Jan. FY1.
GOP Sen. Budget Cmte Analysis of our budget on medicaid + medicare
cc Chris J. — Pauline

See esp. medicare

- The President's budget offers **two new programs** in employment and training to be administered by the **Department of Labor.** One program funded at $50 million, **Jobs for Residents**, will link unemployed youth and adults with jobs in high poverty areas. The other, **Incumbent Worker Demonstration**, funded at $15 million, will make guaranteed loans to business in order for them to improve worker training.

- The **Department of Labor** proposes **to increase its employees by 451 FTE** (full-time equivalent employment). The Administration proposes an overall **increase in Department of Labor programs** of **$1.7 billion** and **unspecified cuts of $170 million**.

- The President proposes terminating **Community Service Employment for Older Americans** for savings of $65 million in fiscal year 1997, $2.3 billion over 7 years. The continuing resolution funds this program at $273 million.

- For the **Administration for Children and Families**, the President is requesting a $1.7 billion increase over the continuing resolution level. Within this account, The President proposes a **new Teen Pregnancy Prevention** initiative to be funded at **$30 million**.

- For **Head Start** the President is requesting $3.98 billion, an increase of $580 million over the continuing resolution.

- The Administration freezes funding for the **Social Services Block Grant** over the next 7 years. For fiscal year 1997, this is $280 million higher than in the continuing resolution.

FUNCTION 550: HEALTH

This function covers all health spending except that for medicare, military health, and veterans health. The major programs include medicaid, health benefits for federal retirees, the Food and Drug Administration (FDA), the Health Resources and Services Administration, the Indian Health Service, the Centers for Disease Control and Prevention (CDC-P), the National Institutes of Health (NIH), and the Substance Abuse and Mental Health Services Administration (SAMHSA).

($ Billions)

	1996	1997	1998	1999	2000	2001	2002
Clinton Budget:							
Budget authority	110.9	134.7	141.2	146.7	152.1	157.3	163.5
Outlays	121.2	134.6	141.3	146.6	152.1	156.4	162.2
Change from 1996:							
Budget authority	---	+23.8	+30.3	+35.8	+41.2	+46.4	+52.6
Outlays	---	+13.4	+20.1	+25.4	+30.9	+35.2	+41.0

Medicaid

- The President's budget proposes reforms to medicaid that would save $59.1 billion over the seven year period 1996-2002, relative to the CBO baseline.[1]

- The President's budget proposes to cut and restructure payments in the Disproportionate Share Hospital (DSH) program. This would account for about $37 billion in savings.[2] The DSH program accounts for about $10.7 billion (11 percent) of 1996 medicaid spending.

- The President's budget proposes a per capita cap to limit federal spending per beneficiary. Payments to states would be restricted, but current law eligibility and benefit requirements would remain. The President's budget emphasizes that the "money would follow the people" in case of migration or economic downturns.

- The most recently submitted detailed medicaid plan, however, did nothing to narrow the difference in spending between states with high federal spending per beneficiary and those with low federal spending per beneficiary. If the President's plan has not changed, then these historical differences would be locked into place in the President's proposal.

[1] Relative to the OMB baseline, OMB estimates these proposals would save $58.7 billion over this same time period.

[2] Detail has not been provided. This estimate is based on CBO analysis of the President's most recent medicaid proposal, which would save $54 billion in total.

- In addition, the President's budget may include an enormous unfunded mandate on the states. Although it takes a significant step by repealing the Boren amendment on provider payment rates, the President's plan leaves the current medicaid program mostly unchanged, and would save federal dollars primarily by transferring costs to states.

- The President's budget makes no mention of, and the Administration has not endorsed, the medicaid reform outline proposed by 48 Governors in early February. Although the Governors' proposal is a significant bipartisan compromise between the President's reform plan and the Medigrant reforms contained in last year's vetoed Balanced Budget Act of 1995, the President's budget seems to ignore this proposal.

Medicaid ($ Billions)

	1996	1997	1998	1999	2000	2001	2002
Clinton Budget:							
Outlays	94.9	105.6	111.3	116.5	122.3	128.6	133.2
Change from 1996:							
Outlays	---	+10.7	+16.4	+21.6	+27.4	+33.7	+38.3

Other health programs

- Funding for **food safety and inspection** (the Food and Drug Administration) would increase $19 million in 1997 over the 1996 level of $555 million. This 3.4 percent increase would be followed by an 8 percent cut in 1998, a 9.1 percent cut in 1999, and a 9.8 percent cut in 2000. The President's budget proposes food safety and inspection user fees totaling $654 million over the seven-year period.

- Funding for the **Centers for Disease Control and Prevention** (CDC-P) would increase $78 million in 1997 over the 1996 level of $1.92 billion. This 4.1 percent increase would be followed by an 8 percent cut in 1998, a 9 percent cut in 1999, and a 10 percent cut in 2000.

- Funding for **consumer safety** would increase $3 million in 1997 over the 1996 level of $918 million. This 0.3 percent increase would be followed by an 8 percent cut in 1998, a 9 percent cut in 1999, and a 10 percent cut in 2000.

- Funding for **health research and training** would increase $488 million in 1997 over the 1996 level of $12.5 billion. This 3.9 percent increase would be followed by a 0.3 percent cut in each year from 1998 through 2000. Of the above amounts, funding for the **National Institutes of Health** (NIH) would increase $467 million in 1997 over the 1996 level of $11.9 billion. This 3.9 percent increase would be followed by flat funding (no growth) through the year 2000.

- Funding for **Indian health** would increase $174 million in 1997 over the 1996 level of $2 billion. This 8.7 percent increase would be followed by flat funding (no growth) through the year 2000.

- Funding for the **Substance Abuse and Mental Health Services Administration** (SAMHSA) would increase $244 million in 1997 over the 1996 level of $1.85 billion. This 13.2 percent increase would be followed by an 8 percent cut in 1998, a 9 percent cut in 1999, and a 10 percent cut in 2000.

- The President's budget proposes **new entitlement spending** costing $8.7 billion over a four year period. This spending would provide premium subsidies to individuals when they lose their jobs, to pay for private insurance coverage for "up to six months." The four year authorization is accompanied by a request for a study into how to make this subsidy permanent.

- If the program were made permanent with the 8.7 percent growth rate in the last two years authorized, this new subsidy would create an additional $5.8 billion in new entitlement spending, for a total of $14.5 billion new entitlement spending over the seven year period, and would worsen the deficit (surplus) by $3 billion in the year 2002.

FUNCTION 570: MEDICARE

This function includes only the medicare program. Medicare pays for medical services for about 37.6 million senior and disabled citizens, and for those with End Stage Renal Disease. Medicare is administered by the Health Care Financing Administration, part of the Department of Health and Human Services.

($ Billions)

	1996	1997	1998	1999	2000	2001	2002
Clinton Budget:							
Net Outlays	177.6	190.1	204.9	218.4	231.1	248.4	267.0
Change from 1996:							
Net Outlays	---	+12.5	+27.3	+40.8	+53.5	+70.8	+89.4

Baseline differences

The President's medicare baseline is significantly lower than the latest CBO medicare baseline. Over the seven-year period, these differences total $52.8 billion.[3] The claims that the President's budget guarantees solvency of the Hospital Insurance (HI) trust fund for "more than a decade" are based on this more optimistic starting point. While the numbers given in the above table are OMB figures to provide consistency with the rest of this document, the analysis below will use the CBO December baseline to ensure accurate comparison with recent Congressional and Presidential proposals. The President's budget indicates the intent is to save $124 billion against the CBO baseline, and includes an additional proposal to ensure that level of savings is achieved.

Aggregate spending and savings

Over the period 1996 - 2002, gross medicare spending[4] in the President's budget would be about $1.77 trillion. For comparison, medicare spending under the Balanced Budget Act of 1995 (BBA), as vetoed by the President, would have been $1.67 trillion, and spending in the most recent Republican offer to the President would be $1.71 trillion.

The President's budget proposes to save $124.2 billion over the seven-year period 1996-2002. The BBA proposed to save $226.7 billion over that same period, and the most recent Republican offer would save $168.0 billion. The difference between the President's budget and the most recent Republican offer is about 45 cents per beneficiary per day.

---

[3] OMB projects lower total baseline spending of $74.7 billion over seven years, and $21.8 billion less premium revenue.

[4] This includes $19 billion in discretionary spending for administration, and is measured against the CBO December 1995 baseline.

Growth rates

In 1993, as part of the effort to promote his health reform plan, the President said, "Today, medicaid and medicare are going up at three times the rate of inflation. We propose to let it go up at two times the rate of inflation. That is not a medicare or medicaid cut. ... only in Washington do people believe that no one can get by on twice the rate of inflation. (Laughter.) So, when you hear all this business about cuts, let me caution you that that is not what is going on. We are going to have increases in medicare and medicaid."[5]

CBO's latest projection for inflation over the period 1995-2002 is 3.0 percent per year. In the long run, nothing can indefinitely grow faster than the economy. CBO's projected long-term (10 year) growth rate for GDP is 5.0 percent per year. This is the *maximum* sustainable long-term growth rate for medicare spending.

Average Annual 7-year Growth Rates

Maximum sustainable long-term medicare growth rate	5.0 %
Two times inflation	6.0 %
Balanced Budget Act medicare growth, as vetoed	7.1 %
Latest Republican offer medicare growth	7.4 %
President's 1997 budget medicare growth	7.9 %
Three times inflation	9.0 %
Baseline medicare growth (CBO)	9.9%

Spending per beneficiary

Current law 1995 spending	$4,820		
Current law 1996 spending	$5,300	Increase from 1995 to 1996	$480, or 10%

[5] Speech to AARP members in Culver City, CA, October 5, 1993.

	Proposed Spending in 2002	Increase from 1995	7-year Average Growth Rate
Balanced Budget Act	$7,090	+$2,270	5.7%
Latest Republican offer	$7,230	+$2,410	6.0%
President's FY 97 budget	$7,620	+$2,800	6.8%
Current law	$8,200	+$3,380	7.9%

Premiums

When medicare was enacted in 1965, the part B premium covered 50 percent of part B program costs. Over time, this declined to 31.5 percent in 1995, and then to 25 percent on January 1, 1996. The President's budget proposes to "continue, but not increase, the requirement that beneficiaries pay 25 percent of Part B costs." The exact same language could have been used to describe the premium policy in last year's vetoed BBA, substituting 31.5 percent.

The President's budget does not propose to relate the medicare premium to income. The BBA, the House "Blue Dog" Coalition, and the Senate Bipartisan Group all included an affluence test for high-income medicare beneficiaries. Relative to current law and the President's plan, this aspect of these other three proposals is more progressive than the President's budget.

Monthly Medicare Part B Premiums (in $)

	1995	1996	1997	1998	1999	2000	2001	2002
Current Law	46.10	43.70	48.20	53.20	55.00	56.90	58.80	60.80
President (6/95)	46.10	43.70	47.00	51.00	56.00	63.00	69.00	77.00
President[6] (3/96)	46.10	43.70	45.50	49.50	53.40	59.50	64.60	70.40
BBA	46.10	51.40	54.90	58.60	62.80	70.70	77.20	84.60
Last GOP offer	46.10	43.70	47.00	51.00	56.00	63.00	69.00	77.00

[6] Uses the CBO baseline for comparison with Congressional plans. Assumes changes to provider payments are the same as in earlier Presidential proposals.

Hospital Insurance (HI) Trust Fund

The President's budget claims to "guarantee solvency of the trust fund for more than a decade." This statement is based on the more optimistic OMB baseline. While CBO estimates are not yet available, Budget Committee staff believe that, measured relative to the CBO baseline, the President's budget would allow the HI trust fund to become insolvent in the year 2004 or 2005.

The President's budget shows the HI trust fund becoming insolvent in the year 2001, rather than 2002.

The President's budget proposes to transfer certain home health spending (about $60 billion over seven years) from medicare part A to medicare part B. This budgetary shell game improves projections for the HI trust fund, but does nothing to address the underlying fiscal problem. This spending transfer shifts costs to future generations. When this home health spending is transferred from part A to part B, it is not included in the part B premium. Technically, the President's premium policy is "25 percent of non-transferred part B spending."

The policy problem to be addressed is the growth of total medicare program spending, not the solvency of the HI trust fund. While impending trust fund bankruptcy is an extremely useful indicator of high part A growth rates, it is not the problem to be solved. The Administration emphasis on "saving the medicare (HI) *trust fund*" is misleading: a more appropriate policy goal might be to "save the medicare *program*" by moving toward a growth rate of program spending that is sustainable in the long run.

Increased managed care

The President's budget proposes to expand the current risk contract program to include preferred provider organizations (PPOs) and provider service networks (PSNs). The President's proposal would compress the regional variation in payments in a manner similar to those proposed in Congress last year. The most significant difference is that the Congressional plan includes more choices: privately offered fee-for-service plans, union, Taft-Hartley, and association plans, and medical savings accounts (MSAs). The Congressional plan would also have severed the link between payments through traditional fee-for-service medicare and payments to health plans (the "95 percent of AAPCC" link).

Provider payments

Details of the President's proposed medicare reform policies are not available in the new documents. Since the numbers are virtually identical to those identified with the President's

proposals over the past several months, this analysis assumes those proposals have not changed significantly. If this assumption is correct, budgetary savings would be as follows (scored by CBO last December against the CBO December baseline):

	Savings, 1996-2002
Hospital market basket updates	$14 billion
PPS-exempt hospital policies	$3 billion
Reduce PPS hospital capital payments	$6 billion
Reduce payments for physicians' services	$20 billion
Oxygen payments	$2 billion
Secondary payor provisions	$6 billion
Home health payments	$9 billion
Skilled nursing facilities	$7 billion
Hospital outpatient department policies[7]	NA

	Savings, 1996-2002
Reduce medicare DSH payments	- less than $1 billion
Eliminate additional payments for "outliers"	$4 billion
End gaming of hospital discharges	$6 billion
Graduate medical education	$6 billion
Preventing fraud and abuse	$1 billion
Rural areas (new spending)	- $1 billion
New benefit spending	- $13 billion

FUNCTION 600: INCOME SECURITY

The income security function contains the: 1) major cash and in-kind means tested entitlements, 2) general retirement, disability and pension programs excluding Social Security and Veteran's compensation programs, 3) federal and military retirement programs, 4) unemployment compensation, 5) low income housing programs and 6) other low-income support programs. Function 600 is the fourth largest functional category after Social Security, defense, and interest on the federal debt

[7] The Budget includes a proposal to reform formula-driven overpayment to achieve the additional savings necessary with the less optimistic CBO baseline.

PRESIDENT CLINTON SUBMITS FY 1997 BALANCED BUDGET
Balances the Budget in 7 Years While Protecting Medicare, Medicaid, Education, And The Environment, And Maintaining Tax Fairness
February 5, 1996

President Clinton's Budget Is The First Genuine Balanced Budget Submitted By A President In 17 Years That Reaches Balance Based On Congressional Budget Office Numbers.

- **President Clinton's Balanced Budget Is Historic. The Savings Are Real. It Reflects America's Values. It Provides Tax Relief For Working Families.**

- **President Clinton's Balanced Budget Is Good For America.** While protecting Medicare, Medicaid, Education, and the Environment, and providing tax relief for working families, it would help lower interest rates, create jobs, and invest in our future, while continuing the strong economic growth our country has enjoyed under President Clinton.

President Clinton's Balanced Budget Includes New Initiatives To Help Meet America's Challenges As We Move Towards The New Century.

- **Health Insurance Reforms.** Require insurers to cover people who have lost insurance because they change or lose their jobs. Help 3.8 million unemployed workers each year purchase health insurance. Limit the ability of insurance companies to deny coverage based on pre-existing condition. Help small businesses buy insurance at cheaper rates.

- **Education Technology Initiative**. Help local efforts to increase Educational Technology -- putting more computers in classrooms, connecting classrooms to the internet, creating better educational software to help children learn, and providing training to help teachers teach new technologies.

- **$10,000 College Tuition Tax Deduction.** Allow families to deduct up to $10,000 a year for the cost of tuition and training. More than 16.5 million students could benefit.

- **$1,000 College Merit Scholarships For Top 5% of High School Students**. Scholarships rewarding excellence and achievement to help more students afford a college education.

- **Brownfields Common Sense Environmental Cleanups.** Tax incentives to businesses that redevelop brownfields in distressed communities over a shorter period of time. This will spur the private sector to create jobs, return land to productive use, and clean up the environment.

President Clinton Urges Republicans To Keep Working With Him So We Can Pass A Balanced Budget. No More Blackmail. We Have The Savings In Common. Let's Get It Done.

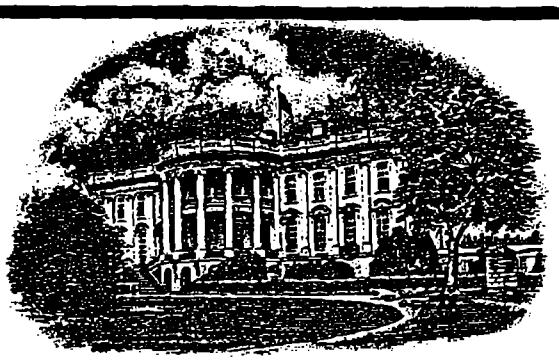
- **Pass Common Savings Now.** Both sides have now agreed on more than enough cuts in common to balance the budget in 7 years and still provide a modest middle-class tax cut, to maintain our obligations to our parents and our children and to the future through Medicare and Medicaid and through our investments in education, and to protect the environment.

- **Congress Must Pass A Longterm Straightforward Debt Extension Now.** Congress must take action to secure a long-term, straightforward debt extension so that we can get on with balancing the budget without the threat of default hanging over our head.

FAX COVER

Health and Personnel Division

Executive Office of the President
Office of Management and Budget
OEOB, Room 262
Washington, D.C. 20503



DATE: 2/28/96

TO: Jennifer Klein

AGENCY:

FAX NO: 62878

FROM: Nancy-Ann Min
Associate Director for Health and Personnel

Phone Number (202) 395-5178
Fax number (202) 395-9119

Number of pages (including cover) 11

COMMENTS: As discussed.

62878

2/28
3 PM

6. STRENGTHENING HEALTH CARE

We still have a lot of work to do. But the answer to the problems of the great American middle class, the answer to the problem of curing the American deficit, the answer to the problem of dealing with the challenge of educating a new generation of Americans for a new, highly competitive economy -- surely the answer to those problems is not to break down the one thing we have done right completely, which is to keep faith with our elderly people.

President Clinton
July 25, 1995

In a recent report in the *New England Journal of Medicine*, two demographers wrote that Americans who reach the age of 80 have a longer life expectancy than their counterparts in Japan, England, France, and Sweden. One reason, they wrote, is that older Americans receive better health care than the elderly in other countries.[1]

highlight the strengths of our HC system and the challenges we face to make sure all have access to it.

For this reason, our our system the challenge we face is

~~Their findings point up the health care challenge~~ that the Nation faces. It is not to tear down the existing system but, rather, to build on it -- to protect its strengths and address its weaknesses -- as the President has tried to do for the last three years. and not to tear it down,

The President has consistently worked to balance two competing demands in health care: (1) improve access to coverage, and (2) make the system more efficient. Thus, he has sought to create an environment in the public and private health systems where plans compete based on quality and cost-effectiveness, not on which can choose the healthiest and cheapest populations to insure. The budget includes health care provisions that reflect this commitment.

Many innovations in health care have helped to contain costs in the private sector. The best of them make our delivery system more efficient, and improve quality by stressing accountability and focusing on medical outcomes. The President proposes to introduce these kinds of improvements into Medicare. For Medicare's 37 million beneficiaries, they will create more plans to choose from, higher quality care, and a more cost-effective program.

---

[1]Manton, Kenneth G., and Vaupel, James W., "Survival After the Age of 80 in the United States, Sweden, France, England, and Japan," *New England Journal of Medicine*, November 2, 1995, pp. 1232-1235.

6. STRENGTHENING HEALTH CARE

For Medicaid, the President's plan proposes to give States an unprecedented degree of flexibility to better manage their programs. They no longer will have to endure a seemingly endless process to receive Federal permission to use managed care for their Medicaid populations, to expand into more desirable home- and community-based service programs for the chronically ill, or to expand coverage.

The plan will let States better negotiate contracts with health providers. And the President's per person limit on Medicaid spending will ensure that federal dollars follow the recipients -- an approach that will limit the growth in Medicaid spending while protecting States that face high population growth or economic downturns. These and other provisions will maintain and strengthen Medicaid's guarantee of coverage for 36 million vulnerable Americans.

In addition, the budget proposes $23 billion, a $1 billion increase over 1996, for a wide range of public health services as well as research and regulatory activities that promote public health:

- The services range from community health centers in inner cities, to clinics on remote Indian reservations, to research activities at prestigious universities and medical schools. Public health clinics provide immunizations to uninsured children, dental care for the underinsured, and prenatal care to millions of low and moderate income women. Other public health services that help those in need include the Ryan White program, which provides states and cities with resources to deliver vital services to people with AIDS.

- The research and regulatory activities include biomedical and behavioral research at the National Institutes of Health (NIH), worker safety and health research at the National Institute for Occupational Safety (NIOSH), and food and pharmaceutical safety regulation and enforcement at the Food and Drug Administration.

A. STRENGTHENING MEDICARE

The budget strengthens and improves Medicare, extending the solvency of the Part A Hospital Insurance (HI) trust fund through the next decade. It gives seniors more choices among private health plans, makes Medicare more efficient and responsive to beneficiary needs, attacks fraud and abuse through programs praised by law enforcement officials, cuts the growth rate of provider payments, and holds the Part B Supplementary Medical Insurance (SMI) premium at 25 percent of program costs.

The plan saves $124 billion over seven years, as estimated by the Health Care Financing Agency's Office of the Actuary. The Administration expects that, for technical reasons -- e.g., different assumptions about how fast Medicare spending will grow, and how providers and beneficiaries will behave -- the Congressional Budget Office (CBO) will estimate that the plan saves slightly less. The Administration has identified a way to close the gap -- specifically, by correcting flaws in how the Government pays outpatient hospital departments.

The Administration is proposing *policies* that save $124 billion in Medicare -- using either the Administration's or CBO's "baseline" (i.e., projection of Medicare spending) as a starting point. The Administration will work with Congress to ensure that any plan that the President proposes will save $124 billion under CBO scoring.

Provider Payment Reforms and Program Savings

- **Hospitals.** The budget reduces the annual inflation increase, or "update," for hospitals; reduces payments for hospital capital; reforms payments for graduate medical education; and begins to reform the payment method for outpatient departments while protecting beneficiaries from increasing charges for those services.

- **Managed Care.** The budget reforms payments by using reasonable rate-of-growth limits on updates for managed care payments and reducing the current geographic variation in payments.

- **Physicians.** The budget reforms physician payments by paying a single update for all physicians and replaces current "volume performance standards" with a sustainable growth rate.

- **Home Health Care/Skilled Nursing Facilities.** The budget implements interim payment reforms, leading to separate prospective payment systems for home health care and skilled nursing facilities.

- **Fraud and Abuse.** The budget introduces aggressive and comprehensive policies to stamp out Medicare waste, fraud, and abuse, and extends and enhances Medicare secondary payor policy to ensure that Medicare pays only when it should.

- **Other Providers.** The budget freezes or reduces payments for durable medical equipment and ambulatory surgical centers.

- **Beneficiaries.** The budget continues, but does not

increase, the requirement that beneficiaries pay 25 percent of Part B costs through the monthly Part B premium; it imposes no other cost increases on beneficiaries.

Provisions to Improve Rural Health Care

The budget enhances access to, and the quality of, health care in rural areas. It extends the Rural Referral Center program, directs Medicare reimbursement for nurse practitioners and physician assistants, improves the Sole Community Hospital program, and expands the Rural Primary Care Hospital program.

Provisions to Expand Choices and Add Preventive Benefits

The budget expands and improves Medicare managed care by:

- ensuring beneficiary protections while increasing the types of plans -- including Preferred Provider Options (PPOs) and Provider Service Networks (PSNs) -- available to seniors, and

- instituting a coordinated annual open enrollment process -- similar to that used by the Federal Employees Health Benefits Plan (FEHBP) -- during which beneficiaries use comparative information to choose among managed care and supplemental insurance options.

In addition, the budget expands coverage of preventive benefits to include annual mammograms and the elimination of mammography coinsurance, colorectal cancer screening, increased payments for flu shots, and diabetes screening and education. Finally, the budget introduces a respite care benefit, providing relief to families caring for relatives with Alzheimer's disease.

B. STRENGTHENING MEDICAID

The budget reforms Medicaid to give states much more flexibility to manage and families their programs, while preserving the guarantee of health coverage for the most vulnerable Americans. Millions of children, people with disabilities, and the elderly will retain the guarantee of basic health and long-term care services.

The budget saves $59 billion over seven years by imposing a per-person limit on spending, and cutting Disproportionate Share Hospital (DSH) payments and retargeting them to hospitals that serve large numbers of Medicaid and uninsured patients. As with Medicare, the Administration expects CBO to make different

estimates about how much the budget would save in Medicaid. In this case, too, the Administration will work with Congress to ensure that any enacted plan saves $59 billion under CBO estimates.

The plan provides special payments for States to transition into the new system, and to meet the most pressing needs. It gives States unprecedented flexibility to administer their programs more efficiently. Finally, it retains current nursing home quality standards and continues to protect the spouses of nursing home residents from impoverishment.

Program Savings

- **Per-person cap.** A per-person cap on Medicaid growth will limit spending to a reasonable level, while retaining current eligibility and benefit guidelines. This approach guarantees that the elderly, people with disabilities, and pregnant women and children who depend on Medicaid will remain eligible for health benefits, while it slows increases in spending to levels that States and the Federal Government can support. In contrast to a block grant, the Administration's plan protects States facing population growth or economic downturns.

- **Disproportionate Share Hospital Payments (DSH).** The budget gradually reduces DSH payments and retargets them to hospitals that serve a large proportion of Medicaid and uninsured patients, including children's and public hospitals. It provides special payments for Federally Qualified Health Centers, Rural Health Clinics, States with large numbers of undocumented immigrants, and States moving into the new system.

Provisions to Increase State Flexibility

The budget includes a number of policies to give States more flexibility in managing their Medicaid programs, such as:

- **Boren amendment.** The plan repeals the "Boren amendment," allowing States more flexibility to negotiate provider payment rates.

- **Managed care.** The plan allows States to adopt managed care without Federal waivers.

- **Home- and community-based care.** The plan allows States to move populations who need long-term care from nursing homes to home- and community-based settings, without Federal waivers.

• **Coverage expansions without waivers.** The plan enables States, without a waiver, to expand coverage to any person whose income is under 150 percent of the poverty line. States would pursue these expansions within their per-person limits, thereby limiting Federal costs.

Protections for Low-income Seniors and Native Americans

The budget retains the policy of helping low-income seniors by preserving the shared Federal-State responsibility for their Medicare premiums, copayments, and deductibles. It also retains payment protections for Medicaid-eligible Native Americans treated in Indian Health Service facilities. These protections are not subject to the per-person cap.

C. MAINTAINING AND EXPANDING COVERAGE FOR WORKING AMERICANS

Reforms to Make Health Coverage More Accessible and Affordable

In his State of the Union address, the President challenged Congress to enact insurance reforms to enable more Americans to maintain health insurance coverage when they change jobs, and stop insurance companies from denying coverage for pre-existing conditions. This budget requires that plans make coverage available to all groups of businesses, regardless of the health status of any group members. Insurers would have to provide an open enrollment period of at least 30 days for all new employees (whether or not they were previously insured), and insurers could not individually underwrite new enrollees -- i.e., their premiums would have to match other enrollees' with similar demographic characteristics.

To increase affordability, the President's insurance reforms phase out the use of claims experience, duration of coverage, and health status in determining rates for small businesses. To put the self-employed on a more equal footing with other businesses, the reforms gradually raise the self-employed tax deduction from 30 to 50 percent. And to help give small businesses the purchasing clout that larger businesses have, the budget gives technical assistance and $25 million a year in grants with which States can set up voluntary purchasing cooperatives.

Health Insurance for the Temporarily Unemployed

The budget gives premium subsidies to individuals who lose their health insurance when they lose their jobs, to pay for private insurance coverage for up to six months. States would receive funding to design and administer the program, which would

provide coverage for about 3.8 million Americans a year. During the four-year period for which this program is authorized, a Commission would study and provide recommendations to the Administration and Congress as to making it permanent.

D. PROMOTING PUBLIC HEALTH

The budget continues our Nation's critical investment in basic biomedical research, an investment that plants the seeds for lifesaving advances in medicine. Under this budget, funding for biomedical research at NIH will rise by $2 billion, or 20 percent, since 1993. Further, this budget advances our efforts to eradicate, once and for all, the dreaded disease of polio. And it supports childhood immunizations, which have proven their cost-effectiveness time and again.

The budget continues the President's commitment to HIV/AIDS prevention and treatment. It increases efforts to prevent HIV transmission by $34 million over 1996 levels. It increases Ryan White funding by $32 million over 1996 to ensure that our most hard-hit cities, States, and local clinics can assist those with AIDS. It increases support for **substance abuse treatment** -- one of the most effective forms of HIV prevention. And it increases AIDS research funding at NIH in the continuing search for effective treatments, vaccines, and a cure.

The budget also increases support for **substance abuse treatment and prevention**, helping expand efforts against drugs and the harm they cause. In addition, it gives the Indian Health Service (IHS) an 8 percent increase -- keeping our Nation's commitment to Native Americans and continuing our efforts to promote tribal administration of IHS programs.

Increased Funding for Biomedical and Behavioral Research: The budget continues the Administration's longstanding commitment to biomedical and behavioral research, which advances the health and well-being of all Americans. The $12.4 billion proposal for the NIH, a $485 million increase for NIH over 1996, invests in research directed to areas of high need and promise, as well as in basic biomedical research that will lay the foundation for future innovations that improve health and prevent disease. The budget includes increases for HIV/AIDS-related research, breast cancer research, high performance computing, prevention research, gene therapy, and developmental and reproductive biology. The budget also includes funding for a new NIH Clinical Research Center, which will give NIH a new, state-of-the-art research facility in which researchers will bring the latest discoveries directly to patients' bedsides. NIH's highest priority will continue to be financing investigator-initiated research project grants.

Increased Funding for Ryan White HIV/AIDS Treatment Grants: The budget proposes $807 million for activities authorized under the Ryan White CARE Act, an increase of $32 million over 1996. This level will fund grants to cities disproportionately affected by the HIV epidemic; to States to provide medical and support services; to community-based organizations for the provision of HIV early intervention services; and to support pediatric AIDS demonstration activities. In addition, the Administration has sought more funds for State AIDS drug assistance programs funded under Title II of the Ryan White program -- to finance new life-extending AIDS therapies that have just been discovered, pending FDA approval. Under this Administration, funding for Ryan White grants has risen by 89 percent. The Administration's proposal for 1997 will increase Ryan White funding by 132 percent since 1993.

Increased Funding for HIV Prevention: The budget proposes $618 million for Centers for Disease Control and Prevention (CDC) HIV prevention activities, a $34 million increase over 1996. At the historic White House Conference on HIV and AIDS, the President made his commitment to HIV prevention clear: "We have to reduce the number of new infections each and every year until there are no more new infections." A portion of these funds will go towards addressing the linkages between substance abuse and HIV infection.

Increased Funding for the Indian Health Service: The budget proposes $2.4 billion for the IHS, a $186 million increase. IHS clinical services -- often the only source of medical care on isolated reservation lands -- grow by $47 million, maintaining our commitment to Native Americans. The President's plan allows the tribes to continue taking greater responsibility for managing their own hospitals and clinics; the "contract support costs" that help underwrite tribal activities would increase by 31 percent, to $201 million. In addition, the budget proposes a major new initiative to bring water and sewer lines to those Native Americans still without adequate access to these basic necessities. The Budget increases support for these efforts by 50 percent, or $43 million. This initiative will ensure that about 4,000 more Native American homes receive water and sewer lines -- a step which has been critical to improving public health.

Increased Funding for Substance Abuse Treatment and Prevention: The budget increases support for State substance abuse treatment and prevention activities by $67 million, to $1.27 billion. The budget reiterates support for Performance Partnerships, which will provide enhanced flexibility to States to better design and coordinate their substance abuse prevention and treatment programs, and better target resources to local priority areas. In addition, it increases funds for substance abuse demonstration and training activities by $140 million, to

$352 million. The budget also establishes a $20 million Substance Abuse Managed Care Initiative that, with the rapid growth of managed care, will help to establish service guidelines and design quality assurance, monitoring, and evaluation systems. This strong support for substance abuse activities will enable hundreds of thousands of pregnant women, high risk youth, and other under-served Americans to receive drug treatment and prevention services.

Increased Funding for Immunizations: The budget proposes $957 million in spending on immunizations, including the Vaccines For Children program. For many diseases, the Administration is ahead of schedule to meet the goal of immunizing 90% of two-year olds by 1996. The most recent figures show that, in the period from April 1994 to December 1995, 90% or more of all two-year-olds were immunized against diphtheria, tetanus, pertussis, and *hemophilus influenza* type B. Further, rates for immunization against measles, mumps, rubella and polio are approaching the 1996 goals. Nevertheless, the Nation must maintain its efforts in order to lock in these achievements and meet the goals for the remaining immunizations.

The budget includes a major $47 million initiative in the Department of Health and Human Services to eradicate polio, which is preventable through immunizations, throughout the world. Polio is already gone from the Western Hemisphere. This shows that Polio, like smallpox, can be wiped from the face of the earth, sparing all children from this crippling disease and saving the U.S. the hundreds of millions we now spend on immunization against polio.

Increased Funding for Infectious Disease: The budget proposes $88 million for CDC's cooperative efforts with the States to address infectious disease, an increase of $25 million. This will support training and applied research, and support States' disease surveillance capability. All Americans face threats from the development of infectious disease problems, such as drug resistant bacteria, and emerging viruses, such as hantavirus. CDC works with State health departments to monitor and prevent such problems and to contain outbreaks.