

JAN 10 1997

97

MEMORANDUM FOR THE PRESIDENT

I want to bring for your consideration a request to make available up to \$6 million in emergency appropriations to help the States of North and South Dakota meet the heating needs arising from the recent cold weather which has impacted most severely on these two States. This is an especially critical situation for the ten Indian Tribes in these two States. Your approval is needed to make available previously appropriated funds to the Low Income Home Energy Assistance Program (LIHEAP).

The FY 1996 Appropriations Act for this Department provided \$420 million for LIHEAP to be used in FY 1997, contingent upon the President submitting a budget request to the Congress, and designating the entire amount as an emergency requirement. The basic LIHEAP statute grants me the authority to target the amount requested to those States or Tribes most in need. I believe that a crisis exists and we must respond immediately to protect the health and safety of all low-income people in these two States. In North Dakota four Tribes receive funds directly; Devils Lake Sioux Tribe, Standing Rock Sioux Tribe, Three Affiliated Tribes, and Turtle Mountain Chippewa. In South Dakota, there are seven directly funded Tribes; Cheyenne River Sioux, Lower Brule Sioux, Ogala Sioux, Rosebud Sioux, Sisseton-Wahpeton Sioux, Standing River Sioux (Tribe is located in both States), and Yankton Sioux.

On October 22, the four North Dakota Tribes received \$1,060,050, and it is our understanding that these funds have been totally expended. This is a result of two factors: the extreme cold temperatures and that propane prices have increased dramatically from \$0.69 to \$1.09 per gallon. Tribal members are heavily dependent upon propane as a source of fuel to heat their homes. I have spoken with Senators Kent Conrad and Byron Dorgan, and Congressman Earl Pomeroy and they are in full agreement that the Tribes needs are severe and should be provided additional funds.

I recommend that you designate this request as emergency funding consistent with the Balanced Budget and Emergency Deficit Control Act of 1985. No further Congressional action will be required to make the \$6 million available. We would allocate up to \$3.4 million to North Dakota and \$2.7 million to South Dakota. This would represent an estimated 42 percent increase over each State's basic allotment for FY 1997.



Donna E. Shalala

*1/15/97*

January 10, 1997

MEMORANDUM FOR THE PRESIDENT

We are pleased to provide you with a progress report on our agencies' efforts to implement your directive of October 3 entitled "Guidelines to States for Implementing the Family Violence Provisions."

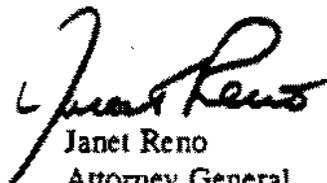
Your continued attention to the issue of domestic violence has been critical to building public awareness and creating both the will and the capacity in states and local communities to address this issue. The complex linkages between domestic violence and welfare are critical, but not well understood. The family violence provisions in the new welfare law create even greater opportunity to expand our knowledge base, disseminate information and guidance and work with our state and local partners to create new avenues for stopping violence in the home. Through close collaboration with these partners we can build temporary assistance systems that require work, promote responsibility and protect children, and that also recognize the unique needs and circumstances of battered women, and provide them with the supports they need to move successfully from welfare to work.

The enclosed progress report demonstrates that our on-going work is proving extremely valuable and instructive in shaping technical assistance, policy guidance and the development of standards and procedures for meeting the needs of battered women.

Thank you again for your leadership on this issue.



Donna E. Shalala  
Secretary  
Department of Health  
and Human Services



Janet Reno  
Attorney General  
Department of Justice

Enclosure



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

FEB 10 1997

MEMORANDUM FOR THE PRESIDENT

March 22, 1997 is the 25th anniversary of the enactment of the Nutrition Program for the Elderly Act, legislation which created the Older Americans Act Nutrition Programs for the Elderly which is made up of home delivered (meals on wheels) and congregate meal programs.

Each day, one million meals are served through locally-run community nutrition programs across America to at risk and needy older persons over the age of 60. Often these meals are the only real source of nutrition and contact with others that a vulnerable older person will have in the course of a day. Whether it be through a hot prepared meal delivered by a volunteer to a senior in their home or through an active senior center or congregate dining site that promotes healthy living and nutritional screening, these nutrition programs often provide the alternatives to premature or unnecessary hospitalization or institutionalization.

In FY 1995 over 240 million meals were served to approximately 3.4 million older persons, and that number is expected to grow as the population ages and grows. The Elderly Nutrition Program of the Older Americans Act is a wonderful example of a successful public private partnership that joins the Federal Government with state, local and private sector associates to meet the unique needs of each aging community across America, including urban, rural, ethnic and native American communities. An important highlight of the Elderly Nutrition Program are the participant contributions which in FY 1995 totaled approximately \$170 million.

In recognition of this historic and significant anniversary, and in tribute to the millions of aging network service providers and volunteers who have served millions of older Americans for the past 25 years, I would like to request that you issue the enclosed resolution honoring the silver anniversary of the Elderly Nutrition Programs of the Older Americans Act. This gesture would continue to show your commitment, appreciation and leadership on behalf of older Americans and the services that allow them to age with grace and dignity.

Donna E. Shalala

Enclosure

12/19/96

DRAFT

Twenty-Fifth Anniversary of the Elderly Nutrition  
Program of the Older Americans Act

A Proclamation

Each day across America one million meals are served by locally-run community nutrition programs to persons 60 years of age and older. For most of these individuals, in particular the vulnerable and isolated, this daily meal represents the only real source of nutrition and human contact they will have that day. A meal delivered to the home can be a lifeline that connects a frail older person with the community. A meal served at a senior center or congregate dining site provides camaraderie, promotes positive health practices, and links older persons to other essential community services.

The Older Americans Act Elderly Nutrition Program, a critical component of the home and community-based system of services provided through the Administration on Aging and its network of state and area agencies on aging, tribal organizations, service providers, caregivers and volunteers, celebrates its silver anniversary in March, a month that has historically been proclaimed as National Nutrition Month. Twenty-five years ago, on March 22, 1972, the Nutrition for the Elderly Act was signed into law establishing what has become the cornerstone and central focal point of the Older Americans Act. This one program has improved the quality of life for millions of senior citizens by enabling them to grow older with dignity and independence, and has repeatedly provided an alternative to premature or unnecessary institutionalization or hospitalization.

One of the most significant characteristics of the Elderly Nutrition Program is that it represents a highly effective public-private partnership that is financed by federal, state, local and private sources as well as participant contributions. These entities work together to tailor nutrition and nutrition-related programs to the unique needs of every community across the country, including urban, rural, ethnic, and native American communities, and are often faced with the often daunting and conflicting challenges of meeting increased demand while at the same time exercising responsible fiscal restraint in the face of budget realities.

In FY 1995, over 240 million meals were served to approximately 3.4 million older persons through the Elderly Nutrition Program of the Older Americans Act. Nearly half of the meal recipients were low income elders and 17 percent of the recipients were members of minority groups. By the year 2030, there will be approximately 70 million older persons, more than twice their number in 1990. As

the population ages and grows, the demand for these critical services will increase and our ability to meet those demands will be tested. We must continue to work together to support these critical programs and to confront the challenge of how to meet the nutritional needs of the increasing numbers of older persons.

On this 25th anniversary of the creation of the Elderly Nutrition program, we celebrate the ongoing successes of these important community programs, the vital role they play in ensuring adequate nutrition and other services critical to an aging America. We honor the aging network, nutrition providers and the private sector who work closely with their communities to serve those in the greatest need. This anniversary is a wonderful opportunity to renew our nation's commitment to these programs and to the older Americans they serve.

NOW, THEREFORE, I, WILLIAM J. CLINTON, President of the United States of America, by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim March 22, 1997 as the 25th Anniversary of the National Elderly Nutrition Program. I call upon Government officials, businesses, communities, volunteers, families, older persons and all citizens of this great nation to acknowledge the vast contributions of the Older Americans Act Elderly Nutrition Program to the health, happiness and quality of life of older Americans during National Nutrition Month and throughout the year.

IN WITNESS WHEREOF, I have hereunto set my hand this        day of March, in the year of our Lord nineteen hundred and ninety-seven and of the independence of the United States of America the two hundred and twenty-second.



Washington, D.C. 20201

JAN 30 1997

Memorandum

TO: The Secretary  
 Through: DS *[Signature]*  
 COS *[Signature]* 2/6  
 ES *[Signature]*

FROM: Acting Assistant Secretary for Aging

SUBJECT: 25th Anniversary of the Older Americans Act Elderly  
 Nutrition Program Proclamation -- ACTION MEMO -  
 Immediate

ISSUE

I would like to request that you approve the attached draft proclamation celebrating the 25th anniversary of the Elderly Nutrition Program of the Older Americans Act and sign the attached letter to the President requesting that he issue a proclamation on or around March 22, 1997.

BACKGROUND

The Elderly Nutrition Program of the Older Americans Act will soon be celebrating its 25th anniversary. On March 22, 1972, President Richard Nixon signed into law the Nutrition Program for the Elderly Act which established the national Nutrition programs for the Elderly we know as home-delivered meals (meals on wheels) and congregate nutrition programs. Since that time, these nutrition programs have grown to become the cornerstone and focal point for the majority of the programs and services provided through the Older Americans Act and the Administration on Aging. Every day over one million meals are served across America in locally-run community nutrition sites to Americans 60 years of age or older. In FY 1995, over 240 million meals were served through both the home delivered and congregate nutrition programs. The FY 1997 Appropriation for the Older Americans Act nutrition program was approximately \$470 million.

The Administration and Congress have consistently shown their support for these critical programs, and senior nutrition programs have often been prominently mentioned in Department or Administration statements. As you know, the President, First Lady and Vice President have visited several nutrition sites around the country during the last four years, and during the second government shutdown during FY 1996, you joined the President at a local senior nutrition site in Washington, D.C. to call

-More-

1997-006



Attachment

Tab A - Letter to the President

Tab B - Draft Proclamation



L/C

FEB 13 1997

**MEMORANDUM FOR THE PRESIDENT**

**ISSUE:**

Whether to issue a Presidential message on the Government's responsibility for the Tuskegee Syphilis Study to the surviving participants, their families, and the African American community.

**BACKGROUND:**

In 1932, Federal, State, and local officials, working with the Tuskegee Institute, began a long-term study of untreated syphilis in African-American males in Macon County, Alabama. The Study was established after surveys revealed a high prevalence of syphilis, particularly in rural areas of the South, and a high rate of untreated syphilis in African-American men. The Study was intended to justify a syphilis treatment program for African-Americans. Instead, it has become known as a classic case of medical research gone wrong.

That is because researchers enrolled about 400 African-American men with non-infectious syphilis and about 200 men without syphilis (the latter group for control purposes) in the Study and told them they were being treated for "bad blood" -- a local term used to describe a number of conditions, including syphilis. Men with infectious, early stage syphilis were treated and excluded from the Study; however, those with late term, non-infectious syphilis received no treatment and none was available at the time the Study was begun. Researchers actually were observing the natural progression of untreated syphilis in their bodies.

The project was scheduled to last for only six months, but it continued for 40 years -- even after penicillin became recognized as the standard of care for treating syphilis by the late 1940s. The Study was not ended until 1972, when a front-page story in the New York Times led to a public outcry and the government convened an advisory panel that declared the Study to be "ethically unjustified."

The Federal Government has tried to mitigate the damage since the study was ended. In 1973, HEW Secretary Weinberger directed the Public Health Service to provide Study participants and certain members of their families with comprehensive medical care for the

Prepared by PHS/Bart

2/19/97/0029

rest of their lives. Also, in 1973, a class-action lawsuit was settled for \$9 million. And, beginning in 1974, regulations for review and approval of experiments on human subjects were instituted to ensure that studies such as Tuskegee do not happen again:

- Since 1974, we have better instituted in research on human beings the practice of obtaining their voluntary informed consent.
- Also since 1974, all Federal studies using human subjects must be reviewed by Institutional Review Boards (IRBs) that are diverse and sensitive to community attitudes.
- In 1995, you created a National Bioethics Advisory Commission to review regulations and procedures, and to provide all possible safeguards for research volunteers.
- A 1996 meeting sponsored by the Centers for Disease Control and Prevention and HHS led to the establishment of the Tuskegee Syphilis Study Legacy Committee, which studied ways to preserve the memory of the Study and to transform the legacy into renewed efforts to bridge the gap between the health conditions of African-Americans and white Americans.

Even so, the Federal Government has never adequately expressed its responsibility for failure to inform Study participants and their families when treatment became available. Many commentators believe that the government's failure to make such an acknowledgment has helped to perpetuate feelings of widespread distrust among African-Americans toward government health-related initiatives. For example, African-Americans are far less likely than any other ethnic group to receive influenza vaccines (33.1 percent in 1993, compared to 50.4 percent for the total population). Similar low participation rates among African-Americans also are evident in research trials, organ donation, accessing simple medical care, and accepting advice from public health officials regarding the prevention of diseases such as AIDS. Even though there are many complex reasons for these low participation rates, the Tuskegee Study is cited as one significant contributing reason.

#### CURRENT ACTIVITIES INVOLVING THE TUSKEGEE STUDY

The Tuskegee Syphilis Study Legacy Committee has urged you to make an apology, and has issued a number of recommendations that would help assure the nation that research like the Tuskegee Study would not be duplicated.

You received last week a letter from two members of the Congressional Black Caucus -- Representative Louis Stokes, the Chairman of the Congressional Black Caucus Health Braintrust, and Representative Maxine Waters, Chairwoman of the Caucus -- requesting that you issue a formal apology on behalf of the United States for the Tuskegee Study, similar to the apology you issued to the so-called "atomic veterans." They note that Black History Month would be "a most appropriate time" to issue such a statement.

Home Box Office has produced a movie about the Tuskegee Study, entitled "Miss Evers' Boys," that is expected to receive substantial attention throughout the month of February, which is National African American History Month. Between February 11 and February 18, public screenings of "Miss Evers Boys" will be held in seven cities across the country -- Washington, New York, New Orleans, Los Angeles, Atlanta, Stamford, and San Francisco. The screenings and ensuing panel discussions will be attended by prominent African-American officials, including United Negro College Fund President William H. Gray III, Charles Drew University President Reed Tuckson, Former HHS Secretary Louis Sullivan, Emory School of Public Health Dean James Curran, Atlanta Journal-Constitution Editor Cynthia Tucker, "Our Common Welfare" Director Fay Brown-Sperling, and CDC Director David Satcher M.D. After the public screenings have been held, HBO will air the movie nationally on February 22.

There are eight participants of the Tuskegee Study still surviving, as well as 23 wives or widows, 15 children and two grandchildren.

RECOMMENDATIONS:

I recommend that you issue a statement similar to the one you made to atomic veterans -- one made on behalf of leaders from another time and era. You could either issue this statement as a written statement, or preferably, you could deliver it in person at an event coordinated to address participants and their families as well as African-American leaders.

In doing so, you would send a positive message that could help shift perceptions within the African-American community about medical research. You could add to your statement an announcement of additional steps you will take to further protect all human participants in research studies. Those steps would be as follows:

Have HHS work with academic institutions and schools of public health to expand bioethics training, paying particular attention to minority perspectives and the needs of minority communities.

Have HHS offer fellowships to postgraduate students for training in bioethics, with the goal of creating a national cadre of individuals -- especially minorities -- who would serve as experts in the conduct of research involving human subjects and as future leaders in the field of bioethics.

Extend for two years the charter of the National Bioethics Advisory Commission, which you created, and ask it to explore ways in which communities -- particularly minority communities -- can become more involved in the development, implementation, and analysis of medical research. (There are other reasons currently under consideration for extending the Charter for two additional years).

DECISIONS

Issue a Presidential message on the Government's responsibility for the Tuskegee Study to the surviving participants, their families, and the African American community.

Approve \_\_\_\_\_ Disapprove \_\_\_\_\_ Other \_\_\_\_\_

Additional steps could be taken with academic institutions and schools of public health, researchers, and the National Bioethics Advisory Commission to further protect human participants in research studies:

- HHS would expand bioethics training that are diverse and sensitive to minority communities.
- HHS would offer fellowships to postgraduate students, including minorities, who would serve as experts in research involving human subjects and in the field of bioethics.
- Extend the charter of the National Bioethics Advisory Commission for two more years and ask it to explore ways to better involve minorities in the mechanics of medical research.

Approve \_\_\_\_\_ Disapprove \_\_\_\_\_ Other \_\_\_\_\_



Donna E. Shalala



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

FEB 13 1997

MEMORANDUM FOR THE PRESIDENT

I am pleased to provide you with the enclosed report that recommends steps to further promote social adjustment, economic self-sufficiency, and naturalization of refugees and asylees.

Your continued support of the domestic refugee resettlement program has been critical to building public confidence and support for the resettlement of those who are forced to flee persecution and make new lives in the United States. The priority for the domestic refugee resettlement program is, and must continue to be, to help refugees obtain self-sufficiency and social adjustment as quickly as possible after their arrival in the United States. Working with staff of the White House Domestic Policy Council, National Security Council; our partners at the Departments of State, Justice, and Education; with State and local governments; and with the private voluntary agencies that resettle refugees, we will continue to improve on our efforts to provide newly arrived refugees with the best possible start in their new homeland.

Thank you again for your support of this important mission.



Donna E. Shalala

Enclosure

2/26/1996 0007

## **REPORT TO THE PRESIDENT**

### **ADDITIONAL STEPS TO INCREASE REFUGEE SELF-SUFFICIENCY, SOCIAL ADJUSTMENT, AND NATURALIZATION**

#### **ISSUE**

On August 22, 1996, President Clinton issued a memorandum on the subject of naturalization. Included in this memorandum was a directive that Secretary of Health and Human Services, in consultation with other agencies as appropriate, present:

"...a report setting out a strategy of additional steps that we can take to promote social adjustment in the United States, economic self-sufficiency, and naturalization [of refugees and asylees]."

The priority for the domestic refugee resettlement program is, and must continue to be, to help refugees obtain self-sufficiency and social adjustment as quickly as possible after their arrival in the United States.

The Department of Health and Human Services (HHS) is cognizant of the role that the domestic refugee resettlement program plays in foreign and domestic policy. Concern over immigrant and refugee use of welfare and the rate of integration into American society has made it clear that in order to maintain public support for refugee resettlement in the future, the self-sufficiency rate and civic integration of refugees need to improve.

The domestic refugee resettlement program will expire this fiscal year. The reauthorization process provides an opportunity for a thorough review of the current domestic refugee resettlement program. The review will consider changes to the current program that promote the social adjustment, economic self-sufficiency, and naturalization of refugees and asylees, and provide a basis for new legislation.

This report provides background on the current domestic refugee resettlement program, recent initiatives and recommendations on initial steps that HHS will take pursuant to the President's directive to promote the social adjustment, economic self-sufficiency, and naturalization of refugees and asylees.

#### **BACKGROUND**

The purpose of the domestic refugee resettlement program is to provide newly arrived refugees with the best possible start in their new homeland. As refugee admissions expanded in the 1970's, the existing federal welfare programs were increasingly utilized to provide cash and medical assistance to refugees and to help them move toward self-sufficiency. The current design of the

refugee program was created when the domestic resettlement program was codified in the Refugee Act of 1980 and the Federal Office of Refugee Resettlement (ORR) was established in the HHS.

Currently, the Department of State funds voluntary agencies to provide refugees with initial resettlement assistance -- helping to orient them to the United States, find housing, enroll children in school, etc. After the initial resettlement phase, refugees are provided employment and social adjustment services through a variety of federal and state programs. About half of the newly arriving refugees have been provided these services through the Aid For Families With Dependent Children (AFDC) program and other mainstream public assistance programs. Other refugees ineligible for AFDC for non-financial reasons may be eligible for the Refugee Cash and Refugee Medical Assistance programs for eight months after their arrival in the United States. This program is entirely funded by the federal government through the HHS Office of Refugee Resettlement.

## RECENT INITIATIVES

HHS has taken many steps over the past few years to improve the self-sufficiency and social adjustment rate of refugees. For example, in 1995, ORR issued regulations that directed States to target refugee-specific services to those refugees who have been in the United States for five years or less. The result is that resources are more focused on newly arrived refugees. Fiscal year 1996 was the first year that States were required to submit outcome goal plans, which has led to a greater focus on increasing self-sufficiency outcomes. In addition, ORR has encouraged states to provide refugee-specific services for those served by mainstream welfare programs and has required ORR-funded services to be culturally and linguistically appropriate for all refugee populations.

Demonstration projects funded under the "Wilson/Fish" statutory authority (Section 412(e)(7) of the Immigration and Nationality Act), have been particularly successful in helping refugees gain self-sufficiency. Key to the success of projects in Kentucky, Massachusetts, and San Diego, California has been the integration of cash assistance with case management; the provision of intensive, up-front services; and the coordination of case management and employment services.

Outcomes have been especially good in these projects: in Kentucky, it usually takes less than 70 days for employable adult refugees to find a job at above minimum wage; in San Diego, during its first year of operation, nearly three-quarters of the refugees enrolled in the project became self-sufficient before the end of 12 months.

Another alternative to the State-administered program is the Matching Grant Program. It is also run by the voluntary agencies, integrating cash assistance with employment services for refugees during their first four months after their arrival. Currently the matching grant program serves approximately 25 percent of all refugee arrivals. In calendar year 1995, 41 percent of the Matching Grant participants were self-sufficient by the fourth month following arrival in the United States. In 1996, this program was enhanced through increased Federal funding to provide

more comprehensive services to refugees and was expanded to provide intensive up-front services to refugees in additional sites.

## RECOMMENDATIONS

In order to improve refugee economic self-sufficiency, social adjustment, and naturalization -- and build upon recent initiatives -- we recommend the following:

**1) *Economic Self-Sufficiency:* The Director of the Office of Refugee Resettlement (ORR) will conduct a series of consultations on the domestic refugee resettlement program that focus principally on how best to achieve early economic self-sufficiency with an increased emphasis on accountability for outcomes.**

We recommend that the consultations take the following into account:

- As stated above, concern over immigrant and refugee use of welfare has made it clear that in order to keep the door open for refugees, the self-sufficiency rate and rate of integration of refugees need to improve.
- The successful models described above (and other models of effective self-sufficiency services for refugees) offer lessons and experiences to build on in moving towards more effective services to promote self-sufficiency and integration.
- Decreasing refugee admissions and increasing ethnic diversity of arriving populations mean that the resettlement program needs to be more flexible to maintain culturally and linguistically appropriate services. The bulk of refugee admissions were former Soviets and Southeast Asians. The refugee service system was established over the years primarily to meet the needs of these two groups. Now, the United States admits many different populations -- such as Somalis, Iraqis, Bosnians, and Sudanese. At the same time, the number of refugees from Southeast Asia and the former Soviet Union is decreasing. There are many volatile regions in the world, making it difficult to predict who will be admitted as refugees and asylees.
- Refugees have unique experiences and come with a range of backgrounds -- from engineers with advanced technical degrees to illiterate farmers -- all of whom need refugee-specific services. Neither welfare nor welfare reform was designed specifically for newcomers who are fleeing persecution.

**2) *Social Adjustment:*** The Office of Refugee Resettlement, together with the voluntary agencies and the Department of State, State Refugee Coordinators, service providers, refugees and others, will develop and implement policies and strategies for the placement and resettlement of refugees in communities that afford refugees the best opportunities for social adjustment and self-sufficiency.

ORR will continue to ensure that funding for services and assistance is made available to those communities where refugees resettle.

In addition, ORR will award grants for English language training and social and cultural adjustment services for underserved refugee groups, such as older refugees, pre-literate refugees, or homebound women. These services will help these refugees attain the level of English proficiency needed to be able to participate in other services and to have an understanding and appreciation of the American culture so that they can become citizens and participate fully in mainstream American civic life.

**3) *Naturalization:*** ORR will set aside \$1 million to launch a new partnership program to provide matching funds for providers who leverage State, local, or private funds for citizenship education.

In addition, ORR will stress the importance of citizenship and naturalization in the refugee resettlement program and encourage its grantees to provide civics education and naturalization assistance through the refugee social services and targeted assistance programs.

To expand naturalization application processing, the Immigration and Naturalization Service (INS) will be invited to collaborate with ORR in building the capacity of community-based organizations, particularly mutual assistance associations, to assist refugees in obtaining citizenship.

PO-5-9  
L/C



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

FEB 21 1997

**MEMORANDUM FOR THE PRESIDENT**

I appreciate this opportunity to follow up on our conversation in Annapolis and provide you with some suggestions for potential addresses to state legislatures on welfare reform.

As you know, many important decisions on implementing the new welfare law are being made now in state legislatures and statehouses across the country. Speaking to state legislatures during this critical period, provides you with an opportunity to reinforce your commitment to welfare reform; to challenge the states to work in a bipartisan manner to make welfare reform work; and to highlight the numerous accomplishments related to welfare reform that we have made already by working together.

Enclosed is a list of proposed states and an appropriate message related to welfare reform on which you could focus your address to each states' legislature.

I look forward to further discussions with you on this issue.

Donna E. Shalala

Enclosure

Prepared for 100-15111-1

3/8/97/0091

**Colorado - Child Support:** In Colorado the message could be focused on the importance of child support in welfare reform. Colorado has a model child support enforcement initiative including a in-hospital paternity establishment program, a license revocation program and a new child support enforcement web site linked to the federal OCSE home page.

**Delaware - Teen Parents/Teen Pregnancy:** In Delaware the message could be on teen pregnancy prevention – focusing on teens to end the cycle of dependency. Delaware's welfare reform plan focuses on teen parents: requiring them to live at home or in an adult supervised setting, attend school, and participate in parenting and family planning education.

**Florida - Child Care:** In Florida you could focus on the importance of child care in helping people move from welfare to work. Florida is making substantial progress and investments in public-private partnerships to finance child care services. The states' Child Care Partnership Act, part of its welfare reform legislation, encourages employers, charitable foundations, and local governments to share in the cost of child care for low-income workers.

**Indiana - Maintaining the Investment in Helping Move People from Welfare to Work:** In Indiana you could highlight the state's investment and commitment to helping people move from welfare to work. Welfare rolls have fallen by more than 40 percent in Indiana. To expand on the state's success, Indiana will continue to conduct projects using state funds to help those hardest to place welfare recipients achieve self sufficiency.

**Missouri - Welfare to Work Jobs Challenge:** In Missouri the focus could be on your welfare to work jobs challenge, as the state has several innovative programs that work with the private sector to create job opportunities for welfare recipients.

**North Carolina - Child Welfare:** You could highlight your commitment to protecting children and improving child welfare services. North Carolina was granted a child welfare waiver in November to make a significant change in the management of its child protective system, by promoting, measuring and rewarding successful outcomes for children.

**Oregon - Moving from Welfare to Work:** In Oregon the focus could be on changing the welfare program to a jobs program. Oregon has an innovative wage supplementation/private sector jobs initiative and a universal health care plan, removing any incentive to remain on welfare simply to receive health benefits.



FEB 2 | 1997

MEMORANDUM FOR ANNE MCGUIRE

Attached is a memorandum for the President, from Secretary Shalala, transmitting a collection of potential addresses to state legislatures on welfare reform.

William V. Corr

Attachment





FEB 26 1997

MEMORANDUM FOR ANNE MCGUIRE

Attached is a memorandum for the President, from Secretary Shalala, responding to an article in *Business Week* on the U.S. savings rate and spending on medical care.

A handwritten signature in cursive script, appearing to read "William V. Corr".

William V. Corr

Attachment

2/19/1996 0027



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

MAR 27 1997

MEMORANDUM FOR THE PRESIDENT

I am pleased to submit this report of the Department of Health and Human Services' activities targeting the earliest years of life as requested in your February 24 memorandum. While this report is not an exhaustive compilation of every HHS program and project that serves very young children, it clearly reveals our tremendous commitment to protect and enhance their development.

We look forward to working with you and the First Lady on this extremely important initiative.

A handwritten signature in cursive script that reads "Donna E. Shalala".

Donna E. Shalala

Enclosure

**DEPARTMENT OF HEALTH AND HUMAN  
SERVICES**

**ACTIVITIES SERVING CHILDREN IN THEIR  
EARLIEST YEARS: A REPORT TO THE  
PRESIDENT**

**MARCH 24, 1997**

L/c



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

APR 2 1997

MEMORANDUM FOR THE PRESIDENT

Subject: Recent Hepatitis A Outbreak

Secretary Glickman and I wanted to share with you the attached background paper on the recent hepatitis A outbreak. (Attached)

One significant fact not included in this background paper is that the USDA Inspector General is investigating the processor of the contaminated product for possible criminal violations. The berries involved appear to have been imported from Mexico. USDA requires companies supplying food for the national school lunch program to certify that their products are domestic. If the company falsely certified in this case, it would be subject to criminal penalties.

CDC, FDA, USDA and State health departments are working in concert to ensure a timely, coordinated response to this food-borne illness. To date, the outbreak is limited in scope; nevertheless, our surveillance system is on high alert to detect any additional cases.

To assure that accurate information is being provided to the public, our departments held a press conference at 4:00 p.m. today. We expect continued media scrutiny over the next week or two as CDC tracks the contamination to its source to determine the cause of this infectious outbreak. CDC will lead our responses to the press and will provide regular updates to the White House and other agencies as needed. CDC, FDA and USDA will make every effort to get necessary information to the public.

This incident underscores, once again, the importance of a strong food safety program to protect the health of the American people. Key components include effective quality control systems to prevent contamination of the food supply and an early, state-of-the-art surveillance system to accurately and rapidly detect outbreaks as they occur. As you know, we are working hard on the food safety initiative you proposed in your FY1998 Budget and expect to submit a report to you later this month.

Donna E. Shalala

Attachment

4/9/1997 lnc 1.2

# Backgrounder

## Hepatitis A Outbreak in Michigan Schools

U.S. Department of Agriculture & U.S. Department of Health and Human Services  
April 2, 1997

### Actions Taken by Food Safety and Public Health Agencies

Centers for Disease Control and Prevention (CDC) has conducted two studies of the hepatitis A outbreak in Michigan and has found a strong association between illness and consumption of food items containing frozen strawberries.

U.S. Department of Agriculture (USDA) has instructed the six states known to have received the implicated product (Michigan, Arizona, southern California, Georgia, Iowa and Tennessee) to suspend the use and distribution of the strawberries until further notice.

As an additional precautionary measure, USDA has informed ten other states (Florida, Illinois, Indiana, Maine, New Jersey, New York, North Carolina, North Dakota, Washington, D.C. and Wisconsin) not to use strawberries from the California-based company until more information is available.

The Food and Drug Administration (FDA) is investigating the packer/processor of these berries, and has inspected the facility and its production records. FDA is continuing to work closely with CDC, USDA and the processor/packer of the strawberries to determine whether any implicated product is still in distribution.

CDC has alerted state epidemiologists about this association and has asked them to work with school officials to identify any students that might benefit from immune globulin.

CDC and FDA have identified the quantities of immune globulin and hepatitis A vaccine currently available, and CDC will be working with state health departments to analyze their needs and help them get the needed doses.

### Summary

Since the beginning of March, approximately 130 cases of hepatitis A have been identified in Calhoun County, Michigan. Nearly all patients are students or staff of three different school districts. Two epidemiological studies by the Centers for Disease Control found a strong association between illness and the consumption of food items containing frozen strawberries.

The strawberries associated with the illness were imported from Mexico and were processed, packed and frozen for institutional use by a company in southern California. Thirteen lots of strawberries produced on three dates in April and May 1996 are implicated in the Michigan outbreak. These frozen strawberries were distributed by three vendors to U.S. Department of Agriculture (USDA) sponsored school lunch programs in six states: Michigan, Arizona, southern California, Georgia, Iowa and Tennessee.

USDA purchases only U.S. grown commodities for the school meals programs, and all suppliers must certify in writing that the product is in fact domestic. In addition to this requirement placed upon the vendors, USDA regularly conducts compliance audits, regarding the origin of the product. A false statement to Federal officials concerning the origin of a product is a criminal offense, punishable by up to five years in prison and significant fines. Civil penalties, including debarment from Federal contracting, and the loss of a license to sell perishable agricultural commodities may also be assessed.

State and Federal authorities working on this outbreak have not been able to determine if transmission was limited to only some of the 13 lots, so all 13 implicated lots are being recalled. The Food and Drug Administration, which is responsible for the safety of processed packaged food, is working closely with CDC, USDA, and the processor/packer of the strawberries to determine whether any frozen strawberries, or products made from the strawberries, are still in distribution.

To date, Michigan is the only state that has reported a cluster of hepatitis A cases. CDC has notified State epidemiologists of the association between frozen strawberries and hepatitis A in Michigan and has asked officials in other states that have received the implicated lots to be on the lookout for hepatitis A cases.

#### Chronology

March 24, 1997: Public health authorities in the State of Michigan invite epidemiologists from CDC to investigate a hepatitis A outbreak.

March 27, 1997: FDA and USDA are informed of the outbreak and its possible link to frozen strawberries provided to school lunch programs in Michigan. FDA officials contact the processor/packer in California and begin an investigation of the facility and its production and distribution records. USDA instructs states that may have received the possibly implicated product to suspend the use and distribution of the frozen strawberries until further notice. USDA's Food, Nutrition and Consumer Services works with states to notify individual schools not to server these strawberries.

Late afternoon, March 28, 1997: CDC concludes that the outbreak is associated with the consumption of frozen strawberries served in school lunch programs.

March 29, 1997: CDC notifies state epidemiologists in those states that had received the suspect product of the association with hepatitis A in Michigan and asks them to work with school officials to identify any students that might benefit from immune globulin.

April 1, 1997: Southern California officials announce that school children in the L.A. School District were served frozen strawberries from the implicated lots within the past week and may be at risk for contracting hepatitis A.

### Hepatitis A

Hepatitis A is a virus that causes fever, malaise, loss of appetite, nausea, abdominal pain, and jaundice. It is transmitted through the fecal/oral route or by consuming food or water contaminated by an infected food handler. Hepatitis A infection is usually a mild and self-limiting illness. It is rarely fatal (less than one percent of all cases) and can be prevented through post-exposure immune globulin or by vaccination.

### Immune Globulin

Many products made from blood plasma, including immune globulin, are frequently in short supply. It is therefore important for parents, health professionals, and state officials to carefully define and identify those patients who can benefit from immune globulin -- patients who were exposed within the last 14 days. CDC and FDA are aware of the quantities of immune globulin that are currently available and will be working with state and local health departments to analyze their needs and help them get an adequate supply.

NOTE: USDA news releases and media advisories are available on the Internet. Access the USDA Home Page on the World Wide Web at <http://www.usda.gov>



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

APR 16 1997

MEMORANDUM TO THE PRESIDENT

SUBJECT: National Campaign to Prevent Teen Pregnancy

I recently met with Belle Sawhill to learn about the progress that has been made by the National Campaign to Prevent Teen Pregnancy, the private sector group that you catalyzed by your statement in the 1995 State of the Union Address. (As you know, Belle is the President of the Campaign and Tom Kean serves as its Chair.) HHS is keeping in close touch with the Campaign as we move forward with the Department's National Strategy to Prevent Teen Pregnancy -- the Strategy you announced in your radio address on January 5, 1997.

I understand from Belle that the Campaign will be launched in Washington, D.C. in early May (Teen Pregnancy Prevention Month). The Campaign's Board is eager to brief you and the First Lady about their progress and Belle is working with Bruce Reed and Melanne Verver to see what arrangements might be made at that time. I wanted you to know that I believe such a meeting would be a good opportunity for you to reconnect with this group and keep the issue of teen pregnancy squarely on the national agenda.

Tom Kean wrote to you about the Campaign's efforts in December and Belle Sawhill has met with me and my staff several times to keep us abreast of what they are doing. Here is a brief update:

The Campaign is now staffed, funded, and fully operational with a distinguished board, four task forces composed of about 60 prominent leaders, and an advisory panel in both the Senate (co-chaired by Senators Lieberman and Snowe) and House (co-chaired by Representatives Lowey and Castle).

They have been to numerous states and local communities to applaud their teen pregnancy prevention activities, to learn from these efforts, and to provide concrete assistance when asked.

They have sent out information packages on the teen pregnancy prevention provisions in the welfare reform bill to people in every state and report that this law has energized states to take a new look at the issue of teen pregnancy.

They have commissioned a number of papers including a review of what works to prevent teen pregnancy by Dr. Douglas Kirby, a prominent scholar. This review has been approved by the Campaign's research task force and was released at a press conference on March 26. The Kirby findings assert that there is no single or simple approach to reducing

teen pregnancy and that the current body of research on teen pregnancy prevention programs is very weak. His findings are consistent with and build on research funded by HHS. Additional publications will be forthcoming from the Campaign over the next few months.

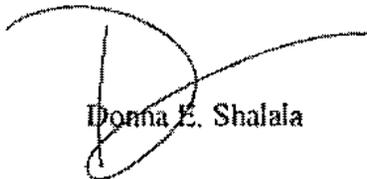
They have engaged a social marketing firm (Porter-Novelli) to conduct focus groups and work with them on message development.

They will be hosting a conference on "how to run a state media campaign" for state officials this summer.

They are doing a series of roundtables on emerging issues in teen pregnancy prevention. The first was on male involvement. The second will be on empowering girls to make choices.

They will be holding a meeting with major national youth organizations on October 15, 1997 co-sponsored by the Urban League and Girls, Inc. They have invited me to speak at this event and I do plan to participate.

I am excited about the official launching of the Campaign in early May. While it appears I will miss the launch events because I am leading the U.S. delegation to the World Health Organization meetings at that time, the Department will be well represented at senior levels for the events.



Donna E. Shalala



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20261

MAY 15 1997

MEMORANDUM FOR THE PRESIDENT

FROM: Donna E. Shalala *Donna E. Shalala*

SUBJECT: AIDS Vaccine Development

Recent advances in biomedical research supported by the National Institutes of Health (NIH) have created new opportunities and encouragement in our search for an effective vaccine against HIV infection. These advances are a direct result of our sustained investment in both basic scientific research and clinical investigation in the area of HIV/AIDS. This era of important scientific progress and renewed hope for the possibility of an AIDS vaccine provides a unique opportunity for you to consider ways to further this critical scientific endeavor.

To sustain this progress and capitalize on new scientific opportunities, we have increased the NIH budget for AIDS vaccine research by 33.6 percent over the past two years to nearly \$150 million in the fiscal year 1998 proposed budget. For now, the funding level is sufficient to maintain the ongoing momentum. Further increases are anticipated in the coming fiscal years. Recently, NIH also established a new NIH AIDS Vaccine Research Committee, chaired by Nobel Laureate Dr. David Baltimore, to provide leadership and guidance to an intensified comprehensive search for an AIDS vaccine.

A safe and effective AIDS vaccine is a global public health imperative. More than 29 million men, women, and children around the world have been infected with HIV. More than 3 million of these infections occurred in just the past year, with nearly 95% in the poorest parts of the world. Without an effective vaccine, AIDS will soon overtake tuberculosis and malaria as the leading infectious cause of death in the world. Even in the U.S., where new and effective anti-HIV therapies are available, complacency is not an option. HIV is capable of mutating and becoming resistant to therapies, and could well become even more dangerous. Only a truly effective preventive anti-HIV vaccine can limit and eventually eliminate the threat of AIDS.

I envision several options to demonstrate a strong Presidential commitment to this priority over several years that will serve to galvanize the worldwide scientific community, renew the commitment of the pharmaceutical industry to AIDS vaccine development, and restate the unwavering commitment of the United States to develop a preventive vaccine:

1. U.S. Proposal for a Global AIDS Vaccine Research Initiative at Denver Summit. The United States has proposed that the leaders of the eight major industrialized nations, meeting at the Denver Summit in June, agree to support a worldwide AIDS vaccine research initiative. This proposal has been discussed by the representatives who are organizing the Summit agenda, and proposed language for the final Summit Communique has been prepared and approved by the "Sherpas."

The proposal calls for the eight participating nations to make a political commitment to provide, in their own countries, the investments necessary to accelerate research toward the development of an HIV/AIDS vaccine as a scientific and public health priority. In the Communique, the nations also will pledge to work together to enhance international scientific cooperation and collaboration in this global initiative, and to work with the Joint United National Program on AIDS (UNAIDS) to address the legal and ethical issues related to vaccine testing.

To facilitate this scientific collaboration, our proposal also calls for meetings of key scientists from the nations participating in the Summit and from other nations integral to AIDS vaccine development. These meetings would take place in concert with that of the NIH AIDS Vaccine Research Committee, chaired by Dr. David Baltimore. This joint group will discuss research progress, identify scientific gaps and opportunities, design collaborative programs aimed at utilizing the unique scientific and clinical resources of each participant, and share scientific information related to the development of AIDS vaccine candidates for worldwide use. At the recommendation of the "Sherpas," the Director of NIH has written to his counterparts in the eight nations to seek their support and collaboration in this initiative.

2. White House Briefing by Key Scientists on Progress towards a Vaccine. The report of a year-long evaluation by more than 100 eminent scientists, known as the Levine Report, called for a reinvigorated and restructured NIH AIDS vaccine research program. The NIH has taken a number of steps to make AIDS vaccine research a top priority, including the initiation of studies to test a new vaccine strategy. You could invite the key scientists to brief you at the White House or at NIH regarding research progress and prospects for the future. If current research leads to a promising vaccine candidate for large-scale clinical testing, additional resources will be necessary to support clinical trials in the U.S. and at international sites.

3. Announcement of New NIH AIDS Vaccine Laboratory. We are in the process of establishing a dedicated intramural HIV vaccine research and development center on the NIH campus, a major new initiative capitalizing on remarkable advances in immunology not previously applied to vaccine development. You could announce

this initiative with the leadership of the NIH AIDS vaccine research program in attendance. In addition, you could visit one of several university-based vaccine labs supported by NIH throughout the country.

4. **Announcement of Awards for New NIH AIDS Vaccine Innovation Grants.** NIH has recently established a new funding mechanism, the "Innovation Grant Program for Approaches in AIDS Vaccine Research." In September 1997, NIH will award grants totaling \$6 million for this new program to encourage novel research in AIDS vaccines. You could announce these grants with those scientists on hand.

5. **White House Meeting to Challenge Industry.** Another option would be to convene a meeting at the White House, to follow-up a meeting held by the Vice President last year, bringing together leading government scientists and CEOs of vaccine manufacturers, to seek solutions to important but complex concerns that have deterred the sustained participation of these companies in HIV vaccine development, such as cost of development, potential market, and legal liability issues.

6. **Presidential Address.** This is an opportune moment for you to deliver a major address on our continuing national commitment to ending the AIDS epidemic with the ultimate goal of developing a preventive vaccine. This could be the focus of one of your upcoming speeches or it could be done in conjunction with the announcement of new initiatives. A good site for such an address could be the National Institutes of Health campus in Bethesda, MD.

I look forward to working with you on these initiatives to speed the pace of progress toward the development of a safe and effective AIDS vaccine. Although no one can predict when such a vaccine may be developed, your efforts would constitute a real legacy to the U.S. and to the world.



MAY 16 1997

MEMORANDUM FOR THE PRESIDENT

SUBJECT: State Use of "Excess" TANF Funds

Recent news stories have asserted that states have "excess" or "surplus" funds available to them under the new Temporary Assistance for Needy Families (TANF) block grant created by the welfare reform legislation. In fact, many states are receiving more federal funds in Fiscal Year (FY) 1997 under TANF than they received in the previous year under the predecessor programs (Aid to Families with Dependent Children (AFDC), Emergency Assistance (EA), and the Job Opportunities and Basic Skills (JOBS) Training program), largely due to setting the funding at historically high levels followed by dramatic caseload decreases. However, these extra funds are distributed very unevenly across states and may be only a first- and possibly second-year phenomenon. Given our commitment to moving welfare families to self-sufficiency, we must take advantage of every opportunity to urge Congress and the states to view these resources not as a "surplus," but rather as essential for making critical early investments to enable welfare families to transition to work.

We all must use every available occasion to strongly encourage states to invest these federal resources (along with state Maintenance of Effort resources) to support the welfare-to-work goals of the legislation. Based on what we know so far about the costs of reaching and serving the most disadvantaged welfare families, we need to ensure that states and cities receive the additional welfare-to-work resources provided in the new budget agreement, and states need to invest wisely to prepare all welfare families for self-sufficiency within the time limits in the statute.

The purpose of this memorandum is to:

- explain what we know now about the level of resources available to states for investment in welfare reform under TANF;
- describe what we know at this interim point in state legislative sessions about the choices that state legislatures are currently making about the use of these resources, and provide some examples both of promising state choices that seem likely to attain the goals of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), and of less promising choices that could undercut those goals;
- argue that achieving the goals of welfare reform, especially in high unemployment areas like inner cities and rural areas, requires both the additional welfare-to-work resources and tools provided in the new budget agreement and that states invest wisely the federal and state resources available to them; and

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- highlight what you can emphasize in your speeches and meetings about this issue.

### Resources Available to States

Since January 1993, the number of welfare recipients has dropped in nearly all states. However, the reductions have not been uniform, and the financial impact varies across states. Table 1 shows that all but four states have a smaller number of welfare recipients now than they did in January 1993, with 36 states experiencing at least 20 percent reductions. The welfare reform law provides fixed federal funding at historically high levels for child care, work programs, and other assistance; for FY 1997 TANF funding exceeds FY 1996 funding for AFDC and related programs by about 10 percent, or \$1.5 billion. While the great majority of states are receiving more money under TANF than their combined federal funding for AFDC, EA, and JOBS in FY 1996, as Table 2 shows, 24 states are receiving only a modest increase, and seven states are actually receiving less federal funding.

States experiencing sizeable reductions in welfare caseloads and funding increases under TANF that have already made substantial investments in work and child care are in an especially good position to continue the historic transformation from welfare programs to job programs. On the other hand, states that have experienced smaller caseload reductions, have low benefit levels, or have unmet needs for supportive services face a tremendous challenge.

Child care is one of the most important services that families need in order to work. As TANF's work requirements (both participation rates and hours) increase, states must make more child care services available. Investments are also needed to provide child care for the working poor in order to enable those parents to sustain their employment and to ensure continuity of care for the children whose parents are making the transition from welfare to work. The PRWORA provides separate and enhanced funding to states for child care that allows them to pay for child care in any of a variety of ways: out of the Child Care Development Fund (CCDF), by transferring (up to 30 percent) TANF funds into the CCDF, or by paying for child care services directly out of TANF. States can also use their own state money on child care. Despite the child care funding increases, resources still may not be sufficient to meet the needs of both transitioning and low-income working parents. We will advise you as we get closer to the next budget cycle about the unmet child care needs and our deep concerns about quality standards.

There also are other important areas in which states must maintain or enhance their investment to help recipients move from welfare to work. One critical area is job creation and partnerships with the private sector, including subsidized workfare positions. In addition, it is generally accepted that after the most employable recipients have made the transition from welfare to work, the remaining adult participants will have more barriers to self-sufficiency and will require more intensive services. These supportive services run the gamut from expanded job readiness and job search programs, public sector jobs, literacy programs, and intensive case management services, to drug testing and treatment, services to address domestic violence, accommodating populations with special needs such as mental and physical disabilities, and rural transportation.

States are required to maintain only 80 percent (or 75 percent if the state meets its mandatory work participation requirements) of historic expenditures. Because the law permits states to disinvest up to 25 percent of their prior expenditures on needy families with children, there is some risk that some or all of these "surplus" funds will simply be used to substitute for state dollars, thereby effectively reverting to state treasuries. The initial choices that states make in spending their TANF funds and in providing child care and other supportive services to families are critical to their success in moving families from welfare to work and to the overall success of welfare reform.

### **What We Know**

It is still too early for the Department to have a full picture of how states will decide to use these "surplus" funds. Many states have not yet made the funding and program design decisions that will shape their TANF programs, but from what we can tell now most changes are incremental. Many states appear to be basing their TANF programs on their welfare reform waiver demonstrations or the AFDC program, without making significant program design changes at this point. Therefore, from a budget perspective, most states are assuming that they will have to spend a certain amount of TANF money on cash assistance and existing job training programs. It should be noted that few state legislatures have completed their sessions for this year, so the information we do have on allocation of funds comes from several different stages in the decision-making process and may represent only preliminary steps in that process. Reports from the Department's Regional Offices and other sources have given us some information about what some states are proposing to do with "excess" TANF funding. Enclosure A includes a fuller discussion of the early information we have on state decisions and the critical investments they are making to spend "excess" TANF funds.

*Welfare-to-Work Programs and Child Care:* It is widely acknowledged that helping recipients move from welfare to work often requires up-front investments in training and supportive services. (Enclosure B provides some information on the costs associated with operating work programs and providing child care services. It should also be noted that the Congressional Budget Office (CBO) estimated that the state costs of meeting the PRWORA work requirements were underfunded in the TANF block grant. If the CBO were to re-estimate the costs of the work program, it is likely that the shortfall would be considerably smaller, given the larger-than-expected caseload decreases.) Many states are assuming that, as time goes on, the remaining adult participants will have more barriers to self-sufficiency than those who have already made the transition from welfare to work, and that such recipients will require more intensive services. As a result, states are also considering spending more money on drug testing and treatment, intensive case management services, rural transportation, job preparation, job training, and public sector jobs. Many states are also considering putting more money into child care services, although it is not yet clear if this represents simply the increased CCDF allocations states received under the PRWORA, plans to spend state "maintenance of effort" (MOE) dollars on

child care, or shifts of TANF welfare funds for additional child care funding. We all need to encourage states to use any "excess" federal TANF funds to supplement rather than supplant state funding needed to access the CCDF.

*Other TANF Purposes:* States are also looking at the broad flexibility they have under the TANF block grant and are considering other types of programs, including juvenile justice and other services formerly funded under the Emergency Assistance program, housing and nutrition programs, teen pregnancy prevention initiatives, energy assistance, family planning, fatherhood conferences, and transfers to the Title XX social services block grant to offset previous federal reductions.

*Rainy Day Funds:* Notwithstanding the availability of the contingency fund, state allocations are fixed regardless of the state of the economy or caseload trends. Therefore, a number of states are considering building a reserve in the event of a recession, since there is no requirement that states spend their full federal allocations in the fiscal year in which they become available.

*Services to Immigrants:* Under the welfare law, qualified aliens are banned from receiving Food Stamps and SSI benefits, and qualified aliens who arrived in the United States after August 22, 1996 are banned from receiving assistance from federal TANF funds for a period of five years. A number of states have indicated that they expect to continue benefits for such aliens nonetheless, using state funds. States also have the option of continuing TANF benefits for immigrants who arrived before the bill's enactment. Only Alabama, South Carolina and Wyoming have indicated that they will not be continuing benefits for these aliens.

*Choices that Undercut the Goals of PRWORA:* Not all states, however, intend to reinvest their savings in welfare-related services or assistance for immigrants. In addition to authorizing federal TANF funding, the welfare reform law requires states to maintain a certain level of historic effort (MOE) in order to access the TANF block grant. Both TANF and MOE funds must be spent to provide assistance to needy families with children and to promote job preparation and work, among other purposes. Some states are treating the difference between the MOE requirement and the amount they would have spent in the absence of welfare reform as a general surplus, to be used for any purpose they desire. Proposed uses include dividing the funds between the state and local governments for unrestricted spending, allocating them to the state's general fund, and replacing state spending on child protection services and the elderly. The state funds thus freed can be used for any purpose including underwriting a tax cut, which has already been proposed in several states.

### **Do States Need More Funding?**

In contrast to the increased child care funds and "excess" TANF funds many states currently have available, other provisions of PRWORA cut funding and increased demands on states. The new law significantly reduced federal funding for other programs serving low-income populations, in particular legal immigrants. It established increasingly tough work requirements within a

framework of time-limited federal assistance for needy families with children. The requirement that families to achieve self-sufficiency within five years or less presents a tremendous challenge to states and demands a commitment to making critical investments as early as possible.

Moving families from welfare to work requires increased state investments in critical services such as child care, supports and subsidies for work, services to address barriers like substance abuse and domestic violence, literacy programs, expanded job readiness and job search programs and expanded case management. Some states have an especially great need for supportive services, have experienced smaller reductions in caseloads, or have other special circumstances (like inner city or rural areas of high unemployment and poverty or large numbers of noncitizen residents) which might necessitate costly investments in economic development or transportation. In addition, since the 80 (or 75) percent MOE requirement is based on FY 1994 expenditures, some states that have experienced significant caseload reductions since 1994 potentially could be required to commit larger sums of state funds under TANF than they would have spent under the predecessor programs. The wide variation in benefit levels across states (as illustrated in table 3) highlights the difficulties some states will face. Clearly the states with higher benefit levels and a history of greater state effort on low-income assistance have more capacity to invest in additional services to help families move from welfare to work and sustain their employment.

States must begin now to make front-end investments if they are to have in place the programs they will need to move large numbers of single parents from welfare to work in the later years, when participation and hours of work requirements are higher and populations begin reaching state time limits. States must also obtain unprecedented commitment from business, non-profit organizations, and religious institutions. The so-called "excess" TANF funds are not a windfall, may be only temporary, and are not available to all states.

### Getting Out the Message

The new budget agreement will enable us to ensure that needed funding is available to states and communities to achieve the goals of welfare reform, especially in areas with high unemployment. Three initiatives included in the new budget agreement have been and continue to be particularly important: enabling welfare families to transition to work, restoring unacceptable cuts in benefits to immigrants, and providing support for low-income working families to sustain their employment. As a result of your efforts, states and communities will have \$2 billion over the next five years to spend on wage subsidies and job creation and retention activities to help the hardest-to-employ long-term welfare recipients find and keep jobs. An additional \$500 million is available in the form of tax incentives to employers to create job opportunities for long-term welfare recipients and able-bodied childless adult food stamp recipients who face work and time limit requirements. Legislation to fulfill your goal of moving people from welfare to work must include the grants and tax incentives necessary to support states, cities, and the private sector in creating job opportunities for the hardest to employ welfare recipients.

The budget agreement will also protect the most vulnerable populations of legal immigrants -- children and individuals with disabilities -- from the restrictions placed on their receipt of Medicaid and SSI benefits. It helps to protect a minimal safety net for the most needy legal immigrants and supports our immigrant traditions and protects public health.

We are already taking the lead in reducing the number of children without health insurance, and this is one of the most important things we are doing. Twenty-three states currently have expanded transitional Medicaid benefits through waivers, some by extending the period of eligibility beyond 12 months and others by expanding who is eligible. Four additional waiver requests are under review, including two new states. In addition, the new budget agreement expands health coverage for millions of uninsured children, including a new grant program that provides additional dollars to supplement state efforts to cover uninsured children in working families.

As I indicated earlier in this memorandum, it is a little too early to know how short the states are on child care money. We are increasingly concerned about quality standards for child care. The recent White House Conference on the Brain highlighted the need for substantial quality investments and high standards. The White House conference planned for later this year will focus on quality child care.

We need your help to encourage states to make the right decisions for their needy citizens and taxpaying citizens alike. Your achievement of the recent historic budget agreement presents a particularly opportune time to take the lead and through your speeches and meetings with public and private sector leaders to encourage all states to make the serious investments that are needed to help move families from welfare to work and sustain their employment. These investments will require not only effective use of federal funding (including the new funds provided through the budget agreement) but also a commitment to continued state funding. The needs are great, as are our opportunities to make a difference in the lives of the nation's most vulnerable populations -- welfare families, children without health insurance, and legal immigrants.

I am sending a copy of this memorandum to Bruce Reed.



Donna E. Shalala

Enclosures

**TABLE I.**  
**CHANGE IN WELFARE CASELOADS**

Total AFDC/TANF recipients by State

State	Jan.93	Jan.94	Jan.95	Jan.97	Percent change '93-'97
Wisconsin	241,098	230,621	214,404	123,758	-49
Wyoming	18,271	18,740	15,434	10,117	-45
Oregon	117,656	116,390	107,610	66,919	-43
West Virginia	119,916	115,376	107,668	68,600	-43
Indiana	209,882	218,061	197,225	121,224	-42
Oklahoma	146,454	133,152	127,336	87,144	-40
Tennessee	320,709	302,608	281,982	194,860	-39
Mississippi	174,093	161,724	146,319	108,365	-38
Massachusetts	332,044	311,732	286,175	207,932	-37
North Dakota	18,774	16,785	14,920	11,904	-37
South Carolina	151,026	143,883	133,567	97,146	-36
Alabama	141,746	135,096	121,837	91,569	-35
Kansas	87,525	87,433	81,504	57,528	-34
Utah	53,172	50,657	47,472	35,442	-33
Michigan	686,356	672,760	612,224	460,793	-33
Florida	701,842	689,135	657,313	478,329	-32
South Dakota	20,254	19,413	17,652	14,050	-31
Virginia	194,212	194,959	189,493	135,908	-30
Colorado	123,308	118,081	110,742	87,074	-29
Kentucky	227,879	208,710	193,722	161,150	-29
New Hampshire	28,972	30,386	28,671	20,627	-29
Ohio	720,476	691,099	629,719	518,595	-28
New Jersey	349,902	334,780	321,151	258,000	-27
Arkansas	73,982	70,563	65,325	54,751	-26
Maine	67,836	65,006	60,973	51,031	-25
Montana	34,848	35,415	34,313	26,294	-25
Nebraska	48,055	46,034	42,038	36,490	-24
Georgia	402,228	396,736	388,913	305,732	-24
North Carolina	331,633	334,451	317,836	252,564	-24
Maryland	221,338	219,863	227,887	169,723	-23
Iowa	100,943	110,639	103,108	78,076	-23
Arizona	194,119	202,350	195,082	151,526	-22
Louisiana	263,338	252,860	258,180	206,582	-22
Texas	785,271	796,348	765,460	625,376	-20
Pennsylvania	604,701	615,581	611,215	483,625	-20
Missouri	259,039	262,073	259,595	208,132	-20
Vermont	28,961	28,095	27,716	23,515	-19
Nevada	34,943	37,908	41,846	28,817	-18
Minnesota	191,526	189,615	167,949	159,855	-17
Delaware	27,852	29,286	26,314	23,141	-16
Illinois	685,508	709,969	710,032	599,629	-13
Rhode Island	61,116	62,737	62,407	54,588	-11
New York	1,179,522	1,241,639	1,266,350	1,074,100	-9
Washington	286,258	292,608	290,940	263,792	-8
Idaho	21,116	23,342	24,050	19,925	-6
New Mexico	94,836	101,676	105,114	89,814	-5
Connecticut	160,102	164,265	170,719	155,578	-3
California	2,415,121	2,621,383	2,692,202	2,474,689	2
District of Columbia	65,860	72,330	72,330	67,871	3
Alaska	34,951	37,505	37,264	36,189	4
Hawaii	54,511	60,975	65,207	65,312	20
<b>United States 1/</b>	<b>14,114,992</b>	<b>14,275,877</b>	<b>13,918,412</b>	<b>11,359,582</b>	<b>-20</b>

1/ Includes Guam, Puerto Rico, and the Virgin Islands.

Source: U.S. Dept. of Health & Human Services, Administration for Children and Families, Office of Family Assistance, AFDC/TANF Flash Report, January 1997.

TABLE 2.

**COMPARISON OF FEDERAL FUNDING FOR AFDC AND RELATED PROGRAMS  
AND FAMILY ASSISTANCE GRANTS UNDER PRWORA**

(In thousands)

State	FY 1996 Grants for AFDC, EA & JOBS 1/	Fy 1997 State Family Assistance Grant 2/	Increase from FY 1996 Level	Percent Increase from FY 1996 Level
Indiana	\$133,119	\$206,799	\$73,681	55.3
Wyoming	14,969	21,781	6,813	45.5
Louisiana	114,252	163,972	49,720	43.5
Tennessee	137,445	191,524	54,079	39.3
Ohio	543,666	727,968	184,303	33.9
Dist. of Columbia	70,813	92,610	21,796	30.6
Virginia	121,366	158,285	36,919	30.4
Massachusetts	353,060	459,371	106,311	30.1
West Virginia	67,683	110,176	22,493	25.7
Oklahoma	116,234	146,014	29,779	25.2
Connecticut	215,259	266,788	51,529	23.9
Mississippi	70,341	88,788	18,427	23.4
Alabama	\$75,909	\$93,315	17,406	22.9
Michigan	632,232	775,353	143,121	22.6
Minnesota	220,839	267,985	47,146	21.3
Utah	64,656	76,829	12,134	18.8
Oregon	142,045	167,925	25,879	18.2
Texas	419,021	466,257	67,236	16.0
Kentucky	157,238	181,288	24,050	15.3
Wisconsin	278,357	318,188	41,831	15.1
Georgia	288,410	330,742	42,332	14.7
Kansas	89,753	101,931	12,178	13.6
New York	2,160,852	2,442,931	282,279	13.1
Florida	497,539	562,340	64,801	13.0
Montana	40,391	45,534	5,143	12.7
Arizona	197,754	222,420	24,666	12.5
Vermont	42,378	47,353	4,975	11.7
Missouri	195,368	217,052	21,684	11.1
New Hampshire	34,677	38,521	3,844	11.1
Arkansas	51,854	56,733	4,879	9.4
Alaska	58,665	63,609	4,944	8.4
South Dakota	20,242	21,894	1,652	8.2
Maryland	214,292	229,098	14,806	6.9
Nevada	41,357	43,977	2,620	6.3
Rhode Island	89,479	95,022	5,543	6.2
South Carolina	94,401	99,966	5,567	5.9
New Jersey	363,177	404,035	20,857	5.4
Maine	74,786	78,121	3,335	4.5
Nebraska	56,014	58,029	2,015	3.6
California	3,622,756	3,733,818	111,062	3.1
North Dakota	25,660	26,460	740	2.9
Iowa	128,853	131,525	2,672	2.1
Idaho	31,297	31,938	641	2.0
Hawaii	97,908	98,905	997	1.0
Washington	415,364	404,332	-11,033	-2.7
Illinois	601,059	585,057	-16,002	-2.7
North Carolina	312,630	302,240	-10,390	-3.3
New Mexico	132,129	126,103	-6,026	-4.6
Pennsylvania	770,098	719,499	-50,599	-6.6
Delaware	35,190	32,291	-2,899	-8.2
Colorado	158,311	136,057	-22,255	-14.1
<b>State Totals</b>	<b>\$14,931,044</b>	<b>\$16,488,667</b>	<b>\$1,557,623</b>	<b>10.4</b>

1/ Excludes IV-A child care. AFDC benefits include the Federal share of child support collections in order to be comparable to the Family Assistance Grant.

2/ Does not include additional funds authorized under P.L. 104-327.

Source: U.S. Dept. of Health &amp; Human Services, Administration for Children and Families, Office of Financial Management.

TABLE 3.

**Maximum AFDC Benefit for a Three-Person Family by State**  
July, 1996

State	Schedule/Geography	Monthly	Annual
Alaska	Statewide	\$923	\$11,076
Hawaii	Statewide	712	8,544
New York	Suffolk Co.	703	8,436
Guam	Statewide	673	8,076
Connecticut	Region A	636	7,632
Vermont	Chittenden	633	7,596
California	Statewide	596	7,152
New York	New York City	577	6,924
Utah	Statewide	568	6,816
Messachusetts	Statewide	565	6,780
Rhode Island	Statewide	554	6,648
New Hampshire	Statewide	550	6,600
Washington	Statewide	546	6,552
North Carolina	Statewide	544	6,528
Minnesota	Statewide	532	6,384
Wisconsin	Urban	517	6,204
Michigan	Region VI (Washtenaw Co.)	489	5,868
Oregon	Statewide	460	5,520
Michigan	Region IV (Wayne Co.)	459	5,508
Montana	Statewide	438	5,256
North Dakota	Statewide	431	5,172
South Dakota	Statewide	430	5,160
Kansas	Schedule 1	429	5,148
Iowa	Statewide	426	5,112
New Jersey	Statewide	424	5,088
Pennsylvania	Group 1	421	5,052
Maine	Statewide	418	5,016
District of Columbia	Statewide	415	4,980
New Mexico	Statewide	389	4,668
Illinois	Group 1	377	4,524
Maryland	Statewide	373	4,476
Nebraska	Statewide	364	4,368
Wyoming	Urban	360	4,320
Colorado	Statewide	356	4,272
Virginia	Group 3	354	4,248
Nevada	Statewide	348	4,176
Arizona	Statewide	347	4,164
Ohio	Statewide	341	4,092
Delaware	Statewide	338	4,056
Idaho	Statewide	317	3,804
Oklahoma	Statewide	307	3,684
Florida	Statewide	303	3,636
Missouri	Statewide	292	3,504
Indiana	Statewide	288	3,456
Georgia	Statewide	280	3,360
Kentucky	Statewide	262	3,144
West Virginia	Statewide	253	3,036
Virgin Islands	Statewide	240	2,880
Arkansas	Statewide	204	2,448
South Carolina	Statewide	200	2,400
Louisiana	Urban	190	2,280
Texas	Statewide	188	2,256
Tennessee	Statewide	185	2,220
Puerto Rico	Statewide	180	2,160
Alabama	Statewide	164	1,968
Mississippi	Statewide	120	1,440

Source: Congressional Research Service, Aid to Families with Dependent Children (AFDC): Program Benefit Rules, July 1, 1996.

## EARLY INFORMATION ON HOW STATES ARE SPENDING "EXCESS" TANF FUNDS

### Very Preliminary Indications

Information about how states propose to spend "excess" TANF funds is only preliminary. Most state legislatures are working out their welfare reform plans now, and are at different stages of decision making. Information from newspaper articles, state press releases, as well as early reports from HHS Regional Offices suggest that many states are making investments in child care, work programs, and supportive services while other states are putting money into less "desirable" practices such as supplanting state funds with federal dollars. At this stage, it is hard to get information on state expenditures and categories of spending. It is particularly difficult at this time to determine whether states will be spending federal TANF monies or state maintenance of effort (MOE) monies on an activity, and whether they are spending new monies or merely supplanting state funds with federal dollars. The following material summarizes our early information.

### *Welfare-to-Work Programs and Child Care*

It is widely acknowledged that helping recipients move from welfare to work often requires up-front investments in training and supportive services. Many states are considering putting more money into child care services. Florida, Michigan and Tennessee reportedly are adding \$60 million, \$44 million and \$25 million, respectively, to child care. It is not yet clear if this represents simply the increased CCDF allocations states received under the PRWORA or shifts of TANF welfare funds for additional child care funding. Georgia's budget includes \$3.5 million in federal TANF funds to hire additional staff to coordinate and determine eligibility for child care services. Under the child care provisions of Wisconsin's W-2 program, the state intends to increase annual child care funding from \$48 million in 1996 to \$186.2 million in 1999. The state has requested legislative authority to transfer \$63.637 million from TANF to child care in 1998. They believe that cash outlays originally targeted for assistance can, as a result of caseload decreases, be rebudgeted for child care, provided that their economy stays strong and their caseload trends continue. Among all states, Wisconsin has had the largest percentage drop in welfare caseloads. These state actions to increase child care subsidies may benefit the working poor as well as welfare recipients. For example, the Wisconsin legislature is considering expanding eligibility for child care by raising income eligibility limits from 165 percent of poverty to 200 percent.

In discussions with our Child Care Bureau, state officials have indicated orally that they are transferring TANF dollars to CCDF in order to invest in child care. States appear to be spending their own funds to draw down fully the CCDF funding as well. States report using these monies for welfare families, quality improvements and working poor families. Because of the multiple demands on TANF dollars, it is worrisome when states spend federal TANF funds on child care

in lieu of state funds or without first having drawn down all of the child care funding to which they are entitled under the CCDF, which can be spent only on child care. If the Administration makes a concerted push to have states spend their excess TANF funding on child care, the message has to be that federal funds should supplement, rather than supplant, state funding needed to access the CCDF.

States are also considering spending more money on drug testing and treatment, intensive case management services, rural transportation, job preparation, job training, and public sector jobs. California, Indiana, Maryland and Massachusetts are reported to be considering these possibilities. These states are aware of the possibility that the remaining adult participants will have more barriers to self-sufficiency than those who have already made the transition from welfare to work, and thus that such recipients will require more intensive services. Georgia's budget includes \$8 million in federal TANF funds to purchase job placement services for recipients who have traditionally been hard to place. New York's proposed budget would set aside \$42 million for client work activity assessments, medical examinations, and incentive bonuses for local district performance, \$45 million to expand work training activities, and \$57 million for a variety of targeted initiatives involving work activities.

#### *Other TANF Purposes*

States are also looking at the broad flexibility they have under the TANF block grant and are considering other types of programs. California is considering putting \$141 million into juvenile justice services formerly funded under the Emergency Assistance program. Indiana, whose welfare caseloads have dropped more than most other states, plans to use MOE monies to create more positions for child welfare workers and to increase funding for employment and training activities. Plans for the state's TANF funding include rural transportation, energy assistance, family planning, working with non-custodial parents, as well as employment services, child care, and data collection. Connecticut reports planning to put \$24 million of TANF funding into programs such as housing and nutrition. Georgia's budget includes \$3.5 million from the Indigent Care Trust Funds to implement teen pregnancy prevention initiatives in support of welfare reform. Indiana is considering funding energy assistance, family planning, and fatherhood conferences, among other services.

#### *Rainy Day Funds*

Because TANF is a block grant, state allocations will not increase in the event of a recession. Therefore, a number of states are considering building a reserve in case the economy cools down and caseloads increase. While only actual expenditures of state funds can count towards the TANF maintenance of effort requirement, there is no requirement that states spend their full federal allocations in the fiscal year in which they become available. Ohio, New York and Vermont are three states that are reportedly considering saving significant portions of their "excess" TANF funds.

### *Services to Immigrants*

Under the welfare law, qualified aliens are banned from receiving Food Stamps and SSI benefits. Those qualified aliens who arrived after August 22, 1996 are banned from receiving assistance from federal TANF funds for a period of five years. A number of states have indicated that they expect to continue benefits for such aliens nonetheless, using state funds. For example, Massachusetts has estimated that it will spend \$26 million on legal immigrants who are not citizens. In states with substantial immigrant populations, most notably California, continuing to provide services to qualified aliens is expected to be a significant financial burden.

### *Other Purposes*

Not all states intend to reinvest their savings in welfare-related services. Some are treating the difference between their MOE requirement<sup>1</sup> and the amount they would have spent under prior law as a general surplus, to be used for any purpose they desire. For example, the Governor of New York has proposed to divide \$416 million between the state and the local governments, to be spent without restrictions. California is considering allocating \$562 million over two years into the state's general fund. Texas' Governor has proposed to use federal TANF funds and part of the state's required maintenance of effort expenditure to replace \$190 million in state spending on child protection services and the elderly. The state funds thus freed can be used for any purpose including underwriting the Governor's proposed tax cut.

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1. Each state's maintenance of effort (MOE) level is set at 75 percent of the state's FY 1994 spending for AFDC, EA, JOBS and IV-A child care (80 percent if the state fails to meet TANF work participation rates).

### INFORMATION ABOUT COSTS OF INVESTING IN WELFARE REFORM

It is difficult to estimate how much more it will cost states to operate welfare to work programs. Since the mid-1980's, MDRC and Abt Associates have evaluated numerous work-oriented demonstrations with relatively high participation rates, and the per recipient costs reported in their major studies have varied as the table below shows. The gross per person costs to the government range from about \$2,200 (in FY 1997 dollars) under Florida's Project Independence to about \$27,000 under the Supported Work program<sup>1</sup>.

Estimated Gross Costs* Per Person for Selected Welfare to Work Programs		
Program	Period of Costs	In 97 Dollars
Supported Work** ( <i>many sites</i> )	27 months	\$26,938
Homemaker- Home Health Aide** ( <i>many sites</i> )	NA	14,588
Grand Rapids JOBS ( <i>Labor Force Attachment</i> )	2 years	4,915
Allanta JOBS ( <i>Labor Force Attachment</i> )	2 years	3,695
Riverside GAIN	2 years	3,299
San Diego SWIM	2 years	2,272
Florida Project Independence	2 years	2,189

Source: MDRC [the Homemaker-Home Health Aide project was evaluated by Abt Associates.]  
 \* Includes costs of job clubs, case managers, child care, and training. \*\* These costs include program wages paid to participants, but do not include non-welfare agency costs. Costs shown in this table are for single-parent AFDC recipients averaged across all experimental group members, including those who did and those who did not participate in program activities.

It should be noted that while each of these programs produced significant increases in employment and declines in welfare outlays, these outcomes do not replicate the work expectations and time limits of the PRWORA. Under the Riverside GAIN program which produced particularly impressive results, only 23 percent of the program participants were working and off AFDC at the end of the project's three-year follow-up period, indicating the challenges faced by these programs.

Some states have an especially great need for supportive services, have experienced smaller reductions in caseloads, or have other special circumstances (like large urban centers, significant areas of rural poverty, Indian reservations, and pockets of high unemployment) which might

The Supported Work Demonstration provided work experience to hard-to-employ target groups including long-term AFDC recipients. To help them achieve self-sufficiency, participants worked in crews in closely supervised jobs with gradually increasing demands.

require that they make greater costlier investments in economic development or transportation. The wide variation in benefit levels across states (as illustrated in Table 3) highlights the difficulties some states will face. Under the AFDC program, the maximum annual benefit for family of three ranged from \$1,440 in Mississippi to \$11,076 in Alaska. Nationally the cost of a part-time child care slot is \$3,160 a year; a full-time, full-year slot costs \$4,406. In 11 states and territories the cost for part-time child care is greater than the welfare benefit.

More than in its predecessor programs, TANF requires that states deal with special needs populations. These include individuals who are substance abusers as well as those who are victims of domestic violence. Over a quarter of the AFDC caseload includes adults with disabilities and, under prior law, these individuals were exempted from the training and work requirements of the JOBS program. States have never addressed preparing recipients with disabilities for work including special case management, remedial services and accommodations.



JUL 11 1997

MEMORANDUM FOR THE PRESIDENT

As you know, the Senate has proposed a number of changes that would affect Medicare beneficiaries, including the introduction of an income-related Part B premium starting at \$50,000 for single beneficiaries and \$75,000 for couples. In our letter to the Conferees, the Administration made clear that while we do not oppose income-relating the Medicare premium in principle, we have a number of concerns about the proposal as currently structured. I wanted to raise to your attention the two aspects of the proposal that I think raise the most significant problems. (I have discussed my concerns with Secretary Rubin).

First, if the Administration agrees to an income-related premium, I believe we should strongly oppose the Senate provision for HHS to administer the collections process. The Administration has consistently taken the position that any such premium should be collected by the Treasury Department, where it could be managed simply and efficiently as part of the filing of a beneficiary's tax return. (As you may recall, this is how we proposed to collect the income-related premium in the Health Security Act; we adhered to this position in the balanced budget negotiations). Part I of this memorandum sets forth in more detail the reasons why administration of an income-related premium by HHS would be impractical, expensive, and more burdensome to beneficiaries. Administration by HHS runs serious risks of alienating several million senior citizens.

Second, I am concerned that the Senate proposal has the potential to cause a substantial percentage of the highest income beneficiaries to opt out of Medicare Part B altogether, because it phases out the premium subsidy entirely at the top end of the income scale. Part II of the memorandum explains why it is very important that we not agree to an income-related premium that includes this feature.

I. Concerns about Administrability of Income-Related Premium by HHS

Administration of an income-related premium by HHS would be a formidable undertaking. HHS does not now have access to information on beneficiary income. In addition to serious concerns about the privacy of income information, requiring HHS to collect an income-related premium would mean establishment of a large and expensive bureaucracy at HHS, a task for which the Department has no expertise or comparative advantage. We estimate that such a bureaucracy, which would duplicate functions performed by Treasury, would require more than 300 new

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Federal employees and cost more than \$30 million per year (not counting start-up costs), and run counter to Administration and Congressional goals of downsizing the Federal government.

Furthermore, the inefficiencies inherent in the Senate proposal for HHS to collect the income-related premium have led both CBO and HCFA actuaries to estimate that less than half of the revenue theoretically obtainable would be achieved. We believe that CBO would estimate that the income-related premium in the Senate bill would raise about \$8-\$9 billion over five years if the collections were handled by Treasury, compared to only the \$4 billion that CBO has estimated if the premium were administered by HHS.

#### A. What HHS Would Have to Do to Administer Income-Related Premium

The Senate bill would require HHS to undertake a complicated series of steps.

- (1) The Senate bill requires Treasury to provide HHS with income information on Medicare beneficiaries since HHS does not have such information. Collecting and reconciling information about beneficiary incomes would be an entirely new function for HHS, one that some beneficiaries may not find appropriate, given the sensitivity of such information.
- (2) The income information provided by Treasury would be three years old. Treasury would send HHS 1995 tax return information, the latest available information, in order to give HHS sufficient time to develop and send to beneficiaries an initial determination (i.e., a preliminary estimate which would need to be reconciled after the actual tax filing for the year) of their 1998 income and an initial determination of their 1998 income-related premium liability, and give the beneficiary an opportunity refute the HHS estimate.

Use of income data three years old is problematic. It would be inherently confusing. Past income is not a good indicator of a Medicare beneficiary's future income. For example, income for beneficiaries who were working in 1995 but later retired would result in an overstatement of estimated 1998 income for the beneficiary. Similarly, if a beneficiary had a capital gain in 1995, that gain would be included in the beneficiary's 1995 income used to project 1998 income.

In contrast, if Treasury were administering the income-related premium, they would not have to use three year-old data. Rather, because the income-related premium would be collected as part of the filing of the beneficiary's tax return, it would be based on actual income information for the relevant year.

HHS would have to respond to the many letters from beneficiaries or Congressional Offices who might be concerned with the general notion of a governmental agency estimating their income for a year and why they had to supply income data to two different governmental agencies.

(3) The Senate bill requires that HHS send the beneficiary an estimate of their income by September 1 of the year before the year for which the income-related premium applied and that the beneficiary be given thirty days to refute the estimate. If the beneficiary refutes the HHS estimate, the Senate bill provides that the beneficiary's estimate would hold. If the beneficiary does not challenge the HHS estimate, the Senate bill specifies that the HHS estimate would hold.

(4) While the Senate bill does not specify how the income-related premiums would actually be collected, they could be collected either by HHS direct billing, or SSA deductions from the Social Security check (for the bulk of beneficiaries).

In the case of exclusive HHS direct billing, HHS would have to send quarterly bills to about 3 million beneficiaries in 1998. For those beneficiaries who did not make timely payment, additional efforts at collection would need to be undertaken.

Alternatively, the beneficiary-specific income-related premium liability could be sent to SSA before the beginning of a year and SSA could deduct the amount from the beneficiary's Social Security check. This method could be used for 85 percent of beneficiaries; the remainder would need to be direct-billed by HHS.

(5) If high-income beneficiaries did not make premium payments, they would be terminated from Medicare Part B coverage. Challenges to terminations could consume additional HHS resources. Termination may also involve correspondence with beneficiaries and Congressional offices.

(6) Since the initial premium payments for a year would be based on the "initial determination" of income and since "actual" income and the actual income-related premium liability for the year may be different from the estimated amounts, the Senate bill requires that there be a reconciliation after the year. The Senate bill requires Treasury to send HHS income information after the beneficiary filed their tax returns for the year. Using actual income, HHS would determine the actual premium liability for the year.

For income-related premium liabilities for 1998, the reconciliation would occur in 2001. This could be confusing to beneficiaries since the reconciliation would involve resurrecting their actual information from a tax return three years earlier and generate additional correspondence.

(7) After HHS reconciled estimated and actual income and income-related premium liabilities, underpayments would have to be collected from beneficiaries and overpayments would have to be refunded. If a beneficiary had died, collections would have to be made from, and refunds made to, the surviving spouse or estate. Special efforts may be needed to recoup underpayments from heirs where estates had already disbursed assets.

- (3) The paperwork burden for HHS administration of an income-related premium is staggering. New forms would have to be developed to send income estimates to beneficiaries, receive their responses and reconcile estimated and actual income. Twelve million bills would need to be sent if HHS did exclusive billing for income-related premiums. Additional correspondence would be involved for delinquent collections. Up to 3 million letters might be sent to handle overpayments and underpayments for a year. Special paperwork might be needed to recoup underpayments from surviving spouses or estates.

#### B. Comparison with Administration by Treasury

In contrast, an income-related premium could be calculated through the income tax return, in a manner similar to the way that the tax on Social Security benefits is currently determined. One line would be added to the 1040 tax form representing the amount owed for income-related premium. Determination of the income-related premium owed would be calculated on a worksheet in the 1040 instructions in the same manner that individuals calculate the amount of their Social Security benefit subject to income taxation. If the individual pays estimated taxes, the income-related premium liability could be included as part of the individual's periodic filing. There would be some increase in Treasury's administrative costs to run this program, but we believe those costs are relatively small.

#### C. Potential Costs of Administration by HHS

In an era of ever more constrained funding for program administration, requiring HHS (and SSA) to take on these administrative functions would be impossible without a more than \$30 million annual increase in administrative funding (and \$20 million in start-up costs) and more than 300 new Federal employees. These estimates of administrative costs do not take into account the need to deal with inquiries or complaints from Congressional offices, or the IRS itself (which will continue to be identified as the source of final income data). In the absence of additional resources, processing those inquiries would detract from the capacity of those organizations to provide other services. Nor do those estimates reflect the additional costs to beneficiaries who believe -- rightly or wrongly -- that there are errors in the information on which their filings are based. Just as other taxpayers incur considerable expenses for accountants, lawyers, and so forth, so for the first time would thousands of Medicare beneficiaries.

#### II. Concerns about the Maximum Beneficiary Contribution in Senate Proposal

The Administration's Health Security Act proposed that beneficiaries pay a maximum contribution of 75 percent at or above the top income level. In other words, there would be a 25 percent subsidy for the highest income beneficiaries.

There is an important rationale for this policy. If the entire subsidy is removed, the younger and

Healthier persons among highest income beneficiaries would have strong incentives to drop out of Part B coverage. On average, Medicare spending for high-income beneficiaries is about 15 percent lower than for all beneficiaries. Since their average expenses would be considerably less than their Part B premium contributions, they could probably purchase a Part B benefit package privately, at less cost than a Medicare premium equal to 100 percent of the average cost for all aged beneficiaries. If a significant number of high-income beneficiaries dropped out, it would raise costs for those who remain. HCFA actuaries assume that about 30 percent of high-income beneficiaries would drop out if the income-related premium were set equal to 100 percent of average program costs. This would increase the Part B premium for every other beneficiary. The Administration believes that the maximum beneficiary contribution at the highest incomes should be 75 percent.

#### Conclusion

For all of these reasons, I strongly believe we should support an income-related premium only if it is administered through Treasury. I also believe that if this provision remains in the bill, the maximum beneficiary contribution should be 75 percent.



Donna E. Shalala

cc: Robert Rubin  
Secretary, Department of Treasury

John Callahan  
Acting Commissioner, Social Security Administration



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

JUL 11 1997

MEMORANDUM FOR THE PRESIDENT

Because of the urgent need to address the issue of genetic discrimination in health insurance, HHS has prepared the enclosed report, *Health Insurance in the Age of Genetics*. The report includes recommendations for federal legislation that would ensure that the discoveries made possible by the Human Genome Project are used to improve the health of Americans and not used by health insurers to discriminate against individuals, families or groups. It recognizes the significant activity by states and the Congress on this issue.

The report builds on the recommendations of two advisory groups: the HHS National Action Plan on Breast Cancer and the NIH-DOE Working Group on Ethical, Legal and Social Implications of Human Genome Research. It supports the remarks you made in your commencement address at Morgan State University in May when you urged Congress to pass bipartisan legislation to prohibit insurance companies from using genetic information to determine the premium rate or eligibility of Americans for health insurance.

I am transmitting the report to you and look forward to working with you on this important issue.

Donna E. Shalala

Enclosure

10/1/97 10/1/97

**Health Insurance in the Age of Genetics**  
**Department of Health and Human Services**  
July 1997

*"Our laws and institutions must go hand-in-hand with progress of the human mind."*  
Thomas Jefferson

As the Human Genome Project makes it ever easier to find genetic alterations associated with human disease, unprecedented opportunities are arising to treat or prevent those diseases. However, as knowledge grows about the genetic basis of disease, so too does the potential for discrimination and stigmatization based on genetic information. Too many Americans fear that their genetic information will be used to discriminate against them and too often they are right. Federal legislation is needed to guarantee access to health insurance coverage irrespective of an individual's genetic makeup.

### **The Promise of Genetic Testing**

The Human Genome Project has brought with it the promise of a whole new way to understand, treat, and prevent many human diseases. For children born with a baffling inherited disorder, genetic technologies can put an end to the often long and agonizing search for a diagnosis. For healthy people from families prone to a later-onset disease, genetic technologies, such as simple DNA tests, can tell people and their health care providers who has an increased likelihood of developing the disorder and who does not. At one time, such medical clairvoyance seemed like science fiction. But not any more. Scientists have made tremendous strides in understanding genetics. In the next few years we will know the exact location and letter-by-letter sequence of each of the 80,000 or so genes in the human genome and begin comprehensive studies to understand how they work.

Genetic tests for glaucoma, colon cancer, inherited kidney cancer, and other disorders are already helping to identify high-risk individuals before they become ill. In a Chicago hospital, for example, "Patty," who had tested positive for a cancer-related gene mutation called MEN2, has had her thyroid gland removed. She inherited the altered gene from her father who had thyroid cancer. Because his children have a 50-50 chance of inheriting the altered gene, doctors tested Patty and her only sibling. Patty turned out to carry the MEN alteration. Because this mutation placed Patty at very high likelihood of developing thyroid cancer, her doctors recommended that she have her thyroid removed. At the time of surgery, Patty's thyroid gland already contained small, potentially lethal, cancers. She now takes a pill every day to replace her thyroid hormones, but her chance of developing MEN-related cancer is very low.

This past year scientists discovered a mutated gene that leads to hereditary hemochromatosis (HH), a common disorder of iron metabolism, affecting about 1 in 400 individuals of Northern European descent. Because HH is so common and easily treatable, it

potentially provides an excellent example for offering genetic testing on a large scale to identify people at risk for a disease and enabling them to avoid becoming ill. The major symptoms of HH--liver cirrhosis, heart deterioration, and other organ failures -- don't occur until mid-life, and left untreated, the disease causes early death. But treatment by simple blood letting to remove excess iron allows people with HH to live a normal lifespan.

Today, genetic tests are available primarily in academic medical centers for some 450 disorders, most of which are rare. Genetic tests can identify DNA alterations in people who have already developed a disease, in healthy persons who may be at risk of developing a genetic disorder later in life, or in people who are at risk of having a child with an inherited disorder. Over the next decade, genetic testing will become ever more commonplace throughout the health care system. For example, an NIH Consensus Development Panel recently recommended that genetic testing for cystic fibrosis mutations be offered to all couples planning a pregnancy or seeking prenatal testing. This is the first time that offering genetic testing has been recommended for such a large population group. Genetic technologies will soon play a role in nearly every field of health care.

Genetic tests can save health care dollars by identifying those in high-risk families who might benefit from close medical surveillance, and who might not. "Beth," for instance, is a 47-year-old mother of two. Two of her brothers and her father were diagnosed with colon cancer, and her grandmother died of uterine cancer. Of course, Beth was concerned that she too might develop cancer. About 10 years ago, she asked her doctor about her colon cancer risk, but Beth's family history pattern did not fit a known syndrome at the time. With no genetic test available for her condition, her doctor could only say that her risk of colon cancer was higher than average. Worried about her risk, and wanting to detect any cancers early, Beth began an annual program of expensive and uncomfortable colonoscopies.

Six years after Beth first inquired about her cancer risk, an experimental genetic test became available that could tell Beth if she inherited the genetic alteration that caused the cancer in her family. Beth took this simple test and learned she had not inherited the cancer-causing alteration. Immediately, Beth stopped the annual colonoscopies, saved thousands of dollars for both her and her insurance company, and brought an end to the unnecessary medical procedure. Perhaps most importantly, because she now knew that her risk for colon cancer was no greater than that of the general population, Beth gained peace of mind for herself and for her two children.

### **Progress in Health Research**

The Human Genome Project has given us the technology to decipher what were once an individual's most personal and intimate "family secrets," that is, the information contained in our DNA. The instructions encrypted in our genes affect nearly every function a human body carries out--in a moment, a day, or a lifetime. Research to understand those instructions offers the

promise of better health because it gives researchers and clinicians critical information to work out therapies or other strategies to prevent or treat a disease.

What if we could prevent or reduce the effects of many common diseases by simple changes in lifestyle or avoidance of specific environmental substances? Many of the diseases we face--such as high blood pressure and other familiar diseases of the heart and circulatory system, diabetes, obesity, cancer, psychiatric illness, asthma, arthritis--have been difficult to study and treat because almost all involve subtle actions of several genes and the environment. Scientists are rapidly developing advanced technologies to identify each of the genes that contribute to a complex disorder and study their interactions all at once. The goal is to tease apart which disease components are genetic and which are environmental.

The slowest part of a disease-gene hunt nowadays is sorting through all the genes in the target region on a chromosome and determining which one is responsible for the disease. But this is rapidly changing. New gene maps now pinpoint the locations of more than one-fourth of all human genes, and more are developed every day.

The complete set of genetic instructions will give researchers basic information about how a human cell works as a system, or how the cells of a brain or a heart work together, or how a single fertilized cell develops into a fully formed baby. Spelling out, letter by letter, the complete genetic instructions of a human being will bring with it new technologies that make identifying DNA differences effortless compared with what we can do today. Imagine analyzing your genetic composition on a computer chip, carrying your DNA "bar code" on a small plastic card, encrypted to protect privacy, that lets health care professionals instantly know your predisposition to disease, your reactions to drugs, or your susceptibility to certain environmental exposures. All of these will become realities as we continue to make advancements in genetics.

### **Genetic Discrimination: A New Twist on an Old Injustice**

The ability to examine our DNA for the presence of disease-related alterations opens the door to a new twist on an old injustice: "genetic" discrimination -- when people, either as groups or individuals, are treated unfairly because of the content of their DNA. The increased availability of genetic information raises concerns about who will have access to this potentially powerful information. Each of us has between 5 and 30 misspellings or alterations in our DNA; thus, we could all be targets for discrimination based on our genes. Like racism, sexism, and other forms of prejudice, genetic discrimination devalues diversity, squanders potential, and ignores achievement.

Genetic information has been used to discriminate against people in the past. In the early 1970's, some insurance companies denied coverage and some employers denied jobs to

African-Americans who were identified as carriers for sickle-cell anemia, even though they were healthy and would never develop the disease.

Of particular concern is the fear of losing or being denied health insurance because of a possible genetic predisposition to a particular disease<sup>1</sup>. For example, a woman who carries a genetic alteration associated with breast cancer, and who has close relatives with the disease, has an increased risk of developing breast and ovarian cancer. Knowledge of this genetic status can enable women in high-risk families, together with their health care providers, to better tailor surveillance and prevention strategies. However, because of a concern that she or her children may not be able to obtain or change health insurance coverage in the future, a woman currently in this situation may avoid or delay genetic testing.

These are real concerns for too many Americans. In a recent survey of people in families with genetic disorders, 22 percent indicated they, or a member of their family, had been refused health insurance on the basis of their genetic information<sup>2</sup>. The overwhelming majority of those surveyed felt that health insurers should not have access to genetic information. A 1995 Harris poll of the general public found a similar level of concern. Over 85 percent of those surveyed indicated they were very concerned or somewhat concerned that insurers or employers might have access to and use genetic information<sup>3</sup>.

Discrimination in health insurance, and the fear of potential discrimination, threaten both society's ability to use new genetic technologies to improve human health and the ability to conduct the very research we need to understand, treat, and prevent genetic disease.

To unravel the basis of complex disorders in the large numbers of individuals they affect, scientists must analyze the DNA of many hundreds of people for each disease they study. Valid research on complex disorders will require the participation of large numbers of volunteers. But a pall of mistrust hangs over research programs because study volunteers are concerned that their genetic information will not be kept confidential and will be used by insurers to discriminate against them. Information about research participant's genetic composition must be protected from misuse.

Participants in Dr. Barbara Weber's research program on breast cancer worry a great deal about genetic discrimination<sup>4</sup>. She and her coworkers in Pennsylvania are trying to understand how to keep women with breast cancer gene mutations healthy by studying them closely for several years. But nearly one-third of the high-risk people Dr. Weber invites into the study refuse because they fear discrimination and/or a loss of privacy. So strong is the fear of misuse of genetic information obtained in research programs that many physician-researchers leave genetic test results out of the study medical record or warn study participants not to give the information to their private physicians. In some instances, patients and/or their providers may be forced to tell outright lies about genetic test results.

In genetic testing studies at the NIH, nearly 32 percent of eligible people offered a test for breast cancer risk decline to take it. The overwhelming majority of those who refuse cite concerns about health insurance discrimination and loss of privacy as the reason.

In an ongoing study, researchers are assessing individuals who have already had cancer and their families. Because individuals who have had cancer have already been categorized as a high risk by insurers, participants in this study are somewhat less concerned about the potential for health insurance discrimination. The vast majority of individuals invited to have genetic testing as a part of the research project have agreed to be tested. Those who have opted not to be tested state that knowledge of how this information might be used was a determining factor.

### **The Need for Legislation**

In 1995, the National Action Plan on Breast Cancer (NAPBC, coordinated by the US Public Health Service Office on Women's Health) and the NIH-DOE Working Group on Ethical, Legal and Social Implications of Human Genome Research (ELSI Working Group) tackled the issue of genetic discrimination and health insurance. This effort built on the ELSI Working Group's long standing interest in the privacy and fair use of genetic information and the NAPBC's mandate to address priority issues related to breast cancer. The following recommendations<sup>5</sup> were published and made available to state and federal policy makers:

- ▶ Insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment or contribution requirements.
- ▶ Insurance providers should be prohibited from establishing differential rates or premium payments based on genetic information, or an individual's request for genetic services.
- ▶ Insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.
- ▶ Insurance providers and other holders of genetic information should be prohibited from releasing genetic information without prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure would be made.

In developing these recommendations, the NAPBC and ELSI Working Group developed the following definitions: "Genetic information" refers to information about genes, gene products or inherited characteristics that may derive from the individual or a family member.

The term "insurance provider" refers to an insurance company, employer, or any other entity providing a plan of health insurance or health benefits including group and individual health plans whether fully insured or self-funded.

These recommendations would prevent insurers from having *access* to genetic information, from being able to *misuse* this information, and from *disclosing* it to others.

### State Initiatives

Today, 19 states have enacted laws to restrict the use of genetic information in health insurance. These range from very narrow prohibitions in earlier legislation (e.g., Alabama in 1982 prohibited insurers from denying coverage because an applicant had sickle cell anemia) to fairly comprehensive prohibitions with strong privacy protections in more recent legislation (e.g., Wisconsin in 1991, New Jersey in 1996, and California in 1994, 1995, and 1996)<sup>6</sup>. Since January of this year, at least 31 states have introduced legislation to prohibit genetic discrimination in insurance<sup>7</sup>. The large volume of legislative activity at the state level is a positive indication of the level of concern about this important issue.

A law passed in Arizona this year prohibits health and disability insurers from rejecting an application or determining rates, terms or conditions on the basis of a genetic condition and prohibits requiring the performance of a genetic test without written informed consent. Governor Symington signed the bill into law in spite of threats by the insurance industry to leave the state.

The Illinois Legislature passed the Genetic Information Privacy Act in May, 1997. The Act is currently pending approval by the governor. The Act prohibits insurers from seeking genetic information derived from genetic testing and from using genetic testing information for nontherapeutic purposes. This bill was originally introduced by Representative Moffitt at the request of an ovarian cancer survivor whose mother and grandmother had died of ovarian cancer. This constituent wanted to be tested for BRCA1 in order to help her daughters and granddaughters. Her doctor warned, however, that if she tested positive, she and members of her family could lose health care coverage. Based on that threat, she chose not to be tested. (She has since been tested anonymously and tested negative.)

### Why State Law Is Not Enough

The current patchwork of state legislative approaches does not provide a comprehensive solution to genetic discrimination in health insurance.

First, private sector employer-sponsored health plans that provide benefits for employees and their dependents through self-funded arrangements are generally exempt from state insurance laws pursuant to the Employee Retirement Income Security Act (ERISA) preemption. Thus, even if states enacted legislation modeled on the NAPBC-ELSI Working Group recommendations, approximately 125 million people, nearly one-half of all Americans, covered by such self-funded plans would not be protected.

Second, with the exception of a few states, these laws focus narrowly on genetic tests rather than more broadly on genetic information generated by family history, physical examination, or the medical record. Although insurers are prohibited from using the results of a chemical test of DNA, or the protein product of a gene, they may still use other physical/physiological (phenotype) indicators, pattern of inheritance of genetic characteristics, or even a request for genetic testing as the basis for discrimination. Thus, meaningful protection against genetic discrimination requires that insurers be prohibited from using all information about genes, gene products, or inherited characteristics to deny or limit health insurance coverage.

### **HIPAA: Significant Steps But Serious Gaps**

In 1996, Congress enacted a law, called The Health Insurance Portability and Accountability Act (HIPAA), which took a significant step toward expanding access to health insurance. But HIPAA doesn't go far enough. Americans are still largely unprotected by federal law against insurance rate hikes based on genetic information and against unauthorized people or institutions having access to the genetic information contained in their medical records. HIPAA includes genetic information among the factors that may not be used to deny or limit insurance coverage for members of a group plan. Further, HIPAA explicitly excludes genetic information from being considered a preexisting condition in the absence of a diagnosis of the condition related to such information. The law specifically uses the broad, inclusive definition of genetic information recommended by the NAPBC-ELSI Working Group. Finally, HIPAA prohibits insurers from charging one individual a higher premium than any other "similarly situated" individual in the group.

These steps towards preventing discrimination based on genetics are significant, but HIPAA left several serious gaps that can now be closed by Administration-supported legislation. First, the protections in HIPAA do not extend to the individual health insurance market. Thus, individuals seeking coverage outside of the group market may still be denied access to coverage and may be charged exorbitant premiums based on genetic information. While only approximately 5 percent of Americans obtain health insurance outside the group market today, many of us will, at some point in our lifetime, purchase individual health insurance coverage. Because genetic information persists for a lifetime and may be transmitted through generations, people who are now in group plans are concerned about whether information about their genes

may, at some point later in their life, disallow them from being able to purchase health insurance outside of the group market.

Second, while HIPAA prohibits insurers from treating individuals within a group differently from one another, it leaves open the possibility that all individuals within a group could be charged a higher premium based on the genetic information of one or more members of the group.

Finally, HIPAA does nothing to limit an insurer's access to or release of genetic information. No federal law prohibits an insurer from demanding access to genetic information contained in medical records or family history or requiring that an individual submit to a genetic test. In fact, an insurer can demand that an individual undergo genetic testing as a condition of coverage. Further, there are no restrictions on an insurer's release of genetic information to others. For example, at present, an insurer may release genetic information, and other health-related information, to the Medical Information Bureau which makes information available to other insurers who can then use it to discriminate. Because genetic information is personal, powerful, and potentially predictive, it can be used to stigmatize and discriminate against people. Genetic information must be private.

### Congressional Initiatives

Congressional interest in securing health insurance protection for genetic information is strong and bipartisan. Senator Hatfield and Representative Stearns introduced the first bill on genetic discrimination in health insurance and employment in November 1995. Twelve bills addressing genetic information access and/or use were introduced in the 104th Congress. Many of these bills are being reintroduced in the current Congress.

Representative Solomon (R-NY) introduced H.R. 328, Genetic Information Health Insurance Nondiscrimination Act of 1996. This bill was rewritten to close the "loopholes" in HIPAA by addressing discrimination in the individual health insurance market, but it does not prohibit rate increases in the group health insurance market.

Genetic Confidentiality and Nondiscrimination Act of 1997 (S. 422) introduced by Senator Domenici (R-NM) is a broad bill that seeks to address privacy and fair use of genetic information in many settings. The bill includes a title that would prohibit health insurers from using genetic information that follows the NAPBC-ELSI Working Group recommendations. However, this bill refers only to "any molecular genetic information about a healthy individual or a healthy family member..." rather than the broader definition of genetic information that includes family history.

The Genetic Information Nondiscrimination in Health Insurance Act of 1997 (H.R. 306) introduced by Representative Slaughter (D-NY) most closely tracks the recommendations made

by the NAPBC-ELSI Working Group. This bill successfully closes the "loopholes" in HIPAA by prohibiting rate increases in the group health insurance market based on genetic information, prohibiting the use of genetic information in the individual health insurance market, and placing restrictions on the collection and disclosure of genetic information by insurers. As of July 1, 1997, H.R. 306 had 132 co-sponsors and 67 supporting groups. The Senate companion bill, The Genetic Information Nondiscrimination in Health Insurance Act of 1997 (S. 89), was introduced by Senator Snowe (R-ME).

### **Recommendations for Federal Legislation**

On May 18, 1997, President Clinton, in his commencement address at Morgan State University, urged "Congress to pass bipartisan legislation to prohibit insurance companies from using genetic information to determine the premium rate or eligibility of Americans for health insurance."

The Administration is proposing that Congress pass a law to ensure that the discoveries made possible by the Human Genome Project are used to improve the health of Americans and not used by health insurers to discriminate against individuals, families, or groups. The Administration recommends that the law build on the effort begun under HIPAA and encompass the NAPBC-ELSI Working Group's recommendations that seek to prevent health insurers from having access to genetic information, from being able to misuse this information, and from disclosing genetic information to others.

The bill should build on HIPAA and extend protection to insurance applicants and participants in four ways. It should --

- Explicitly prohibit health insurers from varying the rate charged to a group based on genetic information pertaining to one or more group members. This would expand the prohibition in HIPAA against using genetic information to vary the premium rates of an individual in a group plan.
- Prohibit insurers in the individual market from requesting or requiring genetic information from an individual, except where the information relates to a disease or condition for which the individual or dependent has been positively diagnosed, and prohibiting insurers from requiring individuals to undergo genetic testing.
- Prohibit insurers in the individual market from using genetic information in the absence of a diagnosis of disease to deny, limit or vary coverage or to set rates.
- Protect the privacy and confidentiality of genetic information by prohibiting insurers from releasing this information for nontreatment purposes without the prior authorization of the individual. This would impose restrictions on the disclosure of genetic information

to other insurers, to plan sponsors, and to other entities regulated by State insurance laws including life, disability, and long-term care insurers. It would also prohibit insurers from releasing genetic information to the Medical Information Bureau or any other entity that collects, compiles, or disseminates insurance information.

HIPAA does acknowledge that protections concerning access to and release of health information, including genetic information, were not provided in the law itself and directs the Department of Health and Human Services (DHHS) to develop recommendations to protect the privacy of health information. Currently, DHHS is preparing recommendations on privacy protections for all individually identifiable health information, including genetic information, as required by HIPAA. Congress may in the future enact legislation that would provide protections for personally identifiable health information in general. However, the public feels especially concerned about the unique properties of genetic information -- its predictive nature, its fundamental linkage to personal identity and kinship ties, its history of abuse, and the speed of development of genetic technologies. Therefore, it is important to move forward with legislation prohibiting health insurance discrimination and restricting health insurers' use and dissemination of genetic information.

### Conclusion

The technology of genetic testing offers great promise for better health. However, genetic tests and genetic information can also be used to deny coverage or increase premiums. The Administration strongly supports efforts to protect individuals from misuse of genetic information by health insurers, while permitting providers and others who can positively use such information to continue to use genetic information in ways that will enhance the treatment and care of individuals.

We now have the opportunity to ensure that our social policy keeps pace with the scientific advances made possible through biomedical research. The American people and the Congress support protections against genetic discrimination in health insurance. Supporting the principles put forth by the NAPBC-ELSI Working Group could ensure that increasing knowledge about ourselves and our genetic heritage is used to benefit Americans, to improve their health and well-being, and not to stigmatize or discriminate against them. This is an issue that ultimately will concern all of us. The universal principles of fairness and justice compel an urgent solution to this growing problem.

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7/17/97



Assistant Secretary for Health  
Office of Public Health and Science  
Washington D.C. 20201

MEMORANDUM FOR THE PRESIDENT

I respectfully submit for your consideration a proposed Executive Order to prohibit smoking in federal executive branch facilities.

Strong scientific evidence documents that exposure to environmental tobacco smoke (ETS) is a serious risk to health. ETS is a known cause of diseases, including lung cancer, in healthy nonsmokers and is a major source of harmful indoor air pollution. ETS is responsible for approximately 3,000 lung cancer deaths each year in nonsmoking adults. ETS also threatens the health of hundreds of thousands of children with asthma and other respiratory illnesses.

Major scientific reports of the Department of Health and Human Services (HHS 1986, 1991, 1996, 1997) and the Environmental Protection Agency (EPA 1993) document these findings. HHS, EPA, and most recently the Department of Labor (DOL), recommend that smoking either be prohibited indoors, or be permitted indoors only in separately-ventilated areas. Protecting nonsmokers from the health consequences of ETS exposure is the primary goal of restrictions on smoking in the workplace.

Our Administration has supported and advocated eliminating indoor exposure to ETS. The most far-reaching effort is DOL's proposed occupational standard to eliminate ETS exposure in virtually all workplaces nationwide. During the 103rd Congress the Administration also supported legislation (H.R. 3434) to prohibit ETS exposure in public buildings and on March 31, 1994 you signed P.L. 103-227, the "Goals 2000: Educate America Act" which prohibited smoking in federally-funded children's services facilities, including most elementary and secondary schools.

Existing General Services Administration (GSA) regulations on this subject were published seven years before the EPA report. The GSA regulations apply to approximately 10 percent of federal domestic facilities and do not cover those federal buildings which are under the control of federal departments and agencies with statutory real property authority. The 1986 GSA rules permit smoking in areas designated by agency heads and do not require that such areas be ventilated separately.

Mr. President, the simple separation of smokers and nonsmokers within the same airspace does not eliminate ETS exposure. As a result, many federal agencies are not now smokefree and federal workers and visitors to federal buildings are exposed unnecessarily to ETS. In view of

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the solid science base and the Administration's public commitment to reducing ETS exposure, it seems inadvisable to continue to permit smoking in federal indoor workplaces.

The Executive Branch has legal authority and strong scientific justification to move ahead to prohibit smoking in federal workplaces. The most expedient mechanism to announce and implement an Executive Branch smoke-free workplace policy would be a Presidential Executive Order. An Executive Order would apply more broadly and could be implemented more quickly than other approaches.

The issuance of an Executive Order would produce substantial savings rather than costs. The federal Government would be promoting the health of its employees while saving money due to reduced sick days, building maintenance, and furniture and carpet replacement. Some studies estimate conservatively that smoking in the workplace costs employers one thousand dollars annually for each employee who smokes. As the nation's largest employer, the issuance of an Executive Order to protect worker health would set an important example to other employers considering adopting smokefree policies.

A proposed Executive Order is attached for your consideration.



Donna E. Shalala

Attachment

## SMOKING IN THE FEDERAL WORKPLACE

Employees of the Federal Government and members of the public visiting or using federal facilities should be protected from exposure to environmental tobacco smoke. The health risks of smoking and exposure to smoke are clearly documented by reports of the Department of Health and Human Services and of the Environmental Protection Agency (EPA). In 1986, the U.S. Surgeon General concluded that exposure to environmental tobacco smoke (ETS) was a cause of lung cancer in otherwise healthy nonsmokers. In 1993, the U.S. Environmental Protection Agency confirmed this finding and categorized ETS as a Group A carcinogen, meaning that it was a known cancer-causing agent in humans. Since these reports, numerous studies have linked ETS exposure to various illnesses including asthma and heart disease. In fact, two recent studies found that exposure to secondhand smoke increases the risk of death from heart disease. The number of nonsmokers who die from exposure to ETS has been estimated to be as high as 56,000 each year. The evidence indicates that smoking is a preventable cause of diseases; exposure to environmental tobacco smoke is a cause of diseases, including lung cancer, in exposed persons, including healthy nonsmokers; and the simple separation of smokers and nonsmokers within the same air space does not eliminate the exposure of nonsmokers to environmental tobacco smoke.

Accordingly, by the authority vested in me as President by the Constitution and laws of the United States of America, it is hereby ordered as follows:

**Section 1. Policy.** It is the policy of the Executive Branch to establish a smoke-free environment for federal employees and members of the public visiting or using federal facilities. The smoking of tobacco products is thus prohibited in all interior space owned, rented or leased by the Executive Branch of the federal government, except as otherwise provided in this order.

**Section 2. Exceptions.** The general policy established by this order is subject to the following exceptions.

- (a) The order does not apply in designated smoking areas which are enclosed and exhausted directly to the outside and away from air intake ducts, and are maintained under negative pressure (with respect to surrounding spaces) sufficient to contain tobacco smoke within the designated area. Employers shall not require workers to enter such areas during business hours while smoking is ongoing.
- (b) The order does not extend to outdoor areas under Executive Branch control except within 50 feet of the entrance of federal buildings, within 50 feet of air intake ducts or within courtyards.
- (c) The order does not extend to any enclosed residential accommodation for persons voluntarily or involuntarily residing, on a temporary or long-term basis, in a building owned, leased, or rented by the federal government.

- (d) The order does not extend to federally-owned buildings leased, rented, or otherwise provided in their entirety to nonfederal parties.
- (e) The order does not extend to places of employment in the private sector or in other nonfederal governmental units that serve as the permanent or intermittent duty station of one or more federal employees.
- (f) The head of any agency may establish limited and narrow exceptions which are essential to accomplish agency missions. Such exception shall be in writing, approved by the agency head and to the fullest extent possible provide protection of nonsmokers from exposure environmental tobacco smoke. Authority to approve such exceptions may not be delegated.

**Section 3. Responsibility for Implementation of Order.** The heads of agencies of the Executive Branch are responsible for implementing and ensuring compliance with the provisions of this order. "Agency" as used in this order means an Executive Agency, as defined in 5 U.S.C. 101, and any employing unit or authority of the Federal Government, other than those of the Legislative and Judicial Branches.

**Section 4. Phase-In of Implementation of Order.** Implementation of the policy set forth in this order shall be achieved no later than one year after issuance of this order. This one year phase-in is designed to establish a fixed but reasonable time for implementing this policy. Agency heads are directed during this period to inform all employees and visitors to Executive Branch facilities about the requirements of this order and the health risks of exposure to environmental tobacco smoke, and to undertake related activities as necessary. All heads of agencies should consult with employee representatives about the implementation of this order.

**Section 5. Consistency with Other Law.** The provisions of this order shall be implemented consistent with applicable law, including the Federal Service Labor-Management Relations Statute, 5 U.S.C. 7101 *et seq.*, the National Labor Relations Act 29 U.S.C. 151 *et seq.* Nothing herein shall be construed to impair or alter the powers and duties of federal agencies established under law. Nothing herein shall be construed to replace any agency policy currently in effect, if such policy is legally established, in writing, and consistent with the terms of this Executive Order. Agencies are required to review their current policy to confirm that agency policy comports with this Executive Order. Agency policies found not in compliance shall be revised to comply with the terms of this Executive Order.

**Section 6. Cause of Action.** Nothing in this order shall be construed to create a new cause of action against the United States, or to affect in any way the liability of the Executive Branch under the Federal Tort Claims Act.

**Section 7. Construction.** Nothing in this order shall limit an agency head from establishing more protective policies for employees and members of the public visiting or using federal facilities.

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L/C



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

AUG 19 1997

## MEMORANDUM FOR THE PRESIDENT

I know you are concerned, as I am, about recent reports suggesting widespread fraud and abuse among home health agencies participating in the Medicare program. This memorandum provides information on those reports and outlines the steps we have taken and are taking to combat fraud and abuse in home health care. It also outlines further actions we are considering.

As you know, home health care, available to any homebound beneficiary who requires skilled care, is the fastest growing expense in the Medicare program. This rapid expansion began in 1989, when, as the result of a lawsuit, changes in Medicare regulations expanded eligibility and eliminated the cap on the number of visits. To some extent, the rapid growth in home health utilization and spending is also a natural result of the successful implementation of the inpatient hospital prospective payment system, which has dramatically reduced the length of hospital stays for Medicare beneficiaries. In 1996, more than 10 percent of Medicare beneficiaries received home services, at a total cost of \$18 billion. The number of home health agencies has also grown exponentially, and about 9,000 home health agencies currently serve Medicare beneficiaries. The rate of growth in the number of home health providers has slowed significantly in the past year, however, as the screening process has improved.

The recent reports outlining widespread fraud among home health agencies are one indication of the Administration's success in targeting waste, fraud and abuse in Medicare. As you know, your Administration has focused unprecedented attention and new resources on this effort since 1993. The result is a series of investigations, indictments and convictions, as well as new management tools to help us better manage Medicare.

In particular, Operation Restore Trust (ORT) has been a ground-breaking project aimed at coordinating federal, state, local, and private resources and targeting them on areas most plagued by abuse. During its two-year, five-state demonstration phase, the project returned \$23 for every \$1 of project costs; identified more than \$187.5 million in fines, recoveries, settlements, audit disallowances and civil monetary penalties owed to the Federal Government; and achieved 74 criminal convictions, 58 civil actions, and 218 provider exclusions. One thing ORT does is train state surveyors who review home

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health agencies to look for care being provided that is not covered by the Medicare program. ORT has now been expanded to 12 states.

Your decision to use trust fund monies to launch broader investigations by the HHS Inspector General, the FBI and the Department of Justice has allowed us to increase fraud convictions by 240 percent since 1993. These reviews and investigations have given new impetus to structural changes we have proposed in Medicare, many of which were approved in the Balanced Budget Act.

### Background on HHS Office of the Inspector General Reports

There are two OIG reports on home health care, which were released concurrently on July 28. Both reports involved Operation Restore Trust (ORT) states: California, Texas, Illinois, New York, and Florida. As you will recall, we selected these states for the original ORT demonstration in 1995 because they represent a significant portion of Medicare beneficiaries and payments (about 35 percent of both). In fact, I specifically asked the OIG to focus its review on home health agencies in these states because we expected that home health was particularly subject to abuse.

The first OIG report focused on a random sample of 250 home health claims in four of the five ORT states (California, Texas, Illinois, and New York). It was designed to be a diagnostic tool that would gauge general patterns and the scope of the problem; it was not designed to be a complete audit of individual agencies with immediate follow-up actions. The OIG estimated that up to 40 percent of services billed either: (a) were not reasonable and medically necessary, (b) did not have valid physician orders, (c) lacked supporting documentation, or (d) did not involve beneficiaries who met the definition of "homebound"—a prerequisite for coverage. (It is worth noting that HCFA loses about half of the cases in which we challenge medical necessity.)

To correct these problems, the OIG recommended that the reimbursement system for the home health benefit be restructured. Specifically, the OIG recommended:

- instituting a prospective payment system so that agencies would no longer have an incentive to inflate volume and intensity of services;
- setting limitations on the number of reimbursable visits;
- requiring preauthorization of payment;
- requiring beneficiary copayments;

- emphasizing the definition of "homebound" in the Medicare guidelines and include additional guidance on certain standards;
- requiring intermediaries to notify beneficiaries of claims made on their behalf;
- requiring intermediaries to enhance medical review by augmenting it with physician and beneficiary interviews; and
- requiring physicians to examine patients before ordering home health services.

In the second report, the OIG reviewed files provided by HCFA and its intermediaries on close to seven hundred "problem providers" in the five ORT states. For purposes of the review, OIG defined "problem provider" as one that exhibited one or more specific characteristics, including reporting inappropriate costs, submitting claims for services that were not medically necessary or not rendered, failing to file cost reports or filing unauditible reports, or demonstrating significant certification deficiencies, or uncollected overpayments.

OIG analyzed the most common abuses identified in the "problem provider" files and made recommendations on steps that could be taken to address them. Specifically, the report concluded that limited resources hamper fiscal intermediaries' oversight efforts and recommended a number of legislative changes, including:

- eliminating periodic interim payments, a system whereby providers receive payments in advance of providing services;
- requiring surety bonds;
- requiring user fees to cover the cost of certification, comprehensive reviews and recertifications;
- creating a data bank of owners, principals, and related organizations;
- requiring Social Security and employer identification numbers as part of the application;
- enhancing certification requirements related to the relevant experience and financial status of home health agencies and their owners and principals; and
- eliminating home health agencies' ability to discharge Medicare debt through bankruptcy.

We note that many of the characteristics and practices identified by the OIG in these two reports are not inherently fraudulent. The "problem provider" report was never intended to be the basis of law enforcement actions against individual providers; rather, it was intended to provide insight into ways home health agencies are able to exploit the program and to provide suggestions to prevent abuse. The report did not contain sufficient evidence to take fraud sanction action against any of the 700 agencies.

### HCFAs' Response to Home Health Problems

For the past two years, we have been attacking fraud and abuse in home health, and in Medicare in general, with every available tool. In a real sense, the current attention is a result of our own success in this area—the recent indictments announced by the Department of Justice, and the OIG reports, would not have been possible were it not for the heightened focus and new resources this Administration has directed at Medicare fraud and abuse. Our successes also secured the additional resources we obtained in last year's Health Insurance Portability and Accountability Act (HIPAA).

### **Balanced Budget Act Provisions Implementing OIG Recommendations**

In 1997 the Administration proposed, and the Balanced Budget Act you signed included, the most significant recommendations made by the OIG. The BBA includes a number of provisions that will help control growth through appropriate payment, including:

- authority to establish a prospective payment system for home health services, to be implemented October 1, 1999. Moving to PPS will be a tremendous tool for stemming the flow of home health care dollars. Instead of open-ended billing, HCFA will set in advance what it will pay for a unit of service, how many visits will be included in that unit, and what mix of services will be provided. In short, providing questionable services will no longer be profitable;
- authority to bar felons from ever participating in Medicare again;
- separation of home health services into two distinct benefits under Medicare Part A and Medicare Part B;
- defining limits on hours and days that home health care can be provided;
- elimination of periodic interim payments that were made in advance to agencies and not justified until the end of the year (part of moving to prospective payment system);

- billing by location of service rather than location of the agency's headquarters. This will stop agencies from getting higher urban reimbursement when, in fact, the service occurred in a lower-cost rural setting;
- establishment of guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the established standard; and
- clarification of the definition of part-time or intermittent nursing care. This clarifies the scope of the Medicare benefit and will make it easier to identify inappropriate services.

In addition, several other key Administration proposals to fight fraud were enacted, including:

- new penalties for kickbacks. Providers who pay kickbacks to induce referrals would be subject to civil money penalties of \$50,000 per violation;
- authority to require health care providers applying to participate in Medicare and Medicaid to provide their Social Security numbers and their employer ID numbers so that the agency can screen out those who have committed fraud in the past;
- a clear definition of skilled services so that home health agencies can no longer pad their bills with unnecessary services when a patient simply needs blood drawn; and
- authority to deny payment to agencies that bill for far more services than other agencies do in similar situations. The authority goes beyond just home health providers and can be applied to any Medicare provider.

In fact, the only significant OIG recommendations that were *not* part of the Balanced Budget Act were:

- requiring beneficiary copayments;
- imposing a more stringent definition of "homebound" (although a study of the definition is required);
- requiring user fees;
- eliminating home health agencies' ability to discharge Medicare debt through bankruptcy; and

- refusing to enter into a provider agreement with any home health agency that is not financially sound, owes money to the Federal Government, or has filed for bankruptcy.

You are well aware of the advantages and disadvantages of requiring beneficiary copayments. While this might well dampen utilization and reduce spending, we are concerned that the beneficiaries who use home health care—many of whom are poor, frail, and elderly—would bear the brunt of this approach. The Administration did propose a provision to impose a more stringent definition of “homebound,” but groups representing disabled beneficiaries protested this as discriminatory and the Congress (including key Democrats in the House) was unwilling to move forward on it. With respect to user fees, the Administration proposed user fees to cover the cost of certifications of home health agencies in your FY 1998 budget, but the Congress has shown no interest in enacting them. I will be recommending that you re-propose user fees in your FY 1999 budget. We would also recommend that the proposal in the FY 1998 budget to eliminate the ability of home health agencies to discharge their Medicare debts through bankruptcy be submitted to Congress again in the FY 1999 budget. Finally, with respect to the OIG’s last recommendation, we agree that we should refuse to enter into provider agreements with home health agencies whose owners and principals do not live up to certain financial standards, and we are examining appropriate ways to do this.

### **New Rules to Tighten Requirements**

In addition, on March 5, 1997, we announced two new proposed rules resulting from a comprehensive three-year evaluation of Medicare’s home health benefit. One rule would revise the “Conditions of Participation” that all home health agencies must meet in order to participate in the Medicare program. The rules we proposed would take several steps to protect beneficiaries and improve quality. These include:

- requiring that home health agencies conduct criminal background checks of home health aides as a condition of employment;

- expanding the current home health aide qualifications to include nurse aides who have completed appropriate nurse aide training or competency evaluation requirements;

- requiring home health agencies to discuss with patients the expected outcomes of care so that patients can be more involved in planning their own care; and

- requiring home health agencies to coordinate all care prescribed by physicians for their patients. Under current rules, several agencies can serve one patient without the coordination that is needed to assure quality.

A second proposed regulation would require home health agencies to use a standardized system called OASIS—the Outcomes and Assessment Information Set—to monitor patients' conditions and satisfaction. Under OASIS, home health agencies must perform a standardized assessment of new patients within 48 hours to determine immediate care and support needs. Home health agencies are then required to update this initial assessment continuously until a patient is discharged to reflect changes in the patient's condition and to measure patient and family satisfaction. Agencies must also evaluate the results of OASIS assessments and apply this information to agency practices as part of their continuous quality improvement programs. This standardized measurement system helps both inspectors and agencies identify opportunities to improve performance and patient satisfaction. The regulations are in various stages of the clearance and comment process, and we are committed to implementing final rules at the earliest possible date.

#### **Enforcement Actions Against "Problem Providers"**

As previously noted, the "problem providers" reviewed by the OIG were identified by HCFA and its intermediaries. During the past two years, HCFA has taken action to deal with many of the providers that were identified as "problem providers" in the OIG review. Of these 698 home health agencies, HCFA has:

- terminated 67;
- referred an additional 75 providers to law enforcement; and
- collected overpayments from 437 entities.

In addition, one was convicted as an individual, and four others as members of a convicted national company.

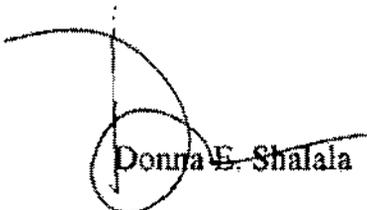
Therefore, of the 698 providers implicated in the OIG report, HCFA has already dealt with a substantial number of them. HCFA continues to scrutinize carefully all of the remaining identified providers to determine appropriate action, but OIG reviews thus far have indicated that a substantial number of these agencies may not be doing anything fraudulent. The OIG confirmed that this is consistent with its expectations and that the "problem provider" report was never intended to be the basis of a law enforcement initiative against any of these providers.

### **Additional Actions Under Consideration**

I have directed HCFA to present me with recommendations, in the next month, for additional actions we can take to combat home health fraud and abuse. Among possible actions, HCFA is considering promulgating additional requirements to promote financial stability, foster experienced and competent management, ensure a business history that is free of fraud, and ensure adequate review of patients by physicians certifying them for eligibility. HCFA is also intensifying its review of home health payments to providers and will suspend payments where there is reliable evidence of fraud and abuse. (We should note that suspension sometimes is not pursued because it would jeopardize other law enforcement activities.) Finally, HCFA is considering directing additional FY 1998 program integrity resources toward home health agency audits to ensure that we are finding the fraud and abuse quickly and dealing with it expeditiously.

### **Conclusion**

The first round of the Administration's comprehensive strategy to fight waste, fraud and abuse in Medicare is already reaping dividends, but much more remains to be done. With new statutory authority under the Balanced Budget Act, coupled with new resources we are receiving under HIPAA, we are in a better position to target fraud in home health care and other areas. It is incumbent upon us to use these new authorities and resources aggressively to eliminate the types of problems identified in the OIG reports. As described above, we already have acted, or are in the process of acting against many of these problem agencies, but we need to accelerate our progress. While we are aggressively pursuing structural reforms to help us target fraud, we must continue to press for legislative changes that Congress has not yet agreed to. The ongoing evaluation of our efforts to date will help us further refine and target our resources for future requests. We will be recommending to you as part of our fiscal year 1999 budget submission the second round of anti-fraud proposals (Operation Restore Trust II). In combination, they represent the most comprehensive and rigorous effort in the history of the program.



Donna E. Shalala



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

OCT 1 1997

MEMORANDUM FOR THE PRESIDENT

As you have so eloquently taught the nation, the tragedy of domestic violence touches all our lives. It touches our children, our senior citizens, our workers, our parents. It affects our hospitals, our schools, our businesses and our courts. It knows no boundaries of income, geography, age or race. Most important, domestic violence is not someone else's problem. We all have a role to play to prevent this devastating national problem and ensure that all our families are safe.

In observance of October as Domestic Violence Awareness Month, I am pleased to report to you the critical work that the Department of Health and Human Services is doing to address the violence which so deeply undermines the health and stability of our families and our nation. Teaming up with our partners, we have worked to create a seamless system that will prevent domestic violence, stop its perpetrators, and help victims get out of abusive situations.

We are proud of our accomplishments. Under the leadership of a Departmental steering committee on violence against women, HHS has focused on implementing two major laws: (a) the HHS-targeted provisions of the Violence Against Women Act of 1994 and (b) the domestic violence provisions of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Since family and intimate violence is a public health issue, we have also focused on the serious health consequences for women and their children.

- o We established the National Domestic Violence Hotline, a 24 hour toll free hotline that has received more than 118,000 calls since it was launched in February 1996;
- o We have enabled all states to establish education and prevention initiatives to reduce sexual assaults against women;
- o We have supported the training and education of health care and social services professionals and have developed and strengthened curricula that are used to prepare professionals who will come in contact with battered women;
- o We have established the National Resource Center on Domestic Violence and three special issue resource centers addressing health, child protection and custody, and the law. We have also funded a resource center to serve Native American tribes and a National Center on Elder Abuse;
- o We have studied school-based prevention curricula for youth and will make recommendations to Congress about models for use in primary, middle and secondary schools;

*Prepared by CNS/Siebenaler*

*10/6/1997/oo*

- o We have increased funding for shelters and related activities for battered women and their children by 53 percent;
- o We funded six community-based coordinated response and projects in FY 1996, and ten primary prevention projects in FY 1997;
- o In response to the President's directive to the Secretary and the Attorney General to assist states in implementing the family violence provisions in PRWORA, we have developed guidance for states, funded new research, and provided technical assistance on ways to address family and intimate violence effectively for victims seeking child support and work opportunities;
- o The Department, under the leadership of its Employee Assistance Program, recently incorporated and distributed a special section on domestic violence with its workplace violence guidelines, and sponsored a Workplace Violence Education Fair in Washington D.C.; and
- o Finally, the Department will shortly launch an Internet web site to provide a focal point for information about federal efforts, and has addressed the limitations of current data by stimulating on-going data collection, research, and evaluation to strengthen our knowledge and understanding of the best ways to prevent and treat family and intimate violence.

But the tragedy of domestic violence is still pervasive and the consequences too profound for us to rest on these accomplishments alone. We must build on them. We must improve the ways we as a society prevent violence and assist battered women and their children in moving from violence to safety. That's why the Department of Health and Human Services is redoubling its efforts in FY 1998.

Working with other Federal Departments, especially the Department of Justice, with the Advisory Council on Violence Against Women, with states and communities, the private sector and families themselves, we will focus on five key areas in the next year:

- I. Strengthening the health care system's ability to screen, treat, and prevent family and intimate violence;
- II. Increasing the ability of battered women, including those on welfare, to obtain and retain employment and access child support;
- III. Encouraging greater linkages between the child welfare, family and intimate violence, and criminal justice fields to protect better both children and parents in homes where violence occurs;

- IV. Enhancing community prevention and response systems by increasing collaboration between HHS and DOJ state and community-based grantees and other community-based groups; and
- V. Increasing the knowledge base about family and intimate violence, through data collection and research.

Domestic Violence Awareness Month offers an excellent opportunity for you to continue to demonstrate the extraordinary leadership you have shown on this issue. The significance of the month provides a chance for you to give attention to the Administration's accomplishments and the future goals we must meet with our partners in government, non-profits, and the private sector.

Thank you for your continued leadership on behalf of the nation's abused women and their families.

A handwritten signature in black ink, appearing to read "Donna", with a long horizontal flourish extending to the right.

Donna E. Shalala

Enclosure

## Addressing Domestic Violence: An Agenda for the Department of Health and Human Services for FY 1998

### Introduction

*"I call on American men and women in families to give greater respect to one another. We must end the deadly scourge of domestic violence in our country."*

*-- President Clinton, State of the Union address, 1996*

The tragedy of domestic violence touches all our lives. It touches our children, our senior citizens, our workers, our parents. It affects our hospitals, our schools, our businesses and our courts. It knows no boundaries of income, geography, age or race. Most important, domestic violence is not someone else's problem. We all have a role to play to prevent this devastating national problem and ensure that all our families are safe.

The Department of Health and Human Services has taken important steps to address the family and intimate violence which so deeply undermines the health and stability of our families and our nation. Teaming up with our partners, we have worked to create a seamless system that will prevent domestic violence, stop its perpetrators, help victims get out of abusive situations and keep all families and children from falling through the cracks. Our past accomplishments and our goals for the future are grounded in several fundamental principles:

- Prevention is key. Attitudes must change to discourage people from acting violently. We must insist upon zero tolerance for violence in families and between partners.
- Every woman should have access to information and emergency assistance wherever and whenever she needs it.
- Battered women who seek self-sufficiency may need assistance. Both child support and employment can be important means by which battered women support themselves and their children and achieve safety.
- Safety for family members must be the first priority; enabling the victim of abuse to pursue a plan of safety for herself and her children must be a key priority.
- Our strategies must address perpetrators as well as victims of abuse. We must find ways to help batterers stop violent behavior and become good partners and parents.
- Preventing family and intimate violence requires the active involvement of all sectors of society, both public and private, at the federal, state, and community levels. Community-based coordinated approaches supported by local resources and commitments are essential.
- Preventive interventions and services must be culturally and linguistically appropriate.
- Program evaluation is critical. We must continue to evaluate prevention and service interventions to

determine their effectiveness, and share the results of these evaluations to improve policy and practice.

We are proud of our accomplishments (Attachment A). Under the leadership of a Departmental steering committee on violence against women, HHS has focused on implementing two major laws: (a) the HHS-targeted provisions of the Violence Against Women Act of 1994 and (b) the domestic violence provisions of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Since family and intimate violence is a public health issue, we have also focused on the serious health consequences for women and their children.

- o We established the National Domestic Violence Hotline, a 24 hour toll free hotline that has received more than 118,000 calls since the President launched it in February 1996;
- o We have enabled all states to establish education and prevention initiatives to reduce sexual assaults against women;
- o We have supported the training and education of health care and social services professionals and have developed and strengthened curricula that are used to prepare professionals who will come in contact with battered women;
- o We have established the National Resource Center on Domestic Violence and three special issue resource centers addressing health, child protection and custody, and the law. We have also funded a resource center to serve Native American tribes and a National Center on Elder Abuse;
- o We have studied school-based prevention curricula for youth and will make recommendations to Congress about models for use in primary, middle and secondary schools;
- o We have increased funding for shelters and related activities for battered women and their children by 53 percent;
- o We funded six community-based coordinated response and prevention projects in FY 1996, and ten primary prevention projects in FY 1997;
- o In response to the President's directive to the Secretary and the Attorney General to assist states in implementing the family violence provisions in PRWORA, we have developed guidance to states, funded new research, and provided technical assistance to states on ways to address family and intimate violence effectively for women seeking child support and work opportunities;
- o The Department, under the leadership of its Employee Assistance Program, recently incorporated and distributed a special section on domestic violence with its workplace violence guidelines, and sponsored a Workplace Violence Education Fair in Washington D.C.; and

- o Finally, the Department has stimulated on-going data collection, research, and evaluation to strengthen our knowledge and understanding of the best ways to prevent and treat family and intimate violence; and will shortly launch an Internet web site to provide a focal point for information about federal efforts.

But the tragedy of domestic violence is still pervasive and the consequences too profound for us to rest on these accomplishments alone. We must build on them. We must improve the ways we as a society prevent violence and assist battered women and their children in moving from violence to safety. That's why the Department of Health and Human Services is redoubling its efforts in FY 1998.

We have been working with other Federal Departments, especially the Department of Justice, with the Advisory Council on Violence Against Women under the leadership of the Secretary and the Attorney General, with states and communities, the private sector and families themselves. Our partners include some of the major professional associations, such as the American Medical Association and the American Bar Association, which have given considerable leadership to addressing the needs of victims of abuse.

We will focus on five key areas in the next year:

- I. Strengthening the health care system's ability to screen, treat, and prevent family and intimate violence;
- II. Increasing the ability of battered women, including those on welfare, to obtain and retain employment and access child support;
- III. Encouraging greater linkages between the child welfare, family and intimate violence, and criminal justice fields to protect better both children and parents in homes where violence occurs;
- IV. Enhancing community prevention and response systems by increasing collaboration between HHS and DOJ state and community-based grantees and other community-based groups; and
- V. Increasing the knowledge base about family and intimate violence, through data collection and research.

#### **The Departmental Agenda**

- I. **Strengthening the health care system's ability to screen, treat, and prevent family and intimate violence.**

Evidence suggests that family and intimate violence is a major risk factor in a wide range of physical and mental health problems.<sup>1</sup> Although not often the presenting problem, a significant

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<sup>1</sup> In this paper, we sometimes use the familiar term "domestic violence." We more frequently refer to "family and intimate violence," in which we include "partner violence," "spouse abuse," "dating violence," "sexual assault," "elder abuse," children in violent homes, and much of what is known as "violence against women."

percentage of emergency room visits by women result from partner violence. Violence is also a contributing factor in some cases of depression, traumatic stress disorder, substance abuse, pregnancy, AIDS and other sexually transmitted diseases, leading to a wide range of physical symptoms. Preventing partner violence could reduce markedly the occurrence of health problems faced by women and the substantial costs associated with treating them.

The health care field has made progress in assisting battered women. The Joint Commission for Accreditation of Hospitals and Health Organizations has made screening for family and intimate violence and elder abuse one criterion in accreditation. Many schools of medicine, nursing and other health professions have included family and intimate violence content in curricula. Some emergency rooms of hospitals and other health facilities have begun programs for screening and assisting battered women and victims of elder abuse. Health professional societies have programs to educate their members about the problem and to provide information about approaches for addressing it.

However, there is still a long way to go. Screening for family and intimate violence by health care providers is still not the norm. When screening is conducted and a problem is identified by the victim, staff often do not know what to do with the information or are reluctant to get involved. Administrators as well as direct services staff need to be trained so providers can institute appropriate policies. Providers also need to know what to do when the issue of violence or managing anger is identified as a problem by an abuser. Professional schools, when they do teach about family and intimate violence, offer limited information and little practical experience in addressing the problem. Few schools provide training on the issue. Few managed care organizations screen for family and intimate violence as a regular part of their patient care. Even fewer provide services to victims of family and domestic violence.

**Next steps:**

We plan to address these issues in two ways. (A) We will work with professional associations and schools to encourage greater attention to family and intimate violence in health care education. (B) We will reach out to accrediting bodies and other quality assurance entities, professional associations, health care providers, and family and intimate violence experts to encourage the adoption or improvement of family and intimate violence and elder abuse standards of accreditation in the full range of health settings.

**A. Enhance the education of physicians, nurses, dentists, and other health professionals to prepare them to identify and respond to family and intimate violence.**

Through our collaborative relationships with academic institutions and associations of the various health disciplines, we will explore ways to enhance the information and experiences students receive about family and intimate violence. We will further the views of the Secretary and the Attorney General expressed in a letter to medical schools recommending the inclusion of violence against women content in their curricula. In addition, we are supporting a collaboration of national nursing organizations in the development of a nursing strategy to address violence against women. Next year, we will develop training and practice protocols for use with professionals who work in community health centers, often the first source of help in low-

income neighborhoods throughout the country.

We know that classroom information is just one aspect of preparation for addressing real world issues. We will encourage schools and training programs to include practical experiences in which students can learn how to identify and helpfully respond to family and intimate violence. Many professional associations have addressed this issue in conferences, continuing education, and journals and by guidance to their members. Through a partnership with these groups and the family and intimate violence community, we will seek to improve the ability of health professionals, who are often the first line of contact with battered women and their children, and sometimes with their partners, to be more effective in helping them.

As we encourage the adoption of curricula and training programs, we need to be mindful of the need to evaluate them. It is through research that we can learn which approaches are effective in improving services to victims of abuse and their families.

**B. Encourage the adoption of specific family and intimate violence standards into recognized protocols for the accreditation of health care providers.**

HHS has begun and will continue to seek the adoption of family and intimate violence-specific standards by organizations that monitor health care practice in various settings. The growth of managed care organizations, with their emphasis on preventive health care, provides an opportunity to reach a large segment of the population. In this regard, the Office of Women's Health initiated a discussion with the National Council for Quality Assurance, the voluntary accreditation and standard setting body for managed care organizations. We have also begun, and will continue, to consult with professional associations, family and intimate violence experts, and the health care industry. We are exploring how feasible the adoption of family and intimate violence standards might be. Adoption of such standards would require consensus building around specific proposals. Family and intimate violence is unlike other health issues for which there are standards in place because many of its dimensions are social rather than disease-based. This year, we will attempt to move this agenda forward and to build support for specific family and intimate violence standards.

**II. Increasing the ability of battered women, including those on welfare, to obtain and retain employment and access child support.**

Being in, or having been in, an abusive relationship can create special difficulties for a woman who seeks to find or retain employment or to pursue child support. For some, partners may exert excessive control and physical abuse that undermines work efforts. For others, pursuing child support may be dangerous and require extra safety precautions. Yet despite these difficulties, many battered women want and need child support and salaries so they and their children can live in safety.

Child support assistance is available to all parents who need it. Federal child support enforcement responsibilities are not limited to welfare recipients. Child support enforcement agencies need to be aware that some custodial parents seeking services voluntarily may be at risk of harm from their child's non-custodial parent. Community-based organizations, such as community action agencies, which may have familiarity with peripheral family members and

community resources, may also be of assistance in providing services to custodial parents.

Although domestic violence plagues families at all income levels, the passage of PRWORA has created new and stronger demands on welfare recipients to work and cooperate in identifying and finding the father of their child for child support purposes. In line with the law the President signed, states now are applying rigorous work requirements and are establishing life-time limits on the number of months a recipient and her family can receive federal benefits.

The interaction between family and intimate violence and the need for welfare varies greatly depending on individual circumstances. One approach is not appropriate to all battered recipients. It is our goal to encourage states to provide a full range of appropriate services necessary to support the ability of battered women to seek and obtain employment, and pursue child support. We will also encourage states not only to recognize the serious effects of domestic violence, but to develop policies that protect battered women and their children from further risk of harm. What is needed are policies and practices that distinguish among battered women those who are able to work or pursue child support from those who suffer serious trauma, are currently being undermined in work efforts by the batterer, or face danger. We need to add to the mix of community resources available to battered women the efforts of community-based organizations which have job creation, job development and the accompanying support systems as their major objectives.

In October, 1996, President Clinton strongly encouraged states to implement the optional Family Violence Provisions of the temporary assistance section of PRWORA. Recognizing the unique needs and circumstances of battered women, he directed HHS and DOJ to provide guidance to states in their efforts to implement these provisions by consulting states, family and intimate violence experts, victims' services programs, law enforcement, medical professionals, and others. Also, he directed us to provide states with technical assistance and to study the scope of the problem.

In response to the President's directive, HHS and DOJ have engaged in extensive consultations with state representatives and experts. We have held many meetings with state officials about effective approaches. We have been implementing a technical assistance strategy that draws on the best thinking of state officials and experts, including information from "Fighting Domestic Violence on the Frontline," a demonstration project in Anne Arundel County, Maryland, funded by the Administration for Children and Families. Guidance about federal administration of the family violence provisions under the new welfare program will be forthcoming in proposed regulations in the next few months.

Although not conclusive, research documenting the prevalence of family and intimate violence, including partner abuse, among welfare recipients is becoming more extensive. Studies show that a significant number of welfare recipients have experienced some abuse in the previous year; for some, the abuse is current and severe. We are learning, too, from anecdotal evidence the ways that abuse can undermine a woman's ability to work or keep her job. For some, the pursuit of greater independence, through employment and child support, can be very dangerous for themselves and their children. However, for others, work and child support payments are ways to extract themselves from abusive situations. The Department will be funding a new resource center on welfare and developmental disabilities which also may increase our

understanding of the connections between welfare, developmental disabilities, and domestic violence.

Recently, Congress, in the Balanced Budget Act of 1997, directed the General Accounting Office to conduct and submit to Congress, within one year, a study of the effect of family violence on the use of public assistance programs, and, in particular, the extent to which family violence prolongs or increases the need for public assistance. We will cooperate with the GAO as they conduct this study.

**Next steps:**

Our strategy has three components. (A) With partners who have ties to businesses that hire low income women, we will encourage employers to adopt policies and practices that are supportive of abused women and aid them in retaining their jobs. (B) We are increasing what we know about family and intimate violence, welfare, and child support through research and demonstrations. (C) We will continue to assist states by sharing effective state practices and the advice of experts.

**A. Encourage employers to adopt family and intimate violence sensitive policies and practices that facilitate the retention in jobs of employees, including former welfare recipients, who had been victims of abuse.**

Abused women who work may be subjected to dangerous and inhibiting actions by their partners or former partners. Women may be harassed on the job with frequent phone calls, visited by their abusers, have their bosses harassed, and may need to take time off because of abuse. Employers that understand this phenomenon and wish to be supportive should adopt workplace violence prevention policies and practices in their business that help battered women become safe and retain their jobs despite difficult experiences. Some employers of larger firms have provided services and make referrals to family and intimate violence experts to assist women in these circumstances. The goal is to encourage more employers to do the same.

As battered welfare recipients move into employment, their chances of staying on the job and remaining self-sufficient will be enhanced considerably if their employers understand how to be supportive. To this end, we have had several discussions with organizations that have links to employers of potential welfare recipients. We will continue to explore with them strategies for providing employers with useful information and seeking their collaboration. We will work with other groups, such as the Welfare to Work Partnership and the Family Violence Prevention Fund's Workplace Violence campaign, to assist business leaders in addressing issues of family and intimate violence.

**B. Increase our knowledge about effective approaches to assisting battered recipients in achieving safety, moving from welfare to work, and obtaining child support.**

The Department will conduct several research and demonstration projects in the coming year that will expand our knowledge about effective approaches to assisting battered recipients of welfare and/or child support. These projects will provide useful information about child support enforcement and welfare to work policies and procedures being tried in states. The

Administration for Children and Families (ACF) is funding several demonstration projects to test procedures for dealing with problems some battered women may encounter when child support cooperation feels dangerous to them. We seek to learn how to pursue child support safely when family and intimate violence exists. ACF also is funding several grants to enhance collaboration between service family and intimate violence service providers and state or local welfare programs and a project to assess the effectiveness of welfare-to-work strategies for abused recipients. The Office of the Assistant Secretary for Planning and Evaluation is conducting an early assessment of the implementation of state welfare policy and practices regarding family and intimate violence.

In addition, Departmental staff are part of a widening network of researchers who have been studying the links between family and intimate violence, welfare and poverty. HHS' Joint Center for Poverty Research at Northwestern/ University of Chicago co-sponsored a September meeting at which new findings were presented and suggestions for future research discussed.

**C. Work with states and their welfare agencies to expand the use of appropriate methods of identifying, assessing, and assisting battered welfare recipients and their children.**

Addressing family and intimate violence in welfare caseloads is complex, given the varied needs of abused women and their children as they attempt to move from welfare to work. Identification and screening needs to be done in ways that encourage women to volunteer information while maintaining their dignity and confidentiality. Decisions have to be made based on careful assessments of recipients needs for safety, past trauma, abusive situations, and work histories. Welfare agencies have to develop ways of working with these recipients that are new to them, working in collaboration with family and intimate violence experts in communities. Also, state child support and welfare to work programs have to develop responses to domestic violence that are coordinated and consistent.

HHS is engaged in a technical assistance process of developing materials that we expect will address these complex issues in thoughtful and practical ways. The Department will conduct workshops and conferences with state officials and domestic violence experts to address issues of domestic violence and welfare, and assist in the development and dissemination of papers that inform public policy. We will continue to collaborate with states to provide materials that help states and localities institute practices that are effective for battered women. For example, ACF is working with the State of Maryland to expand the Anne Arundel County Department of Social Services domestic violence awareness training statewide.

**III. Encouraging greater linkages between the child welfare, family and intimate violence, and criminal justice fields to protect better both children and parents in homes where violence occurs.**

Children in families that experience domestic violence are particularly vulnerable, either as witnesses to the violence or in some cases as victims themselves. We will maintain a strong focus on protecting and assisting these children.

HHS will build on a variety of activities that we have undertaken over the past few years to link

child protective services and child welfare services with services to address family and intimate violence. A good deal of work has been done so far. We have funded the joint training of family and intimate violence practitioners with state or county child welfare staff. We have also funded six schools of social work to develop curricula on training social workers on family and intimate violence. The Department has studied current practice and has published a research report on the experiences of selected programs that are working at building this linkage. NIH is now funding a grant to study an intervention which seeks to reduce the risk for child maltreatment in families whose mothers are departing from battered women's shelters. We fund several national resource centers, one whose charge is child protection and custody, located at the National Council of Juvenile and Family Court Judges, that provides technical assistance on these issues. In addition, staff of the Department have been speaking at many meetings and conferences highlighting the issues and encouraging states and domestic violence programs to build domestic violence/child welfare collaborations.

We are entering the next stage in the development of collaborative efforts between child protection and family and intimate violence. The first phase focused mainly on training of staff and raising consciousness. It has been important to educate child protection workers and domestic violence staff to ways that their clientele overlap. Now, there is a need to address some difficult policy issues that have been identified through research and practice. The issues grow out of the sometimes different yet equally appropriate values of each field: child protection services and providers of services to victims of domestic violence. There are no easy answers to these issues but we can assist in helping to bring together people who are doing the best thinking and work and to prepare guidance materials that reflect their views.

Here are several key issues facing the field:

- **Balancing the safety of children while enabling battered mothers to find the approach to safety that works for them** - Tension exists between the values of the child welfare/child protective services (CPS) system and the domestic violence system. On one hand, society, through CPS must protect children from harm. On the other hand, domestic violence experts know that in order for a woman to move toward safety, she must have time to work out a safety plan for herself and her children, including a safe living arrangement. CPS and domestic violence experts need to work together to achieve a balance in helping her find a path to safety while acting to protect children when necessary.
- **Child Welfare's role in police interventions** - Some jurisdictions require the police, when they answer a family and intimate violence call and find children in the home, to involve automatically child protective services. Domestic violence experts are concerned that this will discourage battered women from seeking police protection out of fear that their children will immediately be placed in foster care. Approaches are needed in which the danger to children is assessed while not undermining the willingness of battered women to seek help.
- **A second victimization of battered women in the CW system** - When children are abused by a parent's partner (i.e. not her spouse) who is also abusing her, child protective services (CPS) agencies often cite the woman for "failure to protect" her

children, a category of neglect. They do so because they have little authority to sanction the partner. The challenge, however, is to avoid a double victimization of the parent, by the partner and by the system.

- **Assisting children who witness violence** - New dialogues are occurring about the role of the child protective services agency in intervening on behalf of children who are not abused but live in homes in which violence occurs. Often such children suffer consequences similar to those from direct abuse.

**Next steps:**

Over the next year, working with our partners in the Department of Justice and experts in the field, we plan to convene several meetings to explore these and other major issues in depth. We will encourage the development of consensus guidance for child welfare agencies on policy issues and will facilitate the dissemination of these materials as widely as possible. We will also work with experts on family violence about the need for protocols and interventions for those who work with children of violent homes. We will call attention through various forums, meetings and conferences to the work that still needs to be done and encourage those who have responsibility for dealing with family violence in its many forms to take concrete steps in policy and practice to meet the continuing need.

**IV. Enhancing community prevention and response systems by increasing collaboration between HHS and DOJ state and community-based grantees and other community-based groups.**

Since the enactment of VAWA, HHS and DOJ have worked together to support greater coordination among HHS and DOJ programs and grantees at the State and community level. DOJ has been a partner in the development of the community-based grants that were authorized by the VAWA. Likewise, CDC, ACF, and other HHS agencies have helped in the development of DOJ-funded STOP Violence Against Women formula grants to states. Through these efforts, we have informed both HHS and DOJ grantees about the programs and resources of each Department and encouraged state and local grantees to work together in addressing family and intimate violence.

In addition to fostering coordinated community responses, HHS and DOJ have a number of additional overlapping interests. One area is the effects of family violence on children. In the discussion about child welfare above, we mention the issue of how law enforcement and child welfare agencies could work together to protect the battered woman and her children. We are both also concerned about the availability of effective health and mental health services for such children. Another area of mutual concern is the problem for the health system in identifying battered women when there are laws in place or being considered that mandate the reporting of family and intimate violence to law enforcement. These laws have serious consequences for how health programs can operate and assist battered women.

In addition, the National Institutes of Health (NIH), the Administration for Children, Youth and Families (ACYF), the Centers for Disease Control (CDC), and DOJ's National Institute of Justice (NIJ) are jointly funding a study of the effectiveness of court orders, a legal intervention

to prevent future contact between women and their abusive partners, as a means of reducing subsequent violence and injury. Another jointly funded research project examines intimate partner homicide, by using police records to identify substance abuse and other risk factors.

**Next steps:**

HHS and DOJ are exploring ways to increase technical assistance to our respective grantees about each others areas of responsibility. For example, we will assist in preparing materials for DOJ STOP grantees about health and child welfare issues and encourage community based women's advocacy and justice agencies to enhance their collaboration with HHS-oriented systems. In return we will develop guidance for HHS family and intimate violence grantees about better ways to collaborate with state and local STOP grantees. HHS and DOJ will also work together to ensure that technical assistance and information about family and intimate violence are made available to other programs and services delivered at the community level. We will pay particular attention to communities of ethnic minorities, hard to service populations, and immigrants. We will make the same information available to DOJ/HHS tribal grantees as well.

HHS, through the Family Violence Prevention and Services Act, funds American Indian tribes to address family and intimate violence. In FY 1997, ACF funded a new national resource center to assist tribes. We will collaborate closely with DOJ in assuring that the resource center reflects the priorities and serves the tribal grantees (who are often the same) of both Departments.

In addition, we will utilize the materials developed by SAMHSA to strengthen the link between substance abuse and family violence services providers in order to prevent further violence by treating perpetrators and victims.

**V. Increasing the knowledge base about family and intimate violence, through data collection and research.**

Information about the scope of violence among intimates has come from a few sources, e.g., surveys whose purpose is to learn about crime or violent behavior. One of the most significant is the on-going National Crime Victimization Survey, conducted by the Department of Justice, that asks women and men about whether they have been victims of a crime, including that by an intimate partner. Another has been the National Family Violence Surveys, conducted in 1975 and 1986. The findings from the latest survey, designed to collect information directly on family violence, will shortly be published by the Center for Policy Research in Denver. This survey was funded by both DOJ and HHS.

National surveys and longitudinal data sets whose purpose is mainly information on violence are limited in the extent to which one can correlate findings with other factors of interest. While one can obtain from these sources information about the scope of the problem, one may not be able to learn about important interactions, such as how violent behavior is related to welfare receipt, how victims of violence utilize health services, or whether the violent partner is related to the children in the household. There is a need for national surveys that collect information on other subjects to include items on violence between partners.

There are several time, methodological, ethical, and cost challenges in accomplishing this goal. Adding new questions to existing surveys adds interview time. Different methods for collecting information have different benefits. Questions arise about reporting requirements. Research costs money. However, these types of issues have been faced before and we can make progress.

**Next steps:**

Evidence about family and intimate violence can be confusing and misleading. Definitions of the phenomenon vary. Consistent data over time are not available. Methodologies need to be improved. Findings are presented without reference to the context of the research from which they come, leading to inappropriate conclusions. Consequently, we must use data cautiously and carefully, reflecting the complex experiences of abused families and the limitations of the research we have to describe them.

We can do better. The Department is currently engaged in a process of trying to develop consensus definitions. We will seek better and more valid approaches to collecting information. Because the rewards for collecting information about family and intimate violence as part of national randomized household surveys would be great, we will explore the feasibility of doing so. We will draw on the expertise of the CDC and the Bureau of Justice Statistics at DOJ.

We plan to initiate discussions with the Census Bureau about the Survey of Program Dynamics for which a late stage is now being planned. We will also explore the feasibility of including violence information in other ongoing longitudinal surveys such as the Survey of Income and Program Participation (SIPP) which would enable us to track individual's experiences over time. Also, we will explore the feasibility of collecting violence information in national health surveys.

HHS is funding a number of studies to increase our understanding of both the scope of family and intimate violence as well as the effectiveness of selected program interventions. In terms of the scope of the problem, for example, NIH is funding studies of the violence, psychological symptoms, health problems, and childhood behavior problems of women and children in high crime, multi-ethnic neighborhoods; and another of the problem of abuse among female care givers in both Anglo-American and Mexican-American families. An exploratory study by ASPE will conduct new secondary analyses of data on the issue of teen dating violence, hold focus group discussions and review legal issues. Another study, funded by the National Institute of Child Health and Development (NICHD), will examine factors which predict relationship violence among inner-city youth.

Studies of program interventions include an NIH-funded evaluation of a cognitive intervention program designed to reduce violence among boys who have shown signs of using violence with their families or intimate partners, and an evaluation of a community-based program administered by nurses which focuses on abuse of female caregivers.

As other new issues are identified, we will explore opportunities for studying them.

**Attachment A**

**Preventing Violence Against Women  
Major Accomplishments of the Department of Health and Human Services**

## PREVENTING VIOLENCE AGAINST WOMEN

### MAJOR ACCOMPLISHMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

*"I call on American men and women in families to give greater respect to one another. We must end the deadly scourge of domestic violence in our country."*

*-- President Clinton, State of the Union address, 1996*

#### **Major Initiatives**

***National Domestic Violence Hotline.*** The hotline has received more than 118,000 calls from all 50 states, the District of Columbia, Puerto Rico and the US Virgin Islands, since it was established in the Violence Against Women Act and launched by President Clinton on February 21, 1996. The vast majority of these calls are from individuals who have never before reached out for assistance. To support the tremendous response to this service, the hotline received \$1.2 million in funding for FY 1997 -- an \$800,000 increase over its original 1997 authorization. A 24-hour, toll-free service, the hotline provides crisis assistance and local shelter referrals for callers across the country. Also in effect is an evaluation of the domestic violence hotline which will tell us how well the hotline is functioning, how well the public is being served, if staff and resources are adequate for tasks involved, and how well information is reaching the intended audiences.

***Executive Action on Domestic Violence and Welfare Reform.*** On October 3, 1996, President Clinton urged all states to implement the Family Violence provisions included in the welfare bill he signed on August 22, 1996. To help welfare recipients who are victims of domestic violence move successfully into work, the provisions give states the option to screen welfare recipients for domestic abuse; refer them to counseling and supportive services; and temporarily waive any program requirements that would prevent recipients from escaping violence or would unfairly penalize them. The President also directed the Department of Health and Human Services to assist states in implementing the provisions. HHS is readying proposed regulations that address domestic violence provisions of the law, has awarded a contract to the National Resource Center on Domestic Violence to provide technical assistance, and is funding research to learn about best practices.

***The Advisory Council on Violence Against Women.*** The Advisory Council on Violence Against Women was created on July 13, 1995. Co-chaired by Attorney General Janet Reno and Secretary of Health and Human Services Donna Shalala, the Council consists of 47 experts -- representatives from law enforcement, media, business, sports, health and social services, and victim advocacy -- working together to prevent violence against women.

***The Violence Against Women Act (VAWA).*** VAWA passed as part of the Crime Act of 1994. It

is landmark bipartisan legislation -- combining tough new penalties with programs to prosecute offenders and help women victims of violence. VAWA is authorized to provide \$1.6 billion over five years to hire more prosecutors and improve domestic violence training among prosecutors, police officers, and health and social services professionals. It provides for more shelters, counseling services, and research into effective public education campaigns. In addition, VAWA sets new federal penalties for those who cross state lines to continue abuse of a spouse or partner. VAWA makes it unlawful for any person who is subject to a restraining order to possess ammunition or a firearm. It also requires states to honor protective orders issued in other states and gives victims the right to mandatory restitution and the right to address the court at the time of sentencing.

Within the Department of Health and Human Services, the following programs were authorized under VAWA.

- o Grants for Battered Women's Shelters. In FY 1997, HHS awarded \$72.8 million to states, territories, tribes and others to expand the availability of shelter services to victims of family violence and their dependents and provide other prevention assistance efforts -- an increase of 53 percent over the \$47.6 million available in FY 1996. These resources will also support related services, such as community outreach and prevention, children's counseling, and linkage to child protection services.
- o Education and Prevention Grants to Reduce Sexual Assaults Against Women. This program provides grants to states for rape prevention and education programs conducted by rape crisis centers or similar nongovernmental, nonprofit entities. States receiving grants must devote at least 25 percent of their funds to education programs targeted to middle school, junior high school, or high school students. HHS funded \$35 million to all states and territories for education and prevention grants to reduce sexual assaults in FY 1997, an increase of 22 percent over its 1996 expenditure.
- o Coordinated Community Responses to Prevent Intimate Partner Violence. This program will help build new community programs, strengthen existing intervention and prevention programs, and evaluate the impact of comprehensive community programs. HHS awarded 10 grants in FY 1997 for primary prevention activities in communities.
- o Education and Prevention Services to Reduce Sexual Abuse Among Runaway, Homeless, and Street Youth. This \$8 million program provides street-based outreach and education to runaway, homeless, and street youth who have been subjected to or are at risk of sexual abuse. The FY 1997 funding was an increase of 42 percent over FY 1996.
- o Youth Education on Domestic Violence. HHS has studied school-based curricula for youth and will make recommendations to Congress about the models for use in primary, middle and secondary schools. Curricula has been examined closely by an expert panel to ensure the development and implementation of successful prevention programs for

educating youth on domestic violence.

*National Resource Centers Addressing Domestic Violence.* HHS funds four national resource centers on domestic violence: general issues, health, child protection and custody, and the law. A fifth resource center to serve Native American tribes has just been funded and will begin operation this year. HHS has also funded the National Center on Elder Abuse.

*Domestic Violence Victims Under the Immigration Law.* At the Administration's urging, Congress included a provision in the immigration bill that the President signed on September 30, 1996, to ensure that immigrant women and children who are victims of domestic violence are eligible for vital public health services and are not denied services or subjected to deportation due to changes in rules. In addition, the immigration law now makes battered immigrants eligible for cash assistance and Medicaid if the states exercise this option.

*Workplace Violence at HHS.* This year, Secretary Shalala announced the completion and distribution of workplace violence guidelines for employees of the Department of Health and Human Services with a special section addressing domestic violence. One goal of this effort is to create and support a work environment in which potentially violent situations in HHS are prevented and effectively addressed. Another goal is to increase employee understanding of the nature of workplace violence. In Washington, DC, HHS sponsored a Workplace Violence Education Fair.

#### Other Major Activities

- I. **Strengthening the health care system's ability to screen, treat, and prevent family and intimate violence.**

*Training of Health Professionals.* HHS has supported numerous activities in this area. For example: development of a framework for evaluating health care provider training programs; surveying all medical schools to determine the extent to which students are being prepared to deal effectively with issues of family and intimate violence; evaluating WomanKind, a hospital-based case management and advocacy program for victims of intimate partner violence, which also trains medical and hospital staff in the identification, referral, and treatment of these victims; development of professional training curricula for nurse-midwives; and an inventory of health care provider training materials to identify and treat victims of partner violence and sexual assault.

*Substance Abuse-Related Materials.* HHS has funded important projects to assist those working in the substance abuse field to address domestic violence. A treatment improvement protocol for providing substance abuse treatment to survivors of domestic violence as well as their perpetrators will be published shortly. HHS supported the development of a comprehensive curriculum and trained community teams on how to address violence against women.

*National Nursing Summit.* HHS is supporting a National Nursing Violence Against Women Strategy Initiative with participants from national nursing organizations to begin collaborations and the development of a national nursing strategy. The first National Nursing Summit on Violence Against Women will be held on October 27, 1997.

**II. Increasing the ability of battered women, including those on welfare, to obtain and retain employment and access child support.**

*Child Support Enforcement.* Demonstration grants were awarded to study issues of domestic violence, child support and welfare-to-work. Each grant will demonstrate approaches by which state and local agencies are addressing domestic violence. The results from these grants will provide additional data on the incidence of domestic violence among the child support/TANF recipients.

*Child Support Enforcement Forum and Report.* In February 1997, HHS convened a group of experts to discuss issues related to domestic violence and child support enforcement. The forum provided an opportunity to share ideas and to specify the technical assistance most needed. Results of this meeting have been widely disseminated. HHS is also working with the National Child Support Enforcement Association in holding a domestic violence conference in Austin, Texas, December 4-5, 1997 to train state child support and TANF staff on these issues.

*Collaboration Between Welfare Agencies and Domestic Violence Providers.* In FY 1997, HHS funded 12 grants to states and localities to enhance collaboration between domestic violence experts and welfare departments.

*Domestic Violence and TANF.* HHS funded a demonstration project in a local welfare agency to test out approaches to screening, case planning, and provision of services to victims of domestic violence so they can move safely from welfare to work.

*Technical Assistance to State Welfare and Child Support Administrators.* HHS is providing technical assistance to state welfare and child support administrators through the National Resource Center on Domestic Violence. Guidance on new approaches to working with battered women is being developed by teams of state officials and domestic violence experts. To help disseminate this information, each state has designated a child support and a welfare contact person for domestic violence issues.

*Persons with Disabilities.* In FY 1997, HHS established a National Technical Assistance Center on Welfare Reform and Disability. One focus of this Center will be to increase our understanding about linkages between welfare, disability, and domestic violence.

**III. Encouraging greater linkages between the child welfare, family and intimate violence, and criminal justice fields to protect better both children and parents in homes where violence occurs.**

*Collaboration Between Child Welfare Agencies and Domestic Violence Providers.* 26 grants have been funded over three years to local programs to stimulate collaboration between child welfare agencies and domestic violence providers. These projects primarily train child welfare staff to identify and respond appropriately to instances of domestic violence in their caseloads.

*Child Welfare Training Grants.* Five child welfare training grants to schools of social work to develop curricula and train social workers in family violence have been funded.

*Community-Based Primary Prevention Projects.* Several of the community-based primary prevention projects, which are described below, will engage in activities directed at youth. These projects seek to change attitudes and knowledge of youth about violence and will study how effective they are in preventing violence.

**IV. Enhancing community prevention and response systems by increasing collaboration between HHS and DOJ state and community-based grantees and other community-based groups.**

*Coordinated Community Response Projects.* These six three-year projects are designed to enhance and evaluate a coordinated community response to intimate partner violence. Three of these projects are being implemented in rural communities for developmental purposes, and the remaining three are being implemented in larger communities with existing intimate partner violence prevention coalitions for expansion purposes. All projects are working with HHS to develop core instruments to evaluate their programs as a multi-site coordinated effort.

*Community-Based Primary Prevention Projects.* A key focus of these 10 projects is on prevention strategies related to children who witness intimate partner violence in the home. Part of the funding has been available only to community-based organizations serving racial and ethnic minority populations in order to gain a greater understanding of prevention strategies within the context of individual cultures. These projects are funded for three years and evaluation results should be available by the spring of 2000.

*Older Women Victimized by Domestic Violence.* Six local and state domestic violence discretionary projects were completed that demonstrate a coordinated system of services and interdisciplinary professional training to meet the needs of older women (defined as women over fifty) victimized by domestic violence.

*Freedom From Fear Campaign.* Region III of HHS sponsored four Freedom From Fear regional conferences during FYs 96 and 97: one on elder abuse; one on violence against women; one on child abuse prevention; and one on family violence connections.

*Increased Public Awareness and Education.* Support was provided to local, state, and national family and intimate violence organizations for the national public awareness campaign *There's No Excuse for Domestic Violence*.

**V. Increasing the knowledge base about family and intimate violence, through data collection and research.**

*National Academy of Science Violence Against Women Research Study.* HHS and DOJ funded this study which continues to guide our research agenda aimed at understanding and controlling violence against women. The primary tasks of the study were to synthesize the relevant research literature and develop a framework for clarifying what is known about the nature and scope of violence against women, supplemented with lessons learned by field professionals and service providers, and finally to identify promising areas of future research. The conclusions of the panel were published by the National Research Council in a report to Congress entitled *Understanding Violence Against Women*.

*National Academy of Science Assessment of Family Violence Intervention.* HHS co-sponsored and supported a study on the characterization and assessment of family violence. This study is developing a synthesis of pertinent research and expert opinion regarding the strengths and limitations of existing program interventions in the area of family violence.

*Violence Against Women and Violence Within the Family.* \$6.7 million was awarded for 12 three-year research grants focusing on violence against women and violence within the family. The grants will encourage research on the abuse of children and elderly, partner violence, sexual violence, and perpetrators and victims of multiple episodes of family violence (e.g., abused children who witness parental domestic violence). Individual grants include the following: Children of Battered Women Project, Intervention for Domestic Abuse Among Latinos, Partner Violence in Native American Women Project, Intervention for Abuse of Aging Caregivers, The Effects of Community Violence on Women and Children, Prevention of Post-Rape Psychopathology in Women, and Treatment of Violent Adolescent Males From Abusive Homes.

*Violence Against Women Research Program of NIMH.* During the last 20 years, funding averaging \$6 million per year has been awarded for scientific research on violence against women as part of HHS' mental health research program. Early epidemiological studies provided strong evidence that family violence, especially child abuse and spouse abuse, were more common events in American families than society had believed. In addition, intervention research examines the effectiveness of treatment and prevention programs.

*National Survey of Intimate Partner Violence.* Through a joint grant by CDC and NIJ, the Center for Policy Research in Denver, Colorado has conducted a national survey of intimate partner violence and other violence against women. The survey has been completed and the initial reports on results will be coming out this year, including a report on stalking, prevalence, incidence, and medical needs of victims.



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OCT 10 1997

MEMORANDUM FOR THE PRESIDENT

The week of Thanksgiving has long been celebrated as a time for our Nation to give thanks for its numerous blessings, but also as a week to acknowledge the countless contributions made on a daily basis by our family caregivers, in particular on behalf of our older family members. This national acknowledgement has come through a traditionally-recognized week designated as "National Family Caregivers Week."

As our population continues to rapidly age, more older persons are suffering from chronic illnesses and could need assistance in dealing with potentially disabling conditions, including Alzheimer's disease. Moreover, individuals with lifelong disabilities are living longer and may require assistance in caring for themselves as they age. Caregivers often fill in to care for family members, sometimes at a moment's notice, when a family member becomes ill, has an accident or needs assistance. While caregiving has no gender bounds, women provide 80 percent of the informal care their families receive. Caregivers reduce the incidence of premature institutionalization and unnecessary hospitalization by maintaining their loved ones in the community and within their own familiar surroundings.

For many years, "National Family Caregivers Week" was a congressionally-designated week sent to the President for final approval and proclamation. The last time Congress made this particular designation was 1994. Last year, in 1996, you re-established this annual tradition by proclaiming the week of Thanksgiving 1996 as "National Family Caregivers Week" which was received with much praise and gratitude by thousands of caregivers across the United States and by those who make up the national aging network consisting of state and area agencies on aging, tribal organizations and service providers who work with seniors every day.

As a tribute to these remarkable individuals who give so much of themselves on behalf of their family members, I would like to once again request that you issue the enclosed proclamation honoring family caregivers during Thanksgiving Week, 1997. This simple, but meaningful gesture will show your continued concern, appreciation and leadership on behalf of families and family members.

Donna E. Shalala

Enclosure

Received by DON/Allen

10/14/1997 [signature]

# National Family Caregivers Week, 1997

*By the President of the United States of America*

## A Proclamation

At this time of national thanksgiving, we are grateful for the many blessings which have been bestowed on us as Americans. Among the most important of these blessings is the love and support of our family, friends, and neighbors. One of the most profound ways in which this love is expressed is through the caregiving support provided by over 22 million caregivers to the 5 million older family members and friends who need help to remain in their homes and communities. Caregivers of frail older persons and persons with disabilities embody the values of family and community life at its best. Their efforts greatly reduce the demands on formal systems of services, and enhance the quality of life of older persons. A growing number of elderly are remaining in their homes and communities thanks to the efforts of caregivers who provide some 80 percent of all the care and help they need.

Today, nearly one in four households is involved in caring for an older relative, friend, or neighbor, providing assistance from personal care and household help to transportation and finances. This is a three-fold increase in the number of families involved in caregiving from a decade ago. Caregivers give not only their time but their money as well, spending some \$2 billion a month from their own assets for groceries, medicine and other aid to elderly relatives.

Thirty percent of caregivers are caring for two or more elderly relatives or friends, 64 percent are employed, and 41 percent also care for children under the age of 18. The average caregiver is 46. Nevertheless, at least 20 percent of caregivers are the young-old caring for the old-old. Women represent 75 percent of caregivers, but husbands are, by far, the oldest caregivers, with 42 percent aged 75 and over.

While disability rates among older Americans are falling dramatically, and the reduction in disability is gaining momentum, the growing number of Americans 85 and older means that there will be a continuing and, indeed, growing need for the services and supports that help so many older Americans and their caregivers to continue to share their lives in the homes and communities where they want to be.

This is also a time to give thanks to the many older Americans who care for nearly 1.3 million children, including those who are disabled. Since 1993, there has been a 27 percent increase in the number of children being raised by their older relatives. Without their loving care, millions of children would be denied the opportunity to grow up in stable homes and communities. While American families have always pitched in to help when parents could not care for their children, we must recognize that grandparents and other relatives who take on parental roles face a range of challenges and they need and deserve our help as well as our heartfelt thanks.

NOW, THEREFORE I, WILLIAM J. CLINTON, President of the United States of America by virtue of the authority vested in me by the Constitution and laws of the United States, do hereby proclaim November 24 through November 30, 1996, as National Family Caregivers Week. I call upon Government officials, businesses, communities, educators, volunteers, and all the people of the United States to acknowledge the contributions of caregivers this week and throughout the year.

IN WITNESS WHEREOF, I have hereunto set my hand this \_\_\_\_\_, in the year of our Lord, nineteen hundred and ninety-seven, and of the Independence of the United States of America, the two-hundred and twenty-second.



OCT 10 1997

MEMORANDUM FOR ANNE MCGUIRE

Attached is a memorandum for the President, from Secretary Shalala transmitting a proposed Proclamation for National Family Caregivers Week 1997.

A handwritten signature in black ink, appearing to read "William V. Corr".

William V. Corr

Attachment

RECOMMENDATION

In order to once again demonstrate the Administration's continued support and commitment to those individuals who work selflessly on behalf of family members, and to continue the tradition of designating the week of Thanksgiving as "National Family Caregivers Week," I recommend that you approve the attached proclamation and request that the President issue this proclamation before the week of Thanksgiving 1997. If you agree, please sign the attached letter to the President and approve the attached proclamation.

DECISION

Approved letter   *D*   Disapproved letter \_\_\_\_\_ Date   OCT 10 1997  

Approved Proclamation \_\_\_\_\_ Disapproved Proclamation \_\_\_\_\_ Date \_\_\_\_\_

*Bill Benson*

William F. Benson

Attachment

Tab A - Letter to the President

Tab B - Draft Proclamation



OCT 20 1997

## MEMORANDUM FOR THE PRESIDENT

As the time approaches for the Medicare Commission to begin its deliberations, we must consider how to help frame the questions that the Commission will address. Although we will not set the Commission's agenda, we can help shape it through our public statements and through our work with the people and organizations who speak out about Medicare's future. I have outlined below the principles I believe should guide our thinking on Medicare reform and some of the questions I believe the Commission needs to consider actively.

Although the Balanced Budget Act sets forth areas for the Commission to study, the Act's directives do not provide a clear or rigorous focus for deliberations. I am concerned that unless we work actively to broaden the agenda for the debate, the public will focus only on financial estimates and years of potential solvency. We must help focus the debate on the fact that Medicare's future is as much about health care and retirement security as about financing. If we solve the system's financial problems, yet the program ceases to deliver meaningful, high-quality benefits or to protect beneficiaries against excessive health costs, we will have failed.

### Key Principles

I believe that the following principles should guide our thinking about Medicare reform:

1. **Medicare is inextricably linked with other retirement programs, the rest of the health care system, and the overall economy; planning about changes to the program should not occur in a vacuum.**

Medicare cannot be considered separately from other public policies. In the lives of workers and beneficiaries, income and health care are the key considerations as people plan for retirement. Thus, Social Security, private pensions, savings, and supplemental sources of insurance -- employers, individual plans, and Medicaid -- are all linked to the future of Medicare.

In addition, trends in the health care market will affect Medicare. For example, increases in health care costs -- driven by inflation, changing technology, and changing practice patterns -- have contributed to rising Medicare costs. Conversely, because Medicare pays for a quarter of all hospital expenditures and a fifth of all physician expenditures, changes in Medicare also affect the health care market. These interactions create both opportunities and hazards for Medicare reform.

The same dynamic exists in the larger economy. For example, savings, labor supply, and immigration policies affect the resources available to pay for Medicare. Part of the solution to

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"the Medicare problem" may lie in policy changes in these and other areas. Future changes that we make within Medicare may create problems in other programs.

- 2. Any long-term solution should be flexible enough to respond to substantial uncertainty about the program's future actuarial status. Long-term reform should be thought of as a series of measured changes with regular reassessment of the program's quality and financial status.**

When the Medicare trustees provide forecasts of the financial status of the Medicare program, they present a range of alternative estimates to accommodate this uncertainty. They show that the future status of the program is highly sensitive to small changes in financial assumptions. The uncertainty of our predictions grows as they reach farther into the future.

Because of this uncertainty, the "long-term" problems that we try to solve in 1999 may not exist by 2030, and other problems will have arisen. In 1965, we would not have imagined that more than 80 percent of workers with insurance would get it through some form of managed care. Thirty years from now, new diseases will emerge, and new treatments and technologies will evolve. A cure for a major disease such as Alzheimer's could transform the needs of the elderly. In addition, unforeseen changes to the economy -- in global markets, new forms of communication and transportation, changes in the work force, and immigration -- further limit our ability to forecast with precision future health care needs and our ability to pay for them.

We must commit to making lasting changes in the Medicare program. In this dynamic system, this can best be achieved through a series of measured changes made according to a consistent plan. This phased strategy will build over time into larger structural reform, while allowing for corrections along the way to respond to unforeseen changes in the system. This Commission is a critical first step in reform -- but we should not see it as the final step. We should institutionalize a process for ongoing assessment and reform.

- 3. The discussion must be as much about retirement security and the future health care needs of the elderly and disabled as it is about the budget.**

The upcoming process should not be a typical budget reconciliation debate, driven solely by financial issues. The Commission should move away from simply taking the actuaries' assumptions as given and focusing only on how to limit expenditures. Such a narrow approach would give the edge to those who are using Medicare's fiscal problems as a justification for radically changing the program's design and the government's role.

Despite the progress that we made this summer toward slowing growth in per capita costs with the provisions included in the Balanced Budget Act, per capita costs will continue to be an issue. However, the demographic trends that will drive program enrollment are independent of per capita costs -- and are much more significant. To shift the discussion, it could be helpful to

highlight this distinction between the level of cost increases that is due to rising per capita costs and the level of cost increases that is due to rising enrollment. The public is likely to be more willing to support higher revenues to cover more people than to cover higher costs per person.

The needs of this growing elderly and disabled population should be the real focus of the debate. As retirement systems change, Medicare must retain its ability to provide beneficiaries with financial security against health care costs. And Medicare will remain the primary way that our society will meet the changing health care needs of future elderly and disabled individuals, particularly those without substantial resources. Determining how Medicare can best meet those needs should be the primary task of the Commission.

### Key Policy Questions

The next section of this memorandum develops some issues that the Commission and the Administration must consider.

#### **Who should participate in Medicare?**

Historically, Medicare has been enormously successful in providing insurance protection to all persons over 65, without splintering the healthy from the sick or the low-income from the better off. Proposals to change eligibility rules could fundamentally change the universal nature of the program.

One proposal has been to raise the eligibility age to correspond with the increase in the eligibility age for Social Security. This could have two effects: leaving a pool of older, sicker beneficiaries enrolled in Medicare, and leaving more retirees, especially those with lower incomes, without coverage. The Commission should examine trends in the availability of health care for workers who retire before they are eligible for Medicare, the needs of the youngest Medicare eligibles, and the potential effects of raising the eligibility age. The Commission should also examine the possibility of allowing individuals to buy into the Medicare program before they reach the eligibility age.

Means-testing benefits -- excluding wealthy beneficiaries from the program or giving them fewer benefits -- would be a more significant change to Medicare's historical role. Medicare's universality and status as "the" health care program for the elderly have been the cornerstones of its success. While we can and should build additional progressivity into Medicare's financing, we must ensure that Medicare is available and attractive to elders of all incomes.

#### **What is the guarantee that Medicare represents to beneficiaries?**

Medicare guarantees access to a particular set of benefits, regardless of changes in health care costs. Critics have argued that Medicare's guarantee should shift toward a defined financial

contribution, which could limit Medicare's liabilities and increase beneficiaries' liabilities if health care costs increased.

An examination of the options along the continuum between a defined benefit package and a defined contribution is unavoidable. However, this exercise should acknowledge that changing Medicare's basic guarantee and reducing Medicare's contribution has the potential to shift billions of dollars of costs to employers, states, and beneficiaries. Perhaps more importantly, a defined contribution approach has a substantial potential to undercut the integrity of Medicare as one program and lead to a tiered structure in which the quality of care depends on a beneficiary's financial status.

#### **What benefits will Medicare offer?**

The Commission should examine both the level and the mix of benefits that Medicare offers. Compared with many private plans, the fee-for-service Medicare benefit package is not generous. Cost sharing is relatively high, and certain benefits widely available to the under-65 insured population (such as prescription drugs) are not provided. In some parts of the country, beneficiaries enrolled in HMOs receive benefits more comparable to what the working insured receive. Other beneficiaries obtain these benefits through supplemental coverage. The relationship between Medicare and these other sources of coverage -- managed care, employers, individual plans, and Medicaid -- should be addressed.

Medicare's benefit package should also be reexamined in the context of changes in health care delivery. When Medicare started, our entire health care system was organized primarily around providing care in hospitals. Over the last decade, delivery has shifted out of the hospitals and into other settings, like doctors' offices and patients' homes. As the population ages and retirees change, the mix of services that Medicare beneficiaries need may change even more. Medicare's role in financing long-term care may also become a more pressing issue.

Beyond the benefits enjoyed by individual beneficiaries, Medicare also finances public goods like medical education, research, and care for the uninsured through disproportionate share facilities. Other financing structures may be necessary to sustain these programs and to more properly account for them as health care system costs rather than Medicare benefit expenses.

#### **How will Medicare's costs be financed?**

Current sources of financing for Medicare include payroll taxes, beneficiary premiums and out of pocket payments, federal budget support for Part B, and Medicaid for low income beneficiaries. The Commission should address what share of Medicare costs each of these sources should bear.

One factor to consider in examining the appropriate financing mix is the possibility of merging Part A and Part B. The extent to which Medicare relies on each funding source is in part driven

by separate funding sources for Hospital Insurance and Supplementary Medical Insurance. As patterns of care change, this split is becoming less and less relevant to the way that care is delivered.

A second issue in the distribution of responsibility for Medicare's costs will be the resources available from each source over time. For example, trends in beneficiary income and tax revenues may show shifting abilities to pay. The current period of sustained economic growth and stock market growth will affect financing options, public perceptions, and future approaches -- but the Commission should also consider what will happen if this growth slows or reverses.

We also need to remember that not all seniors are the same. The Commission should pay particular attention to vulnerable subgroups enrolled in Medicare. It should look at how changes affect different age groups, ethnicities, genders, and income levels. For example, in considering how Medicare's costs will be financed, we must also determine how to continue to protect beneficiaries with the lowest incomes. Conversely, if we build additional progressivity into the program's financing by income-relating the premium, we must be careful to ensure that Medicare remains the right choice for elders of all incomes.

#### **What are the trends in employer-based insurance and financial planning?**

Employment shifts to a service economy and to home-based work have changed the working population's access to insurance. Furthermore, employers have been reducing coverage of retiree health benefits. As the health benefits and retiree health benefits that workers receive change, the needs of Medicare beneficiaries and of workers who retire before they are eligible for Medicare may also change.

Changes are also taking place in Americans' retirement planning. The balance is changing among company pensions, the evolving 401(k) self-directed pensions/savings, traditional savings, housing, and Social Security. Medicare will have to be evaluated as part of this changing system of financial protection. The Commission should be doubly cautious about providing less protection to beneficiaries if their retirement income is also becoming less secure.

#### **How will different policy options interact and shift responsibilities from some to others?**

It is essential that the Commission not consider options individually but also in the context of other options, because of the possible interactions that may arise. For example, if the Commission changed the copayment and deductible structure of the program, this could interact with proposals to change the supplemental insurance system or with proposals to income-relate premiums. Consideration should be given not only to the merit of individual options but what a combined package would be.

Any set of solutions must acknowledge the full burden of health care spending for the elderly and disabled and what resources there are to meet these needs across society as a whole. Limiting Medicare's role will shift costs to other parts of the budget or to beneficiaries and employers. For example, if the Commission raised the age of eligibility, the health care needs of the ineligible population would not disappear. They would be paid for by employers, beneficiaries, and public safety net programs.

Other changes may redistribute the impacts among future vs. current beneficiaries, within the beneficiary population, or among public programs. Postponing reforms may favor current beneficiaries while forcing future beneficiaries to experience more significant changes, for example. Increasing premiums or cost-sharing will shift some of Medicare's burden to Medicaid and the states, in addition to beneficiaries.

#### **How will Medicare's management responsibilities change?**

We should continue to seek out ways to strengthen the integrity of the Medicare program so that each benefit dollar is being spent for needed care and services. Stopping fraud and abuse creates budget savings, but again, it is not only a budget issue. Vigorous oversight is also necessary to sustain public confidence in the program. We should continue to strengthen HCFA's authority and resources to detect fraud, and to prevent it before it occurs.

As we work to address payment issues for the program, we should learn from the successes of the private sector. We also have the opportunity, however, to use our resources to design systems that will also help the private sector. For example, when Medicare was successful in controlling hospital costs with its system of prospective payments for diagnostic related groups, private insurers were able to use the system to control their costs as well.

However, Medicare is no longer just a payer. It now has oversight over a complex and changing health care delivery system. This new emphasis on delivery expands the government's responsibility to ensuring high quality care and consumer protections, in addition to traditional financial oversight.

As we think about how the program will be organized to purchase benefits in the future, we should continue to ask what new responsibilities come with that organization. We should clarify the respective roles and responsibilities of government and the private sector in managing a system of plan choice. And we should ensure that Medicare's administrative resources are sufficient to fulfill these responsibilities.

#### **How shall the Commission educate the public?**

The debates over Medicare and Social Security will require a broad segment of the population -- pre-retirees, baby-boomers, and generation X-ers -- to engage in a broad public debate on the

options outlined by the Commission. Public education and dissemination of information should be one explicit task of the Commission. They should view regular interaction with Congress and other key policy-influencing groups, including the media, as a high priority. These interactions can be the means to shape the way the press, Congress and the public consider these issues.

A handwritten signature in black ink, appearing to read 'Donna E. Shalala', with a stylized flourish at the end.

Donna E. Shalala



NOV 18 1997

MEMORANDUM FOR THE PRESIDENT AND THE FIRST LADY

On the morning of the first-ever White House Conference on Child Care, you reminded the Nation that no parent should ever have to choose between work and family or between earning a decent wage and caring for a child. The growing number of women with children in the labor force is one of the biggest social changes of the 20th century; coming to terms with that change is one of our biggest challenges of the 21st century. As Secretary Rubin pointed out at the Child Care Conference, our new economy cannot continue into the 21st century unless we as a Nation can ensure safe and affordable child care. As we know from both the common sense experience of parents and a range of emerging research, our children cannot grow and thrive unless those child care settings protect their health and safety and provide an environment in which they can learn.

Together, you have lead an extraordinary national dialogue on child care. Over the past five years your Administration has taken important steps to increase funding for child care, particularly for families transitioning from welfare to work. Yet, as your White House Conference demonstrated, we still have a long way to go.

We need a bold new 21st Century Child Care Initiative to draw on the energy the Child Care Conference unleashed from all Americans -- federal, state and local leaders; employers; the faith community; child care providers; and families themselves, both rich and poor. This initiative must build on what we know about what children need to be safe and healthy, about what works in communities, and about what parents and employers need to assure a strong and effective labor force.

We cannot settle for addressing just one of these needs or just one part of the problem, because the stakes are too high for us as a Nation. We cannot meet the 21st century challenge of a thriving economy and growing children if we settle only for making child care more affordable for struggling families while leaving children's safety at risk -- or if we settle only for improving some children's care while leaving the cost of child care out of range for far too many working families. A piecemeal approach will undercut both our short-run and long-run success by failing to respond to the deeply felt needs of parents; by playing different families off against each other, rather than

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building a shared commitment to America's future; and by failing to provide the real leadership that communities, states, employers, and families need to move forward.

Let me say more about what we know now about each of these needs:

Across the country we hear from working families that they are struggling to afford safe care for their children. Low-income working families are spending on average a quarter of their income on child care. Although some 10 million children from working families are eligible for direct child care assistance, federal subsidies serve a little more than one million children. The Dependent Care Tax Credit reaches only a fraction of these families since it is not refundable and provides only minimal support. Your new plan must address these hardworking, low-income families. They get up each day, work hard and play by the rules and yet still cannot afford quality health care or child care.

The children of these working parents too often spend their days in settings that do not promote healthy child development and may even compromise their safety. With millions of infants and toddlers now in care, children can spend years in poor care before they enter school, directly affecting school readiness. The recent National Institute of Child Health and Human Development study clearly demonstrated that high quality care for very young children is consistently related to high levels of cognitive and language development.

Once children enter school, we do not take advantage of the valuable learning time after school and throughout the summer months. Learning does not stop at 3:00 p.m., and it is certainly not seasonal. We no longer need our children to tend our fields during the summer. Furthermore, numerous studies now indicate that the lack of care and attention put our youth at risk for greater alcohol, tobacco, drug use, teen pregnancy, and involvement in crime.

Despite these needs, very few communities have resources to create solutions to the quality, affordability, and availability issues that you outlined at the White House Conference. The vast majority of assistance goes directly to parents to pay for care. A very small amount, about four percent of direct subsidy, goes to quality activities, which are usually planned at the state level. Some communities, like those that Governor Hunt described in North Carolina, are combining a variety of resources to stimulate innovation and capitalize on the commitment of their neighborhood schools, employers, and parents. As you pointed out at the Conference, we need to take the models that are working in one community and give other communities an opportunity to adapt them to meet their specific needs.

Given what we know about child care both from emerging research and from what parents have told us, I have recommended to OMB and White House Staff a series of investments to seriously address the health, safety, and developmental needs of our youngest children and our school-age children, for whom care is most often of poor quality and in short supply.

In your State of the Union address and fiscal year 1999 budget submission, I strongly urge you to put forward a comprehensive plan that would include six critical child care investment strategies to help families and communities.

**For families:**

- o Increase the number of children from low-income working families that receive child care assistance by 250,000 in 1999 by expanding direct assistance by 700 million dollars. This would be an important first step toward the goal of doubling the number of children now receiving direct child care assistance.
- o Reach millions of working families by modifying the Dependent Care Tax Credit (DCTC) in two ways, making it refundable and expanding the credit to provide greater assistance to low-income working families. At a minimum we should update the DCTC; it has not been indexed for inflation since 1982. The time for change in this critical family support is long overdue.

**For communities:**

- o Enable up to 1,000 communities to craft innovative solutions to protect the health and safety of infants and toddlers in care. This will demonstrate your commitment to school readiness in 1999, the tenth anniversary of the education goals. Investment: 800 million dollars.
- o Enable up to 500 communities to find local solutions to school-age child care needs. Link such an effort with an expansion of your Schools of the 21st Century program to ensure that we maximize the use of schools as part of this overall community mobilization effort. A particular emphasis needs to be put on after school alternatives for adolescents. Investment: 300 million dollars.
- o Provide training and education to at least 150,000 providers, affecting the care of about 1.5 million children. This would build on the National Child Care Provider Scholarship Fund that you announced at the White House Conference. Investment: 150 million dollars.

- o Put in place a system of consumer education and supports for research and data collection as well as the use of technology for training providers. This effort would include a national consumer education campaign, a training strategy to reach home providers and caregivers in rural communities and a National Center on Child Care Statistics that will finally give us the critical information we need to plan future policy direction in this area. Investment: 50 million dollars.

Together, you have set the stage for an unprecedented national discussion and investment in child care and after school programs. The American people know we have a child care system that does not work effectively for families or for children.

Building on the momentum that you began with the White House Conferences, your FY 1999 budget and the State of the Union should present a concrete and powerful strategy to build a 21st century child care system.

I believe that with your inspiring leadership, we can add another building block to your effort to redefine the future of working families in America. This will be another historic legacy of your Presidency.



Donna E. Shalala



NOV 13 1997

## MEMORANDUM FOR THE PRESIDENT

Now is the time for our Nation to increase substantially its investment in research that will combat disease and enhance health. As we look toward the final years of the Clinton-Gore Administration, I urge you to set in motion what could prove to be one of your most enduring and significant legacies — a plan to significantly improve the Nation's health by doubling the research budgets of our major scientific research agencies, the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Agency for Health Care Policy and Research (AHCPR).

Today, because of your leadership, our Nation is at peace and on firm economic ground. Many of our citizens are once again living the American dream. They have good jobs. They have the income to buy a home, raise a family, and educate their children. Inflation rates are low. The budget is virtually balanced. High among the remaining concerns of our citizens are disease, disability, and untimely death. Only health research can overcome these scourges and promise longer, healthier lives for ourselves, our children, and our children's children.

At the dedication of the NIH campus in 1940, Franklin Delano Roosevelt said, "We cannot be a strong Nation unless we are a healthy Nation." In recognition of that principle, the Federal Government decided more than half a century ago to invest systematically in health research. This research has led to important innovations in high quality services.

Today, the U.S. has an unrivaled record of achievements inspired by the challenges of human illness. Many of the diseases and disabilities that our parents and grandparents faced a generation ago can now be prevented or treated:

- Age-adjusted mortality from coronary artery disease and stroke has been halved.
- Cancer death rates have begun to fall for the first time in history, and certain formerly lethal cancers like childhood leukemia and testicular cancer are now rarely fatal.
- Smallpox has been eradicated from the entire world, and polio has recently been eliminated from the Western Hemisphere.
- Surgical interventions, such as organ transplantation or cardiac pacemakers, can restore virtually normal life to many who are gravely ill.

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- An entire generation of those suffering from severe depression or schizophrenia is able to lead productive lives because of modern drugs.
- The incidence of childhood diseases preventable with vaccines is at its lowest level ever.
- AIDS patients can plan for a future they would have otherwise been denied just a few years ago, because of new combination therapies.
- Because of new clot-dissolving drugs, many stroke patients no longer live with severe disability.

The ability of patients and clinicians to make informed treatment choices has been greatly expanded as a result of outcomes and effectiveness research. These achievements, and many others, would not have occurred without our Nation's strong and sustained support of research.

While such public health accomplishments are unprecedented in human history, they pale in comparison to what is yet to come. We have entered the "golden age" of biomedical, prevention, and health services research. Today's researchers are unveiling the fundamental properties of cells and genes, the structure of proteins, and the circuitry of the world's most awesome computer, the human brain. Science is yielding stunning new insights into the mechanisms of disease and envisioning the means to treat devastating illnesses and disabilities. It promises a future in which the fear of cancer, heart disease, AIDS, mental illness, birth defects, or diabetes, among others, is enormously reduced.

To deliver on this promise, a bold new investment in health research is needed. To ensure that we all reap the full rewards of this wealth of innovation, our health research agenda must include a substantial investment in health services and prevention research. Health services research can correct the underuse of effective interventions and continued reliance upon outmoded approaches to patient care that contribute to the cost of care and the loss of life. Prevention research can help us to reduce dramatically the incidence of birth defects, injuries, certain cancers, and cardiovascular and sexually transmitted diseases.

This type of research has led to remarkable reductions in vaccine-preventable diseases and childhood lead poisoning. Additional investments in research, conducted in partnership with communities throughout the Nation, could lead to further dramatic reductions in illnesses, injuries and deaths. For example, we know that at least 50 percent of spina bifida and anencephaly could be prevented if all women capable of becoming pregnant took 400 micrograms of folic acid daily. At present only 25 percent of such women take this amount each day; research is needed to learn how to increase this proportion to virtually 100 percent. Or if all bicyclists could be convinced to wear safety helmets, we would reduce the risk of brain injury among bicyclists by 88 percent. Diabetes is another major area for potential prevention research intervention. This research could reduce significantly the development of adult-onset diabetes, as well reduce the complications of diabetes by about half.

Several converging trends argue strongly that the time for investing boldly is now. The aging of the baby-boom generation will increase the prevalence of chronic diseases, such as osteoporosis, Parkinson's and Alzheimer's diseases; preventing or delaying the onset of such diseases will deliver enormous social and economic benefits. The growing health needs of minority and socioeconomically disadvantaged populations demand specific attention to guarantee that all Americans reap the benefits of new health knowledge. Changes in our health care system are challenging traditional means of delivering care and conducting research. Government, industry, academia, and health care providers will need to develop new ways to assess the health of the public, to provide the highest quality care, to measure health outcomes, and to ensure that the most effective interventions — old and new — are being used in everyday practice. In addition, much of our Nation's research infrastructure is obsolete. Investment in new buildings, refurbished facilities, innovative instrumentation, information technology systems, and, most critically, training of scientists, are all vital to preserving our world leadership in health research.

Most importantly, our scientists are poised to change the practice of medicine in the most fundamental ways, in part because of extraordinary new research methods. Important strides in imaging technologies make it possible to visualize living cells and whole organs, as well as the architecture of individual molecules. The Human Genome Project is speeding the discovery of disease genes as it lays open the blueprint of human beings. Computer-based information systems are enabling scientists to analyze rapidly the vast amounts of data being collected with these new methods.

With these and other tools in hand, we can realistically anticipate sweeping changes in our approaches to curing disease and protecting the public health. For example, physicians will be able to select accurately the best course of treatment for cancers of the prostate, breast, ovary and other tissues because of new knowledge about genes and the molecular fingerprint of individual tumors. Laboratory and clinical research will change the management of diabetes; with improved methods for accurate blood glucose measurement and new methods of metabolic control, the debilitating nerve, eye, and kidney complications of this disease will be prevented.

One day, because of genetic research, we will be able to identify individuals at increased risk for diseases like hypertension and stroke, glaucoma, osteoporosis, Alzheimer's disease, or severe depression, and design appropriate interventions. We will have effective vaccines for pandemic diseases such as AIDS, tuberculosis, and malaria. The discovery of the obesity gene and its hormone product, leptin, will be parlayed into novel and safe strategies for appetite and weight control. We will be able to rejuvenate the failing heart by grafting healthy muscle cells to cardiac tissue damaged by a heart attack. New knowledge about the biological basis of craving and addiction will result in medications targeted specifically to receptors in the brain which play a role in substance abuse.

Finally, research to move discoveries into the clinic, to determine what works best in daily practice, and to improve the quality of patient care will lead to direct and immediate public benefits, as well as contribute to the solvency of the Medicare program. Health services research

has shown that 30 percent of patients receive medical procedures that are not appropriate when measured against rigorous clinical standards. By combining research on what works best in daily practice and effectively transferring that knowledge to practitioners with effective strategies for measuring and improving quality, we can reduce inappropriate variation, accelerate the pace at which the benefits of science improve clinical care, and identify clinical treatments which can reduce costs and improve quality.

To achieve these exciting goals, I strongly urge you in your State of the Union address and fiscal year 1999 budget submission to propose these health research investments:

- Double NIH funding in 10 years, with a 50 percent increase in five years. We need a 1999 increase that is significantly larger than the 7.1 percent increase appropriated by the Congress for 1998; I have proposed a 10 percent increase in 1999.
- Address most of the great research university and academic medical center laboratory construction needs in a bold five-year program which combines matching grants and loan guarantees. This would be funded within the NIH total.
- Create a bold new CDC prevention research program to ensure the maximum public benefit from the findings of health research, phasing up to \$1 billion in 2008.
- Reinvent the Agency for Health Care Policy and Research to dramatically commit to the new health services research we need to vigorously exploit new scientific knowledge to improve the quality of health care plans while restraining health care costs, phasing up to \$0.8 billion in 2008.
- The best way to accomplish this dramatic increase in health research, without endangering other priorities, is a dedicated funding source such as an assessment on insurance premiums, or another suitable revenue source such as new tobacco legislation.

Mr. President, you lead the country at an auspicious moment in our history — a moment when scientific opportunity is matched by economic and political feasibility. There is already broad bipartisan support for a doubling of our Nation's investment in health research in response to the extraordinary scientific promises I have outlined. You must seize this moment. By doing so, you, like President Roosevelt a half century ago, will establish a lasting legacy of health for future generations at home and abroad.



Donna E. Shalala