probably included, but in a budget-neutral form	Appears acceptable
Medicaid extension for foster children	Likely included in passback	FLOTUS priority. We should support.
Health coverage options for people ages 55 to 65	Rejected	Moynihan & Gephardt have indicated that they will introduce this; could seem strange if we do not. President still seems interested.
5. PUBLIC HEALTH / UNDERSERVED POPULATIONS		15 2.262 M
Fighting bioterrorism ($100 million)	*Included in passback as part of a larger public health initiative*	*Probably ok but you may want to confirm adequacy for this and the super-bug initiative*
Combating resistant to anti-biotics (super bug) ($20 million)	*Subsumed in bioterrorism initiative*	*See above*
Investing in biomedical research ($500 million plus)	*Very small increase in funding* $49M ↑ 15.7B	*Assume that VP will demand much higher discretionary funding, supplemented by tobacco*
New initiative to prevent and treat asthma ($25-50 million)	*Accepted EPA increase in funding*	*Check to see if any public health or Medicaid money available -- EPA only funding is insufficient*

just for cancer + $ amt ↓.

tobacco MOV

flat line block grants → state resp.

creating discretionary headroom

ruled out resp. ↑ caps.

OVP HIV/AIDS

Ryan White $ # too low

OMB ranking — relative ranking

doesn't include prevention

address in appeal.

HIV $ → Minority

Dan says one time only

emergency issue broad discretion.

DPC Disability

OMB technical problems — language re: entitlement

BRIDGE prog OMB/DPC doesn't like it (Becky Ogle)

Jeffords Kennedy expanding?

process — House wants to look at it & revisit — plenty of opp for

PATH $4m↑

NEW IDEAS	PASSBACK STATUS	REMARKS
President's Race & Health Initiative for targeted diseases with serious disparities in incidence / outcomes ($80 m)	*No new money but earmarked $50 million from new CHC funds*	*Needs new money; will not be viewed as credible without it*
Investment in mental health services and substance abuse treatment ($5-100 million)	*No new money / probably a net cut if you include all mental health budget categories*	*Presents a political problem since mental health is viewed as chronically underfunded & VP and Tipper are hosting 1999 conference*
Improving access to promising HIV/AIDS drugs	*Increase in overall Ryan White funds of* ~~$70-80m~~ $72.2 m	*We probably will need a bit more -- total to about $100 million or so*
Heart disease initiative ($20 m.)	*Do not know status*	*Please check status*
Investing in DoD breast cancer / prostate cancer, osteoporosis programs ($250 million)	*Do not know status. Check funding of previous years.*	*Please check status. We have never put money into this account. If DoD gets big increase, we may as well fund some of our priority disease research here (we have more control over this money).*
Rural emergency system proposal to sustain viability of health care facilities ($50 million)	~~Probably rejected~~ Rejected	*We need to fight to include something in the budget.*
Enhancing drug approvals; food safety and other FDA priorities	*Included, but not anywhere near the request, two user fees fund devices & food initiatives*	*Apparently not a bad number; let HHS push if they want more. User fee structure if very good.*
Improving health for medically underserved Native Americans ($500 million)	*$175 million increase, which is large relative to virtually all other discretionary items but less than the amount it says is needed for basic health*	*Mary Smith recommends at least $225 million*

Items recommended by OMB / not on our list:

- **Medicaid cost allocation**: $2 billion in savings over 5 years from recapturing an overpayment in Medicaid administrative costs. This was in last year's budget and was almost included in the Omnibus Bill but was rejected. Somewhat legitimate policy concerns have been raised by states and advocates about both the mechanism for recapturing this money (i.e., the prohibition on using TANF funds for administrative costs) and the other demands that we are placing on administrative costs in states (e.g., children's health outreach, better enforcement of nursing home standards). **Probably very big mistake to include again, particularly if there can be no draw down from TANF.**

- **Reduction in Medicare hospital payments**. There is growing evidence that Medicare is overpaying hospitals, even with the reductions made by the BBA. However, it is not clear whether this evidence justifies the politically painful act of cutting hospital payments. We are still reviewing the feasibility and advisability. If we use, however, need validation from independent source.

OVP - medium priority

NIH: $700 M.

total NIH baseline 15.3 B
① return to PATH $49 M
② hold harmless for inflation 4% 625 5% 700
③ $1 B.

making increase mandatory?

HHS $500M

OVP

Mental Health - high priority $40M ↑ / opposed to Dan's $20M

straight block grant increase
corelated w/ NIH - b/c NIMH.
Cannot fiat fund services.
Congressional interest in mental health for children
Mental health → 1st day bill SAMHSA Moynihan.
↑ services (accurately) research less essential.
$2-3M in AHCPR.
PBOR arguments play in science in mental health.

OVP

what about diabetes - can we broaden it?
expand prog to diabetes, cancer, CVD, etc.

cancer clinical trials.
counter in study @ Duke?
criteria in trial.
if drug comp won't do it, ↑
we need info - we'll pay pt care cost.

February 28, 1997

MEMORANDUM FOR ERSKINE BOWLES

FROM: BRUCE REED

SUBJECT: DOMESTIC POLICY COUNCIL GOALS AND OBJECTIVES

The central mission of the Domestic Policy Council is to advance the President's domestic agenda. The following memo outlines our goals and objectives in carrying out the domestic priorities that the President set forward in this year's State of the Union.

OVERALL GOAL: Education. Develop and implement, in concert with other White House offices and the Department of Education, a strategy to carry out the President's 10-point plan.

GOAL: Education. Develop and implement policies to achieve high educational standards nationwide and improved student performance to meet those standards.

Objectives:
-Work with Education Department to persuade twenty-plus states this year to agree to administer the President's national tests in 1999.
-Build support in the parent, business, and education communities for the President's testing initiative.
-Work to improve the quality of teaching by promoting the work of the National Board for Professional Teaching Standards; encouraging states and local school districts to adopt policies to place a master teacher in every school; and highlighting successful efforts at the state and local level.
-Continue efforts, in coordination with America Reads, to recruit 100,000 college students to be reading tutors, expand the Department of Education's summer reading initiative, and promote proven approaches to reading instruction.
-Work to increase the number of states with charter schools legislation.

GOAL: Education. Work toward passage of legislation and appropriations to implement the President's education agenda.

Objectives:
-Introduce legislation on school construction, America Reads, and HOPE

scholarships and related tax proposals; identify bipartisan support for each proposal.
-Assist in mobilizing constituencies for these proposals, such as securing an endorsement letter from hundreds of college Presidents.
-Assist in developing and implementing a communications strategy showing how each legislative proposal will improve the lives of students, families, and communities.

GOAL: Welfare. Develop policies that will assist in moving people from welfare to work.

Objectives:
-Work toward enactment of a $3 billion fund to help states and cities find and create jobs for welfare recipients and enhanced tax credits to encourage companies to hire them.
-Assist in conducting an extensive outreach campaign asking companies, nonprofits, the faith community, and government agencies to hire welfare recipients.
-Oversee implementation of the new welfare law to ensure that the Administration does everything in its power, through executive action and guidance, to help states move people from welfare to work.

GOAL: Welfare. Develop and implement policies to ensure that welfare reform promotes family and responsibility.

Objectives:
-Fulfill the President's commitment to restore certain budget cuts, involving legal immigrants and food stamps, included in the welfare law but unrelated to welfare reform.
-Work with HHS in assisting states to ensure strict enforcement of child support rules.
-Develop and implement new teenage pregnancy prevention and statutory rape initiatives.

GOAL: Crime. Enact the President's Anti-Gang & Youth Violence Act of 1997.

Objectives:
-Organize events highlighting main provisions in President's legislation -- involving, for example, handgun safety locks, anti-gang prosecutors, and after-school programs.
-Draft directives, executive orders, and letters in furtherance of the bill's objectives.
-Lead working group meetings with bipartisan Congressional delegation and Administration officials to ensure enactment of President's main priorities.

We need to update

GOAL: Drugs. Promote and secure full funding for the President's 1997 Drug Control Strategy.

Objectives:
-Work closely with ONDCP on National Anti-Drug Media Campaign and organize Presidential event to kick off anti-drug advertisements.
-Work to ensure full funding for President's drug strategy in appropriations process.

GOAL: Health Care. Work toward achieving bipartisan consensus on and enactment of Medicare, Medicaid, health coverage, and quality reforms.

Objectives:
- Continue close coordination of policy development and strategy with HHS, Treasury, Labor and all relevant divisions within the White House.
-Identify opportunities for executive actions that further the President's health care agenda, particularly in relation to quality and coverage initiatives.
-Develop collaborative relationships with Congress and the governors to promote our health care agenda.
-Work with representatives of consumers, providers, insurers / health plans, business, and labor, as well as academics, health economists, and foundations to disseminate and validate the President's positions on health care.
-Refine and implement communications strategy to highlight the President's accomplishments, educate the public on current proposals, and generate support for legislative and executive initiatives.

GOAL: 0-3 Initiative. Promote efforts to enhance development in the earliest years of life.

Objectives:
-Engage in a broad-based review of policy affecting our youngest children and develop new initiatives, involving both executive and legislative action, to support these children.
-Organize, in coordination with other White House offices, a White House Conference on early learning that will examine current scientific research and its practical applications for parenting; explore how different sectors of society can support our youngest children; and highlight Administration accomplishments and initiatives.

GOAL: Service. Work with other offices in the White House to ensure that the Presidents' Service Summit advances the goals of service and voluntarism, while enhancing the AmeriCorps program.

Objectives:

-Work with other White House offices to ensure that we participate in all important decisions about the structure and content of the Summit.

-Develop events highlighting service and voluntarism to prepare the way for the Summit.

-Develop policies and identify federal government "commitments" for the President to announce in his speech at the Summit.

GOAL: Executive Action. Help the President use all the powers of his office to advance his agenda, with or without help from Congress.

Objectives:

-Develop Executive Orders and Memoranda in the priority issues outlined above, as well as in other important issues, such as consumer safety, technology, family, and the environment.

-Vet proposals for executive action on domestic policy coming from agencies and other White House offices to make sure that they advance the President's long-term agenda.

11/13/98

BUDGET SAVINGS OPTIONS

550-HEALTH

- o Increase user fees on products regulated by the FDA.
- o Reduce subsidies for health professions education.
- o Combine and reduce certain block grants administered by the Public Health Service.
- o Reduce funding for the National Health Service Corps.
- o Cap the amount that each state may receive in federal matching funds for Medicaid.
- o Limit average Medicaid expenditures per beneficiary.
- o Tighten caps on future Medicaid DSH spending.
- o Reduce the floor federal matching rate in Medicaid.
- o Restrict the allocation of TANF administrative costs to Medicaid.
- o Reduce spending for Medicaid administration.
- o Combine and reduce Medicaid and Medicare DSH payments and block grant to states.

570-MEDICARE

- o Reduce Medicare's payments for the indirect costs of patient care that are related to hospital's teaching programs.
- o Reduce Medicare's direct payments for medical education.
- o Convert Medicare's payments for graduate medical education to a discretionary program, and slow their rate of growth.
- o Eliminate additional capital-related payments for hospitals with residency programs.
- o Eliminate Medicare's additional payments to sole community hospitals.
- o Index the SMI deductible.

- Collect 20 percent coinsurance on clinical laboratory services under Medicare.
- Impose a copayment requirement on home health visits under Medicare.
- Prohibit first dollar coverage under Medigap policies.
- Increase the SMI premium to cover 30 percent of program costs.
- Simplify and limit Medicare's cost-sharing requirements.
- Relate the SMI premium to enrollees' income.
- Increase and extend PPS market basket reductions.
- Extend other expiring BBA provisions relating to Medicare.
- Reduce Medicare's payments for hospital inpatient capital-related costs.
- Eliminate Medicare's payments to hospitals for enrollees bad debts.
- Eliminate Medicare's payments to non-hospital providers for enrollees' bad debts.
- Reduce Medicare's payments for prescription drugs.
- Increase Medicare's age of eligibility to match Social Security's normal retirement age.
- Combine and reduce Medicaid and Medicare DSH payments and block grant to states. (Same as 550 option.)

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- Increase Medicare's age of eligibility to match Social Security's normal retirement age.
- Combine and reduce Medicaid and Medicare DSH payments and block grant to states. (Same as 550 option.)

Jeanne - I know it's not your area, so only comment if you have time. thanks!

IMPROVING EMERGENCY MEDICAL SERVICES (EMS) IN RURAL AND FRONTIER AREAS

SUMMARY

This proposal would provide funds to States and local communities to improve access to emergency services in rural and frontier areas. States and local communities would receive grants to promote EMS systems development and enhance provider recruitment, retention and education efforts. States and local communities would also receive funds to improve access to 911 services or alternative systems where the 911 option is not economically viable, develop programs to help rural communities train local citizens in CPR and first responder techniques, and administer training programs to help EMS volunteers in rural areas learn, maintain and upgrade their skills to meet state licensure requirements. (Cost: $50 million).

BACKGROUND

- **EMS systems are critical to the health of rural residents.** High quality EMS systems are critical to rural and frontier residents because they experience disproportionate levels of serious injuries. For instance, because of the high rates of occupational injury associated with employment unique to rural areas, such as farming, mining, and fishing, rural residents experience disproportionate rates of trauma and medical emergencies. Although farmers constitute only 4 percent of U.S. workers, 38 percent of all machinery related deaths occur on farms. In addition, the distance that rural residents need to travel to reach traditional health resources increases the morbidity and mortality associated with trauma and medical emergencies.

- **EMS services in rural areas are underfunded.** Justifying a financial investment in rural and frontier EMS systems is often difficult because of the relatively low volume of calls as compared to the overhead costs of full-time preparedness.

- **Inadequate access to medical direction presents challenges when recruiting and training EMS personnel.** The implementation and success of EMS education in rural and frontier areas presents a variety of challenges that must be addressed in order to provide quality education. These include a limited student pool that may include a high percentage of adult learners with little formal education, a small number of qualified instructors, limited access to health care facilities for supervised clinical experiences, and the absence of physician supervision.

- **Rural areas have longer EMS response times.** EMS response times can be two or three times as long in rural areas as in urban or suburban areas. This is due to poor roads, difficult terrain, severe climate conditions, limited telephone service, and insufficient infrastructure resources to support advanced emergency call systems between the field and base hospitals.

- **Harder to retain EMS personnel in rural areas.** The ability to commit time for training

and service for many EMS volunteers is increasingly limited. At the same time, many rural and frontier communities cannot afford to support paid positions for EMS. The problem of maintaining adequate staffing is exacerbated by increased risks from exposures to biological or chemical pathogens or interpersonal violence, perceptions of increased personal liability, and limited funding for training, equipment and supplies. Many of these problems exist even for paid emergency medical technicians, leading to frequent turnover or marginal employee performance.

- **EMS systems in many rural areas are not integrated with local health care services and are unable to effectively address the public health and social services needs of patients.** Traditional EMS systems often transport rural and frontier patients long distances to health care facilites that are not closely affiliated with local health care resources. For patients requiring sophisticated tertiary care, this is appropriate. However, this long distance transportation often reflects the traditional separation of the EMS service from local primary care providers, public health agencies, and social service personnel that might be able to deal effectively with the needs of the patient.

POLICY DESCRIPTION

This policy would provide grants to States and local EMS providers in order to promote EMS systems development, integrate existing EMS systems into the public health infrastructure, and provide the resources for provider recruitment, retention and education.

- **Enhancing EMS systems development.** Grant funds will be used to improve access to 911 services or alternative systems where the 911 option is not economically viable. All emergency personnel answering calls should have training in emergency medical dispatch techniques so that critical first aid and medical advice can be given to callers before emergency responders arrive. In addition, innovative communications approaches, including satellite, telecommunications, telemedicine and cellular technologies, will be supported to allow for the effective exchange of information from the field to facilities and among facilities. Dispatch centers should be considered as partners in implementing triage systems to direct patients to the appropriate level and source of health care service.

- **Integrating EMS systems into the existing public health infrastructure.** With increased training and medical supervision, expanded public health and primary care protocols for selective rural EMS personnel can enhance appropriate access to the overall health care system. Grant funds will be used to integrate emergency medical technicians (EMTs) with primary care providers to supplement evening and weekend coverage by triaging and referring patients back to the local primary care providers. EMS workers can also engage in injury or disease prevention activities within the communities they serve. Grant funds can be used to disseminate public service messages about when and how to call EMS and initiate community-based prevention activities that are targeted to issues of genuine local concern, such as hunting injuries, water safety or farm accidents.

- **New methods of EMS Provider Recruitment, Retention, and Education.** This proposal will provide funds train local citizens in CPR and first responder capabilities,

administer training programs to help EMS volunteers in rural areas learn, maintain and upgrade their technique to meet state licensure requirements, and develop distance learning programs for EMS volunteers, EMS physicians, hospital staff and others who would otherwise have to leave their communities to obtain appropriate training and support. Financial support should ensure that volunteers do not have to pay their own expenses to obtain training, supplies or equipment. Leadership training, critical incident stress management services, safety training and other support should be provided to all EMS personnel.

do you care about this issue? If so, comments are welcome.

IMPROVING ACCESS TO DENTAL SERVICES FOR CHILDREN ENROLLED IN THE MEDICAID PROGRAM

BACKGROUND

- **Tooth decay is the single most common chronic disease of childhood.** Many children have been unable to benefit from the tremendous improvements in dental preventive care that have been made over the last generation. ~~Millions of children still suffer from tooth decay and oral disease~~. Over the last decade, the percentage of children with cavities has remained constant, the percentage of children with untreated cavities has increased, and the percentage of children seeing a dentist before entering kindergarten has decreased. Almost 850,000 schools days are missed each year because of dental concerns. ~~Childhood dental disease has become a significant public health problem~~.

  → specific stats.

- **Low-income, minority children suffer disproportionately from untreated cavities and oral disease.** Fifty years ago, extensive caries experience was an almost universal childhood condition. Today, primarily low income children suffer from significant levels of tooth decay and oral disease. Eighty percent of tooth decay is estimated to occur in only 25 percent of children. Twice as much decay is untreated in children aged six to 18 years old below the poverty line as above the poverty line. Minority children have greater untreated tooth decay than white children at all ages. African American children between the ages of 5 to 17 suffered 26 percent more decayed teeth than white children between those ages.

  what's that? need layman's term?

- **Low income children are not receiving the dental benefits provided to them by Medicaid.** All children enrolled in Medicaid are entitled to comprehensive dental services under the early prevention, screening, diagnosis, and treatment benefit. However, only 18 percent of Medicaid eligible children received even one preventive dental service. Research indicated that nearly 30% of all child health expenditures are devoted to children's dental care, a spending rate greater than ten times higher than the 2.3 percent expended by Medicaid for dental care provided to enrolled children.

  → amazing although that sounds high.

- **Low provider reimbursement rates results in limited provider participation.** Medicaid reimbursement rates to dentists for common pediatric dental procedures are overwhelmingly lower than dentists' average cost of operation. The average regional Medicaid payment rarely exceeds 60% of dentists' usual fees. With Medicaid discounts for common pediatric dental procedures frequently exceeding 50 percent, there is little expectation that dentists will actively participate in Medicaid. More than half of reporting States have less than 50 percent of professionally active dentists providing any Medicaid dental care and two thirds report that less than 20 percent provide enough care to be paid more than $10,000 annually.

- **Decreasing numbers of pediatric dentists exacerbates beneficiary access barriers.** Children seeking to access the dental services provided them by Medicaid are often unable to find an appropriate provider to deliver care. Available specialist manpower to

Access problems

provide dental care for infants and toddlers is declining. Two thirds of applicants to pediatric residencies are not placed because of insufficient training slots. Funding sources for pediatric dentistry programs are inadequate. DHHS has no plans to expand the Federal programs supporting pediatric dental education and is currently reevaluating training priorities. The failure to identify the training of pediatric dentists as a priority augments the current access barriers faced by beneficiaries seeking dental services.

- **Children who are unable to receive preventive dental care often end up receiving costly emergency room treatment.** Dental emergencies account for a significant percentage of all emergency room visits among children younger than six. One third of these children have abscessed teeth; one quarter of them have draining oral lesions. Many toddlers with early childhood caries must be provided comprehensive dental treatment by an oral surgeon while under general anesthesia. More than 25 percent of the children presenting at the emergency room with a dental emergency have never been to the dentist before. The Department of Health and Human Services estimates that the Medicaid program pays between $100 million and $400 million each year to treat these children, each of whom could have avoided the operating room if they had been able to access early and aggressive preventive dental care.

- **Untreated cavities and oral disease have devastating effects on children.** Often viewed as an innocuous and trivial disease, tooth decay and its consequences have larger systemic impact. Chronically poor oral health is associated with diminished growth in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunction in adults.

POLICY OPTIONS

Requiring States to enhance reimbursement rates for pediatric dental services. State experience indicates that increasing reimbursement levels for pediatric dental services would substantially increase the number of dentists willing to schedule appointments for Medicaid patients and remove a significant barrier to beneficiary access. [I am not sure how to do this; is there a way for us to increase the match rate but ensure that the States use the extra money they're getting to enhance the reimbursement rates? Also, I know that this would be extremely expensive for States; CA raised Medicaid reimbursement rates for dental services and State expenditures went up an estimated 400% in 4 years -- with only a modest increase in beneficiaries utilizing care. Is there a way to make this less expensive?]

Providing primary care training support to pediatric dentists. HRSA does not presently recognize pediatric dentists as primary care providers and therefore excludes these residencies from primary care training support. [I will talk to the HRSA people and see what the impact of changing this would be.]

Providing funds for continuing dental education. Traditional dental providers can be retrained through continuing dental education that targets caries management and treatment of infants and toddlers. In addition, funds could be provided to train physicals, nurses, and general

dentists in caries management. [There is a WA state early intervention program that we might be able to build off of.]

Conducting an outreach program through FQHCs, Head Start, WIC, and MCHB. This one is pretty simple - grant funds for an educational campaign to let people know that they're eligible for services and how to access them. Information would be disseminated through community based providers and other programs utilized by this patient population.

1300

LIST OF NEW HEALTH IDEAS
November 5, 1998

We are meeting with OMB 11/6 at 5pm for a discussion of preliminary budget priorities.

NEW IDEAS	STATUS
1. LONG-TERM CARE	
Long-term care tax credit	HHS is sending Treasury its children's definition; Treasury needs to finalize cost estimates; no meetings scheduled
Offering private long-term care insurance to Federal employees	OPM, WH and OMB need to review the finalize legislation; meeting with OPM 11/6
Family Caregiver Support Program	AoA will brief us on 11/12
Nursing home quality initiative	Need to set up briefing by HHS and with HUD week of 11/9 (Chris is talking to HUD); Sarah is working on longer background piece.
2. DISABILITY	
Jeffords-Kennedy Work Incentives Improvement Act.	Met on 11/2 with AIDS office; met on 11/4 with HHS and OMB to review legislation; will meet with small group of disability and AIDS groups in mid-November; OMB will get back to us with any policy concerns
Tax credit for work-related impairment expenses for people with disabilities	Memo sent to Treasury asking them to broaden the credit to include expenses to get to work; met with Treasury to discuss on 11/4; they are working on a 2+ ADL definition of disability for a $1,000 - 3,000 credit.
"Date certain" demonstration BOBW. WDI	In the HHS budget submission; Jeanne needs to set up meeting with staff to review.
Medigap reform for people with disabilities	HHS will present ideas the week of 11/9.
3. MODERNIZING MEDICARE	
Adopting private sector, competitive pricing strategies	HCFA and OMB are reviewing old proposals, preparing for a meeting.
Reducing Medicare fraud and overpayment	Meeting set up on 11/18 to review HHS, Justice and OIG proposals

Prescription drug coverage for Medicare beneficiaries	OMB will send specs to HCFA on 11/6; will schedule meeting when completed
Protecting beneficiaries from withdrawals from Medicare	HHS is working on legislation; need to find out when they can brief us
Redesigning and increasing enrollment in Medicare's premium assistance program	WH/OMB/HHS staff have developed several options which have been sent to Oact for scoring
Cancer clinical trials demonstration	--
Providing needed education funds to children's hospitals.	Staff met on 11/5 to develop list of options; Devorah is developing paper
4. HEALTH INSURANCE COVERAGE EXPANSIONS	
Voluntary purchasing cooperatives	Jeanne sent paper to Gary, Treasury on 11/5; will set up meeting on 11/9 to discuss
Children's health insurance outreach	Specs sent to Oact
Demonstration for providing new coverage options for people ages 55 to 65	Jeanne needs to develop memo for Rick Foster on estimating costs / coverage of demo
5. PUBLIC HEALTH / UNDERSERVED POPULATIONS	
Fighting Bioterrorism	Sarah developed a paper.
Combating resistant to anti-biotics (super bug)	--
Improving access to health care in rural areas	Devorah is working with DHHS to flesh out options and develop paper. She will coordinate with Sarah.
Reauthorizing the Older Americans' Act	Sarah removed from budget document pending a discussion with AoA; it may possibly be added to the VP's list.
Improving access to emergency room care for Veterans	OMB staff are working to reduce the costs of the proposal.
Enhancing drug approvals, food safety and other FDA priorities	FDA is sending additional information. OMB and DHHS are working to figure out the best dollar increase.
Investing in promising DoD breast cancer / prostate cancer programs	Sarah is working with OMB to collaborate on this issue, since it is a separate budget.

Cancer clinic trials
something in PBOR maybe we could skip this — ?

tobacco - .50¢/pack (40B over 5)
7.4B — fight for
where it goes, some will go for health; be totally purist & do cessation, ads, etc

(mental health block grant $20M)

tobacco split? 50¢ → all to States w/ no strings
50¢ → a list of information
$1.00 → big discretionary $;
us w/ governors —
they get to keep their $, some governors supported before; tobacco deal people won't think it's creditable.

generic drug reviews
good government initiative.

HHS feels it's not a race & health issue — doesn't want to be included in that.
they feel it's a good government issue

Continuing the President's successful Race and Health Initiative	Awaiting comments from OMB.
Investing in promising biomedical research	Working with OMB to develop a dollar amount.
Improving access to promising HIV/AIDS drugs	Met with AIDS office on 11/2 and are presently negotiating a dollar amount.
Announcing a New Intiative to Prevent and Treat Asthma	Devorah is developing a paper.
Improving health for medically underserved Native Americans	Working with OMB to develop a dollar amount.

OMB -

$ → IHS 175 (Dan wanted 250) base level of 93

$ → NIH 7 (forward funding)

HHS request 500 over

$ → FDA

user fee (retrospective) food safety
grocery companies need seal of approval
so that consumers will feel safe; they should
be willing to pay for this

$ → CDC
biotemorism
pandemic flu } disease surveillance
food safety

combine streams look @ data flow;
concept of real time surveillance finally
public health epidemiology
grants to states some in CDC
Dan $50 state match

AIDS - ADAP
Ryan White } $76 million (5% increase)
CDC

Race & Health funded w in base
$50 goes away
DAN said $50; Chris $130

OTHER		
Issue	**Action Steps**	**Completed?**
ASTHMA	Find the EPA budget and look to see if its coordinated with HHS	
	schedule another meeting with Sarah and Neera	
HOMELESS PROGRAMS	f/u with Sarah	
OUTREACH EVENT	call Vicki	
	call Barbara	
	call Joy	
	did Teresa schedule meeting	
	do report	done
ELIGIBILITY	another call tentatively scheduled for next week	
CHIP	follow-up with IGA re: MO	yes - Lance
	list for Jeanne	
	discuss overall with Chris and Jeanne	
	get Chris' final comments on WA letter	Jeanne is finishing up Send to Don
NON PROFIT CONVERSIONS	read article	
	write-up for Chris	
	send information and list of questions to Gary	
LABOR	do we need to have another general meeting? call and find out	called Holly Nelson NO
	was the staff level meeting to discuss current proposals scheduled? ask Jeanne	

IHS	find a budget initiative within the 6 race and health areas	
RURAL HEALTH	f/u with Sarah	
UNITED HEALTH CARE ISSUE	Chris mentioned memo - f/u	Elise to send info today & will talk to CEO.
VA MENTAL HEALTH	read information submitted	

CORRESPONDANCE

SHOW to Chris

they haven't contacted her.

FY 2000 BUDGET		
Proposal	**Action Steps**	**Completed?**
GME FOR CHILDREN'S HOSPITALS	develop agenda and show to Jeanne	
	send out e-mail for Th. meeting	
FRAUD AND ABUSE	read A19s	
	meeting will be scheduled next week; invite list includes Dan, Mark, Yvette, Kathy King, Bonnie, HCFA staff, Gary, John B. Chris, Mike Mangano from OIG	f/u with Teresa
NURSING HOME INITIATIVE	call Burt Fretz	
	meeting 11/5	
QI INITIATIVE	SSA demo - ask Jeanne next steps	
	QI program -- HCFA to f/u with us	
	HCFA initiative - Judy Waxman to schedule meeting	
CHIP OUTREACH	2 paragraphs to Jeanne	websites for outreach
MEDICARE COST SHARING	Teresa to schedule meeting for next Thursday; OMB, HCFA, CMSO, ASPE, etc.	
MEDICARE DRUG BENEFIT	call Bill Vaughn and ask for proposal information	done — BUT need to f/u
SMART GUN ~~TECHNOLOGY~~	call Steve Teret — write up	done
O P M MEETING	did Teresa schedule?	yes
HIV SURVEILLANCE	Jeanne to put in NEC ideas? ask Chris	
	Chris to talk with Kevin, Sandy, CDC?	
	talk to Paul re: local mechanics	
	get cost information	

look @ WA leg. what is outreach

FOR MY EDIFICATION		
Proposal	**Questions**	**Follow-Up**
ELIGIBILITY	basic explanation of how 1931 works basic explanation of TMA MOE idea 7/96 floor how family composition interacts exactly which foster care questions are we asking	
WISCONSIN	explain proposal, please	
MEDICARE DRUG BENEFIT	explain current policy explain what indexing is what are all these estimates based on	
GRIJHALVA	what is this issue? and why is Bridgett mad?	
CONVERSIONS	see article questions	
QMB/SLMB	general background on this; the difference between QI-1 and QI-2s	
MEDICARE COST SHARING	what is this proposal	

HEALTH BUDGET IDEAS (November 2, 1998)

1. Long-Term Care: This initiative could be part of a "preparing for Medicare long-term reform" package; a women's initiative if coupled with pension policies for women or family leave policies; or with an elderly housing initiative (policies to promote maintaining home ownership, beginning to promote assisted living facilities, and ensuring quality in nursing homes).

- **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 $6 billion over 5 years).

- **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 serve as a model employer by promoting 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 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; discretionary).

- **Nursing home quality initiative.** (expanding on administrative initiative) On July 21, the President announced an initiative to toughen enforcement tools and strengthen Federal oversight of nursing home quality. On October 22nd, the Justice Department and HCFA held a conference to begin to develop other quality/anti-fraud and abuse initiatives with enforcement agencies from around the nation. Proposals to respond to these challenges and to implement the initiatives the President outlined in July can be included in the budget or as freestanding legislation. The initiative 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: $500 - 750 million over 5 years).

2. Disability. This health initiative could be packaged with the non-health ideas such as the "Bridge" integration grant proposal and the access to information technologies initiative.

- **Jeffords-Kennedy Work Incentives Improvement Act**. (Congressional proposal; not passed in 1998) In the final budget negotiations this year, the Administrative put the Jeffords-Kennedy bill on its list of priorities for passage. 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, the Administration has been stating 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).

- **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 tax credit to workers with disabilities to compensate 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: Depends on the options; at least $800 million over 5 years, helping about 300,000 people).

- **Long-term care choice demonstration.** One of the biggest frustrations for people with severe disabilities and their families is the "institutional bias" in Medicaid -- meaning the tendency to simply put people with great health care needs in nursing homes rather than develop viable, community-based alternatives. In 1998, HHS funded a small demonstration project in 4 states to test different models for offering people with disabilities the choice of care settings. This proposal would build on these tests by developing models to give people residing in a nursing home after a "date certain" a choice of care settings. (Cost: $50 million over 5 years).

3. Modernizing Medicare. These policies could "lay the groundwork" for the recommendations of the Medicare commission and re-affirm our ongoing commitment to improve and modernize Medicare.

- **Adopting private sector, competitive pricing strategies**. (FY 1998 budget) The President has consistently supported 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 increased competition within Medicare since he has supported this approach in the past. (Savings: $0.1 to $0.5 billion, depending on the policies).

- **Reducing Medicare fraud and overpayment**. (Some FY 1999 policies; some new policies) Medicare fraud poses a serious threat to its financial well-being. 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 and develop new ones. (Savings: From $1 to 3 billion over 5 years, depending on the policies).

- **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 in the event that their HMO withdraws from Medicare. (Cost: not clear that there will be costs).

- **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 become larger in the next century since the vast majority of 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, ranging from $1 to 20 billion a year).

- **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).

- **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).

- **Providing needed education funds to children's hospitals.** (new policy) 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).

4. Health Insurance Coverage Expansions. The rising number of uninsured makes the need to propose insurance expansions important.

- **Small business purchasing cooperatives** (different version in previous budgets; not passed). 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 small businesses pay more for the same benefits as larger firms. This initiative encourages the development of coops by allowing them to be considered non-profits (which will facilitate private foundation support), providing Federal grant support, and having the Office of Personnel Management provide technical assistance so that this coops are modeled on the Federal Employees Health Benefits Program (FEHBP). It is also possible to link coops to CHIP or tax credits to encourage employees to purchase insurance through them. (Cost: about $50 to 100 million over 5 years).

- **Children's health insurance outreach** (FY 1999 budget; not passed and new policy). To date, 42 states have had their 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.

To facilitate spending on outreach, this proposal would allow states to draw down more of its CHIP allotment for outreach. An additional proposal is to pay for a nationwide toll-free number that connects families with state eligibility workers. NGA is sponsoring this line for one year only; such a line is essential for the nationwide media campaign that we are planning to launch in January with the NGA. (Cost: small but unknown at this point; could be funded through tobacco recoupment)

- **Demonstration of Medicare buy-in for people ages 55 to 65** (full proposal in 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. The latest report shows that the uninsured are growing at the fastest rate in this age group; by 2010, the number of uninsured people age 55 to 65 will nearly double. Building on last-year's proposal, we could allow a limited number of people ages 62 to 65 and displaced workers ages 55 to 65 to buy into Medicare. As a demonstration, this might gain the support that it lacked last year. (Cost: at least $500 million over 5 years, which would assist about 30,000 people).

- **Demonstration of 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: about $2.5 billion over 5 years, which would help about 600,000 people).

5. 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 in FY 2000).

- **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: approximately $100 million in FY 2000).

- **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 home residents 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 veterans' 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 in FY 2000).

- **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 in FY 2000). 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 in FY 2000).

- **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 in FY 2000).

- **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 in FY 2000).

- **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 in FY 2000).