HHS BUDGET PROPOSALS

1. Countering Bioterrorism

An attack using biological weapons could produce an unprecedented health and medical emergency, generating a demand for medical services that could overwhelm the existing health care system at the local level. It would require the delivery of medical services to a potentially large population of those who have symptoms, providing preventive care to those at risk, and ensuring safe disposition of the deceased.

- **Enhancing the Public Health Infrastructure.** This proposal would increase local, State and Federal surveillance capacity, expand epidemiologic capability to investigate and control potential threats, and coordinate communication among the components of the public health system. Funds would also be used to strengthen local laboratory capacity and implement protocols for safe handling of specimens. (Cost: $198 million)

- **Strengthening the Medical Response Capacity.** This proposal would develop local health response systems to ensure that the medical and public health needs of the population are met in the event of a bioterrorist attack. These response systems, known as Metropolitan Medical Response Systems, would provide on-site victim extraction, antidote administration, decontamination, primary care, emergency transportation, and protective decontamination. (Cost: $22.5 million)

- **Creating a Stockpile of Pharmaceuticals.** This proposal would develop a stockpile of necessary drugs and pharmaceuticals that would meet the needs of the affected population in the event of the release of a chemical or biological weapon. An infrastructure for delivery and distribution of the products would also have to be developed. (Cost: $85.2 million)

- **Enhancing Research, Design, Development and Approval of Diagnostics, Antibiotics, and Vaccines.** This proposal would augment and accelerate research on rapid diagnostics, vaccines, antibiotics, and antivirals. In the short term, this program would address disease priorities, with initial emphasis on microbes such as smallpox and anthrax. This program would eventually target agents such as the Ebola virus, plague, botulism, and turalemia. (Cost: $62.4 million)

2. Strengthening the Public Health Infrastructure

A modernized public health infrastructure is necessary to close the prevention gap between scientific knowledge and human behavior. Currently, more than four out of five public health employees nationwide have no formal degree, certificate, or formal education in public health. Two in five health departments do not have internet access. At the same time, public health emergencies continue to grow. Outbreaks of food-borne illness are becoming increasingly prevalent. Our infrastructure must be strengthened in order to deal with these pressing public health needs.

- **Information and Surveillance Programs.** This proposal will inventory the public health infrastructure, identify weaknesses, and develop standards for optimal performance in order to strengthen public health surveillance, organization, and communication systems. Funds will be dedicated to prevent emerging infectious diseases and to address surveillance changes posed by existing infectious diseases and behavioral factors that predispose Americans to adverse health outcomes. Funds will also be devoted to study product related deaths and injuries. (Cost: $1.8 billion)

- **Science Based Improvements in Public Health.** This proposal will increase the quality and quantity of epidemiology centers, supporting health systems and prevention research. In addition, funds will be dedicated to research and public health programs necessary to prevent occupational illness, injury, disability and death. Special attention will also be paid to implementing violence prevention programs in schools. (Cost: $61.9 million)

- **Improving the Public Health Workforce.** This proposal proposes to invest funds in public health and preventive training programs to develop 15 community and academic partnerships that will deliver both basic and continuing education to more than 400,000 providers over the next four years. (Cost: $61.9 million)

3. Preventing Chronic Disease

Chronic disease accounts for 70% of all deaths and three-fourths of the $1 trillion spend annually on health care nationally. Moreover, they will affect and escalating percentage of Americans as our Nation's population ages, with a disproportionate impact on low-income and minority populations.

- **Start Prevention Early.** This proposal will invest funds in school health interventions, such as Girl Power and Milk Matters, to prevent cardiovascular disease, diabetes, high blood pressure, and cancer. (Cost:$92.4 million)

- **Healthy Aging.** The Department will study the health of elders in managed care settings and create an evidence based center for healthy aging in order to identify interventions appropriate for the aged. Additional interventions include screening for breast and colon cancer, measuring bone mass, promoting elder health in the IHS, and improving minority health in rural areas. (Cost: $210.96 million)

- **Independence and High Quality of Life.** The Department will implement programs providing support for family caregivers, work with managed care organizations to promote effective self-care techniques, and expand the National Diabetes Education Program, which will promote diabetes self management. Special attention will be paid to racial health disparities in undeserved rural areas. (Cost: $263.59 million)

- **Prepare Public Health for the Future of Chronic Disease Prevention.** This proposal invests funds in nursing and health professions training, improves population based prevention strategies, and improves health care database to enhance and guide treatment decisions. (Cost: $49.9 million)

4. Preventing and Controlling Asthma

Currently, 15 million Americans have asthma. This number represents a 100% increase withing the last 15 years, and children under the age of five have the greatest increase in incidence.

- **Preventing Asthma.** This proposal funds biomedical research into the early life origins of asthma. In addition, it funds research on adult onset asthma, especially in women, the relationship of asthma to chronic obstructive pulmonary disease, and the drug interaction of asthma medications. (Cost:$6.6 million)

- **Improving Asthma Management.** This proposal will fund research to prevent fatalities, explore inherited characteristics and their correlation with the proclivity to develop asthma, and improve disease management education techniques. (Cost: $12.5 million.)

- **Implementing Public Health Programs To Reduce the Severity of Asthma Attacks.** The Department will implement public health programs that improve access to care and previously developed guidelines of diagnosis and management for asthma. Additional activities will be undertaken to support State and local public health actions. This includes grants for State outreach activities. (Cost: $10 million)

- **Eliminating the Disproportionate Burden of Asthma in Minority and Low-Income Populations.** Additional research will be conducted into the importance of geographical and environmental factors as they relate to illness, determine the role of poverty and race on emergency room use and hospitalization rates, and examine the impact of managed care among models for delivering quality asthma care to patients most at risk for asthma related illnesses or death. (Cost: $10.2 million)

- **Developing Data Systems and Evaluating Program Effectiveness.** This proposal will provide funding to coordinate local, State and national systems for asthma surveillance to monitor trends, identify populations in significant need of health intervention, and generate data needed to study asthma's impacts. (Cost: $11 million)

5. Long Term Care: A New Direction

Approximately 11.4 million people need assistance to carry out basic activities of daily living such as bathing, dressing, or eating. Most of this assistance is provided by family members or friends; nearly 22 million families provide their loved ones with long-term care assistance. Moreover, the need for long term care will escalate as the 76 million baby boomers age. Demographers predict that 19 million elders will require long-term care by the year 2050.

- **Supporting Informal Caregivers.** Through the Older Americans Act, the Department will establish a national caregiver support program offering assistance to families and other informal caregivers through formula grants to States, State incentive grants, and enhancing ongoing program performance. The support system will provide information to caregivers about existing resources, personal counseling, and respite care. (Cost: $150 million)

- **Helping States Expand and Enhance Community Services.** The Department will support States in reducing their reliance on nursing homes and increasing the availability of home and community based services. The program will consist of a national technical assistance resource center, a capacity building grant program to assist States in developing community based service systems, and performance awards for participating States that successfully demonstrate their ability to reduce institutional use and expand home and community service systems. (Cost: $338 million annually; program will continue for 5 years)

- **Promoting Programs that Enable People to Transition from Nursing Homes into the Community.** The Department will provide grant funds to four or more States working to relocate current nursing home residents. These funds may also be used to provide services that are not in the State Medicaid plan to nursing home residents as they transition into the community and to support community living for former residents. (Cost: $50 million over 5 years)

- **Promoting the Use of Community Based Long-Term Care Services.** This Medicaid eligibility proposal would permit States to cover individuals with income up to 300% SSI (levels which can currently be used for people in nursing homes and receiving home and community based waiver services) for people in the community who have been determined to require and institutional level of care. States could target this option to individuals receiving certain services, or select an array of L.C. services in addition to personal care. (Cost: $130 million in Medicaid funds over 5 years)

- **Implementing the Nursing Home Initiative.** This proposal would follow through on the President's promise to toughen nursing home enforcement tools and strengthen federal oversight of nursing home quality and safety standards. The Department will conduct more frequent surveys of repeat offenders, stagger surveys on weekends and evenings, and develop a repository of best practice guidelines for residents at risk of weight loss and dehydration. In addition, a national registry of nursing home employees convicted of abusing residents will be developed. (Cost: $153 million)

- **Promoting the Expansion of Medicaid Benefits for Working People with Disabilities.** This proposal would allow more individuals to buy into the Medicaid program and maintain medical coverage as they enter or reenter the workforce by removing the 250% FPL income limit, eliminate the unearned income limit, and eliminate the current $2000 asset test. This proposal will allow individuals on SSDI to have access to personal care services and drugs through Medicaid, services they cannot get through Medicare. States would be able to charge premiums and copayments at their discretion. (Cost: $280 million over five years)

6. Curtailing Violence Against Women

Over 5 million women experience domestic or sexual violence each year. Over 4,200 girls and women are murdered annually by someone they know, and more than half of those murders were

committed by intimate partners.

- **Enhancing Services.** This proposal will increase services, such as counseling and emergency shelter services, via existing mechanisms. Efforts will be made to ensure that the services provided are culturally appropriate for under-served populations, such as minorities and rural communities. The proposal will also provide grants to 20 communities to establish integrated response teams for addressing immediate crises, increase the level of services to support survivors beyond immediate crisis needs, establish workplace intervention programs, and expand perpetrator treatment programs. (Cost: $42 million)

- **Evaluating What Works.** This proposal will provide funds to evaluate existing services and the linkages between the child welfare / child protective service system, and the domestic violence service system. Core screening tools will be developed for clinicians to use to identify women who are survivors of domestic violence. (Cost: $14.5 million)

- **Changing Social Norms.** The Department will work with advocates, researchers, and other experts to develop, conduct, and evaluate training workshops for teachers and others who interact with youth that emphasize positive relationships, empathy, conflict resolution skills, and media literacy. A comprehensive media campaign will be developed to focus on populations deemed to be especially vulnerable. Research will also be conducted to help us better understand the specific social norms supporting violence against women. (Cost: $11.8 million)

- prob w/ elderly is that not many are taxpayers—
- this works b/c family members can claim them as dependants → helps get non filers.

DPC/NEC HEALTH BUDGET IDEAS (September 8, 1998 List)

1. Long-Term Care and Medicare Reforms for Elderly, Disabled and Their Families.

disabled benefit here too b/c functionally based.

(flat credit)

- **Long-term care tax credit.** 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 two or more limitations in activities of daily living (ADL) or their care givers a tax credit of $500 (or more, if affordable) to help pay for formal or informal long-term care. This initiative would be coupled with other long-term care policies (e.g., offering private long-term care insurance offering to Federal employees). (Cost: About $4 billion over 5 years, offset by closing some tax loopholes, and would help about 3.4 million people). AARP okay OR 3?

press paper from August

no formal briefing; but cash helps these people b/c needs are expensive

NEXT STEPS: After this memo, we got revised estimates. We can afford a $1,000 credit that costs about $5 billion over 5 years, assisting an estimated 2.3 million people. We could be done with this policy, unless we want to try to expand to more non-filers.

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

OPM wants to avoid specifying standards in legis.

balance btwn standards & lightning rod for legislation; OMB should come

NEXT STEPS: We probably need to finalize clearance of the legislative language; Jeanne will call OMB to see where it is in the process (it started through the LRM in August).

- **Tax credit for work-related impairment expenses for people with disabilities.** 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, strongly advocated by your Task Force on Employment of Adults with Disabilities, would give a 50 percent tax credit, up to $5,000, for impairment-related work expenses. It could be a stand alone proposal in the budget or packaged as a long-term care initiative if we decide to defer announcing the long-term care tax credit. (Cost: About $500 million over 5 years, offset by closing tax loopholes, and would help about 300,000 people).

Becky unhappy b/c its not enough? comm → then to treasury

(matching the bills)

Gene S. would like to expand; unclear as to $ exp or people exp $.

NEXT STEPS: Chris or Jeanne needs to check with Becky Ogle and Bob Williams about whether this policy will be validated by the community. Pending the outcome of this discussion, we will set up a meeting with Treasury (next week). Gene Sperling has expressed an interest in expanding this or the E ITC for people with disabilities.

. Becky
. Bob
. Jonathan
Mtg.

if we do this, does it mean that we don't do Kennedy-Jeffords?

can 1st 2 stand on their own? Jeanne says yes.

Bridge program? from Labor
discretionary funds.

tax proposals are priorities?

Jeanne's tax issue:

pull Medicare Medicaid DSH
$ retarget; Medicare commission
issue. $ in tax code; there's no demonstrable
difference btwn pubs & private.

GME & children's hospitals
Bill Frist priority

not a big pot
of $ left.

rural infrastructure dying; cost-shifting
studies not around; no hospitals shutting
down.

employee tax deduction? individual credits?

mtg: Jeanette T. (Chris 1st)
Dan M
Mark M
Ann Tumlinson

title problem (Reed)

- **New Family Care giver "One-Stop-Shop" Support Program.** 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). Jeanette Takamura

  NEXT STEPS: This proposal is in the HHS Secretary's initiatives. Should we have a meeting with AoA to hear more about its details?

- **Adding prescription drug coverage to Medicare** (new policy). The lack of coverage for prescription drugs in Medicare is widely believed to be its most glaring shortcoming. Recognizing the medical community's reliance on prescriptions for the provision of much of the care provided to Americans, virtually every private health plan for the under-65 population has a drug benefit. Medicare's lack of coverage is largely responsible for the fact that drug costs are the highest out-of-pocket cost for three out of four elderly. This burden will only become more acute in the next century as 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 option, a managed care benefit only approach, and a traditional benefit for all beneficiaries. If desirable, a proposal could be included in the budget or coordinated with the March release of the Medicare Commission's recommendations. (Cost: Varies significantly depending on proposal, but could be $1 -20 billion a year; assumed offset would be Medicare savings, which might more easily be achieved in context of a broader reform proposal). mandate or not? squeeze & reallocate. subsidized supplemental benefit? NO. No duty than Medigap.

  NEXT STEPS: Meeting set up this week (?); Actuaries are ready to talk about analyses. Need also to also think of alternatives like the Waxman proposal or voluntary purchasing coops for Medicare. Will ask Gary and Dan to think about this. Public private needs to happen

- **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).

  Offer again

  NEXT STEPS: Is there any need to revisit this policy?

* Medi-gap * managed care *

mtg: Teresa reschedule segue into a new process

risky b/c of backlash

OMB where we are; quick f/u mtg. this will anger Thomas if we put this into budget.

drug cov for Me benfies → contentious.

→ restrict as a mandate for managed care? FFS would harder. most imp.

this way extracts deeper discounts — 70% MC Me ↑ have mandate.

tax policy around drugs; but then it's not insurance.

not Waxman; competitive purchasing for Cosner.

Dan

Gary.

does this need to cost $; take away higher income to lower income try to fix QR prog w/o spending $

- **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; probably about $500 million to $2 billion over 5 years).

  NEXT STEPS: Devorah is getting from HHS and SSA the latest list of outreach plans. Jeanne will begin meeting with staff to come up with options / costs of fixing the QI program.

2. Health Insurance Coverage Expansions.

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

  NEXT STEPS: Not sure we need to revisit the policy. Should we have the Actuaries reprice for the next budget period?

- **Jeffords-Kennedy Work Incentives Improvement Act**. (Congressional proposal; not passed). In the final budget negotiations, the Administrative put the Jeffords-Kennedy bill on its list of priorities for passage this year. This bill would enable people with disabilities to go back to work by providing an option to buy into Medicaid and Medicare, as well as other pro-work initiatives. Although it was rejected by Republicans, our message is that the Administration will continue to fight to give people with disabilities the opportunity to work -- including the critical health insurance that makes work possible.

  NEXT STEPS: Meeting set up for Monday with OMB and HHS to discuss any modifications needed / how to integrate into budget.

full time part year highest rates of uninsurance

- **Health coverage for the temporarily unemployed** (FY 1997 and 1998 budgets; not passed). Because most health insurance is employment based, job changes put families at risk of losing their health care coverage. Many families do not have access to affordable health insurance when they are between jobs because they work for firms that do not offer continuation coverage or cannot afford individual insurance. The proposal would provide temporary premium assistance for up to six months for workers between jobs who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own. (Costs depend on whether it is done as a demo (about $2.5 billion over 5 years, which would help about 600,000 people) or nationwide (about $10 billion over 5 years, which would cover about 1.4 million persons)).

  NEXT STEPS: These estimates are two years old; last year, we just prorated the previous year's estimates. Should we look into re-estimating?

CBO new baseline; PAYGO?

- **Children's health insurance outreach** (FY 1999 budget; not passed and new policy). By the first anniversary of CHIP, we expect about 45 states to have CHIP plans approved. These new expansions have great potential to help uninsured children, but not if families do not know or understand the need for insurance. Moreover, over 4 million uninsured children are eligible for Medicaid today. Last year's budget included several policies to promote outreach, including allowing states to temporarily enrolling uninsured children in Medicaid through child care referral centers, schools, etc; and allowing States to access extra Federal funds for children's outreach campaigns. An additional proposal is to pay for a nationwide toll-free number that connects families with state eligibility workers. 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 and America's Promise (Colin Powell's group). (Cost: Between $400 and $1 billion over 5 years.)

  NEXT STEPS: Devorah is looking into the content of the HHS budget on outreach. Do we want to consider additional ideas? Washington State type proposals?

need tobacco MOE for Mcaid

- **Parents of children on CHIP** (new policy). Since children who are uninsured usually have parents who are uninsured, an easy way to target uninsured adults is to extend eligibility for Medicaid or CHIP to parents of children covered by these programs. This has been done successfully in some states, through Medicaid 1115 waivers, and would be a logical next step to covering low-income adults. (Cost: Depends on the proposal and assumed take-up rates by the states).

  NEXT STEPS: This is somewhat controversial; some Democrats do not want to continue with CHIP. However, we have some people in the validator community and internally (OMB, GS) who are interested.

use 1931; not parents of CHIP → coupled w eligibility simplification
Jon D. add $ CHIP for parents.

outreach & grandparents & CHIP?

→ Nicole Radner foster kids benefits

- **Optional state coverage expansion through eligibility simplification** (new policy). In the wake of welfare reform, Medicaid eligibility rules have become even more complex since states must cover people who would have been eligible for AFDC under the old rules. Additionally, Medicaid law allows states to cover parents but not adults without children --even if they are very poor. This proposal would allow states to opt for a pure poverty standard for Medicaid eligibility for all people (like we do for children) rather than the old categorical eligibility categories. Not only would such an approach simplify the Medicaid program for families and states; it would provide an opportunity for significant coverage expansion. While any change in Medicaid almost always raises concerns amongst some advocates, this proposal would be strongly supported by the Governors and advocates such as the Center for Budget and Policy Priorities. (Cost: Depends on the proposal and projected coverage expansion take-up rates). subsidized ? buy in?

job transition; welfare to work

15% < 18
20% < 24

NEXT STEPS: Jeanne is holding staff meetings with HHS and OMB about this. The First Lady's office is interested in extending Medicaid for foster kids who turn 18 and lose it. MC Jeanne wants to look at this proposal generally, since people ages 18 to 24 are particularly at risk for being uninsured. would be both

buy into MC ? MC & CHIP

A mandate staying as dependant longer.

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

NEXT STEPS: ??

3. Increase the Indian Health Service budget. In order to reach more of the targeted population, we should provide a significant increase to the IHS budget in order to address areas such as substance abuse, elder health care, injury prevention, domestic violence and child abuse, and sanitation facilities.

NEXT STEPS: ??

long term care for ¶ 80% ¶ in ltc.

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, are ~~starting to beat even~~ becoming resistant to even the strongest anti-biotics, ~~causing~~ causing prolonged illnesses and ~~even~~ death. For example, pneumonia, which there are now strains of 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. In the past we have ~~generally~~ addressed this by developing new antibiotics, but it is becoming increasingly difficult to ~~keep developing~~ develop antibiotics that do not become ineffective. However, this problem could be ~~dramatically reduced~~ alleviated 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 anti-biotics; and improve surveillance and research efforts, ~~to understand which antibiotics are at risk for becoming ineffective and why~~. (Cost: up to $50 million).

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

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

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

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

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

- **Investing in Promising Biomedical Research.** Your FY 1999 budget includes historic increases in the NIH. However, the Congress will no doubt fund NIH at higher levels, regardless of how much you propose in this area. Therefore, you could either continue to fund this research at historic levels or since Congress will likely anyway, you may want to propose less to make room for other priorities. (Cost: over $300 million to $1 billion).

- **Improving Access to Promising HIV/AIDS Drugs.** Since there has been so much progress in therapies for HIV/AIDS, the AIDS community has been pushing to expand access to these drugs. Their expectations were raised last year when the Vice President asked HCFA to look into the feasibility of a demo to expand Medicaid to patients with HIV at an earlier point in their disease. Depending where we end up on Jeffords-Kennedy, we may want to consider additional options to extend drug therapies for patients with HIV/AIDS. Last year, we proposed significant funding for the AIDS Drugs Assistance Programs (ADAP), but there may be other approaches. Regardless of Kennedy-Jeffords, we may receive a great deal of criticism from the community if we propose no increases for treatment or prevention. (Cost: approximately $100 million).

- **Improving Health for Medically Underserved Native Americans.** Native Americans have particularly poor health status (as much as five times higher diabetes rates, and three to four times the rate for SIDS). It is widely recognized that the IHS, the main resource for Indian tribes who deliver health programs to their communities, is not sufficiently funded to address the needs of this population. We could develop a number of initiatives to help improve health for Native Americans, including: focusing on particular health problems such as an elder care, domestic violence, or alcoholism; providing an overall budget increase allowing more resources for all services; or desperately needed improvements in sanitation or other public health infrastructure efforts. This would build on your 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).

HHS Elder Health.

CHRIS – This is Revised per our Sperling discussion (d.t. Not include P.H. ed.t.s.)

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).

I EMAILED IT TO You

- **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).

Added

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).

made more vague

changed Name

- **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).

Tuesday, 11/3/98

9:00 - DPC mtg in Rm 211

11:30 - Lv for Lunch

11:45 - **Lunch** w/Laurie McGinley
Oval Rm at Jackson Place

1:00 - **Conf. Call** "Health Policy"
456-6755/66766 Code 6622

3:00 - "Nat'l Assoc of Comm. Health Centers" mtg.w/B. Woolley
Room 476

5:00 - **Conf. Call** "Issues on FDS Policies on Genetic Drugs" w/Lori Sullivan
Call 1-800-403-1013
Code-891439

HEALTH

1. Long-Term Care and Medicare Reforms for Elderly, Disabled and Their Families.

• **Long-term care tax credit**. 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 two or more limitations in activities of daily living (ADL) or their care givers a tax credit of $500 (or more, if affordable) to help pay for formal or informal long-term care. This initiative would be coupled with other long-term care policies (e.g., offering private long-term care insurance offering to Federal employees). (Cost: About $4 billion over 5 years, offset by closing some tax loopholes, and would help about 3.4 million people).

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

• **Tax credit for work-related impairment expenses for people with disabilities.** 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, strongly advocated by your Task Force on Employment of Adults with Disabilities, would give a 50 percent tax credit, up to $5,000, for impairment-related work expenses. It could be a stand alone proposal in the budget or packaged as a long-term care initiative if we decide to defer announcing the long-term care tax credit. (Cost: About $500 million over 5 years, offset by closing tax loopholes, and would help about 300,000 people).

•**New Family Care giver "One-Stop-Shop" Support Program.** 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).

• **Adding prescription drug coverage to Medicare** (new policy). The lack of coverage for prescription drugs in Medicare is widely believed to be its most glaring shortcoming. Recognizing the medical community's reliance on prescriptions for the provision of much of the care provided to Americans, virtually every private health plan for the under-65 population has a drug benefit. Medicare's lack of coverage is largely responsible for the fact that drug costs are the highest out-of-pocket cost for three out of four elderly. This burden will only become more acute in the next century as 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 option, a managed care benefit only approach, and a traditional benefit for all beneficiaries. If desirable, a proposal could be included in the budget or coordinated with the March release of the Medicare Commission's recommendations. (Cost: Varies significantly depending on proposal, but could be $1 -20 billion a year; assumed offset would be Medicare savings, which might more easily be achieved in context of a broader reform proposal).

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

• **Redesigning and increasing enrollment in Medicare's premium assistance program** (extension of July executive action and new policy). Over 3 million low-income Medicare beneficiaries are eligible but do not receive Medicaid coverage of their Medicare premiums and cost sharing. Many more may not get enough assistance through the new, BBA provision that is supposed to help higher income beneficiaries. We are developing a range of proposals that build on the President's actions in this area to better utilize Social Security Offices to educate beneficiaries about this program, to reduce administrative complexity for states and to give them incentives to engage in more aggressive outreach efforts. (Costs vary depending on policies; probably about $500 million to $2 billion over 5 years).

1- Brian Coyne's office - Chris. J. want Approp. language.

2. **Health Insurance Coverage Expansions.**

2- Jennifer Ryan.

• **Providing new coverage options for people ages 55 to 65** (FY 1999 budget; not passed). Americans ages 55 to 65 have a greater risk of becoming sick; have a weakened connection to work-based health insurance, and face high premiums in the individual insurance market. This three-part initiative would: (1) allow Americans ages 62 to 65 to buy into Medicare, through a premium designed so that this policy is self-financed; (2)

HHS budget

offer a similar Medicare buy-in to displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) give retirees 55 and over whose retiree health benefits have been ended access to their former employers' health insurance. A proposal such as this would be minimally necessary for any serious consideration of proposals to raise Medicare's eligibility age. (Cost: About $1.5 billion over 5 years, which would assist about 300,000 people).

•**Health coverage for the temporarily unemployed** (FY 1997 and 1998 budgets; not passed). Because most health insurance is employment based, job changes put families at risk of losing their health care coverage. Many families do not have access to affordable health insurance when they are between jobs because they work for firms that do not offer continuation coverage or cannot afford individual insurance. The proposal would provide temporary premium assistance for up to six months for workers between jobs who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own. (Costs depend on whether it is done as a demo (about $2.5 billion over 5 years, which would help about 600,000 people) or nationwide (about $10 billion over 5 years, which would cover about 1.4 million persons)).

New Policies?

• **Children's health insurance outreach** (FY 1999 budget; not passed and new policy). By the first anniversary of CHIP, we expect about 45 states to have CHIP plans approved. These new expansions have great potential to help uninsured children, but not if families do not know or understand the need for insurance. Moreover, over 4 million uninsured children are eligible for Medicaid today. Last year's budget included several policies to promote outreach, including allowing states to temporarily enrolling uninsured children in Medicaid through child care referral centers, schools, etc; and allowing States to access extra Federal funds for children's outreach campaigns. An additional proposal is to pay for a nationwide toll-free number that connects families with state eligibility workers. 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 and America's Promise (Colin Powell's group). (Cost: Between $400 and $1 billion over 5 years.)

• **Parents of children on CHIP** (new policy). Since children who are uninsured usually have parents who are uninsured, an easy way to target uninsured adults is to extend eligibility for Medicaid or CHIP to parents of children covered by these programs. This has been done successfully in some states, through Medicaid 1115 waivers, and would be a logical next step to covering low-income adults. (Cost: Depends on the proposal and assumed take-up rates by the states).

• **Optional state coverage expansion through eligibility simplification** (new policy). In the wake of welfare reform, Medicaid eligibility rules have become even more complex since states must cover people who would have been eligible for AFDC under the old rules. Additionally, Medicaid law allows states to cover parents but not adults

without children --even if they are very poor. This proposal would allow states to opt for a pure poverty standard for Medicaid eligibility for all people (like we do for children) rather than the old categorical eligibility categories. Not only would such an approach simplify the Medicaid program for families and states; it would provide an opportunity for significant coverage expansion. While any change in Medicaid almost always raises concerns amongst some advocates, this proposal would be strongly supported by the Governors and advocates such as the Center for Budget and Policy Priorities. (Cost: Depends on the proposal and projected coverage expansion take-up rates).

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

3. Increase the Indian Health Service budget. In order to reach more of the targeted population, we should provide a significant increase to the IHS budget in order to address areas such as substance abuse, elder health care, injury prevention, domestic violence and child abuse, and sanitation facilities.

September 11, 1998

Long-Term Care Tax Credit Beneficiary Counts:
Estimates and Explanations

This note provides some rough preliminary estimates of the characteristics of the chronically ill population and their caregivers. Specifically, we estimated the number of individuals who are potentially eligible for long-term care tax credits by severity of disability, age, and tax status, as well as the costs of various options. The estimates are still preliminary and should not be cited publicly at this time. In particular, estimates of non-tax variables that are not readily available from other sources should be viewed as especially sensitive.

These estimates are somewhat lower than our earlier estimates because of additional data that we have recently been able to incorporate into our analysis. We start by explaining revisions and qualifications on our current estimates (i.e., why they might be revised again), and then provide the estimates.

Key Caveats and Revisions

Estimating long-term care tax credit options is extremely difficult because available data are incomplete. For example, much of the data regarding severity of disability are available only for a point in time in a given year, but we need to calculate disability status and duration of disability for an entire year. Further, there is little information regarding intra-family transfers or support networks between households that can be used to estimate different dependency relationships.

To meet these challenges, we developed on-model imputations and off-model adjustments, but they are still being refined. We have recently improved our estimates by matching data on long term care, provided by HHS and others, to the new 1995-based individual income tax model.

These model and data enhancements have caused downward revisions in the estimates of the proposals since August. For example, the estimates of the cost of the $500 basic credit for chronically ill individuals with two or more activity of daily living limitations (ADLs) have been revised downwards: from $3.9 billion to $3.1 billion between FY 1999 and 2003 and from $12.4 billion to $9.5 billion between FY 1999 and 2008. Our estimates of the total number of chronically ill individuals benefitting from the proposal has declined from 3.4 million persons to 2.9 million persons. Estimates have been revised downwards to account for new information on the numbers of both elderly dependents and disabled filers with pre-credit income tax liability. The growth rates of the elderly disabled population in the community has also been adjusted downwards between FY 1999 and 2008.

As the model continues to be refined, further revisions are possible.

Estimates of Potential Beneficiaries (ALL ESTIMATES ARE PRELIMINARY)

A. Elderly vs. Non-elderly: Using data from the National Long Term Care Survey and the National Health Interview Survey, we find that there are about 3.4 million individuals living in the community who had two or more ADLs or who were cognitively impaired for three or more months when surveyed in 1994. Increasing the ADL limitation to three or more reduces this estimate to 2.6 million individuals.

Extrapolating to 1999 levels and annualizing the estimates, we estimate that there will be 4.7 million individuals living in the community for six or more months with two or more ADLs or who were cognitively impaired. Of these, 2.5 million will be aged 65 or older. Limiting the sample to individuals with three or more ADLs would reduce the total number to 3.6 million and the number of elderly disabled to 2.1 million.

There were about 1.4 million elderly individuals living in nursing homes at some point during 1995. Annualized estimates are not available. Most of these individuals would not qualify for the credit because they have little or no taxable income.

These estimates, even when finalized, should not be cited publicly.

B. Filers vs. Dependents: We estimate that 2.8 million of the 4.7 million individuals with two or more ADLs living in the community would benefit from the credit; of these, half would benefit from filing their own return, and the other half would be claimed as a dependent by another taxpayer (using the residency-based definition of dependents).

Among the 3.6 million people with three or more ADLs living in the community, the number of beneficiaries declines to 2.2 million; again, half of those would benefit from filing their own return, and the other half would be claimed as a dependent by another taxpayer.

Among year-round nursing home residents, only about 100,000 would benefit from the credit. This estimate cannot be further split between filers and dependents.

C. Differing Definitions of Dependents: The proposal would change the definition of dependency: dependents are defined as having gross income below the sum of the exemption amount, standard deduction, and the deduction for the elderly and disabled (rather than just the exemption amount). Further, the support test for dependents under present law is waived if they meet certain residency and relationship tests. Under the new definition, there are roughly 1.4 million dependents with two or more ADLs and 1.1 million with three or more ADLs who qualify for the credit.

If the current law definition of dependents were retained, there would be roughly 800,000 dependents with two or more ADLs and 600,000 with three or more ADLs who would qualify for

the credit

D. Number of Nonfilers with ADLs But Not Qualifying for Credit: There are roughly 1.1 million individuals, aged 65 or older, in homes or community with two or more ADLs (900,000 with three or more ADLs) who would not qualify for the credit. There are approximately 700,000 nonelderly individuals with two or more ADLs in homes or communities (500,000 with three or more ADLs) who would not qualify for the credit.

Estimates of year-long nursing home residents who would not benefit from the credit are not available.

The estimates on nonfilers, even when finalized, should not be cited publicly.

11 am mtg – Budget / Labor
10/21

FY 2000 Budget

PWBA – basically reformatted budget into cross cutting efforts

① conditions for low-wage workers – health & pension coverage. Treas. HHS vetting

Ⓐ welfare to work credits

worker opportunity tax credit; credit for hiring welfare to work

crowd out?

Ⓑ ? Enterprise zones

Ⓒ create health & pension. Consumer tax credit EITC

experimental & bound to welfare to work.

Some by income
Some by size of company

Link in to tax credit for workers w disabilities

possible for demonstration & capping – etc.

incentives
take up rates →
discussion.

crowd out –
complaints from
academic community

OMB → look @
budget request

Treasury → budget size, etc.

get together w ASPE and Labor

Mcare MC Rate Debate

① CHRS
market performance Medicare
BOB Reich

②
Competitive pricing FFS
Competitive bidding HMOs

③

④ Modify drug pricing

⑤ non profits ≤ 3
pay tax → redistribute
to people w uncompensated
care

⑥ Fraud
John Bentivolio
IG Office

Separate LTC section

② Medicaid reform for disabled
→ Medigap

③ Medicare buy-in

insert on nursing home reforms in 9tz. sections

nursing home commission

gov mental health conference

outreach

CHP adults

MC simp for adults

tobacco

administratively
allg simp.

FEHBP in New
voluntary co-op
whatever
purchasing
co-ops.

CJ/JC
Let's talk.
Lots of ideas
(many old but still...

HEALTH BUDGET IDEAS (October 22, 1998)

1. Long-Term Care

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

Yes

Yes
10/31

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

Yes

- **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).

Yes

- **Nursing home quality initiative.** On July 21, the President announced an initiative to tougher nursing home 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 something freestanding. The initiatives will no doubt include new enforcement provisions (e.g., increased penalties, etc.), as well as new funds to conduct more frequent surveys of repeat offenders and improve surveyor training. We are also working with the Department to explore the possibility of establishing a Nursing Home Commission to oversee HCFA's efforts. (Costs:$750 million over 5 years)

Yes

- **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

Want to do more!

the potential to lose Medicaid or Medicare coverage, as the primary barriers to seeking and keeping employment. This proposal would give a 50 percent tax credit, up to $5,000, for impairment-related work expenses. This policy overlaps to some degree with the Jeffords-Kennedy Work Incentive proposal, described later, but has the advantage of helping people in all states irrespective of whether states take up optional coverage. (Cost: About $500 million over 5 years, offset by closing tax loopholes, and would help about 300,000 people).

2. Modernizing Medicare

- **Adopting private sector, competitive pricing strategies.** (FY 1998 budget) The President has consistently supported 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).

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

- **Protecting beneficiaries from HMO withdrawals from Medicare.** This year, a number of HMOs have pulled out of Medicare with only a few months notice, leaving 50,000 beneficiaries with no plan options in their areas. These withdrawals are causing beneficiaries unnecessary hardships as they rush to find alternative sources of coverage. The President has stated his determination to work with the Secretary of HHS and Congress to develop legislation to prevent this behavior in the future (e.g., limit the time between when a plan

files to participate in Medicare and when enrollment begins, making it less necessary for plans to pull out at the last minute). (Cost: not clear that there will be costs).

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

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

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

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

3. Health Insurance Coverage Expansions.

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

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

- **Health coverage for workers between jobs** (FY 1997 and 1998 budgets; not passed). Because most health insurance is employment based, job changes put families at risk of losing their health care coverage. Many families do not have access to affordable health insurance when they are between jobs because they work for firms that do not offer continuation coverage or cannot afford individual insurance. The proposal would provide temporary premium assistance for up to six months for workers between jobs who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own. (Costs depend on whether it is done as a demo (about $2.5 billion over 5 years, which would help about 600,000 people) or nationwide (about $10 billion over 5 years, which would cover about 1.4 million persons)).

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

- **Medicaid options for older children/young adults** (new policy). Nearly one in three people ages 18 to 24 lack health insurance. Additionally, the parents of low-income children covered through Medicaid and CHIP are often left uninsured. One proposals would give states the flexibility to continue covering children who lose eligibility only because they turn 18 years old. This extension would be administratively simple, targeted, and help young people whose first jobs often lack health insurance. Another is to expand state options to cover low-income adults (e.g., adults who are not parents). (Cost: Unknown at this point).

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

4. Paying for Health Education and Uncompensated Care

- **Providing needed education funds to children's hospitals.** Medicare has invested billions of dollars in graduate medical education to hospitals since 1966. However, because of its current formula, free-standing children's hospitals are forced to shoulder the majority of the cost of training pediatricians, placing them at a severe financial disadvantage. This proposal would modify the distribution formula to provide reimbursement for the training costs incurred by children's hospitals. Addressing children's hospitals' education financing has bipartisan support, and Senator Frist has made this a priority for the Medicare Commission (Costs: depends on the proposal).

- **Improving the targeting of tax subsidies for hospitals providing uncompensated care.** About $7 billion in preferential tax treatment is granted each year to nonprofit hospitals to help offset the costs of providing care for uninsured and underinsured people. However, this tax preference is not well targeted: hospitals with a great burden often don't get enough help, while hospitals providing little care get too much. This proposal -- which is very preliminary -- would replace the preferential tax treatment of non-profit hospitals with a new uncompensated care pool. This pool would, through the tax system, provide assistance to hospitals that demonstrate that they provide a lot of uncompensated care. This proposal could be considered in tandem with proposals to reform the Medicare disproportionate share payment (DSH) system, which also intends to cover these costs. (Cost).

5. Increase the Indian Health Service budget. In order to reach more of the targeted population, we should provide a significant increase to the IHS budget in order to address areas such as substance abuse, elder health care, injury prevention, domestic violence and child abuse, and sanitation facilities.

Public Health/Underserved Populations

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

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

Yes -- not u.l this u poss. Pol?

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

Improving Access to Emergency Room Care for Veterans. As part of the President's

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

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

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

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

Investing in Promising Biomedical Research. Your FY 1999 budget includes historic increases in the NIH, and the Congress has funded the NIH at even higher levels (a historic $2

billion increase this year), regardless of how much you propose in this area. Therefore, you could either continue to fund this research at historic levels or since Congress will likely anyway, you may want to propose less to make room for other priorities. (Cost: over $300 million to $1 billion).

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

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

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 are infected with ~~Staph~~ *[we should probably just use the scientific name; Staph is slang, and it also refers to an entire group of diseases, not just the one mentioned here] (staphylococcus aureas)* each year, ~~the most~~ a commonly-acquired, potentially lethal, hospital-based infection. ~~impacting 500,000 Americans per year,~~ This bacteria now responds ~~is now~~ only ~~responding~~ to vancomycin. In a troubling development, CDC has already documented the first cases of resistance to vancomycin, which potentially leaves Americans with no medical defense against this bacteria. ~~this last resort drug~~. The costs associated with treating antibiotic resistant strains of bacteria total ~~Antibiotic resistance costs~~ over $600 million per year in hospitals. This new initiative could address this critical problem through: (1) a major outreach initiative that will help reduce the vast overuse of antibiotics, making diseases less likely to become resistant; (2) new 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 resistence.

- **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~~ approximately 80 percent lower in rural communities than in urban and suburban communities. ~~and even limited services are frequently not well integrated ??~~. The budget could include an initiative that would help maintain and improve access to health care in rural communities by providing grant funding to increase numbers of school based clinics and availability of mobile health services. ~~by providing grants to help emergency medical providers ; 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.~~ (Cost: Unclear. Approximately $100 million). *[I have no idea if this cost is even close.]*

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

- **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 your commitment to this program ~~received increasing scrutiny~~ because ~~as to why~~ your budget has never proposed funding for this critical program. ~~by advocates who question your commitment to this program and believe that~~ These advoacates believe that the lack of an Administration proposal makes it much more difficult to lobby for ~~this~~ funding for this program on the Hill. DoD is somewhat resistant to this concept as they believe that ~~even though~~ although they have developed a model program in response to a Congressional mandate, cancer research is not within their military mission. (Cost: it is unclear what the Congress will propose for this year's funding (the Senate bill includes $250 million). If you chose to fund this area, we would need to at least match FY1999 funding and potentially increase this amount.

- **Continuing the President's Successful Race and Health Initiative.** The race and health initiative proposed in the President's FY1999 budget was extremely well received by the minority and public health communities. This initiative was designed to eliminate the startling racial health disparities in six critical health areas, including cancer, diabetes, heart disease, immunizations, and HIV/AIDS. Last year, we committed to investing $400 million over five years, and it is important for this budget to include no less than the $80 million promised for each year. This initiative could fund: (1) a $30 million grant program designed to test innovative approaches to addressing these disparities; (2) other public health programs that effectively target these disparities, including prostate cancer education efforts, expanding nationwide the National Diabetes Education Program, and innovative education and prevention campaigns on cardiovasuclar diseases; and (3) building on this year's historic efforts to address the ongoing health crisis of HIV/AIDS in the minority community ($80 million - $110 million).

- **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 possiblities, 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 anyway. (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).

- ~~**New Critical HIV Surveillance.** (new policy) As AIDS remains a significant public health threat, it is vitally important to have an accurate national surveillance system to~~

~~target and evaluate limited resources and project the future of the epidemic. Because of successful new drug therapies, people are living longer with HIV that are not captured by the current surveillance system. The Centers for Disease Control is currently updating the current surveillance system to include HIV infected individuals. Both the public health and AIDS communities are concerned that implementing name-based HIV surveillance systems will discourage infected individuals from seeking testing or treatment because of privacy concerns. This proposal would address these concerns by funding a demonstration project providing States with funds to develop HIV surveillance systems utilizing privacy protection codes rather than name-based reporting. These States would be required to apply and evaluate their disease surveillance strategies in ways that link infected individuals with critical health care and social support services. (Cost: Unknown)~~ I think that Chris does not want to include this here, and so I am taking it out.

- **Improving Health for Medically Underserved Native Americans.** Native Americans have particularly ~~poor health status~~ high levels of preventable chronic and acute illnesses (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 ~~Indian tribes who deliver health programs to their communities, is not sufficiently funded~~ does not have sufficient funding to address the needs of this population. We could develop a number of initiatives to ~~help~~ improve health for Native Americans, including: domestic violence prevention, ~~or~~ alcoholism counseling programs, or work~~ing~~ 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).

- **New Comprehensive Initiative To Reduce Asthma.** Currently, 15 million Americans have asthma, nearly an 100 percent increase in the last 15 years. The greatest increases have been for children under the age of five. This initiative includes new investments ~~efforts~~ in biomedical research to better understand why the ~~increasing~~ number of Americans suffering from this illness ~~this epidemic~~ *[asthma is not an epidemic; epidemics are for infections disease]* and to test effective interventions for acute asthma attacks. It also will ~~include~~ implement a comprehensive new public health ~~approach~~ initiative using new guidelines that will soon be released by the Department of Health and Human Services to diagnose and manage this disease, including grants for State outreach activities. (Cost: $40 million)

the options are TRULY sketchy. if any look promising, I will flesh them out substantially. THANKS!!

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.

- **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.

- **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.

- **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

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.

D - IS THE main PROBLEM
- SUPPLY OF DENTISTS
- PARTICIPATION IN MEDICAID
(OR) - OUTREACH / Education. We don't want to do outreach if there are few providers, for example.

POLICY OPTIONS

X **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?]

Assume supply is the problem.

Providing primary care training support to pediatric dentists. HRSA does not presently recognizer 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.]

check - Also, what about Regular Dentists (Not Pediatric)?

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.

This could be problematic since -
(a) if not enough providers, not really helpful
(b) States usually oppose federal initiatives to educate people about services.

November 23, 1998

MEMORANDUM TO THE FIRST LADY

FROM: Chris Jennings, Jen Klein, Jeanne Lambrew

SUBJECT: Response to Questions about Coverage Expansions

cc: Melanne Verveer, Nichole? Neera?

In a recent discussion of the uninsured, you asked about several coverage expansion proposals, including a 55 to 65 coverage option, a Medicaid buy-in, a Federal Employees Health Benefit Plan (FEHBP) buy-in, and a new health insurance option for young adults. This memo summarizes these proposals, discusses their rationale, and provides you with a budget and Congressional status update. As was discussed in the memo to the President on the uninsured, the absence substantial subsidies and the omission of an individual or employer mandate significantly limits the number of Americans who will be newly insured as a result of these policies. Having said this, each of these options (or modifications to them) can improve access to needed health insurance and are being considered for the FY2000 budget.

Medicare Buy-In / Health Insurance Options for People Ages 55 to 65

Policy. In our FY 1999 budget, we proposed three policies: (1) a Medicare buy-in for people ages 62 to 65 that is fully self-financed through an unsubsidized, two-part premium (an up-front premium like we all pay plus a smaller, post-65 premium to compensate for any risk selection); (2) a similar Medicare buy-in for displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) guaranteed access to former employers' insurance for retirees age 55 and over whose retiree health benefits have been ended. According to CBO, this initiative costs about $1.5 billion over 5 years (mostly a temporary cost until the participants begin contributing their post-65 premium) and would assist about 300,000 people.

Rationale. This initiative, according to the latest data, is needed more than ever. Although still low, the number of uninsured people ages 55 to 65 grew the fastest in 1997 -- and will grow exponentially in the future since the number of people in this age cohort is projected to rise by over 60 percent by 2010. Moreover, we have increasing evidence that the individual insurance market -- relied on by this age group more than any other -- is raising its rates dramatically. Kaiser Permanente, for example, will double its individual insurance premiums for its older enrollees on January 1. This initiative gives people in this age group options to purchase insurance that they might not otherwise have. It also would be the bare minimum policy needed if the age eligibility for Medicare were raised -- an idea seriously being contemplated by the Medicare Commission.

Issues. Despite the need, this initiative was victimized by conflicting "too much - too little" criticisms. Republicans (and some conservative Democrats) claimed that the buy-in creates a huge loophole in Medicare that will ultimately lead to large costs. In part, this reflects a disbelief in our technical ability to set premiums that are self-financing in the long run. But mostly, it results from a strong belief that, even if the premium estimates are accurate, we will eventually succumb to the pressure to subsidize these premiums to make them more affordable for the lower income uninsured. In contrast, a number of traditionally liberal advocates and academics criticized the policy for helping too few people to justify the political capital that would be necessary to expend to get the proposal any serious attention by the Republican Congress.

Regardless of its political viability in this Congress, this proposal addresses a population in need, remains generally popular outside the beltway, and will continue to be seriously considered for inclusion in the FY 2000 budget. It is unclear whether it will make the final cut, however. The short-term savings needed to finance this initiative are controversial and/or likely to be used for other priorities (such as for underwriting the costs of the Jeffords/Kennedy disability coverage expansion bill). Also, there is concern about putting this proposal out so close to the final report released by the Medicare Commission this March. No matter how we resolve the budget question, however, we expect Senators Moynihan and Daschle as well as Congressman Gephardt to introduce this bill at the beginning of the next Congress.

Medicaid Buy-In

Policy. A Medicaid buy-in would allow states to charge income-related premiums for people in optional eligibility groups with income above 150 percent of poverty (the level at which states may charge cost sharing under the Children's Health Insurance Program (CHIP)). This proposal could be broadened to allow all people below a fixed income level -- not just those in current optional eligibility groups -- to buy into Medicaid.

Currently, states cannot charge premiums to Medicaid beneficiaries. A lesser known fact is that Medicaid law limits who can be covered as well. Historically, adults were eligible for Medicaid only if they were: (a) single parents, or married but unemployed parents, who receive welfare; (b) low-income elderly or people with disabilities who receive SSI; or (c) nursing home residents. During this Administration, however, new Medicaid eligibility options have been created. Welfare reform gave states the option to cover higher income single parents and unemployed married parents. The exclusion of married employed parents -- which is anti-work and anti-family -- was changed last summer with "100-hour rule" regulation that lets states define "unemployed" as working more than 100 hours a month. And, in the Balanced Budget Act, we created a Medicaid buy-in for people with disabilities with incomes below 250 percent of poverty.

Rationale. A Medicaid buy-in could be an incentive for states to expand coverage to working adults, since even small family contributions improve the acceptance of such expansions. It also gives all states the flexibility that we have permitted through Medicaid waivers and supported in CHIP, as well as in the Medicaid buy-in for workers with disabilities.

Issues. Despite its sound policy basis, the likelihood that a Medicaid buy-in will significantly reduce the uninsured is low. Since large subsidies are required to encourage low-income, uninsured people to purchase health insurance, states would have to charge the families low premiums and pay for most of the costs themselves in order to get meaningful participation. Moreover, only states that have already expanded coverage to 150 percent of poverty could charge premiums to all new participants. Unfortunately, states typically cover few adults with incomes above 50 percent of poverty. Thus, premiums collected through a Medicaid buy-in would not come close to offsetting the large Federal and state costs. Additionally, while allowing premium payments from beneficiaries may be attractive to states, Republicans, and moderate Democrats, it would be vehemently opposed by advocates and liberal Democrats who believe that this opens the door to high premiums for lower-income Medicaid beneficiaries.

One idea that could possibly address the financial limitations of this proposal is to link the Medicaid buy-in proposal to a tobacco recoupment bill. The recent state tobacco settlement will likely lead to legislation about whether and under what terms states may keep the Federal share of that settlement. In such legislation, we could make expansion through a Medicaid buy-in one of the uses (or the sole use) of the Federal share. Congressional Democrats and advocates have long argued that tobacco settlements should be directly linked to health care, health insurance expansions, and Medicaid. It is possible they would accept a buy-in in a recoupment bill that assures Medicaid expansions. States, obviously, do not want any strings on the uses of the Federal share of the settlement, but may have the hardest time arguing against Medicaid investments since the settlement itself is premised on Medicaid costs resulting from tobacco use. The clear downside to this option is that money spent on expansions would limit the money used for other priorities like child care. This issue will be debated in our budget process.

FEHBP Buy-In

Policy. Another proposal for expanding coverage is opening up the Federal Employees Health Benefits Plan (FEHBP) to various groups of people (e.g., workers in small businesses, people ages 55 to 65 years old). In order to participate in FEHBP, health plans would have to offer health insurance to the designated group of eligibles. There are two option for how premiums would be set: first, new participants could be charged the same premiums as Federal employees; second, new participants could be charged premiums separately, depending on their own costs.

Rationale. The FEHBP buy-in would give certain groups of uninsured people the benefit of accessing the health plan options, information and possibly premiums that Federal government negotiates for its employees. It also reinforces our support for group health insurance purchasing, plan choices, and adequate information with which to make such choices.

Issues. Depending on how premiums are set, the FEHBP buy-in would either be costly to new participants or affect the premiums and choices of all Federal employees. Because newly eligible people who wish to purchase insurance who are healthy can likely find individual insurance that is cheaper, the population that decides to go into FEHBP is likely to be sicker. This will increase premiums of all current Federal employees if they are charged the same premium. It could also reduce plans participating in FEHBP if their enrollees include more costly, new participants than

Federal employees (which could happen in rural areas). As a consequence, most FEBHP buy-in proposals assume a risk pool separate from that of Federal employees for setting premiums. But because this pool would be a smaller and include less healthy people, premiums would be more expensive than FEHBP. As a consequence, most analysts project a relatively small effect on coverage because over time this pool would become more and more selected against and premiums would spiral. The only way to address this would be subsidies which carry significant cost implications. These complexities explain why there have been few FEHBP buy-in bills.

Given concerns about its use as a source of coverage, FEHBP may be better used as a model for other coverage expansion proposals. What makes FEHBP successful -- purchasing power for a large group of people; consumer information; plan choices -- could be incorporated into small businesses purchasing coalitions. These coalitions, promoted in previous budgets, provide any small business in the area with a set of plan choices and more affordable premiums. This year, we are examining options to aggressively encourage their development. For example, FEHBP managers could provide technical assistance in establishing these coalitions. They could also be granted non-profit status to facilitate private foundation support.

Catastrophic Coverage for Young Adults

Proposal. You mentioned an interest in policy options that would provide catastrophic coverage for young adults. Medicare, Medicaid, and FEHBP all provide comprehensive coverage, although they could conceivable develop a special program for catastrophic coverage. It is also possible through regulation to require individual insurers to offer such coverage to young adults.

Rationale. Young adults are more likely than any other age group to be uninsured -- nearly one in three 18 to 24 year olds lacks insurance. In part, this problem results because young adults are usually healthy and do not think that their need justifies the cost of comprehensive coverage. Thus, catastrophic coverage may be the best option for young adults since it is cheaper and protects them from the real risk of illness or injury that can be financially devastating.

Issues. Catastrophic coverage options probably would not insure many young adults. Few young adults would purchase even the lowest-cost catastrophic coverage without significant subsidies. In fact, some analysts believe that only an individual mandate will make young adults pay any level of premium for health insurance. This is because they rarely recognize their financial risk (e.g., one in four young adults sustains major injuries in a year and one in 20 is hospitalized). Second, while catastrophic coverage makes economic sense, people interested in insurance do not appear to like it. The lack of interest in the medical savings account (MSA) demonstration has shown that people prefer lower cost sharing and coverage of primary care.

Recognizing these challenges, we continue to examine policies to allow young adults to buy into Medicaid. Some of the most needing of insurance in this age group are foster care children who have aged past their 18th birthday (and thus last year of Medicaid eligibility.) We are working with OMB to provide a new state option for those Governors interested in expanding Medicaid coverage to this population. We believe it will be affordable (about $50 million over 5), sound policy that a number of states will pick up. As of this writing, the chances of this proposal being included in the budget appear to be quite good.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

November 24, 1998

Elena Chris ✓

NOTE TO ELENA KAGAN AND CHRIS JENNINGS

Attached is a copy of a memorandum to Bruce Reed and Gene Sperling from Secretary Shalala that was forwarded to them on Friday, November 20. As you can ascertain from the memorandum, Secretary Shalala was interested in sharing some thematic ideas which may be useful during the preparation of the 1999 State of the Union Address. Please contact me at 690-7431 with any questions or comments.

Mary Beth Donahue

Attachment

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Chief of Staff
Washington, D.C. 20201

FACSIMILE

DATE: 11/30/98

TO: Chris Jennings

FAX#: 456-5557

FROM: Mary Beth Donahue
Chief of Staff

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

Please see the attached memo. A hard copy was forwarded to you on Friday.

_____**Pages [including this cover]**

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

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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.

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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

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