HHS MEMOS

PHOTOCOPY
PRESERVATION

"STATES WIN UNDER HEALTH REFORM":
HHS STATE-BY-STATE RELEASE

Talking Points

March 1, 1994

SUMMARY: *The Department of Health and Human Services today released a study showing that all states will save under the President's approach to health reform. These state-by-state reports are great news for the Governors and state legislators who have been struggling with the high cost of providing care to their citizens. And they are great news to the hardworking taxpayers in these states who spend more and more of their earnings on health care every year.*

ALL STATES WILL SAVE UNDER THE PRESIDENT'S APPROACH:

- The President's approach to health reform will produce savings for **all states**. This will reduce the burden on taxpayers and state and local budgets, allowing states to redirect resources towards other priorities -- such as improving education, fighting crime, building highways, and expanding job training.

- **Overall, states will save at least $45.8 billion between 1996 and 2000 under the President's approach.**

  Savings come from three primary areas:

  - ***Medicaid Program:*** States will experience dramatic savings when they enroll current Medicaid beneficiaries in private health plans, where costs would increase at a slower rate.

    These savings will total $31.9 billion over 5 years.

  - ***Home and Community Based Long-Term Care:*** The Health Security Act creates a new federal/state program of home and community-based care for the elderly and disabled that would enable states to qualify for increased federal revenues.

    These savings will total $7.6 billion over 5 years.

  - ***As Employers:*** States will benefit from both a slower rate of growth in health insurance premiums for public employees, as well as from assistance in health care costs for their early retirees.

    These savings will total $6.3 billion in the year 2000 alone, including $704 million in savings for early retirees.

STATES BEAR THE BURDEN OF TODAY'S HEALTH CARE SYSTEM:

- Today's system forces state taxpayers to bear the burden of skyrocketing health care costs. In recent years, record high growth rates in the Medicaid program -- which is financed jointly by states and the federal government -- have consumed state budgets, taking limited resources away from all other state programs.

  - State Medicaid costs have skyrocketed in the last few years -- growing from 10% of state spending in 1987 to 17% of state spending in 1992. [National Association of State Budget Officers]

  - In 1993, for the first time in history, states spent more on health care than they did on tax-financed higher education. [National Association of State Legislators]

BUSINESSES AND WORKERS WHO NOW PROVIDE ALSO SAVE:

- Employers who now buy insurance for their workers will save an average of **$605 per worker** on premiums in the year 2000. This totals $59.5 billion in 2000 alone.

- Workers employed in firms that provide insurance will save an average of **$293 per worker** on premiums in the year 2000. This totals $28.9 billion in 2000 alone.

ALL INDEPENDENT EXPERTS AGREE THAT STATES WILL SAVE:

- Three independent experts -- the cost accounting firm of Lewin-VHI, the non-partisan Congressional Budget Office, and the Urban Institute -- all agree that states will save under reform. [Lewin-VHI, Inc., 12/8/93; Urban Institute, 2/14/94; CBO, 2/8/94]

- In fact, the Administration's estimates are conservative. Both Lewin-VHI and CBO show even greater overall savings to state and local governments than are projected in the HHS study.

file

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release **March 1, 1994**

DEPARTMENT OF HEALTH AND HUMAN SERVICES RELEASES STUDY ON THE FINANCIAL IMPACT OF THE HEALTH SECURITY ACT ON STATES

The Department of Health and Human Services released today an analysis of the economic impact on states of the Health Security Act. The study demonstrates that all states will experience significant savings through the reduction of costs in three primary areas: by enrolling Medicaid beneficiaries in private health plans; through the creation of a new federal-state home and community-based long-term care program; as employers through reducing the rate of growth in health insurance expenditures for public employees as well as assistance in health care costs for their early retirees.

"States are clearly among the winners under the Health Security Act. These studies show that the combination of guaranteed private insurance, long term care coverage and effective cost containment under the President's plan results in considerable savings to state governments as well as to American workers and businesses in these states," said Kenneth E. Thorpe, Deputy Assistant Secretary for Health Policy and author of the study.

The study is supported by the findings of three independent experts: The Congressional Budget Office, The Urban Institute and the cost accounting firm of Lewin VHI.

bcc: Evelyn Lieberman

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FYI Melanne

September 13, 1993

MEMORANDUM

TO: Hillary

FROM: Peter Edelman PBE

SUBJECT: Public Health Reform Aspects of the Health Care Reform

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I have seen the planning document as it was marked up by senior OMB people. The fiscal bottom line is that they were willing to put up $3 billion annually in new money, which was considerably less than we think is needed, and to make matters worse, they demanded $2 billion in cuts to go along with it. There were marginal notes throughout the document which betrayed a belief that the health care reform is all we need to do to change the health care system. That is terribly wrong, and it is what occasions this memo to you.

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Office of the Secretary

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bcc: Maggie Williams
Evelyn Lieberman

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

SEP 15 1993

MEMORANDUM FOR THE FIRST LADY

As you know, over the course of the past week, we here at HHS, together with members of your staff, have held discussions with numerous members of Congress, and many others both inside and outside of government. We are encouraged by much of what we hear. This is a bold vision and people want to believe in it and want to reform the medical care system.

Still, based on those discussions, we believe a number of key issues deserve closer attention before a final proposal is released. The first set involve the plan's assumptions regarding the financing and tightness of the budget. Over and over, we are hearing that the savings and cost estimates are simply too optimistic. More worrisome is a growing sense that the plan cumulatively is too "big, regulatory, top-down government." Our second set of concerns involve other administrative and policy issues. Our very detailed comments on a range of issues are included in Tabs A-D.

I. KEY FINANCING/BUDGET ISSUES

Medicare Savings

The current level of Medicare savings raise serious policy and political issues for many different constituencies. Our experience of the last few weeks suggests that a storm of protest may be brewing among some constituencies we would expect to be supporters. Members of Congress worry that certain hospitals are likely to be hit harder than others: in particular rural and inner city teaching hospitals who will be squeezed by the private sector and Medicare. Especially in the face of the large cuts already a part of the budget, many regard these new reductions in growth as much too large.

We fear that the perception may be growing that we are financing expanded coverage for the uninsured out of cuts in Medicare and Medicaid. Providers, beneficiaries, and advocacy groups are clearly troubled and many worry that the bill which emerges will not have the levers or the will to control private costs, but the Medicare savings will be imposed nonetheless. One strategy might be to tie Medicare savings to successful private sector savings.

Medicaid Savings

While we think the level of Medicaid savings are more plausible, legitimate concerns have surfaced about the timing and the method of phasing out disproportionate share payments. In particular,

some hospitals will need special help. Part of this is an adjustment problem as hospitals shift their method of financing from one which relies heavily on Medicaid DSH payments to one which relies on health plan payments for the formerly uninsured. But part of the problem includes the continuing need for such hospitals to serve illegal immigrants, and to deal with the substantial and continuing needs of their low income communities. Many of these will be the same hospitals hit by Medicare reductions. Thus, we urge more thought about the level and timing of the phase out of DSH payments and whether other forms of assistance to these facilities may be appropriate.

Public Health

We understand that OMB has proposed a lower investment in public health initiatives. This change suggests a potential reduction of funding for important public health strategies designed to promote the achievement of the goals established for health care reform. Insurance alone cannot guarantee the availability of services in rural and urban areas that now lack service. That guarantee is especially important as we eliminate DSH payments.

The public health initiatives focus on removing non-financial barriers to care and improving disease prevention and health promotion programs. They support a major re-structuring of health professional training which is essential to create a health workforce that meets the needs of alliances, plans, and consumers. Finally, the initiatives support data collection, analysis, and health-related research to inform decision-making by consumers, providers, and policymakers. This information is critical to cost-containment efforts at the state and federal level.

The reduction of funding for public health initiatives seriously impairs our ability to ensure that we not only reform our insurance system for taking care of illness, but also our public health infrastructure which prevents illness in the first place. Reducing funds for public health now will undermine our guarantee that all Americans will have primary, prevention, and emergency services.

Tightness of the Budget

Much of the legitimacy of Medicare and Medicaid savings is tied to the credibility of the budgets imposed on Alliances. We are hearing a chorus of disbelief. We note again that excessively tight budgets create the impression that this will be a government regulated system which will alienate supporters of managed competition while offering opponents a convenient issue to attack.

Ultimately the issues regarding budgets and financing boil down

to two: who is being hurt and are the assumptions credible. A very tight budget for Medicare and Medicaid seems to threaten certain providers who have already been asked to control costs and fees considerably more than those who have eschewed serving the old and the poor.

Estimates that are not credible undermine a cornerstone of our message: security. Many in Congress and most outside experts seem to regard savings of this magnitude as implausible. The newspapers are rapidly making this the health reform story. That makes the plan vulnerable to the attack that Americans cannot count on the security we are promising.

II. OTHER CRITICAL CONCERNS

Protecting Low-Income Families

The common sense proposition that low income families should not be worse off as a result of this plan runs into problems when one looks at the level of subsidies available for low-income persons. Compared to Medicaid, some will be worse off. Discussions with members of Congress suggest that subsidies for low-income persons need to be revised to provide a real choice of plans. Subsidies for the low-income should at least parallel those provided the SSI disabled--that is, a choice of a fee-for-service plan, including subsidies for cost-sharing, even if the plan is above the weighted average premium. The $10 per visit cost sharing in the HMO plan is too high for both AFDC and the SSI-disabled.

Allowing Medicare Beneficiaries to Elect Alliance Coverage

Allowing Medicare beneficiaries unlimited choice among plans in an Alliance likely over time will result in a deterioration of the Medicare risk pool. The proposed arrangement may hurt the Medicare program. Some fear that younger (and healthier) persons will choose to stay in the Alliance, while older persons remain in Medicare. (In addition, we would prefer to use our existing Medicare HMO payment methodology for Alliance plans.)

Shifting VA and DOD costs to the Medicare Trust Fund

Last Spring the Social Security Trustees reported that the Medicare Trust Fund was in serious financial trouble. If the growth in Medicare costs is slowed, the problem will be reduced. Consequently, it is both dangerous and illogical at a time when significant cuts in Medicare are contemplated to also ask the Medicare system to pay costs previously covered by the VA and DOD. This proposal has been defeated repeatedly in the Congress. It was also reviewed and rejected by the President and the Vice President when it was proposed for the Reinventing Government Initiative.

Transition

Many regard the transition as not allowing sufficient time for the states and federal government, including the Board, to put appropriate systems in place. While everyone appreciates the need to bring states into the new system quickly, both to extend coverage and control costs, we fear that doing so too quickly will not permit states sufficient time to certify health plans and develop monitoring procedures nor will the federal government be able to develop a credible regulatory framework. A slower phase-in would also allow new federal subsidies to be phased in.

Fragmented Authority and Confusing Accountability

The current structure creates a confusing array of accountability and authority. The National Health Board sets some policies; States set others. The Board is responsible for enforcing the budget, even though Alliances are creatures of the states. Both HHS and Labor audit Alliances. The Board may direct Cabinet Secretaries to impose penalty taxes and run a health system in a state which fails to do so (even though the federal government cannot assume state powers to regulate insurance, providers, and other aspects of the health care system). Yet, ultimately states are supposed to ensure that the Alliances are effective and accountable. Authority and accountability ought to be in the same place.

The National Health Board

We are also hearing and reading significant concerns that the National Health Board will simply be a new bureaucracy duplicating functions already performed elsewhere but requiring a net increase in government personnel to do so. We believe that the board would need to have a significant staff to carry out all of the functions it is assigned and that the transition will be delayed while the board is established and becomes operational. We urge that its role be reduced and that many operational functions be performed elsewhere.

Early Retiree Benefits

There are clear political advantages to the current policy regarding early retirees. Still, the plan can create perceived inequities worthy of attention. While many of those helped will be middle class, beneficiaries will include those with sizable unearned incomes. Questions of equity arise both for people under 55 and over 64. And we believe induced retirements would further damage the precarious Social Security, Medicare Trust Funds, and private pensions. Moreover, the retirement age will gradually increase for Social Security benefits over the next several decades. Perhaps the subsidies here could be better targeted to low-income early retirees. These issues need substantial high

level review.

All of these remarks are meant to make the President's health plan even better. Rest assured that my colleagues and I will continue to be the strongest voices in support of the plan.

Donna E. Shalala

ATTACHMENTS

Tab A: Significant policy concerns

Tab B: New text on fraud and abuse and a mark-up of benefits text

Tab C: Additional policy concerns

Tab D: Editorial comments and mark-ups

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

September 26, 1993

NOTE FOR MELANNE VERVEER

SUBJECT: Hillary R. Clinton's Remarks Accepting Award at the National Breast Cancer Awareness Dinner, September 30, Mayflower Hotel

The founding sponsors of National Breast Cancer Awareness Month are Zeneca (the manufacturer of tamoxifen, a leading pharmaceutical given to breast cancer patients) and Cancer Care, Inc. This is the 9th year that they have supported a broad-based, media savvy effort to increase awareness about breast cancer, and to promote mammographic screening by launching the first National Mammography Day, October 19.

The media package being distributed carries the names of CDC and NCI on their logo as co-sponsors. The package includes recommendations that women be screened for breast cancer at 40. This material has not been updated to reflect the recent changes in scientific opinion and revised recommendations which will be issued shortly by NCI/CDC.

The NCI and CDC currently recommend routine mammographic screening of asymptomatic women under the age of 50, and annual screening thereafter, but is revising these recommendations. NCI/CDC are in the process of changing these guidelines to reflect the consensus developed at an international NIH workshop convened in February, 1993, which found "no basis for the promotion of mammographic screening in women under age 50 in the general population," and "no demonstrated ultimate benefit," e.g., reduction in mortality. For women over 50, the benefit of screening remains clear and they are working with the American Cancer Society and other groups to encourage them to change their recommendations. The basic package of benefits in the national health plan provides for routine bi-annual screening in women age 50 and over and earlier if the doctor recommends due to a woman's risk status.

Bernadine Healy's recent criticism of the HCR package because it "doesn't provide mammography for women under 50" is clearly not true, but some women's groups have been concerned.

The First Lady may wish to address this directly in her talk to avoid any confusion/unnecessary questions. If it is not appropriate for this event, you should just be aware of the issue. Thanks.

Philip R. Lee, M.D.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

September 13, 1993

MEMORANDUM

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HHS

cc: Melanne
Maggie

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

AUG 19 1993

August 18, 1993

MEMORANDUM FOR THE FIRST LADY

From: Donna E. Shalala

Subject: Medicare Cuts Under Reform

Background

We understand the necessity of significantly reducing health care inflation for health care reform financing, but we are convinced that the level of Medicare cuts Scenarios 1 and 2 call for would be bad policy and worse politics. The first impression of the health plan will be crucial to its success; the first impression of either Scenario 1 or 2 as applied to public programs will be deadly. Even Scenario 3 runs some serious risk of alienating our friends at the onset.

Serious further cuts in Medicare are necessary to make health reform work, provided these cuts are captured for reform purposes as opposed to deficit reduction. We can then use savings rather than substantial new revenues to help form the centrist coalition of Democrats and Republicans necessary to pass health reform. If Medicare cuts can serve the dual purpose of meeting entitlement caps and financing a portion of reform, the liberal Democrats could be mollified somewhat. The lesson of budget reconciliation is that a balanced financing package is essential. As Exhibit 1 shows, however, Scenario 1 Medicare cuts would exceed the cost of expanded Medicare benefits by $88 billion; Scenario 2 cuts exceed expansion by $62 billion. We believe both numbers are much too high.

The danger is that a proposal to use Medicare to finance so large a part of reform will raise a firestorm of immediate protest from our strongest supporters. Supportive physician groups such as the American College of Physicians and the American Academy of Family Physicians will face enraged members who view further Medicare payment cuts as another broken government promise. Members of the American Hospital Association will see themselves as unable to survive the twin onslaught of aggressive pricing from qualified health plans and continued Medicare erosion. The elderly will raise the very legitimate question of why they are paying more for reform than they will receive in benefits to themselves. A major change in the current positions of any of these supporters could doom the plan at the onset.

Provider and beneficiary response will greatly influence the Hill's reaction. Senator Moynihan and the Ways and Means members will be inclined to protect teaching and urban hospitals if they appear to be in danger. Both House and Senate rural caucuses will focus on the impact on providers, particularly hospitals, in their districts. Mr. Waxman will be sympathetic to the protests of physician groups.

In choosing the amount of financing to come from Medicare, we are operating in the context of new savings from Reconciliation, which have yet to take effect, that will total $56 billion over 5 years. Scenario 3 cuts in Medicare are more stringent than the entitlement caps in the Nunn/Domenici proposal and will be very difficult to achieve both technically and politically. If we move to Scenario 1 cuts we will be asking the Medicare program to provide, in new savings, an amount equal to four times the savings already achieved under the Reconciliation bill. Even Scenario 3 cuts would require almost three times the Reconciliation savings.

This is not just a political problem, but a technical one as well. Public programs simply cannot provide the same savings to support the plan as can the private sector, which has operated largely unchecked during a decade of Medicare restrictions. It would be inappropriate, from a policy point of view, to impose the same degree of expenditure limitation on Medicare and the private sector when the number of persons covered by Medicare is growing more rapidly than the rest of the population. Equal total growth rates for the two segments will mean lower per capita growth for Medicare. In addition, our strategy for achieving the targets for private sector savings relies very heavily on one time reductions in administrative costs, savings which are not available in Medicare.

One result of ten year's worth of cost containment efforts in Medicare is that provider payments under the program are already fully one third less than the private sector's with the result that the better group model HMOs are increasingly reluctant to accept Medicare capitation rates. In fact, bringing the private sector to current levels of Medicare spending, age and risk adjusted, by itself would save tens of billions of dollars.

The attached document reviews some of the most pertinent facts with respect to proposed Medicare savings.

Attachment

MANY RURAL AND INNER CITY HOSPITALS COULD GO OUT OF BUSINESS

- Almost 2/3 of all hospitals currently have negative Medicare margins -- that is, they spend more on Medicare patients than Medicare pays them. In 1991, Medicare losses nearly equaled losses for uncompensated care. Some hospitals make up these losses by charging private payers more. Under health care reform, however, hospitals will be experiencing cutbacks from private payers as well. Hospitals that are squeezed from all sides are likely to respond by reducing staff and/or services -- or closing altogether.

- About 30 percent of sole community hospitals, 39 percent of small rural hospitals, and 24 percent of large urban hospitals are currently operating in the red overall. Another 25 percent of large urban hospitals are teetering on the edge -- their margins are only .1 percent. While operating efficiencies may be possible, many hospitals will not be able to respond quickly enough. The additional Medicare payment cuts along with private reductions may force closures.

- Many inner-city hospitals, particularly public hospitals, are facing crumbling infrastructures. Taken together, the Medicare and private sector cuts will mean less capital to invest and rebuild. Given their deteriorating structures, quality problems will eventually surface. Such hospitals cannot compete in the health care market.

PROMISES TO PHYSICIANS, ESPECIALLY PRIMARY CARE PHYSICIANS, WILL BE BROKEN

- We are committed to increasing Medicare payments for primary care services. Significant cuts in Medicare physician payments under health care reform (on top of billions in reconciliation cuts) will prove politically very difficult to deliver if all physician fees must be reduced to the extent required to meet Scenario 1 or 2 levels.

- Further significant cuts in physician payments could allow gaps in access to develop in certain areas. Reconciliation essentially froze Medicare physician fees in real dollar terms and will lead to substantial geographic redistribution in order to keep our promises with respect to primary care. Reductions needed to reach Scenarios 1 or 2 would require substantial reductions in Medicare payment levels. While access to physicians by Medicare beneficiaries may not be a problem immediately or in all areas, pockets of problem areas are sure to crop up.

EMPLOYMENT COULD SUFFER

- Almost 4 million individuals are employed by community hospitals. The annual payroll (including fringe benefits) of these employees is about $140 billion year. Cuts in Medicare hospital payments could jeopardize the jobs of many of these workers and negatively affect the economy in their communities. Hospitals are now the largest employers in many distressed cities; their employees are disproportionately women and minorities so the job loss will worsen the effects of the current economy on the most vulnerable individuals and communities.

- Hospitals are also major employers in rural America. Studies show that the presence of a hospital in a rural area guarantees an inflow of funds. If hospitals significantly cut back on staffing or close, rural areas especially could be hard hit by layoffs.

STATES WOULD SPEND MORE

- Medicaid pays Medicare cost-sharing amounts for poor beneficiaries. If the Medicare cost-sharing is increased, the States would have additional liability. Each extra billion in beneficiary cost-sharing translates into $470,000 more in State dollars.

- Given the continued inadequacy of the Medicare benefit package compared to the comprehensive package under health reform, cuts of the Scenario 3 magnitude will make it impossible for any State to integrate Medicare beneficiaries into its system.

UNINTENDED CONSEQUENCES ON BENEFICIARIES

- It is difficult to predict the effect of increasing beneficiary cost-sharing on beneficiaries, since cost-sharing amounts depend on the type of service provided and whether or not the beneficiary is covered by supplemental insurance. However, we have concerns that some beneficiaries may be negatively affected.

    + For example, there are 240,000 elderly living in families with incomes $200 or less above the poverty line. 290,000 live in families from $200 to $250 above poverty. Policies requiring beneficiaries to pay $200 or $250 more out-of-pocket per year could be detrimental to individuals teetering above the poverty line.

Medicare in Health Care Reform
($'s in Billions)
Scenario 1

	1994	1995	1996	1997	1998	1999	2000	1996–2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-7	-17	-30	-45	-62	-161
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-9	-10	-10	-47
Sub-total	-2	-2	-18	-28	-42	-58	-75	-221
Total, Scenario 1	-2	-2	-2	-7	-16	-26	-36	-87

Scenario 2

	1994	1995	1996	1997	1998	1999	2000	1996–2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-6	-13	-25	-38	-52	-134
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-17	-24	-38	-51	-66	-196
Total, Scenario 2	-2	-2	-1	-3	-12	-19	-27	-62

Scenario 3

	1994	1995	1996	1997	1998	1999	2000	1996–2000
New Benefits								
Drug Benefit w/rebate	0	0	13	14	15	16	17	75
Long-term Care	0	0	3	7	11	16	22	59
Sub-total	0	0	16	21	26	32	39	134
Reductions								
Medicare savings to meet global budget	0	0	-4	-10	-19	-30	-42	-105
Income Test Premiums	-2	-2	-2	-2	-3	-3	-3	-13
Offset for Employed Bene's	0	0	-9	-9	-10	-10	-11	-49
Sub-total	-2	-2	-15	-21	-32	-43	-56	-167
Total, Scenario 3	-2	-2	1	0	-6	-11	-17	-33

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

93JUN 9 A8:00

JUN 7 1993

TO: The President and Mrs. Clinton

FROM: Secretary Shalala

SUBJECT: Public Portrayal of the Medicare Program

As we move from the stage of formulating our plan for Health Care Reform to the process of explaining it to the public and shepherding it through the Congress, my staff and I are increasingly concerned about the way in which the Administration publicly portrays the Medicare program. In particular, we are dismayed by the credence which seems to be attached to any complaint about the program, no matter how ill-founded. While there are many problems with Medicare - which we are trying to address in a number of ways - the program continues to enjoy extremely broad support not only from its beneficiaries and other key constituency groups, but from the general public as well. Key Congressmen are especially sensitive to its political importance.

As representatives of the Administration have met with provider groups, especially physicians, they have heard a continuing litany of complaints about Medicare. Many of these complaints are well-founded. It should be understood, however, that for the last twelve years Medicare has been run by administrations fundamentally hostile, on ideological grounds, to its very existence, unwilling to spend money to improve its operations, and eager to discredit it in a number of ways. Partially as a result, beginning in the mid-'80s, the Congress began micromanaging the program by writing extremely detailed legislation, which has made responsive and constituent-sensitive administration even more difficult.

It's also important to understand that, at the root of many provider complaints about Medicare is the feeling that they are not getting paid enough. If we really agreed with that perception, it would be difficult to justify adding another $20 to $30 billion in provider payment reductions to a Reconciliation package which already contained almost $50 billion in reductions.

In fact, by any objective measure, Medicare is the most efficiently-administered health insurance program in the world. As we showed you in charts last month (attached), since 1983 it has also significantly outperformed the private sector in terms of cost containment, despite insuring an increasingly sick and disabled population. And while there are serious problems in the Medicare HMO program - which we are in the process of fixing - Medicare is still the largest buyer of HMO services in the world.

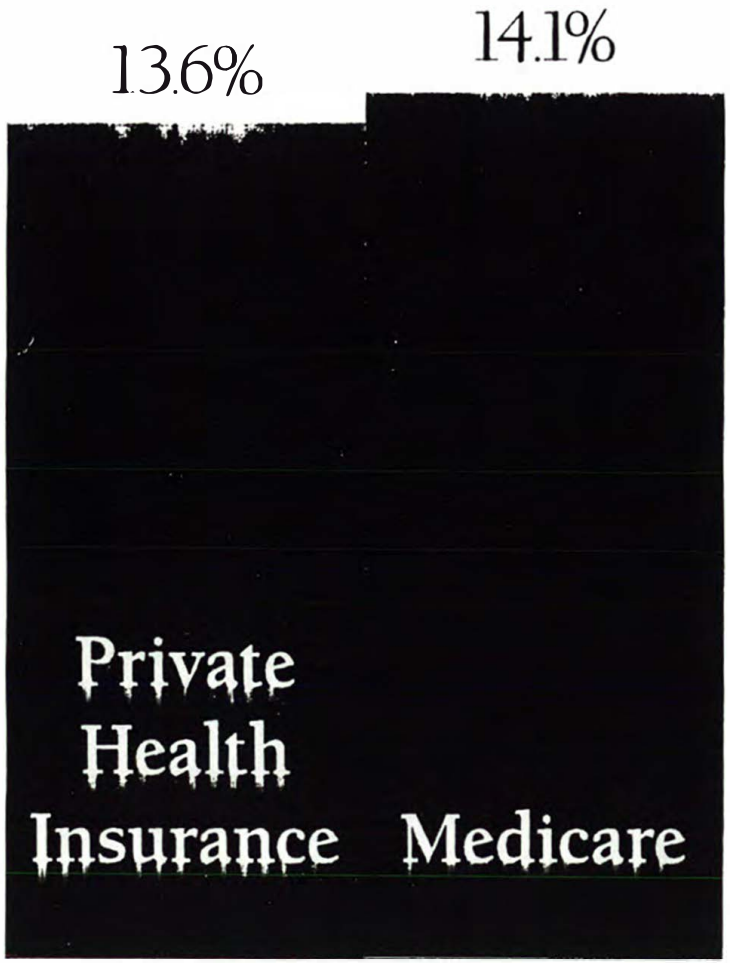
As the extent of the flap over last month's leak that we were even considering integration of Medicare into Health Care Reform reveals, Medicare beneficiaries are not only extremely protective of the program, but highly mobilized. Moreover, to the extent that we reinforce the notion that the government can not even run this most popular of all its programs, we give ammunition to those who would argue that we are incapable of the far more complex task of administering Health Care Reform. We thus run the risk of alienating our friends while giving comfort to our enemies.

For thirty years, Democrats of all persuasions have considered Medicare one of our proudest accomplishments. As New Democrats, we should improve upon and modernize those accomplishments rather than appearing to agree too readily with those who never believed in the principle of social insurance for the aged and disabled in the first place. Otherwise, we run the risk of sending out some very confused and confusing signals about our views on health care and Health Care Reform.

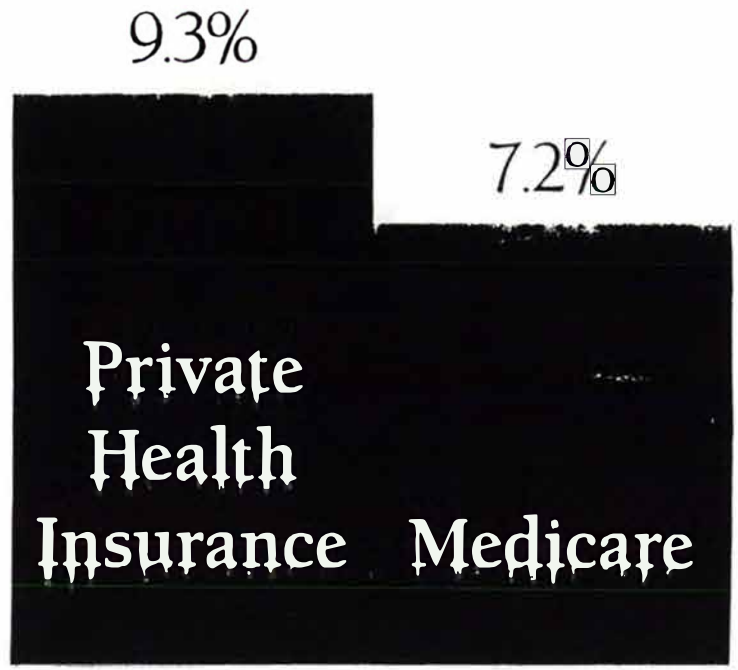
Attachment

cc: Carol Rasco

Comparison of Growth Rates in Expenditures Per Enrollee: Private Health Insurance and Medicare

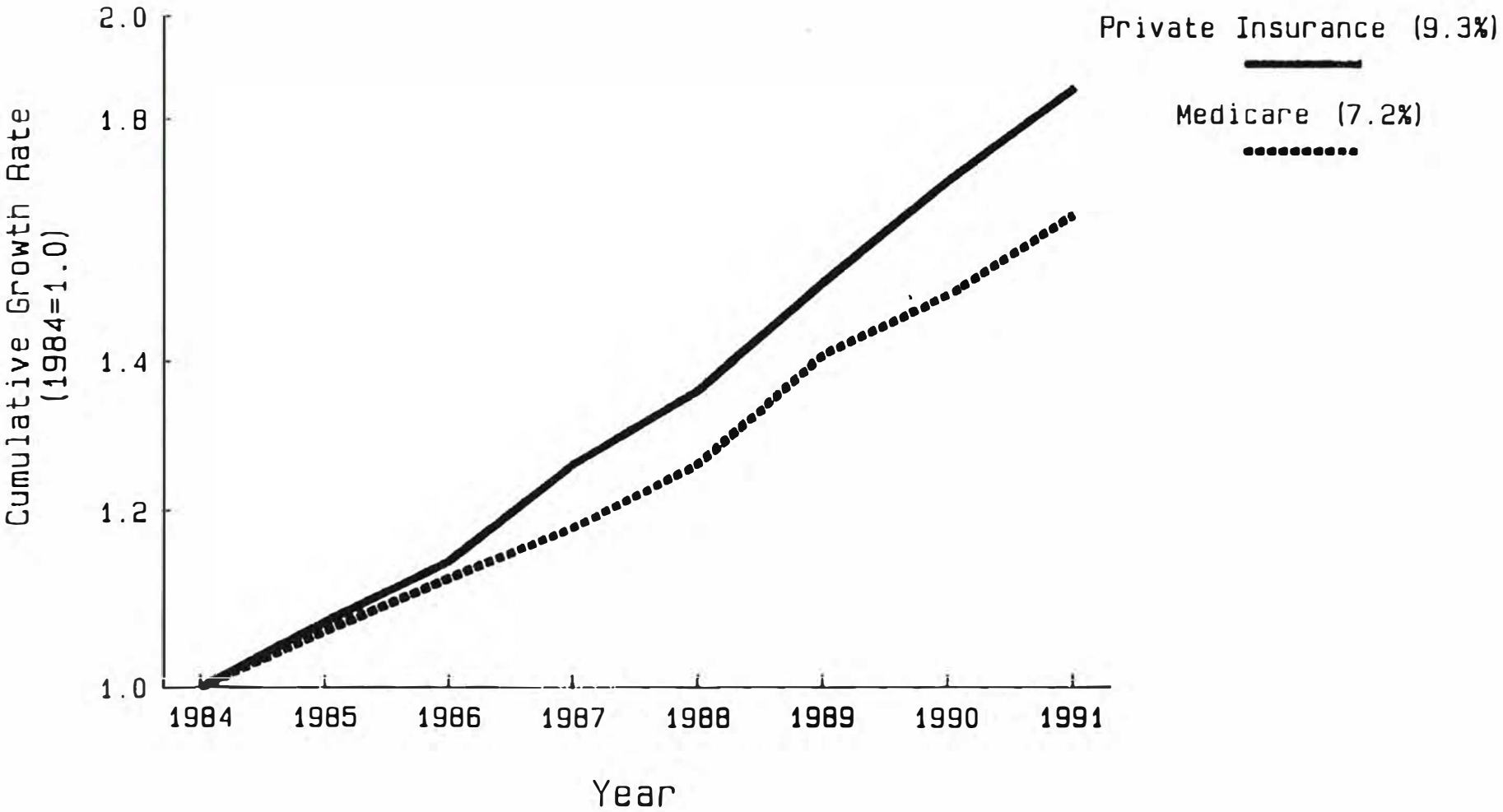


Before Payment Reforms
(1976-1984)



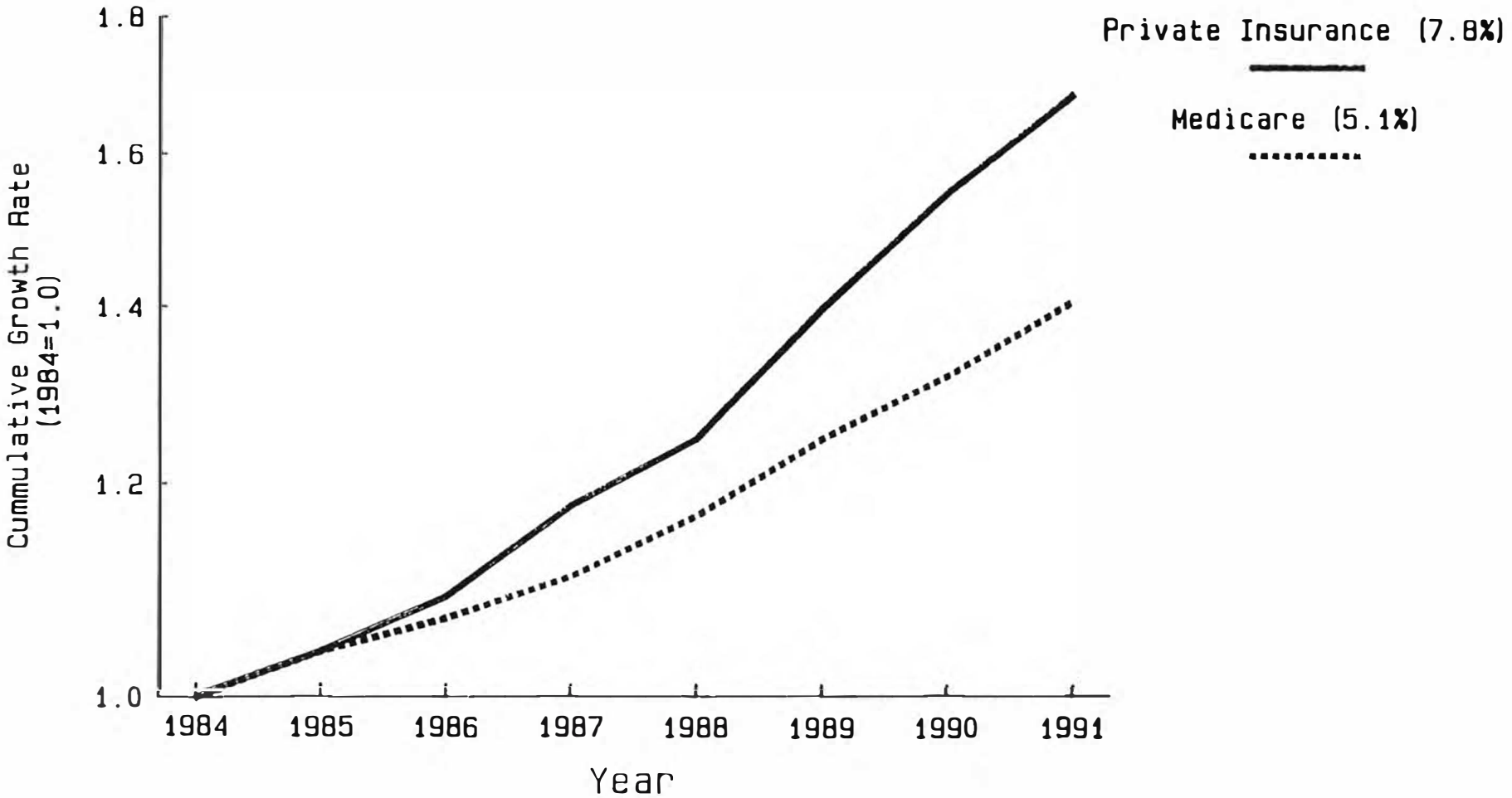
After Payment Reforms
(1984-1991)

Comparison of Growth Rates in Expenditures Per Enrollee: Private Health Insurance and Medicare 1984–1991



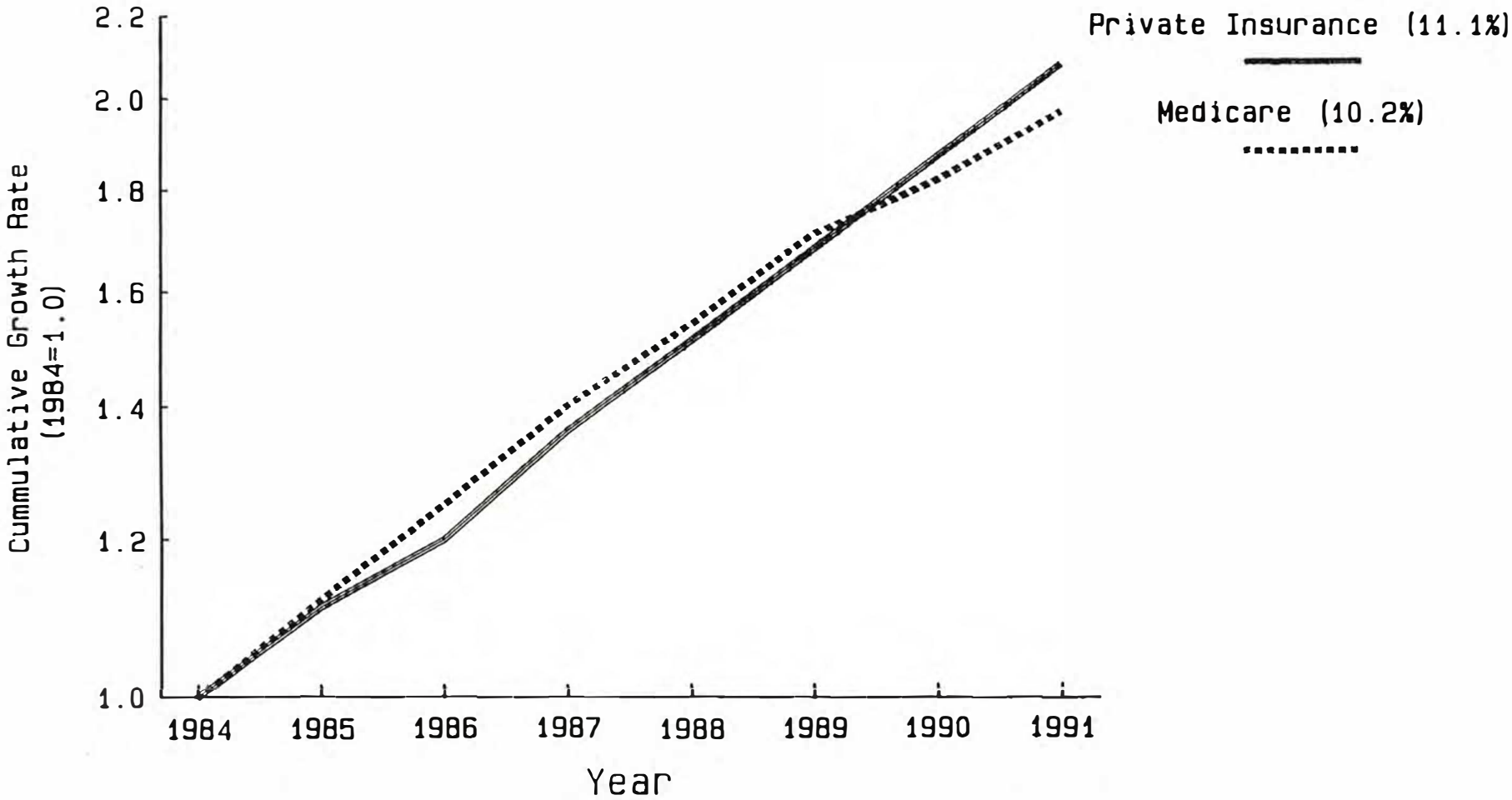
Note: Numbers in parentheses are the 1984-1991 compound average annual rates of growth.

Comparison of Growth Rates in Hospital Expenditures Per Enrollee: Private Health Insurance and Medicare 1984–1991



Note: Numbers in parentheses are the 1984-1991 compound average annual rates of growth.

Comparison of Growth Rates in Physician Expenditures Per Enrollee: Private Health Insurance and Medicare 1984–1991



Note: Numbers in parentheses are the 1984-1991 compound average annual rates of growth.

EXECUTIVE CORRESPONDENCE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

SEP 10 1993

MEMORANDUM FOR THE FIRST LADY

From: The Assistant Secretary for Health

Subject: Public Health Initiatives Under Reform

The success of the Health Security Act ultimately will be judged by whether it improves the health of Americans at an affordable cost and reduces disparities in health status across different sectors of the population. While universal insurance coverage and market reforms will go a long way toward achieving these goals, a restructured and strengthened public health system is equally important. Experience here and in other countries has clearly demonstrated that insurance coverage alone does not automatically result in access to needed care, and that personal medical services are not sufficient to protect or improve the health of the population. The Public Health Service initiatives within the Health Security Act will ensure that the promise of health care reform is realized by:

- removing nonfinancial barriers to care, thereby assuring that all Americans have access to the services to which they are entitled;
- protecting and improving the health of populations through programs directed at disease prevention and health promotion;
- creating a workforce that meets today's needs, by providing Americans with comprehensive, coordinated, patient-centered care; and
- supporting informed decisionmaking by consumers, providers, and policymakers through data collection, performance monitoring, and health-related research.

The proposed initiatives envision a new and far more effective role for the public health system under reform than was possible in the past. Working in concert with alliances, health plans, and providers, public health will provide the reformed delivery system with vital support. This will benefit the health care system financially because plan expenses and alliance premiums will be lowered to the extent that the health status of their populations is improved. At the same time, the responsibility of alliances and plans for defined populations, and their ability to inform and educate individual patients and practitioners within these populations, will assist the public health system in meeting its objectives.

Public Health Access Initiatives

As you are aware, lack of health insurance is only one barrier to medical care. Others include an inadequate supply of providers and health plans; lack of transportation, translation, and child-care services; lack of understanding about the need for or availability of services, and cultural gaps that stem from a lack of minority providers. Segments of the population disproportionately affected by these barriers -- such as low-income, minority, rural, and inner-city populations; children; the homeless; and persons suffering from conditions such as HIV/AIDS, chronic mental illness, and serious disability -- often do not receive the services to which they are entitled, resulting in reduced health status and quality of life.

We only need to think about the difficulties involved in providing covered services to hard-to-reach populations (for example, prenatal care for rural or inner-city teens, tuberculosis treatment for the homeless, substance abuse treatment for intravenous drug abusers) to appreciate the limitations of market and insurance reforms in assuring access to care. Outreach and enabling services will not be included in the comprehensive benefit package. Health plans will be providing care for populations with whom they have little experience or expertise. And plans will need additional assistance and incentives to expand into underserved areas and to ensure that hard-to-reach populations get access to care.

Because of its longstanding role supporting safety-net providers, the Public Health Service is uniquely positioned to deal with many of these problems. The proposed initiatives take advantage of universal insurance coverage to shift the emphasis of public health funding from providing personal health services that will be included in the benefit package to the equally important task of removing nonfinancial barriers to care. The programs include:

- expansion of the National Health Service Corps to reduce the shortage of primary care practitioners in medically underserved areas;

- a new capacity expansion program that will:

  -- provide residents in underserved areas with an adequate supply and choice of providers and plans;

  -- support the development of practice networks that form the backbone of community-oriented plans; and

  -- ensure that all public health providers currently funded under Federal programs become fully integrated in the new system;

- support for outreach, enabling, and linkage services through current categorical and formula-grant programs and new grants to States;

- assurance of access and continuity of care for vulnerable populations through a

five-year program of mandatory reimbursement or contracting with essential community providers; and

- support for the special needs of school-aged youth in high risk settings through comprehensive health education programs and the provision of physical, mental health, and social services in school-based clinics.

Some of these programs will be time-limited, such as those aimed at increasing the supply of practitioners, practice networks, clinics, and health plans in underserved areas and at helping providers currently supported by public sector funds adapt to the reformed delivery system. Others, such as those designed to help alliances and plans reach out and deliver culturally-sensitive care to vulnerable segments of their populations, will be ongoing, but with the flexibility to address local community problems and changing needs over time. By assuring access to needed services, these initiatives will protect not only the health of individuals, but also (e.g., when services relate to the prevention or treatment of communicable diseases) of the entire community as well.

Public Health Core Function and Prevention Initiatives

The American people depend on public health agencies to protect them against preventable infectious disease outbreaks, to educate them about behavioral and environmental risks to their health, and to protect their environments against health-threatening exposures. Historically, the most important improvements in health status have derived from public health efforts directed at entire populations rather than the provision of personal medical services. Yet the capacity of public health agencies to deliver on their responsibilities has been seriously eroded in recent years.

For the Nation as a whole, overall support for public health's basic population-based functions has fallen 25 percent behind increases in support for personal health care services during the period from 1980 to 1993, from about 1.2 percent to 0.9 percent of total health care expenditures. The consequences of this erosion have been tragic and costly: outbreaks of childhood preventable diseases such as measles and pertussis in low-income inner cities where immunizations have not been delivered; an outbreak of water-borne diseases affecting nearly 250,000 in one Wisconsin community; outbreaks of food-borne diseases resulting in deaths of children in the Northwest; and failure to gain successes parallel to those in smoking for other behaviorally-related health risk areas such as sexual behavior, alcohol abuse, dietary patterns, and physical activity.

Failure to adequately support the primary public health functions of prevention and protection jeopardizes both the health and economic objectives of reform. In 1982, the Institute of Medicine estimated that only 10 percent of preventable early death, disease, and disability is related to insufficient delivery of personal medical services, whereas 70 percent is related to environmental and lifestyle factors that can be addressed by public health. In recent years,

however, especially with the challenge of HIV/AIDS, public health's energies and resources have increasingly been focused on providing personal health care services to the uninsured and underinsured, to the detriment of essential, population-based functions.

The Health Security Act, by providing universal insurance coverage, will allow public health agencies at the national, State, and local levels to turn their resources and expertise to carrying out the core functions of public health. Equally important, by supporting the establishment of alliances and health plans, it will enable public health agencies to link with these entities in achieving population-wide health status improvements. The following initiatives are designed to take full advantage of the opportunities inherent in reform:

- new grants to States to strengthen core public health functions at State and community levels:

  -- health data collection, surveillance, monitoring;
  -- quality assurance; accountability for service delivery
  -- protection of environment, housing, food, water
  -- investigation/control of diseases and injuries
  -- community information, education, mobilization
  -- laboratory services
  -- training and education of public health professionals

- funds to enhance the Federal capacity to support public health functions. This program will achieve economies of scale by consolidating currently fragmented data systems, enhancing communication of information, and providing States and communities with expert technical assistance; and

- a competitive grant program to support the development and evaluation of innovative interventions to address priority health problems of national and regional significance (e.g., violence, immunization, cigarette smoking, tuberculosis, HIV/AIDS).

Health Care Workforce

Ensuring access to quality care for all Americans under the Health Security Act will require a national workforce policy. Additional practitioners will be needed to serve previously uninsured or underinsured individuals, to provide care in rural and inner-city underserved areas, and to provide culturally-sensitive care for ethnic and minority populations. Changes in the specialty distribution and the training of practitioners will also be needed to help health plans provide comprehensive, prevention-oriented care to all segments of their populations.

The proposed initiatives will assure that all federal funding is promoting a culturally diverse workforce capable of providing high quality, patient centered care, even in underserved

communities.

- National and regional councils will allocate funds to training programs to assure that health plans in all geographic regions have access to an appropriate mix of primary care and and specialty physicians;

- The National Health Service Corps will be expanded and tax incentives will be provided to attract and retain physicians in underserved rural and urban areas;

- The Health Professions Training Programs will be redirected to shift the balance of physicians from specialist to primary care and to increase the supply of nurse practitioners and physician assistants; and

- Medicare payments will be modified to increase payments for primary care physicians.

Health Research Initiatives

Better information to guide decisions about care and consumer choice of plans is essential to the Health Security Act. Three types of research are needed to provide this information. Prevention research identifies avoidable causes of illness. Health services research increases the ability of providers and plans to deliver effective, high-quality care. Evaluation research provides reliable measures to evaluate the performance of health plans and also assesses the extent to which reform is making health care available to all Americans.

The proposed research initiatives will support the needs of reform by:

- expanding prevention research and promoting the development of health and wellness interventions;

- promoting a major expansion in quality, effectiveness, and outcomes research;

- developing health plan quality and performance measures as well as clinical practice guidelines; and

- monitoring the effects of reform at national, State, and local levels.

Budget

Overall, the public health initiatives incorporated in the Health Security Act will require $4.8 billion in investment increases in FY 1996:

•	Public Health Access Initiatives	$ 1.6 billion
•	Public Health Core Function Initiatives	$ 1.1 billion
•	Health Care Workforce	$ 0.2 billion
•	Health Research Initiatives	$ 1.9 billion

Attached is a table summarizing the investments for FY 1994 through FY 1998.

Clearly, there are existing programs within the Public Health Service (e.g., Community and Migrant Health Centers, Maternal and Child Health, Family Planning Clinics, Mental Health and Substance Abuse) that fund services which will be included in the comprehensive benefit package under reform. Considerable new revenues will flow to the grantees of these programs as reform becomes fully implemented. The plan under consultation with the Congress includes a public health programs savings offset of $2 billion, primarily in the programs mentioned above.

These public health programs also fund services that **will not** be paid for by plans, however, such as outreach and enabling services. With universal coverage, additional persons are likely to require such services to get the care to which they are entitled. Moreover, new programs, such as the capacity expansion program and the school-aged youth initiative, will be required to assure underserved and vulnerable populations access to care. It has been our assumption in developing the budget for the public health initiative that the savings from payments for covered services would be redirected to these new activities. It is OMB's view, however, that some or all of these savings should be returned to the Treasury in the form of reduced appropriation levels for public health programs.

Political Considerations

Finally, we must consider the strong political support for public health programs. Critical Members of the House and Senate will demand support for public health programs that address the needs of the underserved under reform. These Members realize, through a long history of advocating for underserved and vulnerable populations, that the President's vision of access to care for all Americans cannot be achieved through insurance reform alone. Unless the Administration proposes a credible approach to these issues, it will not be positioned to negotiate new, more effective public health strategies under reform as we have proposed. Instead, the Congress is likely to continue categorical grant programs that do not reflect our new agenda for change.

Philip R. Lee, M.D.

Attachments

cc: Ira Magaziner

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a tabbed divider. Given our digitization capabilities, we are sometimes unable to adequately scan such dividers. The title from the original document is indicated below.

Budget

Divider Title:_____

PUBLIC HEALTH SERVICE
Health Care Reform Incremental Budget
(Dollars in Millions)

PUBLIC HEALTH INITIATIVE

Program/Activity	Incremental Increase/Decrease				
	FY 1994	FY 1995	FY 1996 1/	FY 1997	FY 1998
Workforce Changes	**3**	**24**	**204**	**204**	**204**
AHC	3	4	4	4	4
Health Professions	0	20	200	200	200
Health Research Initiatives	**213**	**389**	**1,939**	**2,161**	**2,286**
Prevention Research	3	12	1,530	1,530	1,530
Health Services Research	210	377	409	631	756
PHS Access	**10**	**590**	**1,557**	**2,082**	**2,259**
NHSC	0	0	75	175	175
Capacity Expan. (Non-Sch)	0	300	500	500	500
School Based Expansion	0	100	275	350	430
Formula Grant	0	0	200	300	400
School Education	0	50	50	50	50
Ment. Hlth. & Subst. Abuse	0	100	200	400	400
Indian Health Service	10	40	257	307	304
Public Health Services	**0**	**12**	**1,100**	**1,300**	**1,500**
Core	0	12	700	850	1,000
Priority	0	0	300	350	400
Federal Intramural	0	0	100	100	100
Total Public Health Initiative	**$226**	**$1,015**	**$4,800**	**$5,747**	**$6,249**

ADMINISTRATIVE PROGRAMS 2/

Program/Activity	Incremental Increase/Decrease				
	FY 1994	FY 1995	FY 1996 1/	FY 1997	FY 1998
Data/Surveys	**$150**	**$200**	**$200**	**$200**	**$200**
Quality Improvement	**19**	**48**	**175**	**245**	**298**
Natl. Quality Mgt. Program	7	26	45	65	68
Research	12	22	130	180	230
Workforce - Alloc. System	15	25	25	25	25
Total Administrative Programs	**184**	**273**	**400**	**470**	**523**

1/ Assumes full implementation of Health Care Reform by January 1, 1996.

2/ These activities were previously included in the PHS incremental budget, but per Ira Magaziner's decision, will be covered through the start-up and federal administration budget of Health Reform.

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Divider Title: **Access Initiatives**

HEALTH CARE ACCESS INITIATIVES

In the existing health care system, major financial and non-financial barriers reduce access for a number of population groups in American society. Population groups that particularly confront barriers to care include:

- Low-income groups and individuals who have little education.
- Members of certain racial, cultural and ethnic groups and those who speak languages other than English.
- Residents of central cities, rural and frontier communities.
- Individuals who lack a stable residence, such as migrant workers and homeless individuals or families.
- Adolescents.
- Individuals with certain severe health problems, such as HIV infection, AIDS, chronic mental illness, substance abuse or serious disability.

As a result, members of those population groups often experience reduced health status and quality of life. Health care reform will significantly improve access to care by providing all Americans with comprehensive coverage for treatment services, clinical preventive services, mental health and substance abuse services.

However, universal insurance coverage and market reforms alone will not eliminate all barriers to care or ensure quality. In order to meet their obligations to provide comprehensive health care benefits, health plans will require assistance and financial incentives to expand into low-population areas and to ensure that hard-to-reach populations have access to quality care.

In order to fulfill the promise of health reform, other inadequacies requiring attention include: the supply of providers and health plans in both rural and low-income urban areas; poor integration and coordination of care between primary care and specialized services; cultural and linguistic barriers; transportation and hours of service; lack of understanding among consumers about the availability of services; and resistance to the use of services. Many health care providers who are skilled and committed to serving populations most affected by access barriers also will require special assistance to prepare for and ensure their effective participation in the reformed system.

GOALS AND STRATEGY OF THE PUBLIC HEALTH SERVICE ACCESS INITIATIVES

The programs described in the following section are designed to reduce disparities in health status by ensuring access to needed services for low-income, underserved, hard-to-reach, and otherwise vulnerable populations. They build on the strengths of the reformed delivery system, the expertise and experience of current public health providers, and the enhanced capacities of state and local public health agencies.

The Public Health Service access initiatives are designed to:

- **Expand capacity** by increasing the supply of practitioners, practice networks, clinics, and health plans in underserved areas.

- **Assist alliances and health plans** to deliver culturally-sensitive care to vulnerable segments of their populations.

- **Achieve accountability** by assuring that health plans enroll vulnerable populations and meet their personal health care needs.

- **Assist organizations and professionals supported by public funding** to adapt to the reformed system. Integration of these providers into practice networks or health plans will ensure that they receive payment for covered services from plans. It will provide critical support services (administration, information systems, telecommunications, specialty services) to improve the delivery and coordination of care.

- **Shift the emphasis of existing public funding** away from the delivery of services covered in the standard benefit package and toward:

  - Activities designed to enable, enhance and ensure access to care by addressing persistent barriers, especially hard-to-reach populations.

  - Services not covered in the benefit package but essential to prevent morbidity and mortality among certain populations;

- **Integrate and coordinate current programs** to provide the federal government, states, health departments and community-based organizations flexibility to tailor their activities to the varied health needs and problems of different populations and geographic regions.

  - Reduce the current administrative burden of multiple grant application procedures, management structures, funding requirements, and reporting systems.

ACCESS INITIATIVE PROGRAMS

- **The National Health Service Corps** expands to reduce the shortage of primary care practitioners in underserved areas.

- **Categorical Programs and Formula Grants** continue to pay for personal health services for specific populations that confront barriers to care (such as community and migrant health centers, family planning clinics, health care for the homeless program, and portions of the maternal and child health block grant) continue.

  However, as reform is implemented, with the exception of the Ryan White HIV/AIDS program, funding shifts from clinical services to expansion of health care capacity in underserved areas in order to ensure access for vulnerable populations (see discussion below).

- **New Grants and Loans** support capacity expansion undertaken by a new federal authority with the mission of ensuring adequate choice of providers and health plans in underserved areas, supporting the development of networks of care providers, and overseeing the integration of federally funded providers into the new system.

  Flexible grants provide start-up and operating funds and guaranteed loans to community-based providers and public and non-profit health care institutions. Funds also provide capital infrastructure development to expand access in underserved areas for low-income, hard-to-reach, or otherwise vulnerable populations.

  New funds allocated for this purpose are supplemented by development and expansion funds transferred from existing programs. The federal government determines the allocation of funding among states and types of programs. A specific portion supports initiatives such as school-based clinics. States have expanded input into the decision-making process.

- **New Formula Grants** to states provide funds to ensure access to health care for low-income, underserved, hard-to-reach, and otherwise vulnerable populations. Grants cover:

  - Outreach and enabling services (e.g. transportation, translation/interpretation, child care).
  - Supplemental services.
  - The development of linkages between health plans and providers through improved information and referred systems.
  - Integration of health services with community health and social services.
  - Advocacy and follow-up services.

States become eligible for formula grants as they implement reform, using funds to reduce disparities in access and health status among population groups and monitor access for vulnerable populations. (Programs designed to build state capacity are described in the section on public health initiatives.)

To assure accountability, state and local public health agencies follow local indicators measuring access as well as health status measures closely linked to access. To participate in the formula-grant program, states must demonstrate improvement over time.

State allocations are based on demographic and need factors. To encourage states to implement reform and encourage enrollment of vulnerable populations, the program will not include a matching requirement other than maintenance of effort in state and local funding for services to vulnerable populations. After reform is fully implemented, a state matching formula will be developed.

- **Designation of Essential Community Providers** assures access and continuity of care during the first five years of reform by requiring health plans to contract with and reimburse established community-based providers. Independent health professionals and health care institutions operating in underserved areas may apply to the Department of Health and Human Services for designation as essential providers.

  Plans are required either to contract with essential providers at a capitated rate no less than that paid to other providers for the same services or to reimburse them at rates based on Medicare payment principles.

  By the end of five years, providers either become integrated into health plans or join together to create new, community-based health plans. At that time, health plans must either demonstrate their capacity to provide access for all participants or continue contracting arrangements with essential providers.

- **Adolescent and School-Aged Youth Initiative** supports the delivery of clinical services through school-based or school-linked sites (consistent with goals of health reform and Goals 2000) and comprehensive health education in high-risk schools.

  Dedicated funds in the capacity expansion program (see above) support school-based clinics targeted at middle schools and high schools. Clinics provide physical and mental health services and counseling in disease prevention and health promotion as well as in individualized risk behavior reduction.

  School-based clinics established under the program are automatically designated as essential community providers.

  Authorized as a formula grant to states funded jointly by the Department of Health and Human Services and the Department of Education, health education focuses on the reduction of risk behaviors among adolescents and adults. The curriculum is linked to *Healthy People 2000* objectives and will target those areas of health risk where research suggests that health education can reduce risk-taking behavior and improve health outcomes.

  Grantees have flexibility in determining what services and what service delivery mechanisms are most appropriate for their community.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Mental health and substance abuse initiatives refocus existing formula grants to encourage development of community-based programs by:

- **Restructuring Existing Formula Grants**

  As states implement reform, funding through Community Mental Health and the Substance Abuse Prevention and Treatment Formula Grant is required only for treatment in excess of the comprehensive benefit. Funds shift from support for direct treatment to service system development, supplemental services, and population-based prevention services.

  State Systems Development Program and Mental Health Systems Improvement Program continue to be funded with the five percent technical assistance set aside from formula grants.

- **Maintenance of Effort**

  States are required to maintain support for mental health and substance abuse treatment activities, although they may obtain a waiver to assist in the development of community-based systems of care to promote the eventual integration of the public and private systems for the treatment of mental and addictive disorders.

- **Special Initiatives**

  Competitive project grants to states support pilot projects related to integrating the private and public mental health and substance abuse systems. Funds support linkage of treatment and prevention for substance abuse with a broad array of health services and systems management for seriously emotionally disturbed children.

- **Research and Demonstration Projects**

  Funds support the development of improved outreach strategies for AIDS and HIV-infected drug abusers, the homeless, individuals involved in the criminal justice system, and populations with co-morbidity, including mechanisms for sharing information about the applicability of promising approaches to prevention within specific populations and service-delivery settings and the effectiveness of prevention and early intervention services in reducing health costs.

  Funds also support development of systems that link substance abuse and mental health treatment with primary care, target rural and remote areas and culturally distinct populations, and facilitate the transfer of knowledge.

- **Training and Staff Development**

  The Department of Health and Human Services expands its curriculum development and health education efforts in clinical prevention within schools of medicine, nursing, and social work as well as its information services for current health professionals and provides primary care professionals with information and training to screen and identify mental health and substance abuse problems and risk factors.

- **Capital Assistance**

  Direct loan and loan-guarantee programs support the development of additional non-acute, residential treatment centers and community-based ambulatory clinics, particularly in medically underserved areas.

AMERICAN INDIANS AND ALASKA NATIVES

Supplemental financing and services provide access to health care for American Indians and Alaskan Natives populations with diverse language and cultural needs, many of whom live in remote and underserved reservation areas. Supplemental services include transportation, outreach and follow-up, community health representatives, public health nurses, non-medical case management, child care during clinic visits, health education, nutrition, home visiting, and supplemental mental health and substance abuse prevention and treatment services.

The Indian Health Service also expands population-based public health and prevention activities. Under new authority, it covers all residents, Indian and non-Indian, living on reservations in addition to populations living near reservations.

Population-based public health and prevention activities include surveillance and monitoring of health status, medical outcomes, threats to public health, public health laboratories, community- based control programs, community health protection and public health information.

HEALTH WORKFORCE

To increase the recruitment, preparation, and retention of American Indians and Alaska Natives into medical, nursing, public health and other health professions, existing programs are expanded.

The Indian Health Scholarship Program and Loan Repayment Program expands to fund all eligible applicants under the current authorities of sections 104 and 108 of P.L. 94-437. Additional financial assistance increases the number of American Indians and Alaska Natives entering training programs under current authorities of sections 103 and 105 of P.L. 94-437.

SANITATION AND ENVIRONMENTAL HEALTH

Additional funding expands construction of water, sewer, and other sanitation and environmental health facilities, as well as provide for training and technical assistance to tribes that wish to operate tribal facilities under P.L. 86-121 and Section 302 of P.L. 94-437.

RURAL COMMUNITIES IN THE NEW SYSTEM

Economic and demographic characteristics of many rural communities result in a larger number of uninsured and underinsured citizens in rural areas. Under the American Health Security Act, access to care is ensured for Americans who live in rural areas through:

- Alliance requirements to serve rural areas
- Investment in infrastructure
- Creation of incentives to expand rural community-based networks and plans
- Investments for the development of the health workforce
- Expansion of the rural public health system.

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Divider Title: **Core Function Initiatives**

PUBLIC HEALTH INITIATIVE

The public health system and the reformed health care delivery system share a common purpose: to improve the health of the American population at an affordable cost.

While health reform strengthens the personal care delivery system, an enhanced public health system also plays an essential role to:

- Protect Americans against preventable, communicable diseases, exposure to toxic environmental pollutants, harmful products and poor quality health care.
- Identify and control outbreaks of infectious disease and patterns of chronic disease and injury.
- Inform and educate consumers and health care providers about their roles in preventing and controlling disease and the appropriate use of medical services.
- Define and validate new prevention and control interventions.

The public health initiative builds on the capability of health alliances and plans to reach out to their participants, providing them with information about prevention and appropriate use of medical services. The initiative promotes readiness and flexibility in the public health system by strengthening core functions at the local, state, and federal level. It also focuses attention on specific health problems of regional and national significance to consolidate categorical programs into an integrated health system, reducing administrative burdens.

The public health initiative repairs, strengthens and consolidates essential federal, state and local public health functions through three approaches:

- Improving the performance of the core functions of public health.
- Authorizing a flexible pool of resources to address priority health problems of regional and national significance.

- Expanding federal support for unified data systems, technical assistance and information networks.

Because dealing effectively with public health problems requires the coordinated involvement of multiple parties, the initiative is designed to foster inter-agency collaboration and public-private partnerships, including close working relationships between public health, community groups, alliances, and plans.

CORE PUBLIC HEALTH FUNCTIONS

Health reform clears the way for the emphasis of public health activities to shift away from the direct delivery of health services. It positions public health to maintain a strong defense against preventable diseases and conditions that affect local communities and to work with the health delivery system to address them. The following essential functions are supported:

- **Health-related data collection, surveillance, and outcomes monitoring** -- The basic tool for the health care system as a whole, providing for regular collection and analysis of information on key dimensions to ensure timely awareness, decisions, and interventions related to epidemics, emerging patterns of disease and injury, prevalence of risks to health, and outcomes of personal health services.

- **Protection of environment, housing, food, and water** -- Enforcement functions related to air pollution (including indoor air), exposure to high lead levels, water contamination, handling and preparation of food, sewage and solid waste disposal, radiation exposure, radon exposure, noise levels and abatement, consumer protection and safety.

- **Investigation and control of diseases and injuries** -- Identification, containment and provision of appropriate emergency and treatment resources for community-wide health problems, including emergency preparedness and control of violence.

- **Public information and education** -- The mobilization of communities and motivation of individuals to reduce risks to health, such as tobacco use, abuse of alcohol and other drugs, sexual activity that increases vulnerability to HIV infection and sexually transmitted diseases, inadequate nutrition, physical inactivity, and childhood immunization.

- **Accountability and quality assurance** -- Enforcement functions to ensure that providers, clinics, hospitals, long-term care facilities, laboratories, and allied health providers meet established standards through licensure, certification, and inspection.

- **Laboratory services** -- The provision of individual testing and pathology services, including the system of state laboratories that screen for metabolic diseases in newborns, provide toxicology assessments of blood lead levels and other environmental toxins, diagnose sexually transmitted disease and tuberculosis requiring partner notification, test for cholera and other infections or food-borne diseases, and monitor the safety of water and food supplies.

- **Training and education** -- Ensuring adequate training with special emphasis on public health professionals such as epidemiologists, biostatisticians, health educators, public health administrators, sanitarians, and laboratorians.

- **Leadership, policy development, and administration** -- Public health's responsibility to define health goals, standards, and policies that affect the health of whole communities; to define health issues of major importance and devise interventions to address them; to build coalitions with related public sectors such as housing, public transportation, and agriculture; and to ensure accountability for public resources devoted to health. Public health coordinates closely with the leadership of alliances and plans, mobilizing community support for public health policies and initiatives.

Funds are distributed to states using a formula based on three weighted factors that take into account population (one-third), poverty rate (one-third), and years of productive life lost (one-third). No state receives an allocation less than the State's grant in the last year preceding enactment of this initiative. To receive funds under the formula, states are required to maintain their current level of support for public health and prevention activities at no less than the average of the past two years' funding level.

Funds are used to develop and strengthen public health core functions at the state and local level, including county, district and municipality levels. Accountability for effective use of state formula grant funds are monitored through reporting progress in achieving health improvements using a common data set of health outcomes developed as a part of the *Healthy People 2000* initiative.

PRIORITY HEALTH PROBLEMS OF REGIONAL AND NATIONAL SIGNIFICANCE

Additional funds support a federal program to develop innovative strategies for addressing priority health needs of regional and national significance. The purpose of this program is to address specific issues in ways that are responsive to the needs of populations served by alliances and plans and that consolidate rather than proliferate authorities, management structures, and funding and reporting requirements.

Congress establishes some priorities for funding through dedicated appropriations. The Secretary of the Department of Health and Human Services identifies other areas of priorities relying on recommendations of a national advisory board representing the perspective of the Public Health Service, states and local public health agencies, as well as regional health alliances and plans.

The Secretary solicits proposals for innovative interventions that link public health agencies and the delivery system to achieve measurable reductions in the incidence of illness and injury. Grants are made through competitive awards to state and local government agencies, not-for-profit organizations and research institutions. As effective interventions from these projects are identified, information is disseminated to facilitate their adoption in other communities.

The following are examples of the types of regional and national priority health issues to be addressed:

- **Infectious diseases**

  Immunization -- Education and outreach to ensure the broadest possible immunization coverage against childhood vaccine-preventable infectious diseases, as well as influenza, pneumonia, hepatitis B, and tetanus among adults.

  HIV/AIDS — Education for prevention, confidential screening programs, and partner notification programs particularly in urban areas with special focus on minorities, women, children, and adolescents.

  Tuberculosis -- Case location, targeted education, and training for providers regarding treatment and control measures, with special attention to its spread among homeless people.

- **Chronic and environmentally related diseases**

  Diabetes -- Community-oriented diabetes education and control programs, directed especially to minority and low-income populations at highest risk, appear to offer economies of scale to complement individually provided medical services.

  Violence and injury control — The leading cause of years of potential life lost among Americans and the leading cause of death among children, adolescents, and young adults this category requires close collaboration among several systems, including law enforcement, education, transportation, and recreation and parks. It is linked to alcohol misuse and requires an integrated multi-faceted set of interventions.

- **Health-related behavior and other priority issues**

  Tobacco prevention — The increasing incidence of smoking among adolescents and women poses future risks for heart disease and cancer, as well as low-birthweight babies and infant morbidity.

Comprehensive school health -- Furthering development of links between health and education in a nascent program of comprehensive school health program.

Maternal, child health, and family planning -- With continued special attention is needed to provide education and outreach to prevent infant mortality and morbidity. In addition, the persistent and intractable incidence of adolescent and unwanted pregnancy calls for targeted education and outreach in support of family planning services. Closely linked to social services, interventions include targeted public education, programs of home visiting, case management for children with special needs, and child and spouse abuse services.

ENHANCEMENT OF FEDERAL CAPACITY TO SUPPORT PUBLIC HEALTH

In support of federal assistance for core public health functions and categorical activities, additional funds improve direct federal capacity, including:

- **Federal surveillance and health statistics, laboratories, and epidemiologic services** — Whether fighting the "old" diseases such as tuberculosis and cholera or "newer" ones such as Lyme disease or antimicrobial-resistant infections, public health's basic tools are data collection and biostatistical analysis, laboratory capacity, and epidemiologic expertise. An effective and efficient central capacity at the Federal level provides for economies of scale in addressing many of these health problems.

  An essential part of reinventing public health is the consolidation of currently fragmented public health data systems and the integration of these systems with the regional and national data network described in the Information Systems chapter. The need for separate public health data systems is minimized to the extent that the elements included in the regional and national data network support public health functions. The unified health information system provides timely information to support health policy development, budget formation, efficient program administration and general improvement of the public's health and does so at the lowest cost and burden.

- **Technical assistance and national health information networks** -- To support the refocus of public health at local, State, and Federal levels and the application of findings from priority health programs described above, technical assistance and information networks are needed to link Federal, State, and local public health agencies and various grant-supported programs carried out by State, local, and not-for-profit agencies. Information from these networks and the health data system provide the basis for regular reports to the President and the Congress for purposes of monitoring the effectiveness of this initiative.

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Workforce

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WORKFORCE

The National Health Services Corps and related programs expand to reduce the shortage of health care providers in rural areas. Incentives are provided to attract and retain health professionals in rural areas.

Tax incentives encourage practice in rural areas. Incentives include:

- A non-refundable personal tax credit of $1,000 per month that can be recaptured during the first five years of practice by a physician in a rural area with a shortage of health professionals ($500 for physician assistants and nurse practitioners).
- The exclusion from gross income of National Health Service Corps Loan Repayments received under section 338B.
- An allowance of up to $10,000 annually (depreciation not required) for the purchase of medical equipment used in areas with a shortage of health professionals.
- Deductibility of up to $5,000 in annual student loan interest for physicians, physician assistants, advanced practice nurses and registered nurses performing services under agreements with rural communities.

The allocation of residency positions in new health care systems involves special attention to geographic factors.

Increased relative compensation for primary care physicians also encourages practice in rural areas. (See section on Creating a New Health Workforce)

PUBLIC HEALTH SYSTEM

To assure access to health care in rural areas, supplemental services are provided for low-income populations. These services include: transportation, outreach, non-medical case management, translation, child care during clinic visits, health education, nutrition, social support and home visiting services. (See section on Public Health Service Access Initiatives)

CREATING A NEW HEALTH WORKFORCE

Ensuring quality health care and access for all Americans requires adjustments to the focus of investments in health care training and education in the following areas:

- Shifting the balance in the graduate training of physicians from specialties to primary care.
- Increasing investments in the training of nurse practitioners and physician assistants.
- Recruiting and supporting the education of health professionals from population groups under-represented in the field.
- Supporting workforce planning for health professions at the state level.
- Adjusting Medicare payment formulas to increase reimbursement for primary care.

DEVELOPMENT AND SUPPORT FOR GRADUATE MEDICAL EDUCATION

Legislative authority establishes a new system to manage the supply of specialty training for physicians, encompassing several initiatives:

Managing the number of post-graduate training positions for physicians: After a five-year phase-in period, at least 50 percent of new physicians are trained in primary care rather than in the specific specialty fields in which an excess supply currently exists. Primary care includes family medicine, general internal medicine and general pediatrics.

To achieve the goal of bringing primary care and specialty training into balance, the number of filled primary care residency positions increases by approximately 7 percent each year over the five-year period. During the same period, the number of filled specialty training positions in specialties in which excess supply exists decline by approximately 10 percent each year.

The total number of first-year residency positions available continues to exceed the number of graduates of U.S. medical and schools in the new system. The new system also encourages the location and focus of physician training to more closely reflect community medical practice.

Determination of approved residency positions: The Secretary of the Department of Health and Human Services determines the number of training positions in each specialty acting on the recommendations of the National Council on Graduate Medical Education and allocated to regional councils. Regional councils distribute positions to individual residency programs within each area of the country.

The Secretary appoints the National Council on Graduate Medical Education, which includes medical educators, practicing physicians, consumers, hospital administrators, nurses and others.

The Council recommends the total number of training positions for each medical specialty, based on the national need for new physicians in specific specialties. The national Council apportions residency positions to regions taking into account:

- Current regional distribution and quality of training programs.
- The need to maintain access to a range of primary care and specialty training positions for members of under-represented minority groups.
- Other factors relating to specific specialties and training programs

In developing its recommendations, the Council seeks the views of professional medical, hospital and educational associations and other appropriate organizations. Positions are allocated for each post-graduate year to account for differences among specialties in the point of training when residents enter specialty training. For example, family medicine training begins in the first year of post-graduate training, while training in internal medicine specialties begins in the fourth year.

Because the integrity and success of the Graduate Medical Education system depends on commitment to it by all programs and training institutions, programs operating in institutions that continue training slots not covered in the allocation under the Graduate Medical Education system become ineligible for GME funding.

Allocation of residency positions: The Secretary of the Department of Health and Human Services appoints ten regional councils to allocate training slots among individual residency training programs.

Regional councils include representatives of academic institutions training physicians in the region, as well as representatives of regional health alliances and health plans, consumers and others.

Regional councils receive applications from training institutions in each area for residency positions in each specialty. Positions are allocated to accredited residency programs based on such factors as:

- Program quality.
- Relevance of the training program curricula to the future practice of physicians.
- Participation of under-represented minority groups.
- Participation of locally coordinated education programs.

The Secretary of the Department of Health and Human Services reviews regional council decisions and retains the right to amend allocations for good cause. To ensure continuity, allocations to program are available for periods of up to three years and are made at least one year in advance of the residency training year.

Funding for residency training: Funds to support graduate medical education are pooled from all insurers to reflect the benefits that all patients and health plans receive from graduate medical education and training. Residency programs receive funds for each approved training position. Payments are based on a formula which considers the national average for resident salaries and the costs of faculty supervision and other related teaching expenses.

Funds from two sources are pooled (estimated at $6 billion for FY 1994):

- Medicare contributes to the direct medical education fund based on the percentage of hospital bed days its patients use (38 percent in 1992).
- Other payers contribute through a surcharge on health plan premiums.

Currently, Medicare pays explicitly for graduate medical education, based on historic costs. In FY-1992, Medicare payments for Graduate Medical Education totalled $1.5 billion. (Other payers currently support Graduate Medical Education implicitly through elevated hospital charges.)

Allocation of payments: Funding is provided directly to training programs approved for residency training positions, encouraging the development of non-hospital based training, particularly programs that provide a greater portion of their training in ambulatory and primary-care settings, such as Health Maintenance Organizations and community clinics.

Transition payments: Transition payments are provided to teaching hospitals which are required to reduce their residency training programs. Hospitals receive transition payments to offset a portion of the costs associated with hiring replacement staff and maintaining services.

Payments phase out over a five-year period, beginning at the rate of 150 percent of the national average for direct medical education payments for an equivalent position under the new payment system. Payments decline by 25 percent each year.

LOAN FORGIVENESS PROGRAM FOR PRIMARY CARE

A national "loan forgiveness" program for medical students is established to encourage physicians to devote their first years of practice to primary care.

RE-TRAINING PHYSICIANS IN PRIMARY CARE

In order to further expand the availability of primary care physicians, support are provided for the development of programs to re-train mid-career specialists to serve as primary care physicians. Areas to be explored include the use of incentives, the type and length of effective retraining programs and the development of certification criteria.

COMMUNITY-BASED TRAINING OF PRIMARY CARE PHYSICIANS

Health reform supports community-based undergraduate and graduate medical training, continuing education and faculty development in primary care, broadening the impact of existing public support, which is limited to programs at the pre-doctoral and residency levels in family medicine and general internal medicine and general pediatrics.

SUPPORT FOR TRAINING OF MINORITIES AND DISADVANTAGED PERSONS

To increase the diversity of the health care workforce, support is provided to programs that increase the number of health professionals among racial minority groups and disadvantaged persons. The goal of these programs is to double the level of under-represented minorities enrolled in the first year of medical school to a level of 3,000 students by the year 2000.

Strategies include:

- Continuing financial assistance for under-represented minorities and disadvantaged students entering health professions training programs.

- Increasing support for recruitment and retention of under-represented minority and disadvantaged students in medicine, dentistry, nursing, public health and other health professions.

- Maintaining efforts to foster interest in health careers among under-represented minorities at the pre-professional and professional levels.

- Supporting programs to increase the number of minority faculty in the health professions, minority health services researchers and minority basic scientists.

TRAINING FOR NURSE PRACTITIONERS, NURSE MIDWIVES AND PHYSICIAN ASSISTANTS

Expanded training: Current funding for training of nurse practitioners, and physician assistants, will be amended to

- Increase current funding levels to double the number of graduates produced annually, giving priority to the expansion of existing programs, and

- Establish long-term goals and a funding strategy to maintain the supply of practitioners.

A similar program is implemented to support nurse midwives.

Barriers to practice: To remove inappropriate barriers to practice, the Secretary of the Department of Health and Human Services develops and encourages the adoption of model professional practice statutes for advanced practice nurses and physician assistants.

RURAL HEALTH PROVIDER GRANTS

A rural health provider grant program supports a wide range of activities, including new community training programs for rural practitioners, the development of rurally oriented health education curricula, and the improvement of medical communications technology.

PRIORITY PROJECTS

A health professions special projects and demonstration training authority is established to support the transition to the new health system, including support for the following new projects:

- Training of providers in mental health, substance abuse treatment and prevention, geriatrics, and developmental disabilities.
- Training for school-based health providers in immunization, reduction of substance abuse, dealing with teen pregnancy, control of violence, and linking students and families with the community health system.
- Students in baccalaureate-level nurse training programs preparing for careers in teaching, community health service, and specialized clinical care.
- Training related to managed care, cost-effective practice management, continuous quality improvement practices, and provision of culturally sensitive care.
- Training of lower-level administrative and clerical workers in the health care field for higher-wage, higher-skill positions as technicians, nurses and physician assistants.
- Demonstration programs to develop more open occupational career ladders in health care institutions.

Programs also support Priority Health Training Programs designed to improve the supply, distribution, and quality of providers, including those in areas with inadequate health systems, especially rural areas and inner-city areas.

Support expands for:

- Service-linked regional educational networks; e.g., AHECs, geriatric education centers
- Health administration, public health training positions, special projects and preventive medicine
- Professional nurse clinician and nurse anesthetist training positions and nursing special projects

Primary care loans are provided for students in nursing and targeted allied health professions; e.g., occupational health and physician therapy.

Federal support for development of information related to the health care workforce expands, including research on primary care training practices in such areas as: relationship between education and practice patterns, effective use of practitioners and development of skills to meet future needs in health care.

INCENTIVES FOR PHYSICIANS TO PROVIDE PRIMARY CARE

In addition to refocusing federal support for physician education to focus on primary care, the Medicare programs increases its rates of reimbursement for primary care physicians.

RATE INCREASES

Reduce rates for office consultations to equal office visits and use savings to increase fees for all office visits: Office consultations are reduced to the same level as other office visits. The relative values for office consultations are redistributed to office visits without increasing total spending.

Because office consultations currently pay more than office visits, the change has the effect of increasing fees for office visits. Because primary care physicians perform consultations less often than sub-specialists perform them, it increases payments for primary care without increasing Medicare spending.

Increase the relative value of allowances for office visits to reflect time spent before and after visits: Currently, the relative values for procedures, including medical visits, account for physician time spent immediately prior to an office visit for preparation and immediately after an office visit for chart work, patient instructions, etc. Increasing the work component under primary care services by 10 percent increases spending for those services; the increase is offset by reducing relative values for all non-primary care services.

Establish a resource-based method to pay for the physician overhead component of the physician fee-schedule: The Secretary develops a methodology and data sets for implementing a resource-based system for determining practice expense relative value units for each physician's service. In addition, primary care practice expense RVUs increase 10 percent.

The current physician-fee schedule includes a work component that accounts for the physician's activities and a practice expense component that accounts for overhead (other than malpractice). The work component is based on resources used; the practice expense component is based on historic charges.

Because primary care services occur more often in office settings, actual overhead costs are higher than for surgical services. Under the current system, surgical services are assigned a higher overhead fee than primary care services. Collecting data on actual overhead costs and developing an allocation method for assigning overhead to individual procedures increases the relative value primary care services and decreases it for many non-primary care services.

Provide a higher expenditure target rate of growth for the separate primary care services target: Increasing the target for primary care services to GDP per capita plus 5 percentage points for FY-1995 decreases the target for other services.

Bonus Payments: The 10 percent bonus payment for non-primary care services in urban Health Professional Shortage Areas will be eliminated. This will increase the bonus payment to 20 percent for primary care services in rural and urban HPSA's.

Reduce Outlier Intensity Procedures: Reducing the work component of services with "outlier intensity" values allows the application of savings to increase the work component of the relative value of primary care services.

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Research

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HEALTH RESEARCH INITIATIVES

The American Health Security Act encourages cost-conscious choices on the part of consumers and health care providers through explicit financial incentives. At the same time, expanded investments in health research represent integral features of cost control and quality goals under health reform. The assessment of costs and effectiveness of new procedures and technologies will be increased through expanded funding and refocusing of clinical trials on more common conditions, high cost procedures, and highly variable treatment patterns.

Advances in medical science, development of new medications and technology, as well as innovations in the organization and delivery of personal and public health services hold the promise of increased efficiency in the health care system, longevity and improved quality of life.

New funding for health research focuses on two areas:

- **Prevention research** related to biomedical and behavioral aspects of health promotion and prevention of disease.

- **Health services research** related to the development of quality and outcome measures, access and financing and cost effectiveness, as well as research related to consumer choice and decision making, primary care and evaluation of health reform.

PRIORITY AREAS FOR PREVENTION RESEARCH

The National Institutes of Health expands prevention research in priority areas including:

- **Child health, including perinatal health, birth defects and diseases of childhood, unintentional injuries, learning and cognitive development, and adolescent health.**

- **Chronic and recurrent illnesses, including research on Alzheimer's disease, cancer, cardiovascular diseases, bone and joint diseases, and other chronic diseases and conditions.**

- Reproductive health, including contraceptive development and use, sexually transmitted diseases, adolescent pregnancy, and pregnancy-related complications.

- Mental health, including research in the area of mental disorders in children and adolescents, child abuse and neglect, women's mental health, mental disorders in the elderly and their caregivers, severe mental disorders, and violence.

- Substance abuse, including targeted research related to vulnerable populations, such as high-risk youth, the development of medications and prevention of dependence on tobacco, alcohol, and drugs.

- Infectious diseases, focusing on new and emerging infectious diseases, vaccine development and basic vaccine research, as well as infectious diseases including:

  - HIV infection and AIDS - Research on behavior, vaccines, transmission of HIV, and prevention of disease progression to AIDS.

  - Tuberculosis - Research on new vaccines to prevent TB, early diagnosis, and preventing disease progression.

- Health and Wellness Promotion including:

  - Nutrition - Includes defining optimal diets, dietary links to disease, and obesity.

  - Physical activity - Includes an emphasis on fitness for all ages, and fitness and aging.

  - Environmental health - Includes an emphasis on identifying health hazards and their effects, and disorder-specific research.

- Prevention Research and Infrastructure Resource Development including basic science development providing foundations for prevention efforts across a range of diseases and disorders, encompassing behavioral and social approaches, and genetics.

- Resource development including support for prevention research training and enhancement of statistical and epidemiologic techniques.

COORDINATION AND FUNDING OF PREVENTION RESEARCH

The National Institutes of Health distributes funds using three mechanisms: grants, contracts, and NIH intramural research.

The NIH Associate Director for Prevention coordinates the prevention research programs of the national research institutes and will report annually to the NIH Director and the Secretary on the status and progress of prevention research activities.

In consultation with the national research institutes, the NIH Associate Director will develop an ongoing plan for prevention research activities conducted by the NIH.

Prevention research findings are translated into, or appropriately integrated with, personal health services and public health programs to maximize the impact of prevention research on disease reduction and improved health status.

PRIORITY AREAS FOR HEALTH SERVICES RESEARCH

This research provides the knowledge to increase the cost effectiveness, appropriateness and quality of care in a reformed health care system. The health services research program includes research designed to improve the effectiveness and appropriateness of clinical practice through several interrelated activities, including:

- Effectiveness research

- Quality and outcomes research

- Development and dissemination of clinical practice guidelines

- Research and evaluation related to administrative simplification under health care reform
- Research on consumer choice and information resources
- Evaluation of health care reform
- Workplace injury and illness prevention research and demonstration programs

A new generation of health services research intended to answer critical questions on the effectiveness of treatments for common clinical conditions is initiated. Patient–outcomes research and the development of clinical practice guidelines form a central part of the health services research agenda.

Examples of specific areas of health services research:

- Effectiveness research which examines the appropriateness and effectiveness of alternative strategies for the prevention, diagnosis, treatment, and management of clinical conditions, in terms of patient outcomes. The Medical Treatment Effectiveness Program research focuses on conditions that meet one of more of the following criteria:
  - Large number of individuals are affected.
  - Uncertainty or controversy regarding effectiveness of treatment exists.
  - Associated risks and/or costs of treatment are high.
- Patient outcomes research teams (PORTs) are 5–year grants that include elements of formal literature synthesis, data acquisition and analysis, development of clinical recommendations, dissemination of findings, and evaluation of the effects of findings on change in clinical practice.

- The development of clinical practice guidelines improves the quality, appropriateness, and effectiveness of health care. The guidelines also represent standards of quality, performance measures, and medical review criteria through which health care providers may assess or review the provision of health care. Guidelines assist in the determination of how diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

- Research and evaluation regarding computerized medical records and information systems simplifies the administration of health care.

- Studies assess the impact of barriers to access, utilization, and continuity of health care services on health care reform.

- Research and analytic work contributes to efforts to devise, implement, maintain, and evaluate the new system of health care budgets, at the national, state and alliance levels.

- Expanded research into risk adjustment facilitates efficient measurement of health care needs.

- Long-term care research and demonstrations focused on new program models expand the range of financing and administration for those services.

- Research into service organization and structure include examination of the relationship of continuity, accessibility, and comprehensiveness of primary care to cost, quality, and access.

EVALUATION OF HEALTH CARE REFORM

The introduction of comprehensive health reform affects every aspect of American health care. To support implementation of the American Health Security Act, evaluation research includes:

- Short-term research – Evaluate the responsiveness of the system to health care reform, including its effects on institutions, health care professionals, and specific population groups.

- Long-term monitoring – Examine the effect of reforms on cost, quality and access. Longitudinal studies using databases developed through the augmentation of national and regional surveys and analyses of secondary data are needed.

- Demonstrations and evaluations – Address critical issues in health care reform, such as quality assurance and medical liability.

CONSUMER CHOICE AND DECISION-MAKING RESEARCH

Research aimed at improving information resources that enable purchasers to make health care choices based on their relative value and quality assumes top priority. This research contributes to improved decision making by consumers, resulting in more cost-effective service delivery and health plan selection. Prospective research efforts include:

- Consumer awareness of benefit plans, availability of supplemental coverage, cost-sharing, and utilization.

- Effect of consumer knowledge on the selection of health plans including the relationship between health status and choice of plan.

- Types of information and form of media most effective in assisting consumers in selecting health plans and providers, including information on costs and quality of care.

- Impact of improved information on consumer satisfaction, access to care, quality of care and cost of services.

- Patient choice and decision making related to treatment alternatives.

COORDINATION OF HEALTH SERVICES RESEARCH

The Agency for Health Care Policy and Research in the Public Health Service and the Office for Research and Demonstrations in the Health Care Financing Administration assume administrative responsibility for research related to the impact of health care reform. Research activities are conducted through intramural and extramural programs using the mechanisms of grants, contracts, and cooperative agreements.

ACADEMIC HEALTH CENTERS

The American Health Security Act creates a national pool of funds to support costs associated with the institutional costs of research, development of new medical technology, treatment of rare and unusually severe illnesses and provision of specialized patient care.

Medicare payments and a surcharge on private health insurance premiums flow into the pool (estimated at $6 billion for FY 1994). Funds are allocated to academic health centers and affiliated teaching hospitals through a fixed percentage added to hospital payments.

Academic health centers, including affiliated teaching hospitals, receive a new, separate payment as reimbursement for costs incurred over and above the cost of routine patient care. Only institutional costs not covered by typical fees for patient care, and which can be analytically justified, are included in the formula.

This approach represents a revision of the current Medicare indirect medical education payment formula to factor in the impact of universal health insurance coverage. The revised system reduces Medicare payments to teaching hospitals for the cost of caring for uninsured patients and disproportionate share of low-income patients because such payments will no longer be required once universal coverage exists.

In Fiscal Year 1992, Medicare Indirect Medical Education payments totalled $3.6 billion, including the cost of bad debts, charity care and other costs not related to medical education. As these costs decline, Medicare IME costs are reduced accordingly, and Medicare payments reflect the program's proportionate share of the total remaining costs. All private payers also contribute explicitly to the national fund on a proportionate basis.

FINANCING CLINICAL RESEARCH

The American Health Security Act expands investment in clinical investigations and research related to the delivery of health services and outcomes. Health plans also are required to provide coverage for routine patient care associated with approved clinical trials. (See Guaranteed National Benefit Package.)

ENSURING ACCESS TO ACADEMIC HEALTH CENTERS

To ensure that all patients receive the specialized services available through academic health centers when appropriate (see Health Care Access Initiatives):

- The Department of Health and Human Services, in cooperation with states and health alliances, identifies rare diseases, specialized procedures and treatments for which health plans are required to establish contractual relationships with academic health centers.

- Health alliances monitor contractual relationships between health plans and academic health centers to assure appropriate coverage for severity of illness and to prevent anti-competitive pricing.

- Health alliances oversee quality management and patient grievance mechanisms to ensure appropriate detection, referral, morbidity and mortality of illnesses eligible for referral and specialized treatment.

- Health alliances provide health professionals and consumers with information regarding potential eligibility for clinical trials of relevant investigational treatments.

ENSURING RURAL AND URBAN ACCESS TO ACADEMIC HEALTH CENTERS

To secure appropriate access to academic health centers for patients in rural and urban areas with inadequate health care systems:

- Grants to academic health centers assist in the development of an information and referral infrastructure to support rural health networks.

- Grants to establish health-care networks in inner-city areas build on existing urban charity hospitals and affiliated neighborhood clinics.

- Health alliances institute additional protection to ensure access by rural and urban underserved populations to special services.

PHOTOCOPY
PRESERVATION

HHS - MEMOS

~~CONFIDENTIAL~~
July 24, 1993

MEMORANDUM TO THE FIRST LADY

From: Donna Shalala

Re: Health Reform

We are finally in the home stretch of health reform, and it is time to make the key decisions. Cooperation is occurring at last between the Department and the team at the White House. On a host of issues, we have come to resolution. We do now feel that we are part of the process. Still, the really big questions remain on the table, and we believe how they are resolved will determine the ultimate success of our efforts. The issues that need attention are:

- Critical Trade-offs
- Financing
- Medicaid
- Timing and Phase-in
- Administration
- Consumer Choice
- Medicare
- Accountability

Throughout the process of developing a reform plan we have all stressed a number of critical goals: **security, comprehensive benefits, protection of the poor, choice of providers, cost control, and feasibility.** Our fear is that on the issues above, we may fail to meet these central objectives.

Critical Trade-offs--No Scenarios to Understand the Tough Choices

Everything in this plan depends on a few crucial decisions: financing, subsidies, benefits, cost containment, and phase-in. And choices in one area affect those in another. For example, smaller employer subsidies allow a more generous benefit package or less cost sharing for the poor. Throughout this whole exercise, all of these elements have been in constant motion leaving almost no one with a clear sense of what the key trade-offs are. Even now the financing system is still changing daily. We find it extremely difficult to comment on other parts of the plan that remain in flux. *Our plea is to stop trying new variations on financing plans, and in the next week concentrate on putting together a memo and a presentation for the President which clearly illustrates the choices we face.*

We all recognize that we face difficult tradeoffs. It's time to make the big decisions, realizing that we cannot have it all. But they cannot be made one at a time because they are interdependent. Thus, we suggest that together we identify four or five scenarios which illustrate the impact of variations in the most important elements. (Attachment A presents examples of three scenarios and Attachment B outlines illustrative list of policy trade-offs).

Financing–Too Complex

Security, protection of the poor, our ability to provide comprehensive coverage and everything else hinges on the logic and feasibility of the financing system. Yet the financing scheme that is emerging looks so complicated that our opponents can contend it will reduce rather than increase people's sense of security.

Ultimately we must be able to explain the financing easily to the public and the Congress. Unfortunately, the emerging system of family and individual based premiums, extensive reconciliation, subsidy schemes administered by alliances (presumably giving them access to confidential financial information and requiring complex reporting, verification, and tracking structures), the possibility that families might move between Medicaid coverage, employer alliances, regional alliances, and self-employment premiums over the course of one or several years, along with a host of other complexities, all combine to make the system seem extremely perplexing.

We believe these complexities will allow our opponents to claim the system has made people's lives less rather than more secure. It will fail to create a broad base of enthusiastic support from our allies–organized labor, consumer groups, and the elderly. Just imagine two administration witnesses publicly disagreeing over what happens to a particular family. We also worry that complicated reporting and record-keeping burdens on employers will make the system seem worse for them as well. Part of the problem, we believe, is that we have tried so hard to insure the plan is fair from every possible angle, and worked so hard to get every dollar out of every possible situation, that we are left with a system that will not be perceived as intelligible, sensible or fair. Thus *our second plea is for as simple a financing system as possible, even if it costs slightly more or it raises some questions regarding fairness.* A clear and simple approach will buy a lot more good will than one which no one understands because it tries so hard not to hurt anyone.

My staff has already forwarded one such simplified plan (Attachment C). The issue is not whether this is the best or perfect plan, but whether simplicity isn't worth some price. And sometimes simplicity can save money on administration. Social Security (OASDI) and SSI both serve the aged and disabled and both are administered by the Social Security Administration. But the income-tested SSI program, which must closely track changing circumstances of individuals and families, has administrative costs averaging 7% of benefits while the much more universal and straightforward OASDI program averages less than 1% in administrative costs.

Medicaid--The Poor Must Not Be Separate

There is continuing talk of keeping Medicaid out of the system. Frankly, to be contemplating such far-reaching reform while leaving the welfare-like medical coverage system in place seems both ill-conceived and self-defeating. States will have every incentive to shift costs to private payers by moving people out of Medicaid and into the alliance, creating unpredictable burdens for the private sector. There will be continuing questions as to whether Medicaid or employers provide coverage to the people who move in and out of work. And people will continue to perceive a two-tier system. In short, *if we leave Medicaid out, we have not created security, we have not protected the poor, and we probably have created an unstable program which states will try to shift away from.*

The reason for keeping Medicaid recipients out is to avoid increases in private premiums. We believe there are other means to achieve this end, based on conversations we've been having with the actuaries. We much prefer a proposal the Task Force developed early on which would fold in the Medicaid population as they went to work. This will lead to the gradual elimination of Medicaid, in a straightforward way.

We have a second concern regarding the poor: the proposed cost-sharing system for them. By limiting subsidies to the cost-sharing levels we prescribe for managed care plans, we are either forcing unreasonably large coinsurance and deductibles on the poor, or we are restricting their choices violating our promises. If millions of low-income Americans are forced into an HMO, will they perceive this plan as providing choice? Is this the security they were promised? And what happens in the situation where the HMO is full or not available where a person lives? Do the poor have to pay the higher premium and cost sharing? As currently written, they do. A better approach would provide full cost-sharing protection for the very poor, rather than limiting choice of plan.

Implementation and Timing--Daunting and Unrealistic

The magnitude of changes contemplated in the health plan are extraordinary. The transition and implementation will be complex and filled with unanticipated problems, slip-ups and set-backs. Medicaid took eight years for most states to implement effectively. And that was a far smaller task than contemplated here.

Consider all that must be done to get the plan running in a state. Once federal legislation is enacted, a national board must be established and staffed, criteria developed for evaluating state plans, budgets established, developmental grants to the states awarded, benefit package and coverage rules specified, Federal quality standards and monitoring mechanisms in place, a risk adjustment mechanism adopted, stand-by cost containment mechanisms in place, information systems designed, and inter-alliance financing mechanisms established. At the state level, a similar level of activity must occur. States must pass their own legislation to define authorities and geographic areas for alliances and set standards for health plans. State

plans will have to be reviewed and approved. And only then can the states, alliances and plans begin the really complex work of developing solicitations and bidding structures, setting fee schedules, implementing enrollment processes, designing quality and information systems and the like.

This is not to say the task is impossible, only that it is not feasible for all these tasks to be completed by January 1996 in most states. We understand that a slower timetable has cost containment, administrative and political ramifications. But if we are going to make proper decisions, we must be realistic. If we are going to sell this plan to the public and the Congress, it must be believable. But *we don't think we can credibly argue the plan will be in place in the two-year time frame.* It would be far better to let the states that are equipped to move fast do so, while others are given more time.

Administration--A Major New Bureaucracy

Throughout this process we have argued that it would be terribly counterproductive to create a major new bureaucracy. The public will respond very poorly to the concept that yet another government agency will have control over their lives. While conceptually we have all agreed that the proposed National Health Board should have limited responsibilities, when one tabulates the duties listed for it, the Board will have to be immense. In Attachment D, we have included our compilation of the responsibilities assigned to the Board. Many of these duties duplicate functions the HHS already provides. Let's use and improve the people and systems we have in place. *A complex new bureaucracy will heighten public frustrations with government inefficiency.*

Consumer Choice--Rhetoric Versus Reality

We are also concerned that our policy and rhetoric on choice are inconsistent. Choice has two components: choice of plan and choice of doctor. Our rhetoric implies that everyone will be guaranteed a choice of plans for 20 percent of the average premium. However, if those plans are full or not available where a person lives, people may have to pay more than their 20 percent share. Our rhetoric also implies that everyone will have their choice of doctor. Under our policy, alliances must offer a fee-for-service plan, the kind of plan that gives consumers open choice. But if the fee-for-service plan is more costly than the average premium, people will have to pay more than they expect. *Our rhetoric should make clear that open choice of doctor may have financial consequences for the individual.*

Medicare--Unresolved Safeguards

Integrating Medicare into the new system continues to pose some difficulties. We have not come to agreement on the safeguards for beneficiaries and providers when states request integration. Nor have we resolved differences on how to allow new Medicare beneficiaries to participate in the alliance, when the programs are not fully integrated. In addition, we remain concerned that the current proposals to integrate DoD and the VA into the new system will inappropriately shift costs to the ailing Medicare trust fund. (See Attachment E) *Protecting beneficiaries and the trust fund is critical.*

Accountability—Who Pays?

The plan is virtually silent about who is ultimately responsible for failures in the system. If a plan goes under, who pays? If an alliance fails to effectively collect premiums or to pay them properly to providers, to adequately serve the needs of the public, to provide accurate quality information, who steps in? These are especially serious problems during the transition period. All new markets go through a period of considerable shake out. But unlike other new markets, someone is guaranteeing that all the shake outs will still leave the consumer protected. The question is who gets stuck holding the bag? *In some ways the biggest security question of all is simply this: what happens to people when some things don't work?*

Moving Forward From Here

We believe that it is absolutely essential to announce the new health plan in September. If that deadline is to be met, we must immediately and *jointly prepare a trade-offs document to put before the President.* At the same time, we must continue to work together to refine the final proposal. (See Attachment F) Major substantive issues must be resolved or presented to the President.

ATTACHMENTS

Attachment A

CAPPED PREMIUM SCENARIOS		
PLAN "A"	**PLAN "B"**	**PLAN "C"**
* Lean on benefits and helping the poor * Good for middle class * No cost control	* Good on benefits and helping the poor * Tougher on middle class * Tight on cost controls	* Good on benefits and helping the poor * Tougher on middle class * Minimal cost control
Minimum Benefits	High Benefits	High Benefits
9% Premium Cap	12% Premium Cap	12% Premium Cap
HMO Cost Sharing Subsidy Only	All Plan Cost Sharing Subsidy	All Plan Cost Sharing Subsidy
Medicaid Out	Medicaid In	Medicaid In
No Short-Term Cost Controls	Short-Term Cost Controls	No Short-Term Cost Controls
Long Term Controls at GDP+4	Long-Term Controls at GDP	Long-Term Control at GDP+2
Full Implementation in 1996	4 Year Phase-In	Full Implementation in 1996

Attachment B

ILLUSTRATIVE POLICY TRADEOFFS

Option A. Capped Premium

Design Feature	Impact on: Government Spending	Household Spending	Business Spending	Total Spending
A. Generosity of Benefit Package				
Basic 20th Percentile				
Dental Benefits				
Augmented Mental				
Prevention				
Vision				
Total 70th Percentile				
B. Level of Cap on Premium				
9 percent of payroll				
12 percent of payroll				
C. Out of Pocket Subsidy for poor				
Subsidize cost sharing in all plans.				
Limited to HMO Cost Sharing				
D. Medicaid In/Out of Alliances				
In				
Out				

E. Firm Size Cut-off for Inclusion in Alliance	
5000	
1000	
300	
F. Cost Controls	
Yes	
No	
G. Long Term Growth	
GDP-1	
GDP	
GDP+1	
H. Phase in Per Year	
25 percent	
50 percent	
100 percent	

Option B. Wage-Based Premium

...	

Attachment C

ALTERNATIVE FINANCING OPTION

In looking over the proposed financing system we were troubled by the complexity of the premium system. But we also recognized the problems with a payroll system. We tried to see if we could design a plan that got most of the advantages of the premium plan (limited redistribution, close links between payments and true premium cost) while retaining the simplicity of the payroll based system. There appear to be three major sources of complexity in the current premium system being discussed: the need to track families and their employer's contributions as their members move from employer to employer and in and out of employment, elaborate subsidy rules for employers and employees, and the end of the year reconciliation to deal with people with high self-employment or unearned income with low wages. We ask that you consider an slightly modified alternative which may get most of the premium system benefits without sacrificing so much in the form of complexity.

Here is the proposal:

All employers and employees would pay a premium for health insurance. There would be only two types of premiums: adult, and adult with children. All persons with children (whether living with the children or not) would be required to select an adult plus child premium. (Thus both parents would be expected to take an adult plus child premium if both were working. This is a simple rule requiring no question of which employer gets stuck paying a higher family premium.) Employers would pay 80% of the basic premium, employees would be responsible for the rest.

Employer payments would be limited to 7.6% of payroll. There would be no attempt to keep track of contributions on the basis of employers for individual workers. Premiums might be allowed to vary by the number of hours worked in a month. And employers with very low payrolls could have payroll contributions capped at a smaller percentage, at least at first.

To capture money from people who have low wages and high non-wage income, a simple tax wold be imposed on people. For individuals with wages over $40,000 no tax would be due. For individuals with wages under $40,000, a tax equivalent to 9% of any self-employment or unearned income up to a maximum of $40,000 less wages would be imposed. In other words a tax would be owed on any non-wage income between wages and total income of $40,000. For families the same rules would apply with a limit of $60,000.

Thus all employers pay premiums on all employees, but are assured of not paying more than 7.6% of payroll. Employees pay only the modest difference between the employer contribution and the cost of the plan they choose. And self-employed persons pay through a simple tax structure. There is no end of the year reconciliation, no need to track employer contributions to families, no need to decide which employer pays a family premium and how that person is subsidized. There are some losses in terms of equity here, but gains in terms of simplicity.

Attachment D

NATIONAL HEALTH BOARD

We continue to be very concerned about the role of the National Health Board.

We all agreed that there are certain functions that should reside in the board. Politically sensitive topics such as the budget, benefits package, and quality report card are clearly best handled by the board. However, we also agreed that we wanted to avoid creating a large new bureaucracy that duplicates functions that are provided elsewhere. Moreover, we want to avoid placing such excessive responsibilities on a new agency that implementation of reform would be unnecessarily impeded.

The following lists the duties now assigned to the board. We believe such an extensive list violates these principles.

NATIONAL HEALTH BOARD RESPONSIBILITIES

The National Health Board is responsible for setting national standards and overseeing the establishment and administration of the new health care system. The Board primarily:

- Establishes requirements for state plans, ensures universal access and monitors compliance with federal standards.
- Interprets and updates the nationally guaranteed benefits package.
- Issues regulations relating to implementation of the national budget for health care spending and enforces the budget for the first three years (e.g. establishes national per capita premium target, baseline alliance targets and anticipated weighted average premiums).
- Establishes and manages a performance-based system of quality management and improvement (e.g. develops a core set of performance measures and publishes annual reports outlining the results of those measures).

In addition to the encompassing responsibilities outlined above the National Health Board also:

System Implementation

- Develops minimum standards that prohibit marketing practices by insurance companies and agents.
- Promulgates a risk-adjustment system nine months before the date on which states first enroll consumers in regional alliances.

- Provides technical assistance to states and alliances in implementing the federal system and creates an advisory committee to provide advise and recommendations regarding the development of the risk-adjustment system.

- Conducts research and undertakes demonstration projects to support the development of the system.

Additional Budget Obligations

- Establishes the rate at which health insurance premiums are allowed to increase each year.

- Adjusts the inflation factor for each state and develops the methodology for making such adjustments. Prior to the establishment of the annual inflation factor, the Board must also consult with each state.

- Provides alliances with information and technical assistance to aid during the first year of bidding.

Quality Assurances

- Provides annual reports to the states on the comparative performance of health plans and state quality programs.

- Furnishes results of a small number of quality measures to health care institutions, doctors and other practitioners.

- Explores developing standards for a single annual inspection of health care institutions.

Basic Data Responsibilities

- Develops and implements uniform national standards for administrative, clinical, financial and other health care related information (e.g. including standards for automation of insurance transactions, claims payments and status reports, remittance advice, eligibility, coordination of benefits and utilization management).

- Establishes unique identifier numbers for plans, providers and patients (e.g. the Board has the authority to designate the Social Security Number as a unique identifier).

- Identifies, consolidates and reviews existing standards in the health care industry.

- Designates national standards that providers, plans, alliances and employers adopt as a condition of participation in the health system.

Governing Authorities

- Oversees the National Health Data Advisory Council which manages the information and data activities of the federal government under health care reform.
- Supervises the advisory committee which determines the standard information requirements and data definitions.
- Governs the Pharmaceutical Review Commission.
- Appoints an advisory commission to recommend adjustments to the methodology for calculating premium targets. The Board also provides states and alliances with information about regional differences in health care costs and practice patterns.
- Oversees the National Quality Management Program advisory council.

Attachment E

MEDICARE ISSUES

State Integration

In cases where States wish to integrate Medicare beneficiaries into their system, we have not reached agreement on all the necessary beneficiary and provider safeguards.

- A critical beneficiary safeguard is not included in the Plan. We believe strongly that States must guarantee that Medicare beneficiary out of pocket costs (premiums and cost-sharing) for the comprehensive standard benefit package, in at least one fee-for-service plan, will not be any greater than beneficiaries face under Medicare. Without this protection, the richer benefit package in the Alliances, along with the capped Medicare program contribution, will result in many beneficiaries paying more than they do now. In essence, it would have the same effect as forcing all beneficiaries to purchase Medigap policies.

- Providers must be protected from discrimination and have the ability to appeal exclusion from a plan on grounds other than cost or quality. Our fear is that inner city hospitals, for example, will be excluded from many plans and have no recourse. Not only will this discriminate against the hospital, but it will discriminate against beneficiaries who live around the inner city hospital. In essence, it keeps those beneficiaries out of the plan.

Individual Integration

Prior to state integration, in cases where individuals reaching age 65 wish to remain in an Alliance plan, we have not reached agreement on the kinds of plans individuals could choose or the kinds of payment safeguards that should be in place.

Plan Selection. We believe that it may not be fair to ask new Medicare enrollees to leave their plan if the plan is an HMO- type delivery system (a risk-based plan). Entry into Medicare would mean changing that delivery system. However, if the plan they are in is fee-for-service, we believe that they should be in Medicare.

- Our reason for restricting plan choice to risk-based plans is because of our inability to adjust for health status. Plans are exceptionally clever at encouraging healthy people to remain and unhealthy people to leave.

- We do not yet know how to adjust our payment to plans to reflect health status. If individuals can choose between any plan or Medicare, we expect plans to encourage healthy individuals to choose them and encourage unhealthy individuals to choose Medicare. As a result, the government will be paying plans an average amount for

persons of above average health and paying more than average amounts for those in Medicare.

Payment to Plans. We believe Medicare should pay risk plans in the Alliance the same way it pays risk plans that contract with Medicare -- at 95% of the average per capita cost. Even at 95%, we have been over paying because healthier than average persons have been enrolling in risk plans. If we pay plans in the Alliance at even higher rates, clearly that will be placing an unfair burden on the Medicare Trust Fund.

Plan Bid. We believe we should place a ceiling on the amount plans can charge Medicare beneficiaries. This ceiling can be related to the bid for younger beneficiaries. Otherwise, plans who do not wish to serve Medicare beneficiaries can bid at ridiculously high amounts.

Administrative Streamlining

In an effort to reduce the burden on providers, the Plan has a new Medicare and Medicaid requirement that just does not make sense. It limits changes in regulations and requirements for Medicare and Medicaid programs to once every six months.

- If we were limited to that requirement, we could not always meet Congressional deadlines (mammography screening was passed one month and effective that next); we would have to put off regulations providing new benefits to individuals; we would have to put off corrections that would benefit providers, e.g, payment mistakes.

- We currently issue about 85 regulations per year. This limitation is outrageous.

DoD and VA Payment

Currently the Medicare program does not pay for individuals dually entitled to Medicare and DoD/Va who receive care at DoD/VA facilities. The Plan changes that policy and we do not concur.

- Dually entitled Medicare beneficiaries who elect to enroll in a DoD plan will be paid for by Medicare. This could add $1 billion annually to Medicare Trust Fund responsibilities.

- Higher income dually entitled Medicare beneficiaries who elect to enroll in a VA plan will be paid for by Medicare. It is unclear how much additional cost this shifts from VA to the Medicare Trust Funds but it could be consequential.

- We see no rationale for a transfer of funding responsibilities from DoD or VA to the ailing Medicare Trust Fund.

Attachment F

OTHER UNRESOLVED ISSUES

The following issues are in various stages of discussion and are still unresolved. In some areas, changes in the White House draft has occurred since our last review, necessitating new discussions. In others, we have only recently come to decisions that need to be reflected.

The following issues remain to be resolved:

Budget level and bidding process
Short-term cost containment
Malpractice
Quality
Information and administrative simplification
New health workforce
Academic health centers
Medical research
Public health initiatives
Protecting underserved populations
Long-term care
Indian Health Services

file

TO: Melanne
FROM: Jen Jen

Nicole asked me to find out about abstinence programs. Attached please find a description of the Adolescent Family Life Demonstration Project. Please note that this program, which began in the 1980s, has been controversial -- referred to as the "chastity" or "just say no" program that has funded small, quite conservative projects. HHS is trying to focus in the next year or so on new, more mainstream approaches to education about the risks of sexual activity and the choice of abstinence. I have also put in a call to the Department of Education, but have not heard back yet. I wanted you to have this in case you need it in the meantime.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Washington DC 20201

ADOLESCENT FAMILY LIFE PROGRAM

The Adolescent Family Life (AFL) program was enacted in 1981 as Title XX of the Public Health Service Act. With a FY 1994 budget of approximately $7 million, AFL focuses on the issues of adolescent sexuality, pregnancy and parenting. The program provides funding in three areas--(1) care demonstration projects (2) prevention demonstration projects and (3) research projects. Approximately 179 care and prevention demonstration projects and 61 research projects have been supported by the program since its inception.

Care demonstration projects serve pregnant adolescents, adolescent parents, their infants and their families.

- AFL care projects are required to provide health, education and social services and to test new approaches for their delivery.
- Most projects are either hospital or agency based and many provide home visiting services.
- A major focus of AFL care projects is a case management approach where each adolescent works one-on-one with a case manager throughout the pregnancy and early parenting period to address her needs, as well as those of her infant and family.

Prevention demonstration projects serve preadolescents, adolescents and their families.

- The major focus of AFL prevention projects is, by statute, to develop and test abstinence-based programs designed to delay the onset of sexual activity and thus reduce the incidence of adolescent pregnancy and STD transmission.

- Projects are either school or community based and generally provide basic sexuality education, as well as training in life skills, social skills and resistance skills in various combinations.

Both care and prevention projects are required to be independently evaluated, incorporating a process evaluation of program implementation and operation, as well as an outcome evaluation of the impact of the program.

The AFL program has also supported research projects in an effort to improve understanding of the issues surrounding adolescent sexuality, pregnancy and parenting. This includes investigating factors that influence adolescent sexual, contraceptive and fertility behaviors, the nature and effectiveness of care services for pregnant and parenting adolescents and why adoption is a little-used alternative among pregnant adolescents.

The AFL program's authorizing legislation expired in 1985. The program has been operating under funding provided in the annual Congressional appropriations process.

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