

FY 1999 Budget

Department of Health and Human Services

November 25, 1997

FY 1999 Budget
Department of Health and Human Services
Overview

- **The President has agreed that the process of deciding budget levels for the FY 1999 President's Budget will be different than in past years. Instead of passing back a single set of budget authority and outlay estimates for each agency -- composed of funding for both base programs and new initiatives -- the OMB passback includes two sets of estimates.**
- **The first set of estimates will be OMB's assessment of what the agency requires for base program operations and previously-announced Presidential priorities over FY 1999-2003.**
 - **The agency may discuss the composition of this passback level with OMB. The agency may appeal this level; however, all appeals for base program operations will compete against initiatives for funding from the Presidential Priority Reserve (see below). Thus, agencies are urged to discuss with their RMO financing additional spending for important base programs within this first passback level. Presidential priorities cannot be adversely affected by this process.**
 - **Base programs levels (including previously announced Presidential priorities) will be considered final for agencies that do not appeal these levels. Base programs levels will remain open if agencies appeal, and those levels may be increased, decreased, or remain unchanged during the final portion of the budget process.**
- **The second set of estimates is a list of candidates (and their associated funding levels) for the Presidential Priority Reserve. This list includes initiatives submitted by the agencies or by others to be presented to the President for decision. The items on this list do not represent decisions on what will be included in the FY 1999 budget; rather, they are candidates that will be presented to the President for his decision. The combined cost of the items on the list of candidates greatly exceeds funding available in the Presidential Priority Reserve. Agencies may appeal to add additional items to the list or to increase the funding for items already on the list.**
- **OMB will review the comprehensive list of candidates for the Presidential Priority Reserve, by programmatic category (e.g., anti-terrorism, health, research, etc.). Funding for agency appeals -- both for base programs and proposed new initiatives -- will compete with new initiatives for funding from the Presidential Priority Reserve.**

The following table displays aggregate discretionary funding and total FTE levels for HHS base activities:

HHS BA, Outlays, and FTE (FY 1997 - FY 2003) for Base Programs (\$ in millions)							
HHS Totals	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
BA	\$33,604	\$35,862	\$34,844	\$35,001	\$35,097	\$35,185	\$35,764
OL	\$33,418	\$34,790	\$34,967	\$34,982	\$34,982	\$35,034	\$35,497
FTE	57,569	57,756	57,756	57,756	57,756	57,756	57,756

- **Appeals**— HHS appeals of the FY 1999 Passback, including appeals of outyear estimates, must be submitted to OMB no later than noon on December 4th. All HHS appeal items should specify if the appeal is to be offset within the HHS passback total, or if it will compete for funding from the Presidential Priority Reserve.

Detailed funding decisions have been made for several specific programs, and are detailed on the attached table. These specific funding amounts are exempt from the broad discretion that HHS has to re-allocate resources within the FY 1999 level, so if HHS prefers to change any of these funding levels, they will be treated as an appeal within the base.

- **Outlays**— Dollar appeals must identify changes in BA and outlays from the passback level for FYs 1999-2003. Any increase in total HHS outlays resulting from HHS' re-pricing of passback BA levels will be treated as appeal items. Therefore, the HHS appeal package should include HHS' estimates of outlays by OPDIV for FY 1997 through FY 2003. Backup outlay analysis tables should also be included.

FY 1999 Budget
Department of Health and Human Services
HHS Summary Table

Health and Human Services Discretionary Funding
FY 1999 Budget
\$ in millions - receiving account basis

		FY 1997 Enacted	FY 1998 Enacted	Passback for Base Programs					Poss. Init. FY 1999
				FY 1999 /1	FY 2000	FY 2001	FY 2002	FY 2003	
FDA	PL	995.887	1,037.774	1,044.228	1,039.768	1,031.557	1,019.761	1,047.271	86.000
	BA	887.616	925.145	800.000	796.583	790.293	781.256	802.331	
HRSA /2	BA	3,413.673	3,628.303	3,584.065	3,571.047	3,547.079	3,512.648	3,592.946	100.000
IHS	PL	2,339.275	2,431.255	2,446.293	2,436.131	2,417.422	2,390.545	2,453.226	
	BA	2,057.000	2,098.612	2,088.649	2,080.015	2,064.118	2,041.281	2,094.540	
CDC /3	BA	2,302.168	2,378.552	2,326.197	2,316.756	2,299.374	2,274.405	2,332.638	68.000
NIH	BA	12,740.843	13,647.843	13,647.843	13,647.843	13,647.843	13,647.843	13,647.843	1,000.000
SAMHSA	PL	2,184.812	2,196.743	2,216.743	2,060.305	2,044.769	2,022.451	2,074.500	200.000
	BA	2,134.812	2,146.743	2,068.743	2,060.305	2,044.769	2,022.451	2,074.500	
AHCPR	PL	143.979	146.435	124.588	124.116	123.246	121.997	124.910	25.000
	BA	96.567	90.229	58.588	58.398	58.047	57.543	58.718	
Healthy Life	BA								30.000
HCFA	PL	1,780.037	1,883.000	2,072.388	2,063.537	2,047.241	2,023.831	2,078.427	
	BA	1,734.300	1,743.066	1,668.000	1,660.876	1,647.760	1,628.918	1,672.860	
DM	BA	235.480	211.141	188.941	188.185	186.794	184.795	189.457	1.000
OIG	BA	32.769	31.921	29.000	28.876	28.648	28.321	29.085	
ACF /3 <i>Head Start (non-add)</i>	BA	7,139.000	8,095.600	7,518.800	7,726.600	7,917.600	8,140.600	8,404.000	342.000
	BA	3,981.000	4,355.000	4,489.000	4,710.000	4,983.000	5,259.000	5,325.000	
AoA	BA	830.200	865.100	865.100	865.100	865.100	865.100	865.100	
Total, HHS	BA	33,604.428	35,862.255	34,843.926	35,000.584	35,097.424	35,185.160	35,764.017	1,852.000
	OL	33,418.025	34,789.924	34,966.913	34,981.742	34,981.803	35,034.254	35,496.780	

/1 Unallocated savings -- Within the FY 99 passback total, HHS will identify and then reallocate an additional \$8 million in resources that will be used to add \$8 million to the FDA rent account, bringing the FDA rent total to \$67 million in FY 99.

/2 HRSA totals include app. \$6M in BA & OL for Vaccine Injury Compensation Program appropriated through the C/J/S Appropriations Bill (app. \$7M for FY 98 Enacted).

/3 CDC and ACF totals include Violent Crime Reduction Trust Fund.

Selected Passback Details

(BA in millions of dollars)

(Non-adds in italics; indented lines are non-adds to the line above)

	FY98	FY99
	Enacted	Passback
FDA – Program Level	1,037.8	1,044.2
<i>FDA – User fees</i>	<i>112.6</i>	<i>244.2</i>
<i>FDA – Budget Authority</i>	<i>925.1</i>	<i>800.0</i>
<i>Food Safety</i>	<i>24.0</i>	<i>24.0</i>
<i>Tobacco</i>	<i>34.0</i>	<i>34.0</i>
HRSA	3,628.3	3,584.1
<i>Ryan White</i>	<i>1,150.2</i>	<i>1,150.2</i>
<i>Health Centers</i>	<i>826.0</i>	<i>826.0</i>
<i>Health Professions</i>	<i>291.1</i>	<i>291.1</i>
<i>Maternal and Child Health Block Grant</i>	<i>683.0</i>	<i>683.0</i>
<i>Healthy Start</i>	<i>96.0</i>	<i>96.0</i>
<i>National Health Service Corps</i>	<i>115.4</i>	<i>115.4</i>
<i>Health Care Facility Construction</i>	<i>28.0</i>	<i>0.0</i>
<i>Bone Marrow Donor Registry</i>	<i>15.3</i>	<i>15.3</i>
<i>Black Lung Clinic</i>	<i>5.0</i>	<i>5.0</i>
<i>Family Planning</i>	<i>203.5</i>	<i>207.5</i>
IHS – Program Level	2,431.3	2,446.3
<i>IHS – Budget Authority</i>	<i>2,098.6</i>	<i>2,088.6</i>
<i>Collections</i>	<i>302.6</i>	<i>327.6</i>
<i>Hospitals and Clinics</i>	<i>906.8</i>	<i>896.7</i>
<i>Contract Health Services</i>	<i>373.4</i>	<i>373.4</i>
<i>Contract Support Costs</i>	<i>168.7</i>	<i>168.7</i>

CDC	2,378.6	2,326.2
<i>HIV Prevention</i>	634.3	634.3
<i>STDs</i>	113.7	113.7
<i>TB</i>	119.2	119.2
<i>Childhood Immunizations</i>	427.3	427.3
<i>Breast and Cervical Cancer Screening</i>	145.0	145.0
<i>Heart Disease/Health Promotion</i>	61.8	61.8
<i>Tobacco</i>	28.4	28.4
<i>Infectious Disease</i>	115.2	115.2
<i>Food Safety</i>	14.5	14.5
<i>Diabetes and Other Chronic Diseases</i>	56.1	56.1
<i>Diabetes</i>	46.0	46.0
NIOSH	152.8	152.8
<i>Mine Safety and Health</i>	36.0	36.0
<i>Preventive Health Block Grant</i>	150.0	150.0
<i>NCHS (Budget Authority)</i>	26.8	0.0
<i>NCHS 1% Funding</i>	59.2	86.0
<i>NCHS Program Level</i>	86.0	86.0
<i>Violence Against Women Act/Crime Act Activities</i>	51.0	51.0
<i>Injury Control</i>	50.5	50.5
<i>Lead Poisoning</i>	38.2	38.4
<i>Environmental Disease</i>	55.5	55.5
<i>Cancer Registries</i>	24.2	24.2
<i>Prevention Centers</i>	8.1	8.1
<i>Office of the Director/Program Support Savings</i>		-11.0
<i>Buildings and Facilities</i>	21.5	6.8
SAMHSA -- Program Level	2,196.7	2,216.7
<i>SAMHSA -- Budget Authority</i>	2,146.7	2,068.7
<i>Mental Health Total</i>	451.3	451.3
<i>Mental Health Block Grant</i>	275.4	275.4
<i>Projects for Assistance in Transition from Homelessness</i>	23.0	23.0
<i>Substance Abuse Total</i>	1,641.0	1,565.0
<i>Substance Abuse Block Grant</i>	1,310.1	1,310.1
<i>Substance Abuse KDA's</i>	239.9	169.9

HCFA – Program Level	1,883.0	2,072.4
<i>HCFA – User fees</i>	139.9	404.4
<i>HCFA – Budget Authority</i>	1,743.1	1,668.0

GDM/OCR/PR	211.1	188.9
<i>Adolescent Family Life Grants</i>	16.7	4.7
<i>Office of Minority Health Grants</i>	29.1	23.1
<i>GDM Other (Rent/Attrition)</i>	102.3	98.1
<i>GDM - Office of Emergency Prep.</i>	10.0	10.0
<i>Policy Research</i>	14.0	14.0
<i>Office for Civil Rights</i>	19.7	19.7

ACF	8,095.6	7,518.8
<i>LIHEAP</i>	1,000.0	658.0
<i>Refugee and Entrant Assistance</i>	419.0	360.0
<i>Child Care & Development Block Grant</i>	1,002.7	1,002.7
<i>Head Start</i>	4,355.0	4,489.0
<i>Community Services Block Grant</i>	490.6	490.6
<i>Other ACF Services</i>	837.3	771.5
<i>Violent Crime Trust Fund</i>	93.0	105.0
<i>Research Rescission</i>	-21.0	0.0
<i>Social Services Block Grant</i>	-81.0	-358.0

AoA	865.1	865.1
<i>Congregate Meals</i>	374.4	374.4
<i>Home Delivered Meals</i>	112.0	112.0
<i>Other AoA Programs</i>	378.7	378.7

Anti-Drug Abuse Portion of HHS Programs	2,463.0	2,493.0
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Possible Initiatives that will Compete for Funding from the Reserve

(BA in millions of dollars)
(Non-adds in italics)

<u>Activity</u>	<u>FY 1999</u>		
	<u>Possible Initiatives</u>		
Tobacco	+ 100.0	—	x
<i>FDA</i>	+ 46.0		
<i>CDC</i>	+ 54.0		
Food Safety	+ 50.0	—	?
<i>FDA</i>	+ 40.0		
<i>CDC</i>	+ 10.0		
Ryan White --HRSA	+ 100.0		✓
Lead Poisoning --CDC	+ 4.0		
Health Research -- NIH	+ 1000.0		✓
Substance Abuse -- SAMHSA	+ 200.0		x
Health Care Quality -- AHCPR	+ 25.0		
Office for Civil Rights	+ 1.0		✓
LIHEAP--ACF	+ 342.0		
Healthy Life	+ 30.0		✓

**THE PRESIDENT'S FY 1999
MANDATORY BUDGET:
HEALTH INITIATIVES**

- **Tobacco Legislation to Protect America's Children:** Every day, 3,000 young people become regular smokers and 1,000 of them will die prematurely from tobacco-related disease. The President will work with Congress to enact comprehensive, national tobacco legislation to reduce youth smoking.
- **Health Research in the 21st Century Research Fund for America:** Biomedical research has led to breakthroughs in prevention and treatment of many, serious diseases. To build on this progress, the President proposes an unprecedented, multi-year commitment to health research in his "21st Century Research Fund for America," which includes a nearly 50 percent, five-year increase in National Institutes of Health funding.
- **Coverage of Cancer Clinical Trials for Medicare Beneficiaries:** Americans over age 65 make up half of all cancer patients, yet Medicare only covers treatments that are established as standard therapies. The President proposes a three-year, \$750 million demonstration to cover Medicare beneficiaries' patient care costs associated with certain Federally-sponsored cancer clinical trials.
- **Children's Health Outreach:** While the new Children's Health Insurance Program will reduce the number of uninsured children, over 3 million are already eligible for Medicaid. The President's budget includes options for States to access higher Federal matching funds for outreach activities and to temporarily enroll children at sites like schools.
- **Improving Access to Health Insurance for People Ages 55 to 65:** Americans ages 55 to 65 are difficult to insure: they have less access to employer-based insurance and greater risk of having health problems. The President proposes to: (1) allow Americans ages 62 to 65 to buy into Medicare; (2) offer a similar Medicare buy-in to displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) give retirees 55 and over whose retiree health benefits have been ended access to their former employers' health insurance. Any Medicare costs of these policies would be fully offset by Medicare anti-fraud, waste and abuse savings.

**THE PRESIDENT'S FY 1999 MANDATORY BUDGET
HEALTH INITIATIVES**

(Fiscal Years, Dollars in Millions)

	1999	2000	2001	2002	2003	99-03
TOBACCO-FUNDED PRIORITIES						
Research Fund for America: Health						
National Institutes of Health Increase	1,150	2,013	2,984	4,349	6,540	17,036
AHCPR & CDC Research Increase	50	53	57	60	65	285
VA Research Increase	28	—	—	—	—	28
Medicare Beneficiaries' Cancer Clinical Trials Demonstration	200	250	300	—	—	750
Children's Health Outreach	110	150	210	210	220	900
MEDICARE						
Medicare Buy-In	101	387	364	343	339	1,534
Anti-Fraud, Waste & Abuse	-180	-420	-515	-600	-665	-2,380
Net Medicare Savings	-79	-33	-151	-257	-326	-846

TOBACCO LEGISLATION TO PROTECT AMERICA'S CHILDREN

The President has called on Congress to pass comprehensive, national bipartisan legislation that includes five key principles: (1) it must mandate the development of a comprehensive plan to reduce teen smoking, including raising the cost of cigarettes by \$1.50 per pack over the next 10 years as necessary to meet youth smoking targets; (2) it must affirm the FDA's full authority to regulate tobacco products; (3) it must include measures to hold tobacco companies accountable, especially for marketing products to children; (4) it must include concrete measures to improve public health, from investing in research to reducing second-hand smoke to expanding smoking cessation; and (5) it must protect the financial well-being of tobacco farmers and their communities from the loss of income caused by our efforts to reduce smoking.

BACKGROUND

Every day, 3,000 young people become regular smokers and 1,000 of them will die prematurely from tobacco-related disease. Tobacco use is responsible for over 400,000 deaths each year — about 20 percent of all deaths. The average smoking-related death reduces the life of its victim by up to 15 years.

POLICY DESCRIPTION

The President has outlined five key principles that must be at the heart of any national tobacco legislation:

- A comprehensive plan to reduce youth smoking, including: tough penalties on tobacco firms that continue to market to youths; price increases; public education and counter advertising; and expanded efforts to restrict access and limit appeal.
- Full authority of the Food and Drug Administration to regulate tobacco products.
- Changes in how the tobacco industry does business, including an end to marketing and promotion to children and broad document disclosure.
- Progress towards other public goals, including a reduction of secondhand smoke; promotion of cessation programs; public health research; the strengthening of international efforts to control tobacco; and other urgent priorities.
- Protection for tobacco farmers and their communities.

The budget would apply the receipts from tobacco legislation to:

- Fund research into tobacco-related and other diseases at the National Institutes of Health, the Agency for Health Care Policy and Research, and the Centers for Disease Control
- Fund a cancer clinical trials demonstration project for Medicare beneficiaries
- Support smoking prevention efforts by the Centers for Disease Control and Prevention
- Strengthen the Food and Drug Administration's enforcement programs
- Fund smoking cessation programs
- Expand outreach efforts to ensure that children eligible for health coverage are enrolled
- Sponsor counter-advertising
- Protect tobacco farmers
- Support other initiatives associated with national tobacco legislation.

It proposes that States receive a substantial portion of the net receipts, partly through block grants that they can use to provide child care and reduce class size in schools, and partly through unrestricted funds.

BUDGET EFFECTS

The Administration proposes that the legislation provide for annual lump-sum payments by tobacco manufacturers, with the amounts paid by each determined by formula. The budget assumes net Federal receipts from this legislation will total at least \$10 billion in 1999, rising each subsequent year for a total of \$65 billion between 1999 and 2003. These amounts are consistent with the President's call for an increase in per-pack cigarette prices of up to \$1.50 (in constant dollars) over 10 years as necessary to meet the targets set to reduce youth smoking.

HEALTH RESEARCH IN THE 21ST CENTURY RESEARCH FUND FOR AMERICA

As part of his "21st Century Research Fund For America", the President proposes an unprecedented investment in health research, including a historic \$1.15 billion increase in medical research and a 50 percent increase over five years, \$25 million in a new prevention research program, \$25 million in research on improving quality and health outcomes, and \$28 million in research on veterans' health issues.

BACKGROUND

Recent progress in biomedical research has ensured that many of the diseases Americans faced a generation ago can now be prevented or treated. Smallpox has been eradicated from the entire world and polio is gone from the Western Hemisphere. There are new therapies for some of the most devastating diseases, such as AIDS. These successes would not have occurred without a strong sustained support of biomedical research. Even more breakthroughs are in sight. For example, new knowledge about both genetics and the structure of tumors may enable scientists to pinpoint more effective treatments for prostate, breast, and ovarian cancer. There are also new opportunities to learn more about preventing diseases. Finally, there are new possibilities to determine how to translate cutting edge discoveries into practical, improved care.

POLICY DESCRIPTION

To build on this progress and new possibilities, the "21st Century Research Fund" contains an unprecedented, multi-year commitment to improve health care research. It contains new funding for investments in biomedical research, prevention research, and research to improve health outcomes. In 1999 alone, this Fund contains:

- **An Historic \$1.15 Billion Investment in Biomedical Research.** To build on the progress in biomedical research, the Fund contains a historic up-front investment in biomedical research — a \$1.15 billion increase in FY 1999 — and proposes an increase in National Institutes of Health (NIH) funding of nearly 50 percent over the next five years. Under the President's proposal, the NIH will devote over \$20 billion to biomedical research in 2003. This increases funding at all of the Institutes at NIH, including a 65 percent increase in cancer research funding.
- **\$25 Million Increase in New Prevention Research.** The Fund also includes a new Prevention Research Program at CDC to identify interventions that prevent diseases.

- **\$25 Million Increase In Quality and Health Outcomes Research.** Research at the Agency of Health Care Policy and Research (AHCPR) bridges the gap between what scientists know and the health care Americans receive. In FY1999, total funding for AHCPR would increase by \$25 million to a total of \$171 million. Funding for health care quality improvement, which will address the scientific research recommendations of the President's Quality Commission, would double from \$15 million to \$30 million.
- **\$28 Million Increase In Veterans' Research.** The Budget provides a \$28 million increase to VA's research program to conduct basic clinical, epidemiological, and behavioral studies across the entire spectrum of scientific disciplines. FY 1999 research will focus on aging, chronic diseases, mental illness, substance abuse, sensory loss, trauma, health systems, special populations (including Persian Gulf veterans), and military occupation and environmental exposures.

BUDGET EFFECTS

Most of the research increase would be funded from tobacco legislation.

	FY 1999 to 2003 (\$ millions)
National Institutes of Health Increase	17,036
Centers for Disease Control and Prevention (CDC) Prevention Research Increase	138
Agency for Health Care Research and Policy Increase	147
Veterans' Administration Research Increase	28

COVERAGE OF CANCER CLINICAL TRIALS FOR MEDICARE BENEFICIARIES

The President's initiative, for the first time, would explicitly provide coverage of cancer clinical trials for Medicare beneficiaries, giving them access to cutting-edge treatments and encouraging higher participation in clinical trials. The \$750 million three-year demonstration pays for the patient care costs associated with certain Federally-sponsored clinical trials.

BACKGROUND

More than 40 percent of Americans will be diagnosed with cancer during their lifetime and more than 20 percent will die from it. Less than three percent of cancer patients participate in clinical trials. Moreover, Americans over the age of 65 make up half of all cancer patients, and are 10 times more likely to get cancer than younger Americans. Many scientists believe that higher participation in clinical trials could lead to faster development of therapies for more of those in need, as it often takes between three and five years to enroll enough participants in a cancer clinical trial to make the results scientifically legitimate and statistically meaningful. Older Americans and people with disabilities covered by Medicare frequently cannot participate in cutting-edge cancer clinical trials because the program does not pay for such treatments until they are established as standard therapies.

POLICY DESCRIPTION

The President has proposed a demonstration that would help Medicare beneficiaries access these cutting-edge cancer treatments.

- **Three-Year Demonstration Program for Medicare Beneficiaries.** The proposal would establish a three-year \$750 million demonstration program for Medicare beneficiaries to cover the patient care costs associated with certain cancer treatment clinical trials (research studies with patients).
- **Covers Certain Cancer Clinical Trials.** Studies sponsored by the National Institutes of Health (NIH) would qualify. This includes:
 - Trials conducted by NCI programs that oversee and coordinate extramural clinical cancer research;
 - Trials conducted by Cooperative Groups programs;
 - NCI-sponsored trials at NCI-designated cancer centers;
 - NCI grants supporting clinical investigators; and
 - Clinical trials for cancer conducted at other NIH institutes.

After one year, the proposal also allows for amendments and/or additions to this set of trials by the Secretary of Health and Human Services within the same funding constraints, with the advice of the Institute of Medicine's National Cancer Policy Board.

- **Includes Report to Congress Following Three-Year Demonstration.** The proposal includes a review and evaluation of the demonstration by the Secretary of Health and Human Services, in consultation with the Institute of Medicine's National Cancer Policy Board, to consider whether to extend and/or expand the demonstration, no later than 30 months after enactment.
- **No Impact on the Medicare Trust Fund.** The demonstration would be administered by the Health Care Financing Administration, which administers Medicare, but would be funded by \$750 million in receipts from tobacco legislation. It would therefore have no effect the financial condition on the Medicare Trust Fund.
- **Builds on the Bipartisan Legislation in the Congress.** Senator Mack and Senator Rockefeller and Representative Nancy Johnson have taken leadership in this area by proposing similar legislation that would provide cancer clinical trial coverage for Medicare beneficiaries.

BUDGET EFFECTS

The cancer clinical trials demonstration, a capped, mandatory program, would be funded from tobacco legislation.

	FY 1999 to 2003 (\$ millions)
CANCER CLINICAL TRIALS DEMO	750

Note: Funded for three years.

CHILDREN'S HEALTH OUTREACH

To encourage enrollment of millions of uninsured children through Medicaid and the new Children's Health Insurance Program, the President has proposed policies and administrative actions to encourage children's health outreach. These include: enrolling uninsured children through child care referral centers, schools, and others who work with children; allowing States to access extra Federal funds for children's outreach campaigns; and encouraging linkages between health insurance programs through the use of a single, simple application. These policies, along with strong, creative efforts at the State and local level, will help assure that the President's goal of covering up to 5 million uninsured children is met.

BACKGROUND

Last year, the President, with bipartisan Congressional support, signed into law the largest single expansion of children's health insurance in 30 years. The Children's Health Insurance Program (CHIP) provides funds for coverage of millions of working families' uninsured children. These families typically have too much income to qualify for Medicaid but too little to afford health insurance. But, to ensure the success of this program, an aggressive campaign to enroll eligible, uninsured children is needed.

In addition, over 3 million children are uninsured but eligible for Medicaid today. Educating families about their options and enrolling them in Medicaid has always been difficult, but it has recently become even more challenging. The number of children enrolled in Medicaid leveled off in 1995 and, according to the Census, dropped by 6 percent in 1996. While some of this decline may be due to the lower number of children in poverty, another reason for this decrease may be families' misunderstanding of their children's continued eligibility for Medicaid that the welfare reform explicitly guaranteed.

POLICY DESCRIPTION

To give States the tools and funding to find and enroll uninsured children, the President's 1999 Budget invests \$900 million over 5 years in children's health outreach policies.

- **Fund for outreach.** In welfare reform, a special \$500 million pool was created to fund efforts to improve Medicaid enrollment of families affected by welfare reform.

The President's 1999 Budget includes a proposal that would expand the use of this fund. States would be able to receive a 90 percent matching rate for most outreach activities for all uninsured children, not just those who would have been eligible for welfare. The Federal funds to cover the extra matching (above Medicaid's regular matching amount) would come from this fund. In addition, the proposal would remove the sunset of the fund in 2000 and add another \$25 million to assist States with increased outreach activities. This outreach fund would provide States with the resources to simplify enrollment systems, launch ad campaigns, educate community volunteers, and conduct other outreach campaigns to find and help enroll uninsured children.

- **Allowing immediate Medicaid coverage through schools, child care resource and referral centers, and other sites.** The Balanced Budget Act (BBA) of 1997 gave States a new option in Medicaid to grant "presumptive eligibility" to children. Certain children may receive immediate Medicaid coverage on a temporary basis while waiting for a full Medicaid eligibility determination.

The President's 1999 Budget proposes to make this presumptive eligibility option more flexible and attractive to States. First, it would broaden the definition of who can determine presumptive eligibility to include sites such as schools, child care resource and referral centers, child support enforcement agencies and CHIP eligibility workers. These people are on the front lines in caring for children and could help educate and enroll them in Medicaid. Second, it would eliminate the requirement that States subtract the costs of presumptive eligibility from their CHIP allotments. Instead, these costs would be matched as a regular Medicaid State plan option. Both of these changes would give States greater incentives and flexibility for using this option.

In addition, the Department of Health and Human Services (HHS) has identified a number of ideas and options for States to simplify enrollment and integrate Medicaid and CHIP. This includes encouraging "out-stationing" of eligibility workers; using mail-in, simple applications; and using a joint application form for both Medicaid and CHIP. *(See letter to State Health Officials from HHS, dated January 23, 1998 for details).*

BUDGET EFFECTS

The children's health outreach proposals would be funded from tobacco legislation.

	FY 1999 to 2003 (\$ millions)
MEDICAID	
Access to Outreach Fund	330
Presumptive Eligibility Expansion	570
TOTAL	900

IMPROVING ACCESS TO HEALTH INSURANCE FOR PEOPLE AGES 55 TO 65

The President has proposed a three-part initiative to provide Americans ages 55 to 65 new health insurance options: (1) allowing Americans ages 62 to 65 to buy into Medicare, through a premium designed so that this policy is self-financed; (2) offering a similar Medicare buy-in to displaced workers ages 55 and over who have involuntarily lost their jobs and health care coverage; and (3) giving retirees 55 and over whose retiree health benefits have been ended access to their former employers' health insurance. Any Medicare costs of these policies would be fully offset by Medicare anti-fraud, waste and abuse savings. Thus, this initiative will not add a dime to the deficit or hurt the Medicare Trust Fund.

BACKGROUND

Americans ages 55 to 65 face special problems of access and affordability. They face greater risks of health problems, with twice the chances of heart disease, strokes, and cancer as people aged 45 to 54. As people approach 65, many retire or shift to part-time work or self-employment as a bridge to retirement, sometimes involuntarily. Displaced workers aged 55 to 65 are much less likely than younger workers to be re-employed or re-insured through a new employer. As a result, more of them rely on the individual health insurance market. Without the benefits of having their costs averaged with younger people, as with employer-based insurance, these people often face high premiums.

Such access problems will increase, due to two trends: declines in retiree health coverage and the aging of the baby boom generation. Recently, businesses have cut back on offering health coverage to pre-65-year-old retirees; only 40 percent of large firms now do so. In several small but notable cases, businesses have dropped retirees' health benefits after workers have retired. These "broken promise" retirees lack access to employer continuation coverage and could have problems finding affordable individual insurance. Finally, the number of people 55 to 65 years old will rise from 22 million to 35 million by 2010 — or by 60 percent.

POLICY DESCRIPTION

The President has proposed three policy options to improve access to affordable health insurance for targeted groups of Americans ages 55 to 65.

1. Medicare Buy-In for People Ages 62 to 65

The centerpiece of this initiative is the Medicare buy-in for people ages 62 to 65.

- **Eligibility:** People ages 62 to 65 who do not have access to employer sponsored or Federal health insurance may participate.

- **Premium Payments:** Participants would pay two, geographically adjusted premiums:
 - **Pre-65 premium:** The pre-65 premium would be paid monthly between enrollment and when the participant turns age 65. It is the part of the full premium that represents the average Medicare costs for people in this age group. For 1999, it would be around \$300 per month and would be updated annually.
 - **Post-65 premium:** The post-65 premium would be paid monthly beginning at age 65 until the beneficiary turns age 85. It is the part of the premium that represents the extra costs if participants are sicker than average. For 1999, it would be around \$16 per month for each year of participation (about \$48 per month for a person who buys in from age 62 to 65). At the time of enrollment, participants would be told their post-65 premium. The post-65 premium would be re-estimated for future participants to ensure that it reflects actual experience. This premium would be added to their Part B Medicare premium.

This two-part payment plan acts like a mortgage: it makes the up-front premium affordable but requires participants to pay back the Medicare "loan" with interest.

- **Enrollment:** Eligible people would apply at Social Security offices. They would bring proof of their age and eligibility for Medicare when they turn 65. They would do this within 63 days of either turning 62 or losing access to employer-based or Federal insurance (63 days is the maximum time period that a person can be uninsured and still be protected by Health Insurance Portability and Accountability Act).
- **Applicability of Medicare Rules:** Benefits and most protections would be, for paying participants, the same as those of Medicare beneficiaries. Participants would have the choice of fee-for-service or managed care. No Medicaid assistance would be offered to participants for premiums or cost sharing. Medigap policy protections would apply, but the open enrollment provision remains at age 65.
- **Disenrollment:** People could stop buying into Medicare at any time. People who disenroll would pay the post-65 premium as though they had been enrolled for a full year (e.g., a person who buys in for 3 months in 1999 would pay the post-65 premium as though they participated for 12 months). This is intended to act as a disincentive for temporary enrollment. People may only enroll once; for example, a participant may not disenroll at age 63 and re-enroll at age 64.
- **Medicare Trust Fund Impact:** According to HCFA, the 62 to 65 year old buy-in is self-financing and will not, in the long-run, decrease the life of Medicare's Trust Funds. Premium collections will be allocated to the Trust Funds in proportion to spending from those Funds for participants. The Medicare Part B premium and managed care rates for regular Medicare beneficiaries will be calculated independently of the buy-in.

2. Medicare Buy-In for Displaced Workers Ages 55 and Over

In addition to people ages 62 to 65, a targeted group of 55 to 61 year olds could buy into Medicare. The Medicare buy-in would be the same as above, with the following exceptions.

- **Eligibility:** People would be eligible if they are between ages 55 and 61 and: (1) lost their job because their firm closed, downsized, or moved, or their position was eliminated (defined as being eligible for unemployment insurance) after January 1, 1998; (2) had health insurance on their previous job for at least one year (certified through the process created under HIPAA to guarantee continuation coverage); and (3) do not have access to employer sponsored, COBRA, or Federal health insurance. Spouses of these eligible people may also buy into Medicare.
- **Premium Payments:** Participants would pay one, geographically adjusted premium, with no Medicare "loan". This premium represents the average Medicare costs for people in this age group (one premium for age 55 to 59, another for 60 to 61) plus an add-on to compensate for some of the extra costs of participants who may be sicker than average. For 1999, the premium would be \$400 per month and would be updated annually.
- **Disenrollment:** Like people ages 62 to 65, eligible displaced workers and their spouses must enroll in the buy-in within 63 days of becoming eligible. Participants continue to pay premiums until they voluntarily disenroll, gain access to employer-based insurance or turn 62 and become eligible for the more general Medicare buy-in. Once they disenroll, they may only re-enroll if they meet the eligibility rules again (e.g., are displaced again).

3. Employer Buy-In (COBRA Continuation Coverage) for Certain Retirees

The President would also help retirees whose former employer unexpectedly drops their retiree health insurance, leaving them uncovered and with few places to turn.

- **Eligibility:** Termination of retiree health benefits (i.e., they were covered but their employer ended that coverage) for retirees age 55 to 64 and their dependents would become a COBRA qualifying event.
- **Premium Payments:** Participants would pay 125 percent of the active employees' premium. This premium is higher than what most other COBRA participants pay (102 percent) to help offset the additional costs of participants.
- **Enrollment:** Participants would enroll through their former employer, following the same rules as other COBRA eligibles.
- **Disenrollment:** Retirees would be eligible until they turn 65 years old. Dependents would be eligible for other related periods of eligibility as other COBRA enrollees.
- **Federal Budget Impact:** There is no Federal budget impact because costs would be paid for by the private sector, primarily through retiree premium contributions.

Medicare Anti-Fraud, Waste and Abuse Initiatives

The Medicare buy-in would produce some costs primarily because Medicare is "loaning" participants part of the premium at ages 62 to 65. Even though in the long-run the buy-in for 62 to 65 year olds is self-financing, the President has proposed a set of anti-fraud, waste and abuse provisions to offset the up-front "loan" and any costs of the displaced workers' buy-in. These policies also are part of the President's ongoing effort to root out fraud and waste in Medicare. Five of the President's anti-fraud, waste and abuse initiatives produce scorable budget savings.

- **Eliminating Excessive Medicare Reimbursement for Drugs.** A recent report by the HHS Inspector General found that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than would be paid if market prices were used. For more than one-third of these drugs, Medicare pays more than double the actual acquisition costs, and in one case pays as high as ten times the amount. This proposal would ensure that Medicare payments be provider's actual acquisition cost of the drug without mark-ups.
- **Eliminating Overpayments for Epogen.** A 1997 HHS Inspector General report found that Medicare overpays for Epogen (a drug used for kidney dialysis patients). This policy would change Medicare reimbursement to reflect current market prices (from \$10 per 1,000 units administered to \$9).
- **Eliminating Abuse of Medicare's Outpatient Mental Health Benefits.** The HHS Inspector General has found abuses in Medicare's outpatient mental health benefit — specifically, that Medicare is sometimes billed for services in inpatient or residential settings. This proposal would eliminate this abuse by requiring that these services are only provided in the appropriate treatment setting.
- **Ensuring Medicare Does Not Pay For Claims Owed By Private Insurers.** Too often, Medicare pays claims that are owed by private insurers because Medicare has no way of knowing the private insurer is the primary payer. This proposal would require insurers to report any Medicare beneficiaries they cover. Also, Medicare would be allowed to recoup double the amount owed by insurers who purposely let Medicare pay claims that they should have paid, and impose fines for failure to report no-fault or liability settlements for which Medicare should have been reimbursed.
- **Enable Medicare to Negotiate Single, Simplified Payments for Certain Routine Surgical Procedures.** This proposal would expand HCFA's current "Centers of Excellence" demonstration that enables Medicare to pay for hospital and physician services for certain high-cost surgical procedures through a single, negotiated payment. This lets Medicare receive volume discounts and, in return, enables hospitals to increase their market share, gain clinical expertise, and improve quality.

A series of other anti-fraud, waste and abuse actions are proposed as well (see "Ten-Point Plan," announced by the President on January 24, 1998).

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Anne Maguire

BUDGET EFFECTS

The Medicare buy-in initiative, which includes the Medicare anti-fraud, waste and abuse proposals, yields overall savings over 5 years. Thus, it will not increase the deficit. According to the HCFA Actuaries (who also monitor the status of the Trust Funds for the Medicare Trustees), this initiative will not decrease the life of Medicare's Trust Funds.

	FY 1999 to 2003 (\$ millions)
MEDICARE	
Part A (HI)	
Medicare Buy-In Spending	2,977
Medicare Buy-In Premiums	-2,200
Anti-Fraud, Waste & Abuse	-1,010
Net Part A Savings	-233
Part B (SMI)	
Medicare Buy-In Spending	2,896
Medicare Buy-In Premiums	-2,139
Anti-Fraud, Waste & Abuse	-1,370
Net Part B Savings	-613
NET MEDICARE*	-846

* Note: There is an indirect effect on OASDI of this proposal (\$545 million over 5 years). This amount is offset in the Federal budget by the Medicare anti-fraud, waste and abuse savings, yielding a net savings of \$301 million.

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Budget 1999 ~~to~~ FY

September 8, 1998

MEMORANDUM FOR BRUCE REED
ELENA KAGAN

FROM: Domestic Policy Council Staff
SUBJECT: **Compilation of Preliminary New Ideas**

CHILDREN AND FAMILIES

✓ 1. **Child Care.** While this is not a new idea, we must maintain our support for our child care initiative in order to have credibility on the rest of a new "families first" agenda.

✓ 2. **Paid Parental Leave.** Funding for paid-parental leave for the purpose of looking after a newborn baby, or a newly-adopted child for up to 12 weeks (although we may reduce the length of time, depending on costs). A leave initiative may be targeted to families whose incomes are below a certain level.

✓ 3. **Home visitation.** Funding for programs that counsel and support new parents. These programs are often conducted by trained professionals, such as nurses and counselors, and they can dramatically decrease levels of abuse, which in turn decreases rates of delinquency and crime amongst children and youth.

Bury 4. **Child Welfare.** Additional funding for and improvements to the independent living program to assist youth in foster care "aging out" of the child welfare system with life skills training and vocational and educational needs.

no 5. **Child Tax Credit.** Double the Child Tax Credit, from \$500 per child to \$1000, for parents of children aged 0 to three.

From
at? 6. **Home Office Tax Deduction.** Expand the allowable expenses for those who work out of their home.

Yes 7. **Flex-Time.** Offer tax incentives for companies that offer flexible work hours for their employees, compressed work weeks, part-time work with benefits, job sharing, career sequencing, and extended parental leave.

For
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How
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now? 8. **After-School Programs.** Support after-school programs in both school-based and non-school-based settings, with a priority to those programs that are tailored to work hours.

CIVIL RIGHTS

1. **Enhance the CRS program at Justice.** The Community Relations Service at Justice has been a significant force in cooling racial tensions in communities all over the country. Since the 1980s, their budget has been decimated. This initiative could (1) enhance CRS's ability to provide mediation services to resolve

community civil rights concerns as an alternative to litigation; and (2) provide CRS conflict resolution training and technical assistance to communities. The CRS is very popular with the AG and she often talks of wanting it strengthened.

2. Inter-Agency Task force on Discrimination. This initiative would create an inter-agency task force (headed by the Civil Rights Division at Justice) to expand research on the extent of racial discrimination in the country. The research would focus on developing uniform testing protocols in housing, employment, and access to capital and then using these tools to assess the nature and extent of discrimination in these areas. This effort could be linked to agency compliance and/or enforcement work.

3. Improve Civil Rights Information Sharing. This proposal would provide funds to establish and maintain a system that links the data bases of agencies with civil rights enforcement responsibilities -- thus allowing, for example, OCR at Education to have better access to work being done by the Education Section at Civil Rights.

4. Becoming an American. A national effort to focus on easing the transition to the U.S. for new immigrants. We could provide grants to community-based organizations that fund English and civics classes for new immigrants. Also, we could encourage the development of programs that provide practical transition-type help to new immigrants -- such as understanding the public education system; understanding the housing system, etc. According to the INS, there is a bit of this being done on the community level, but they do not fund any of it. Also, some of the education bits are done by the Dept. of Ed. (adult education and/or literacy), but not in a coordinated way. HHS funds some transition work for refugees. This general idea was first talked about by the Jordan Commission.

5. Sweat-Shop Initiative. Expand enforcement against labor abuses in "sweatshops" and on farms that employ migrant farm laborers. Many of the wage & hour laws in place to protect low-wage workers are not adequately enforced by the Department of Labor, in part because of dramatic reduction in funding for these efforts during the 1980s. These workplaces often serve as places of gateway employment for new immigrants, and thus the abuses disproportionately affect Latinos and Asians.

6. Equal Pay. A program that could be run by the EEOC and DOL to increase outreach to businesses to educate them about the legal requirements for paying equal wages, provide technical assistance, improve training for EEOC employees and resources for increases in enforcement capabilities.

COMMUNITY EMPOWERMENT

1. Access To Capital For All Americans.



•**CDFI Tax Credit.** In 1996, we proposed a tax credit for investors in CDFIs. We could re-propose this \$100 million non-refundable tax credit. The maximum amount of credit allocable to a particular investment would be 25 percent of the amount invested.

•**Voluntary CRA.** Launch a bully pulpit effort to encourage non-bank financial institutions to develop and implement principles for community investment.

✶ •**Micro-Enterprise.** Provide authorization and funding for CDFI Fund to provide technical assistance to micro enterprise organizations and micro-entrepreneurs (PRIME Act, Kennedy-Domenici).

•**Secondary Market.** Develop coordinated administration initiative to take first steps towards secondary market for community development loans, including data collection, education, standardization, regulatory review, and the creation of a loan loss reserve fund to back pools of community development loans pooled and sold by the private sector.

•**Fair Lending.** Continue to push the Fed to permit collection of data on race and income of small business borrowers; consider legislation if this fails.

•**Capital Access Programs.** Push to give the CDFI Fund authorization to launch small business capital enhancement program to back state-run loan loss reserve funds that permit banks to make more difficult small business loans.

2. Sustainable Development.

✶ •**Environmental Activity Bonds.** In response to the growing needs of urban areas, an environmental bond would help cities meet the environmental goals set by the Clinton Administration. EPA has identified three areas which would be candidates eligible to receive funding: brownfields, drinking water, urban river/waterfront cleanup, and the creation of parks and other public spaces. Drinking water (as cities need to improve infrastructure to meet the requirements of the Safe Drinking Water Act) and brownfields are two areas that cities continue to seek assistance for financing. Our preference is to be more inclusive and allow municipalities increased flexibility to identify their priorities. However, there should be attention paid to how this financing would intersect with other Administration initiatives like the Clean Water Action Plan, Drinking Water Revolving Loan Fund, and TEA-21.

•**Urban River Corridors and Wetlands Restoration Projects.** EPA proposes urban river corridor and wetlands restoration efforts tailored to improve the human health and economic opportunities in urban communities. To date, EPA has made small grants to a number of cities and municipalities for these types of projects. With additional grants to local communities, the Agency could provide the necessary funding for projects to improve community water resources. These projects would provide employment opportunities for residents, benefit the economic welfare and technical competence of local residents, and empower the community to build for a better future. Restored areas can serve to attract and sustain business as well as provide outlets for recreation.

•**Community Preference and Visualization Tools.** Building the social capital necessary to change transportation and land-use policies to create more livable communities also requires tools that the average citizen can use to understand the implications of major policy choices. EPA proposed to act as a catalyst in the development and use of such innovative decision making tools. The types of tools would include: 1) Community Preference Surveys, which show communities pictures of different neighborhood types, and help the community reach a consensus about the types of development that are desirable; 2) simulation tools, which would get a community "development ready" or help a community experiment with alternatives that have been proposed; and 3) new

software, accessible to the public as well as urban planners, to view and evaluate alternative urban designs for any community.

② • **Asthma Initiatives.** Through better implementation and new investments, EPA believes the Federal government can take action that will show immediate and long term results to reduce asthma rates among children.

✱ • **Air Quality Credits.** EPA proposes to provide incentives to transportation planning by developing protocols for potential air quality credits toward state attainment plans for locally-initiated strategies and projects that create less auto-dependent communities. Similarly, the Agency proposes to create the next generation of the Clean Air Brownfields Partnership Pilot by continuing and expanding its ongoing efforts to link air quality goals and brownfields/infill redevelopment. After 2000, EPA proposes to partner with cities that have a significant brownfield site in the decision-making phase of redevelopment, work with the city, state, and developer to come up with a project design that maximizes air quality benefits, and allow credit for these activities under the State Implementation Plan.

3. Job Creation in Distressed Communities.

• **Local Infra structural Improvement and Economic Revitalization Fund.** Emil forwarded this idea to establish a Federal grant program to fund local Infra structural improvements. This would spark revitalization of declining or stagnant low-income areas by providing funds to upgrade local infrastructure. These Federal dollars could leverage State, local, and private funds for such Infra structural efforts.

• **Community Revitalization Tax Credit.** LISC proposes a Community Revitalization Tax Credit (CRTC) --similar to the Low-Income Housing Tax Credit --to help stimulate private-sector investment in commercial property in under served neighborhoods.

• **Community Development Corporation Tax Credit.** In 1993, we put in place a demonstration tax credit for investors in 20 CDCs. According to this report for Bruce Katz' shop at Brookings, this program has been effective. We could propose expanding this CDC tax credit to more areas. The author of this report also proposes some changes to make the tax credit more effective.

• **Expand and Rationalize Employer-Side Tax Incentives.** This includes EZs, Welfare to Work, WOTC, DC Jobs Credit.

• **Working Ventures Fund.** Fund one or more national non-profits to fund, evaluate, share best practices, develop networks, and link non-profits to their business community, in the job training and placement field, as LISC and Enterprise do in the housing

• **Community Empowerment Fund.** a) Include targeting for welfare to work projects; b) allow links to venture capital focused on minority-owned or small business in distressed areas; c) eliminate mandatory pledge of CDBG dollars for CEF loans.

•**Metro Jobs/Community Development Corporation (CDC) Links.** Would target job-poor but CDC-served central-city neighborhoods to create or strengthen a welfare-to-work infrastructure that is place-based but people-focused and regional in orientation (where the jobs are). Would build on HUD's Bridges to Work and complement DOL and HHS efforts, focusing on concentrations of assisted housing run by CBOs.

4. Low Income Savings.

•**Asset Development for Section 8 Voucher Recipients.** Currently, an individual still sees the size of their subsidy reduced for each extra dollar he/she earns. This new idea from Liebman and Orszag would roll-over any savings --or a part of the savings --from an individual earning more money into an Individual Development Account (IDA). That is, if the size of a person's Section 8 voucher is reduced by about 30 cents for each extra dollar he/she earns, we could put this savings --up to 30 cents --in an IDA. We could also the capabilities created by EFT '99 to electronically transfer money to efficiently establish IDAs for more Americans.

•**Brownfields Meets Community Development.** Under this proposal, we would push banks to invest in brownfields as part of their CRA commitments.

5. Affordable Housing.

•**Elderly Housing Initiative.** 1) Housing modernization grants to existing elderly housing projects for modernization, physical redesign, and/or conversion to assisted living; 2) Expanded and more flexible service coordinator grants to meet needs of increasingly frail population in public and assisted housing; 3) authority for PHAs to use vouchers for the housing component of assisted living costs.

•**Regional Affordable Housing Initiative.** Targeting regions with severe jobs-housing imbalance and established partnerships for regional collaboration, HUD would provide grants and loan guarantees to support planning, regulatory streamlining across jurisdictions, and development.

✱ •**Vouchers.** An expanded request will focus on incrementals, welfare to work, and homeless.

6. Promoting Homeownership In Distressed Communities.

✱ •**Low-Income Homeownership Tax Credit.** Self-Help --a community group in North Carolina --proposes a tax credit for investors who provide second mortgages to low-income families. This could significantly reduce the barriers to homeownership among low-income families, who do not really benefit from the home mortgage interest deduction.

2 •**Increase Allocation of Mortgage Revenue Bonds.** Each state receives a supply of tax-exempt mortgage revenue bonds. These bonds help low-income families become homeowners and help develop affordable rental housing. There are currently 53 co-sponsors of legislation in the Senate and 316 co-sponsors of legislation in the House to increase the allocation of mortgage revenue bonds by slightly more than 50 percent and then index it to the rate of inflation.

• **Expand Use of Mortgage Credit Certificates.** Mortgage Credit Certificates (MCCs) are credits against federal income tax equal to between 10 and 50 percent of mortgage interest (to a limit of \$2,000 per homeowner) issued by state governments. MCCs count *against* state's ability to issue mortgage revenue bonds. We could propose to expand the MCC program to allow the limit to be \$4,000 for homeowners in EZs or ECs. We could also propose allowing states to not have to count MCCs against their mortgage revenue bond base.

X • **First-Time Homebuyer Tax Credit.** The 1997 tax law put in place a \$5,000 tax credit for first-time homebuyers in the District of Columbia. To boost homeownership in Empowerment Zones, we could propose allowing any first-time homebuyer in an EZ to take advantage of this tax provision.

UP X • **Historic Homeownership Assistance Tax Credit.** The National Trust for Historic Preservation proposes a 20-percent tax credit to homeowners who rehabilitate or purchase a newly rehabilitated historic home and occupy it as a principal residence.

X • **Homeownership Vouchers.** Already authorized, would apply rental subsidies to mortgage-related expenses for first-time homebuyers who were Section 8 tenants.

EDUCATION

Teacher quality enhancement.
1. **Class Size Reduction.** Reintroduce President's proposal to reduce class size in grades 1-3 to an average of 18. Needs to be funded on the mandatory side. If necessary, we could combine this with a teacher quality/recruitment initiative, so that funds in the early years of the program are devoted to (1) incentives for people to enter teaching and/or (2) teacher training and professional development.

2. **School Modernization.** We've tried this on the mandatory side and we've tried this on the tax side. Assuming we don't get it this year, we've got to try again next year.

3. **School Discipline/Safety.** We are working on an overhaul of the Safe and Drug Free Schools Program, that will: (1) focus the program on comprehensive, proven approaches to improve school discipline and safety; (2) better target the funds to schools/communities with the greatest needs; and, (3) improve data collection and reporting, including school report cards on safety/discipline issues. Because the program currently spreads (small amounts of) funds around to almost all school, and because of its initial emphasis on keeping schools drug-free, the politics of this program will probably require that any shift in emphasis on greater targeting will require additional resources.

✓ 4. **Teacher Supply and Quality.** Here are three initial ideas for improving teacher quality. The first two came out of our initial discussions on the President's race report. We can decide down the road whether to keep them focused on high poverty schools, or make them more universal. We can also break out particular pieces of them into separate initiatives if we want to:

• **Make sure there are qualified teachers in high poverty schools.** First, encourage and support state and local efforts to improve the preparation, certification, recruitment, selection, induction,

retention, evaluation, reward and dismissal of teachers overall. Support necessary R&D on critical components of an upgraded system, such as assessing teacher competence in the classroom. Second, work to end the practice of disproportionately placing and keeping unqualified teachers in high poverty schools. Require states to require prospective teacher to pass basic skills/subject matter tests (and help them develop more demanding assessments) in order to be licensed. Prohibit school districts receiving Title 1 funds from staffing Title 1 funded classes (what about schoolwides???) with unqualified teachers, and bar those without an effective system for teacher evaluation (including removal of incompetent teachers) from receiving Federal (or just Title 1) funds. Require K-4 teachers in Title 1 schools to successfully complete training in teaching reading, and fund the training. Third, help attract and retain the best teachers for high poverty schools. Fund induction and continuing professional development programs in high poverty schools. Provide incentives for Board-certified teachers to teach in high poverty schools.

- **Recruit More Minority Teachers.** Many believe that a major factor influencing children's success in education is role models. Enhance current recruitment programs with effective incentives to attract more minorities to the teaching profession. Minority teachers, administrators, and school personnel serve as role models for minority students and can provide an important link between schools and parents.

- **Establish subject-specific teacher/administrator training institutes/academies/centers in every state.** There are crying needs to train existing teachers in key subject areas, such as reading, technology use, math/science and other academic subject. We should establish subject specific training centers in each state (or perhaps in geographic regions within states). The idea is to create a place, probably at a university, that has the subject-matter capacity and can work with school systems to develop and implement a strategy for ensuring that every teacher who needs it gets high quality, intensive and ongoing training in the subject and how to teach it. This could either substitute for or complement the current teacher training program (Eisenhower Professional Development Program), which provides funds to states and school districts on a formula basis, with broad discretion on how the funds can be used for professional development. We could also establish training centers for principals and other school leaders.

- **Continuing the Troops to Teachers (TTT) program** (due to phase out in Oct 1999). TTT provides stipends to encourage retired military personnel to teach and school districts to hire and train them. TTT attracts more minorities and men into the teaching profession than are traditionally represented, they have background in understaffed subjects such as math and science, and are more willing to teach in inner-city classrooms.

5. Recruiting and Training Principals. Most states and communities lack good strategies for recruiting and preparing individuals with the knowledge and skills to provide the kind of leadership and management schools need right now. We could propose a competitive demonstration program to provide focus, leadership and effective models for the field. This would not be a big-ticket item.

6. Urban/Rural Initiative. This could take two forms. One would be some version of Education Opportunity Zones--a competitive grants program that rewards performance and requires accountability. A second would be to create local performance partnerships, in which local communities agree to create schools that are safe, have high standards and qualified teachers, after-school programs, tutors and other forms of extra help for kids,

technology, etc. The districts would be responsible for creating schools with these opportunities, and would be accountable for improving achievement across the board (perhaps as measured against national standards). In return, the districts would (1) be able to combine funds from relevant ED and other programs, so they can figure out the best way to provide the learning opportunities; (2) get extra funding over and above the funding from the existing categorical programs; and (3) gain or lose additional funding based on performance (with some floor established to minimize the risk for districts).

7. Choice Demonstration Program. Establish a demonstration program to challenge states and school districts/cities to expand the range of high quality schools students and families can choose among, thereby enabling students in low performing schools to move to better ones. A variety of approaches should be encouraged, including:

- **Community College Enrollment.** High school students should be permitted to enroll in community colleges, for high school level or college level courses. This step could provide inner city students with access to more qualified teachers, because most community colleges have faculty with subject matter expertise (whereas urban high schools often have teachers teaching out of field). It could also help boost minority enrollment in college. [see if this can build on existing tech-prep programs, or other articulation agreements.]

- **Contract School System.** Transform urban school systems from bureaucracies which operate large numbers of schools into systems in which the local governing body contracts out the operation of each school--to teachers, nonprofits, school management firms, etc. In effect every school becomes a charter school, with a distinct mission, control over its own staffing and budget, and accountable for results. The local school board is responsible for selecting the schools, identifying new types of schools that might be needed and soliciting proposals to operate the school, monitoring the performance of each school and holding it accountable. Under this approach, all schools would eventually be schools of choice.[see Paul Hill's work for background on this]

- **Schools located at large employers.** Encourage large employers to provide facilities on site for schools for children of their own employees, while the school district provides the teachers, curriculum, instructional materials, etc. Dade County's Satellite Learning Centers provide the model for this approach. Dade's experience shows that these schools can (1) be more diverse than other schools, because work sites are more diverse than residential neighborhoods (2) save the school districts the cost of new facilities (3) save employers costs associated with employee turnover and (4) increase parental involvement in the schools.

- **Expanding choice through smaller, schools-within-schools.** Transform large, impersonal schools into smaller schools-within-schools that would dramatically expand choices within public education for families without requiring students to leave their neighborhoods. Many parents want more choice in education but don't want to send their children to school far from home. This proposal would address that need and enable many more students to get the personalized learning attention that so many families want; it also may reduce discipline and violence problems. A grants program could support networks of schools or school districts to plan and implement this concept and provide information and counseling to help students and their families make good choices. This proposal could be linked or combined with the "contract" schools concept by creating a competitive process to award contracts to manage each school-within-a-school to teachers, non-profits, charter schools, etc.

8. English Language Acquisition. As part of the planned overhaul of the Bilingual Education Program, we should consider a number of initiatives:

- **Make every LEP child competent in English within 3 years of obtaining services.** English language competency is the key to success in schooling and the economy. ESL and similar services should be made universally available to all students who need them. Federal funding can provide matching grants to States to do this. The requirement--including funding and accountability--for serving LEP kids and helping them become competent in English within 3 years should be built into the Title 1 program. Other programs, such as after-school and technology, should also be designed so that in schools with significant numbers of LEP kids, they are also focused on helping kids learn English within 3 years.

- **Support English Plus.** In addition to ensuring that all LEP students learn English, we should promote foreign language learning, starting in the early grades, for student's whose native language is English. The objective is to dramatically increase the number of students who leave school fluent in two or more languages, regardless of their native language.

- **Support demonstrations of, and if effective greatly expand "Newcomer High Schools" for recently arrived immigrant students.** Many school districts are facing an increasing number of secondary immigrant students who have low level English or native language skills, and in many cases, have had limited formal education in their native countries. In order to prevent these students from dropping out (and these children are a significant factor in the 40% Hispanic drop-out rate), these students must learn English, take the required content courses and catch up to their U.S. peers. Some district have developed Newcomer programs --either a separate school or a school-within-a-school. These programs typically educate students for a limited period of time (most for less than two years) before enrolling them in their home schools. Three such schools are 4-year high schools. The programs reach beyond the students themselves, providing classes to orient parents to the U.S. and 63% offer adult ESL classes. There are currently 75 such programs in 18 States and the Center for Applied Linguistics has sponsored an evaluation of their effectiveness.

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9. **Quality pre-school education.** We can propose an initiative to make quality pre-school universally available, or at least universally available for poor kids. There should be two key components to this. One is to provide a number of funding streams to pay for it. Head Start should be the base, though we should also look at ways in which Title 1 could play a larger role. Second, we should provide incentives to both preschools and school districts that receive federal funds, to work together to help ensure that the preschools programs are focused on helping kids get ready for school, by requiring the schools to reach out to preschools and let them know what they expect kids to know and be able to do when they come to kindergarten, and by giving the preschools the help they need to provide an appropriate curriculum.

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10. **Federal Matching Funds for AP courses and for AP and SAT/ACT Preparation.** The President has made universal access to two years of higher education a priority, and has created ways to alleviate the financial hurdles. A logical next step in improving the quality of access is to make all students more competitive by closing the gaps in advanced course availability as well as SAT and ACT test scores. The Federal government could establish funding matching mechanisms to encourage states to improve access to AP courses and preparation for AP tests in low-income schools; in areas where AP courses are not available, funds could be used for partnerships with community colleges that offer similar courses. Similarly, matched funds could be

used to do one of a number of things for SAT/ACT preparation: pay for low-income youth to attend prep courses (e.g., Kaplan; Princeton Review); fund poor school districts to set up their own test prep programs; as in America Reads, waive the federal match for Work Study students who help prepare disadvantaged students for the tests.

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11. "High Hopes" for Adults. While the President has made enormous progress in making available resources for higher education for people of all ages, the primary focus of Administration informational campaigns and initiatives like High Hopes have been to encourage young people to go to college. A new initiative could combine two efforts. First, the Administration could launch an informational campaign encouraging adults to go back to school and inform them of new resources available to help, including Lifetime Learning and Hope Scholarship Tax Credits, Individual Training Accounts under the new Workforce Investment Act, and Pell Grants (which apparently few realize can be used for part-time students). Second, a new "High Hopes" grants program targeted at adults, partly focused on encouraging minorities and women to go back to school, could support local partnerships of business, community colleges, labor unions, one-stop centers and others to provide the information and counseling needed to encourage and assist adults to enroll in courses and programs that will help them succeed in their local job market.

12. Encourage High Schools to Offer/Require Service Learning. We should consider expanding the service learning initiative (Learn and Serve) to encourage more school districts to incorporate service into their education programs. The service learning program could be expanded to provide a stronger infrastructure, e.g., service coordinators for high schools, in order to make the service experience both more rewarding and educational for students.

HEALTH

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

- **Providing new long-term care tax credit.** Along with the lack of coverage of prescription drugs, the poor coverage of long-term care represents a major cost burden for the elderly and their families. Long-term care costs account for nearly half of all out-of-pocket health expenditures for Medicare beneficiaries. This proposal would give people with two or more limitations in activities of daily living (ADL) or their care gives a tax credit of \$500 (or more, if affordable) to help pay for formal or informal long-term care. This initiative would be coupled with other long-term care policies (e.g., offering private long-term care insurance offering to Federal employees). (Cost: About \$4 billion over 5 years, offset by closing some tax loopholes, and would help about 3.4 million people).
- **Offering private long-term care insurance to Federal employees.** Since expanding Federal programs alone cannot address the next century's long-term care needs, the Federal government --as the nation's largest employer --could illustrate that a model employer should promote high-quality private long-term care insurance policies to its employees. Under this proposal, OPM would offer its employees the choice of buying differing types of high quality policies and use its market leverage to extract better prices for these policies. There would be no Federal contribution for this coverage. (Cost: Small administrative costs; OPM estimates about 300,000 participants).

• **Providing new tax credit for work-related impairment expenses for people with disabilities.** Almost 75 percent of people with significant disabilities are unemployed; many of those within the population cite the cost of employment support services and devices, as well as the potential to lose Medicaid or Medicare coverage, as the primary barriers to seeking and keeping employment. This proposal, strongly advocated by your Task Force on Employment of Adults with Disabilities, would give a 50 percent tax credit, up to \$5,000, for impairment-related work expenses. It could be a stand alone proposal in the budget or packaged as a long-term care initiative if we decide to defer announcing the long-term care tax credit. (Cost: About \$500 million over 5 years, offset by closing tax loopholes, and would help about 300,000 people).

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

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• **Adding prescription drug coverage to Medicare (new policy).** The lack of coverage for prescription drugs in Medicare is widely believed to be its most glaring shortcoming. Recognizing the medical community's reliance on prescriptions for the provision of much of the care provided to Americans, virtually every private health plan for the under-65 population has a drug benefit. Medicare's lack of coverage is largely responsible for the fact that drug costs are the highest out-of-pocket cost for three out of four elderly. This burden will only become more acute in the next century as the vast majority of advances in health care interventions will be pharmacologically-based. Responding to this fact, Republicans and Democrats on the Medicare Commission, as well as almost every health care policy expert, are consistently stating that reforming Medicare without addressing the prescription drug coverage issue would be a mistake. We are developing a wide variety of options, including a means-tested option, a managed care benefit only approach, and a traditional benefit for all beneficiaries. If desirable, a proposal could be included in the budget or coordinated with the March release of the Medicare Commission's recommendations. (Cost: Varies significantly depending on proposal, but could be \$1 -20 billion a year; assumed offset would be Medicare savings, which might more easily be achieved in context of a broader reform proposal).

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

• **Redesigning and increasing enrollment in Medicare's premium assistance program for vulnerable seniors (extension of July executive action and new policy).** Over 3 million low-income Medicare beneficiaries are eligible but do not receive Medicaid coverage of their Medicare premiums and cost sharing. Many more may not get enough assistance through the new, BBA provision that is supposed to help higher income beneficiaries. We are developing a range of proposals that build on the

President's actions in this area to better utilize Social Security Offices to educate beneficiaries about this program, to reduce administrative complexity for states and to give them incentives to engage in more aggressive outreach efforts. (Costs vary depending on policies; probably about \$500 million to \$2 billion over 5 years).

2. Health Insurance Coverage Expansions and Reforms

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

• **Expanding health insurance options for people with disabilities --Jeffords/Kennedy bill (new policy, but the concept was endorsed by you in this past summer during your ADA anniversary commemoration).** People with disabilities who want to return to work not only lose their cash benefits (SSI and SSDI) but also lose their Medicaid and Medicare coverage. You succeeded in incorporating a provision in BBA that provides an option to states to allow workers to buy into the Medicaid program. Unfortunately, because of limitations that the Republicans insisted on incorporating (like an income cap on eligible populations), no state has yet taken up this option. Working with Senators' Jeffords and Kennedy, we are proposed to: (1) expand the BBA Medicaid buy-in option by lifting strict income and resource limits and allowing states to cover less disabled people as well (such as working people with HIV AIDS); (2) provide grants to states as incentives to take these options; and (3) extend Medicare coverage for people leaving SSDI for work. So far, the disability groups, the NGA and a growing bipartisan Congressional coalition are supportive. (Cost: about \$1.3 billion over 5 years, offset by Medicare and SSA fraud savings that were in the FY 1999 budget).

• **Offering health coverage for the temporarily unemployed (FY 1997 and 1998 budgets; not passed).** Because most health insurance is employment based, job changes put families at risk of losing their health care coverage. In fact, 58 percent of the two million Americans who lose their health insurance each month cite a change in employment as the primary reason for losing coverage. This break in coverage not only leaves the worker and his or her family extremely vulnerable to catastrophic health care costs, it puts them at risk of losing the portability protection provided by the Kassebaum-Kennedy law. The proposal would provide temporary premium assistance for up to six months for workers between jobs who previously had health insurance through their employer, are in between jobs, and may not be able to pay the full cost of coverage on their own. (Costs depend on whether it is done as a demo (about \$2.5 billion over 5 years, which would help about 600,000 people) or nationwide (about \$10 billion over 5 years, which would cover about 1.4 million persons).

• **Providing coverage to parents of children on CHIP (new policy).** Since children who are uninsured usually have parents who are uninsured, an easy way to target uninsured adults is to extend

eligibility for Medicaid or CHIP to parents of children covered by these programs. This has been done successfully in some states, through Medicaid 1115 waivers, and would be a logical next step to covering low-income adults. (Cost: Depends on the proposal and assumed take-up rates by the states).

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

• **Establishing new and effective children's health insurance outreach initiatives (FY 1999 budget; not passed and new policy).** The success of the Children's Health Insurance Program (CHIP) and Welfare reform may well depend on our success at targeting and signing up the over 4 million children who are eligible, but not enrolled in CHIP or Medicaid. Last year's budget included several policies to promote outreach, including allowing states to temporarily enrolling uninsured children in Medicaid through child care referral centers, schools, etc; and allowing States to access extra Federal funds for children's outreach campaigns. An additional proposal is to pay for a nationwide toll-free number that connects families with state eligibility workers. NGA is sponsoring this line for one year only; such a line is essential for the nationwide media campaign that we are planning to launch in January with the NGA and America's Promise (Colin Powell's group). (Cost: Between \$400 and \$1 billion over 5 years.)

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

• **Strengthening OPM's hand in negotiating with FEHBP plans to better constrain costs (new policy).** Last year, premiums in FEHBP rose by 8 percent; this year, they are projected to grow at a slightly higher rate. In part, this reflects trends out of FEHBP's control, such as continued rapid increases in drug costs and an aging employee population. However, it also results because OPM has fewer tools at its disposal than private sector employers. This proposal would increase the bargaining power of OPM as well as implement other provisions that could reduce health premium costs to both the Federal government and Federal employees. Although these types of proposals have been controversial since they affect plans that want to participate in FEHBP, there may be an opening this year because of two consecutive years of high premium growth. (Could be savings, depending on the proposal).

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3. Public Health/Underserved Populations

- **Combating Resistance to Anti-biotics (Super Bug).** Recent reports have indicated that resistance to anti-biotics is becoming a major public health crisis. Some viruses, such as pneumonia and many hospital-based infections, are starting to beat even the strongest anti-biotics, causing prolonged illnesses and even death. For example, pneumonia, which impacts over 500,000 Americans per year, is becoming resistant to the strongest antibiotics. CDC believes that this critical public health problem is on track to affect more and more viruses. In the past we have generally addressed this by developing new antibiotics, but it is becoming increasingly difficult to keep developing antibiotics that do not become ineffective. However, this problem could be dramatically reduced if we knew more about which viruses are likely to become resistant and why and if drugs were prescribed and used more appropriately. For example, there are over 50 million inappropriate outpatient antibiotic prescriptions written annually. The budget could fund a major public health campaign that would: educate consumers and health providers to help assure appropriate use of anti-biotics; and improve surveillance and research efforts to understand which antibiotics are at risk for becoming ineffective and why. (Cost: up to \$50 million).
- **Improving Access to Health Care in Underserved Rural Areas.** The 25 million Americans that live in rural areas frequently do not have access to adequate health care services. For example, the physician-to-patient ratio is more than 80 percent lower in rural communities and more rural Americans are uninsured and lack access to health care services. The budget could include an initiative that would help maintain and improve access to health care in rural communities by: giving grants to help develop creative emergency services to enable rural health facilities to remain operational and responsive to the needs of their populations; providing assistance to states to help take advantage of a Balanced Budget Act provision that provides higher Medicare payments to hospitals that revamp services to meet the specific needs of their communities; and increasing the number of health professionals in rural communities by providing loan repayments or scholarships to train rural Americans who are likely to stay in the communities to become nurse practitioners. (Cost: Unclear. Approximately \$100 million).
- **Improving Access to Emergency Room Care for Veterans.** As part of the President's request to bring Federal health programs into compliance with the patients' bill of rights, the issue of whether the VA provides veterans adequate access to emergency room services has been widely publicized. The VA currently only reimburses for VA emergency visits at VA hospitals, which is certainly not consistent with the patient protection to assure emergency services when and where the need arises. We expect Senator Daschle to offer a proposal to extend VA access to emergency room services, and it may well be advisable for us to address this issue so we are not perceived as falling short on our commitment to apply the patients' bill of rights where we can. (Cost: VA's current proposal costs \$550 million per year. However, OMB has been working to dramatically reduce the costs of this proposal).
- **Enhancing Drug Approvals, Food Safety, and other FDA priorities.** The FDA has unprecedented new challenges, including: a surge in promising technologies and drugs that need approval; increasingly challenging diseases, such as AIDS and emerging pathogens; important public health issues such as food and blood safety; as well as major new statutory responsibilities from FDA reform. However, funding for this agency has not increased in several years. This has serious implications for the agency, as food inspections, organ banks, and drug companies are rarely inspected and it is more challenging to meet drug approval needs. Since Congress has been unwilling to fund user

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fees for FDA, it may be necessary to make it a priority to fund FDA at higher levels (Cost: \$100 to \$300 million).

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• **Food Safety.** The President's FY 2000 budget will build on the food Safety Initiative by expanding resources for collecting food safety data (Foodnet, Pulsenet), inspections (especially imports), and research. This continues the President's historic efforts to ensure food safety issues are considered as part of a comprehensive, science-based, policy.

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

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

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

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

• **Improving Health for Medically Underserved Native Americans.** Native Americans have particularly poor health status (as much as five times higher diabetes rates, and three to four times the rate for SIDS). It is widely recognized that the IHS, the main resource for Indian tribes who deliver

health programs to their communities, is not sufficiently funded to address the needs of this population. We could develop a number of initiatives to help improve health for Native Americans, including: focusing on particular health problems such as an elder care, domestic violence, or alcoholism; providing an overall budget increase allowing more resources for all services; or desperately needed improvements in sanitation or other public health infrastructure efforts. This would build on your efforts to elevate the Director of IHS to an Assistant Secretary position and your participation in the conference on "Building Economic Self-Determination in Indian Communities" and would compliment well the President's race and health initiative. (Cost: about \$100 million).

~~4. **Increase the Indian Health Service budget.** In order to reach more of the targeted population, we should provide a significant increase to the IHS budget in order to address areas such as substance abuse, elder health care, injury prevention, domestic violence and child abuse, and sanitation facilities.~~

HOMELESS

1. Homeless Veterans. The National Coalition of Homeless Veterans estimates that there are as many as 275,000 homeless veterans on any given night. According to the Department of Veterans Affairs, an approximately \$60 million increase in funding would constitute the single largest investment into breaking the cycle of homelessness among veterans. This proposal would seek to increase residential alternatives, community-based contracted care, job preparation activities, stand down activities (community-sponsored events that conduct one-stop service delivery programs for homeless veterans), the distribution of clothing, and long-term housing. The VA estimates that this proposal would positively impact approximately 100,000 to 150,000 veterans annually.

2. Allow VA to sell surplus property with 10 percent of proceeds going to homeless veterans. OMB proposes to amend the Property Act of 1949 to create a 5-year pilot project for the VA to sell off property with 10 percent of the proceeds going to local homelessness projects under the McKinney Act (with this 10 percent being earmarked for homeless veterans) and the other 90 percent going to the VA for capital funds (buildings, equipment, infrastructure, but not staff). Currently, the way the law works is that all the proceeds from surplus property goes to homelessness, but this has not provided an incentive to the agencies to sell property because they do not get to keep any of the proceeds. OMB states that since 1989, only one piece of property has been sold under this provision. OMB will be circulating their proposal within a couple of weeks. OMB would propose to permit VA to sell 25 pieces of property, but does not have a cost estimate yet.

3. Homelessness Demonstration Project Modeled after TANF. Funds could be set aside in the FY2000 budget to create a demonstration project so that one state, region, or locality could try to move persons from homelessness to self-sufficiency. The demonstration project should set up performance goals similar to TANF so that there is a measure of how many persons have been made self-sufficient. There could be a performance bonus for the demonstration project if the goal of the project is met.

4. Medicaid Outreach Project for Homelessness. A Medicaid outreach project could be set up, similar to the CHIP outreach project, that would reach out and cover homeless persons. We should develop a cost estimate to determine that, over time, dollars would be saved if persons are treated under Medicaid rather than on an as-needed basis in emergency rooms and clinics. This idea could be expanded to reach out to more than simply the homeless population to include all groups who are Medicaid-eligible.

CONSUMERS

1. Consumer Bill of Rights. A consumer bill of rights could address a number of areas such as enforcement, notice to consumers, and dissemination of information. We could announce this bill of rights as a package, but then pull out separate pieces for separate events like we do in the Patients' Bill of Rights area. We could include a number of different areas such as the following:

- Auto Insurance Fraud.** Auto insurance fraud is a \$13 billion-a-year problem in America. We could propose significant funding for a Justice Department anti-auto insurance fraud. Since an estimated 13 percent of auto-insurance premiums go to pay for fraud, we could claim that this effort will help drive down auto-insurance premiums.

- Slamming/Cramming.** Cramming, in which con artists add bogus charges to consumers' telephone bills, and slamming, the unwanted switching of long-distance telephone service from one carrier to another, and are the top two respective complaints reported to the National Fraud Information Center in 1998. In 1997, the FCC received more than 20,000 complaints from customers who were slammed. So far, the FCC has fined slammers, announcing a \$5.7 million fine this year, and announced voluntary guidelines for cramming that local telephone companies say they will follow. We could add money for enforcement to the FCC and/or DOJ. In May, the Senate overwhelming passed legislation that would impose new penalties on slammers and would eliminate common slamming methods, such as contest entry forms that, when signed by unsuspecting customers, authorize a switch of their long-distance carriers.

- Telemarketing Fraud.** Telemarketing fraud is among America's worst white-collar crimes, robbing unsuspecting victims of an estimated \$40 billion per year. We could increase the FBI budget to increase investigations of this type of fraud. Recently, the Washington Post reported that volunteers from the American Association of Retired Persons (AARP) work undercover for the FBI, posing as potential victims to catch telemarketers on the prowl. Because telemarketing fraud often is targeted against the elderly, we could combine this piece with the elder abuse in a separate event.

- ATM Proposal.** Weinstein proposes that Treasury publish an annual report on consumer financial issues, including ATM fees. In each report, Treasury would provide a list of insured financial institutions based on geographic divisions and by size. Treasury would report on the following categories: (1) Fees charged to depositors at ATMs at their home branches; (2) Fees charged by institutions to depositors using other banks ATMs; (3) Fees charged by ATM networks; (4) ATM fees charged to non-member depositors by institutions; (5) Minimum deposit requirements for checking and savings accounts; (6) Fees for overdrafts; and (7) Checking account fees. We will need to develop categories which underscore the differences in types of accounts. If we just list checking account fees, the fees that aren't reported would increase.

TOBACCO

1. Tobacco Counter advertising. Fund a \$200 million per year tobacco Counter advertising and education campaign, as proposed in the President's 1999 budget and McCain legislation. This campaign would develop

Counter advertising and purchase enough media time to reach teens at least four times a week. The campaign would also fund an extensive school-and community-based anti-tobacco education campaign.

2. Tobacco Cessation. Each year, 20 million smokers attempt to quit, but only 1 million, or 5 percent, succeed. More than 90 percent smokers who attempt to quit do so on their own, and the vast majority fail within 2 to 3 days. However, research shows that effective cessation methods could raise success rates to 10-20 percent (over 2 million people annually). The Agency for Health Care Policy and Research (AHCPR) endorsed 5 smoking cessation methods that have been proven to be effective in helping people to quit: gum, patch, nasal spray, inhaler, and pill (Zyban). A full course of these treatments costs around \$200-300 (for a three months supply, without counseling). However, less than half of managed care organizations provide coverage of any AHCPR-approved therapies, and those that provide coverage may impose cost-sharing requirements that hinder access to treatment. In fact, a study of managed care in Washington State found that eliminating copayments for smoking cessation services significantly increased participation rates.

3. Continued call for comprehensive legislation to stop children from smoking before they start. Total combined cost of all these initiatives: \$855 million over 5 years. We could make a series of proposals, some part of the budget and some not: (1) Fall --announce new DOD anti-tobacco plan, and new DOL and OPM tobacco-free workplace programs; (2) Winter --propose Medicaid and Veterans coverage of cessation benefits through FY2000 Budget; and (3) Spring --tax coverage of cessation as a medical expense and expanded coverage of cessation benefits in FEHBP.

- **New Department of Defense anti-tobacco plan.** This plan is still being vetted at the agency but will likely include covering over-the-counter nicotine replacement therapies under military health care coverage as part of a comprehensive military-wide anti-tobacco plan. Cost: \$60 million per year.

- **Anti-tobacco workplace initiatives by DOL and OPM.** DOL could expand its drug-free workplace initiative to provide information to employers on steps they can take to reduce tobacco use among employees (cost: \$63,000 per year). OPM could disseminate a model workplace cessation program for all federal agencies (agencies would use existing appropriated funds).

Medicaid correction

- **Medicaid coverage.** Currently, smoking cessation prescription and non-prescription drugs are optional state benefits under the Medicaid statute. We could propose to require states to cover cessation, as the McCain bill did (CBO estimated cost: \$120 million over 5 years, HCFA estimated \$114 million). Alternatively, we could propose an enhanced federal matching rate for smoking cessation treatments, in order to offer the states an incentive to cover these services. The Hansen-Meehan bill establishes a 90 percent match rate for state costs of smoking cessation services at an estimated cost of about \$110 million over 5 years. Currently, 23 states cover Zyban, 6 states cover non-prescription treatments, and 5 states cover cessation counseling. A study by the Center on Addiction and Substance Abuse at Columbia University found that over 42 percent of Medicaid recipients smoke, as compared to 25 percent of the general population and that nearly 10 percent of all Medicaid hospital days are attributable to smoking.

- **Veterans.** We should re-propose the plan from the President's 1999 budget which created a new discretionary program open to all veterans who began using tobacco products while in the service, regardless of their eligibility for other VA health care services (currently less than 15 percent of veterans receive their health care through the VA system because of statutory limits --veterans must be low

income or have a service-related injury.) The VA would contract with private sector entities to furnish AHCPR-approved services to interested veterans. OMB estimates that this proposal would cost \$87 million for the first year, and \$435 million over 5 years. Thirty-six percent of the 25 million veterans in this country smoke.

- **Tax Treatment.** Currently, the cost of cessation treatment cannot be claimed as a deductible medical expense because the IRS does not recognize smoking or tobacco addiction as a "disease." The IRS has indicated in written opinions that an official medical authority classification of smoking as a disease would allow cessation to deduct these expenses. Treasury is interested in pursuing this in 1999. This would be done outside of the budget.

- **Federal Employees Health Benefit Program.** We could require enhanced coverage of smoking cessation services. One option is to raise coverage limits to more accurately reflect the cost of AHCPR-approved treatments, and to raise the number of treatments allowed per lifetime to account for the fact that the average smoker requires three to five cessation attempts before they successfully quit (i.e., require coverage of \$300-400 per treatment, with three maximum treatments covered per lifetime). Another option is to waive the deductible and copayment requirement for cessation benefits. Currently FEHBP fee for service plans, which cover 70 percent of beneficiaries, are required to provide only \$100 in smoking cessation benefits. Generally, this coverage does not kick in until after the calendar-year deductible has been met, and most plans restrict benefits to once per lifetime. Many plans only cover prescription drugs. HMO coverage of smoking cessation benefits varies greatly. This would be done outside of the budget, but would have to occur in the spring as part of OPM's annual letter to contracting plans, establishing the terms for the following year of coverage.

WELFARE

1. Helping the Hardest-to-Employ Get and Keep Jobs.

- **Extend Welfare-to-Work Grants and Strengthen Focus on Fathers.** Funding for the \$3 billion grant program that the President fought for in the Balanced Budget Act ends in FY 1999. These funds are targeted at the hardest-to-place welfare recipients, and non-custodial parents of children on welfare, and at concentrated areas of poverty. 75% of the funds are allocated to states, who in turn pass them to local Private Industry Councils and 25% of the funds are available on a competitive basis. We expect DOL to propose extension of the grant program in their FY 2000 budget proposal. We should consider revising the statutory language to increase the focus on increasing employment of fathers. While there is a significant level of interest in serving this population, there is likely more we could do to increase the quantity and quality of services. This should also increase support from the Ways & Means committee as Shaw is very interested in fatherhood issues. Possible approaches include requiring states and communities to designate a minimum portion of WTW formula funds for fathers, setting aside a portion of competitive grant funds for this purpose, or earmarking funds for needed technical assistance and capacity building on this relatively new area. Other changes worth considering: shifting more funds toward competitive grants, increasing tribal set aside (currently 1%), and streamlining data collection requirements. Assuming level funding, this would cost \$1.5 billion annually.

• **Request Additional Welfare-to-Work Housing Vouchers.** We are unlikely to get the full 50,000 housing vouchers requested for FY 99. This approach continues to have merit, both in helping families move from welfare to work and as a catalyst for changing the way local housing authorities, and HUD, do business. Cost to fully fund 50,000 vouchers is \$283 million. Some, including Deich and Edley, have also suggested allowing housing authorities to convert Section 8 vouchers that are turning over to the more flexible approach of the WTW vouchers.

• **Invest in Increasing English Language and other Literacy Skills.** There is evidence that those with low education levels have a harder time leaving welfare. There is also emerging evidence that English language may be a barrier for some minority welfare recipients, including immigrants. We may want to explore whether there is more the federal government could do to increase access to ESL and other basic education that is combined with work, though this does not necessarily have to be done with TANF funds. We need to first explore what is available, whether there are successful models that can be replicated, and what the demand is.

2. Helping New Workers Succeed in the Workforce/Achieve Self-Sufficiency.

There are several ways to ensure people moving from welfare to work can get to their jobs:

• **Request full \$150 million authorized for Access to Jobs for FY 2000 (TEA-21 set guaranteed funding from the Highway Trust Fund at \$60 million for FY 2000).** This would allow DOT to fund more competitive grants. Note these funds can be spent on current and former welfare recipients, as well as families up to 150% of poverty so they help the working poor as well.

• **Donate surplus federal vehicles to welfare to work programs.** These could be given, leased, or sold to current and former welfare recipients for whom public transit is not a viable option, including those living in rural areas. Cars could be allocated through community-based organizations or intermediaries. This could be modeled after the initiative to donate federal computers to schools.

• **Help former welfare recipients access funds to purchase cars.** In some areas, public transit is not a viable option for a family moving from welfare to work. In addition, owning a car is something many poor families aspire to, and something that helps them become part of the economic mainstream. Family Services of America, and other organizations, currently offer revolving loans for low income families to purchase cars. FSA's model currently operates in 20 sites and is scheduled to expand to 60 sites later this Fall, with partial funding from foundations and private financial institutions. They are also seeking federal funding to help with this expansion. Possible sources include: HUD, Treasury, DOL WTW grants, as well as existing federal and state TANF funds. Another option is to expand allowable uses of IDAs to include purchasing a car needed to go to work.

• **Connection between TANF and Unemployment Insurance.** There is growing interest in exploring the relationship between these two systems. Historically, few welfare recipients have qualified for UI, and some have essentially used AFDC as a form of unemployment insurance. As more welfare recipients joining the labor force, we need to consider the most appropriate way to provide income support to them between jobs. Various approaches include: (a) changing rules of the UI system that make it hard for former welfare recipients to qualify for UI once they go to work and in the event they lose a job and (b) creative uses of federal TANF or state MOE funds to provide income support to people in between jobs. Either approach should be accompanied by a strong effort to promote job

retention and rapid re-employment. This could be considered as part of a more comprehensive UI reform initiative that NEC has been considering, but it would not depend on that. NOTE: NGA has a grant to explore this issue and several states are trying innovative approaches. While we do not have to frame the issue in terms of planning for economic downturns, it seems prudent to address this issue earlier rather than later.

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

•**Transitional Medicaid.** Families can currently receive Transitional Medicaid for up to 12 months after leaving welfare, but only about 20 to 30 percent of eligible families are enrolled. The program has many procedural hurdles that make it more difficult to access than regular Medicaid coverage and the 12 months transitional period is too short for many families. The budget could eliminate some of the current prescriptive reporting requirements now in the law (that, for example, requires families to report earnings in the fourth, seventh, and tenth months of coverage and divides the 12 months of coverage into two 6 month segments with different co-pay and benefit rules) and allow states to provide a full 12 months of coverage without regard to changes in family circumstances, similar to the 12-month option for children that was adopted in the Balanced Budget Act. In addition, the budget could provide states the option of extending transitional Medicaid to 24 or 36. These ideas need to be fully discussed, vetted, and costed out. The current program reauthorization sunsets in 2001.

•**Extend the Work Opportunity Tax Credit and Welfare-to-Work Tax Credits** (WOTC has already expired and WTW will expire in 1999).

Child support

DISABILITY POLICY

1. **Expanding the Defense Department's "CAP" program.** The Defense Department's Computer Accommodations Program ("CAP") purchases equipment for DOD employees with disabilities to allow them to keep working if they become disabled, or for new employees just joining the workforce. By using a central \$2 million fund for such purchases, individual offices do not have to bear the cost within their own budgets, and are less likely to be deterred from hiring a person with a disability. CAP is also able to get better prices on equipment through its bulk purchases and expertise. It has a showroom to help employees try out appropriate adaptive devices (CAP makes the decision on what equipment is purchased, not the employee). It has provided over 9,000 accommodations since its inception in 1990. This program is a good example of how employers and employees are taking advantage of new (and increasingly cheap) technology, such as computers for the blind that talk and listen, and alternative computer keyboards for people with dexterity problems, that allow

people with disabilities to work. Expanding the program has the strong support of the Administration's appointees with disabilities, in particular for Tony Coelho, chair of the President's Committee on Employment of People with Disabilities.

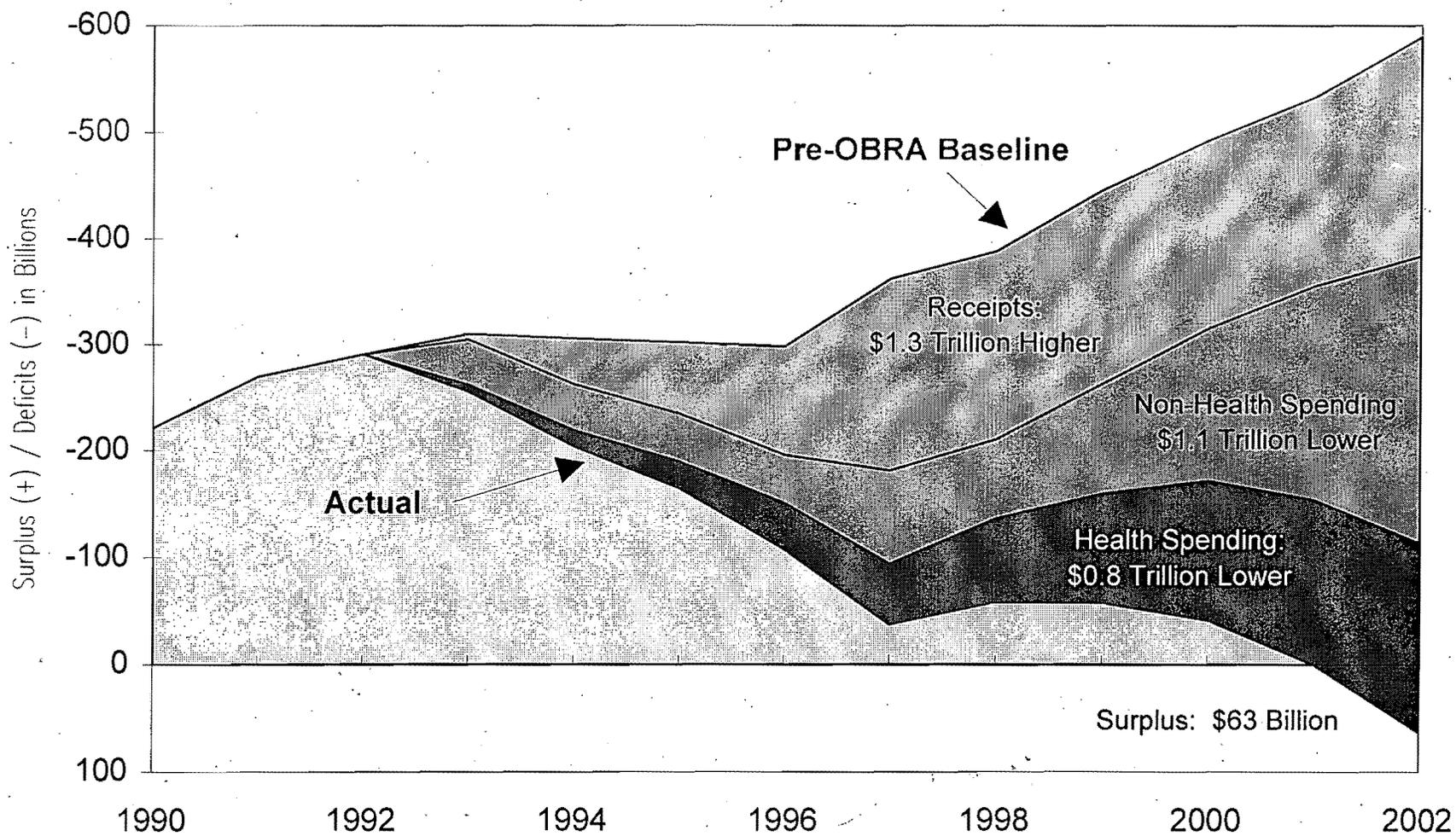
Defense has estimated that it would cost \$8 million a year to expand CAP government-wide, but this is likely overstated since CAP now serves the entire Defense Department for \$2 million a year. A more realistic range is \$2 -5 million a year. While having DOD perform this service for all federal employees is a bit unusual, they have a great deal of expertise at this task and they are ready to take on the added responsibility.

2. Tax Credit for Disability Related Expenses. New tax credit for employers and/or individuals with disabilities with extraordinary disability-related expenses, such as assistive technology or a personal assistant. The proposed credit would allow a credit of 50 percent of the first \$10,000 of disability-related work expenses. [Need Treasury information on scoring.]

3. New BRIDGE grant program. This program would create interdisciplinary consortiums of service providers (employment, transportation, etc.) to better assist people with disabilities in going to work. NEC and DPC will receive revised proposal shortly from the President's Task Force on Employment of People with Disabilities and will evaluate and vet.

4. Information and Communication Technologies for People with Disabilities. NEC has developed draft proposals now being vetted to ensure that new technologies will be designed from the beginning to be accessible to people with disabilities. Ideas include leveraging federal government procurement, investing in R&D, funding industry consortia, training the next generation of engineers, etc. (Tom Kalil is working on this, coordinating with DPC and OMB).

Health Spending's Contribution to Ending the Deficit: 25 Percent of Total Reduction and 42 Percent of Spending Reduction



MANDATORY HEALTH SPENDING INITIATIVES MEDICARE

USE	DESCRIPTION	1999-2003*
Pre-65 Coverage	Combination of: Medicare buy-in for Medicare beneficiaries' spouses ages 55-65 COBRA (employer plan buy-in) for "broken promise" retirees 55-65	< \$1 b
	Combination of: Medicare buy-in for people ages 62-65 Medicare buy-in for displaced workers ages 55-65 COBRA (employer plan buy-in) for "broken promise" retirees 55-65	\$1.5 - 2 b
Long-Term Care	Information on qualified private long-term care policies in the annual Medicare managed care choice information	< \$25 m
	Demonstration to test: Medicare catastrophic / private insurance option Managed care for long-term care Tax incentive options	Variable (\$0.5 to 4 b)
Clinical Cancer Trial Coverage	Coverage of patient care costs associated with certain cancer clinical trials	\$1.7 b
SOURCES		
Anti-Fraud	A series of policies related to Medicare fraud	\$1.5 to 2 b
Income-Related Premium	Phase out the current Medicare Part B premium subsidy Begin at: \$90,000, \$75,000 or \$50,000 for singles Raise premium to 75 percent or 100% of total cost	At least \$6 b

* Note: All cost estimates are preliminary, not OMB cleared, and subject to change

MANDATORY HEALTH SPENDING INITIATIVES COVERAGE INITIATIVES

USE	DESCRIPTION	1999-2003*
Outreach for Medicaid Children	"Performance bonus" for finding uninsured children eligible for Medicaid	\$0.5 to 1 b
	Move enrollment to schools, child care, and Head Start sites through expansion of the Medicaid "presumptive eligibility" and other options	\$500 m
	Access to special TANF fund for outreach for all children	\$200 m
Workers Between Jobs	Grants to all states for assistance up to 240% of poverty (last year's policy)	\$13 b
	Limited program based on: Less funding for all states; State option built off CHIP Fewer years Full funding for fewer states (demo)	Variable (\$0.5 to \$5 b)
Purchasing Coops	Grants to states to establish voluntary purchasing cooperatives for small employers (last year's policy). It also could be limited to a subset of states.	\$50 to 100 m
SOURCES		
Medicaid Admin. Matching Rate	Reduce from 75 to 50 percent (the usual administrative matching rate) certain matching rates for Medicaid administrative costs	Up to \$500 m
Medicaid Cost Allocation	Recapture some state funding increases in Medicaid / TANF/ Food Stamps administration by lowering the Medicaid administrative matching rate	Up to \$2 b
Tobacco Residual		?

* Note: All cost estimates are preliminary, not OMB cleared, and subject to change

Coverage

Mutual

Research

Medical Savings

COBLA

62-85

Preliminary Ideas for Mandatory Health Spending for the Budget

(Dollars in Billions, Fiscal Years; ALL PROPOSED OPTIONS' COST ESTIMATES ARE PRELIMINARY/UNOFFICIAL)

	FY 1998 BUDGET (AS PROPOSED)		FY 1999 BUDGET OPTIONS	
	Provision	Savings / Cost	Provision	Savings / Cost
MEDICARE: Savings	Traditional reductions & structural reforms	15 - 20 per yr 115 over 5 yrs	Income-related Part B premium	About 1 per yr 8 over 5 yrs
			Miscellaneous payment reductions & fraud prevention	0.3 - 0.7 per yr 1 - 2 over 5 yrs
Spending	Preventive benefits	1.5 - 2 per yr 8 over 5 yrs	Medicare buy-in for pre-65	0.1 - 1.0 per yr 0.5 - 4 over 5 yrs
	Respite benefit	0.5 per yr 2 over 5 yrs	Private long-term care insurance options for Medicare beneficiaries	0.1 - 1 per yr 0.5 - 4 over 5 yrs
	Hospital outpatient coinsurance buy-down	1 per yr 5 over 5 yrs	Clinical cancer trial coverage	0.6 per yr 3.2 over 5 yrs
MEDICAID: Savings	Per capita cap and DSH reductions	2 - 3 per yr 16 over 5 yrs	Certain administrative matching reductions	0.1 - 0.2 per yr 0.5 - 1 over 5
Spending	State option to buy in disabled workers	10 m per yr 50 m over 5	Demonstration for people with disabilities (ADAPT)	0 - 0.5 per yr 0 - 2.5 over 5 yrs
COVERAGE	Temporarily unemployed health insurance program	2 per yr 10 over 4 yrs	Demonstration for families between jobs	0.5 - 1 per yr 3 - 4 over 5 yrs
	Children's health	1 per yr 10 over 5 yrs	Children's outreach: Medicaid incentive or presumptive eligibility	0.1 - 1.0 per yr 0.5 - 5 over 5 yrs
	Voluntary purchasing cooperatives	20 m per yr 100 m over 5	Small group insurance options	0-20 m per yr 0-100 m over 5

MEDICARE HIGH-INCOME PREMIUM

FACTS

- Medicare subsidizes 75 percent of the cost of Part B coverage for all elderly and disabled beneficiaries — including wealthy beneficiaries. Recent studies have shown that wealthier beneficiaries on average live longer and actually place a greater demand on the Medicare program for additional health care services during their longer life spans.

POLICY

- **Higher premiums for higher income:** Certain high-income Medicare beneficiaries would pay either 75 percent or 100 percent of the value of the Part B benefit.

- **Income thresholds for 1999:**

Single beneficiaries: Beginning at \$50,000 (\$75,000) with full payment at \$100,000

Couple: Beginning at \$65,000 (\$90,000) with full payment at \$115,000

After 1999, eligibility thresholds would be indexed to inflation.

- **Administration:** This premium increase would be administered by the Treasury Department. Most eligible beneficiaries would fill out a Medicare Premiums Adjustment Form that is sent out with their annual tax returns. Beneficiaries would compare their income with a premium schedule and pay the extra premium amount in a check made out to the Medicare Trust Fund.

ADVANTAGES

- **No reason to wait:** Given Medicare's long-term problems, we should continue promoting structural reforms. The Commission is not an excuse for inaction.
- **Supports priority Medicare improvements:** Funding from the premium could be used for initiatives like a pre-65 Medicare buy-in, a long-term care pilot, and / or clinical cancer coverage.

DISADVANTAGES

- **Treasury administration may be problematic:** Both the controversy surrounding the IRS and the Republican opposition to using Treasury during the Balanced Budget debate may make Treasury administration more difficult.
- **Democratic base and aging groups would oppose.**

STATUS

- An interdepartmental working group has been refining the policy options since September. Will have discrete policy options in the next two weeks.

MEDICARE FRAUD AND OTHER SAVINGS

FACTS

POLICY

- [HHS is developing for the budget]
- EPO
- Managed care reimbursement
- Miscellaneous Medicaid administrative matching rates
- Cats and dogs

ADVANTAGES

DISADVANTAGES

STATUS

- Expecting HHS ideas in then next couple weeks.

MEDICARE BUY-IN FOR PRE-65 ELDERLY

FACTS

- Retiree health coverage for people less than 65 years old has declined precipitously. In 1985, 75 percent of employers offered such coverage but today it is about half.
- This lower access to employer-based coverage makes people aged 55 to 65 the largest proportionate purchasers of individual health insurance — the most unregulated type of insurance whose premiums are often too high for older and / or sicker people to afford.

POLICY

- **Medicare buy-in:** Allow certain uninsured people under 65 years old to buy into Medicare is a cost-effective way to reduce the uninsured in this age bracket.
- **Eligibility:** The age limits would be 62 through 65 years old. To limit “crowd out” of existing coverage, this option could require that Medicare is secondary payer to any employer plan and that people use 18 months of COBRA before enrolling. Enrollment could be capped and/or limited geographically.
- **Premiums:** The managed care payment rates would be age-rated and risk adjusted for this option. A selection add-on could be added to the Medicare premiums over the course of the person’s lifetime.
- **Evaluation:** A built-in evaluation would answer questions like: how many / what type of people participate; does this option cause crowd out; what is the effect on Medicare?

ADVANTAGES

- **Expands coverage:** This offers an affordable option for people who might otherwise have few choices. As such, it fits with the overall agenda to improve health coverage.
- **Tests approach for broader use:** The idea of a Medicare buy-in has been widely discussed as a coverage option if the age eligibility for Medicare were postponed. However, testing the approach is critical to knowing it is sufficient and viable.

DISADVANTAGES

- **Leads to crowd out:** Any proposal for this age group risks affecting retirement decisions and switching from private to public insurance.
- **Adverse selection:** Since it is a voluntary program, it is likely that sicker, more expensive people will take this option, making it costly for the Medicare program.

STATUS

- An interdepartmental working group has met several times primarily to discuss the problem and insurance / work dynamics of this group. Beginning to discuss this option.

PRIVATE LONG-TERM CARE INSURANCE FOR MEDICARE BENEFICIARIES

FACTS

- The retirement of the Baby Boom generation will affect long-term care as well as Medicare. Today, one in four people over age 85 live in a nursing home. The proportion of elderly living to age 90 is projected to increase from 25 percent to 42 percent by 2050.
- Unlike acute care, long-term care is not primarily financed by private insurance, which only pays 6 percent of its costs. Medicaid pays for 38 percent, Medicare pays for 16 percent, and families pay for one-third of the costs out of pocket.
- State Medicaid programs, which are the primary payer for two-thirds of nursing home residents, may not be able to sustain this role given the impending demographic change.

POLICY

- **Option 1: Medicare long-term care plan:** On a demonstration basis, develop a Medicare / private long-term care option. The plan would be a risk-sharing arrangement where Medicare would bear most of the catastrophic risk and the private plan would cover the front-end risk. Beneficiaries ages 45-65 years old would have the option to buy these plans which could be marketed with the Medicare Choice plans.
- **Option 2: Encourage private long-term care options:** Standardize long-term care options and add information on qualified private long-term care plans for Medicare beneficiaries to the Medicare Choice information brochures. An advisory council, similar to that in the Health Security Act, could develop the guidelines for plans that may be included in the Choice material.

ADVANTAGES

- **Affirms commitment to addressing a major, looming problem:** While the strain on the acute health care system due to the retirement of the Baby Boom generation will be addressed by the Medicare Commission, few are paying attention to the demographic change's consequences for long-term care. Although this initiative is modest, it helps develop long-term options.
- **Encourages development of private long-term care funding and improvement of private plans:** Today's long-term care insurance market suffers from lack of use and poor quality.

DISADVANTAGES

- **Could be perceived as adding another benefit to Medicare:** At a time when many are considering reducing Medicare's benefits, linking long-term care with Medicare may be misperceived as creating a large, new entitlement.
- **May not be popular:** A problem with private long-term care insurance is that people often are not interested in purchasing it before they need it; this may not be different.

STATUS

- Interagency work group has begun working on these options.

MEDICARE CLINICAL TRIAL COVERAGE

FACTS

- Medicare only covers treatments that are approved by the Food and Drug Administration (FDA).
- However, this policy limits both beneficiaries' choices of treatments and the understanding of how cancer treatments affect seniors, almost all of whom are Medicare beneficiaries.

POLICY

- **Medicare coverage of certain clinical trials:** Allow Medicare to cover patient care costs associated with certain cancer-treatment clinical trials that are of high quality, specifically:
 - Clinical trials that are sponsored by the National Cancer Institute;
 - Clinical trials that are sponsored by an organization that has a peer-review process that is comparable to that of NCI, as determined by the Secretary; and
 - Clinical trials that are approved under a review process determined by the National Cancer Policy Board.
- **Beneficiary protections:** Enrollment and choices for beneficiaries would be guaranteed.

ADVANTAGES

- **Access to important anti-cancer treatment:** The proposal would expand the choices of treatment that beneficiaries have by providing for Medicare coverage of high-quality cancer clinical trials. For those beneficiaries who are currently receiving care through a non-covered, qualified clinical trial, Medicare would now pay for the patient care costs associated with that trial.
- **Strong Congressional support:** Senators Rockefeller and Mack are strong proponents.

DISADVANTAGES

- **Costs could be high:** HCFA actuaries suggest that this costs \$3.2 billion over 5 years; CBO scored a more generous provision at \$2 billion over five years.

STATUS

- HHS is working on ideas to constrain the costs of this proposal.

MEDICAID DEMONSTRATION FOR PEOPLE WITH DISABILITIES

FACTS

- Medicaid is a major source of coverage for people with disabilities. In 1996, about one-third of Medicaid expenditures were for the 6 million people with disabilities covered by Medicaid.
- Part of the high cost of Medicaid for people with disabilities is the use of institutional care. Although necessary in many cases, in others it is both more cost-effective and preferable to use home and community-based care.
- Medicaid covers personal care, home care and allows for waivers to cover home and community-based care where it is budget neutral. Although there are currently over 200 home and community-based waivers in nearly all states, they may not be sufficient to overcome the institutional bias in Medicaid payment rates.

POLICY

- **Demonstration to support community assisted living:** Building on the home and community-based care waiver model, develop a demonstration that allows for innovative programs such as providing vouchers for certain personal care services or financing services like medication reminders or transportation that makes community living possible for people with disabilities. NOTE: A HCFA working group has been working both on budget-neutral demonstrations and demonstrations that cost.

ADVANTAGES

- **Tests ideas that may save Medicaid money and improve the standard of living for some people with disabilities:** There is controversy about whether ideas like these are indeed cost effective. Given a strong research component, this demonstration could come to conclusions:
- **Widespread support:** The group ADAPT has encouraged the Administration to look at a much broader version of this proposal, called "Community Attendant Services Act (CASA). They met with both the President and Congressman Gingrich and received support.

DISADVANTAGES

- **May not be enough for advocates:** ADAPT is quite aggressive and may view this as a watered down compromise, especially if Gingrich carries through on his support.
- **Could be costly:** HCFA has looked at ideas like this for years and has always been concerned that they could be too costly in the long-run.

STATUS

- HCFA promised at the September 10 meeting with the President to look into the idea of a demonstration; an interagency group is working on a proposal.

DEMONSTRATION FOR FAMILIES BETWEEN JOBS

FACTS

- More than half of the uninsured became uninsured because of job change or loss.
- These breaks in health coverage may not last long, but are very common. One in three Americans spends at least one month without insurance over a three year period.

POLICY

- **Provide limited Federal subsidies for the purchase of transitional health insurance coverage:** To ensure that people can maintain continuity of health coverage, provide about \$1 billion in Federal funding for time-limited (6 months) premium assistance to uninsured, low-income families (less than 200 percent of poverty) in several states, to test the approach for general use. Eligibility rules and subsidy amounts would be the same across states.
- **State-run test of different approaches:** States would submit applications for the Federal funds and propose their own unique approach. We would choose states to receive funds on both the merits and diversity of their approaches. For example, we could choose some states that use COBRA, use Medicaid, and subsidize parents of children enrolled in CHIP.

ADVANTAGES

- **Makes continuity of health insurance coverage affordable:** While the Kassebaum-Kennedy makes health insurance portable from one job to the next, it may not make it affordable. Many families may not be able to afford health insurance between jobs or during a waiting period.
- **State option: Can compare approaches:** Delivery approaches can be compared for broader use. This could also be used to cover some parents of children receiving CHIP coverage.

DISADVANTAGES

- **Political support may be difficult to generate:** There were surprisingly few proponents of the Temporarily Unemployed program last year. The states may not want another administrative burden as they implement welfare reform and the children's health insurance program. Limiting assistance to several states may also be problematic given our funds for all states last year.

STATUS

- PRELIMINARY / no interagency discussion yet.

CHILDREN'S HEALTH OUTREACH

FACTS

- About 3 million uninsured children are eligible for Medicaid — but not eligible for the new Children's Health Insurance Program (CHIP). Although we anticipate that there will be a "carry-over" effect on Medicaid of outreach for the new program, it may not be enough.

POLICY

- **Option 1: Bonus for outreach:** States would receive a "bonus" for enrolling new children in Medicaid — an extra matching amount for each additional child enrolled in Medicaid. This amount would be based on the states' increase in covered children, costs per child, and new matching rate under the Children's Health Insurance Program (CHIP). Successful states would get this amount at the end of the year based on their performance.
- **Option 2: Financial incentives for eligibility simplification:** A series of policy changes could facilitate enrollment in Medicaid and CHIP. First, states could access the 90 percent matching rate for the TANF \$500 million set-aside for outreach for all children (not just children losing AFDC/Medicaid). Second, we could expand the "presumptive eligibility" provision in the BBA so it (a) more types of people/sites could give children temporary Medicaid coverage and (b) the expenditures for such children are not subject to the \$24 billion Federal allotment limit. Third, we could simplify Medicaid eligibility rules for children to make it easier for states to use a single application for both Medicaid and CHIP.

ADVANTAGES

- **Removes differences between Medicaid and CHIP to ease coordination:** These policy changes would make the two programs align better both financially and administratively.
- **"Bonus" rewards strategies that work:** Rather than simply increasing funding for outreach campaigns that may or may not work, this approach offers a financial reward based on proven success in enrolling uninsured children in Medicaid. It also evens out the matching rate, so it is the same for a child enrolled in Medicaid and CHIP.
- **Cost effective:** About two-thirds of children eligible but not enrolled in Medicaid are uninsured, meaning that the risk of "crowding out" private coverage is very low.

DISADVANTAGES

- **7 or 8 million children covered:** Given the focus on the claimed 5 million children covered by the budget, we would have to justify how many more children we could cover with this initiative.
- **Paying for what states should be doing anyway:** There was some Congressional opposition to the idea of outreach bonuses due to concern that there is already significant Medicaid matching for these children.

STATUS

- These ideas have been discussed in the budget debate and informally among staff.

SMALL BUSINESS INSURANCE OPTIONS

FACTS

- Workers in small firms are most likely to be uninsured. About one-third of workers in firms with fewer than 10 employees lack health insurance — more than twice the nationwide average.
- In part, this results from the greater difficulties that smaller employer have in purchasing insurance. Studies have shown that administrative costs are higher and that small businesses pay more for the same benefits as larger firms.

POLICY

- **Encourage responsible association plan:** [Still working on this]
- **Voluntary purchasing cooperatives:** To give small businesses the same negotiating power as large businesses, encourage them to band together in purchasing cooperatives. Offer \$25 million per year in grants to cover the start-up costs for such cooperatives.
- **Link Children's Health Insurance Program (CHIP) with small insurance group purchasing cooperatives:** Under CHIP, states may get a waiver to buy children into group coverage. We could make waiver approval automatic if the state purchases group coverage through a cooperative. We could also increase the amount of the grant for start-up costs for such cooperatives if they linked them with their CHIP program.

ADVANTAGES

- **Addresses an important problem:** The increase in the number of people working in small businesses implies that the deterioration of employer-based health insurance will continue. This initiative attempts to address this.
- **Builds on momentum in Congress:** Both the House and Senate have been considering legislation to help small businesses purchase coverage; this contributes to that effort.

DISADVANTAGES

- **Not the type of reform that small businesses want:** Small businesses may only be interested in association plan-type arrangements that are self-funded and thus exempt from state insurance regulation. They are unlikely to support the voluntary purchasing cooperatives.
- **Too little:** This initiative has not generated widespread support in the past because it is considered too small to make a dent in this important problem.

STATUS

- HHS and DOL have been working on options.