

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

*(Italics indicate discretionary funding)*

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

*Will need to determine priority*

*Worth pushing*

*Worth pushing*

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

JRC

Will need push. Even

we are thinking about needs these additional dollars.

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

Items recommended by OMB / not on our list:

- **Medicaid cost allocation:** \$2 billion in savings over 5 years from recapturing an overpayment in Medicaid administrative costs. This was in last year's budget and was almost included in the Omnibus Bill but was rejected. Somewhat legitimate policy concerns have been raised by states and advocates about both the mechanism for recapturing this money (i.e., the prohibition on using TANF funds for administrative costs) and the other demands that we are placing on administrative costs in states (e.g., children's health outreach, better enforcement of nursing home standards). **Probably very big mistake to include again, particularly if there can be no draw down from TANF.**
- **Reduction in Medicare hospital payments.** There is growing evidence that Medicare is overpaying hospitals, even with the reductions made by the BBA. However, it is not clear whether this evidence justifies the politically painful act of cutting hospital payments. We are still reviewing the feasibility and advisability. If we use, however, need validation from independent source.

10/22/98

Bruce,

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

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

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

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

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

Chris

## HEALTH BUDGET IDEAS (October 22, 1998)

### 1. Long-Term Care

- ✓ **Long-term care tax credit.** (new policy) Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major cost burden for the elderly and their families. Long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries. This proposal would give people with three or more limitations in activities of daily living (ADL) or their caregivers a tax credit of up to \$1,000 to help pay for formal or informal long-term care. (Cost: About \$4.6 billion over 5 years, offset by closing some tax loopholes; helps about 2.3 million people).
- legis or ED? **Offering private long-term care insurance to Federal employees.** (new policy) Since expanding Federal programs alone cannot address the next century's long-term care needs, the Federal government --as the nation's largest employer --could illustrate that a model employer should promote high-quality private long-term care insurance policies to its employees. Under this proposal, OPM would offer its employees the choice of buying differing types of high quality policies and use its market leverage to extract better prices for these policies. There would be no Federal contribution for this coverage. (Cost: Small administrative costs; OPM estimates about 300,000 participants).
- Family Caregiver Support Program.** (new policy) About 50 million people provide some type of long-term care to family and friends. Families who have a relative who develops long-term care needs often do not know how to provide such care and where to turn for help. This proposal would give grants from the Administration on Aging to states to provide for a "one-stop-shop" access point to assist families who care for elderly relatives with 2 or more ADL limitations and/or severe cognitive impairment. This assistance would include providing information, counseling, training and arranging for respite services for caregivers. (Cost: About \$500 -750 million over 5 years).
- \* **Nursing home quality initiative.** Last July, the President announced an initiative to dramatically improve the quality of nursing homes, by strengthening nursing home enforcement tools and improving Federal oversight. This past week, the Justice Department and HCFA held a conference to begin to develop other nursing home quality/anti-fraud and abuse initiatives with enforcement agencies across the nation. To respond to the critical need to improve quality of nursing homes, implementing the initiatives the President outlined in July or other new efforts could be included in the budget or as a freestanding initiative. These initiatives will no doubt include new enforcement provisions (e.g., increased penalties, etc.), as well as new funds to

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

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

## 2. Modernizing Medicare

- **Adopting private sector, competitive pricing strategies.** (FY 1998 budget) The President has consistently supported making Medicare more competitive by giving the Health Care Financing Administration the same tools to manage health care costs as are used by private sector plans. This includes competitive pricing for services like durable medical equipment and other supplies; expanding the competitive pricing demonstration for managed care; and adopting new payment methodologies like Centers of Excellence, among others. Although these ideas are being considered by the Medicare Commission, the President could take the lead on improving competition within Medicare since he has supported this approach in the past. (Savings: \$0.1 to \$0.5 billion, depending on the policies).
- **Prescription drug coverage for Medicare beneficiaries (new policy).** The lack of coverage for prescription drugs in Medicare is widely believed to be its most glaring shortcoming. Virtually every private health plan for the under-65 population has a drug benefit, in recognition of the medical community's reliance on prescriptions for the provision of much of the care provided to Americans. Lack of Medicare coverage of drugs results in high out-of-pocket beneficiary costs—which will only increase in the next century as most advances in health care interventions will be pharmacologically-based. Responding to this fact, Republicans and Democrats on the Medicare Commission, as well as almost every health care policy expert, are consistently stating that reforming Medicare without addressing the prescription drug coverage issue would be a mistake. We are developing a wide variety of options, including a means-tested Medicaid option, a managed care benefit only approach, a traditional benefit for all beneficiaries, and an unsubsidized purchasing mechanism that uses Medicare's size as leverage for drug discounts for beneficiaries. If desirable, a proposal could be included in the budget or coordinated with the March release of the Medicare Commission's recommendations. (Cost: Varies significantly depending on

Popular?  
w/RA's

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

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Change?  
NH?

What's new

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

New?

### 3. Health Insurance Coverage Expansions.

- **Providing new coverage options for people ages 55 to 65** (FY 1999 budget; not passed). Americans ages 55 to 65 have a greater risk of becoming sick; have a weakened connection to work-based health insurance, and face high premiums in the individual insurance market. This three-part initiative would: (1) allow Americans ages 62 to 65 to buy into Medicare, through a premium designed so that this policy is self-financed; (2) offer a similar Medicare buy-in to displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) give retirees 55 and over whose retiree health benefits have been ended access to their former employers' health insurance. A proposal such as this would be minimally necessary for any serious consideration of proposals to raise Medicare's eligibility age. (Cost: \$1.5 billion over 5 years, which would assist about 300,000 people).
- **Jeffords-Kennedy Work Incentives Improvement Act.** (Congressional proposal; not passed). In the final budget negotiations, the Administration put the Jeffords-Kennedy bill on its list of top priorities for passage this year. This bill would enable people with disabilities to go back to work by providing an option to buy into Medicaid and Medicare, as well as other pro-work initiatives. Although it was rejected by Republicans, we received a great deal of credit from the disability community for advocating this policy and for sending a message that we will continue to fight to give people with disabilities the opportunity to work --including the critical health insurance that makes work possible. (Cost: About \$1.2 billion over 5 years)
- **Health coverage for workers between jobs** (FY 1997 and 1998 budgets; not passed). Because most health insurance is employment based, job changes put families at risk of losing their health care coverage. Many families do not have access to affordable health insurance when they are between jobs because they work for firms that do not offer continuation coverage or cannot afford individual insurance. The proposal would provide temporary premium assistance for up to six months for workers between jobs who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own. (Costs depend on whether it is done as a demo (about \$2.5 billion over 5 years, which would help about 600,000 people) or nationwide (about \$10 billion over 5 years, which would cover

→ WHAT CAN WE GET DONE?

FEHB?

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about 1.4 million persons).

- **Children's health insurance outreach** (FY 1999 budget; not passed and new policy). Only shortly after the first anniversary of CHIP, about 45 states have CHIP plans approved. These new expansions have great potential to help uninsured children, but not if families do not know or understand the need for insurance. Moreover, over 4 million uninsured children are eligible for Medicaid today but are not enrolled. Last year's budget included several policies to promote outreach, including allowing states to temporarily enroll uninsured children in Medicaid through sites such as child care referral centers, schools; and allowing States to access extra Federal funds for children's outreach campaigns. An additional proposal is to pay for a nationwide toll-free number that connects families with state eligibility workers. Such a line is essential for the nationwide media campaign that we are planning to launch in January with the NGA. However, NGA is sponsoring this line for one year only. (Cost: Between \$400 and \$1 billion over 5 years; could be funded through tobacco recoupment)
- **Medicaid options for older children/young adults** (new policy). Nearly one in three people ages 18 to 24 lack health insurance. Additionally, the parents of low-income children covered through Medicaid and CHIP are often left uninsured. One proposal would give states the flexibility to continue covering children who lose eligibility only because they turn 18 years old. This extension would be administratively simple, targeted, and help young people whose first jobs often lack health insurance. (Cost: Unknown at this point).
- **Voluntary purchasing cooperatives** (FY 1997, 1998, and 1999 budgets; not passed). Workers in small firms are most likely to be uninsured; over a quarter of workers in firms with fewer than 10 employees lack health insurance —almost twice the nationwide average. This results in large part because administrative costs are higher and that small businesses pay more for the same benefits as larger firms. This proposal would provide seed money for states to establish voluntary purchasing cooperatives. These cooperatives would allow small employers to pool their purchasing power to try to negotiate better rates for their employees. The Office of Personnel Management would provide technical assistance, so that <sup>the</sup> ~~this~~ coops are modeled on the Federal Employees Health Benefits Program (FEHBP) (Cost: about \$100 million over 5 years).

#### 4. Paying for Health Education and Uncompensated Care

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

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

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

## *Public Health/Underserved Populations*

- **Combating Resistance to Anti-biotics (Super Bug).** Recent reports have indicated that resistance to anti-biotics is becoming a major public health crisis. Some viruses, such as pneumonia and many hospital-based infections becoming resistant to even the strongest anti-biotics, causing prolonged illnesses and even death. For example, pneumonia, which impacts over 500,000 Americans per year, is becoming resistant to the strongest antibiotics. CDC believes that this critical public health problem is on track to affect more and more viruses as it is becoming more difficult to develop new effective antibiotics. However, this problem could be reduced if we knew more about which viruses are likely to become resistant and why and if drugs were prescribed and used more appropriately. For example, there are over 50 million inappropriate outpatient antibiotic prescriptions written annually. The budget could fund a major public health campaign that would: educate consumers and health providers to help assure appropriate use of antibiotics; assure awareness about appropriate guidelines, and improve surveillance and research efforts to understand which antibiotics are at risk for becoming ineffective and why. (Cost: up to \$50 million).
- **Improving Access to Health Care in Underserved Rural Areas.** The 25 million Americans that live in rural areas frequently do not have access to adequate health care services. For example, the physician-to-patient ratio is more than 80 percent lower in rural communities and more rural Americans are uninsured and lack access to health care services. The budget could include an initiative that would help maintain and improve access to health care in rural communities by: giving grants to help develop creative emergency services to enable rural health facilities to remain operational and responsive to the needs of their populations; providing assistance to states to help take advantage of a Balanced Budget Act provision that provides higher Medicare payments to hospitals that revamp services to meet the specific needs of their communities; and increasing the number of health professionals in rural communities by providing loan repayments or scholarships to train rural Americans who are likely to stay in the communities to become nurse practitioners. (Cost: Unclear. Approximately \$100 million).
- **Reauthorizing the Older Americans' Act.** The Older Americans' Act has played a critical role in responding to the diverse needs of our nation's seniors. For example, it provides 240 million meals to over one million vulnerable seniors each year through its meals-on-wheels program; finances and supports an ombudsman program that helps resolve tens of thousands of problems affecting nursing homes and other vulnerable populations, including abuse and neglect; and, in many communities, it provides the type of adult day care that gives families a much needed respite from caregiving responsibilities. Many in the aging community believe the fact that the Congress has not reauthorized this program in several years undermines this program and the critical services. We could propose a reauthorization of this program to enhance emphasis on ombudsman and other programs, while proposing an increase for many of these critical programs.

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- **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 AIDS). 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).

## HEALTH BUDGET IDEAS (November 1, 1998)

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

- \* • **Long-term care tax credit.** (new policy) Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major cost burden for the elderly and their families. Long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries. This proposal would give people with three or more limitations in activities of daily living (ADL) or their caregivers a tax credit of up to \$1,000 to help pay for formal or informal long-term care. (Cost: About \$6 billion over 5 years). *may cost more*
- **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). *Legislation - E.O. to develop legis.*
- ? • **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: \$750 million over 5 years).

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

- **Jeffords-Kennedy Work Incentives Improvement Act.** (Congressional proposal; not passed in 1998) In the final budget negotiations this year, the Administration 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). *mandatory*
- **Tax credit for work-related impairment expenses for people with disabilities.** (new policy) Almost 75 percent of people with significant disabilities are unemployed; many of those within the population cite the cost of employment support services/devices, as well as the potential to lose Medicaid or Medicare coverage, as the primary barriers to seeking and keeping employment. This proposal would give a 50 percent tax credit, up to \$5,000, for impairment-related work expenses. This policy overlaps to some degree with the Jeffords-Kennedy Work Incentive proposal, described later, but has the advantage of helping people in all states irrespective of whether states take up optional coverage. (Cost: At least \$800 million over 5 years, would help about 300,000 people).
- **"Date Certain" demonstrations.** 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).

*old, but  
good  
validation*

- 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). 30-600/5

- **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). old
- **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). old
- **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). HRC

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

- **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. 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. 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). Drop

- ✓

*More coverage options*

**Voluntary purchasing cooperatives** (FY 1997, 1998, and 1999 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. Building on previous year's proposals, this proposal would encourage coops to develop by allowing them to be considered non-profits -- which facilitates their receiving private foundation support. This would complement Federal grants that would provide seed money for establishing cooperatives. The Office of Personnel Management would provide technical assistance, so that this coops are modeled on the Federal Employees Health Benefits Program (FEHBP). We also could possibly link coops to CHIP or tax credits to encourage employees to purchase insurance through them. (Cost: about \$50 to 100 million over 5 years). *Small retired (AOWA)*
- Tobacco menu?*

**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. 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 and uninsured adults** (new policy). Nearly one in three people ages 18 to 24 lack health insurance and about 8 million poor adults are uninsured. Yet, under current Medicaid rules, states cannot expand to these groups without a budget-neutral waiver. A broad option would be to create a new eligibility class for uninsured adults. A narrower option is to focus on young adults or children losing Medicaid because they turn 18 years old. This extension would be administratively simple, targeted, and help young people whose first jobs often lack health insurance. A related option is to extend Medicaid coverage to foster children turning age 18 (part of a larger package for such children). (Cost: Unknown at this point).
- 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)).

## 5. Public Health / Underserved Populations

- \* **Combating Resistance to Anti-biotics (Super Bug).** Recent reports have indicated that resistance to anti-biotics is becoming a major public health crisis. Some viruses, such as pneumonia and many hospital-based infections becoming resistant to even the strongest anti-biotics, causing prolonged illnesses and even death. For example, pneumonia, which impacts over 500,000 Americans per year, is becoming resistant to the strongest antibiotics. CDC believes that this critical public health problem is on track to affect more and more viruses as it is becoming more difficult to develop new effective antibiotics. However, this problem could be reduced if we knew more about which viruses are likely to become resistant and why and if drugs were prescribed and used more appropriately. For example, there are over 50 million inappropriate outpatient antibiotic prescriptions written annually. The budget could fund a major public health campaign that would: educate consumers and health providers to help assure appropriate use of antibiotics; assure awareness about appropriate guidelines; and improve surveillance and research efforts to understand which antibiotics are at risk for becoming ineffective and why. (Cost: up to \$50 million in FY 2000).
- Improving Access to Health Care in Underserved Rural Areas.** The 25 million Americans that live in rural areas frequently do not have access to adequate health care services. For example, the physician-to-patient ratio is more than 80 percent lower in rural communities and more rural Americans are uninsured and lack access to health care services. The budget could include an initiative that would help maintain and improve access to health care in rural communities by: giving grants to help develop creative emergency services to enable rural health facilities to remain operational and responsive to the needs of their populations; providing assistance to states to help take advantage of a Balanced Budget Act provision that provides higher Medicare payments to hospitals that revamp services to meet the specific needs of their communities; and increasing the number of health professionals in rural communities by providing loan repayments or scholarships to train rural Americans who are likely to stay in the communities to become nurse practitioners. (Cost: approximately \$100 million in FY 2000).
- Reauthorizing the Older Americans' Act.** The Older Americans' Act has played a critical role in responding to the diverse needs of our nation's seniors. For example, it provides 240 million meals to over one million vulnerable seniors each year through its meals-on-wheels program; finances and supports an ombudsman program that helps resolve tens of thousands of problems affecting nursing home residents and other vulnerable populations, including abuse and neglect; and, in many communities, it provides the type of adult day care that gives families a much-needed respite from caregiving responsibilities. Many in the aging community believe the fact that the Congress has not reauthorized this program in several years undermines this program and the critical services. We could propose a reauthorization of this program to enhance emphasis on ombudsman and other programs, while proposing an increase for many of these critical programs.

Disease terrorism  
Avian malaria

NSC?

- Improving Access to Emergency Room Care for Veterans.** As part of the President's request to bring Federal health programs into compliance with the patients' bill of rights, the issue of whether the VA provides veterans adequate access to emergency room services has been widely publicized. The VA currently only reimburses for VA emergency visits at VA hospitals, which is certainly not consistent with the patient protection to assure emergency-services when and where the need arises. We expect Senator Daschle to offer a proposal to extend veterans' access to emergency room services, and it may well be advisable for us to address this issue so we are not perceived as falling short on our commitment to apply the patients' bill of rights where we can. (Cost: VA's current proposal costs \$550 million per year. However, OMB has been working to dramatically reduce the costs of this proposal).
- Enhancing Drug Approvals, Food Safety, and other FDA priorities.** The FDA has unprecedented new challenges, including: a surge in promising technologies and drugs that need approval; increasingly challenging diseases, such as AIDS and emerging pathogens; important public health issues such as food and blood safety; as well as major new statutory responsibilities from FDA reform. However, funding for this agency has not increased in several years. This has serious implications for the agency, as food inspections, organ banks, and drug companies are rarely inspected and it is more challenging to meet drug approval needs. Since Congress has been unwilling to fund user fees for FDA, it may be necessary to make it a priority to fund FDA at higher levels (Cost: \$100 to 300 million in FY 2000).
- Investing in Promising DoD Breast Cancer/Prostate Cancer Programs.** We have continually highlighted DoD's innovative, popular cancer research programs (most recently the President announced grants in the DoD prostate cancer research program in his Father's Day radio address). However, we have received increasing scrutiny as to why your budget never proposes funding for this critical program by advocates who question your commitment to this program and believe that the lack of an Administration proposal makes it much more difficult to lobby for this funding on the Hill. DoD is somewhat resistant to this concept as they believe that, even though they have developed a model program in response to a Congressional mandate, cancer research is not within their military mission. (Cost: it is unclear what the Congress will propose for this year's funding (the Senate bill includes \$250 million in FY 2000). If you chose to fund this area, we would need to at least match FY1999 funding and potentially increase this amount).
- Continuing the President's Successful Race and Health Initiative.** The race and health initiative proposed in the President's FY1999 budget was extremely well received by the minority and public health communities. As part of this initiative designed to eliminate racial health disparities in six critical health areas, we committed to investing \$400 million over five years. Therefore, it is important that the President's FY2000 budget include no less than the \$80 million we promised for each year, and we may want to consider additional funding for this issue. (Cost: \$80 million in FY 2000).
- Investing in Promising Biomedical Research.** Your FY 1999 budget includes historic increases in the NIH, and the Congress has funded the NIH at even higher levels (a historic \$2 billion increase this year), regardless of how much you propose in this area. Therefore,

*Fight w/VA*

*Disinfect Heart Disease*

*→ what specific disease increases?*

you could either continue to fund this research at historic levels or since Congress will likely anyway, you may want to propose less to make room for other priorities. (Cost: over \$300 million to \$1 billion in FY 2000).

- **Improving Access to Promising HIV/AIDS Drugs.** Since there has been so much progress in therapies for HIV/AIDS, the AIDS community has been pushing to expand access to these drugs. Their expectations were raised last year when the Vice President asked HCFA to look into the feasibility of a demo to expand Medicaid to patients with HIV at an earlier point in their disease. We may want to consider additional options, perhaps in the context of the Jeffords-Kennedy legislation, to help people with HIV/AIDS have better access to treatment. Last year, we proposed significant funding for the AIDS Drugs Assistance Programs (ADAP), but there may be other approaches. Regardless of status of Jeffords-Kennedy, we may receive a great deal of criticism from the community if we propose no increases for treatment and also for prevention and enhancing HIV surveillance efforts at the Centers for Disease Control (Cost: approximately \$100 million in FY 2000).
- **Improving Health for Medically Underserved Native Americans.** Native Americans have particularly poor health status (as much as five times higher diabetes rates, and three to four times the rate for SIDS). It is widely recognized that the IHS, the main resource for Indian tribes who deliver health programs to their communities, is not sufficiently funded to address the needs of this population. We could develop a number of initiatives to help improve health for Native Americans, including: domestic violence, or alcoholism; or elder care, working with HCFA, to help develop home-and-community based care options for Native Americans. This would build on the President's efforts to elevate the Director of IHS to an Assistant Secretary position and your participation in the conference on "Building Economic Self-Determination in Indian Communities" and would compliment well the President's race and health initiative. (Cost: about \$100 million in FY 2000).

• ASTHMA

OTHER NON-BUDGET

PBoR

Genetic discrimination

\* Privacy - possible legislation in the spring

Insurance reforms to fix holes in K-K