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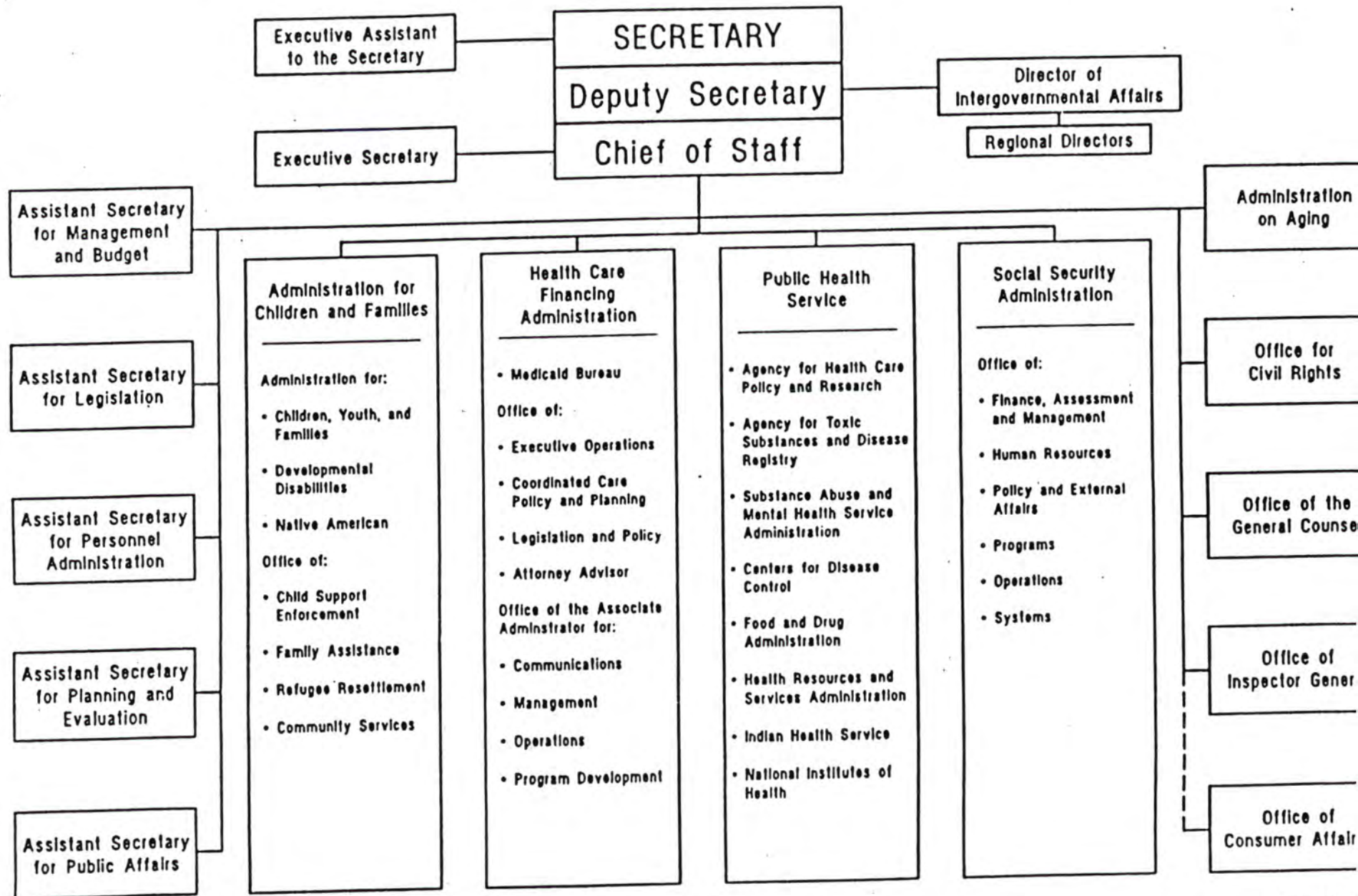
HHS Mission

Divider Title: _____

Mission

- Administer national social security programs for the elderly and persons with disabilities in an equitable, effective, efficient, and caring manner.
- Provide physical and mental health care services, finance health care services for the nation's elderly and disabled through the Medicare program, and finance health care services for the nation's poor in partnership with the states.
- Promote economic and self-sufficiency of low-income families by securing timely child support payments, preparing families for work through education and training programs, and by providing related services such as child care to avoid welfare dependency.
- Prevent and control disease, and alcohol and drug abuse.
- Conduct and support biomedical, medical, and services research providing a national focus to advance the state of knowledge and promote effective strategies to improve the health of American people, and effectively address the nation's health and social problems.
- Provide services to promote child development and protect the welfare of children, and assist the elderly to lead full and productive lives.
- Assure the safety and efficacy of drugs, and protect against impure and unsafe foods, cosmetics, medical devices, and radiation producing products.
- Enforce Federal civil rights laws that prohibit discrimination by health care and human service providers that receive federal funds.

U.S. Department of Health and Human Services



• Located administratively in HHS but reports to the President

Chart 2-13. HEALTH CARE EXPENDITURES
(as a percent of GDP)

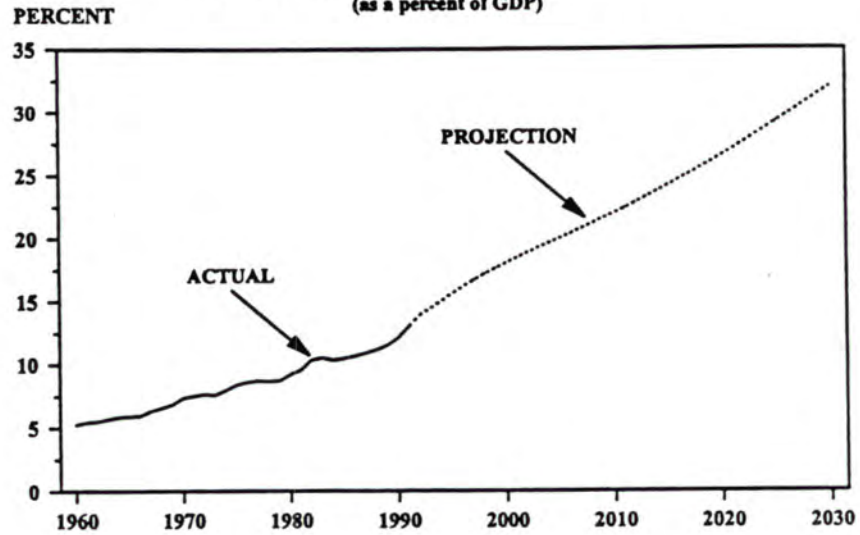
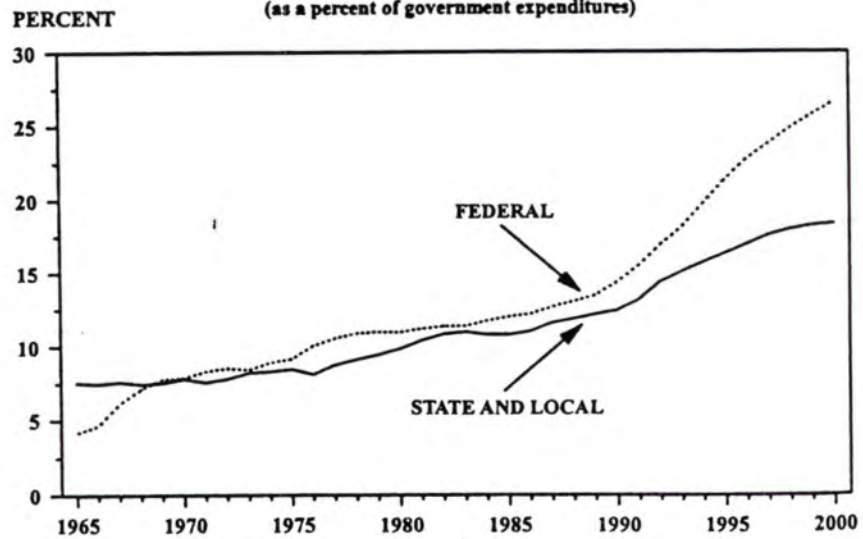


Chart 2-14. HEALTH CARE EXPENDITURES
(as a percent of government expenditures)



Ensuring Economic Recovery and Creating Jobs: Economic Stimulus

First things first. None of the things we want for America can be accomplished while millions of our citizens are unemployed and hundreds of billion of dollars of industrial capital lie idle. Americans will not tolerate another false start; and they shouldn't. We must get our economy moving again—and producing jobs.

Two criteria guided the design of the stimulus package.

Speed. Any tax reductions or spending programs included in the package had to be fast-acting and job-creating. The unemployed have waited too long. We consulted with mayors and governors as well as with all the major agencies to ensure that the money requested in 1993 could be obligated quickly for projects that were ready to go and that workers would be hired right away—this summer—to work on them.

Content. Items selected for inclusion had to be worthwhile on their merits and consistent with the long-run goal of shifting the nation's attention to its future. The stimulus package is *a down payment on the Administration's long-run investment program*. For example, our long-run investment plan puts major emphasis on ensuring that all children get a healthy start in life and come to school ready to learn. To generate major new efforts for children quickly, we included these elements in the stimulus package: summer Head Start, an increase in funding for the Supplemental Food Program for Women, Infants and Children (WIC), and a fast start on a new immunization initiative. Similarly, the investment package stresses the improvement of our nation's infrastructure, including major upgrading of our highway network. Hence, the stimulus package includes funding for highway projects that can be started quickly, especially repair and resurfacing projects that can employ workers soon.

The Size of the Stimulus

The Administration proposed its economic stimulus program in part to provide insurance for the twice-stalled economic recovery. The economy harbors heavy imbalances: large accumulations of debt by households, businesses, and governments at all levels; shaky financial institutions; an enormous overhang of vacant commercial real estate; and extraordinary competition from imports. These imbalances make the course of recovery far less predictable than it was after past recessions. The impact of substantial corporate downsizings, though they were announced over the last two years, is yet to be fully translated into actual layoffs. The defense base closings that were absorbed in the national consciousness over the last three years are just beginning to be realized; and more defense conversion is yet to occur as the Cold War fades into history.

Thus, we have an economy that may have achieved a self-sustaining recovery, but that is operating well below its capacity. The unemployment rate is still higher than it was at the bottom of the recent recession, and inflation remains well under control—in part under intense competition from imported products. The risks posed by a short-term economic stimulus are thus small; and the rewards—in greater near-term economic growth and in forestalling any possible relapse into recession—are significant.

Under these circumstances, the Administration has chosen a stimulus program that is substantial enough to provide real impetus to the recovery, but that is small enough to avoid jarring the financial markets or triggering inflation. The program is targeted to the investments in the administration's long-term economic program, on both the tax and the spending sides of the budget.

In spending, the stimulus program provides additional budget authority equal to \$16.3 billion—the amount by which the 1993 appropriations fell short of the combined discretionary spending caps in the Budget Enforcement Act. Thus, the discretionary spending proposed in the stimulus program will not increase the deficit relative to what was outlined in the 1990 budget agreement.

The program also increases the obligation limit for transportation funding under the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA) by \$3.0 billion. This increase allows for full funding of the portion of ISTEA devoted to Federal-aid highways, and also increases potential obligations for the Airport Improvement Program and mass transit. The stimulus further includes \$3.3 billion to increase loan levels, primarily for the Small Business Administration 7(a) loan guarantee program. Of that amount, \$220 million is specified as the long-term budget subsidy.

In tax incentives, the program provides over \$12 billion in temporary incremental investment tax credit. This provision will be available through calendar year 1994; over \$6 billion will be received by taxpayers as reductions in liabilities in 1993.

While much of the additional budget authority will not be spent in 1993, the near-term economic impact will be greater than the outlay figures indicate. Many of the investment programs—including prominently the ISTEA highway program—will result in binding contracts with private firms within the fiscal year, even though payments will not be made until the work is completed in later years. Those contractors will hire workers and begin work immediately. Thus, the contractual obligations will trigger economic activity even before outlays register in the budget itself. Likewise, private investors will commit themselves to investment projects because of the stimulus program's investment tax credit before they can actually claim the tax savings on their returns.

This economic stimulus will be felt most directly in the creation of new jobs; the lack of new jobs especially marks the current recovery, and constrains the spending needed to create a self-sustaining economic expansion. Several of the spending programs in the stimulus package—particularly community develop-

ment block grant assistance to States and localities, and highway programs—promote substantial job creation. The youth summer jobs program of the Job Training Partnership Act, as well as the summer Head Start program, will have particularly strong impacts in the summer months. The investment tax credit and even the longer-term business incentives will stimulate spending on capital goods and thereby promote hiring in the private sector. We estimate that the tax and investment proposals together will create almost 500,000 new jobs by the end of 1994.

All told, this plan provides almost \$30 billion in outlays and tax incentives in 1993 and 1994. This stimulus will provide insurance against renewed economic weakness in the near term; create jobs; help boost the recovery; add to economic growth over the next two years; cushion the beginning of the Administration's deficit reduction program; and begin the investment program that will lay the foundations for enhanced private-sector productivity and prosperity.

Infrastructure

One of the key elements of the Administration's long-term investment package is the strengthening of our nation's infrastructure. Some of the initiatives in that area can be advanced into 1993, providing an immediate impact on jobs and economic growth. In this category, the stimulus package contains transportation projects, Army Corps of Engineers water projects, and improvements in deteriorating Department of Veterans Affairs medical facilities. Details of these investments follow.

Transportation/Federal-aid highway program. The Administration proposes to expand the Federal-Aid Highway program to the levels contained in the Intermodal Surface Transportation Efficiency Act (ISTEA) for 1993. This will require increasing total obligations for Federal-aid Highways from the current level of \$17.7 billion to \$20.6 billion, a 17-percent increase of almost \$3 billion. More than one-third of the increase will be directed to fast-spending resurfacing, rehabilitation, and restoration projects, which can proceed quickly and bring jobs on line most rapidly. This measure will create an additional 13,000 jobs in 1993 and 45,000 in 1994. This increase will improve the conditions and performance of the 155,000 mile National Highway System. This system carries over forty percent of all highway traffic.

Transportation/Mass transit capital improvements. The Administration proposes to increase 1993 funding for mass transit capital improvements by \$736 million. The funds will be used to replace over age buses and vans, and to fund rail cars and rail rehabilitation projects. Of the \$736 million, about \$270 million will be entirely devoted to quick-to-acquire bus and van purchases, while the remaining \$466 million may be used for either bus or rail capital purposes. This initiative will create more than 9,000 jobs in 1993 and 1994. The bus/van

program will permit the acquisition of more than 100 full-size buses, 1,800 small buses, and 2,000 vans.

Transportation/Amtrak capital projects. This initiative provides \$188 million for AMTRAK to purchase new train cars and locomotives, modernize stations and maintenance facilities, and overhaul aging equipment. These will help to improve Amtrak's financial performance, moving it closer to achieving operating self-sufficiency.

Transportation/Airport grants. Many of the Nation's airports are congested, resulting in unacceptable delays for air travelers. Growth in air travel in the future will only add to the problem. Increased airport capacity can help reduce delays, speed air travel, and increase safety in many cases. This proposal to add \$250 million for airport grants in 1993 will enable airports to undertake safety and capacity improvement projects that are "ready-to-go".

Army Corps of Engineers water project construction and cyclic maintenance. The Administration proposes an additional \$94 million to speed construction of about 30 projects nationwide for flood damage reduction, inland waterway and deep-draft harbor transportation, hydropower, environmental restoration, and recreation.

Veterans Affairs/Medical Care and Minor Construction. The Administration proposes \$235 million to fund much needed improvements, largely in VA medical facilities, such as roof repairs, interior finishing, utility systems upgrades, and projects to ensure compliance with current safety and fire codes. This investment will create more than 4,000 jobs in an eight-month period.

A Summer of Opportunity

The Administration's stimulus package seeks to expand the opportunities for learning for children, youth, and workers while providing thousands of jobs, particularly during the summer months. In several instances, the initiatives are the leading edge for a specific program contained in the long-term investment plan.

HHS/Head Start Summer Program. The Administration is proposing a new Head Start summer program, which eventually would enroll up to 350,000 disadvantaged children. The purpose of the program is to help the youngest pre-school and school children to retain the social and intellectual gains made during the school year. It would expand the proven benefits of Head Start to the summer months and reduce further the learning disadvantages faced by children served by the program. This initiative would employ up to 50,000 Head Start staff (12,500 full-year equivalent) during 1993.

Education: Chapter 1 Summer School Program. The Administration proposes new, one-time supplemental funding of \$500 million to expand summer school programs in 1993 for educationally disadvantaged children. Funds would be

allocated to schools with concentrations of poor children. About 14,000 full-year equivalent jobs would be created.

Education: Chapter 1 Census Supplemental. The proposal would provide \$235 million in 1993 to substantially mitigate the effects on distribution of Chapter 1 funds caused by changes in the location of poor children in the U.S. that occurred between the 1980 and 1990 censuses. The Chapter 1 compensatory education program will, for the first time, use 1990 census data to distribute 1993 appropriations used during the 1993-94 school year. The total number of poor children ages 5 to 17 increased between 1980 and 1990, and the distribution of those children shifted. Poor children are increasingly concentrated in the schools of the western States and less concentrated in the schools of the eastern States. The supplemental will ease the transition to a smaller compensatory education program in communities that would otherwise have the size of their Chapter 1 grants substantially reduced for the 1993-94 school year.

Agriculture/WIC Program. The Administration proposes to expand 1993 funding by \$75 million for the Special Supplemental Food Program for Women, Infants, and Children (WIC), which pays for supplemental foods, health care referrals, and nutrition education for low-income pregnant and post-partum women, infants, and children under 5 years of age who are found to be at nutritional risk. The increase will permit the program to serve 300,000 additional participants, most of whom will be children ages 1-4. It is a down payment on the Administration's commitment in the long-term investment plan to provide full funding for WIC so that it serves all eligible children.

Agriculture/Emergency Food Assistance Program. The Administration proposes to provide \$23 million worth of food to the States through The Emergency Food Assistance Program (TEFAP). This successful program provides surplus food to about 2.5 million needy households and has been an important weapon in the Nation's arsenal against hunger.

HHS/Childhood immunizations. The President's plan to increase childhood vaccinations will immunize one million children during the summer of 1993. The Administration proposes to award \$300 million to support a community-based effort to finance vaccine purchases and education and outreach campaigns. This program will help to raise the Nation to the standards of child immunizations set by other advanced countries, which we have fallen far behind. Too many families are deterred by outrageously high costs from having their children immunized. The President intends to end that problem.

Labor/Summer Youth Employment and Training Program. Young Americans have an especially hard time finding jobs. The problem is worse for disadvantaged youth, and worse yet in the cities. The Summer Youth Employment and Training Program employs economically disadvantaged youth ages 14 to 21 to work at public and nonprofit agencies during the summer months. The Administration proposes to boost program funding by \$1 billion in the summer of 1993. This will finance almost 700,000 summer jobs, bringing to

nearly 1.4 million the total number of youth who could participate in the program. Approximately one-half of this summer's funding will be concentrated on the 100 American cities—small and large—with the greatest number of eligible youth. The public summer jobs program will be coupled with and complemented by a campaign to expand private summer job opportunities for young Americans.

National Service. This is a first step in the President's long range national service initiative. The Administration proposes to implement a program in the summer of 1993 to train a core group of leaders to spur service around the country. Combining leadership training with service, this initial phase of the national service initiative will cost \$15 million.

Extension of Emergency Unemployment Compensation. For millions of workers, the apparent recovery has not brought employment opportunities. The rate of job growth in the economy relative to past recoveries has been extremely sluggish. The Administration proposes to extend the current Emergency Unemployment Compensation program for seven months, through October 2, 1993. The program provides an additional 20 to 26 weeks of support for workers who have exhausted their regular unemployment benefits. The net estimated cost is \$5.6 billion over two years.

Education/Pell Grant unfunded shortfalls. The Administration proposes to make up shortfalls in the Pell Grant program, providing over \$2.0 billion to ensure that the program is funded at estimated current law levels through school year 1993-94.

HHS/AIDS/Ryan White Act. To initiate the President's long-term investment plan to fully fund HIV/AIDS prevention efforts under the Ryan White Act, the Administration proposes to increase funding for 1993 grants by \$200 million. These programs focus on AIDS prevention efforts.

Agriculture/Child and Adult Care Food Program. The Administration proposes an increase of \$56 million for the Child and Adult Care Food Program, which pays for meals and snacks at Head Start centers, to serve the children in the proposed Summer Head Start program.

Labor/Worker profiling. The Administration proposes establishment of a \$14 million program in 1993 and 1994 to assist the States in developing automated systems to identify laid-off workers who may have difficulties in finding new jobs, and to assist them in finding employment. This initiative seeks to respond to the problems faced by many workers laid off because of business downsizing and restructuring. Federal funding for this initiative will cover the up-front costs of developing worker profiling systems in the States.

Labor/Community Service Employment for Older Americans. The Administration proposes \$33 million to expand participation in the Community Service Employment for Older Americans program, which offers low-income seniors meaningful work experience in community service projects. This investment will finance over 5,000 jobs in the current year.

Interior/Bureau of Indian Affairs (BIA) School Operations. The Administration proposes that \$49 million be provided to cover currently identified shortfalls in funding due to rising enrollments to improve the educational performance of over 40,000 Indian students at the elementary and secondary level attending BIA-funded schools.

Equal Employment Opportunity Commission. Financing of \$9 million for additional staff to enforce the Americans with Disabilities Act and the Civil Rights Act will help stem the ballooning backlog of cases filed under those Acts.

Technology Investments

A very important part of the Administration's efforts to promote long-term economic growth is to increase investment in new, productivity-enhancing technology. A number of such projects are funded in the stimulus package because they can be initiated quickly, with immediate increases in jobs.

Industry-Led Federal R&D at the National Institute of Standards and Technology (NIST). The Advanced Technology Program at the National Institute of Standards and Technology provides matching grants for industry-led research projects for the development and commercialization of pre-competitive generic technologies and refining manufacturing practices. The Administration proposes \$103 million for the program in the current fiscal year.

Commerce/Information Highway Demonstrations. The development of a broadband, interactive telecommunications network linking the Nation's schools, libraries, health care facilities, governments, and other public information producers could pay enormous dividends to the U.S. economy. Interactive networks such as this are in their very early stages of development. The Administration proposes to make \$64 million available to the Department of Commerce's National Telecommunications and Information Administration to accelerate development of such information highways.

National Science Foundation/Research and development. Investments in research and development (R&D) tend to be the strongest and most consistent positive influence on productivity growth. Most of the National Science Foundation's (NSF) investments are in competitively selected university-based R&D programs. These activities contribute to the nation's productivity by generating new scientific and engineering knowledge and contribute to the training of the next generation of scientists and engineers. The Administration proposes an investment in 1993 of \$188 million to restore NSF funding to roughly the level that was planned for in 1993.

Networking and computer applications. The Administration proposes that programs be initiated at the National Institute of Standards and Technology, the National Science Foundation, the National Aeronautics and Space Administration, and the National Institutes of Health to develop applications which use

advanced computers and communication networks to solve problems in health care, education, manufacturing, and access to library information.

National Oceanic and Atmospheric Administration equipment acquisition. The Administration proposes an investment of \$81 million to accelerate the modernization of National Weather Service and central NOAA data systems, to procure hardware for more efficient utilization of the nation's fisheries, to improve weather prediction technologies, and to further climate and atmospheric research in areas of global concern such as atmospheric ozone.

HHS/Disability Insurance processing. The Administration proposes that \$302 million be provided to help the Social Security Administration reduce delays in processing of Disability Insurance claims, review cases earlier, and make other improvements to improve delivery of services. There has been a tremendous backlog of Disability Insurance claims in recent years, which this investment would help alleviate.

Treasury/Accelerate implementation of Internal Revenue Service Tax System Modernization. The IRS is now operating with severely outdated computer equipment. Through Tax System Modernization (TSM), the IRS is undertaking a multi-billion-dollar, decade-long effort to re-invent its operations. The Administration proposes fiscal stimulus funding of \$148 million to enable the IRS to accelerate several TSM projects and replace computer and telecommunications equipment that in many cases is nearly ten years old. This is a down payment on a long-term investment in the IRS modernization program.

Urban Development and Housing Initiative

The fiscal stimulus contains several initiatives to provide additional resources for housing and other development in the Nation's urban areas. These efforts are critical to our hopes of reviving our cities.

Housing and Urban Development/Community Development Block Grants. Community development projects are an important source of jobs and economic development in America's communities. States and local governments have a backlog of unfunded projects that are ready to begin, such as basic street and bridge work, painting and resurfacing, building rehabilitation, and public service projects. The Administration proposes a one-time supplemental appropriation of \$2.5 billion for Community Development Block Grants to fund such projects and create about 60,000 jobs during 1993–1995. The Administration will propose modifications to the program to ensure that projects have an immediate economic impact.

Commerce/Economic Development Administration grants. The Administration proposes \$94 million for Economic Development Administration awards to economically distressed areas to rebuild basic infrastructure—industrial parks, water and sewer improvements, and access roads to industrial sites. The grants are also for the purpose of planning for economic development.

HUD/Crime in public housing. The Administration proposes an Urban Partnership Against Crime initiative to address the increase in gang- and drug-related crime activity in many public housing developments across the country. Crime has exacted a profound and intolerable toll on public housing residents. Living in a constant state of fear of physical harm, residents have been robbed of their sense of community and personal well-being. Meanwhile, they have witnessed an ever-increasing expenditure of scarce public resources on repairing the damage done by crime to the physical environments of these developments. This initiative, costing \$138 million in 1997 and \$312 million over four years, would allow the Department of Housing and Urban Development to work with public housing and other local officials in an intensive effort to reduce crime in public housing. It focuses resources on those developments with greatest need, and gives flexibility to local officials to develop solutions (like community policing, neighborhood watches, youth activities) to the problems of crime in their communities.

HUD/Restore dilapidated public housing. This investment would provide an additional \$138 million in 1997 and \$241 million over the next four years to rehabilitate and restore severely dilapidated public housing projects that today are not only uninhabitable, but also contribute to the economic and social problems of the surrounding neighborhoods. These economically viable public housing units would then provide, once again, decent, safe, and affordable housing for low-income renters.

Lifelong Learning

Becoming a productive member of the community requires certain basics: like a healthy, supportive childhood; safe, sound schools; a chance to serve your country; and the opportunity to be retrained for the challenges of today's global economy. The Administration's commitment to major investments in these kinds of "human capital" promises payoffs for the nation far beyond their original price.

HHS/Full funding of Head Start. Children who participate in Head Start do better in school and become more productive as adults. By giving them the caring, stimulating environment they need, Head Start programs enable at-risk children to become problem-solvers instead of problems. Thousands of parents and selected studies have testified to the program's success, but for years our government—despite promises—has failed to make Head Start available to all the children who need it. With this initiative, one of our country's most cost-effective programs will become far more widely available and help change countless lives. The Administration will increase funding for Head Start by \$3.2 billion in 1997, \$8 billion over four years, achieving full funding for an estimated 1.4 million eligible disadvantaged children by 1999.

USDA/Head Start-related child care feeding. Pay for meals at Head Start centers and serve them to the participants added by the Administration's Head Start initiative; \$237 million in 1997; \$590 million over four years.

HHS/Head Start related Medicaid. Fund new entrants in the Medicaid program resulting from Head Start expansion; \$116 million in 1997, \$275 million over four years.

USDA/Full funding of WIC program. If our nation is going to prosper, our children will have to grow up healthy, not hungry. This special supplemental food program for women, infants, and children (WIC), helps make sure they do. By the end of 1996, all eligible children ages 1 to 4, including some 2 million who were not served last year, can be assisted with the proposed investment of \$1 billion in 1997, \$2.6 billion over four years.

HHS/Parenting and family support. These initiatives stem from a simple reality: governments don't raise children; parents do. These proposals will empower parents with the skills and the tools they need to help raise their children. They will support disadvantaged parents, including activities to help them work with their children at home and parenting classes, with an investment of \$500 million in 1997, \$900 million over four years.

Department of Education/Reforms and initiatives. All American children need greater access to better education—not just to make the American Dream more available, but to make the American economy more productive. These initiatives will provide \$2.7 billion in 1997, \$6.2 billion over four years, to support reforms and reauthorizations in elementary, secondary, and postsecondary education, including state and local systemic reforms, a new SAFE Schools program, student assistance program improvements, and support of Historically Black Colleges and Universities.

National Service. The national service initiative will help young people pay for college and other postsecondary education by serving their country. In conjunction with income-contingent loan repayment, which will help Americans take low-paying community service jobs and still pay off their student loans, the program will provide dramatic new opportunities to serve our country. Young people will meet pressing national needs in areas including education, public health, environmental protection, and public safety. In return for one or two years of service, they will be able to receive a significant educational benefit. As it enables Americans of all backgrounds to help themselves and their country at once, the initiative will reinvigorate American citizenship—lifting our country up and bringing our people together. The Administration's commitment to a fully realized program of national service is behind its plan to invest \$7.4 billion in the next four years, building from \$389 million in budget authority in 1994 to \$3.4 billion in 1997.

Labor/Dislocated workers program. Legislation will be proposed for a new program to replace and improve upon two existing programs to help workers who lose their jobs because of restructuring of their industries, international competition, or defense downsizing to secure rapid reemployment or train for new careers. The program will cost an additional \$2 billion in 1997, \$4.6 billion over four years.

Labor/Job Corps expansion. Provide resources to increase the size of the Job Corps program by 50 percent by 2001. This will increase the number of Job Corps participants to 104,000, from the current 70,000. Job Corps provides remedial education, occupational skills training, supportive and job placement services to severely disadvantaged youth in its network of 110 residential centers. The plan would finance 50 new residential centers. The 1997 cost is \$202 million; the 1994-97 cost is \$341 million.

Labor/Job Corps maintenance. Spend \$50 million in 1997 and \$105 million over four years to repair and renovate Job Corps' aging residential centers.

Labor/Summer youth employment and training program (SYETP). The SYETP offers economically disadvantaged youth age, 14 through 21, work experience in minimum wage jobs in public and nonprofit agencies during the summer months. This investment of \$625 million in 1997 and \$2.0 billion over four years would finance about 2 million additional summer youth jobs. The plan includes an enriched program of work experience, basic skills training, testing and counseling, and closer coordination with schools.

Labor/One-stop career shopping. This program would make it easier for adults seeking to change jobs or careers or upgrade their skills to obtain access to the confusing array of Federal programs and services by developing "one-stop shop" career centers. Over four years, the proposed investment is \$900 million, \$250 million of which is to be spent in 1997.

Labor and Education/Youth apprenticeship. This program would finance a nationwide system of school- and work-based learning programs for high school youth who do not plan to attend college, in order to reduce drop-out rates and help them make a successful transition to meaningful careers in technical occupations. The proposal provides \$500 million in 1997, a total of \$1.2 billion over four years.

Rewarding Work

Earned Income Tax Credit (EITC). In America, no one who works should have to raise a family in poverty. The EITC currently provides refundable tax credits to low-income working families with children. By expanding the EITC, we will assure that a family of four will not be forced to live in poverty, if one of the parents works full-time at a minimum wage job. The cost of the entire proposal is \$6.7 billion in 1997 and \$19.9 billion over four years.

Welfare Reform. Later this year, the Administration will present a comprehensive reform plan to end welfare as we know it. The President's plan will carry out his pledge that no one with a family who works full-time has to live in poverty, that parents who bring children into the world should be held accountable for raising them, and that welfare ought to be a second chance, not a way of life. The plan, coupled with the Earned Income Tax Credit, tougher child support enforcement to crack down on deadbeat parents, increased training, parenting, and family support for moving people from welfare to work, will

move toward a time-limited system of welfare. This will give people on welfare the education and training they need for up to two years, but after that, require all those who can work to go to work.

Justice

Justice/Crime initiative. A comprehensive program to support and improve all aspects of the criminal justice system. The initiative includes: (1) a new Community Policing/"Cops on the Beat" grant program to localities to create safer streets and to community policing, thereby building a bond of trust between citizens and police so that they can work together to fight crime; (2) a new Police Corps program, to provide scholarships to would-be police officers in exchange for a commitment to service as a State or local police officer; (3) a Criminal Records Upgrade program to assist States in improving their criminal records infrastructure and link with the FBI's criminal information databases; (4) increased funds to meet costs associated with detaining and incarcerating the growing Federal prison population, which has resulted from increased arrests and the imposition of minimum mandatory sentences; and (5) increased funds for existing Federal law enforcement activities. The budget authority investment is \$900 million in 1997, \$2.8 billion over four years.

Equal Employment Opportunity Commission (EEOC)/Enforcement. Increase EEOC enforcement staff in field offices to provide full enforcement of the Americans With Disabilities Act and the Civil Rights Act of 1991. The proposed outlays are \$18 million in 1997, \$63 million over four years.

Health Care

HHS/AIDS, immunizations, NIH research, and other public health initiatives. This investment provides substantial new funding—\$3.4 billion in 1997 and \$8.2 billion over four years—for a number of public health initiatives including: (1) HIV/AIDS research; (2) research on women's health issues; (3) the President's plan for increasing childhood immunizations; (4) teen pregnancy programs, and (4) other efforts to promote public health.

HHS/Substance abuse prevention and treatment. Challenge grants to the States to create substance abuse treatment capacity where it is needed most and for hard-to-treat populations. It will serve 30,000 people in 1994 and more in years after. The outlays are \$800 million in 1997, \$1.5 billion over four years.

USDA/Food Safety and Inspection Service. Improve the existing meat and poultry inspection system by increasing the number of Food Safety and Inspection Service inspectors available in order to ensure that visibly diseased animals are not processed, slaughterhouses and processing plants are clean and follow safe food handling procedures, and plant employees follow proper hygiene. Food safety research would also be enhanced. This responds to a clear need for improvements, highlighted by the recent food poisoning outbreak in Washington State. The initiative adds 200 inspectors. The investment is \$34

million in 1997, \$111 million over four years, and it would create some 275 jobs in 1994.

Rural Health Initiative. This proposal provides grants and other assistance to small rural hospitals to upgrade needed services. Grants may be used to launch integrated health systems and telecommunications links for remote consultation and diagnosis in low manpower areas. Estimated \$50 million in 1994.

VA/Medical care. This four-year investment provides a \$2.5 billion increase over the baseline to ensure high quality health care for veterans by such measures as providing adequate staff levels to meet requirements on residency education programs and automating drug dispensing in VA hospitals.

HHS/Social Security Administration/Disability insurance processing. Increase resources for the processing of dramatically increased disability benefit claims by \$200 million in 1995-98. This will cut down on the significant delays that have occurred in recent years and reverse the general decline in service.

HHS/Ryan White Act. HIV/AIDS is now the ninth leading cause of death overall. Currently, approximately 1 million people are infected with HIV in the U.S., and about 60,000 new AIDS cases are reported each year. The President has pledged to respond to this need by fully funding the Ryan White Act and increasing Federal support for HIV/AIDS prevention efforts. To begin fulfilling these pledges this year, this proposal would increase funding for grants authorized under the Ryan White Act by \$120 million in 1994. The proposal includes additional funding of approximately \$1 billion over the next four years.

State and Local Relief. Within the Health Care, Rewarding Work and Lifelong Learning investment packages, the Administration will design a program to offset the impact of refugees and undocumented residents on the budgets of State and local governments, including those in California, Texas and Florida.

Investment Package: Tax Incentives

We recognize that the only way to lay the foundation for renewed American prosperity is to spur investment. New investment will create jobs, putting people back to work today, and will provide the productive equipment that we need to compete in the global economy.

Our overall program consists of outlays for physical and human capital and investment tax incentives for the private sector. Outlays for physical capital will help rebuild the crumbling foundations of the United States, create millions of high-wage jobs, and smooth the transition from a defense to a commercial-based economy. Our program will concentrate on the transportation, environment, and communications infrastructure. The program of tax incentives will increase private investment over the long run. Like the outlay programs, these incentives are designed to increase investment in human and physical capital. These incentives will be particularly helpful to small business which generates the lion's share of jobs.

Permanent small business tax credit. As discussed in the stimulus package, the plan provides that small businesses will now be eligible for a permanent investment tax credit on their equipment. The credit will generally be 7 percent in 1993 and 1994, and 5 percent thereafter. Small businesses operate at the margin and need a permanent incentive to invest, grow and provide new employment opportunities.

Incentive for investment in small business. The program provides relief from the capital gains tax for investors in small businesses. This proposal will allow investors generally to exclude 50 percent of the gains earned from investment in the stock of a qualified small business (less than \$25 million capitalization) when held at least 5 years. Furthermore, 50 percent of the excluded gain is not subject to taxation under the alternative minimum tax. The tax incentives will both stimulate job creation over the short-run and increase investment over the long-term.

Research and experimentation tax credit. The economic plan will permanently extend the research and experimentation credit. This will encourage firms to undertake the research necessary to develop the technological innovations required to increase the supply of good jobs.

Real estate. The plan also permanently extends both the low-income housing credit and mortgage revenue bond provisions. Doing so will provide a stimulus to increase the supply of housing for low-income families. In addition, the program modifies the passive loss rules for persons in certain real estate trades or businesses, relaxes restrictions on pension investments in real estate and extends the depreciable life of nonresidential real estate.

Enterprise zones. This part of the program authorizes the establishment of a number of enterprise zones. Businesses located in enterprise zones will be eligible for a wage credit for the hiring of enterprise zone residents and accelerated depreciation or expensing of investments in enterprise zone property. In addition, small businesses in qualifying economically distressed areas will be eligible to obtain low interest rate loans through tax-exempt financing even if the area is not selected as one of the zones. Combined with the other tax incentives and other non-tax initiatives targeted to urban areas, these benefits should help promote investment and job creation in these areas.

Simplifying and enhancing depreciation provisions for companies subject to the alternative minimum tax (AMT). As noted in the discussion of the stimulus package, the plan substantially enhances the investment incentives for taxpayers subject to the AMT and simplifies the AMT by using the shorter regular tax depreciable lives for minimum tax as well as regular tax purposes. Because they reduce the net cost of acquiring depreciable assets, this proposal will provide a lasting stimulus to investment for affected companies.

Targeted jobs tax credit; employer-provided educational assistance. The plan permanently extends these two provisions, thus providing an incentive for American businesses to continue to invest in human capital. The plan also

expands the targeted jobs tax credit to include workers in an apprenticeship program. An educated workforce will be more productive and better able to adapt to the challenges of a modern information-based economy.

Health insurance deduction for the self-employed. The plan calls for an extension of the 25 percent deduction for health insurance premiums of the self-employed through the end of 1993. This will retain the current law tax treatment of these premiums for affected individuals until the Administration's comprehensive health care proposals are enacted.

Small issue bonds and high speed rail facilities. The ability to issue tax-exempt bonds for qualifying small businesses and certain farmers would be extended permanently under the plan. In addition, in order to promote the development of high speed rail facilities, tax-exempt bonds issued for that purpose will not be subject to the State private activity bond volume limitations.

revitalization and crime fighting throughout the country. Estimated savings are \$552 million in 1997, \$1.2 billion over four years.

Tennessee Valley Authority. The Administration proposes to terminate the Tennessee Valley Authority's fertilizer research activities and its economic development program. The fertilizer industry is fully capable of financially supporting fertilizer research without the need for taxpayer subsidized work in TVA. With regard to economic development, while these activities have a long and noted history, other much larger programs with similar purposes have been put into place, and are slated to receive substantial increases from the Administration's stimulus and investment proposals. The estimated savings from this proposal are \$188 million from 1994 to 1997, including \$50 million in 1997.

Eliminating Subsidies; Charging Fees for Government Services

The nation can no longer afford subsidies and giveaways to those who don't need them, and we must assure that the taxpayer is fairly compensated for services or resources provided by government.

USDA/Phase out below-cost timber sales. Timber sales from some National Forests do not cover the costs to the government of making the timber available for sale. This proposal would gradually eliminate sales in those forest regions where timber-sale program costs exceed timber-sale revenue. This gradual phase-out would reduce the economic impacts on rural communities dependent on the timber industry. Below-cost forests would be reviewed periodically to determine if sales could proceed at no net loss to the Government. Estimated savings are \$86 million in 1997, \$274 million over four years.

Expand Agriculture user fees. New user fees for three USDA agencies (the Federal Grain Inspection Service, the Agricultural Marketing Service, and the Agricultural Cooperative Service) to recover costs for Federal services being provided to a specific group. Estimated savings are \$16 million in 1997, \$59 million over four years.

USDA/Meat and poultry fees. Requires all slaughterhouses and processing plants with overtime shifts to reimburse the government for the full cost of Federal meat and poultry inspections. Estimated savings are \$104 million in 1997, \$416 million over four years.

HHS/Food and Drug Administration user fees. Identifiable beneficiaries of government services should pay for the value conferred by certifying the safety and efficacy of drugs and medical devices. Estimated savings are \$336 million in 1997, \$1 billion over four years.

Bureau of Alcohol, Tobacco and Firearms (BATF) user fees. BATF is required to approve all alcoholic beverage labels and conduct various laboratory analyses to assure compliance with Federal law. There is currently no charge for these services, though manufacturers receive real, tangible benefits from them.

Veterans Affairs/Internal Revenue Service income verification. The Administration proposes to extend permanently the Department of Veterans Affairs' authority to access IRS tax data to verify income reported by pension and medical care beneficiaries. There are no savings from this extension in the 1994-97 period. Savings in 1998 are \$197 million.

Veterans Affairs/Permanently extend pensions-Medicaid nursing home provisions. The Administration proposes to extend permanently the current \$90 monthly limit on pension benefits paid to any veteran or survivor without dependents who receives Medicaid coverage in a Medicaid-approved nursing home. This proposal would reduce an indirect federal subsidy from veterans programs to state Medicaid programs. There are no savings in the 1994-97 period. Savings in 1998 would be \$300 million.

Veterans Affairs/Service members' contributions to the Montgomery GI Bill Education Program. The Montgomery GI Bill program provides monthly benefit payments to eligible service members and veterans who are enrolled in a post-secondary education program. To become eligible, military personnel agree to contribute to the program through a reduction in their basic pay during their first year of service. In two steps over the last three years, Congress has increased the monthly benefits by 33 percent without increasing individuals' payroll contributions to the program. Before the increases in benefits, the program funding match was 9:1 (government:service members). This proposal would prospectively increase their contributions to restore the 9:1 match. Estimated savings are \$339 million over four years, including \$98 million in 1997.

Controlling Health Care Costs

Systemwide health care reform is a top Administration priority, but some additional short-term savings proposals, focusing on providers rather than beneficiaries, make immediate sense.

Medicare:

HHS/10 percent capital reduction, inpatient. The proposal would extend current law beyond 1995. Hospitals receive payments for Medicare's share of capital expansions and improvements of both inpatient and outpatient department (OPD) facilities. The current payment level was reduced in OBRA 90 by 10 percentage points to 90 percent of Medicare's share of capital costs in every year. Estimated savings: over four years—\$680 million; 1997—\$380 million.

HHS/10 percent capital reduction, OPD. The proposal would extend current law beyond 1995. Hospitals receive payments for Medicare's share of capital expansions and improvements of both inpatient and outpatient department (OPD) facilities. The current payment level was reduced in OBRA 90 by 10 percentage points to 90 percent of Medicare's share of capital costs in every year. Estimated savings: over four years—\$260 million; 1997—\$150 million.

HHS/Maintain calendar year 1995 ratio of premium collections to program outlays with a 27 percent ceiling. Under this proposal, beginning in January, 1996, the monthly Part B premium would be set to maintain the percentage of program costs covered by premium collections in the previous year, but with a ceiling of 27 percent. The monthly Part B premium amount currently is set in law through the end of calendar year 1995 (\$36.60 in CY93, \$41.10 in CY94, \$46.10 in CY95), and premium collections are projected to cover about 27.5 percent of program costs in 1995. When originally established, SMI premiums were intended to cover 50 percent of program costs. They eroded significantly over the years, however, and TEFRA 1982 established a temporary 25 percent premium floor, beginning in 1984. Congress extended the floor twice, and OBRA90 set fixed premium amounts in law through 1995 at levels then estimated to be approximately 25 percent of program costs. Beginning in 1996, calculation of the premium is scheduled to increase by the lower of the OASI COLA adjustment to the previous year's premium, or to be set at 50 percent of program costs. Estimated savings: over four years—\$5 billion; 1997—\$3.9 billion.

HHS/Eliminate add-on payment for hospital-based HHAs. This proposal would eliminate the separate add-on payment that hospital-based home health agencies (HHAs) receive in addition to payment under the Medicare cost limits. Eliminating the add-on would create a level playing field on which all home health agencies can compete. Estimated savings: over four years—\$840 million; 1997—\$250 million.

HHS/Eliminate skilled nursing facility return on equity payments. The proposal would eliminate the Medicare payment policy that pays proprietary skilled nursing facilities (SNFs) a return on equity (ROE) invested in the SNF. Medicare should pay for services rendered to beneficiaries; it should not subsidize private investment. Estimated savings: over four years—\$560 million; 1997—\$160 million.

HHS/Lower IME to 5.65 percent. This proposal would gradually lower the Medicare indirect medical education (IME) from 7.7 percent to 5.65 percent for each .1 increase in the intern and resident to be a ratio (IRB ratio). Teaching hospitals currently receive an additional 7.7 percent payment to the Medicare DRG payment for each .1 increase in their IRB ratio, above their base year levels. The adjustment is intended to compensate these hospitals for the higher costs of delivering care incurred by inexperienced residents. In addition, teaching hospitals tend to have sicker case mixes than non-teaching hospitals. The General Accounting Office (GAO) and the Prospective Payment Assessment Commission (ProPAC) have both found that the 7.7 percent adjustment overcompensates teaching hospitals for these costs and have recommended that the adjustment be reduced. ProPAC has recommended setting the adjustment at 5.4 percent. Lowering the IME adjustment would also encourage teaching hospitals to instill within their residents more cost-effective patterns of care at an

early stage in the residency. Estimated savings: over four years—\$1.94 billion; 1997—\$1.4 billion.

HHS/Permanently extend 2 percent laboratory fee update. This proposal would extend the 2 percent annual update of Medicare reimbursement rates for clinical laboratory services. OBRA 90 established a 2 percent update through the end of 1993, after which laboratory fees would be updated by the urban component of the Consumer Price Index (CPI-U), approximately 3.5 percent annually. There is no evidence, however, to indicate that laboratory costs are increasing by the rate of inflation. Medicare payments to laboratories should more closely reflect decreasing costs due to technological advances, such as increased automation, and changes in the market, such as lower-cost equipment. Medicare payments to laboratories are already excessive. An OIG study found that Medicare paid laboratories 90 percent more than physicians paid for the same tests. Moreover, a GAO study indicated that laboratories use higher profits from Medicare to subsidize discounts to other, private payers. Estimated savings: over four years—\$740 million; 1997—\$380 million.

HHS/Provide incentive to encourage submission of claims via electronic format. In total, Medicare Part B outlays were projected to be \$59.8 billion in 1993. The proposal would save 0.1 percent of the 1994–98 Medicare Part B baseline. The proposal would encourage physicians and other Part B providers to submit claims via the more administratively efficient electronic format by charging physicians and other providers \$1 for each paper claim filed. The proposal would not take effect until January 1, 1996, to give providers lead time to adjust their filing systems. Estimated savings: over four years—\$265 million; 1997—\$175 million.

HHS/Medicare Secondary Payer (MSP) reforms. The MSP requirements currently vary depending upon the category of enrollee. This proposal would create a consistent MSP threshold for the aged, disabled, and end stage renal disease (ESRD) patients—all employers of 20 or more would be primary payers. Current law already requires that Medicare enrollees with employer-based health insurance use their private health insurance before drawing upon their Medicare policies. This applies more consistent standards and more efficient enforcement of these provisions to save Medicare costs. Estimated savings are \$947 million for 1994 through 1997; and \$305 million in 1997.

HHS/Permanently extend reduction of payments for hospital outpatient services by 5.8 percent. OBRA 1990 reduced Medicare reimbursement for hospital outpatient department (OPD) reasonable costs by 5.8 percent through 1995. This proposal would extend that provision permanently. Depending on the service, OPDs are paid based upon varying formulas, some of which take into account the OPDs' reasonable costs. The overall reduction to OPDs would be much less than 5.8 percent, because less than half of Medicare reimbursement is based on reasonable costs. Because hospital inpatient reimbursement rates are constrained by DRGs, hospitals have shifted services and costs to the outpatient setting. As a result, outpatient services are one of the fastest growing

components of the Medicare program, rising by an average of 17 percent per year in the 1980s. Legislators approved a 5.8 percent reduction in OBRA 1990 in an attempt to counter this rapid growth. If this provision is allowed to expire, outpatient costs, which continue to grow in the double-digits, will start growing even faster. Support for this proposal is well-established through previously approved legislation. Estimated savings are \$950 million for 1994 through 1997; and \$525 million in 1997.

HHS/Reduce hospital outpatient department reimbursement by an additional 4.2 percent. In total, Medicare Part B outlays were projected to be \$59.8 billion in 1993. The proposal would save 0.5 percent of the 1994-98 outpatient services base. Currently, Medicare reimbursement for outpatient services is based in part on the OPD's reasonable costs minus 5.8 percent, while reimbursement for outpatient capital costs is reduced by 10 percent. This proposal would reduce reimbursement for OPD services by an additional 4.2 percent beginning in 1996, to a 10 percent reduction. This would make payment for both categories consistent by reimbursing both at 90 percent of costs. Estimated savings: over four years—\$690 million; 1997—\$375 million.

HHS/Ban physician self-referrals. A Physicians may not refer a Medicare or Medicaid patient to a clinical laboratory in which the physician or the physician's relatives have a financial interest. Several exceptions are specified in statute. This proposal would extend ownership and referral prohibitions to additional services, such as physical and occupational therapy, durable medical equipment, and parenteral/enteral nutrition equipment and supplies. Estimated savings: over four years—\$250 million; 1997—\$100 million.

HHS/Set EPO at non-U.S. market rates. The proposal would reduce the amount Medicare pays for erythropoietin (EPO) from \$11 per 1,000 units to \$10 per 1,000 units. EPO is the drug used by patients suffering from kidney failure, to counter anemia by increasing the body's production of red blood cells. Medicare is virtually the sole purchaser of EPO and should exercise its market power to pay reasonable costs while maintaining access for all Medicare beneficiaries. Estimated 1997 savings are \$50 million. Estimated savings 1994-1997—\$160 million; savings for 1994-1998—\$210 million.

HHS/Resource-based practice expense phase-in. This proposal is an interim step toward a resource-based system for practice expenses. It would reduce practice expenses in relation to the relative value work units by one-half of the difference between practice expense and physician work relative value units, not no lower than 110 percent. Phase-in to a resource-based system for practice or overvalued expenses under the physician fee schedule would begin in 1997. The recently implemented physician payment reform system divided payment into three distinct components—overhead, work, and malpractice expenses. The work component is based on an extensively-researched relative value system, developed in 1991. The existing practice expense component is based upon an obsolete fee schedule and bears no relationship to the reformed work component of the fee schedule. This proposal would only reduce the practice component in

extreme instances—when it exceeds the value of the work component. More comprehensive reform of the practice component is expected to take several years to develop. This proposal provides a simple, intermediate step to address immediately the most egregious inequities in the reimbursement framework. Estimated 1997 savings—\$875 million. Estimated savings 1994–1997—\$2,025 million; savings for 1994–1998—\$2,975 million.

HHS/Pay hospitals for inpatient services by hospital-based physicians. Include payment for radiology, anesthesia, and pathology (RAP) services as an add-on to the hospital DRG payment. Separate billing by physicians for these services would not be allowed. Quality of care would be improved and unnecessary utilization would be minimized. Estimated 1997 savings are \$160 million; 1994–1997—\$390 million.

HHS/Single fee for surgery. The fee paid to a primary surgeon would be reduced by the amount paid to assistants-at-surgery. HHS would establish exceptions by regulation in which the difficulty of the procedure or the condition of the patient necessitated the use of physicians as assistants-at-surgery. Whether assistants are used and what type of personnel are used are primarily dependent on geographic practice patterns and the practice styles of individual surgeons, rather than on characteristics related to the specific patient and the surgery performed. Evidence does not show that quality of care would be jeopardized. Estimated 1997 savings is \$120 million; 1994–1997—\$380 million.

HHS/Durable Medical Equipment (DME) options—Set DME at market levels. Initially, fee schedules for DME would be adjusted downward with an upper limit based upon the median DME fee schedule, rather than the national average. The fee schedule for prosthetics and orthotics would also be recomputed with a national median cap. The HHS Secretary would be authorized to adjust DME rates based upon market factors, including surveys of what other providers, such as the VA, DoD and the private sector, pay for DME. The Secretary also would be authorized to initiate competitive bidding programs for DME supplies where appropriate. Granting broader HHS discretion would allow adjustments to be made to reflect changes in technology, utilization patterns and other market factors. Estimated savings are \$510 million for 1994–97; and \$160 million in 1997.

HHS/Direct medical education. This proposal would base Medicare direct medical education payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighing of the national average resident salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident salary, down from the average

weight of about 215 percent under current law. Estimated savings: over four years—\$1.4 billion; 1997—\$330 million.

HHS/Set laboratory rates at market levels. The proposal initially would limit the Medicare Part B laboratory fee schedule to 76 percent of the median of all fees (as opposed to current maximum of 88 percent). Later, based on market surveys, the Secretary of HHS would adjust Medicare payment rates to laboratories to account for technological changes or other market factors. This proposal would address excessive Medicare payments for laboratory tests. An OIG study found that Medicare paid laboratories 90 percent more than physicians paid for the same tests. Moreover, a GAO study indicated that laboratories use higher profits from Medicare to subsidize discounts to private payers. In addition, the proposal would control growth in Medicare Part B laboratory payments, which more than doubled from 1985 to 1990. Estimated savings: over four years—\$3.1 billion; 1997—\$1.1 billion.

HHS/Reduce default Medicare volume performance standard and update. The effect of this proposal is to reduce the amount of increases in physician fees in future years. This proposal would reduce the Medicare volume performance standard (MVPS) default formula and the default update for Medicare payments to physicians. These two factors determine annual aggregate physician payment levels. Estimated savings: over four years—\$850 million; 1997—\$650 million.

HHS/Permanently extend three current Medicare Secondary Payer (MSP) provisions. The proposal would extend three OBRA '90 Medicare Secondary Payer provisions due to expire at the end of 1995 including: (1) 1862(b) of the Social Security Act authorizing MSP for disabled active individuals with employer group health plan (EGHP) coverage; (2) 1826(c) of the Social Security Act amended by OBRA '90 authorizing MSP for individuals with ESRD after 18 months (expanded from 12 months); and (3) 8051 of OBRA '90 authorizing an IRS/SSA data match for MSP. The data match authorizes access to tax data to identify the existence of EGHP for MSP purposes. Estimated savings over four years—\$1.845 billion; 1997 savings—\$1.115 billion.

HHS/Put hospitals on calendar year update. Medicare payments to hospitals for inpatient care are updated October 1 of each year. Most other Medicare services are updated January 1 or July 1. This proposal would move the hospital update to January 1. Estimated savings: over four years—\$4.6 billion; 1997 \$1.3 billion.

HHS/Fully increase primary care fees; modestly increase doctor fees in 1994. The proposal would update in full the physician fee schedule in CY 1994 for primary care services only. For all other physician services, the update would be two percentage points less than the full update. Estimated savings: over four years—\$1.3 billion; in 1997—\$400 million.

HHS/Reduce Medicare hospital update market basket by 1 percent in 1994 and 1 percent in 1995. This proposal would extend the current law practice of PPS updates of less than the hospital market basket index (HIMBI). The 1993

update of the PPS standardized amount is set at the HMBI minus 1.55 percent for urban hospitals and HMBI minus 0.55 percent for rural hospitals, as set in OBRA 1990. Under current law, the update for urban hospitals will equal the market basket rate of increase in 1994 and 1995. For rural hospitals the update is set at market basket plus 1.5 percent for 1994 and the HMBI plus an adjustment needed to match the urban rate in 1995. Estimated savings: over four years—\$5.19 billion; 1997—\$1.7 billion.

HHS and others: Third party liability—enhanced identification of other health coverage. Federal and State taxpayers spend over \$1.5 billion a year for health care that should be paid for by others. Inappropriate payments have been identified in most federally-assisted or financed health programs including: Medicare, Medicaid, Veterans Affairs Health, CHAMPUS/DOD Direct Care, and the Indian Health Service. This proposal removes many of the structural impediments hindering proper identification and billing of third party liability (TPL) by: (1) requiring employers to report employment based health coverage data annually on the W-2; (2) granting access to this data to all federally-assisted and financed health programs; (3) reinforcing existing coordination of benefits (which payer pays and in what order) laws and regulations; and (4) removing impediments that hinder states from collecting from private insurers. Rather than the current 'pay and chase' procedures where federal programs pay first and chase payers afterwards, this proposal focusses on avoiding erroneous payments by identifying the appropriate coverage before payment.

Medicaid:

HHS/Tighten estate recovery/transfer of assets rules. Total Federal Medicaid outlays for 1993 are projected to be \$80.3 billion. This proposal would save approximately 0.1 percent of the 1994–98 Medicaid baseline. This proposal would strengthen transfer-of-asset rules to restrict further the diverting of property to qualify for Medicaid. In addition, the Federal government would require States to operate estate recovery programs and would enhance States' abilities to implement these programs. Estimated savings: over four years—\$395 million; 1997—\$155 million.

HHS/Remove prohibition on State use of drug formularies. This proposal would repeal the OBRA 1990 statutory provisions that prohibit States from using formularies. Before OBRA 1990, States were allowed to limit the number of drugs listed on their formularies, e.g., States could cover only the generic alternative of a multiple-source drug. The OBRA 1990 formulary restriction resulted in increased expenditures for States and the Federal government. Estimated savings: over four years—\$70 million; 1997—\$25 million.

HHS/Eliminate mandatory Medicaid personal care. This proposal would ensure that personal care remains an optional benefit after 1994. The Medicaid statute requires States to cover home health services for all individuals who are eligible for nursing home services. Currently, States also have the option to pay for personal care services to these individuals. Due to a legislative drafting error,

OBRA-90 designated personal care as a home health service. Therefore, coverage of personal care services would become mandatory for all States in 1995, if Congress does not amend the statute. In an era of increasing fiscal pressures and growing Medicaid spending, Congress should avoid imposing additional mandates upon State Medicaid programs. Moreover, maintaining personal care as an optional service would allow States continued flexibility in designing and administering Medicaid long-term care strategies. Estimated savings: for four years—\$4.1 billion; 1997—\$1.5 billion.

Shared Contribution

For deficit reduction to succeed, all groups must contribute. Only if there is a sharing of the load can the entire country be sure that everyone is participating.

Social Security/Conform taxation of benefits to private pensions. Up to 50 percent of Social Security and Railroad Retirement (Tier I) benefits are currently included in taxable income for those recipients with income and benefits exceeding \$25,000 for individuals, and \$32,000 for couples. The Administration proposes including up to 85 percent of benefits in adjusted gross income, for those with income and benefits exceeding the current \$25,000/\$32,000 thresholds. This would move the treatment of Social Security and Railroad Retirement Tier I benefits toward that of private pensions. Under current law, pension benefits that exceed an employee's after-tax contributions to qualified pension plans are subject to tax at distribution. Extending this approach to Social Security would mean including at least 85 percent of benefits in taxable income for nearly all recipients. However, maintaining the existing income thresholds protects most low- and middle-income beneficiaries from benefit taxation.

HHS/Strengthening child support enforcement. Of the over 10 million women living alone with their children, only half have child support orders and only half of those women receive full payment. Child support enforcement will be strengthened by streamlining paternity establishment; using the IRS to collect seriously delinquent child support; making sure that absent parents who can pay child support do; setting up a national registry to track down deadbeat parents; requiring employees to report child support obligations on IRS W-4 forms; and improving medical support for children. Better child support enforcement will ensure both parents' responsibility for the well being of their children and decrease the burden of welfare on the taxpayer. Estimated Savings: over four years—\$328 million; 1997—\$109 million..

HHHS/Equate matching rates for welfare programs. Currently, States are reimbursed by the Federal Government at different rates for the various costs of administering Aid to Families with Dependent Children (AFDC), Food Stamps, and Medicaid. The Administration proposes to set the Federal reimbursement rate at a uniform 50 percent for all administrative costs of each of these three programs. There will be waivers for some States, in hardship cases. Estimated savings: over four years—\$1.8 billion; 1997—\$600 million.

The Task Remaining

The urgent question of our time is whether we can make change our friend and not our enemy.

Bill Clinton

The plan presented in these pages is as bold as the challenges it confronts are daunting. It calls for fundamental change—to invest in people; to reward hard work and restore fairness; to recognize our families and communities as the cornerstones of America's strength; to reclaim our future.

This plan promises rising standards of living, productivity and national savings. It stimulates job growth and provides insurance that the current slow recovery will be lasting and strong. It invests in the education, training and health of our people. It encourages the private sector to modernize and acquire the tools and technology to compete in the global economy. And it confronts our deficit head on, with a serious, fair plan to bring it under control and generate economic growth.

The Perils of Inaction

Achieving this change will not be easy. But the cost of not changing is far greater.

After the fiscal failures of the last twelve years, we cannot accept the status quo. While every American can sense the weakness in our economy from day to day, the real cost of inaction becomes clear only when we examine the course that our economy and budget will follow if we do not change.

Under the policies left by the previous Administration and taking a cautious view of the economic outlook, the budget deficit will decline for the next two years, and then begin to grow even as the economy continues to recover and expand (Chart 4-1). As a percentage of the GDP, a better measure of its impact on the economy, the deficit declines through 1996, but then begins to climb (Chart 4-2).

Far more troubling, however, these deficits will be so large that the national debt will grow faster than the economy (and thus will increase as a percentage of the GDP) all the way to the forecast horizon (Chart 4-3). This path cannot be sustained. If rising deficits are left to cascade into debt, hence into interest costs, and then back into still higher deficits, there can be no good economic outcome.

And the longer this vicious cycle is left to build its momentum, the more painful the jolt when—invariably—it is broken.

The Administration's economic plan controls the deficit before the deficit controls our economy. In a fair and measured way, the plan will bring the deficit down until, by 1997, it will be \$140 billion lower than it would be if we cling to the status quo. The deficit under this program falls from 5.4 percent of the GDP in fiscal year 1993 to 2.7 percent in 1997. This is 1.9 percent of GDP lower than would occur under the policy left behind by the previous Administration.

To be cautious, we have based our deficit projections on an extremely unfavorable path of economic growth, with slow progress of productivity and real economic output growing less than two percent per year in the long run. Under those circumstances, the deficit would rise slowly after 1996—even with the aggressive deficit reduction policies recommended by this Administration. Though much improved relative to past economic policies, this outcome is unacceptable (Chart 4-1). As a percentage of the GDP, the deficit would rise in the long run (Chart 4-2); and the growth of the national debt relative to the GDP would continue (Chart 4-3).

This Administration believes that its policies of deficit reduction and public and private investment will increase the growth of productivity and incomes, thereby increasing Federal revenues, retarding the expansion of Federal spending, and forcing the deficit down. If the economic outcome is more favorable than we have assumed, the deficit will grow more slowly. Under the more optimistic assumptions, the deficit will be nearly stabilized as a percentage of the GDP. The economy will grow more rapidly than the national debt, and so the debt as a percentage of the GDP will fall slowly. Eventually we will reverse the borrow and spend legacy of the 1980s.

The Role of Health Care Costs

Even the most favorable scenarios for economic growth under our plan leave unfinished business, however. The budget totals conceal rapidly rising health care spending that threatens to bankrupt our national treasury.

Recently, health care costs have accounted for almost half of the increase in Federal spending; if we do nothing, by decade's end one in every four Federal dollars will go to providing health care. Relentlessly rising costs will continue to stunt long-term economic growth—and terrorize American families—unless and until we achieve fundamental change.

Later this spring we will deliver to the Congress a comprehensive plan for change. That plan will control health care costs and will provide security to families, so that they cannot be denied the coverage they need. It will root out fraud and outrageous charges, and make sure that paperwork no longer chokes

consumers or doctors. And it will maintain American standards—the highest quality medical care in the world, and the choices we all deserve.

Our health care plan will bring costs under control. And while the savings we achieve will go mostly to the private sector, taxpayers will benefit as well. Federal funds will be freed for investments in education, training, and the technologies of tomorrow.

That reform will control the growth of Medicare and Medicaid spending in the long term, and thereby supplement the deficit reduction in this economic program. If the growth of Federal health care costs can be limited to the rate of growth of the population, plus the rate of inflation, plus two percent, the deficit will decline in dollar terms and as a percentage of the GDP (Charts 4-1 and 4-2); and the increase in the ratio of the national debt to the GDP of the 1980s will be reversed (Chart 4-3).

Enactment of the economic plan and health care reform together will reverse the failures of the 1980s, and put the economy on a sound footing for the next century. It will reduce the threat of financial instability posed by a national debt rising faster than our income. It will stop sending the signal to the rest of the industrialized world that our economic policy is out of control. Most important, it will add to the prosperity and security of the American people and allow us to compete more effectively in the global economy.

Conclusion: A Vision of Change for America

Throughout our history, at every critical moment, Americans have summoned the courage to change, to adapt our nation's policies and institutions to changing problems and a changing world. Once again we face such a challenge. Now we must change our course.

We need a change to restore what makes America great: a vision of economic and political freedom; of the rewards of hard work and initiative; of a fundamental sense of fairness, of our families and our communities as foundations of our strength; and of every generation's obligation to create a better life for those that follow.

The plan we present invests in our people and promises an America where a growing economy produces rising living standards and high-wage, high-skill jobs. It rewards hard work and restores fairness, providing opportunity in return for responsibility. It ends twelve years of government that served only the privileged and returns that government to its rightful owners: the American people.

Here in Washington, the powerful special interests are already doing their best to suffocate change. They oppose it because they profit from the status quo. They refuse to listen to the American people's call for change.

The Task Remaining

It is our responsibility to answer that call and restore hope to our people. The voices of conventional wisdom will first whisper and then shout that it cannot be done. But we must summon the wisdom and courage to reject convention and embrace the new direction that we have needed for so long.

Thus, we have an economy that may have achieved a self-sustaining recovery, but that is operating well below its capacity. The unemployment rate is still higher than it was at the bottom of the recent recession, and inflation remains well under control—in part under intense competition from imported products. The risks posed by a short-term economic stimulus are thus small; and the rewards—in greater near-term economic growth and in forestalling any possible relapse into recession—are significant.

Under these circumstances, the Administration has chosen a stimulus program that is substantial enough to provide real impetus to the recovery, but that is small enough to avoid jarring the financial markets or triggering inflation. The program is targeted to the investments in the administration's long-term economic program, on both the tax and the spending sides of the budget.

In spending, the stimulus program provides additional budget authority equal to \$16.3 billion—the amount by which the 1993 appropriations fell short of the combined discretionary spending caps in the Budget Enforcement Act. Thus, the discretionary spending proposed in the stimulus program will not increase the deficit relative to what was outlined in the 1990 budget agreement.

The program also increases the obligation limit for transportation funding under the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA) by \$3.0 billion. This increase allows for full funding of the portion of ISTEA devoted to Federal-aid highways, and also increases potential obligations for the Airport Improvement Program and mass transit. The stimulus further includes \$3.3 billion to increase loan levels, primarily for the Small Business Administration 7(a) loan guarantee program. Of that amount, \$220 million is specified as the long-term budget subsidy.

In tax incentives, the program provides over \$12 billion in temporary incremental investment tax credit. This provision will be available through calendar year 1994; over \$6 billion will be received by taxpayers as reductions in liabilities in 1993.

While much of the additional budget authority will not be spent in 1993, the near-term economic impact will be greater than the outlay figures indicate. Many of the investment programs—including prominently the ISTEA highway program—will result in binding contracts with private firms within the fiscal year, even though payments will not be made until the work is completed in later years. Those contractors will hire workers and begin work immediately. Thus, the contractual obligations will trigger economic activity even before outlays register in the budget itself. Likewise, private investors will commit themselves to investment projects because of the stimulus program's investment tax credit before they can actually claim the tax savings on their returns.

This economic stimulus will be felt most directly in the creation of new jobs; the lack of new jobs especially marks the current recovery, and constrains the spending needed to create a self-sustaining economic expansion. Several of the spending programs in the stimulus package—particularly community develop-

ment block grant assistance to States and localities, and highway programs—promote substantial job creation. The youth summer jobs program of the Job Training Partnership Act, as well as the summer Head Start program, will have particularly strong impacts in the summer months. The investment tax credit and even the longer-term business incentives will stimulate spending on capital goods and thereby promote hiring in the private sector. We estimate that the tax and investment proposals together will create almost 500,000 new jobs by the end of 1994.

All told, this plan provides almost \$30 billion in outlays and tax incentives in 1993 and 1994. This stimulus will provide insurance against renewed economic weakness in the near term; create jobs; help boost the recovery; add to economic growth over the next two years; cushion the beginning of the Administration's deficit reduction program; and begin the investment program that will lay the foundations for enhanced private-sector productivity and prosperity.

Infrastructure

One of the key elements of the Administration's long-term investment package is the strengthening of our nation's infrastructure. Some of the initiatives in that area can be advanced into 1993, providing an immediate impact on jobs and economic growth. In this category, the stimulus package contains transportation projects, Army Corps of Engineers water projects, and improvements in deteriorating Department of Veterans Affairs medical facilities. Details of these investments follow.

Transportation/Federal-aid highway program. The Administration proposes to expand the Federal-Aid Highway program to the levels contained in the Intermodal Surface Transportation Efficiency Act (ISTEA) for 1993. This will require increasing total obligations for Federal-aid Highways from the current level of \$17.7 billion to \$20.6 billion, a 17-percent increase of almost \$3 billion. More than one-third of the increase will be directed to fast-spending resurfacing, rehabilitation, and restoration projects, which can proceed quickly and bring jobs on line most rapidly. This measure will create an additional 13,000 jobs in 1993 and 45,000 in 1994. This increase will improve the conditions and performance of the 155,000 mile National Highway System. This system carries over forty percent of all highway traffic.

Transportation/Mass transit capital improvements. The Administration proposes to increase 1993 funding for mass transit capital improvements by \$736 million. The funds will be used to replace over age buses and vans, and to fund rail cars and rail rehabilitation projects. Of the \$736 million, about \$270 million will be entirely devoted to quick-to-acquire bus and van purchases, while the remaining \$466 million may be used for either bus or rail capital purposes. This initiative will create more than 9,000 jobs in 1993 and 1994. The bus/van

program will permit the acquisition of more than 100 full-size buses, 1,800 small buses, and 2,000 vans.

Transportation/Amtrak capital projects. This initiative provides \$188 million for AMTRAK to purchase new train cars and locomotives, modernize stations and maintenance facilities, and overhaul aging equipment. These will help to improve Amtrak's financial performance, moving it closer to achieving operating self-sufficiency.

Transportation/Airport grants. Many of the Nation's airports are congested, resulting in unacceptable delays for air travelers. Growth in air travel in the future will only add to the problem. Increased airport capacity can help reduce delays, speed air travel, and increase safety in many cases. This proposal to add \$250 million for airport grants in 1993 will enable airports to undertake safety and capacity improvement projects that are "ready-to-go".

Army Corps of Engineers water project construction and cyclic maintenance. The Administration proposes an additional \$94 million to speed construction of about 30 projects nationwide for flood damage reduction, inland waterway and deep-draft harbor transportation, hydropower, environmental restoration, and recreation.

Veterans Affairs/Medical Care and Minor Construction. The Administration proposes \$235 million to fund much needed improvements, largely in VA medical facilities, such as roof repairs, interior finishing, utility systems upgrades, and projects to ensure compliance with current safety and fire codes. This investment will create more than 4,000 jobs in an eight-month period.

A Summer of Opportunity

The Administration's stimulus package seeks to expand the opportunities for learning for children, youth, and workers while providing thousands of jobs, particularly during the summer months. In several instances, the initiatives are the leading edge for a specific program contained in the long-term investment plan.

HHS/Head Start Summer Program. The Administration is proposing a new Head Start summer program, which eventually would enroll up to 350,000 disadvantaged children. The purpose of the program is to help the youngest pre-school and school children to retain the social and intellectual gains made during the school year. It would expand the proven benefits of Head Start to the summer months and reduce further the learning disadvantages faced by children served by the program. This initiative would employ up to 50,000 Head Start staff (12,500 full-year equivalent) during 1993.

Education: Chapter 1 Summer School Program. The Administration proposes new, one-time supplemental funding of \$500 million to expand summer school programs in 1993 for educationally disadvantaged children. Funds would be

allocated to schools with concentrations of poor children. About 14,000 full-year equivalent jobs would be created.

Education: Chapter 1 Census Supplemental. The proposal would provide \$235 million in 1993 to substantially mitigate the effects on distribution of Chapter 1 funds caused by changes in the location of poor children in the U.S. that occurred between the 1980 and 1990 censuses. The Chapter 1 compensatory education program will, for the first time, use 1990 census data to distribute 1993 appropriations used during the 1993-94 school year. The total number of poor children ages 5 to 17 increased between 1980 and 1990, and the distribution of those children shifted. Poor children are increasingly concentrated in the schools of the western States and less concentrated in the schools of the eastern States. The supplemental will ease the transition to a smaller compensatory education program in communities that would otherwise have the size of their Chapter 1 grants substantially reduced for the 1993-94 school year.

Agriculture/WIC Program. The Administration proposes to expand 1993 funding by \$75 million for the Special Supplemental Food Program for Women, Infants, and Children (WIC), which pays for supplemental foods, health care referrals, and nutrition education for low-income pregnant and post-partum women, infants, and children under 5 years of age who are found to be at nutritional risk. The increase will permit the program to serve 300,000 additional participants, most of whom will be children ages 1-4. It is a down payment on the Administration's commitment in the long-term investment plan to provide full funding for WIC so that it serves all eligible children.

Agriculture/Emergency Food Assistance Program. The Administration proposes to provide \$23 million worth of food to the States through The Emergency Food Assistance Program (TEFAP). This successful program provides surplus food to about 2.5 million needy households and has been an important weapon in the Nation's arsenal against hunger.

HHS/Childhood immunizations. The President's plan to increase childhood vaccinations will immunize one million children during the summer of 1993. The Administration proposes to award \$300 million to support a community-based effort to finance vaccine purchases and education and outreach campaigns. This program will help to raise the Nation to the standards of child immunizations set by other advanced countries, which we have fallen far behind. Too many families are deterred by outrageously high costs from having their children immunized. The President intends to end that problem.

Labor/Summer Youth Employment and Training Program. Young Americans have an especially hard time finding jobs. The problem is worse for disadvantaged youth, and worse yet in the cities. The Summer Youth Employment and Training Program employs economically disadvantaged youth ages 14 to 21 to work at public and nonprofit agencies during the summer months. The Administration proposes to boost program funding by \$1 billion in the summer of 1993. This will finance almost 700,000 summer jobs, bringing to

nearly 1.4 million the total number of youth who could participate in the program. Approximately one-half of this summer's funding will be concentrated on the 100 American cities—small and large—with the greatest number of eligible youth. The public summer jobs program will be coupled with and complemented by a campaign to expand private summer job opportunities for young Americans.

National Service. This is a first step in the President's long range national service initiative. The Administration proposes to implement a program in the summer of 1993 to train a core group of leaders to spur service around the country. Combining leadership training with service, this initial phase of the national service initiative will cost \$15 million.

Extension of Emergency Unemployment Compensation. For millions of workers, the apparent recovery has not brought employment opportunities. The rate of job growth in the economy relative to past recoveries has been extremely sluggish. The Administration proposes to extend the current Emergency Unemployment Compensation program for seven months, through October 2, 1993. The program provides an additional 20 to 26 weeks of support for workers who have exhausted their regular unemployment benefits. The net estimated cost is \$5.6 billion over two years.

Education/Pell Grant unfunded shortfalls. The Administration proposes to make up shortfalls in the Pell Grant program, providing over \$2.0 billion to ensure that the program is funded at estimated current law levels through school year 1993-94.

HHS/AIDS/Ryan White Act. To initiate the President's long-term investment plan to fully fund HIV/AIDS prevention efforts under the Ryan White Act, the Administration proposes to increase funding for 1993 grants by \$200 million. These programs focus on AIDS prevention efforts.

Agriculture/Child and Adult Care Food Program. The Administration proposes an increase of \$56 million for the Child and Adult Care Food Program, which pays for meals and snacks at Head Start centers, to serve the children in the proposed Summer Head Start program.

Labor/Worker profiling. The Administration proposes establishment of a \$14 million program in 1993 and 1994 to assist the States in developing automated systems to identify laid-off workers who may have difficulties in finding new jobs, and to assist them in finding employment. This initiative seeks to respond to the problems faced by many workers laid off because of business downsizing and restructuring. Federal funding for this initiative will cover the up-front costs of developing worker profiling systems in the States.

Labor/Community Service Employment for Older Americans. The Administration proposes \$33 million to expand participation in the Community Service Employment for Older Americans program, which offers low-income seniors meaningful work experience in community service projects. This investment will finance over 5,000 jobs in the current year.

Interior/Bureau of Indian Affairs (BIA) School Operations. The Administration proposes that \$49 million be provided to cover currently identified shortfalls in funding due to rising enrollments to improve the educational performance of over 40,000 Indian students at the elementary and secondary level attending BIA-funded schools.

Equal Employment Opportunity Commission. Financing of \$9 million for additional staff to enforce the Americans with Disabilities Act and the Civil Rights Act will help stem the ballooning backlog of cases filed under those Acts.

Technology Investments

A very important part of the Administration's efforts to promote long-term economic growth is to increase investment in new, productivity-enhancing technology. A number of such projects are funded in the stimulus package because they can be initiated quickly, with immediate increases in jobs.

Industry-Led Federal R&D at the National Institute of Standards and Technology (NIST). The Advanced Technology Program at the National Institute of Standards and Technology provides matching grants for industry-led research projects for the development and commercialization of pre-competitive generic technologies and refining manufacturing practices. The Administration proposes \$103 million for the program in the current fiscal year.

Commerce/Information Highway Demonstrations. The development of a broadband, interactive telecommunications network linking the Nation's schools, libraries, health care facilities, governments, and other public information producers could pay enormous dividends to the U.S. economy. Interactive networks such as this are in their very early stages of development. The Administration proposes to make \$64 million available to the Department of Commerce's National Telecommunications and Information Administration to accelerate development of such information highways.

National Science Foundation/Research and development. Investments in research and development (R&D) tend to be the strongest and most consistent positive influence on productivity growth. Most of the National Science Foundation's (NSF) investments are in competitively selected university-based R&D programs. These activities contribute to the nation's productivity by generating new scientific and engineering knowledge and contribute to the training of the next generation of scientists and engineers. The Administration proposes an investment in 1993 of \$188 million to restore NSF funding to roughly the level that was planned for in 1993.

Networking and computer applications. The Administration proposes that programs be initiated at the National Institute of Standards and Technology, the National Science Foundation, the National Aeronautics and Space Administration, and the National Institutes of Health to develop applications which use

advanced computers and communication networks to solve problems in health care, education, manufacturing, and access to library information.

National Oceanic and Atmospheric Administration equipment acquisition. The Administration proposes an investment of \$81 million to accelerate the modernization of National Weather Service and central NOAA data systems, to procure hardware for more efficient utilization of the nation's fisheries, to improve weather prediction technologies, and to further climate and atmospheric research in areas of global concern such as atmospheric ozone.

HHS/Disability Insurance processing. The Administration proposes that \$302 million be provided to help the Social Security Administration reduce delays in processing of Disability Insurance claims, review cases earlier, and make other improvements to improve delivery of services. There has been a tremendous backlog of Disability Insurance claims in recent years, which this investment would help alleviate.

Treasury/Accelerate implementation of Internal Revenue Service Tax System Modernization. The IRS is now operating with severely outdated computer equipment. Through Tax System Modernization (TSM), the IRS is undertaking a multi-billion-dollar, decade-long effort to re-invent its operations. The Administration proposes fiscal stimulus funding of \$148 million to enable the IRS to accelerate several TSM projects and replace computer and telecommunications equipment that in many cases is nearly ten years old. This is a down payment on a long-term investment in the IRS modernization program.

Urban Development and Housing Initiative

The fiscal stimulus contains several initiatives to provide additional resources for housing and other development in the Nation's urban areas. These efforts are critical to our hopes of reviving our cities.

Housing and Urban Development/Community Development Block Grants. Community development projects are an important source of jobs and economic development in America's communities. States and local governments have a backlog of unfunded projects that are ready to begin, such as basic street and bridge work, painting and resurfacing, building rehabilitation, and public service projects. The Administration proposes a one-time supplemental appropriation of \$2.5 billion for Community Development Block Grants to fund such projects and create about 60,000 jobs during 1993–1995. The Administration will propose modifications to the program to ensure that projects have an immediate economic impact.

Commerce/Economic Development Administration grants. The Administration proposes \$94 million for Economic Development Administration awards to economically distressed areas to rebuild basic infrastructure—industrial parks, water and sewer improvements, and access roads to industrial sites. The grants are also for the purpose of planning for economic development.

HUD/Crime in public housing. The Administration proposes an Urban Partnership Against Crime initiative to address the increase in gang- and drug-related crime activity in many public housing developments across the country. Crime has exacted a profound and intolerable toll on public housing residents. Living in a constant state of fear of physical harm, residents have been robbed of their sense of community and personal well-being. Meanwhile, they have witnessed an ever-increasing expenditure of scarce public resources on repairing the damage done by crime to the physical environments of these developments. This initiative, costing \$138 million in 1997 and \$312 million over four years, would allow the Department of Housing and Urban Development to work with public housing and other local officials in an intensive effort to reduce crime in public housing. It focuses resources on those developments with greatest need, and gives flexibility to local officials to develop solutions (like community policing, neighborhood watches, youth activities) to the problems of crime in their communities.

HUD/Restore dilapidated public housing. This investment would provide an additional \$138 million in 1997 and \$241 million over the next four years to rehabilitate and restore severely dilapidated public housing projects that today are not only uninhabitable, but also contribute to the economic and social problems of the surrounding neighborhoods. These economically viable public housing units would then provide, once again, decent, safe, and affordable housing for low-income renters.

Lifelong Learning

Becoming a productive member of the community requires certain basics: like a healthy, supportive childhood; safe, sound schools; a chance to serve your country; and the opportunity to be retrained for the challenges of today's global economy. The Administration's commitment to major investments in these kinds of "human capital" promises payoffs for the nation far beyond their original price.

HHS/Full funding of Head Start. Children who participate in Head Start do better in school and become more productive as adults. By giving them the caring, stimulating environment they need, Head Start programs enable at-risk children to become problem-solvers instead of problems. Thousands of parents and selected studies have testified to the program's success, but for years our government—despite promises—has failed to make Head Start available to all the children who need it. With this initiative, one of our country's most cost-effective programs will become far more widely available and help change countless lives. The Administration will increase funding for Head Start by \$3.2 billion in 1997, \$8 billion over four years, achieving full funding for an estimated 1.4 million eligible disadvantaged children by 1999.

USDA/Head Start-related child care feeding. Pay for meals at Head Start centers and serve them to the participants added by the Administration's Head Start initiative; \$237 million in 1997; \$590 million over four years.

HHS/Head Start related Medicaid. Fund new entrants in the Medicaid program resulting from Head Start expansion; \$116 million in 1997, \$275 million over four years.

USDA/Full funding of WIC program. If our nation is going to prosper, our children will have to grow up healthy, not hungry. This special supplemental food program for women, infants, and children (WIC), helps make sure they do. By the end of 1996, all eligible children ages 1 to 4, including some 2 million who were not served last year, can be assisted with the proposed investment of \$1 billion in 1997, \$2.6 billion over four years.

HHS/Parenting and family support. These initiatives stem from a simple reality: governments don't raise children; parents do. These proposals will empower parents with the skills and the tools they need to help raise their children. They will support disadvantaged parents, including activities to help them work with their children at home and parenting classes, with an investment of \$500 million in 1997, \$900 million over four years.

Department of Education/Reforms and initiatives. All American children need greater access to better education—not just to make the American Dream more available, but to make the American economy more productive. These initiatives will provide \$2.7 billion in 1997, \$6.2 billion over four years, to support reforms and reauthorizations in elementary, secondary, and postsecondary education, including state and local systemic reforms, a new SAFE Schools program, student assistance program improvements, and support of Historically Black Colleges and Universities.

National Service. The national service initiative will help young people pay for college and other postsecondary education by serving their country. In conjunction with income-contingent loan repayment, which will help Americans take low-paying community service jobs and still pay off their student loans, the program will provide dramatic new opportunities to serve our country. Young people will meet pressing national needs in areas including education, public health, environmental protection, and public safety. In return for one or two years of service, they will be able to receive a significant educational benefit. As it enables Americans of all backgrounds to help themselves and their country at once, the initiative will reinvigorate American citizenship—lifting our country up and bringing our people together. The Administration's commitment to a fully realized program of national service is behind its plan to invest \$7.4 billion in the next four years, building from \$389 million in budget authority in 1994 to \$3.4 billion in 1997.

Labor/Dislocated workers program. Legislation will be proposed for a new program to replace and improve upon two existing programs to help workers who lose their jobs because of restructuring of their industries, international competition, or defense downsizing to secure rapid reemployment or train for new careers. The program will cost an additional \$2 billion in 1997, \$4.6 billion over four years.

Labor/Job Corps expansion. Provide resources to increase the size of the Job Corps program by 50 percent by 2001. This will increase the number of Job Corps participants to 104,000, from the current 70,000. Job Corps provides remedial education, occupational skills training, supportive and job placement services to severely disadvantaged youth in its network of 110 residential centers. The plan would finance 50 new residential centers. The 1997 cost is \$202 million; the 1994-97 cost is \$341 million.

Labor/Job Corps maintenance. Spend \$50 million in 1997 and \$105 million over four years to repair and renovate Job Corps' aging residential centers.

Labor/Summer youth employment and training program (SYETP). The SYETP offers economically disadvantaged youth age, 14 through 21, work experience in minimum wage jobs in public and nonprofit agencies during the summer months. This investment of \$625 million in 1997 and \$2.0 billion over four years would finance about 2 million additional summer youth jobs. The plan includes an enriched program of work experience, basic skills training, testing and counseling, and closer coordination with schools.

Labor/One-stop career shopping. This program would make it easier for adults seeking to change jobs or careers or upgrade their skills to obtain access to the confusing array of Federal programs and services by developing "one-stop shop" career centers. Over four years, the proposed investment is \$900 million, \$250 million of which is to be spent in 1997.

Labor and Education/Youth apprenticeship. This program would finance a nationwide system of school- and work-based learning programs for high school youth who do not plan to attend college, in order to reduce drop-out rates and help them make a successful transition to meaningful careers in technical occupations. The proposal provides \$500 million in 1997, a total of \$1.2 billion over four years.

Rewarding Work

Earned Income Tax Credit (EITC). In America, no one who works should have to raise a family in poverty. The EITC currently provides refundable tax credits to low-income working families with children. By expanding the EITC, we will assure that a family of four will not be forced to live in poverty, if one of the parents works full-time at a minimum wage job. The cost of the entire proposal is \$6.7 billion in 1997 and \$19.9 billion over four years.

Welfare Reform. Later this year, the Administration will present a comprehensive reform plan to end welfare as we know it. The President's plan will carry out his pledge that no one with a family who works full-time has to live in poverty, that parents who bring children into the world should be held accountable for raising them, and that welfare ought to be a second chance, not a way of life. The plan, coupled with the Earned Income Tax Credit, tougher child support enforcement to crack down on deadbeat parents, increased training, parenting, and family support for moving people from welfare to work, will

move toward a time-limited system of welfare. This will give people on welfare the education and training they need for up to two years, but after that, require all those who can work to go to work.

Justice

Justice/Crime initiative. A comprehensive program to support and improve all aspects of the criminal justice system. The initiative includes: (1) a new Community Policing/"Cops on the Beat" grant program to localities to create safer streets and to community policing, thereby building a bond of trust between citizens and police so that they can work together to fight crime; (2) a new Police Corps program, to provide scholarships to would-be police officers in exchange for a commitment to service as a State or local police officer; (3) a Criminal Records Upgrade program to assist States in improving their criminal records infrastructure and link with the FBI's criminal information databases; (4) increased funds to meet costs associated with detaining and incarcerating the growing Federal prison population, which has resulted from increased arrests and the imposition of minimum mandatory sentences; and (5) increased funds for existing Federal law enforcement activities. The budget authority investment is \$900 million in 1997, \$2.8 billion over four years.

Equal Employment Opportunity Commission (EEOC)/Enforcement. Increase EEOC enforcement staff in field offices to provide full enforcement of the Americans With Disabilities Act and the Civil Rights Act of 1991. The proposed outlays are \$18 million in 1997, \$63 million over four years.

Health Care

HHS/AIDS, immunizations, NIH research, and other public health initiatives. This investment provides substantial new funding—\$3.4 billion in 1997 and \$8.2 billion over four years—for a number of public health initiatives including: (1) HIV/AIDS research; (2) research on women's health issues; (3) the President's plan for increasing childhood immunizations; (4) teen pregnancy programs, and (4) other efforts to promote public health.

HHS/Substance abuse prevention and treatment. Challenge grants to the States to create substance abuse treatment capacity where it is needed most and for hard-to-treat populations. It will serve 30,000 people in 1994 and more in years after. The outlays are \$800 million in 1997, \$1.5 billion over four years.

USDA/Food Safety and Inspection Service. Improve the existing meat and poultry inspection system by increasing the number of Food Safety and Inspection Service inspectors available in order to ensure that visibly diseased animals are not processed, slaughterhouses and processing plants are clean and follow safe food handling procedures, and plant employees follow proper hygiene. Food safety research would also be enhanced. This responds to a clear need for improvements, highlighted by the recent food poisoning outbreak in Washington State. The initiative adds 200 inspectors. The investment is \$34

million in 1997, \$111 million over four years, and it would create some 275 jobs in 1994.

Rural Health Initiative. This proposal provides grants and other assistance to small rural hospitals to upgrade needed services. Grants may be used to launch integrated health systems and telecommunications links for remote consultation and diagnosis in low manpower areas. Estimated \$50 million in 1994.

VA/Medical care. This four-year investment provides a \$2.5 billion increase over the baseline to ensure high quality health care for veterans by such measures as providing adequate staff levels to meet requirements on residency education programs and automating drug dispensing in VA hospitals.

HHS/Social Security Administration/Disability insurance processing. Increase resources for the processing of dramatically increased disability benefit claims by \$200 million in 1995-98. This will cut down on the significant delays that have occurred in recent years and reverse the general decline in service.

HHS/Ryan White Act. HIV/AIDS is now the ninth leading cause of death overall. Currently, approximately 1 million people are infected with HIV in the U.S., and about 60,000 new AIDS cases are reported each year. The President has pledged to respond to this need by fully funding the Ryan White Act and increasing Federal support for HIV/AIDS prevention efforts. To begin fulfilling these pledges this year, this proposal would increase funding for grants authorized under the Ryan White Act by \$120 million in 1994. The proposal includes additional funding of approximately \$1 billion over the next four years.

State and Local Relief. Within the Health Care, Rewarding Work and Lifelong Learning investment packages, the Administration will design a program to offset the impact of refugees and undocumented residents on the budgets of State and local governments, including those in California, Texas and Florida.

Investment Package: Tax Incentives

We recognize that the only way to lay the foundation for renewed American prosperity is to spur investment. New investment will create jobs, putting people back to work today, and will provide the productive equipment that we need to compete in the global economy.

Our overall program consists of outlays for physical and human capital and investment tax incentives for the private sector. Outlays for physical capital will help rebuild the crumbling foundations of the United States, create millions of high-wage jobs, and smooth the transition from a defense to a commercial-based economy. Our program will concentrate on the transportation, environment, and communications infrastructure. The program of tax incentives will increase private investment over the long run. Like the outlay programs, these incentives are designed to increase investment in human and physical capital. These incentives will be particularly helpful to small business which generates the lion's share of jobs.

Permanent small business tax credit. As discussed in the stimulus package, the plan provides that small businesses will now be eligible for a permanent investment tax credit on their equipment. The credit will generally be 7 percent in 1993 and 1994, and 5 percent thereafter. Small businesses operate at the margin and need a permanent incentive to invest, grow and provide new employment opportunities.

Incentive for investment in small business. The program provides relief from the capital gains tax for investors in small businesses. This proposal will allow investors generally to exclude 50 percent of the gains earned from investment in the stock of a qualified small business (less than \$25 million capitalization) when held at least 5 years. Furthermore, 50 percent of the excluded gain is not subject to taxation under the alternative minimum tax. The tax incentives will both stimulate job creation over the short-run and increase investment over the long-term.

Research and experimentation tax credit. The economic plan will permanently extend the research and experimentation credit. This will encourage firms to undertake the research necessary to develop the technological innovations required to increase the supply of good jobs.

Real estate. The plan also permanently extends both the low-income housing credit and mortgage revenue bond provisions. Doing so will provide a stimulus to increase the supply of housing for low-income families. In addition, the program modifies the passive loss rules for persons in certain real estate trades or businesses, relaxes restrictions on pension investments in real estate and extends the depreciable life of nonresidential real estate.

Enterprise zones. This part of the program authorizes the establishment of a number of enterprise zones. Businesses located in enterprise zones will be eligible for a wage credit for the hiring of enterprise zone residents and accelerated depreciation or expensing of investments in enterprise zone property. In addition, small businesses in qualifying economically distressed areas will be eligible to obtain low interest rate loans through tax-exempt financing even if the area is not selected as one of the zones. Combined with the other tax incentives and other non-tax initiatives targeted to urban areas, these benefits should help promote investment and job creation in these areas.

Simplifying and enhancing depreciation provisions for companies subject to the alternative minimum tax (AMT). As noted in the discussion of the stimulus package, the plan substantially enhances the investment incentives for taxpayers subject to the AMT and simplifies the AMT by using the shorter regular tax depreciable lives for minimum tax as well as regular tax purposes. Because they reduce the net cost of acquiring depreciable assets, this proposal will provide a lasting stimulus to investment for affected companies.

Targeted jobs tax credit; employer-provided educational assistance. The plan permanently extends these two provisions, thus providing an incentive for American businesses to continue to invest in human capital. The plan also

expands the targeted jobs tax credit to include workers in an apprenticeship program. An educated workforce will be more productive and better able to adapt to the challenges of a modern information-based economy.

Health insurance deduction for the self-employed. The plan calls for an extension of the 25 percent deduction for health insurance premiums of the self-employed through the end of 1993. This will retain the current law tax treatment of these premiums for affected individuals until the Administration's comprehensive health care proposals are enacted.

Small issue bonds and high speed rail facilities. The ability to issue tax-exempt bonds for qualifying small businesses and certain farmers would be extended permanently under the plan. In addition, in order to promote the development of high speed rail facilities, tax-exempt bonds issued for that purpose will not be subject to the State private activity bond volume limitations.

revitalization and crime fighting throughout the country. Estimated savings are \$552 million in 1997, \$1.2 billion over four years.

Tennessee Valley Authority. The Administration proposes to terminate the Tennessee Valley Authority's fertilizer research activities and its economic development program. The fertilizer industry is fully capable of financially supporting fertilizer research without the need for taxpayer subsidized work in TVA. With regard to economic development, while these activities have a long and noted history, other much larger programs with similar purposes have been put into place, and are slated to receive substantial increases from the Administration's stimulus and investment proposals. The estimated savings from this proposal are \$188 million from 1994 to 1997, including \$50 million in 1997.

Eliminating Subsidies; Charging Fees for Government Services

The nation can no longer afford subsidies and giveaways to those who don't need them, and we must assure that the taxpayer is fairly compensated for services or resources provided by government.

USDA/Phase out below-cost timber sales. Timber sales from some National Forests do not cover the costs to the government of making the timber available for sale. This proposal would gradually eliminate sales in those forest regions where timber-sale program costs exceed timber-sale revenue. This gradual phase-out would reduce the economic impacts on rural communities dependent on the timber industry. Below-cost forests would be reviewed periodically to determine if sales could proceed at no net loss to the Government. Estimated savings are \$86 million in 1997, \$274 million over four years.

Expand Agriculture user fees. New user fees for three USDA agencies (the Federal Grain Inspection Service, the Agricultural Marketing Service, and the Agricultural Cooperative Service) to recover costs for Federal services being provided to a specific group. Estimated savings are \$16 million in 1997, \$59 million over four years.

USDA/Meat and poultry fees. Requires all slaughterhouses and processing plants with overtime shifts to reimburse the government for the full cost of Federal meat and poultry inspections. Estimated savings are \$104 million in 1997, \$416 million over four years.

HHS/Food and Drug Administration user fees. Identifiable beneficiaries of government services should pay for the value conferred by certifying the safety and efficacy of drugs and medical devices. Estimated savings are \$336 million in 1997, \$1 billion over four years.

Bureau of Alcohol, Tobacco and Firearms (BATF) user fees. BATF is required to approve all alcoholic beverage labels and conduct various laboratory analyses to assure compliance with Federal law. There is currently no charge for these services, though manufacturers receive real, tangible benefits from them.

Veterans Affairs/Internal Revenue Service income verification. The Administration proposes to extend permanently the Department of Veterans Affairs' authority to access IRS tax data to verify income reported by pension and medical care beneficiaries. There are no savings from this extension in the 1994-97 period. Savings in 1998 are \$197 million.

Veterans Affairs/Permanently extend pensions-Medicaid nursing home provisions. The Administration proposes to extend permanently the current \$90 monthly limit on pension benefits paid to any veteran or survivor without dependents who receives Medicaid coverage in a Medicaid-approved nursing home. This proposal would reduce an indirect federal subsidy from veterans programs to state Medicaid programs. There are no savings in the 1994-97 period. Savings in 1998 would be \$300 million.

Veterans Affairs/Service members' contributions to the Montgomery GI Bill Education Program. The Montgomery GI Bill program provides monthly benefit payments to eligible service members and veterans who are enrolled in a post-secondary education program. To become eligible, military personnel agree to contribute to the program through a reduction in their basic pay during their first year of service. In two steps over the last three years, Congress has increased the monthly benefits by 33 percent without increasing individuals' payroll contributions to the program. Before the increases in benefits, the program funding match was 9:1 (government:service members). This proposal would prospectively increase their contributions to restore the 9:1 match. Estimated savings are \$339 million over four years, including \$98 million in 1997.

Controlling Health Care Costs

Systemwide health care reform is a top Administration priority, but some additional short-term savings proposals, focusing on providers rather than beneficiaries, make immediate sense.

Medicare:

HHS/10 percent capital reduction, inpatient. The proposal would extend current law beyond 1995. Hospitals receive payments for Medicare's share of capital expansions and improvements of both inpatient and outpatient department (OPD) facilities. The current payment level was reduced in OBRA 90 by 10 percentage points to 90 percent of Medicare's share of capital costs in every year. Estimated savings: over four years—\$680 million; 1997—\$380 million.

HHS/10 percent capital reduction, OPD. The proposal would extend current law beyond 1995. Hospitals receive payments for Medicare's share of capital expansions and improvements of both inpatient and outpatient department (OPD) facilities. The current payment level was reduced in OBRA 90 by 10 percentage points to 90 percent of Medicare's share of capital costs in every year. Estimated savings: over four years—\$260 million; 1997—\$150 million.

HHS/Maintain calendar year 1995 ratio of premium collections to program outlays with a 27 percent ceiling. Under this proposal, beginning in January, 1996, the monthly Part B premium would be set to maintain the percentage of program costs covered by premium collections in the previous year, but with a ceiling of 27 percent. The monthly Part B premium amount currently is set in law through the end of calendar year 1995 (\$36.60 in CY93, \$41.10 in CY94, \$46.10 in CY95), and premium collections are projected to cover about 27.5 percent of program costs in 1995. When originally established, SMI premiums were intended to cover 50 percent of program costs. They eroded significantly over the years, however, and TEFRA 1982 established a temporary 25 percent premium floor, beginning in 1984. Congress extended the floor twice, and OBRA90 set fixed premium amounts in law through 1995 at levels then estimated to be approximately 25 percent of program costs. Beginning in 1996, calculation of the premium is scheduled to increase by the lower of the OASI COLA adjustment to the previous year's premium, or to be set at 50 percent of program costs. Estimated savings: over four years—\$5 billion; 1997—\$3.9 billion.

HHS/Eliminate add-on payment for hospital-based HHAs. This proposal would eliminate the separate add-on payment that hospital-based home health agencies (HHAs) receive in addition to payment under the Medicare cost limits. Eliminating the add-on would create a level playing field on which all home health agencies can compete. Estimated savings: over four years—\$840 million; 1997—\$250 million.

HHS/Eliminate skilled nursing facility return on equity payments. The proposal would eliminate the Medicare payment policy that pays proprietary skilled nursing facilities (SNFs) a return on equity (ROE) invested in the SNF. Medicare should pay for services rendered to beneficiaries; it should not subsidize private investment. Estimated savings: over four years—\$560 million; 1997—\$160 million.

HHS/Lower IME to 5.65 percent. This proposal would gradually lower the Medicare indirect medical education (IME) from 7.7 percent to 5.65 percent for each .1 increase in the intern and resident to be a ratio (IRB ratio). Teaching hospitals currently receive an additional 7.7 percent payment to the Medicare DRG payment for each .1 increase in their IRB ratio, above their base year levels. The adjustment is intended to compensate these hospitals for the higher costs of delivering care incurred by inexperienced residents. In addition, teaching hospitals tend to have sicker case mixes than non-teaching hospitals. The General Accounting Office (GAO) and the Prospective Payment Assessment Commission (ProPAC) have both found that the 7.7 percent adjustment overcompensates teaching hospitals for these costs and have recommended that the adjustment be reduced. ProPAC has recommended setting the adjustment at 5.4 percent. Lowering the IME adjustment would also encourage teaching hospitals to instill within their residents more cost-effective patterns of care.

early stage in the residency. Estimated savings: over four years—\$1.94 billion; 1997—\$1.4 billion.

HHS/Permanently extend 2 percent laboratory fee update. This proposal would extend the 2 percent annual update of Medicare reimbursement rates for clinical laboratory services. OBRA 90 established a 2 percent update through the end of 1993, after which laboratory fees would be updated by the urban component of the Consumer Price Index (CPI-U), approximately 3.5 percent annually. There is no evidence, however, to indicate that laboratory costs are increasing by the rate of inflation. Medicare payments to laboratories should more closely reflect decreasing costs due to technological advances, such as increased automation, and changes in the market, such as lower-cost equipment. Medicare payments to laboratories are already excessive. An OIG study found that Medicare paid laboratories 90 percent more than physicians paid for the same tests. Moreover, a GAO study indicated that laboratories use higher profits from Medicare to subsidize discounts to other, private payers. Estimated savings: over four years—\$740 million; 1997—\$380 million.

HHS/Provide incentive to encourage submission of claims via electronic format. In total, Medicare Part B outlays were projected to be \$59.8 billion in 1993. The proposal would save 0.1 percent of the 1994–98 Medicare Part B baseline. The proposal would encourage physicians and other Part B providers to submit claims via the more administratively efficient electronic format by charging physicians and other providers \$1 for each paper claim filed. The proposal would not take effect until January 1, 1996, to give providers lead time to adjust their filing systems. Estimated savings: over four years—\$265 million; 1997—\$175 million.

HHS/Medicare Secondary Payer (MSP) reforms. The MSP requirements currently vary depending upon the category of enrollee. This proposal would create a consistent MSP threshold for the aged, disabled, and end stage renal disease (ESRD) patients—all employers of 20 or more would be primary payers. Current law already requires that Medicare enrollees with employer-based health insurance use their private health insurance before drawing upon their Medicare policies. This applies more consistent standards and more efficient enforcement of these provisions to save Medicare costs. Estimated savings are \$947 million for 1994 through 1997; and \$305 million in 1997.

HHS/Permanently extend reduction of payments for hospital outpatient services by 5.8 percent. OBRA 1990 reduced Medicare reimbursement for hospital outpatient department (OPD) reasonable costs by 5.8 percent through 1995. This proposal would extend that provision permanently. Depending on the service, OPDs are paid based upon varying formulas, some of which take into account the OPDs' reasonable costs. The overall reduction to OPDs would be much less than 5.8 percent, because less than half of Medicare reimbursement is based on reasonable costs. Because hospital inpatient reimbursement rates are constrained by DRGs, hospitals have shifted services and costs to the outpatient setting. As a result, outpatient services are one of the fastest growing

components of the Medicare program, rising by an average of 17 percent per year in the 1980s. Legislators approved a 5.8 percent reduction in OBRA 1990 in an attempt to counter this rapid growth. If this provision is allowed to expire, outpatient costs, which continue to grow in the double-digits, will start growing even faster. Support for this proposal is well-established through previously approved legislation. Estimated savings are \$950 million for 1994 through 1997; and \$525 million in 1997.

HHS/Reduce hospital outpatient department reimbursement by an additional 4.2 percent. In total, Medicare Part B outlays were projected to be \$59.8 billion in 1993. The proposal would save 0.5 percent of the 1994-98 outpatient services base. Currently, Medicare reimbursement for outpatient services is based in part on the OPD's reasonable costs minus 5.8 percent, while reimbursement for outpatient capital costs is reduced by 10 percent. This proposal would reduce reimbursement for OPD services by an additional 4.2 percent beginning in 1996, to a 10 percent reduction. This would make payment for both categories consistent by reimbursing both at 90 percent of costs. Estimated savings: over four years—\$690 million; 1997—\$375 million.

HHS/Ban physician self-referrals. A Physicians may not refer a Medicare or Medicaid patient to a clinical laboratory in which the physician or the physician's relatives have a financial interest. Several exceptions are specified in statute. This proposal would extend ownership and referral prohibitions to additional services, such as physical and occupational therapy, durable medical equipment, and parenteral/enteral nutrition equipment and supplies. Estimated savings: over four years—\$250 million; 1997—\$100 million.

HHS/Set EPO at non-U.S. market rates. The proposal would reduce the amount Medicare pays for erythropoietin (EPO) from \$11 per 1,000 units to \$10 per 1,000 units. EPO is the drug used by patients suffering from kidney failure, to counter anemia by increasing the body's production of red blood cells. Medicare is virtually the sole purchaser of EPO and should exercise its market power to pay reasonable costs while maintaining access for all Medicare beneficiaries. Estimated 1997 savings are \$50 million. Estimated savings 1994-1997—\$160 million; savings for 1994-1998—\$210 million.

HHS/Resource-based practice expense phase-in. This proposal is an interim step toward a resource-based system for practice expenses. It would reduce practice expenses in relation to the relative value work units by one-half of the difference between practice expense and physician work relative value units, not no lower than 110 percent. Phase-in to a resource-based system for practice or overvalued expenses under the physician fee schedule would begin in 1997. The recently implemented physician payment reform system divided payment into three distinct components—overhead, work, and malpractice expenses. The work component is based on an extensively-researched relative value system, developed in 1991. The existing practice expense component is based upon an obsolete fee schedule and bears no relationship to the reformed work component of the fee schedule. This proposal would only reduce the practice component in

extreme instances—when it exceeds the value of the work component. More comprehensive reform of the practice component is expected to take several years to develop. This proposal provides a simple, intermediate step to address immediately the most egregious inequities in the reimbursement framework. Estimated 1997 savings—\$875 million. Estimated savings 1994–1997—\$2,025 million; savings for 1994–1998—\$2,975 million.

HHS/Pay hospitals for inpatient services by hospital-based physicians. Include payment for radiology, anesthesia, and pathology (RAP) services as an add-on to the hospital DRG payment. Separate billing by physicians for these services would not be allowed. Quality of care would be improved and unnecessary utilization would be minimized. Estimated 1997 savings are \$160 million; 1994–1997—\$390 million.

HHS/Single fee for surgery. The fee paid to a primary surgeon would be reduced by the amount paid to assistants-at-surgery. HHS would establish exceptions by regulation in which the difficulty of the procedure or the condition of the patient necessitated the use of physicians as assistants-at-surgery. Whether assistants are used and what type of personnel are used are primarily dependent on geographic practice patterns and the practice styles of individual surgeons, rather than on characteristics related to the specific patient and the surgery performed. Evidence does not show that quality of care would be jeopardized. Estimated 1997 savings is \$120 million; 1994–1997—\$380 million.

HHS/Durable Medical Equipment (DME) options—Set DME at market levels. Initially, fee schedules for DME would be adjusted downward with an upper limit based upon the median DME fee schedule, rather than the national average. The fee schedule for prosthetics and orthotics would also be recomputed with a national median cap. The HHS Secretary would be authorized to adjust DME rates based upon market factors, including surveys of what other providers, such as the VA, DoD and the private sector, pay for DME. The Secretary also would be authorized to initiate competitive bidding programs for DME supplies where appropriate. Granting broader HHS discretion would allow adjustments to be made to reflect changes in technology, utilization patterns and other market factors. Estimated savings are \$510 million for 1994–97; and \$160 million in 1997.

HHS/Direct medical education. This proposal would base Medicare direct medical education payments on a national per resident amount derived solely from the average of salaries paid to residents. Direct medical education payments would reflect differential weighing of the national average resident salary, based on the specialty area a resident is pursuing and the length of the residency. A resident in a primary care specialty would be weighted at 240 percent, a non-primary care resident in the initial residency period would be weighted at 140 percent, and a non-primary care resident beyond the initial residency period would be weighted at 100 percent. The average weight would be 175 percent of the national average resident salary, down from the average

weight of about 215 percent under current law. Estimated savings: over four years—\$1.4 billion; 1997—\$330 million.

HHS/Set laboratory rates at market levels. The proposal initially would limit the Medicare Part B laboratory fee schedule to 76 percent of the median of all fees (as opposed to current maximum of 88 percent). Later, based on market surveys, the Secretary of HHS would adjust Medicare payment rates to laboratories to account for technological changes or other market factors. This proposal would address excessive Medicare payments for laboratory tests. An OIG study found that Medicare paid laboratories 90 percent more than physicians paid for the same tests. Moreover, a GAO study indicated that laboratories use higher profits from Medicare to subsidize discounts to private payers. In addition, the proposal would control growth in Medicare Part B laboratory payments, which more than doubled from 1985 to 1990. Estimated savings: over four years—\$3.1 billion; 1997—\$1.1 billion.

HHS/Reduce default Medicare volume performance standard and update. The effect of this proposal is to reduce the amount of increases in physician fees in future years. This proposal would reduce the Medicare volume performance standard (MVPS) default formula and the default update for Medicare payments to physicians. These two factors determine annual aggregate physician payment levels. Estimated savings: over four years—\$850 million; 1997—\$650 million.

HHS/Permanently extend three current Medicare Secondary Payer (MSP) provisions. The proposal would extend three OBRA '90 Medicare Secondary Payer provisions due to expire at the end of 1995 including: (1) 1862(b) of the Social Security Act authorizing MSP for disabled active individuals with employer group health plan (EGHP) coverage; (2) 1826(c) of the Social Security Act amended by OBRA '90 authorizing MSP for individuals with ESRD after 18 months (expanded from 12 months); and (3) 8051 of OBRA '90 authorizing an IRS/SSA data match for MSP. The data match authorizes access to tax data to identify the existence of EGHP for MSP purposes. Estimated savings over four years—\$1.845 billion; 1997 savings—\$1.115 billion.

HHS/Put hospitals on calendar year update. Medicare payments to hospitals for inpatient care are updated October 1 of each year. Most other Medicare services are updated January 1 or July 1. This proposal would move the hospital update to January 1. Estimated savings: over four years—\$4.6 billion; 1997 \$1.3 billion.

HHS/Fully increase primary care fees; modestly increase doctor fees in 1994. The proposal would update in full the physician fee schedule in CY 1994 for primary care services only. For all other physician services, the update would be two percentage points less than the full update. Estimated savings: over four years—\$1.3 billion; in 1997—\$400 million.

HHS/Reduce Medicare hospital update market basket by 1 percent in 1994 and 1 percent in 1995. This proposal would extend the current law practice of PPS updates of less than the hospital market basket index (HIMBI). The 1993

update of the PPS standardized amount is set at the HMBI minus 1.55 percent for urban hospitals and HMBI minus 0.55 percent for rural hospitals, as set in OBRA 1990. Under current law, the update for urban hospitals will equal the market basket rate of increase in 1994 and 1995. For rural hospitals the update is set at market basket plus 1.5 percent for 1994 and the HMBI plus an adjustment needed to match the urban rate in 1995. Estimated savings: over four years—\$5.19 billion; 1997—\$1.7 billion.

HHS and others: Third party liability—enhanced identification of other health coverage. Federal and State taxpayers spend over \$1.5 billion a year for health care that should be paid for by others. Inappropriate payments have been identified in most federally-assisted or financed health programs including: Medicare, Medicaid, Veterans Affairs Health, CHAMPUS/DOD Direct Care, and the Indian Health Service. This proposal removes many of the structural impediments hindering proper identification and billing of third party liability (TPL) by: (1) requiring employers to report employment based health coverage data annually on the W-2; (2) granting access to this data to all federally-assisted and financed health programs; (3) reinforcing existing coordination of benefits (which payer pays and in what order) laws and regulations; and (4) removing impediments that hinder states from collecting from private insurers. Rather than the current 'pay and chase' procedures where federal programs pay first and chase payers afterwards, this proposal focusses on avoiding erroneous payments by identifying the appropriate coverage **before** payment.

Medicaid:

HHS/Tighten estate recovery/transfer of assets rules. Total Federal Medicaid outlays for 1993 are projected to be \$80.3 billion. This proposal would save approximately 0.1 percent of the 1994–98 Medicaid baseline. This proposal would strengthen transfer-of-asset rules to restrict further the diverting of property to qualify for Medicaid. In addition, the Federal government would require States to operate estate recovery programs and would enhance States' abilities to implement these programs. Estimated savings: over four years—\$395 million; 1997—\$155 million.

HHS/Remove prohibition on State use of drug formularies. This proposal would repeal the OBRA 1990 statutory provisions that prohibit States from using formularies. Before OBRA 1990, States were allowed to limit the number of drugs listed on their formularies, e.g., States could cover only the generic alternative of a multiple-source drug. The OBRA 1990 formulary restriction resulted in increased expenditures for States and the Federal government. Estimated savings: over four years—\$70 million; 1997—\$25 million.

HHS/Eliminate mandatory Medicaid personal care. This proposal would ensure that personal care remains an optional benefit after 1994. The Medicaid statute requires States to cover home health services for all individuals who are eligible for nursing home services. Currently, States also have the option to pay for personal care services to these individuals. Due to a legislative drafting error,

OBRA-90 designated personal care as a home health service. Therefore, coverage of personal care services would become mandatory for all States in 1995, if Congress does not amend the statute. In an era of increasing fiscal pressures and growing Medicaid spending, Congress should avoid imposing additional mandates upon State Medicaid programs. Moreover, maintaining personal care as an optional service would allow States continued flexibility in designing and administering Medicaid long-term care strategies. Estimated savings: for four years—\$4.1 billion; 1997—\$1.5 billion.

Shared Contribution

For deficit reduction to succeed, all groups must contribute. Only if there is a sharing of the load can the entire country be sure that everyone is participating.

Social Security/Conform taxation of benefits to private pensions. Up to 50 percent of Social Security and Railroad Retirement (Tier I) benefits are currently included in taxable income for those recipients with income and benefits exceeding \$25,000 for individuals, and \$32,000 for couples. The Administration proposes including up to 85 percent of benefits in adjusted gross income, for those with income and benefits exceeding the current \$25,000/\$32,000 thresholds. This would move the treatment of Social Security and Railroad Retirement Tier I benefits toward that of private pensions. Under current law, pension benefits that exceed an employee's after-tax contributions to qualified pension plans are subject to tax at distribution. Extending this approach to Social Security would mean including at least 85 percent of benefits in taxable income for nearly all recipients. However, maintaining the existing income thresholds protects most low- and middle-income beneficiaries from benefit taxation.

HHS/Strengthening child support enforcement. Of the over 10 million women living alone with their children, only half have child support orders and only half of those women receive full payment. Child support enforcement will be strengthened by streamlining paternity establishment; using the IRS to collect seriously delinquent child support; making sure that absent parents who can pay child support do; setting up a national registry to track down deadbeat parents; requiring employees to report child support obligations on IRS W-4 forms; and improving medical support for children. Better child support enforcement will ensure both parents' responsibility for the well being of their children and decrease the burden of welfare on the taxpayer. Estimated Savings: over four years—\$328 million; 1997—\$109 million..

HHS/Equate matching rates for welfare programs. Currently, States are reimbursed by the Federal Government at different rates for the various costs of administering Aid to Families with Dependent Children (AFDC), Food Stamps, and Medicaid. The Administration proposes to set the Federal reimbursement rate at a uniform 50 percent for all administrative costs of each of these three programs. There will be waivers for some States, in hardship cases. Estimated savings: over four years—\$1.8 billion; 1997—\$600 million.

The Task Remaining

The urgent question of our time is whether we can make change our friend and not our enemy.

Bill Clinton

The plan presented in these pages is as bold as the challenges it confronts are daunting. It calls for fundamental change—to invest in people; to reward hard work and restore fairness; to recognize our families and communities as the cornerstones of America's strength; to reclaim our future.

This plan promises rising standards of living, productivity and national savings. It stimulates job growth and provides insurance that the current slow recovery will be lasting and strong. It invests in the education, training and health of our people. It encourages the private sector to modernize and acquire the tools and technology to compete in the global economy. And it confronts our deficit head on, with a serious, fair plan to bring it under control and generate economic growth.

The Perils of Inaction

Achieving this change will not be easy. But the cost of not changing is far greater.

After the fiscal failures of the last twelve years, we cannot accept the status quo. While every American can sense the weakness in our economy from day to day, the real cost of inaction becomes clear only when we examine the course that our economy and budget will follow if we do not change.

Under the policies left by the previous Administration and taking a cautious view of the economic outlook, the budget deficit will decline for the next two years, and then begin to grow even as the economy continues to recover and expand (Chart 4-1). As a percentage of the GDP, a better measure of its impact on the economy, the deficit declines through 1996, but then begins to climb (Chart 4-2).

Far more troubling, however, these deficits will be so large that the national debt will grow faster than the economy (and thus will increase as a percentage of the GDP) all the way to the forecast horizon (Chart 4-3). This path cannot be sustained. If rising deficits are left to cascade into debt, hence into interest costs, and then back into still higher deficits, there can be no good economic outcome.

And the longer this vicious cycle is left to build its momentum, the more painful the jolt when—inevitably—it is broken.

The Administration's economic plan controls the deficit before the deficit controls our economy. In a fair and measured way, the plan will bring the deficit down until, by 1997, it will be \$140 billion lower than it would be if we cling to the status quo. The deficit under this program falls from 5.4 percent of the GDP in fiscal year 1993 to 2.7 percent in 1997. This is 1.9 percent of GDP lower than would occur under the policy left behind by the previous Administration.

To be cautious, we have based our deficit projections on an extremely unfavorable path of economic growth, with slow progress of productivity and real economic output growing less than two percent per year in the long run. Under those circumstances, the deficit would rise slowly after 1996—even with the aggressive deficit reduction policies recommended by this Administration. Though much improved relative to past economic policies, this outcome is unacceptable (Chart 4-1). As a percentage of the GDP, the deficit would rise in the long run (Chart 4-2); and the growth of the national debt relative to the GDP would continue (Chart 4-3).

This Administration believes that its policies of deficit reduction and public and private investment will increase the growth of productivity and incomes, thereby increasing Federal revenues, retarding the expansion of Federal spending, and forcing the deficit down. If the economic outcome is more favorable than we have assumed, the deficit will grow more slowly. Under the more optimistic assumptions, the deficit will be nearly stabilized as a percentage of the GDP. The economy will grow more rapidly than the national debt, and so the debt as a percentage of the GDP will fall slowly. Eventually we will reverse the borrow and spend legacy of the 1980s.

The Role of Health Care Costs

Even the most favorable scenarios for economic growth under our plan leave unfinished business, however. The budget totals conceal rapidly rising health care spending that threatens to bankrupt our national treasury.

Recently, health care costs have accounted for almost half of the increase in Federal spending; if we do nothing, by decade's end one in every four Federal dollars will go to providing health care. Relentlessly rising costs will continue to stunt long-term economic growth—and terrorize American families—unless and until we achieve fundamental change.

Later this spring we will deliver to the Congress a comprehensive plan for change. That plan will control health care costs and will provide security to families, so that they cannot be denied the coverage they need. It will root out fraud and outrageous charges, and make sure that paperwork no longer chokes

consumers or doctors. And it will maintain American standards—the highest quality medical care in the world, and the choices we all deserve.

Our health care plan will bring costs under control. And while the savings we achieve will go mostly to the private sector, taxpayers will benefit as well. Federal funds will be freed for investments in education, training, and the technologies of tomorrow.

That reform will control the growth of Medicare and Medicaid spending in the long term, and thereby supplement the deficit reduction in this economic program. If the growth of Federal health care costs can be limited to the rate of growth of the population, plus the rate of inflation, plus two percent, the deficit will decline in dollar terms and as a percentage of the GDP (Charts 4-1 and 4-2); and the increase in the ratio of the national debt to the GDP of the 1980s will be reversed (Chart 4-3).

Enactment of the economic plan and health care reform together will reverse the failures of the 1980s, and put the economy on a sound footing for the next century. It will reduce the threat of financial instability posed by a national debt rising faster than our income. It will stop sending the signal to the rest of the industrialized world that our economic policy is out of control. Most important, it will add to the prosperity and security of the American people and allow us to compete more effectively in the global economy.

Conclusion: A Vision of Change for America

Throughout our history, at every critical moment, Americans have summoned the courage to change, to adapt our nation's policies and institutions to changing problems and a changing world. Once again we face such a challenge. Now we must change our course.

We need a change to restore what makes America great: a vision of economic and political freedom; of the rewards of hard work and initiative; of a fundamental sense of fairness, of our families and our communities as foundations of our strength; and of every generation's obligation to create a better life for those that follow.

The plan we present invests in our people and promises an America where a growing economy produces rising living standards and high-wage, high-skill jobs. It rewards hard work and restores fairness, providing opportunity in return for responsibility. It ends twelve years of government that served only the privileged and returns that government to its rightful owners: the American people.

Here in Washington, the powerful special interests are already doing their best to suffocate change. They oppose it because they profit from the status quo. They refuse to listen to the American people's call for change.

The Task Remaining

It is our responsibility to answer that call and restore hope to our people. The voices of conventional wisdom will first whisper and then shout that it cannot be done. But we must summon the wisdom and courage to reject convention and embrace the new direction that we have needed for so long.

Clinton Presidential Records Digital Records Marker

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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.

FY 96 Budget Press

Divider Title: _____

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Washington, D.C.



THE FISCAL YEAR 1996 BUDGET

The attached document is based on the President's Budget scheduled for delivery to the Congress on February 6, 1995 and is strictly embargoed until 1:00 p.m. that day.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FY 1996 BUDGET

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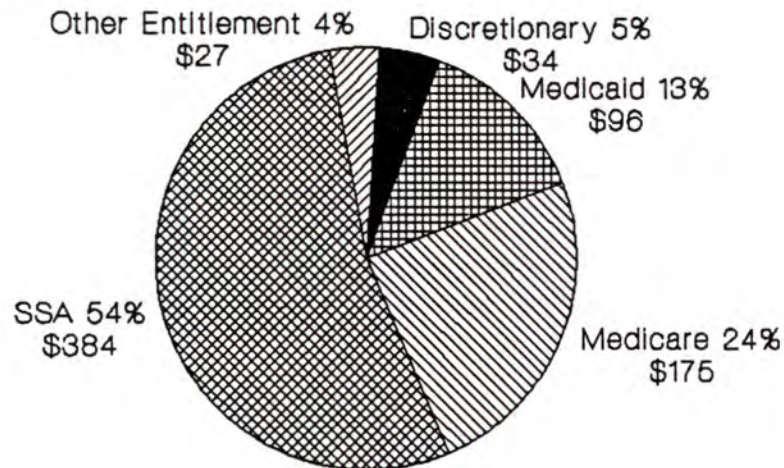
SUMMARY

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Budget Authority/Income	\$695,331	\$726,561	\$723,675	\$773,675	+\$50,659
Outlays	623,718	661,428	665,894	715,765	+49,871
<i>FTE</i>	127,362	127,211	127,211	125,445	-1,766

FY 1996 DISTRIBUTION OF OUTLAYS



\$716 Billion

(Dollars in Billions)

SUMMARY

FULFILLING OUR PROMISE TO THE AMERICAN PEOPLE

The President's FY 1996 budget is another step in this Administration's drive to make government work harder to meet the needs of the American people. Across the country, citizens are demanding that government act responsibly, listen to their concerns, and serve their interests. We are working to meet their demands.

The FY 1996 budget is built around our promise to maintain fiscal responsibility, streamline and restructure the bureaucracy, strengthen our partnerships with States and communities, make our operations more efficient, and invest in our future. It makes hard choices, but these choices will serve the American people well.

The FY 1996 budget for the Department of Health and Human Services (HHS), including the Social Security Administration (SSA), totals \$716 billion in outlays, an increase of 7.5 percent over FY 1995. The discretionary portion of our budget totals \$37 billion for FY 1996. Within that level, we have held overall growth to 4 percent, while increasing funding for program priorities by more than 10 percent. Those priorities include: programs that help children and working families; biomedical and behavioral research; HIV/AIDS; and chronic substance abuse. Our budget also ensures that HHS will continue to improve its services to our customers today and in the future, by increasing efficiencies, investing in new technologies, protecting against waste, fraud and abuse, and advancing our agenda to improve this nation's health and welfare systems.

Our FY 1996 plan includes a "down-payment" on our next phase of Reinventing Government, including program consolidations and restructuring. Over the coming weeks, we plan to unveil more details for the second phase of reinventing HHS.

Our FY 1996 budget also identifies ways to cut spending right now. In FY 1995, we plan to rescind \$51 million, primarily in those lower priority areas where the President requested reductions last year and where we are proposing lower levels for FY 1996. We believe that these rescissions will not prevent the affected agencies from accomplishing their program missions for FY 1995.

STREAMLINING AND RESTRUCTURING HHS

Through its Reinventing Government initiative, this Administration is creating a government that works better and costs less. As part of this effort, we are rethinking our business at HHS, making sure that our programs work well and achieve their intended results. Four major initiatives resulting from this process include: consolidating our programs; reinventing our processes; restructuring our field operations; and streamlining our workforce.

Consolidating Programs into Performance Partnerships

One way to improve program management is to consolidate numerous categorical grant activities into fewer and more simplified programs. State and local communities are on the front lines when it comes to serving the needs of the American people. In FY 1996, our proposals for Performance Partnerships will improve the ability of States and communities to coordinate and target resources to meet local needs, while continuing to ensure that broad Federal priorities are addressed. These new programs will lessen the burden on States, allowing them to concentrate less on program applications and more on program performance.

As part of the FY 1996 budget, PHS is proposing to consolidate 108 program activities into 16 Performance Partnerships. These partnerships are proposed for the Centers for Disease Control (CDC), the Health Resources and Services Administration (HRSA), and the Substance Abuse and Mental Health Services Administration (SAMHSA). They are expected to save an estimated 230 FTE and \$15 million in administrative costs in FY 1996, and 700 FTE and \$218 million over the next five years.

The Administration for Children and Families (ACF) has already made progress on consolidations by centralizing its child care programs under the Child Care Bureau, which now serves as a single point of contact on child care issues. To ensure consistency and coordination among all HHS child care programs, ACF is proposing to consolidate three child care-related programs into the Child Care and Development Block Grant. In the FY 1996 budget, ACF is also planning to consolidate three separate programs that address the problems of runaway and homeless youth into a single funding source.

Re-Engineering Processes

Our Continuous Improvement Program is examining opportunities to make HHS even more customer-focused and results-oriented. For example, the Health Care Financing Administration (HCFA) is radically redesigning the processing of health care bills through its Medicare Transaction System, which will replace the current 14 systems and result in significant administrative savings. The National Institutes of Health (NIH) is improving efficiencies in its grants peer review process, and the Food and Drug Administration (FDA) is consolidating its regional laboratories.

Restructuring Operations in the Field

As we re-engineer our processes, we must also re-examine our structures. One major change will take place in March 1995 when SSA will become an independent agency. As SSA leaves, it will take with it almost 50 percent of our staff, including much of our regional staff. We have started to make some changes consistent with this departure. For example, we plan to transform our regional administrative offices into field offices. In the future, these offices will house only those functions that are mission-critical, including program oversight, compliance and integrity functions, and customer service activities. Overhead functions will be eliminated, and administrative responsibilities decentralized to the agencies. This restructuring will save an estimated 54 FTE in 1996 and \$24 million. As we approach the second phase of Reinventing Government, we will continue to explore ways to consolidate our activities in the field, realigning our structure and operations to best serve the needs of the American people.

Streamlining the HHS Workforce

Our reinvention efforts have helped us to dramatically streamline our workforce. We are making progress on our plan to reduce our headquarters functions by 41 percent, cut our control functions (personnel, budget, acquisition, and accountants/auditors) by 18 percent, and double the ratio of employees to supervisors. These changes will save 7,960 FTE over the next five years, bringing HHS in line with the President's plan to shrink the Federal government to its smallest size in 30 years.

STRENGTHENING OUR PARTNERSHIPS

A responsive government forges stronger partnerships with States and communities to get closer to the people it serves. Our FY 1996 budget plan builds on and strengthens our existing partnerships by supporting State innovations in Medicaid and AFDC, sharing the cost of providing services to undocumented individuals, improving our health care data, and supporting State and community efforts to prevent violent crime.

Supporting State Innovation in Health Care and Welfare

We recognize that States need to be able to explore new approaches to address the needs of their Medicaid and AFDC populations. Accordingly, over the past two years, HHS has approved seven major state-wide health care reform waivers and 24 state welfare reform waivers, more than any previous Administration. HHS has relied, and will continue to rely, on States as laboratories to find better and more efficient ways to provide health care for the uninsured, and to encourage self-sufficiency for those in need of support.

Health care reform waivers increase State flexibility to improve services, implement more cost-effective systems of care, and expand coverage to the uninsured.

The four States where demonstrations are underway have already expanded coverage to over 530,000 uninsured beneficiaries not otherwise eligible for Medicaid. If the waivers are fully implemented in all States, this number could reach 2,000,000. Under the demonstrations, States are able to take advantage of savings from cost control measures, such as managed care, to expand coverage. HHS has worked closely with the States to ensure that the waivers not only save the States money, but control Federal costs as well. State innovations have helped to hold Medicaid growth to 8.7 percent in FY 1996.

Our welfare reform demonstration waivers have supported State and local initiatives to help welfare recipients achieve self-sufficiency. HHS is committed to making the waiver process more efficient, giving States more flexibility to manage programs while maintaining high quality for our beneficiaries. Within the past six months, HHS has approved nine welfare reform demonstration waivers. States with approved waivers are experimenting with approaches to help families leave the welfare rolls, including: providing education and work incentives; setting time limits on benefits; and increasing asset disregards. Those initiatives that are most successful in helping people achieve self-sufficiency hold important lessons for our own efforts "to end welfare as we know it."

Providing Assistance to States for the Costs of Undocumented Individuals

The Administration recognizes that some States are especially burdened by the costs of illegal immigration. As part of a more comprehensive plan to fulfill the Federal responsibility to manage the immigration system and help those States with the largest populations of undocumented immigrants, the FY 1996 budget proposes \$150 million in new discretionary health grants. These grants will provide relief to those States that face disproportionately high costs associated with providing emergency medical services to undocumented immigrants.

HHS-Wide Data Initiative

The health reform debate has highlighted the need for core health data to measure health program and performance outcomes and track the level of current health problems in our communities. Since these data are critically important to us and to our State partners as we plan for health reform, HHS is requesting \$20 million to boost its data capacities in FY 1996.

Violent Crime Prevention Programs

We must work together to stop the wave of violent crime sweeping across this country. The programs in the Crime Bill balance prevention and punishment efforts to combat crime. Our FY 1996 budget requests \$144 million for programs that help communities strengthen their prevention efforts. These programs will focus on creating economic partnerships, developing before-and-after school activities, promoting education, and preventing violence. HHS plans to distribute these funds through competitive grants to non-profit community-based organizations, through demonstration grants, and through formula grants to States.

WORKING HARDER TO BETTER SERVE THE AMERICAN PEOPLE

The American people entrust the Federal government with their tax dollars. We must live up to that trust -- not only by delivering the highest quality services possible, but by fighting waste, fraud and abuse. Our FY 1996 budget concentrates resources in those areas that have high potential for returns, including investigations and audits within the Office of Inspector General, program integrity initiatives, and survey and certification activities.

Revised Baseline Estimates Show Unexpected Savings

Actuarial estimates project Medicare and Medicaid costs to be significantly lower than projected just two years ago. Under this Administration, anticipated spending between 1994 and 1998 on Medicare and Medicaid will drop by \$212 billion. The projected growth rate in Medicare has dropped from an average of 11.9 percent per year to an average of 9.9 percent per year, saving \$79 billion over five years. Expected growth in Medicaid has fallen from 13.9 percent per year to 8.7 percent per year, saving an additional \$133 billion.

There are several reasons why the Medicare and Medicaid baselines are coming down. The President's successful economic program curbed both general and health inflation, providing the foundation for slower growth. Program efficiencies and changes to limit inappropriate financing schemes have also helped to bring down costs.

Protecting Against Waste, Fraud and Abuse

Last year, the HHS Inspector General's Office executed a record number of successful prosecutions and sanctions, and helped coordinate one of the largest health care fraud settlements in history. This year, with a FY 1996 program level of \$102 million, the Office of the Inspector General will focus on Medicare and Medicaid, child support collection, and Public Health Service delivery programs. In 1994, the return on investment has reached \$80 dollars saved for every OIG budget dollar spent -- an activity well worth the investment.

Ensuring Program Integrity

Every day, millions of elderly and disadvantaged people rely on Medicare and Medicaid to meet their critical health care needs. In turn, every American who helps finance these health programs relies on HCFA to protect them from waste, fraud and abuse. We must make our best efforts to ensure that every dollar of these programs is well spent. HCFA is committed to further improving its oversight and enforcement activities, which currently realize a return of \$6 to \$8 for every dollar invested. As part of the next phase of reinventing government, HHS will propose new and innovative ways for HCFA and the IG to prevent and detect fraud and abuse.

Advancing Technology

Over the past two years, SSA has been aggressively addressing the workload backlogs caused by the rising number of disability applications. The FY 1996 budget requests \$534 million to further the Administration's investment in the State Disability Determination Services and other components of disability processing. The additional funds will allow SSA to more than double its FY 1994 level of effort for processing continuing disability reviews.

To support projected workload increases, the FY 1996 budget request also includes \$357 million for SSA to continue its \$1.1 billion, five-year investment in automation. The Intelligent Workstation Local Area Network initiative is the key strategic investment to improve efficiency and service in SSA. Together, the disability and automation initiatives are critical to SSA's ability to provide quality customer service now and in the future.

Providing high quality medical and consumer services to its 70 million beneficiaries is HCFA's highest priority. With the "graying" of America, the number of beneficiaries HCFA serves will continue to grow. Technology must be developed now if we are to guarantee consumer awareness and satisfaction, develop better delivery of health care services, and improve outreach to vulnerable populations in the future. That's why the FY 1996 budget provides \$10 million to assist Medicare and Medicaid beneficiaries in making more informed choices and avoiding expensive, unnecessary treatments.

Improving the Quality of Services to Native Americans

For the first time in any Administration, Native Americans and Alaska Natives were invited to participate in the formulation and prioritization of our spending on their behalf. While we have seen significant improvements, the health status of American Indians and Alaska Natives continues to lag behind that of all Americans. Tribes and Tribal organizations have been contracting for an increasing number of hospitals, outpatient facilities and other services. The FY 1996 budget requests an additional \$107 million in budget authority for health services, primarily to staff four new facilities opening in FY 1996, and meet other operating expenditures. This request includes a \$17 million, or 11 percent, increase in support costs for new contracts to Tribal organizations. These investments will help the IHS to keep pace with the increasing costs of providing health care, and to expand access to care in underserved areas.

Guaranteeing the Safety of our Food and Drugs

FDA is responsible for the safety and effectiveness of human drugs and medical devices entering the U.S. marketplace. Already, FDA has met or exceeded many of its performance goals for future years by approving drugs 21 percent faster, and medical devices 50 percent faster, in 1994 than in 1993. The FY 1996 budget requests additional funding to accelerate the review and approval of new medical devices, improve the efficiency of FDA's regulatory compliance program for imported products, and ensure that all medical facilities comply with the Mammography Quality Standards Act.

Improving Care for Older Americans

The FY 1996 request for the Administration on Aging includes an \$19 million increase to provide grants to States and Indian Tribal organizations to improve home and community-based care services for older Americans. The additional funds will give States the capacity to develop or build systems that track and target service delivery, develop and use performance measures, and more effectively coordinate Older Americans Act programs and other long-term care services for vulnerable populations.

INVESTING IN THE FUTURE: SETTING PRIORITIES

The FY 1996 HHS budget contains funding increases in four significant areas: children and families; biomedical and behavioral research; HIV/AIDS; and chronic substance abuse.

Continuing Our Commitment to Children and Families

This Administration believes that the best way to invest in our future is to invest in our children and families. Responding to their needs, our FY 1996 budget proposes significant increases in spending for childhood immunization, Head Start, and Child Care.

The Administration's unwavering commitment to childhood immunization is reflected in the highest immunization rates for basic vaccines for children under two in our history. The FY 1996 budget requests \$844 million to help the nation's Childhood Immunization program meet its goal of immunizing 90 percent of this nation's children by the year 2000. These funds will help purchase a full series of vaccines for an estimated 346,000 children whose families might otherwise be unable to afford it, and will help communities throughout this nation improve access to immunization services.

Consistent with the recommendations of the Head Start Advisory Committee and the changes in the Head Start Reauthorization Act of 1994, the FY 1996 budget for Head Start requests an increase of \$400 million. This is an 11 percent increase over the FY 1995 level. This increase will create 32,000 new opportunities for part-day programs, and expand current part-day slots to full-day, full-year places that meet the needs of working families. Funds will also support 10,000 new Head Start slots for children ages 0-3, bringing the total number of children under the age of 3 served by this program to 25,000. The Head Start program will continue to improve quality and responsiveness while emphasizing a more family-centered approach.

The Administration has long recognized that child care is essential for working families and families striving to become self-sufficient. To support them, the FY 1996 budget requests an increase of \$100 million for the Child Care and Development Block Grant. In 1993, over 700,000 children were served through this program, enabling parents to pursue work and training activities. The additional \$100 million will allow States to improve the quality and availability of child care for low-income families.

Advancing Biomedical and Behavioral Research

Biomedical and behavioral research is critical to furthering our knowledge of the causes of disease. The FY 1996 budget request for the NIH is \$11.8 billion -- an increase of \$468 million, or 4.1 percent, over FY 1995. This additional funding will be used to target high priority research areas, increase spending on research with potential to yield the highest returns, and continue our commitment to basic research.

Almost one-third of this increase will be targeted to several key areas: HIV/AIDS research, breast cancer and other women's health research, minority health research, and tuberculosis. About 25 percent of the increase will go to biomedical research in areas such as brain and brain disorders, gene therapy, musculoskeletal diseases, DNA sequencing, and other areas that offer great potential to yield high returns. Much of the remaining increase will support NIH's continued emphasis on basic research.

The \$426 million request for breast cancer research is targeted toward a multi-faceted and coordinated program. As a result of our continued investment in this area, the BRCA-1 gene, which is linked to breast cancer, was discovered last year. But more must be done. The Administration remains committed to further progress against this disease. Additional funds will allow NIH to initiate new studies identifying risk, and to develop new diagnostic approaches to improving breast imaging. We will continue our support for the Secretary's National Action Plan on Breast Cancer, which emphasizes early detection and information dissemination.

Strengthening Efforts Against HIV/AIDS

As the number of children, adolescents, and adults living with the human immunodeficiency virus (HIV) and AIDS continues to grow, funds to battle AIDS and HIV infection become more critical. AIDS has now become the eighth leading cause of death overall, and the number one cause of death for Americans between the ages of 25 and 44. The FY 1996 budget includes nearly \$3 billion for PHS HIV/AIDS-related discretionary activities. This is an increase of approximately \$200 million, or 7 percent, over the FY 1995 level.

The Administration's efforts against HIV/AIDS include expanding National Institutes of Health (NIH) research efforts by 5 percent, or \$73 million, in FY 1996. More than half of the requested HIV/AIDS increase in FY 1996 will be used to support basic science research. As well as increasing our understanding of the HIV disease, basic research on HIV/AIDS is expected to have a significant impact on research in non-AIDS areas.

The Ryan White Comprehensive AIDS Resources (CARE) Act is central to the Administration's efforts to work with States and communities to improve the quality and availability of emergency relief services for individuals and families with HIV and AIDS. The FY 1996 budget requests \$723 million for Ryan White HIV/AIDS activities, an increase of \$91 million over the FY 1995 level. This increase will provide funds to the estimated 10-14 newly eligible communities, and will guarantee that communities continue to receive the same formula grants they received in 1995.

Treating Chronic Drug Abuse

The chronic drug user is a significant contributor to crime and violence in this country. To address the most serious and hard-to-reach population of substance abusers, the FY 1996 budget includes an increase of \$60 million in Substance Abuse Performance Partnerships, which may be used for the treatment of chronic drug abusers. In addition, \$40 million will be redirected to fund the consolidated Substance Abuse Demonstration and Training programs available to States to evaluate the program impacts on target populations.

WELFARE REFORM AND HEALTH CARE REFORM

Last year, the Administration introduced the Work and Responsibility Act of 1994 -- a comprehensive plan to "end welfare as we know it." Our approach to fixing the broken welfare system is based on the fundamental principles of providing education, job training and child care, and in return, demanding work and responsibility. We believe in the importance of time limits, job placement assistance and training, tough child support enforcement, teen pregnancy prevention, and State flexibility. These provisions will help to break the cycle of dependency, while promoting the well-being of the nation's children and families. The Administration is committed to working with the new Congress to enact a bill that will embody these principles and produce real, lasting reform.

This Administration remains committed to expanding health insurance coverage for every American, and to containing health costs for families, business and governments. We look forward to working with Congress to achieve this goal.

HHS BUDGET BY OPERATING DIVISION

(Dollars in millions)					
	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
Public Health Service					
BA	\$21,566	\$22,203	\$22,172	\$22,938	+\$766
Outlays	19,760	21,830	21,818	22,415	597
Health Care Financing Administration					
BA	\$252,639	\$262,178	\$262,158	\$286,739	+\$24,581
Outlays	244,528	265,863	265,863	294,082	+28,219
Social Security Administration					
BA	\$404,425	\$428,775	\$424,885	\$448,573	+23,718
Outlays	346,623	360,189	364,385	384,288	19,903
Administration for Children and Families					
BA	\$33,313	\$32,392	\$32,818	\$34,469	+\$1,651
Outlays	29,453	32,533	32,815	34,105	+1,290
Administration on Aging					
BA	\$878	\$877	\$877	\$897	+\$20
Outlays	\$860	\$868	\$868	\$880	+12
Departmental Management					
BA	\$135	\$136	\$136	\$134	(\$2)
Outlays (Federal Funds)	\$141	\$185	\$185	\$105	(80)
Office for Civil Rights					
BA	\$22	\$22	\$22	\$21	(\$1)
Outlays (Federal Funds)	\$18	\$18	\$18	\$18	-
Office of Inspector General					
BA	\$100	\$100	\$100	\$102	+\$2
Outlays (Federal Funds)	\$62	\$64	\$64	\$68	+4
Receipts					
BA	-\$17,747	-\$20,122	-\$20,122	-\$20,198	-\$76
Outlays	-17,747	-20,122	-20,122	-20,198	76
FY 1994 Emergency Supplemental					
BA	\$43	-	-	-	-
Outlays	20	-	-	-	-
TOTAL, HHS					
BA	\$695,331	\$726,561	\$723,016	\$773,675	\$50,659
Outlays	623,718	661,428	665,894	715,765	49,871
<i>Full-time Equivalents . . .</i>	<i>127,362</i>	<i>127,211</i>	<i>127,211</i>	<i>125,445</i>	<i>-1,766</i>

COMPOSITION OF THE HHS BUDGET

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
<u>Entitlement Programs (outlays):</u>					
Social Security	\$319,570	\$331,712	\$336,159	\$356,082	+\$19,923
Medicare	\$159,542	\$174,476	\$174,475	\$194,806	+\$20,331
Medicaid	\$ 82,034	\$ 88,438	\$ 88,438	\$95,930	+\$7,492
Supplemental Security Income	\$26,281	\$27,752	\$27,504	\$27,528	+\$24
Family Support Payments to States	\$16,508	\$16,921	\$17,260	\$17,918	+\$658
Foster Care and Adoption Assist.	\$3,030	\$3,363	\$3,596	\$4,051	+\$454
Social Services Block Grant ..	\$2,728	\$3,240	\$2,996	\$3,343	+\$347
JOB Opportunities and Basic Skills	\$839	\$1,031	\$937	\$943	\$6
State Legalization Impact Assist. Grts	\$652	\$244	\$356	\$5	-\$351
Benefits for Disabled Coal Miners	\$772	\$724	\$722	\$678	-\$44
Family Support and Preservation	\$1	\$131	\$67	\$148	+\$81
Other	\$358	\$444	\$444	\$456	+\$12
Less Medicare receipts	-\$17,747	-\$20,122	-\$20,122	-\$20,198	-\$76
Less Administrative Costs ...	-\$4,432	-\$4,910	-\$4,803	-\$5,250	-\$447
 SUBTOTAL, Entitlement Programs					
Outlays	\$590,136	\$623,444	\$628,029	\$676,438	\$48,410
Percent of Total Outlays ...	95%	94%	94%	95%	
 <u>Discretionary Programs (Budget Authority)</u>					
National Institutes of Health .	\$10,926	\$11,306	\$11,305	\$11,773	+\$468
Other Public Health Programs	\$10,165	\$10,416	\$10,386	\$10,692	+\$306
SSA Limitation on Admin. Expenses	\$2,589	\$3,124	\$3,124	\$3,033	-\$91
HCFA Program Management .	\$2,163	\$2,199	\$2,188	\$2,404	+\$216
Children & Family Services Programs	\$4,220	\$4,404	\$4,431	\$4,922	+\$491
Low Income Home Energy Assistance	\$1,737	\$1,319	\$1,319	\$1,319	-
Grants to States for Child Care	\$907	\$949	\$949	\$1,049	+\$100
Administration on Aging	\$878	\$877	\$877	\$897	+\$20
Community Services	\$464	\$473	\$473	\$417	-\$56
Refugee & Entrant Resettlement	\$400	\$406	\$406	\$414	+\$8
Departmental Management ..	\$112	\$113	\$113	\$110	-\$3
Office for Civil Rights	\$22	\$22	\$22	\$21	-\$1
Office of the Inspector General	\$84	\$84	\$84	\$86	+\$2
Emergency Supplemental ...	\$43	-	-	-	-
 SUBTOTAL, Discretionary Programs					
Budget Authority	\$34,710	\$35,692	\$35,677	\$37,137	+\$1,460
Outlays	\$33,581	\$37,985	\$37,867	\$39,326	+\$992
Percentage of Total Outlays	5%	6%	6%	5%	
 TOTAL, HHS OUTLAYS ...	\$623,718	\$661,428	\$665,894	\$715,762	+\$49,869

PHS SUMMARY

(Dollars in millions)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
<u>Discretionary</u>					
Food and Drug Administration .	\$934	\$975	\$975	\$1,025	+\$50
Health Resources and Services					
Administration	2,947	3,082	3,053	3,105/1	+52
Indian Health Service	2,124	2,176	2,176	2,274	+98
Centers for Disease Control					
and Prevention	2,148	2,186	2,185	2,304	+119
National Institutes of Health . . .	10,937	11,317	11,316	11,784/1	+468
Substance Abuse & Mental Health					
Services Administration	2,150	2,195	2,195	2,244	+49
Agency for Health Care Policy					
and Research	154	163	163	194	+31
Office of the Assistant					
Secretary for Health	67	67	67	66	-1
Less Intra-agency Transfers . . .	<u>-42</u>	<u>-45</u>	<u>-45</u>	<u>-87</u>	<u>-42</u>
 SUBTOTAL, PHS Discretionary					
Program Level	\$21,419	\$21,116	\$22,085	\$22,909	+\$824
 Offsets	<u>-328</u>	<u>-394</u>	<u>-394</u>	<u>-444</u>	<u>-89</u>
 TOTAL, PHS Discretionary					
Budget Authority	\$21,091	\$21,722	\$21,691	\$22,465	+\$774
 TOTAL, PHS Entitlement					
Budget Authority	<u>\$475</u>	<u>\$481</u>	<u>\$481</u>	<u>\$473</u>	<u>-\$8</u>
 TOTAL, PHS Budget Authority	\$21,566	\$22,203	\$22,172	\$22,938	+\$766
FTE	52,561	51,925	51,925	51,381	-544

/1 Reflects \$15 million transfer from NIH to HRSA for the Bone Marrow Donor Registry.

FOOD AND DRUG ADMINISTRATION

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
Program Level	\$934	\$975	\$1,025	+\$50
Budget Authority	873	884	883	-1
<i>FTE/1</i>	<i>9,342</i>	<i>9,510</i>	<i>9,592</i>	<i>+82</i>

1/ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Food and Drug Administration (FDA) is \$1.0 billion in program level spending, \$142 million to be derived from targeted, industry-specific user fees. FDA plans to build on the success of the Prescription Drug User Fee Act by proposing two new additive user fees--medical device user fees and FDA regulated products import user fees. These new fees would permit FDA to accelerate the review and approval of new medical devices and reduce risks from harmful products reaching the marketplace through imports. Both new fees require Congressional authorization. Under the FY 1996 request,

total budget authority will be maintained at approximately the FY 1995 level; however, because of the elimination of one-time FY 1995 construction costs, an increase of \$10 million is available to retain priority scientific and investigative staff capabilities.

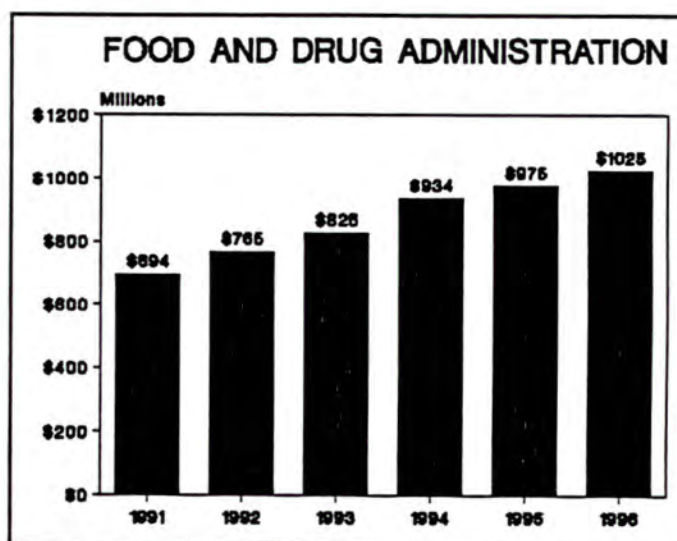


Figure 1

Prescription Drug User Fees

The Prescription Drug User Fee Act, first implemented in 1993, has been highly successful in enabling FDA to significantly accelerate approval of safe and effective human drugs. Already, FDA has met or exceeded many of the Act's performance goals for future years. FDA has succeeded in clearing 90 percent of the backlog of overdue applications by the end of FY 1994 and reviewing and acting upon 65 percent of FY 1993 applications within 12 months of receipt. The latter achievement already exceeds the FY 1995 performance goal of 55 percent. The final performance goals, to be reached by FY 1997, remain far above the

current level of achievement. To sustain momentum toward reaching these goals, the FY 1996 budget includes \$85 million in user fees, a 7 percent increase. This will provide for an additional 100 review staff.

Medical Device User Fees

With the successes in accelerating the approval of new prescription drugs, FDA will now turn attention to pursuing similar advances in the medical device field. The current average review time for a medical device application--ranging from 12.5 months for a pre-market approval application to 6 months for a premarket notification--still has room for improvement. To eliminate the current backlog and to reduce the time it takes to approve medical device applications, FDA is proposing to incorporate the concepts embodied in the effective Prescription Drug User Fee Act into the medical devices field. The FY 1996 budget request includes an additional \$24 million and 109 reviewers to accelerate approval of safe and effective medical devices to ensure their availability for the American public. Since 1984, the number of medical device applications has increased by 34 percent. FDA will work with this Congress and the industry to devise a suitable fee structure.

Import Inspection Enhancement

FDA is requesting the authority to collect \$15 million in additive fees to improve the effectiveness and efficiency of its regulatory compliance program for imported products. This new user fee proposal will provide FDA the resources necessary to substantially reduce the risk posed by potentially harmful goods and other products reaching the American marketplace through import channels. The import fees will expand and enhance the operation of OASIS--the Operational and Administrative System for Import Support--which will provide FDA with immediate data on which products are being imported, by whom, and where and when they are arriving. The system will permit greater coordination with the United States Customs Service. Similar to the Justice Department's "ENFORCE" system, which tracks entry or attempted entry of aliens, OASIS will allow FDA to immediately identify rejected shipments attempting to enter through a different port, identify which shipments are from statistically problematic importers in need of particular scrutiny, and highlight for action imports from troublesome ports-of-call. For example, during an FY 1994 pilot of the OASIS system, a shipment of falsely labeled mushrooms contaminated with bacterial toxins was found at one port. Because the system was in place, additional shipments at a number of other ports also were discovered.

Mammography Quality Standards Act

On October 1, 1994, FDA certified over 10,000 mammography facilities nationwide. FDA will focus its energies in FY 1996 on ensuring that all facilities are meeting the quality standards for mammography. During FY 1995, for the first time, certified personnel will be inspecting over 7,000 facilities. In FY 1996, FDA will ensure that deficiencies identified during the FY 1995 inspections are corrected. To achieve these goals, the FDA request

includes \$26 million for implementing the Mammography Quality Standards Act, of which \$13 million is to be collected in fees from inspected facilities, as authorized by the Act.

Streamlining

While overall staffing in FDA shows a slight increase, those financed from non-user fee supported activities will decline by 2 percent. FDA is able to absorb these decreases because it has begun a number of initiatives which will improve FDA operations. For example, FDA has undertaken the Administrative System Automation Project (ASAP) as one of its strategic information systems initiatives. ASAP will reduce administrative costs, generate more timely reports, improve data integrity, improve communications, expedite reviews and actions and eliminate redundant systems.

FDA OVERVIEW

(Dollars in millions)				
	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1996 Request</u>	<u>Request +/-Enacted</u>
Salaries & Expenses:				
Foods	\$213	\$215	\$233	+\$18
Drugs	422	447	456	+9
Medical Devices	159	166	199	+33
National Center for Toxicological Research	35	35	35	—
Program Management	<u>43</u>	<u>43</u>	<u>43</u>	<u>—</u>
Subtotal, Salaries & Expenses . .	\$872	\$906	\$966	+\$60
GSA Rental Payments	49	46	46	—
Buildings & Facilities	8	18	8	-10
Revolving Fund	<u>5</u>	<u>5</u>	<u>5</u>	<u>—</u>
SUBTOTAL, FDA Program Level	\$934	\$975	\$1,025	+\$50
Less User Fees:				
Prescription Drug	\$56	\$79	\$85	+\$6
Medical Devices	—	—	24	+24
Import Inspection	—	—	15	+15
Mammography	—	7	13	+6
Revolving Fund	<u>5</u>	<u>5</u>	<u>5</u>	<u>—</u>
Subtotal, User Fees	\$61	\$91	\$142	+\$51
TOTAL, FDA Budget Authority	\$873	\$884	\$883	-\$1
FTE	9,342	9,510	9,592	+82

HEALTH RESOURCES AND SERVICES ADMINISTRATION

(Dollars in millions)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
Program Level	\$2,947	\$3,082	\$3,053	\$3,105	+\$52
Budget Authority	2,940	3,073	3,044	\$3,099	+55
FTE/1	2,536	2,213	2,213	2,064	-149

1/ The 1996 request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Health Resources and Services Administration (HRSA) is \$3.1 billion, a net increase of \$52 million, or two percent, above FY 1995.

As part of the government-wide reinvention effort, the HRSA request consolidates 50 categorical programs into nine. Major program consolidations are proposed in the health services and health professions programs. These program clusters will provide grantees with greater flexibility in managing their programs and streamline the need for Federal administrative resources.

The FY 1996 request continues the Administration's commitment to treat those infected with HIV/AIDS by including a \$91 million increase in funding for Ryan White AIDS programs. In addition, a \$6 million increase is proposed for family planning. With few exceptions, most other HRSA programs are maintained at the FY 1995 level.

The FY 1995 revised budget reflects a proposed rescission of \$29 million from categorical health professions programs and facilities construction.

Health Services Clusters

The FY 1996 request calls for consolidating 13 health services programs into 4 clusters as part of a re-inventing government effort. These clusters will enhance the ability of communities to bring together resources from multiple sources and use them to improve the health of their populations and close the gaps in the health status of vulnerable populations, while maintaining important relationships with the range of institutions that make up service delivery systems. Tables are included which show how these programs will be consolidated.

- The Health Centers cluster consolidates four HRSA programs which provide grants to local health centers--Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Health Care for Residents of Public Housing. This proposal recognizes the important roles played by a diverse health delivery system and provides these grantees with greater flexibility in applying the funds to community needs, while eliminating the need to prepare multiple HRSA grant applications. The new program will continue to provide accessible, quality health care services to 7.7 million individuals in over 720 sites nationwide.
- The Rural Health cluster addresses the distinctive needs of rural America. Nearly one fourth of all Americans are rural residents; and because of where they live, they often lack adequate health care. Two programs will be merged into one.
- The Emergency Medical Services (EMS) cluster consolidates two programs which currently address specific areas of EMS service, namely children's services and trauma services. This new cluster will continue to address the special needs of children in EMS and the problems of trauma patients and will work to improve the EMS system such that all patients are accorded a high level of care in a comprehensive and integrated manner.
- The Special Populations cluster recognizes the unique and special needs of other specific groups and will reduce existing barriers which prevent special populations--e.g., Native Hawaiians and Black Lung patients--from receiving the special assistance they require.

Health Professions Clusters

The FY 1996 budget request for health professions programs of \$389 million proposes a fundamental re-shaping and refocusing in the way support for health professions training and curriculum assistance is allocated. The health professions consolidations merge 36 separate programs into five clusters over a period of three years. Creating new performance partnerships will strengthen and provide flexibility in the Nation's capacity to address health professions shortages and re-tool the Nation's health care personnel resources to meet the challenges of ever-changing health care delivery systems. The clusters will enhance our ability to assist students financially, encourage expansion of multi-disciplinary, outcome-oriented primary care training, as well as bring simplicity to the administrative processes of application submission and grant issuance. Tables are included which show how these programs will be consolidated.

- The Health Professions Workforce cluster will merge six student assistance programs into one program, providing student assistance through obligated financial assistance, non-service subsidized loans, and non-service market rate loans as well as focus on national workforce research and data efforts. This cluster will include the entire National Health Service Corps.
- The Enhanced Area Health Education Training cluster incorporates eight categorical programs into one program which will require the formation of consortia to link

educational systems with States, communities and employers to expand the operation of interdisciplinary, outcome oriented training.

- The Minority and Disadvantaged Health cluster consolidates eight programs into one program which will support targeted, outcome oriented activities that increase the number of minority and disadvantaged health professionals. This program will help address the President's Executive Order to advance the development of human potential and strengthen the capacity of Historically Black Colleges and Universities. This cluster will eliminate restrictive eligibility and project requirements while increasing flexibility in responding to minority and disadvantaged health professions needs.
- The Primary Care Medicine and Public Health Training cluster consolidates nine programs. This program will fund comprehensive, flexible, and effective activities that will increase the number and enhance the quality of primary medical care providers and public health workers in order to meet national, state, and local health care needs.
- The Nursing Education Practice Initiatives cluster combines six programs into three activities focusing on basic nurse training, advanced practice nurse training, and workforce diversity.

The budget includes a proposal to rescind \$27 million--the amount the Congress added last year for health professions. This reduction will be applied to nearly all programs. In addition, the budget includes a proposal to rescind \$2 million from the Medical Facilities Construction program.

Ryan White

The FY 1996 President's Budget continues the Administration's commitment to improve the quality and availability of care for individuals and families with HIV and AIDS. The FY 1996 request for Ryan White AIDS activities is \$723 million, a \$91 million, or 14 percent increase over the 1995 level. This request includes an additional \$51 million for Emergency Relief for Cities (Title I) to ensure that each of the 42 metropolitan communities funded in 1995 will receive the same formula grant as well as provide funds to any newly eligible communities (estimated to be 10-14). To

accomplish this, legislation is being proposed to permit the reallocation of funds between the formula and competitive portions of Title I. Included in the request is a 12 percent increase for formula grants to States to improve services in areas with critical gaps for underserved and hard to reach populations as well as to augment States' flexibility in selecting

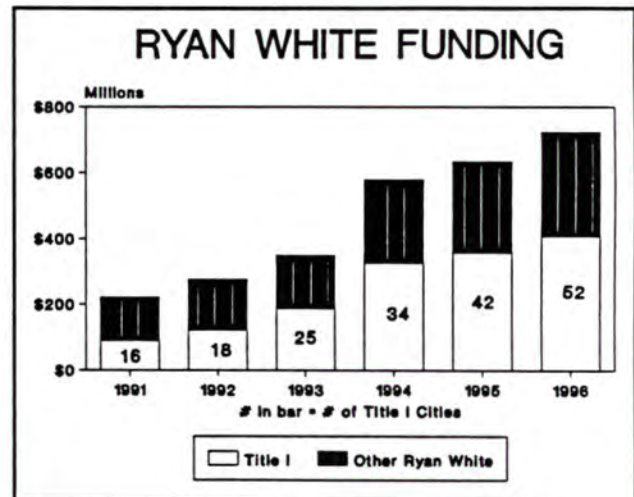


Figure 1

pharmaceuticals. A 20 percent increase is requested in discretionary grants to allow an additional 10,600 individuals who are infected with, or at-risk of, HIV infection to receive primary care services. The 23 percent increase provided for Title IV will provide enhanced services for preventing maternal HIV transmission.

Family Planning

The FY 1996 budget request also includes \$199 million for the Title X Family Planning program, an increase of \$6 million, or three percent, over FY 1995. This program provides services to approximately 4 million persons, primarily women and adolescents, in over 4,000 clinics nationwide. The funds will increase outreach to underserved individuals, place an emphasis on comprehensive reproductive health services, and focus on adolescent pregnancy and sexually transmitted disease prevention.

Other HRSA

For the remaining HRSA programs, a total spending reduction of \$40 million is proposed. Included are Healthy Start, Maternal and Child Health Block Grant, the Malpractice Databank, Rural Health Research, and Medical Facilities Construction. Faced with overall discretionary spending limitations, reductions of this magnitude are being proposed. In the case of the Medical Facilities Construction, the \$13 million in FY 1995 represents one-time construction grant costs.

HRSA OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
HEALTH SERVICES CLUSTER:					
<u>Health Centers Cluster</u>	—	—	—	\$757	\$757
Community Health Centers . .	604	617	617	—	-617
Migrant Health Centers	59	65	65	—	-65
Health Care for the Homeless .	63	65	65	—	-65
Health Care In/Near Public					
Housing	9	10	10	—	-10
<u>Rural Health Cluster</u>	—	—	—	29	+29
Rural Health Outreach	26	27	27	—	-27
State Offices of Rural Health .	3	4	4	—	-4
<u>Emergency Medical Services (EMS)</u>					
Cluster	—	—	—	15	+15
Trauma Care	5	5	5	—	-5
EMS for Children	8	10	10	—	-10
<u>Special Populations Cluster</u> . . .	—	—	—	17	+17
Black Lung	4	4	4	—	-4
Alzheimer's Demonstrations . .	5	5	5	—	-5
Payment to Hawaii	3	3	3	—	-3
Pacific Basin	1	1	1	—	-1
Native Hawaiian Health Care .	4	5	5	—	-5
HEALTH PROFESSIONS CLUSTERS:					
<u>Workforce Development</u>	—	—	—	\$128	+\$128
National Health Service Corps	124	125	125	—	-125
Community Based Scholarships	—	—	—	—	—
Nurse Loan Repayment	2	2	2	—	-2
Other Health Professions	2	2	2	—	-2
<u>Enhanced Area Health Education</u>					
Training	—	—	—	\$39	+\$39
Other Health Professions	47	51	39	—	-39
<u>Minority/Disadvantaged</u>	—	—	—	\$89	+\$89
Other Health Professions	91	95	89	—	-89
<u>Primary Care Medicine & Public</u>					
Health	—	—	—	\$76	+\$76
Other Health Professions	81	81	76	—	-76
<u>Nurse Education</u>	—	—	—	\$57	+\$57
Other Health Professions	61	61	57	—	-57
<i>Health Professions (Non-Add)</i> . .	(282)	(290)	(263)	(—)	(-263)
Ryan White	\$579	\$633	\$633	\$723	+\$91
Other HIV/AIDS Services	23	23	23	23	—
Family Planning	181	193	193	199	6
Maternal and Child Health Block	687	684	684	681	-3
Healthy Start	98	110	110	100	-10
Program Management	124	124	124	123	-1
Medical Facilities Construction .	—	15	13	—	-13

HRSA OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Rural Health Research	\$9	\$13	\$13	\$9	-\$4
Other Services	36	40	40	40	--
Malpractice Databank	8	9	9	6	-3
Less Admin. Savings	--	--	--	-6	-6
SUBTOTAL, Disc. Program Level	\$2,947	\$3,082	\$3,053	\$3,105	+\$52
Offsets	-7	-9	-9	-6	+3
TOTAL, Budget Authority . . .	\$2,940	\$3,073	\$3,044	\$3,099	+\$55
FTE	2,536	2,213	2,213	2,064	-149

Consolidated HRSA Programs
Consolidates 50 Programs into 9 Programs

Health Professions Clusters
Consolidates 37 Programs into 5 Programs

**Health Professions Workforce
Development (\$127.7 M)**

National Health Service
Corps Field Operations
National Health Service
Corps Recruitment
Community Based Scholarships
Nursing Loan Repayment
Health Professions Data Systems
Research on Health Professions
Data Systems

**Enhanced Area Health Education
Training (\$38.8 M)**

Area Health Education Centers
Health Education and Training
Centers
General Dentistry Training
Allied Health Special Projects
Geriatric Education Centers
Rural Health Interdisciplinary
Training
Podiatric Medicine
Chiropractic Demonstrations

**Nurse Education/Practice
Initiatives (\$57.0 M)**

Advanced Nurse Education
Nurse Practitioner/Midwife
Nursing Special Projects
Disadvantaged Nursing
Professional Nurse Traineeships
Nurse Anesthetist Training

**Minority/Disadvantaged
(\$89.4 M)**

Centers for Excellence
Health Careers Opportunity Program
Exceptional Financial Need Scholarships
Loan Repayment for Faculty
Financial Assistance for Disadvantaged
Health Professionals
Loans for Disadvantaged Students
Scholarships for Disadvantaged Students
Minority Faculty Fellowships

**Primary Care Medicine & Public Health
Training (\$75.6 M)**

Family Medicine
General Medicine/Pediatrics
Physicians Assistants
Pacific Basin Medical Officer Training
Public Health Traineeships
Public Health Special Projects
Preventive Medicine Residencies
Health Administration Traineeships
Dental Public Health Training

Health Services Clusters
Consolidates 13 Programs into 4 Programs

Health Centers (\$ 756.5 M)

Community Health Centers
Migrant Health Centers
Health Care for the Homeless
Health Care for Residents
of Public Housing

**Emergency Medical Services
(\$14.8 M)**

Trauma Care
Emergency Medical Services
for Children

Rural Health (\$29.0 M)

Rural Health Outreach
State Offices of Rural Health

Programs for Special Populations (\$ 17.3 M)

Black Lung
Alzheimer's Disease Demonstrations
Pacific Basin
Payment to Hawaii
Native Hawaiian Health Care

INDIAN HEALTH SERVICE

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
Program Level	\$2,124	\$2,176	\$2,274	+\$98
Budget Authority	1,943	1,963	2,059	+96
<i>FTE</i> ^{1/}	15,507	15,425	15,195	-230

1/ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Indian Health Service (IHS) is \$2.3 billion, a 4.5 percent increase over FY 1995. Included in this \$2.3 billion request is \$2 billion for Health Services and \$247 million for Facilities. This level assumes collections of \$210 million from insurance payments for Indian patients, consistent with FY 1995 levels. The FY 1996 request includes full funding for medical and other inflation, pay raises and staffing for the four new facilities opening in FY 1996.

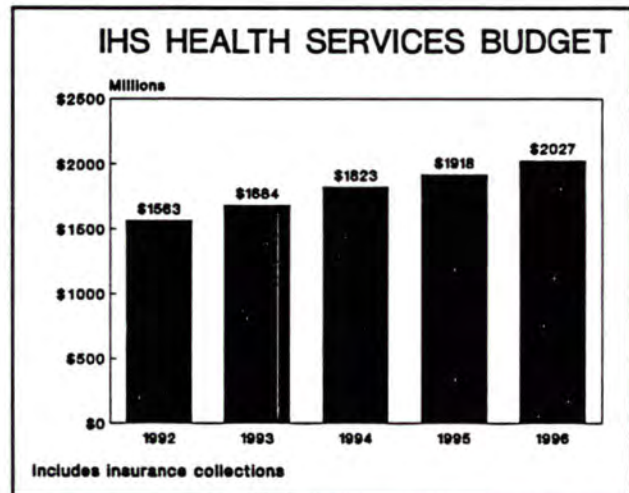


Figure 1

IHS provides medical care to about 1.4 million American Indians and Alaska Natives (AI/ANs) who are members of Federally recognized Indian Tribes. This care is provided directly, through a network of 143 service units, 49 hospitals, and 188 health centers in 34 States and, where not provided directly, care is provided through contracts with other providers. Substantial public and preventative health services are also provided, including alcohol/substance abuse, mental health, and preventive health. In addition, IHS provides education assistance to health professionals willing to work in Indian country and funds urban health grantees in 41 cities.

Health Status

Since 1973, there have been significant improvements in the health status of AI/ANs, including a 42 percent decrease in age-adjusted mortality, a 54 percent decrease in the number of years of productive life lost, and a 20 percent increase in life expectancy at birth. Although AI/AN health status continues to lag behind that of all Americans (e.g., 12 percent greater mortality, a 2-year shorter life expectancy), the gap is narrowing.

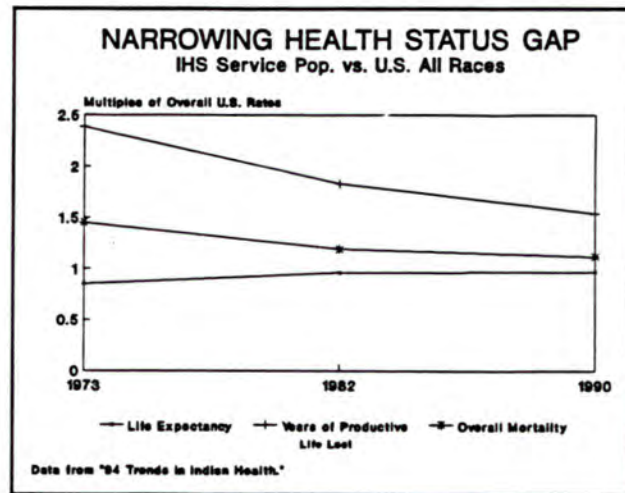


Figure 2

Greater Consultation with Tribes

The President, following an historic meeting with 350 elected Tribal Leaders last April, announced that the head of each government agency shall consult, to the greatest extent practicable, with tribal governments prior to taking any action that would affect them. This is the first IHS budget in which Tribes, through the National Indian Health Board and other groups, have participated in the development and final prioritization of the IHS budget. This consultation process will continue for future IHS budgets, and be expanded to include input on the reinvention of IHS.

Self-Determination

In FY 1995, Tribes and Tribal organizations will contract for the operation of nine of the hospitals and 119 of the health centers providing 14 percent of inpatient days and 36 percent of outpatient visits.¹ One third of the FY 1995 appropriation will be used for contracts and grants with Tribes. Additional contracting and compacting is expected in FY 1996, and, as always, this will be done only at the invitation of the Tribes. Indian Tribes will soon operate most IHS health delivery programs in Alaska, the Pacific Coast States, the eastern U.S., and portions of Oklahoma. In order to ensure that Tribes which wish to do so are able to take over the operation of their health programs, an 11 percent increase is requested for contract support costs (for a total of \$171 million in FY 1996), including \$8 million for the support costs of new contracts through the Indian Self-Determination Fund.

Health Facilities

The FY 1996 Facilities request for IHS is \$247 million, a 4 percent decrease below the FY 1995 appropriation. After accounting for non-recurring construction costs of new

¹ Inpatient and outpatient figures from FY 1993.

facilities which will be completed with FY 1995 funds, the facilities request represents a 2.6 percent increase. The request contains sufficient funds to provide water and waste disposal services to new Indian homes and reduce the backlog of existing homes without such service (\$85 million), as well as complete outpatient facilities at Hayes, MT and White Earth, MN (\$11 million). An additional \$151 million, five percent above FY 1995, is requested to support maintenance and improvement, facilities and environmental health support, and purchase of medical equipment.

Staffing

IHS is requesting a staffing level of 15,195 FTE in FY 1996, two percent less than the FY 1993 baseline figure of 15,507 FTE. By comparison, HHS, in the aggregate, will sustain a five percent reduction between the FY 1993 baseline and the FY 1996 President's Budget. This relief from the average staffing reductions associated with the Federal Workforce Restructuring Act is testament to the high priority the Administration places on providing health services to AI/ANs. To provide this level, larger reductions were taken in other HHS agencies than would otherwise have been expected. IHS plans to take its reductions at the Headquarters and Area Offices levels rather than from staff providing direct health services.

Streamlining

The Director of IHS has developed a restructuring process, with Tribal consultation, to improve and streamline the IHS without adversely affecting the level of health care services provided to the AI/AN. Resources will continue to be shifted from Headquarters and the Area Offices to provide both greater autonomy for the field and staffing for new health facilities. IHS will increasingly contract for auxiliary and support operations (e.g., record keeping, maintenance, housekeeping) leaving Federal staff to concentrate on medical functions. Additional health staff will also be provided by increasing the number of affiliations with universities.

IHS OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
<u>Health Services:</u>				
Clinical Services	\$1,502	\$1,580	\$1,662	+\$82
Preventive Health	74	77	81	+4
Contract Support	142	154	171	+17
Direct Operations	49	50	52	+2
Other	<u>56</u>	<u>57</u>	<u>61</u>	<u>+4</u>
Subtotal, Health Services	\$1,823	\$1,918	\$2,027	+\$109
<u>Health Facilities:</u>				
Facility Construction	\$86	\$28	\$11	-\$17
Sanitation Construction	85	85	85	-
Maintenance & Improvements . .	42	43	44	+1
Facility/Env. Health Support . .	87	89	93	+4
Other	<u>1</u>	<u>13</u>	<u>14</u>	<u>+1</u>
Subtotal, Facilities	\$301	\$258	\$247	-\$11
Total, Program Level	\$2,124	\$2,176	\$2,274	+\$98
<u>Offsets:</u>				
Insurance, Medicare & Medicaid	\$154	\$175	\$176	-\$1
Insurance, private	23	33	34	-1
Rental of Quarters	<u>4</u>	<u>5</u>	<u>5</u>	<u>-</u>
Subtotal, Offsets	-\$181	-\$213	-\$215	-\$2
Total, Budget Authority	\$1,943	\$1,963	\$2,059	+\$96
<u>FTE</u>	<u>15,507</u>	<u>15,425</u>	<u>15,195</u>	<u>-230</u>

CENTERS FOR DISEASE CONTROL AND PREVENTION

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Program Level	\$2,148	\$2,186	\$2,185	\$2,304	+\$119
Budget Authority	2,051	2,088	2,087	2,192	+105
<i>FTE/1</i>	6,752	6,560	6,560	6,445	-115

1/ The 1996 request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 President's Budget request for the Centers for Disease Control and Prevention (CDC) provides a \$2.3 billion level of spending, a net increase of \$119 million, or five percent, over FY 1995.

CDC is the leading public health agency responsible for disease prevention and health promotion efforts. Consistent with the strategies articulated in the Healthy People 2000 report, emphasis is placed on expanding proven prevention services which target improving the health status of all Americans. Special attention is placed on healthy lifestyles at an early age and on preventing costly health problems, particularly those affecting the economically disadvantaged. As CDC moves closer to the millennium, the Agency is focusing on developing measures of prevention effectiveness and health outcomes.

Performance Partnership Grants

The FY 1996 budget proposes to consolidate 32 CDC categorical grant programs into three Performance Partnership Grants. As proposed, these consolidations are designed to increase State flexibility, streamline Federal management, and ensure accountability.

Three new discrete Performance Partnership grants are being shaped--an HIV/STD/TB Grant, a Chronic Disease and Disability Prevention Grant, and an Immunization Grant--from 32 on-going programs. Public Health Departments in the States and local communities are at the forefront of delivering personal health services such as screening, immunizations, etc., as well as protecting the entire community by responding to infectious disease outbreaks, prevention education, etc. The CDC has been a long-term partner with these State and local departments, fostering enhancements and strengthening capacity. With the creation of these new, simplified grants, CDC will be able to extend Federal resources to States with fewer strings attached, with less grant submissions, reviews, and negotiations, and with broader

discretion at the State level to pursue their own priorities. States will be asked to submit a single annual grant application for each grant program.

CDC is proposing a three-year phase-in. During this period, for the HIV/STD/TB grant, States will be given funds for consolidated programs but will be required to maintain the current stream of funds provided for discrete categorical programs. Over three years, the walls will come down between each of the program funding areas. This transition period is proposed to protect critical programs while community constituencies develop well-organized groups to assist in the State planning process. Each of the other grants also will have transition periods. In addition, each of the consolidated grants includes "incentives-based" resource packages to reward performance and exceptional public health programs.

CDC will retain responsibility for research, demonstration, training, and technical assistance programs as well as targeted national programs including: purchasing childhood vaccines, addressing new emerging infectious diseases and environmental health issues, and eliminating child lead poisoning. CDC also will retain the existing Prevention Block Grant. Restructuring of extramural grants programs will save \$6 million in CDC administrative costs in FY 1996.

FY 1996 investments are discussed below within the existing budget structure, and amounts of program budgets being consolidated into Performance Partnership grants are highlighted on a table at the end of this section. The table also displays how each consolidated program is configured.

Childhood Immunization Initiative

It is the President's goal that, no later than the year 2000, at least 90 percent of the nation's two-year-olds will be fully immunized. The Administration believes that States are well on the way towards accomplishing this goal. Between 1992 and 1993 alone, the rate of full immunization of toddlers rose from 55 percent to 67 percent.

To advance the Childhood Immunization Initiative (CII), CDC is seeking an appropriation increase of \$40 million (27 percent) to buy pediatric vaccine for children served in public health clinics who are not eligible to receive vaccine purchased through the Vaccines for Children (VFC) entitlement program. Total Federal spending for Childhood Immunization will be \$844 million in FY 1996, including \$529 million for vaccine purchase and \$315 million for service delivery and infrastructure. Of the total vaccine purchased, \$365 million (69 percent) will be financed through the VFC entitlement and \$164 million (31 percent) through the CDC appropriation. While proposing to save \$72 million in Federal

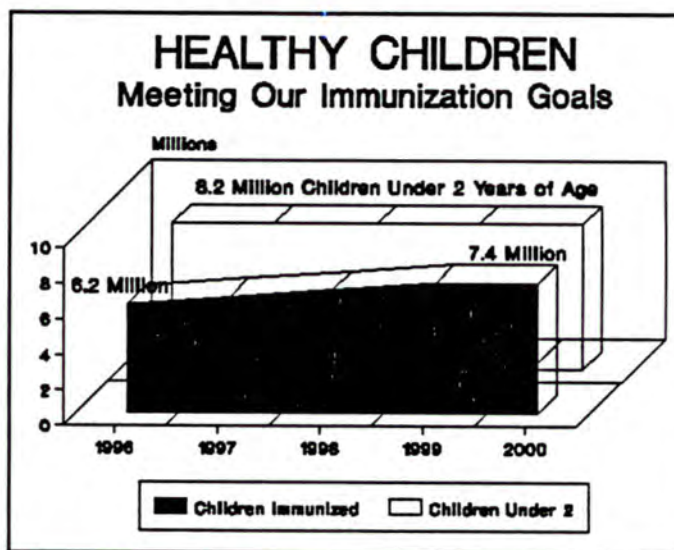


Figure 1

vaccine excise taxes, the FY 1996 budget provides a 14 percent increase in child vaccine purchasing power over FY 1995.

Of the total of \$479 million available for immunization in the CDC appropriation--after savings on excise taxes--\$177 million will be awarded through the Performance Partnership grant; \$135 million will remain with CDC for national and global outreach and education, technical assistance, and research; and \$167 million will be used to purchase pediatric vaccine for children immunized at public health clinics--who are not eligible for VFC vaccine.

Vaccine Excise Tax Savings

Legislation will be proposed to reduce the total cost of excise taxes paid by all purchasers of vaccines, including CDC, by 50 percent--saving CDC \$25 million in FY 1996. This policy will also save the Vaccines For Children entitlement program \$47 million in FY 1996. The new vaccine excise structure is still under review. The current excise tax structure was set in 1986 through the Vaccine Injury Compensation Trust Fund. Based on experience since then, the Department of Treasury has concluded that trust fund revenue exceeds projected liability. At present, the trust fund resources total \$809 million.

HIV/AIDS

An increase of \$36 million (6 percent) is requested to fund applied HIV/AIDS research which will enable CDC and its prevention partners to identify effective interventions for specific populations, better target future prevention efforts, and improve current ongoing efforts. Regional and local community-level planning efforts will continue to customize programs to meet the needs of the diverse communities across this nation. In FY 1994, planning groups representing all constituencies were formed to target resources where they are most needed and will have the most impact. As part of this strategic planning effort, communities are redirecting resources to programs that work and meet the needs of persons who might otherwise be overlooked--for example, adolescents. Of the total \$625 million available for HIV/AIDS, \$298 million will be awarded through the Performance Partnership Grant and \$327 million will remain with CDC for national outreach and education, technical assistance, and research.

Sexually-Transmitted Diseases

The FY 1996 request includes an increase of \$4 million (4 percent) to expand regional infertility prevention programs to primary health care, migrant health care, adolescent health and other health care settings in Regions III (Philadelphia, PA), VII (Kansas City, MO), and VIII (Denver, CO). This investment will be used to reduce the burden of STDs that cause infertility, related complications, and increased health care costs. A secondary outcome will be the reduction of eye and respiratory infections in infants. Of the total \$110 million available for STDs, \$87 million will be awarded through the Performance Partnership Grant and \$23 million will remain with CDC for national direction, education and research.

New And Emerging Infectious Diseases

In recent years, infectious disease outbreaks have taught us that we are susceptible to infectious diseases--HIV, plague, and influenza are good examples of that risk. Potential threats to U.S. health are steadily escalating because of increasing global interdependence, modern transportation, trade, and changing social and cultural patterns. CDC is seeking an increase of \$10 million, or 18 percent, in its infectious disease activities to further implement a national strategy for addressing emerging infectious disease threats. This effort began in FY 1995. The request would provide financial and technical support to 20 State health departments for surveillance, epidemiologic and laboratory investigations, and educational programs of infectious diseases, including rapid identification and investigation of outbreaks and drug resistant diseases. Two additional population-based Emerging Infections Programs would be established. This investment has the potential to reduce the burden of illness due to infections and reduce health care costs substantially.

Health Data Initiative

HHS has closely reviewed current health data resources and identified areas where core health data are not available to measure health program and performance outcomes. CDC, as lead agency of this initiative, is seeking \$20 million to finance a health data initiative which includes implementing a National Health Interview Survey disability component, updating the National Health Provider Inventory, surveying providers of core public health services, upgrading the Census Bureau Services and Demographics Surveys; enhancing the specialty mental health provider inventory; surveying substance abuse and mental health treatment providers; expanding the area resource file; and developing community-level data linkage demonstrations. These data are critically important to States as they implement various aspects of health care reform and as we move toward shifting decision-making and accountability to the States.

Violent Crime Control and Law Enforcement Act of 1994

In FY 1996, CDC will begin three new programs authorized by the Violent Crime Control and Law Enforcement Act of 1994. Of a total of \$39 million available, CDC will distribute \$35 million to States as part of the Prevention Block Grant for rape prevention and education; award \$4 million for domestic violence demonstration projects; and will undertake a \$100 thousand study to determine the number and cost of injuries caused by violence.

Streamlining

As part of overall Executive Branch efforts to improve performance and re-engineer existing programs and procedures, CDC is actively involved in developing new approaches for managing the national public health enterprise. Despite a reduction of 115 FTE, CDC will maintain its current programs in part through progress it has made in re-engineering. Examples include re-structuring CDC organizational jurisdictions and use of a broad array of automation innovations--such as travel authorizations/voucher systems and time cards for

federal administrative processes; CD-ROM data product lines; and on-line access to public health information such as the Morbidity and Mortality Weekly Report.

CDC OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Data Initiative	--	--	--	\$20	+\$20
<u>Immunization Partnership Grant</u>	--	--	--	\$177	+\$177
Vaccine Purchase	\$196	\$152	\$152	192	+40
Other Immunization	<u>332</u>	<u>314</u>	<u>314</u>	<u>135</u>	<u>-179</u>
Subtotal	\$528	\$466	\$466	\$504	+\$38
<u>HIV/STD/TB Partnership Grant</u>	--	--	--	\$488	+\$488
HIV/AIDS	542	589	589	326	-263
TB Elimination	117	120	120	17	-103
Sexually Transmitted Diseases	<u>100</u>	<u>105</u>	<u>105</u>	<u>23</u>	<u>-82</u>
Subtotal	\$759	\$814	\$814	\$854	+\$40
<u>Chronic Diseases & Disability Grant</u>	--	--	--	\$118	+\$118
Chronic & Environ. Diseases	123	140	140	103	-37
Breast/Cervical Cancer	78	100	100	23	-77
From HIV/AIDS	<u>1</u>	<u>1</u>	<u>1</u>	<u>--</u>	<u>-1</u>
Subtotal	\$202	\$241	\$241	\$244	+\$3
Preventive Health Svc's Block Grant	\$157	\$158	\$158	\$156	-\$2
Rape Prevention/Education . . .	--	--	--	35	+35
Injury/Violence Control	39	45	45	45	--
Domestic Violence Demos	--	--	--	4	+4
Infectious Diseases	48	54	54	62	+10
Prevention Centers	7	7	7	7	--
Occupational Safety and Health .	128	133	133	133	--
Health Statistics	81	84	84	84	--
Lead Poisoning Prevention . . .	30	35	35	35	--
Epidemic Services	74	74	74	74	--
Buildings & Facilities	17	4	4	4	--
Toxic Substances & Disease Registry	67	69	69	69	--
Director's Office	3	3	3	3	--
<u>Less Savings:</u>					
Vaccine Tax Cut	--	--	--	-\$25	-\$25
Grant Consolidation Admin. Cut	<u>--</u>	<u>--</u>	<u>--</u>	<u>-6</u>	<u>-6</u>
Total, Savings	--	--	--	-\$31	-\$31
Subtotal, CDC Program Level .	\$2,148	\$2,186	\$2,185	\$2,304	+\$119
Less: PHS Intra-agency Transfers, Receipts	<u>-\$98</u>	<u>-\$98</u>	<u>-\$98</u>	<u>-\$112</u>	<u>-\$14</u>
TOTAL, CDC Budget Authority	\$2,051	\$2,088	\$2,087	\$2,192	+\$105
<u>FTE</u>	<u>6,752</u>	<u>6,560</u>	<u>6,560</u>	<u>6,445</u>	<u>-115</u>

Consolidated CDC Programs
Consolidates 32 Programs to 3 Programs

HIV/STD/TB Grant
(Formula Grant)
(20 Programs)
(\$487.7 million)

HIV/AIDS:

- ▶ Surveillance for HIV/AIDS Reporting
Timeliness
- ▶ Other Ongoing Surveillance Activities
- ▶ IDU-Health Education/Risk Reduction
- ▶ Other Health Education/Risk Reduction
- ▶ IDU-Counseling, Testing, Partner
Notification
- ▶ Other-Counseling, Testing, Partner
Notification
- ▶ HIV Prevention Among Drug Users
- ▶ Public Information
- ▶ State & Local Minority Initiative
- ▶ Direct Funding of Minority Community-
Based Organizations
- ▶ Women's & Infants Perinatal AIDS
Reporting

Sexually-Transmitted Diseases:

- ▶ Prevention & Control
- ▶ Infertility Prevention
- ▶ Surveillance/Monitoring Disease Trends
- ▶ STD Accelerated Prevention Campaign
- ▶ TB/HIV

Tuberculosis:

- ▶ Prevention Control & Elimination
- ▶ Surveillance Assessment
- ▶ Research Demonstration
- ▶ TB Laboratory Capacity

Chronic Disease and Disability Grant
(Formula Grant)
(6 Programs)
(\$118.1 million)

Behavioral Risk Factor Surveillance (BRFS)
Cancer Registries
Diabetes
Disabilities
Breast & Cervical Cancer
Tobacco

Immunization Grant
(Formula Grant)
(6 Programs)
(\$176.7 million)

State Operations
Parent/Patient Notification
Surveillance & Response
Infrastructure
Program-Based Incentives
National & State Specific
Immunization Level Assessment

NATIONAL INSTITUTES OF HEALTH

(Dollars in millions)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
Program Level	\$10,937	\$11,317	\$11,316	\$11,784	+\$468
Budget Authority	10,926	11,306	11,305	11,773	+468
<i>FTE/1</i>	<i>16,235</i>	<i>16,197</i>	<i>16,197</i>	<i>16,135</i>	<i>-62</i>

1/ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the National Institutes of Health (NIH) totals \$11.8 billion, an increase of \$468 million, or 4 percent, over the revised FY 1995 level. As this request indicates, the Administration remains strongly committed to preserving NIH as a world-renown biomedical research institution.

NIH is devoted to exploring exceptional opportunities for breakthroughs in areas that expand the research knowledge base and to developing clinical applications that offer hope for a healthier future for all citizens. The FY 1996 budget for NIH is a well-balanced distribution of resources between specific targeted projects and more general investments in basic biomedical and behavioral research.

The budget for FY 1996 continues to focus on important priority needs by investing an additional \$151 million on: HIV/AIDS, breast cancer and other women's health research, minority health, high performance computing, and tuberculosis. NIH will also add \$121 million to biomedical research that offers great potential to yield a high return on the Federal investment in biomedical research. Such areas include research on the brain and brain disorders; bone, muscle, and connective tissue diseases; disorders of developmental and reproductive biology; mutations and environmental cancers; DNA sequencing technology; gene therapy; structural biology and drug design; and prevention research. The FY 1996 budget also requests expanded support for intramural infrastructure maintenance and improvement, as well as for shared instrumentation awards to help the extramural biomedical research community keep pace with leading-edge technological advances in scientific equipment. The remaining increase of \$196 million is primarily for basic research in all other NIH areas utilizing the mechanism of investigator-initiated activities. In addition, the FY 1996 President's Budget proposes a \$1 million rescission in the FY 1995 funds for extramural construction grants.

Breast Cancer Research

Breast cancer continues to be the type of cancer most frequently diagnosed in women in the United States. In the decade of the 1990s, it is estimated that more than 1.5 million new cases of breast cancer will be diagnosed and nearly 500,000 American women will die of breast cancer.

Encouragingly, though, breast cancer screening rates are at their highest levels in history; and the BRCA-1 gene, which has been linked to breast cancer, was discovered last year. In January of 1994, the Department reported that the overall death rate for breast cancer in American women declined 4.7 percent between 1989 and 1992, the largest short-term decline in four decades. For white women in their 30s, 40s and 50s, death rates from breast cancer fell 8 to 9 percent over this time period. However, African-American women did not share in this mortality decline, in fact, their rate of death due to breast cancer increased 2.6 percent over the same time period.

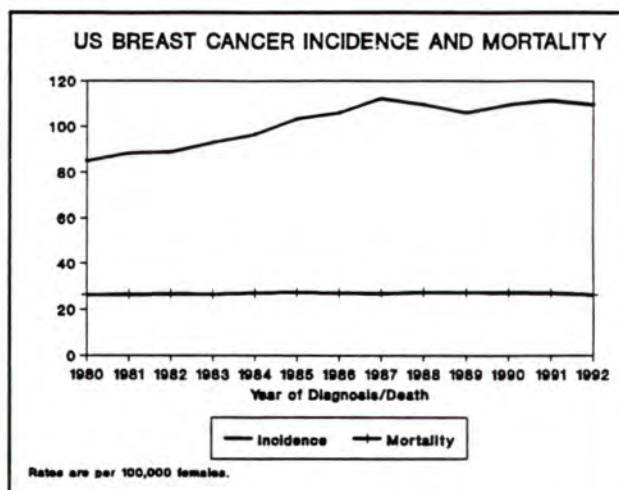


Figure 1

The Administration's commitment to making more progress against this disease remains unwavering. In FY 1996, NIH plans to spend \$426 million for breast cancer research, an increase of 13 percent, or \$49 million over FY 1995, and a 72 percent increase over the last three years. NIH supports a multi-faceted and coordinated breast cancer research program in basic research, prevention, treatment, rehabilitation and community outreach. The increase will allow NIH to initiate new studies in occupational risk effects, develop new diagnostic approaches to improve breast imaging, and expand research efforts in genome mapping to determine breast cancer risk.

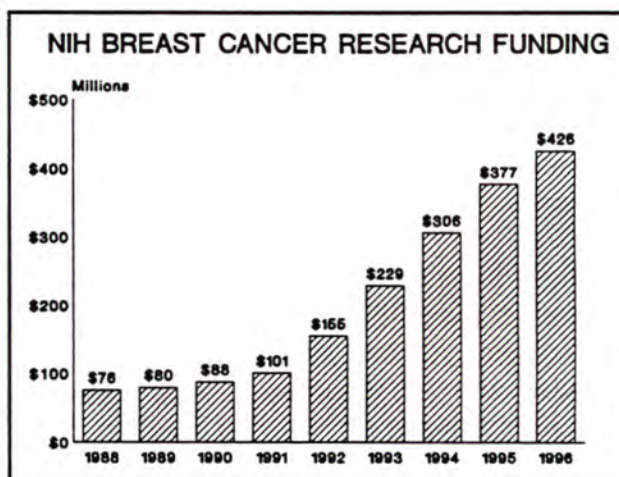


Figure 2

Within the \$49 million increase, at least \$10 million will support the continued implementation of the Secretary's National Action Plan on Breast Cancer. NIH, in conjunction with CDC, will emphasize a wide range of actions related to breast cancer. Efforts will include research to improve imagery of breast tissue to better detect cancer at an earlier stage; develop resource banks on breast cancer to link registries and other data sources; and establish a clearinghouse for breast cancer information for health professionals, consumers, breast cancer patients and the scientific community.

HIV/AIDS

AIDS and AIDS-related scientific endeavors are now well into their second decade, and NIH has made major contributions to the basic understanding and therapeutic management of all stages and manifestations of HIV infection and AIDS. Yet, still, one American dies of AIDS every three minutes. Only 13 years ago, HIV/AIDS was unknown. Today, it is the number one killer of all Americans ages 25-44 years. It is also the number six killer among young people ages 15-24, and the eighth leading cause of death overall. Through December 1994, a total of 270,870 Americans have died from AIDS, highlighting the urgent need to advance research to stem the human, societal and economic loss due to this pandemic.

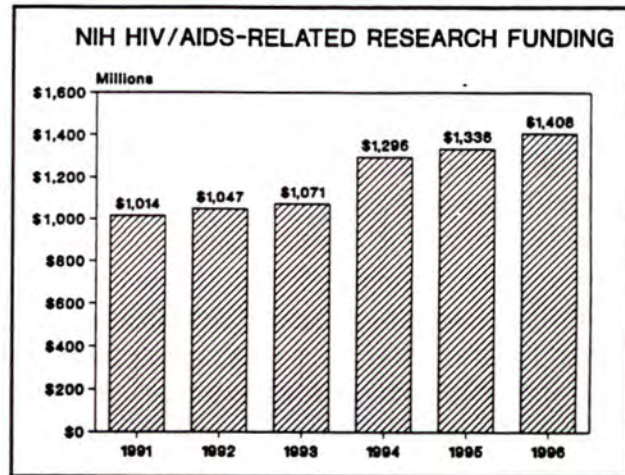


Figure 3

The FY 1996 budget includes \$1.4 billion for HIV/AIDS related research. This is an increase of 5 percent over FY 1995. While all of NIH's AIDS-related research areas will be expanded, more than half of the requested HIV/AIDS increase in FY 1996 will be used to support basic science research. Greater understandings of the HIV disease--the details of the viral life cycle, the functions of the viral proteins, and the interactions of the virus with the immune system--are clearly needed to underpin major new advances in HIV/AIDS treatments and vaccines. Fundamental research on HIV/AIDS is expected to have a significant impact on research in non-AIDS areas as well, as NIH focuses on better integrating behavioral and biomedical research programs related to HIV/AIDS.

The FY 1996 budget continues to include all AIDS-related funds in a single appropriation account for the Office of AIDS Research (OAR), consistent with the provisions of the NIH Revitalization Act of 1993. The Director of OAR will transfer AIDS funds to the Institutes in accordance with the comprehensive plan for AIDS research developed by the OAR along with the Institutes.

Minority Health

A total of \$63 million is requested for the Minority Health Initiative, an increase of \$5 million, or nearly 8 percent, over the FY 1995 level. These funds will support expanded research efforts on injuries, lead poisoning, asthma, learning disorders, and vision and speech impairment among minority children; on community-based health behavior interventions directed to adolescent and young adult minorities; and on research in kidney disease, diabetes in African-American and Hispanic women, hypertension, glaucoma, AIDS, and breast cancer.

Commitment to Basic Science

The Federal government's commitment to basic research through NIH is an investment in the Nation's future. Biological sciences are at a remarkable phase of growth, productivity and promise. Clinical triumphs in HIV/AIDS, breast cancer, and tuberculosis can only result from small, steady, successful steps in many fields of basic science. We must gauge our success--relationships between fundamental science and later benefits to health--not simply by the most recent clinical breakthroughs. These breakthroughs are the culmination of smaller discoveries over many years that do not necessarily make headlines, but are the result of this Nation's long-standing commitment to a strong investment in biomedical research. NIH will support new genetic and biochemical research methods, build up the field of structural biology, foster the medical applications of computer sciences, and allow the fields of molecular biology and neurosciences to open windows and lead us to revolutionized approaches to better understand effects on human health.

Tuberculosis

The FY 1996 budget request continues NIH's commitment to prevent, treat and eradicate the resurgence of tuberculosis (TB). Funding for TB research will increase by \$2 million to a total of \$53 million. This is over ten times the amount NIH spent on TB in FY 1991. This continued investment is necessary because the number of TB cases did not steadily decline as expected during the 1980s, but rather, took an upturn due to a variety of factors, including the HIV/AIDS epidemic, increased poverty, injection drug use, and homelessness. The TB problem has been compounded by the emergence of drug-resistant strains of TB.

Research Project Grants

Cutting across all areas of disease research, NIH's highest priority continues to be increasing support for new and promising ideas initiated by bench scientists across the country through the research project grant (RPG) mechanism. In FY 1996, the NIH budget provides \$6.2 billion to support a total of 23,874 RPGs, including 6,046 new and competing RPGs in FY 1996. This represents a decrease of 522 new and competing RPGs from FY 1995. The decrease is due to cycling of new and competing grants from FY 1995 to noncompeting status. The total number of RPGs remains constant at nearly 24,000.

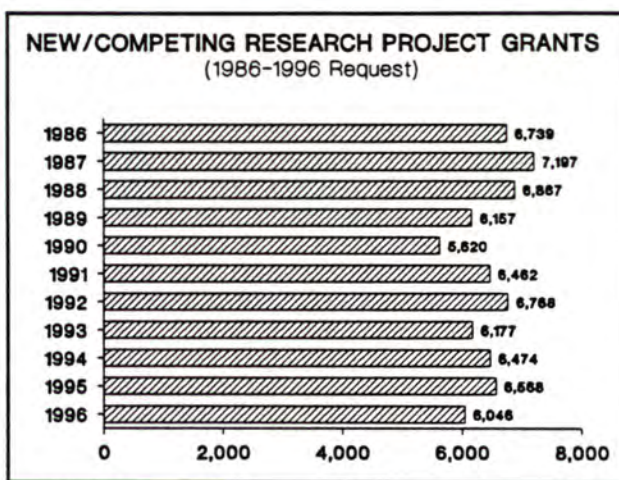


Figure 4

In this budget, the Administration is also planning several important changes in how the Federal government pays for costs allocated to Federally-sponsored research by university grantees. These changes will simplify administrative and accounting procedures; promote

stability, equity, and consistency in Federal payments for research; and make the Federal investment in research more understandable to the public and to Congress. These proposals are the result of several months work with the university communities and with the major Federal research funding agencies. Most of the proposed changes will address the facilities component of research costs, which have accounted for almost all of the growth in indirect cost rates over the last decade and explain much of the variation in rates among schools. In the long-run, these proposals are expected to generate cost-savings. However, there are no reductions in FY 1996 as a result of these changes.

Streamlining

As part of the Administration's National Performance Review, the NIH Extramural Program has been designated as a "Reinvention Laboratory," to lead the process of change for grants administration in the Public Health Service. Currently underway are a series of pilot programs related to grants policy, including the peer review process, designed to streamline and reduce the administrative burden associated with the grant application process and to improve cost management. These pilot programs include: using triage to reduce the peer review burden by focusing only those applications that are truly competitive without compromising the quality of the review; streamlining the format of summary statements; and requiring the submission of "just-in-time" data whereby detailed budget and administrative data are collected only for those applications most likely to be funded. NIH is also testing an "electronic research administration" system that may eventually allow all applications to be submitted and reviewed over the Internet, significantly reducing time and paperwork related to the review and funding process.

NIH OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Research Project Grants	\$5,876	\$6,001	\$6,001	\$6,229	+\$228
[# of Non-competing]	[17,602]	[17,284]	[17,284]	[17,828]	[+544]
[# of New/Competing]	[6,474]	[6,568]	[6,568]	[6,046]	[-522]
[Total # of Grants]	[24,076]	[23,852]	[23,852]	[23,874]	[+22]
SBIR/STTR Grants	126	172	172	194	+22
Centers	974	1,015	1,015	1,034	+19
Research Training	373	381	381	391	+10
R&D Contracts	754	777	777	803	+26
Intramural Research	1,201	1,235	1,235	1,272	+37
Research Management/Support	499	509	509	521	+12
National Library of Medicine (NLM)	129	140	140	150	+10
Office of the Director	227	240	240	258	+18
Women's Health Study [non-add]	[59]	[57]	[57]	[57]	[-]
Minority Health Study [non-add]	[55]	[58]	[58]	[63]	[+5]
Other Research	667	733	732	788	+56
Buildings and Facilities	<u>111</u>	<u>114</u>	<u>114</u>	<u>144</u>	<u>+30</u>
 SUBTOTAL, NIH					
Program Level	\$10,937	\$11,317	\$11,316	\$11,784	+\$468
 Less NLM Receipts	<u>-11</u>	<u>-11</u>	<u>-11</u>	<u>-11</u>	<u>--</u>
 TOTAL, NIH					
Budget Authority	\$10,926	\$11,306	\$11,305	\$11,773	+\$468
 FTE	<u>16,235</u>	<u>16,197</u>	<u>16,197</u>	<u>16,135</u>	<u>-62</u>

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

(Dollars in millions)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1996 Request</u>	<u>Request +/-Enacted</u>
Program Level	\$2,150	\$2,195	\$2,244	+\$49
Budget Authority	2,150	2,195	2,244	+\$49
<i>FTE</i> ^{1/}	738	656	606	-50

^{1/} The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Substance Abuse and Mental Health Services Administration (SAMHSA) totals \$2.2 billion, an increase of 2 percent over the FY 1995 level. To enhance State and local governments' ability to deliver high quality mental health and substance abuse services and to streamline the administrative apparatus, SAMHSA proposes to consolidate 26 programs into four programs and expand its block grants into Performance Partnerships with the States. The consolidation would save \$3 million and 50 FTE in FY 1996.

The proposed SAMHSA consolidation transforms both the Mental Health and Substance Abuse block grants into Performance Partnerships, increasing mental health by \$51 million (by folding in the PATH and Protection and Advocacy Programs) and substance abuse by \$60 million. Further, a total of 21 programs now directly managed by SAMHSA will be consolidated into two consolidated Demonstration and Training programs--\$113 million for mental health and \$453 million for substance abuse.

Implementation of these concepts will permit SAMHSA to streamline its program management and devote more effort to working with State and local partners in developing priorities for mental health and substance abuse and evaluating progress. SAMHSA will maintain a Federal leadership role in data collection, information dissemination, coordination, public education, quality assurance and monitoring performance and results.

Improving Drug Treatment

Within the Substance Abuse programs, the FY 1996 budget focuses on the treatment of substance abusers--with a special focus on groups which use a disproportionate share of treatment resources, contribute disproportionately to the societal costs of drug abuse, and for whom little improvement has been made. The chronic drug user accounts for more than

two-thirds of the illicit drugs consumed, and is a significant contributor to crime and violence. The FY 1996 request includes a \$60 million increase to the Substance Abuse Performance Partnership and redirects \$40 million of the demonstration funds toward this target population. This program will give States maximum flexibility to develop treatment systems that ensure access, quality, and improved outcomes for substance abusers, particularly in areas of high incidence and prevalence. Through the Substance Abuse Performance Partnership and the Consolidated Substance Abuse Demonstration and Training program, 221,000 persons will be served.

Consolidated Demonstration and Training Programs

Over the next two fiscal years, SAMHSA's Consolidated Demonstration and Training programs, which total \$566 million, will be reduced by 47 percent to \$300 million by FY 1998. The freed-up resources will be folded into the two Performance Partnerships to increase available funding for the States. The three-year transition period will allow the closeout of grants already awarded. Many earmarks and set-asides currently directing States in the use of these Federal funds will be removed and the grant review process simplified and improved.

Development of a targeted demonstration agenda will be key to the success of SAMHSA's programs. Proposed new demonstration funds will be used for projects in six areas of emphasis. resources dedicated to each will be adjusted once the demonstration agenda is developed and project proposals are assessed. These areas are: Managed Care, Systems and Partnerships, Evaluation/Technology Development and Transfer, Client-Oriented Services, Training, and Public and Consumer Education. Existing programs will be continued.

In conjunction with State agencies, community groups, and other public and private service providers, SAMHSA will identify and prioritize major issues facing the drug abuse and mental health fields. Further, through this interactive process, managed care, systems and partnerships, evaluation and technology, client-oriented services, training, and public and consumer education will be emphasized.

Performance Partnerships

While similar in concept to the current block grant program, the Performance Partnerships will differ in several important ways. There will be fewer earmarks, increased State flexibility, development of performance measures and increased emphasis on outcomes. States will be encouraged to develop and implement a performance measurement system.

Funds previously allocated to the PATH Homeless Formula Grant and the Mental Health Protection and Advocacy programs will be folded into the Mental Health Performance Partnership. This will expand funds available to States for mental health programs while providing flexibility to States to meet the most pressing needs identified for their specific population. However, the States will be required to set funds aside from their allotments for the continuation of the Protection and Advocacy systems in the States.

The FY 1996 budget requests an increase of \$60 million over FY 1995 for the Substance Abuse Performance Partnership. This increase may be used to treat chronic substance abusers. States will still be required to use 20 percent of their substance abuse awards for prevention.

Streamlining

SAMHSA has centralized administrative functions (personnel, legislative services, policy and information resources management), and consolidated grant and contract review functions across the agency, resulting in improved efficiency and lower FTE levels. SAMHSA has also established a Customer Service Committee to find ways of improving agency responsiveness to the needs of the grantee and application community.

SAMHSA OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
SUBSTANCE ABUSE PREVENTION:				
<u>Consolidated Demos/Prevention</u>	--	--	\$216	+\$216
Prevention Demonstrations . .	113	94	--	-94
Community Prevention	115	115	--	-115
Public Educ. and Dissemination	11	13	--	-13
Training	<u>15</u>	<u>16</u>	<u>--</u>	<u>-16</u>
SUBTOTAL, Prevention	\$253	\$239	\$216	-\$22
SUBSTANCE ABUSE TREATMENT:				
<u>Consolidated Demos/Treatment</u>	--	--	\$237	+\$237
Target Cities Demos	35	36	--	-36
Treatment Improvement Demos	169	162	--	-162
AIDS Demos and Training . .	<u>21</u>	<u>18</u>	<u>--</u>	<u>-18</u>
Subtotal	\$225	\$216	\$237	+\$21
Substance Abuse Block Grant . .	1,178	1,234	1,294	+60
Treatment Capacity Expansion 1/	<u>15</u>	<u>7</u>	<u>--</u>	<u>-7</u>
SUBTOTAL, Treatment	\$1,417	\$1,457	\$1,531	+\$74
MENTAL HEALTH:				
<u>Consolidated Mental Health Demos</u>	--	--	\$113	+\$113
Mental Health Demonstrations	47	47	--	-47
Children's Services Programs .	35	60	--	-60
Training and AIDS Training .	<u>5</u>	<u>5</u>	<u>--</u>	<u>-5</u>
Subtotal	\$87	\$112	\$113	+\$1
Expanded MH Block Grant . . .	278	275	326	+51
Homeless PATH Grants 2/ . . .	29	29	--	-29
Protection and Advocacy 2/ . .	<u>22</u>	<u>22</u>	<u>--</u>	<u>-22</u>
SUBTOTAL, Mental Health . .	\$417	\$439	\$439	--
Program Management	\$61	\$61	\$61	--
Buildings and Facilities	1	--	--	--
Forfeiture Fund (non-add) . . .	<u>(25)</u>	<u>(14)</u>	<u>--</u>	<u>-14</u>
Less Admin. Savings	--	--	-3	-3
TOTAL, Budget Authority . . .	\$2,150	\$2,195	\$2,244	+\$49
FTE	738	656	606	-50

1/ The FY 1996 consolidation proposal adds Treatment Capacity Expansion as a component of the Substance Abuse Block Grant.

2/ The FY 1996 consolidation proposal adds Homeless PATH Grants and Protection and Advocacy as components of the Mental Health Block Grant.

Numbers may not add due to rounding.

CONSOLIDATED SAMHSA DEMONSTRATIONS/BLOCK GRANTS

Consolidates 26 programs into 4 programs

Consolidated Substance Abuse Demonstration and Training

(15 programs) \$453 million

Pregnant Woman and Infants

Community Prevention

Target Cities

High Risk Youth

Pregnant/Postpartum Women

Criminal Justice Program

Comp. Community Treatment Programs

AIDS Linkage

AIDS Outreach

Critical Populations

Substance Abuse Prevention Training

Addition Treatment Training/AIDS Training

Public Education and Dissemination Program

Program Contract/Campus Project

Treatment Improvement

Consolidated Mental Health Demonstration and Training

(6 programs) \$113 million

Community Support Program

Prevention Demonstrations

Homeless Demonstrations

AIDS Demonstrations

Clinical and AIDS Training

Children's Mental Health

Substance Abuse Performance Partnership

(2 programs) \$1.3 billion

Treatment Capacity Expansion

Substance Abuse Block Grant

Mental Health Performance Partnership

(3 programs) \$326 million

Protection and Advocacy

PATH Formula

Mental Health Block Grant

AGENCY FOR HEALTH CARE POLICY AND RESEARCH

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
Program Level	\$154	\$163	\$194	+\$31
Budget Authority	141	144	148	+4
<i>FTE</i> ^{1\}	267	271	268	-3

1\ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 request for the Agency for Health Care Policy and Research (AHCPR) provides a program level of \$194 million, an increase of \$31 million, or 19 percent, over FY 1995. AHCPR is continuing its investment in the third National Medical Expenditure Survey (NMES) and funding initiatives that will assist States in their efforts to reform their own health care systems.

AHCPR is charged with developing clinically-based, policy-relevant information for use in improving the quality, appropriateness, and effectiveness of health care; improving access to health care services; and providing leadership in health services research. The research funded by the Agency helps promote improvements in clinical practice as well as the organization, financing, and delivery of health care services. As State health care systems and the medical marketplace evolve, AHCPR will strive to provide the tools necessary to measure patient outcomes and health services delivery performance.

Medical Treatment Effectiveness Program

Of the FY 1996 request, \$88 million is requested for the Medical Treatment Effectiveness Program (MEDTEP), an increase of \$7 million, or 9 percent, over FY 1995. AHCPR is committed to helping consumers make more informed choices about their health care. Part of that effort is to first determine what works in clinical practice and then educate consumers and providers through its clinical practice guidelines program. In FY 1996, to further promote patient and provider shared decision-making, AHCPR will fund grants to develop more innovative tools--such as interactive video discs--to help patients better understand their health care treatment options. The Agency will also expand its capacity to evaluate new medical technologies by providing \$2 million to establish two Technology Assessment Centers or Consortia. Also, a long overlooked women's health issue will be addressed by the funding of clinical effectiveness trials to evaluate treatments for non-cancerous conditions of the uterus, including hysterectomy. The request includes \$4 million for these trials.

AHCPR will continue to support eleven MEDTEP Research Centers on Minority Populations. These Centers focus on what clinical strategies are best for clinical conditions with the greatest prevalence among African-Americans, Latinos, Asian and Pacific Islanders, American Indians, and/or Alaska Natives. Conditions being studied include high blood pressure, kidney disease, tuberculosis, low birthweight, substance abuse, and certain cancers. Pharmaceutical outcomes projects will also be continued in FY 1996 to study the efficacy and cost effectiveness of prescription drugs and related pharmaceutical interventions for treating clinical conditions. Finally, as part of reinvention and continuous improvement, AHCPR will continue to refine and improve its techniques. Improved methodologies have been developed for the second round of Patient Outcomes Research Teams (PORT II), and AHCPR plans to evaluate clinical practice guidelines, their dissemination, and their impact in terms of physician behavior, quality of care, and health outcomes.

To date, 15 guideline sets have been completed on topics such as: heart failure, mammography, benign prostatic hyperplasia, cataracts, early HIV infection, and depression. These guidelines not only reduce medical treatment uncertainty, they can directly benefit consumers and medical practitioners by improving patient outcomes and quality of life. AHCPR guidelines can also benefit the nation by eliminating or reducing the use of medical tests and therapies that do not work or are unnecessary. Two of the latest clinical practice guidelines released are good examples. Pressure ulcer guidelines are expected to save more than \$40 million per year: in just one hospital, Intermountain Health Care saved \$240 thousand in six months after implementing AHCPR guideline recommendations. Adopting the guidelines on acute low back problems is projected to save the nation \$5 billion annually.

Health Care Cost, Quality and Access Research

The FY 1996 budget includes \$67 million to support health services research initiatives, an increase of \$3 million, or 5 percent, over FY 1995 levels. AHCPR will fund several extramural grants to develop, test, and refine measures which will permit more appropriate adjustments in health insurance premium rates. Correlations between the following elements will be examined--socioeconomic status, risk behaviors, high-cost and chronic care, patient vulnerability and risk, and provider efficiency and quality of care. An initiative also will be undertaken to examine the primary care workforce--its size, composition, and diversity of organizational configurations--as well as measuring relative provider productivity.

The request also continues support of five Rural Health Centers which address regional issues related to the development of rural health policy for cost and quality of, and access to, health services--particularly for rural disabled and minority populations. Centers operate in Seattle, Minneapolis, Chapel Hill, Denver, and Buffalo.

National Medical Expenditure Survey (NMES 3)

AHCPR is seeking \$36 million, an increase of \$21 million over FY 1995, to support a broad range of NMES 3 survey activities. In FY 1996, the actual NMES 3 field survey will begin--employing innovations such as computer assisted personal surveys which will greatly

improve the timeliness of survey results. Early access to data for analysis will allow health care policymakers to base decisions on more current information than has been available in the past. Costs incurred in FY 1996 will include the bulk of interviewer training and significant data collection activities--including screening, baseline, and two main rounds of data collection.

The NMES 3 survey is projected to cost a total of \$92 million and will be completed in FY 1998. So far, \$25 million has been invested in this comprehensive health care data project. Analytic work will begin in FY 1997 and is expected to be complete by FY 2001.

Information gathered through NMES 3 will continue to support the restructuring of health care in the private sector and at Federal and State levels. Reform can only take place when better data are available to explain the various dimensions of health care--the social and financial implications of proposals for change, and the most effective ways to achieve the quality, efficiency, and equity we expect from our health care system.

AHCPR OVERVIEW

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
Medical Effectiveness	\$81	\$81	\$88	+\$7
Health Care Services Research & Technology	61	64	67	+3
NMES III	10	15	36	+21
Program Support	<u>2</u>	<u>2</u>	<u>2</u>	<u>—</u>
Subtotal, AHCPR Program Level	\$154	\$163	\$194	+\$31
Less Transfers:				
PHS Intra-agency	<u>-\$13</u>	<u>-\$18</u>	<u>-\$45</u>	<u>-\$27</u>
TOTAL, AHCPR Budget Authority	\$141	\$144	\$148	+\$4
Medicare Trust Funds [Non add]	[-\$6]	[-\$6]	[-\$6]	[-]
FTE	267	271	268	-3

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
Program Level	\$68	\$67	\$66	-\$1
Budget Authority	68	66	66	--
<i>FTE</i> ^{1/}	1,184	1,093	1,076	-17

1/ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Office of the Assistant Secretary for Health (OASH) totals \$66 million, \$1 million less than the amount appropriated in FY 1995. An additional \$167 million is requested for retirement and health insurance payments for the Commissioned Corps of the Public Health Service. The OASH provides staff necessary for the Assistant Secretary for Health's overall direction of the Public Health Service (PHS), supports small but high profile programs focusing on cross-cutting PHS initiatives (e.g., Disease Prevention and Health Promotion, Vaccines, HIV/AIDS, Women's and Minority Health), and houses various administrative functions, some supported by the PHS Service and Supply Fund, which are more efficiently performed centrally. As a share of the PHS budget, the OASH budget has decreased by over 20 percent in the last five years.

The following programs and activities will be undertaken by OASH in FY 1996:

- Adolescent Family Life - supports grants which encourage adolescents to delay sexual behavior, provides service to pregnant and parenting teens, and researches adolescent pregnancy issues. The request will support the same number of grants (18) as in FY 1995.
- Disease Prevention/Health Promotion - coordinates health promotion and disease prevention activities among PHS agencies, other Federal Departments, and the private and voluntary sectors.
- Office of Minority Health - coordinates disease prevention, health promotion, and health service delivery for disadvantaged and minority individuals and supports research on minority health topics.
- National AIDS Program Office - provides leadership and coordination of HIV/AIDS activities within HHS and serves as liaison with other Federal departments, state and local governments, and international and non-governmental organizations.

- National Vaccine Program Office - coordinates vaccine research, development, and immunization activities on behalf of PHS and other Federal departments, in conjunction with the National Vaccine Advisory Committee.
- Office of Health Policy, Planning and Evaluation - provides additional support for national health goals such as increasing the public's awareness that good public health and disease prevention are keys to improving overall health, and ensuring that populations traditionally served by PHS are not disadvantaged by the transition to managed care.
- Office of Women's Health - provides leadership and monitors the implementation of the "PHS Action Plan for Women's Health." This plan was developed by a PHS-wide task force using Healthy People 2000 as its foundation.

OASH OVERVIEW

(Dollars in millions)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1996 Request</u>	<u>Request +/-Enacted</u>
Adolescent Family Life	\$6	\$7	\$6	-\$1
Disease Prev/Health Promotion	5	5	5	-
Office of Minority Health	20	21	21	-
National AIDS Program Office	3	2	2	-
National Vaccine Prog. Office	2	1	1	-
Office of Health Policy, Planning and Evaluation	4	4	4	-
Emergency Preparedness	2	2	2	-
Office of Women's Health	1	3	3	-
PHS Management	20	17	17	-
Other	5	5	5	-
<i>Entitlements (non-add):</i>				
Commissioned Corps Retirement	\$153	\$159	\$167	+\$8
PHS Trust Fund	61	61	61	-
Total, Budget Authority	\$68	\$67	\$66	-\$1
 <i>FTE</i>	 1,184	 1,093	 1,076	 -17

HEALTH CARE FINANCING ADMINISTRATION

(Dollars in millions)

	1994 <u>Actual</u>	1995 ¹ <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Income	\$252,639	\$262,158	\$286,739	+\$24,581
Outlays ²	\$226,781	\$245,742	\$273,885	+\$28,143
FTE ³	4,119	4,129	4,147	+18

¹ Includes a negative supplemental request of \$1 million for research in the Hospital Insurance program and \$20 million in Budget Authority for the Program Management account.

² Includes non-HCFA administrative costs, and is net of offsetting receipts.

³ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Health Care Financing Administration (HCFA) is \$274 billion (net of offsetting receipts) for Medicare and Medicaid benefits and operating costs, an increase of \$28 billion over FY 1995 (see Figure 1 for the distribution of spending). Spending for the Medicare and Medicaid programs represents 38.2 percent of the total HHS budget for FY 1996.

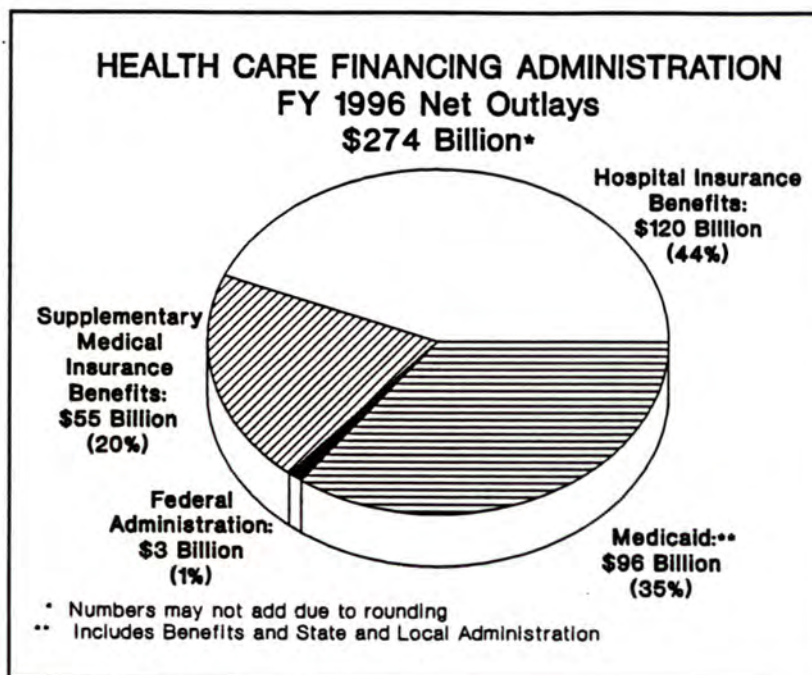


Figure 1

The Medicare and Medicaid budget includes legislative proposals that reduce spending by \$206 million in FY 1996. These proposals represent extensions of Medicare current law provisions which would otherwise expire, Medicare administrative savings, and Medicaid savings from reduced vaccine excise taxes. The budget also requests an additional \$150 million in FY 1996 for an undocumented immigrants proposal. Medicare and Medicaid combined will pay for the health care costs of approximately 70 million elderly, disabled and economically disadvantaged Americans in FY 1996 (individuals eligible for both Medicare and Medicaid are not double counted in this figure). In FY 1996, the number of people served by these programs will increase by about 3 million, or 4 percent, over FY 1995. Slightly more than one-fourth of all Americans will receive Medicare or Medicaid services in FY 1996.

MEDICARE

Summary

Medicare is a Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 1996, the program will serve approximately 38.3 million eligible individuals. Medicare consists of two parts:

- Part A--Hospital Insurance (HI)

Pays for inpatient hospital care, certain inpatient care furnished in skilled nursing facilities, home health care and hospice care. The HI program is funded through the HI Trust Fund. The Fund receives most of its income from the HI payroll tax (2.9 percent of payroll, split between employers and employees).

- Part B--Supplementary Medical Insurance (SMI)

Pays for medically necessary physicians' services, outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. The Fund receives income from two sources: a general revenue transfer and premiums paid by enrollees.

Total Medicare benefit outlays in FY 1996, including the effect of legislative proposals, are estimated at \$195 billion, 11.7 percent higher than FY 1995 estimated benefit outlays. This increase in outlays reflects projected growth in beneficiary enrollment, service utilization and inflation.

Medicare Legislative Proposals

The FY 1996 budget for Medicare benefits anticipates the enactment of the legislation to extend certain current law policies that will otherwise expire. These are **not new Medicare cuts**; rather, these are policies that are currently part of the Medicare program. Inclusion of these extender provisions in the budget will lower the projected FY 1996 outlays by \$140 million, and the total FY 1996 through FY 2000 outlays by \$9.8 billion.

Listed below are descriptions, as well as savings estimates through FY 2000, for each of the proposals:

- Permanently set Part B premiums at 25 percent of SMI program costs. Under current law, Congress has set premiums at 25 percent of estimated program costs since 1982.

This law has been extended by Congress several times and will expire in 1998 (saves \$4 billion in FY 1999 and FY 2000).

- Extend the savings from the OBRA 1993 Home Health Agency (HHA) and Skilled Nursing Facility (SNF) two year temporary freeze proposals. Unlike other freezes or reductions to Medicare payments, which are permanently built into the payment base, the savings from the HHA and SNF freezes are temporary. Without new legislation, when the freezes expire, the baseline will revert to pre-OBRA or pre-freeze levels. The FY 1996 budget would permanently extend the savings stream (but not the freeze) in setting future HHA and SNF limits by not allowing for the inflation that occurred during the freeze years (saves \$1.3 billion for SNFs and \$1.6 billion for HHAs between FY 1996 and FY 2000).
- The Medicare Secondary Payer (MSP) proposals are extensions of provisions that would expire at the end of 1998. The proposals would:
 - Extend the data match between HCFA, IRS, and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare (saves \$430 million in FY 1999 and FY 2000).
 - Extend the provisions making Medicare the secondary payer for disabled employees with employer-based health insurance (saves \$2.4 billion in FY 1999 and FY 2000).
 - Extend the provision requiring non-Medicare insurers to be the primary payer for ESRD patients for 24 months before Medicare becomes the primary payer (saves \$120 million in FY 1999 and FY 2000).

In addition to these proposals, the budget includes a \$20 million negative supplemental in research and a Home Health Initiative in Survey and Certification. These proposals result in small administrative outlay savings in the Hospital Insurance trust fund of \$1 million in FY 1995 and \$62 million from FY 1995 through FY 2000.

Medicare Baseline

Under current law, we project Medicare spending to reach \$276 billion by the year 2000, based on average annual growth of 9.1 percent between 1996 and 2000. These projections are \$40 billion lower (over five years) than our Mid-session Review estimates released last summer, at which time we projected an average annual increase of 10.3 percent.

Several factors have contributed to these lower projections:

- Both general inflation and health care inflation forecasts are lower, reducing the Medicare rate of spending growth for both hospitals and physicians.
- The slower projected Hospital Insurance (HI) growth results primarily from a decline in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.
- In the Supplementary Medical Insurance (SMI) program, projected spending for both Independent Laboratory services and Outpatient services has been reduced from the Mid-session review.
- Effective program management has also helped to lower projections. For example, we have replaced five under-performing Medicare contractors, and redoubled our efforts to combat fraud and abuse against the Medicare and Medicaid programs.

MEDICARE OVERVIEW

(Beneficiaries in millions)				
	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>+/-</u>
<u>Persons Enrolled</u>				
Hospital Insurance (HI Part A)	36.3	37.0	37.6	+0.6
Supplementary Medical Insurance (SMI Part B) . . .	35.0	35.6	36.2	+0.6
(Outlays in millions) ¹				
	<u>1994 Actual</u>	<u>1995 Revised²</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
<u>Current Law:</u>				
HI Benefits	\$101,350	\$110,166	\$120,961	+\$10,795
SMI Benefits (including ESRD) .	57,997	64,016	73,619	+9,603
Peer Review Organizations . .	195	294	385	91
Subtotal, Med. Ben. w/PROs .	\$159,542	\$174,476	\$194,965	+\$20,489
HCFA Admin/Research	2,110	2,143	2,362	+219
SSA/Non-HCFA Admin	843	793	985	+192
Subtotal, Admin.	\$2,953	\$2,936	\$3,347	+\$411
 TOTAL, MEDICARE Current Law Outlays	 \$162,494	 \$177,411	 \$198,312	 +\$20,770
<u>Proposed Legislation :</u>				
Part A Savings	—	-1	-160	-159
Part B Savings	—	—	—	—
TOTAL, MEDICARE Outlays, Net Proposed Law	 \$162,494	 \$177,410	 \$198,152	 +\$20,742
<u>Offsetting Receipts</u>	-17,747	-20,122	-20,198	-76
Effect of P.L. on Offsetting Receipts ³	—	—	+1	+1
 TOTAL, MEDICARE Net Outlays ⁴	 \$144,748	 \$157,288	 \$177,955	 +\$20,667

¹ Numbers may not add due to rounding.

² The 1995 revised numbers reflect re-estimated benefits and a rescission request of \$1 million in outlays for research in the Hospital Insurance program.

³ Offsetting receipts include premiums collected from beneficiaries under Medicare Parts A and B.

⁴ Total Net Medicare Outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts. Total does not include the Clinical Laboratory Improvement Amendment (CLIA) or the HMO Loan Fund.

MEDICAID

Summary

In FY 1996, Medicaid will provide grants to States for the medical care of about 38 million low-income individuals. The Federal share of Medicaid payments is expected to reach \$96 billion. This is a \$7.5 billion (8.5 percent) increase over projected FY 1995 spending.

Enhancing State Flexibility

States have considerable flexibility in structuring the Medicaid programs, including determining provider payment rates, certification standards, and developing alternative health care delivery programs. In addition, waivers from various portions of the broad Federal guidelines are also available to States.

Freedom-of-choice waivers allow States to implement cost-effective systems of care, such as case management and competitive bidding arrangements. Home and community-based service waivers allow States to cover community-based care as an alternative to institutionalization.

States have also begun to restructure eligibility and coverage under Medicaid through the use of Section 1115 demonstration waiver.¹ Under these demonstrations, States acquire savings by incorporating managed care concepts, redirecting uncompensated care payments, and consolidating State health programs. States use these savings to expand coverage to previously uninsured populations. States are using Section 1115 waivers to reform health care by expanding coverage without increasing the amount the Federal Government would have otherwise spent. This Administration has approved seven Section 1115 demonstrations, and is committed to working cooperatively with additional States to support innovative ideas. Oregon, Tennessee, Hawaii, and Rhode Island are currently operating approved demonstrations, extending health care coverage to about 530,000 Americans who were not insured. Florida, Kentucky, and Ohio have approved waivers but have not begun operation of their demonstrations. Once fully implemented, these seven demonstrations could extend coverage to over two million individuals, at no increased cost to the Federal Government.

Background

State expenditures for medical assistance are matched by the Federal Government using a formula that measures per capita income in each State relative to the national average. Current matching rates for FY 1996 are projected to range from 50 to 78 percent for medical assistance payments and from 50 to 100 percent for administrative costs. The Federal matching rate on average is approximately 57 percent.

¹Arizona has operated its Medicaid program as a Section 1115 demonstration since inception in 1982.

Most individuals' eligibility for Medicaid is based on qualifying under the cash assistance programs of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). All AFDC and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States cover some individuals not eligible for AFDC or SSI (e.g., higher income persons in institutions, low-income pregnant women and children, and aged, blind and disabled persons below the poverty line). States may also cover "medically needy" individuals. Such persons would meet the categorical eligibility criteria, but have too much income or resources. By incurring medical expenses, these persons may spend down to the medically needy standard.

States are required to provide a core of 13 services to all eligible recipients. Those mandatory Medicaid services include inpatient and outpatient hospital care, health screening, diagnosis and treatment to children, family planning, physician services and nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, and services provided in intermediate care facilities for the mentally retarded.

Changes in Medicaid have expanded eligibility and services for certain populations, particularly previously uninsured children and pregnant women. Under these expansions, States must cover children under the age of six and pregnant women whose family income does not exceed 133 percent of the Federal poverty level. States must also phase in coverage of children aged 6 through 18, born after September 30, 1983 whose family income does not exceed 100 percent of the Federal poverty level. By 2002, all children under the age of 19 living below the poverty level will be covered by Medicaid. In addition, States are required to pay Medicare premiums and cost sharing for Medicare coverage of certain poor seniors and disabled individuals eligible for Medicare, also referred to as Qualified Medicare Beneficiaries (QMBs).

Federal Medicaid outlays rose dramatically from FY 1989 through FY 1992, at a 25 percent average annual rate. However, outlay growth slowed to less than 12 percent in FY 1993, followed by 8 percent growth in FY 1994. The decline in the rate of Medicaid increases is due to many factors, including legislative changes (such as Limits on Provider Specific Taxes and Donations), decreases in the projected growth of SSI caseloads, and States' efforts to control costs.

Legislative Proposals

Vaccines for Children: The Administration's proposal to reduce the tax revenue to the Vaccine Injury Trust Fund by 50 percent results in \$46.8 million savings to the Medicaid program in FY 1996. Reducing the vaccine excise tax results in lowering vaccine costs for public and private purchasers, which also lowers program costs in mandatory vaccine purchases for the Vaccine for Children program run by CDC and financed by Medicaid.

Undocumented Immigrants: The Administration proposes a new program to provide funding that would help offset the health-related costs of undocumented immigrants on the budgets of State and local governments. Through this \$150 million discretionary program, grants would be provided to States disproportionately affected by undocumented individuals.

MEDICAID OVERVIEW

(Recipients in thousands)

	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>+/-</u>
<u>Beneficiaries:</u>				
Aged 65 and Over	4,039	4,214	4,373	+159
Blind and Disabled	5,604	6,138	6,474	+336
Needy Adults	7,744	7,893	8,211	+318
Needy Children	16,895	17,178	17,879	+701
Other	<u>642</u>	<u>642</u>	<u>642</u>	<u>+--</u>
Unduplicated Total	34,924	36,065	37,579	+1,514

(Outlays in millions)

	<u>1994 Actual</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
<u>Current Law:</u>				
Benefits	\$78,763	\$84,836	\$92,235	+\$7,399
State and Local Administration	3,074	3,377	3,509	+132
Survey and Certification . .	132	147	154	+7
State Medicaid Fraud				
Control Units	<u>65</u>	<u>79</u>	<u>79</u>	<u>+--</u>
TOTAL, MEDICAID Current Law	\$82,034	\$88,438	\$95,977	+\$7,539
<u>Proposed Law:</u>				
Savings Proposals. .	<u>--</u>	<u>--</u>	<u>-\$47</u>	<u>-\$47</u>
TOTAL, MEDICAID Outlays, Net Proposed Law	\$82,034	\$88,438	\$95,930	\$7,492

PROGRAM MANAGEMENT

Summary

HCFA's FY 1996 Program Management budget request is \$2,254 million, a 2.1 percent increase over FY 1995. In addition to the Program Management total, we are requesting authority to spend an additional \$150 million for undocumented immigrants (see the Medicaid legislative proposals). The Program Management account provides resources for administering the Medicare and Medicaid programs. Program Management supports these activities: Medicare Contractors, Federal Administration, Medicare Survey and Certification, and Research, Demonstrations and Evaluation.

While workloads have continued to increase every year, the Program Management budget has remained relatively flat, requiring HCFA to find more efficient methods to accomplish its goals as established in its new strategic plan. HCFA has begun fulfilling this mission with the development and implementation of HCFA On-Line, the agency's multi-year communications enhancement initiative designed to improve customer service to the 70 million Medicare and Medicaid beneficiaries and their families. The plan employs modern management techniques and the use of information technology to maximize efficiency while providing increased integrity in HCFA's programs. During the FY 1996 budget process, all aspects of the program management account have been guided by this plan, positioning HCFA to administer and to re-engineer itself more productively for the challenging times ahead.

Medicare Contractors

The Medicare program is administered through private organizations, usually private insurance companies, which are referred to as contractors. Contractors' responsibilities include processing claims and making benefit payments, performing certain functions to ensure the appropriateness of Medicare payments and to protect the Medicare trust funds, developing management improvements called productivity investments, and performing a number of services to our many customers and stakeholders, the Medicare beneficiaries and the provider community.

As a result of a growing investment in the Medicare Transaction System (MTS) and an increasing claims workload, the Medicare Contractor budget will increase by 1.3 percent, from \$1,609.7 million in FY 1995 to \$1,631.1 million in FY 1996. The four key contractor activities are claims processing, beneficiary and provider services, payment safeguards and productivity investments.

Approximately 55 percent of the FY 1996 contractor budget request, or \$891.4 million, has been designated for claims processing, a 2 percent increase over FY 1995. HCFA's success

in increasing electronic media claims submissions and in reducing the unit costs of processing claims will allow the agency to process an expected 822 million claims workload in FY 1996, while remaining within statutory limits for processing times. This workload level represents a nearly 5 percent increase over revised FY 1995 estimates.

Beneficiary and provider services comprise 17 percent of the Medicare Contractors' FY 1996 request, or \$272 million. This amount will maintain funding for the Medicare beneficiary toll-free telephone lines, timely hearings and reconsiderations, prompt responses to provider and beneficiary inquiries, provider education and training efforts, and the Medicare participating physicians program. HCFA will continue with its innovative use of audio response units (ARUs) for telephone inquiries and with its use of the telephone to conduct hearing reviews and reconsiderations. These activities demonstrate HCFA's combined efforts towards more cost-effective management and a greater commitment to providing better customer service.

This request provides \$396.3 million for payment safeguard activities to prevent and recover inappropriate Medicare payments, an amount equal to the FY 1995 appropriation. Because of HCFA's commitment to these operations, surplus current year Medicare Contractor funding was channeled to payment safeguard activities. These activities include financial audits, medical and utilization reviews, and the identification of Medicare beneficiaries who have other insurance plans with primary responsibility for paying claims. Funds are earmarked to support carrier efforts in detecting, developing and investigating program fraud and abuse. HCFA expects to generate \$6.2 billion in savings to the Trust Funds with its \$391 million investment in payment safeguard activities in FY 1996, a 16 to 1 return on investment.

The budget request allocates \$72 million for productivity investments. Productivity investments enhance the cost-effectiveness and quality of contractor operations and are part of the long-term reform of Medicare administration. In FY 1996, HCFA will continue its work completing the Medicare Transaction System (MTS), a single claims processing system to replace the 11 shared systems currently in use. Other examples of FY 1996 productivity investments include transition costs for contractors leaving the program, as well as a number of administrative simplification efforts. These efforts include data standardization and electronic data interchange (EDI).

Federal Administrative Costs

In FY 1996, HCFA requests \$396 million for Federal administrative costs. This includes \$30 million to support the extensive processing requirements for the Medicare and Medicaid programs together with the necessary maintenance and enhancement of 80 automated data systems. This funding level also allows HCFA \$10 million to implement the first phase of its new investment program, HCFA On-Line, to develop more customer-friendly service.

This request also includes a staffing level of 4,147 FTE, an increase of 18 from FY 1995. This increase is the result of a reorganization of the Department that transferred to HCFA 43 FTE from the Departmental Management functions located in the regional offices. Department-wide, however, we will meet our FTE targets, thereby supporting the President's mandate on reducing the size of the Federal workforce.

Research, Demonstrations and Evaluation

FY 1996 budget requests \$64.5 million for the Research, Demonstrations and Evaluation program will support initiatives that increase HCFA's ability to better manage the Medicare and Medicaid programs by examining and developing potential program refinements. Program changes such as prospective payment for hospitals, the resource-based relative value scale for physician services and coverage of services provided by health maintenance organizations largely stem from previous research efforts.

In addition to basic research, this budget funds a rural health grant program, Information, Counseling and Assistance Grants and the Medicare Current Beneficiary Survey. The Research budget includes a negative supplemental request for FY 1995 to decrease funding by \$20 million by eliminating the Rural Health Transition Grants and the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Grant programs. These programs are no longer a priority, and the reduction eliminates a request for these programs in FY 1996.

Survey and Certification

Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA negotiates annual agreements with State agencies to perform surveys of health facilities providing services to Medicare and Medicaid beneficiaries and to ensure compliance with Departmental regulations and instructions. Facilities are routinely surveyed as a requirement of participation in the programs. The costs of these surveys are funded through the State Survey and Certification activity of HCFA's Program Management account and the Medicaid Administrative Costs activity of the Grants to States for Medicaid account.

In FY 1996, HCFA requests a total of \$162.1 million for direct survey and certification activities and workloads. This \$16.3 million increase over FY 1995 is necessary both to conduct initial inspections of more than 2,000 facilities expected to request Medicare participation, and to undertake a critical re-design of the survey process. As mandated by OBRA 87, HCFA conducts recertification surveys (over 20,000) on nursing facilities and home health agencies annually - a coverage level of 100 percent. HCFA plans to reach a recertification coverage level on non-accredited hospitals and psychiatric hospitals, hospices and other providers of 20 percent.

In addition, HCFA proposes legislation to require home health agency surveys on an average of once every 24 months, rather than the current requirement that they be surveyed every 12 months. HCFA experience with home health agency surveys indicates that quality can be maintained at this level, freeing up limited resources for targeting problem providers. All mandatory surveys will be conducted with resources more specifically targeted to error-prone facilities.

Clinical Laboratory Improvement Amendments of 1988

The Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes. CLIA '88 also introduced user fees for clinical laboratories to finance survey and certification activities. User fees are credited to the Program Management account but are available until expended for CLIA activities. The CLIA program is fully operational with about 151,000 laboratories registered with HCFA; about 25 percent of the labs are subject to routine inspection under the program.

PROGRAM MANAGEMENT OVERVIEW

(Obligations in millions)¹

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
<u>Program Management:</u>					
Medicare Contractors					
Claims Processing	\$867	\$885	\$876	\$891	+\$15
Bene./Prov. Services	262	272	272	272	0
Payment Safeguards ²	397	396	415	396	-19
Productivity Investments	<u>64</u>	<u>57</u>	<u>47</u>	<u>72</u>	<u>+25</u>
Subtotal, Medicare Contractors	1,590	1,610	1,610	1,631	+21
Survey and Certification	146	146	146	162	+16
Federal Administration	347	354	354	396	+42
Research ³	<u>80</u>	<u>89</u>	<u>69</u>	<u>65</u>	<u>-4</u>
SUBTOTAL, Program Management Budget Authority (current law) .	\$2,163	\$2,199	\$2,179	\$2,254	+\$75
Undocumented Immigrants	-	-	-	150	+150
TOTAL, PROGRAM MANAGEMENT Budget Authority (proposed law)	\$2,163	\$2,199	\$2,179	\$2,404	+\$225
CLIA	<u>24</u>	<u>46</u>	<u>46</u>	<u>45</u>	<u>-1</u>
TOTAL, PROGRAM LEVEL . .	\$2,187	\$2,245	\$2,225	\$2,449	+\$224
Total, FTE	4,119	4,129	4,129	4,147	+18

¹ Numbers may not add due to rounding.

² The FY 1995 Appropriation for payment safeguard was \$396 million. Surplus funds from the Medicare Contractor budget will be directed to these activities. The revised column reflects this estimate.

³ FY 1995 Revised includes proposed rescission of \$20 million from the Research program.

HCFA SUMMARY

(Outlays in millions)¹

	<u>1994</u> <u>Actual</u>	<u>1995</u> <u>Revised</u> ²	<u>1996</u> <u>Request</u>	<u>Request</u> <u>+/-Revised</u>
<u>Current Law:</u>				
Medicare Benefits (includes PROs and ESRD)	\$159,542	\$174,476	\$194,965	+\$20,489
Medicaid Benefits	82,034	88,438	95,977	+7,539
HCFA Administration ³ . .	2,110	2,143	2,362	+219
Other-HHS Administration	843	793	985	+192
HMO Loan Fund	—	15	—	-15
TOTAL, HCFA OUTLAYS Current Law	\$244,528	\$265,864	\$294,289	+\$28,425
<u>Proposed Law:</u>				
Medicare	—	-1	-160	-159
Medicaid	—	—	-47	-47
TOTAL, HCFA OUTLAYS Net Proposed Law . .	\$244,528	\$265,863	\$294,082	+\$28,219
<u>CLIA [Non-Add]</u>	[26]	[41]	[44]	[+3]
<u>Offsetting Receipts</u> ⁴ . . .	-17,747	-20,122	-20,198	-76
Effect of P. L. On Offsetting Receipts . .	—	—	+1	+1
TOTAL, NET OUTLAYS ⁵	\$226,781	\$245,742	\$273,885	+\$28,143
TOTAL, FTE	4,119	4,129	4,147	+18

¹ Numbers may not add due to rounding.

² The 1995 revised numbers reflect re-estimated benefits and a rescission of \$1 million in outlays in the Hospital Insurance program, as a result of the proposal to rescind \$20 million in discretionary budget authority from Research.

³ In FY 1996, includes \$150 million for the undocumented immigrants proposal.

⁴ Offsetting receipts include premiums collected from beneficiaries under Medicare Parts A and B.

⁵ Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

SOCIAL SECURITY ADMINISTRATION

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/- Revised</u>
Income	\$404,425	\$428,775	\$424,855	\$448,573	+\$23,718
Outlays	\$346,623	\$360,189	\$364,385	\$384,288	+\$19,902
FTE ¹	64,484	64,930	64,930	64,032	-898

¹ Represents FTE for all programs.

Summary

The Social Security Administration (SSA), which will be established as an independent agency on March 31, 1995, administers income security programs for the aged, disabled and economically disadvantaged. These programs include the retirement, survivors and disability insurance programs financed by the Social Security trust funds, and the Supplemental Security Income (SSI) and Black Lung programs that are funded from general revenues (see Figure 1). These funds will be distributed as cash benefits to about 50 million people. SSA's administrative costs continue to reflect the agency's efficiency by totaling less than 2 percent of overall outlays.

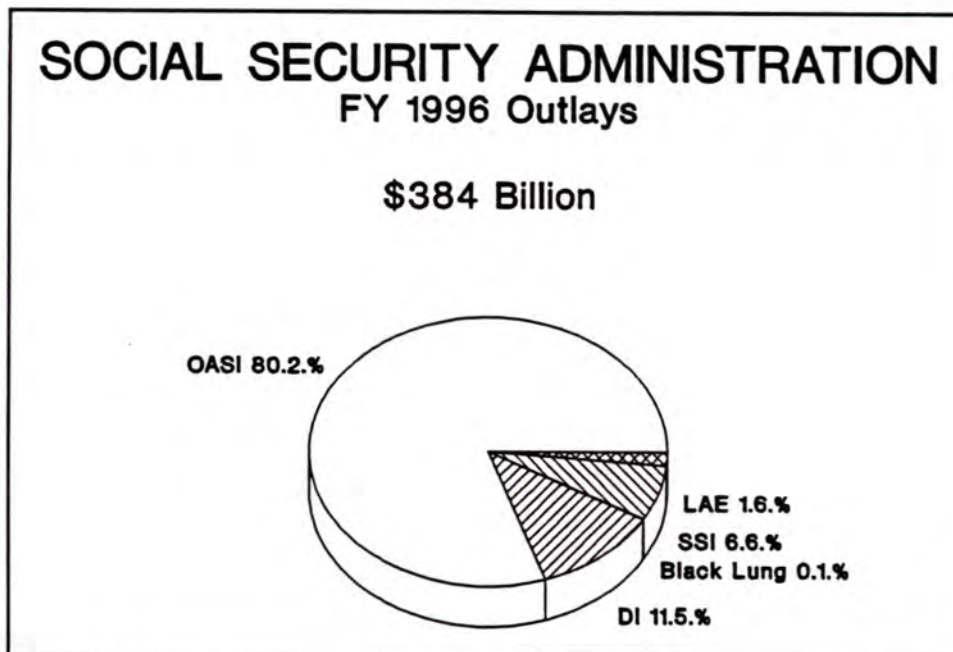


Figure 1

TRUST FUND PROGRAMS

Old Age, Survivors and Disability Insurance (OASDI)

In FY 1996, OASDI outlays will increase by \$19.9 billion, or 5.9 percent, over FY 1995. This increase can be attributed to: approximately 757,000 more beneficiaries; higher benefit amounts due to higher earnings of new beneficiaries; awards to more disabled workers; and the annual cost-of-living increase (COLA), estimated at 3.1 percent, payable in January 1996. The combined OASDI trust fund reserves will grow by nearly \$66 billion in FY 1996 and will be about \$548.7 billion or 154 percent of yearly outlays.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) moved trust fund income and disbursement off-budget. Under the terms of the Budget Enforcement Act (BEA) and OBRA 90, SSA's administrative expenses remain within discretionary spending limits.

OASDI OVERVIEW

(Outlays in Millions¹)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/- Revised</u>
<u>Outlays:</u>					
OASI Benefits	\$276,291	\$284,379	\$289,276	\$302,960	+\$13,684
DI Benefits	36,823	40,788	40,394	44,248	+3,854
Administration	2,894	2,828	2,723	3,419	+696
Other	<u>3,563</u>	<u>3,717</u>	<u>3,766</u>	<u>5,455</u>	<u>+1,689</u>
TOTAL, OASDI . . .	\$319,570	\$331,712	\$336,159	\$356,082	+\$19,923
<u>Budget Authority/Income:</u>					
OASI	\$342,278	\$364,579	\$326,342	\$361,583	+\$35,241
DI	<u>34,049</u>	<u>35,481</u>	<u>69,800</u>	<u>60,463</u>	<u>-9,337</u>
TOTAL, Budget Authority/Income . . .	\$376,327	\$400,060	\$396,143	\$422,045	+\$25,902

¹ Totals may not add due to rounding.

OASDI Program Data

Social Security pays monthly cash benefits to retired and disabled workers and their dependents, and to survivors of deceased workers. Benefits are financed primarily by payroll taxes paid by employees, employers and the self-employed. Disability applications have experienced a 10.5 percent average annual growth rate since 1990 and an additional 710,000 disability beneficiaries will have joined the rolls since 1994. The table below provides information on benefit payments and the payroll tax.

OASDI BENEFICIARY OVERVIEW

(Beneficiaries in millions)				
<u>Fiscal Year</u>				
	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>+/-</u>
<u>Average Number Beneficiaries:</u>				
OASI	37.0	37.4	37.8	+.4
DI	<u>5.3</u>	<u>5.7</u>	<u>6.1</u>	<u>+.4</u>
TOTAL, Beneficiaries	42.3	43.1	43.9	+.8
<u>Average Monthly Benefit:</u>				
Retired Worker	\$670	\$693	\$718	+\$25
Disabled Worker	\$636	\$654	\$676	+\$22

<u>Calendar Year</u>			
	<u>1994</u>	<u>1995</u>	<u>1996</u>
Projected COLA			
Payable in January	2.6%	2.8%	3.1%
Taxable wage base			
(Maximum earnings			
recorded)	\$60,600	\$61,200	\$63,000
FICA tax rate (Employers			
and employees each,			
including HI portion)	7.65%	7.65%	7.65%
SECA tax rate			
(Self-employed, including			
HI portion)	15.3%	15.3%	15.3%

Limitation on Administrative Expenses Account

The Limitation on Administrative Expenses Account (LAE) provides resources for SSA to administer the OASDI programs, the SSI program and certain health insurance functions. Included are funds for: personnel costs and operating expenses such as equipment, and space and building services; processing retirement, disability and survivors' claims; processing applications for Social Security numbers and annual earnings reports; operating a nationwide 800-number; and operating and improving SSA's automated data processing and telecommunications systems.

Although administrative costs represent less than two percent of the agency's total outlays, SSA is initiating and continuing a number of activities to ensure it is operating at the highest levels of efficiency while offering its customers world class service. These activities include continuing investments in automation and disability, as well as establishing, for the first time, a minimum funding level for conducting reviews of those on the disability rolls to ensure their continued eligibility for benefits.

The LAE budget request for FY 1996--\$6.2 billion--supports an independent SSA's drive for efficiencies and service improvements. This total includes \$534 million to continue the President's FY 1995 investment in the State Disability Determination Services (DDSs), the Office of Hearings and Appeals (OHA) and throughout other SSA components to process disability workloads resulting from increased disability applications. The total also includes \$357 million to continue the \$1.1 billion five-year investment in automation to support all of SSA's workloads, including disability. This funding provides for Intelligent Workstations, Local Area Networks and interactive software essential to the service improvements and cost reductions envisioned in the Agency Strategic Plan (ASP). This investment represents the down payment for longer-term service improvements.

The key strategic investment which will allow SSA to deal with the significant workload increases projected for the turn of the century is the Intelligent Workstation, Local Area Network initiative. It will provide the automation and communications platform essential to the service and efficiency improvements envisioned in the ASP. This technology will support reengineered business processes, such as disability, continued automation to streamline administrative and programmatic operations, and a consistent high level of customer service.

Over the last five years (1989-1994), applications for Disability Insurance and SSI disability increased by over 64 percent. As applications move through the initial decision phase and into the appeals process, the OHA is experiencing an unprecedented growth in hearings and appeals workloads. SSA projects that by FY 1996 these workloads will grow by 311,000 hearings over the FY 1989 level, an increase of 104 percent.

The Administration has targeted SSA's disability workloads as a key investment area that requires both a long and short-term strategy with several interrelated parts. For the long term, we have developed a reengineering plan for the disability process and are strongly

committed to implementing it. In the near-term we will combine additional resources with short-term initiatives to continue the recent reversal of a four year trend of increasing disability claims and hearings pending workloads. This budget request projects that the number of initial disability claims pending in State DDSs will decline by over 200,000 from FY 1994 to FY 1996, and the number of hearings pending in SSA's OHA will decrease by over 70,000 during this same period.

As SSA brings its pending disability claims and hearings workload under better control, it is increasing its monitoring of individuals currently receiving disability benefits by processing additional continuing disability reviews in FY 1996. For the first time, SSA will set a minimum funding level of \$215 million in administrative resources toward conducting continuing disability reviews. In FY 1996, SSA expects to process 431,000 CDRs compared to 270,000 in FY 1995 and about 153,000 in FY 1994.

The FY 1996 budget includes \$1.3 billion for the DDSs. This will allow States to process almost 3 million initial disability claims.

SSA will handle increasing workloads in all areas as we move into the next century by enhancing the productivity of the agency workforce through new initiatives for streamlining and restructuring, as well as automation. SSA's streamlining and restructuring will decrease supervisory ratios by 50 percent, and reduce "headquarters" staff functions and target control positions. SSA will be reallocating within its base so that we can focus agency staffing on direct workload processing in SSA field offices and OHA, reinforcing the Administration's commitment to disability workload processing.

LAE OVERVIEW

(Budgetary Resources in millions)					
	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
<u>Program Financing:</u>					
Appropriations:					
Base	\$4,877	\$5,132	\$5,132	\$5,297	+\$165
Investments:					
Disability	320	320	320	534	+214
Automation	<u>220</u>	<u>88</u>	<u>88</u>	<u>357</u>	<u>+269</u>
TOTAL, Budget Resources .	\$5,417	\$5,540	\$5,540	\$6,188	+\$648
LAE FTE¹	64,017	64,548	64,548	63,652	-896

¹ These FTE support OASDI, HI, SMI and SSI programs only. For Total FTE for all programs see SSA Overview.

GENERAL FUND PROGRAMS

Supplemental Security Income (SSI)

The SSI program provides a standard benefit for low-income aged, blind and disabled individuals and couples, as well as disabled children. Amounts paid to recipients generally vary from the standard benefit amount depending on income (e.g., earnings and Social Security benefits) and living arrangements (e.g., residence in one's own home, the household of another person, or in a nursing home which meets Medicaid standards).

SSI OVERVIEW

(Outlays in Millions¹)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Enacted</u>
Federal Benefits	\$24,461	\$25,179	\$24,990	\$25,244	+\$254
Beneficiary Services	34	143	88	143	+55
Administrative Costs . . .	<u>1,786</u>	<u>2,430</u>	<u>2,426</u>	<u>2,141</u>	<u>-285</u>
TOTAL, SSI	\$26,281	\$27,752	\$27,504	\$27,528	+\$24

¹ Totals may not add due to rounding.

Note: There are 13 SSI benefit payment checks in FY 1994, 12 in FY 1995 and 11 in FY 1996.

SSI Program Data

The maximum Federal benefit amount, adjusted for the 2.8 percent January 1995 COLA, is \$458 per month for an individual and \$687 per month for a couple. This amount will increase to \$472 per month for an individual and \$709 per month for a couple when payments are adjusted for the estimated 3.1 percent COLA payable in January 1996. Total outlays are projected to remain level from FY 1995 through FY 1996 at about \$27.5 billion per year. Outlays rise primarily as a result of the projected net increase of about 329,000 Federal recipients and the effect of the annual cost-of-living increases in January 1995 (2.8 percent) and January 1996. These increases will be offset by a reduction for the effect of 11 benefit payments in FY 1996 vs. 12 benefit payments in FY 1995 and a \$257 million reduction in funds for the SSI program share of SSA's administrative expenses.

States may choose to supplement the Federal payment and have SSA administer these supplements. Nationwide, approximately 39 percent of SSI recipients who receive Federal benefits also receive Federally-administered State supplements.

On August 15, 1994, President Clinton signed into law P.L. 103-296, the Social Security Independence and Program Improvements Act of 1994. The law places a 36-month limitation on SSI benefit payments to disabled individuals for whom drug addiction or alcoholism is a contributing factor material to the determination of disability and establishes barriers to prevent a recipient from using SSI to support an addiction. In FY 1994 and FY 1995, SSA expanded the SSI referral and monitoring program for drug addicts and alcoholics to 49 States and the District of Columbia. SSA expects to have agreements with all 50 states in FY 1995.

Benefit payments in the FY 1996 budget reflect an estimated increase of only \$254 million or about 1 percent over FY 1995. The net increase is due in large part to a projected 3.1 percent COLA and an increase of 329,000 recipients. This net increase is relatively small because the projected FY 1996 outlays include funds for 11 regular monthly benefit payments, compared to the 12 payments in FY 1995.

SSI PROGRAM DATA

(Recipients in thousands)				
	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>+/-</u>
<u>Average Number of SSI Recipients:</u>				
Federal Payments:				
Aged	1,330	1,325	1,310	-15
Blind and Disabled	<u>4,442</u>	<u>4,808</u>	<u>5,147</u>	<u>+339</u>
Subtotal	5,772	6,133	6,457	+324
State-Only Supplementary				
Payments	<u>335</u>	<u>335</u>	<u>340</u>	<u>+5</u>
TOTAL, SSI Recipients . . .	6,107	6,468	6,797	+329

(Payments in dollars)				
	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>+/-</u>
<u>Average Federal Monthly Payment:</u>				
Aged Recipients	\$209	\$217	\$226	+9
Blind and Disabled Recipients	\$358	\$372	\$386	+14
All SSI Recipients	\$324	\$338	\$353	+15

Special Benefits for Disabled Coal Miners

The Special Benefits for Disabled Coal Miners appropriation provides funds to pay monthly benefits to coal miners disabled by black lung disease and to their widows and certain other dependents, as well as pay-related administrative costs. SSA is responsible for claims filed before July 1973. The Department of Labor is responsible for most claims filed after that date.

The \$44 million decrease in the FY 1996 request reflects the continuing decline in the number of beneficiaries receiving payments administered by SSA. The number of beneficiaries is expected to decline by an additional 12,000 in FY 1996. This decline is due not only to the death of disabled coal miners, but also to the declining population of widows entitled to survivors benefits under the program.

DISABLED COAL MINERS OVERVIEW

(Outlays in millions)					
	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>+/-</u>
Benefit Payments	\$764	\$719	\$717	\$673	
Administration	<u>7</u>	<u>5</u>	<u>5</u>	<u>5</u>	
TOTAL, Special Benefits	\$772	\$724	\$722	\$678	-\$44
(Beneficiaries in thousands)					
Beneficiaries	162	150	150	138	-12

SSA SUMMARY

(Outlays in millions¹)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1995 Revised</u>	<u>1996 Request</u>	<u>Request +/-Revised</u>
<u>Trust Fund Programs:</u>					
Old Age and Survivors Insurance (OASI) . .	\$281,586	\$289,701	\$294,598	\$310,450	+\$15,852
Disability Insurance (DI)	<u>37,984</u>	<u>42,012</u>	<u>41,561</u>	<u>45,631</u>	<u>+4,070</u>
Subtotal	\$319,570	\$331,712	\$336,159	\$356,082	+\$19,923
<u>General Fund Programs:</u>					
SSI	\$26,281	\$27,752	\$27,504	\$27,528	+\$24
Black Lung	<u>772</u>	<u>724</u>	<u>722</u>	<u>678</u>	<u>-44</u>
Subtotal	\$27,053	\$28,476	\$28,226	\$28,206	-\$20
Limitation on Admin. Expenses [non-add] ² .	[5,417]	[5,540]	[5,540]	[6,188]	[+ 648]
SUBTOTAL, SSA . .	<u>\$346,623</u>	<u>\$360,189</u>	<u>\$364,385</u>	<u>\$384,288</u>	<u>+\$19,902</u>
Medicare Trust Fund	757	731	702	898	+196
Less HHS Admin . . .	<u>(39)</u>	<u>(40)</u>	<u>(40)</u>	<u>(40)</u>	<u>- -</u>
TOTAL, SSA	\$347,341	\$360,880	\$365,047	\$385,146	+\$20,099
FTE ³	64,484	64,930	64,930	64,032	-898

¹ Totals may not add due to rounding.

² These LAE amounts represent net budget authority.

³ Represents FTE for all programs.

ADMINISTRATION FOR CHILDREN AND FAMILIES

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
Program Level/BA:					
Entitlement	\$25,585	\$24,815	\$25,241	\$26,347	+\$1,106
Discretionary	<u>7,728</u>	<u>7,577</u>	<u>7,577</u>	<u>8,122</u>	+\$545
Total	\$33,313	\$32,392	\$32,818	\$34,469	+\$1,651
Outlays:					
Entitlement	\$23,759	\$24,930	\$25,212	\$26,406	+\$1,194
Discretionary	<u>5,694</u>	<u>7,603</u>	<u>7,603</u>	<u>7,699</u>	+\$96
Total	\$29,453	\$32,533	\$32,815	\$34,105	+\$1,290
FTE //	<u>1,965</u>	<u>1,983</u>	<u>1,983</u>	<u>2,009</u>	+26

1/ The 1996 Request includes the effect of FTE transfers from Departmental Management.

Summary

The FY 1996 budget request for the Administration for Children and Families (ACF) is \$34.5 billion, a net increase of \$1.7 billion over the FY 1995 level.

ACF Entitlement Programs

ACF's budget request for entitlement programs is \$26.3 billion. This represents a net increase of \$1.1 billion over the budget authority for FY 1995 in programs such as Aid to Families with Dependent Children (AFDC), Emergency Assistance, Child Support Enforcement, Foster Care, Job Opportunities and Basic Skills Training Program (JOBS), and Family Preservation and Support.

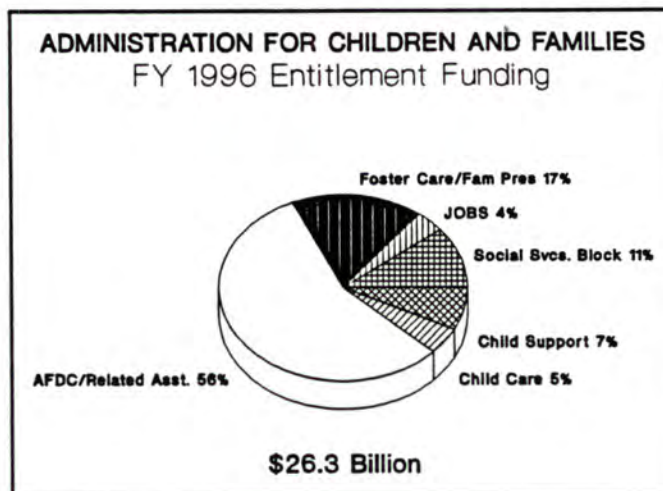


Figure 1

ACF Discretionary Programs

The FY 1996 budget includes \$8.1 billion for ACF discretionary programs--an increase of \$545 million over the FY 1995 appropriation. As displayed in Figure 2, 65 percent of ACF's discretionary spending is devoted to programs serving young children--the Head Start program and the Child Care and Development Block Grant program. The President's Budget proposes continued increases for each of these priority programs. In addition, several program consolidations and terminations are proposed.

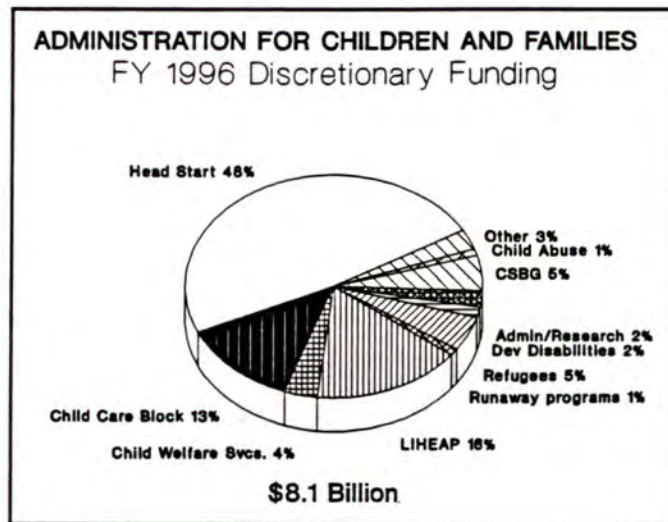


Figure 2

Head Start

Head Start is the nation's most successful program for disadvantaged children and families, providing comprehensive education, nutrition, and health services. Evaluations of Head Start children have shown positive impacts on school readiness, as well as increases in children's cognitive skills, self-esteem, achievement motivation and school social behavior. Head Start also helps to improve the parenting skills and employment related skills of Head Start parents.

Over the past two years, this Administration has targeted significant funding increases toward enhancing Head Start program quality. The strategy for these quality improvements was built on decades of research, culminating in the comprehensive report of the Head Start Advisory Committee, published in January 1994. The recommendations of this report became the guiding tenets of the 1994 Head Start Act which passed with overwhelming bipartisan support last year. Many of the Act's provisions have already resulted in measurable improvements in program quality.

In the last year, HHS has moved forcefully to ensure accountability and take prompt action against poor performers. At the same time, programs were given the resources and the flexibility to determine how best to use increased funding to correct problems and to achieve quality outcomes. Approximately 60 percent of the increased funds available to grantees in FY 1994 were used to improve facilities, hire needed family workers, and provide more competitive salaries and benefits to retain quality staff. The remaining funds were used to serve 120,000 children for more hours per day and days per year, including the provision of full-day services to 20,000 Head Start children whose parents are working or in training, and to increase enrollment by nearly 28,000 children.

Having begun the process of improving program quality and responsiveness, ACF will expand its focus in FY 1996 to increase the number of children who will benefit from Head Start. The FY 1996 budget will create 32,000 new opportunities for children and families to participate in part-day programs. In addition, 22,000 current part-day slots will be expanded to provide full-day, full-year Head Start services for children whose parents either work or are in job training. The budget includes \$3,935 million for Head Start, an increase of \$400 million, or 11 percent over the FY 1995 level.

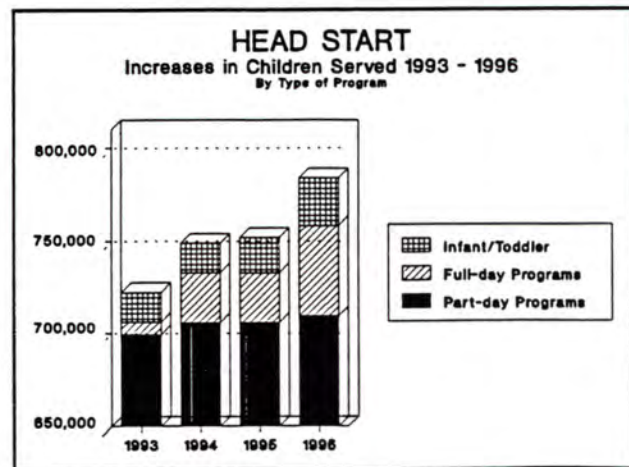


Figure 3

In FY 1996, 4 percent of the Head Start appropriation (\$157 million) will be dedicated to the recently authorized "Early Head Start Initiative" for families with infants and toddlers. Decades of research and practice have shown that high-quality programs enhance children's physical, social, emotional, and cognitive development; enable parents to be better caregivers and teachers to their children; and help parents meet their own goals, including economic independence. In developing this Early Head Start Program, HHS consulted widely with experts in early childhood development, health, and family services through a formal Advisory Committee and approximately 30 informal focus groups. The resulting program guidance will ensure that each program funded provides early, continuous, intensive, and comprehensive child development and family support services on a year-round basis to low-income families with children under age three and pregnant women. The Parent and Child Centers Program and the Comprehensive Child Development Program have been consolidated into this new initiative. In FY 1996, HHS will issue final performance standards, a Request for Proposals (RFP) for training and technical assistance, and a RFP for local evaluations. In addition, this budget request will fund 40-50 new local Head Start programs.

Child Care and Development Block Grant

Child care provides critical developmental services to children and is an essential support service to working families and families striving to become self-sufficient. Funding for child care related activities is currently provided through a number of Federal programs. This situation hampers program coordination and impedes State and local flexibility in program administration. To improve coordination among child care programs, ACF has taken two important steps. First, on January 11, 1995 a consolidated Child Care Bureau was formally established. This new organizational structure will facilitate the development of uniform policy and program guidance for all HHS child care programs. In this way, HHS hopes to move closer to providing a seamless child care continuum which spans entitlement programs for welfare recipients at one end (JOBS and Transitional Child Care) to programs for the working poor (At-Risk Child Care and the Child Care and Development Block) at the other end.

In addition, the FY 1996 budget proposes consolidating the Dependent Care and Planning Grants program and the Child Development Associate Scholarship program into the Child Care and Development Block Grant. This consolidation will provide States with a single source of funding (\$1.049 billion in FY 1996) for these complementary activities, increasing the efficiency of the Federal grants process and reducing the number of small discretionary programs. Under the existing statute, States can carry out activities to improve the quality and availability of child care and to establish early childhood development programs and before- and after-school programs.

Funding for the Block Grant will increase by \$100 million, or nearly 11 percent, above the comparable funding provided for these programs in FY 1995. This investment reflects the President's continued commitment to providing low income families with access to child care services.

CONSOLIDATED CHILD CARE BLOCK GRANT

	(Dollars in millions)		
	FY 1994 <u>Actual</u>	FY 1995 <u>Enacted</u>	FY 1996 <u>Request</u>
Child Care and Development Block Grant . .	\$893	\$935	\$1,049
Dependent Care and Planning	13	13	—
Child Development Associate Scholarships . .	<u>1</u>	<u>1</u>	<u>—</u>
TOTAL, Budget Authority	\$907	\$949	\$1,049

Runaway and Homeless Youth Consolidation

Until now, ACF has funded three separate programs to address the problems of runaway and homeless youth -- the Runaway and Homeless Youth program, the Transitional Living for Homeless Youth program, and the Drug Education and Prevention for Homeless Youth program. The FY 1996 budget proposes to consolidate these programs into a single funding source that will be phased in as current grants are completed. Since many local grantees receive funding from more than one of these three programs, this consolidation will reduce administrative overlap and allow grantees to develop proposals that focus on the runaway and homeless youth services most needed in their communities rather than meeting the specific requirements of any single program. A total of \$69 million is requested for the consolidated program, the same level provided for the component programs in FY 1995.

RUNAWAY AND HOMELESS YOUTH PROGRAMS

	(Dollars in millions)		
	FY 1994 <u>Actual</u>	FY 1995 <u>Enacted</u>	FY 1996 <u>Request</u>
Consolidated program	—	—	\$69
Basic center grants	\$36	\$40	—
Drug prevention activities	15	15	—
Transitional living	<u>12</u>	<u>14</u>	<u>—</u>
TOTAL, Budget Authority	\$63	\$69	\$69

Empowerment Zones and Enterprise Communities

The Community Empowerment Initiative is the cornerstone of the Administration's efforts to reinvigorate depressed urban and rural areas. On December 21, 1994, President Clinton formally designated nine empowerment zones and 95 enterprise communities in America's most economically distressed areas. Following the President's designation of these areas, HHS obligated \$640 million of the Title XX for social services funding available to these areas. The remaining \$360 million will be distributed on October 1, 1996 to the 6 urban and 3 rural empowerment zones. In addition to these social services funds, the zones and communities will benefit from \$2.5 billion in tax incentives.

The social services funds provide designated areas with a highly flexible funding source for activities such as programs to train and employ zone residents in the construction and rehabilitation of public infrastructure and affordable housing; after-school programs to keep schools open in the evenings and on weekends; and drug and alcohol prevention and treatment programs that provide comprehensive services for pregnant women, mothers and their children.

Community Schools, Youth Services and Supervision Program

The FY 1996 budget includes \$72.5 million, a \$47 million increase for the Community Schools Program authorized in the Violent Crime Reduction Act of 1994. The concept of community schools has already met with tremendous success in a number of locations across the country, including New York City's Beacon Schools, California's Healthy Start program, and St. Louis' Walbridge Caring Communities -- to name a few. Through this new program, ACF will help States and communities provide safe, nurturing environments for children, youth, and their families. The community schools' movement will help re-install schools as one of the centers of community life and will serve as a catalyst for other State and community activities.

Funds may be used for job creation activities -- complementing activities such as those funded under the JOBS program, with particular emphasis on community-based solutions. ACF anticipates that community organizations experienced in economic development will be targeted as the principal recipients of this funding. Funding for this program is provided from the Violent Crime Reduction Trust Fund.

Violence Against Women Programs

In FY 1996, ACF will request a number of budgetary increases for activities funded from the Violent Crime Reduction Trust Fund including:

- an additional \$15 million for grants for battered women's shelters, bringing the total resources available for grants to States, Indian Tribes, and domestic violence coalitions to \$48 million. This program provides funding for immediate shelter needs of victims of domestic violence and their dependents as well as some violence prevention activities.

- \$7 million to fund a new program of education and prevention grants to reduce sexual abuse of runaway, homeless, and street youth.
- \$400 thousand for a community demonstration program on domestic violence.

Community Economic Partnership Investment Fund

The FY 1996 budget for ACF includes \$10 million for the recently authorized Community Economic Partnership Investment Fund. This activity will provide lines of credit to community development corporations to be used for revolving loan funds, and will help strengthen emerging Community Development Corporations. Loans for small businesses made available by this fund are critical to revitalizing inner city areas that have been ravaged by crime. Funding for this activity is provided from the Violent Crime Reduction Trust Fund.

Low Income Home Energy Assistance Program (LIHEAP)

The LIHEAP program helps to offset home energy costs for low income families. Funds are provided through block grants to States, territories, Tribes, and Tribal organizations for their use in programs tailored to meet the unique requirements of their jurisdictions. Funds also support weatherization activities and "leveraging" programs which encourage State innovation. In 1993, an estimated 5.6 million households received help with heating costs. This represents approximately 20 percent of those eligible by statute.

Proposed funding for LIHEAP in FY 1996 is over \$1.3 billion, the same as in the FY 1995 appropriation. ACF recognizes that a number of low income households bear unusually high energy costs in relation to their incomes. The \$600 million contingency fund established in the FY 1995 appropriation will remain available in FY 1996 for severe weather emergencies.

Community Services Programs

The FY 1996 budget for the Community Services programs is \$417 million, a decrease of \$56 million from FY 1995. Funding for the formula Community Services Block Grant (CSBG) will remain at \$392 million, the same as for FY 1995. The Emergency Community Services for the Homeless program also will be funded at the FY 1995 level -- \$19 million. No funding is requested for the Community Economic Development, National Youth Sports, Rural Housing, Farmworkers Assistance, CSBG Technical Assistance, and Demonstration Partnership programs. These terminations reflect the impact of tightened discretionary spending limitations and the desire to reduce the number of Federal programs.

Refugee Resettlement

The FY 1996 budget request for the Refugee and Entrant Assistance program is \$414 million, a \$14 million increase over FY 1995. The increase is requested in order to

continue funding eight months of Transitional and Medical Services, the same level as in FY 1995. These funds will support State efforts to help refugees and Cuban and Haitian entrants become employed and self-sufficient as quickly as possible. Sufficient funding is included to support the anticipated refugee ceiling of 90,000 in 1996 as well as the costs of anticipated Cuban migration resulting from the bilateral U.S. - Cuban joint migration agreement.

Electronic Benefits Transfer

ACF is requesting \$2 million towards development of a government-wide system to deliver benefits electronically (EBT). This system will replace today's multiple paper systems, help reduce benefit fraud, and provide better service to recipients at a lower cost to the taxpayer. Under EBT, recipients use a single EBT card to electronically access one or more types of benefit payments ranging from welfare to Social Security.

Federal Administration

To administer the programs funded by ACF, \$174 million is requested in FY 1996, an increase of \$11 million or 6.7 percent over FY 1995. Activities supported by this appropriation include salary and benefit costs for Federal employees, computer support, communications charges, rent and utilities payments, printing costs, and travel to support program activities including Congressionally mandated reviews. The increase requested will support: transfer of regional administrative functions; increased programmatic and financial oversight of federally funded activities; and improvements in automated systems to support streamlining and program reform efforts.

CHILD WELFARE

Foster Care, Adoption Assistance and Independent Living

A total of \$4.3 billion, an increase of \$684 million over FY 1995, is requested in FY 1996 for the Foster Care, Adoption Assistance and Independent Living programs. The majority of this increase, \$622 million, is needed for the Foster Care program, which will assist almost 273,000 children each month. This increase is for State operational services, training, and enhanced (75 percent) matching for Statewide child welfare case management systems, as well as maintenance costs. In FY 1996, under the Adoption Assistance program, \$488 million (an increase of \$62 million over FY 1995) is requested to provide subsidy payments to families who have adopted children, as well as a supplemental request of \$26 million for FY 1995. Such payments will support almost 119,000 children each month in FY 1996. Payments are received on behalf of adopted children through their 18th birthday. For the Independent Living program, \$70 million is again requested to continue services to help teenagers make the transition to living on their own.

Family Preservation and Support

This program provides innovative family preservation and support services to families who previously would have received little more than foster care placement services. In FY 1996, funding will grow to \$225 million, an increase of \$75 million from the previous year. Funds from the Family Preservation and Support program allow States to develop community-based family support programs that assist parents in improving their parenting skills and help them find support among their peers, as well as intensive family preservation services to help families at imminent risk of dissolution. Funds will also be used to provide rigorous evaluations of family preservation and support programs.

INCOME SUPPORT AND TRAINING

Job Opportunities and Basic Skills Training

A total of \$1 billion is requested in FY 1996 to support the Job Opportunities and Basic Skills Training (JOBS) program, mandated by the Family Support Act of 1988, the centerpiece of current efforts to help welfare recipients achieve self-sufficiency. The program gives States flexibility to provide training and work opportunities geared to their particular AFDC recipients' needs.

Currently, over 640,000 people are active in JOBS programs each month. States have wide flexibility in structuring the mix of programs they offer to recipients. Programs must include: educational activities (e.g., high school or equivalent level, basic and remedial education); job skills training; job readiness training activities; and job development and placement assistance. States must also include at least two of the following components in their programs: job search; on-the-job training; work supplementation programs; and community work experience programs.

Aid to Families with Dependent Children and Related Programs

The Aid to Families with Dependent Children (AFDC) program provides funding to States for cash assistance to low-income families with dependent children who have been deprived of parental financial support due to the death, disability, unemployment or continued absence of a parent. New budget authority requested for AFDC benefits increases in FY 1996 by \$545 million (4.4 percent), to \$12.9 billion. Budget authority for AFDC State and local administrative costs also increases to \$1.8 billion, albeit at a slower rate of 3.1 percent.

The increased AFDC costs reflect continued growth (+181,000 cases) as well as higher average monthly benefits (+\$4.19/case) projected for the AFDC caseload. While this growth is projected to slow substantially following FY 1996, increases in the range of 2 percent annually persist. This reflects the continuing problem posed by the formation of a growing number of poor, single, female-headed households.

In addition to AFDC benefits, States also have the option of operating the AFDC Emergency Assistance (EA) program. This program provides financial assistance, medical, and/or social services to needy families with children to meet temporary, emergency needs. Budget authority of \$974 million is requested for FY 1996, including \$79 million to pay for claims from prior years. The request reflects a 62 percent increase in funds over the last two years. In past years this was a relatively small program, implemented by about half the States, with annual Federal costs of less than \$200 million. Fifty jurisdictions, up from 40 in 1993, were operating EA programs as of January 1995. At the same time, increasing numbers of States have decided to cover a wider range of emergencies (e.g., various types of child protective services and medical emergencies for children not receiving Medicaid) and to cover a broader range of recipients (e.g., expanding eligibility to other than current AFDC recipients by using the AFDC needs standard, which is generally lower than the poverty level).

AFDC Child Care

The Family Support Payments to States account funds child care for JOBS participants, former AFDC recipients, and those at risk of becoming AFDC recipients. Just over \$1.2 billion is requested for these child care programs in FY 1996. More than half of these funds, \$734 million, will support current AFDC recipients' efforts to become self-sufficient by paying for the child care these recipients need to participate in JOBS activities. These funds are projected to serve over 512,000 children each month. As recipients become self-sufficient and leave the AFDC rolls due to increased employment income, the Transitional Child Care program will provide up to 12 months of child care to ease the transition from welfare to work. A total of \$220 million is requested for this program in FY 1996, to serve more than 139,000 children monthly. Finally, the At-Risk (non-AFDC) Child Care program provides child care assistance to families at risk of becoming AFDC recipients. The FY 1996 request for this program totals \$300 million.

Child Support Enforcement

The Child Support Enforcement (CSE) program is a joint Federal, State and local partnership that seeks to locate noncustodial parents, establish paternity, and set and enforce support orders. Costs of these activities are jointly financed by the Federal Government (66 percent) and the States (34 percent). The first \$50 of currently-due support collected on behalf of an AFDC family in a month are given to that family, while the balance can be used by Federal, State and local governments to offset their costs of assisting these families. From the Federal share, States also receive an incentive payment based on program efficiency and the amount of their collections. The remaining Federal share is available to offset Federal AFDC benefit costs. Collections made on behalf of non-AFDC families are paid directly to these families. For non-AFDC families with low incomes, receipt of child support collections assists them in remaining off the welfare rolls.

Since the creation of the child support enforcement program, total child support collections have increased annually. In recent years, States have increased collections by using approaches such as income withholding, offset of income tax refunds, support guidelines and closer links to credit bureaus. In FY 1996, \$11.2 billion in child support collections are

projected to be distributed to families and shared by governments, an 8.6 percent gain in collections over FY 1995. In FY 1996, this represents a total return of almost \$4 for every dollar invested in the administration of the program. Since the inception of the program in FY 1975, a total of \$72.5 billion has been collected.

In 1994, the Office of Child Support Enforcement (OCSE) launched a new initiative to promote dramatically improved performance, service quality and public satisfaction with the child support enforcement program. As part of a two-year pilot project under the Government Performance and Results Act (GPRA), HHS has begun to "reinvent" and strengthen its partnerships with State child support agencies. For example, OCSE has approved 28 applications from State and local governments to implement innovative approaches for addressing major issues in the program. Examples include new efforts to improve access to medical insurance, encourage welfare mothers cooperation in identifying and locating alleged fathers, and provide employment counseling to noncustodial parents.

CHILD SUPPORT ENFORCEMENT AND COLLECTIONS AND COSTS

	(Dollars in millions)			
	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
<u>Total Collections:</u>				
AFDC	\$2,466	\$2,612	\$2,853	+\$241
Foster Care	18	19	20	+1
Non-AFDC/FC	<u>7,124</u>	<u>7,721</u>	<u>8,371</u>	<u>+650</u>
Collections	\$9,608	\$10,352	\$11,244	+\$892
<u>Distribution of AFDC/FC Collections:</u>				
Paid to AFDC Families	\$454	\$479	\$520	+\$41
Retained by Government				
Net Federal Share	768	811	875	+64
State Share plus Incentives . .	<u>1,244</u>	<u>1,322</u>	<u>1,458</u>	<u>+136</u>
TOTAL	\$2,466	\$2,612	\$2,853	+\$241
<u>Administrative Costs:</u> (Obligations)				
Federal Share	\$1,757	\$1,957	\$1,952	-\$5
State Share	<u>814</u>	<u>907</u>	<u>975</u>	<u>+68</u>
Costs	\$2,571	\$2,864	\$2,927	+\$63
<u>Program Savings and Costs:</u> (Collections minus Costs)				
Federal Costs.	\$989	\$1,146	\$1,077	-\$69
State Savings	<u>-430</u>	<u>-415</u>	<u>-483</u>	<u>-68</u>
Net Costs	\$559	\$731	\$594	-\$137

ACF OVERVIEW

(Program Level, Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
<u>Discretionary Programs:</u>					
Head Start	\$3,325	\$3,535	\$3,535	\$3,935	+\$400
Comprehensive Child Dev. . . .	46	—	—	—	—
Low-Income Home Energy . . .	1,437	1,319	1,319	1,319	—
Emergency funding	300	—	—	—	—
Child Care, Consolidated Program:					
Child Care and Dev. Block . .	\$893	\$935	\$935	\$1,049	+\$114
Dependent care	13	13	13	—	-13
Child develop. scholar.	<u>1</u>	<u>1</u>	<u>1</u>	<u>—</u>	<u>-1</u>
Subtotal, Child Care	\$907	\$949	\$949	\$1,049	+\$100
Community Services Programs .	464	473	473	417	-56
Refugee & Entrant Assistance . .	400	406/1	406/1	414	+8/1
Runaway and Homeless Youth:					
Consolidated Program	—	—	—	\$69	+\$69
Basic Grants	36	40	40	—	-40
Drug Activities	15	15	15	—	-15
Transitional Living	<u>12</u>	<u>14</u>	<u>14</u>	<u>—</u>	<u>-14</u>
Subtotal, RHY programs	\$63	\$69	\$69	\$69	—
Child Welfare Services	295	292	292	292	—
Developmental Disabilities	115	122	122	122	—
Child Abuse Prevention	76	77	77	77	—
Native Americans	38	38	38	38	—
Violence Against Women Programs	28	34	34	55	+21
Community Schools	—	26	26	73	+47
Community Economic Partnership	—	—	—	10	+10
Social Services Research	14	15	15	15	—
Other Children's Programs	60	61	61	61	—
EBT Task Force	—	—	—	2	+2
Federal Administration	<u>160</u>	<u>163</u>	<u>163</u>	<u>174</u>	<u>+11</u>
PROGRAM LEVEL/BA	\$7,728	\$7,577	\$7,577	\$8,122	+\$545

1/ An additional \$6 million in Technical Assistance Funding was made available through the Foreign Operation Appropriation.

ACF OVERVIEW, CONTINUED

(Program Level, Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1995 <u>Revised</u>	1996 <u>Request</u>	Request <u>+/-Revised</u>
<u>Entitlement Programs:</u>					
Social Services Block	\$2,800	\$2,800	\$2,800	\$2,800	--
Social Svcs. Empowerment . . .	1,000	--	--	--	--
Obligations: [non-add]	[--]	[640]	[640]	[360]	[-280]
Foster Care/Adoption Assist. . .	2,993	3,597	3,624	4,308	+684
Family Support & Pres	60	150	150	225	+75
JOBS (BA)	1,100	1,300	1,300	1,000	-300
Obligations: [non-add]	[873]	[965]	[980]	[930]	[-50]
Family Support Payments:					
AFDC/Related Assist	11,804	11,754	11,593	12,073	+480
Emergency Assistance	553	656	864	974	+110
Child Care	1,006	1,011	1,222	1,254	+32
AFDC State Admin	1,668	1,612	1,716	1,770	+54
Child Support Enforcement . .	<u>1,789</u>	<u>1,929</u>	<u>1,966</u>	<u>1,943</u>	<u>-23</u>
Subtotal, FSP	\$16,820	\$16,962	\$17,361	\$18,014	+\$653
SLIAG	812	6	6	--	-6
 SUBTOTAL, Entitlements	 \$25,585	 \$24,815	 \$25,241	 \$26,347	 +\$1,106
 TOTAL, ACF	 	 	 	 	
Budget Authority	\$33,313	\$32,392	\$32,818	\$34,469	+\$1,651
FTE	1,965	1,983	1,983	2,009	+26

ADMINISTRATION ON AGING

(Dollars in millions)

	<u>1994</u> <u>Actual</u>	<u>1995</u> <u>Enacted</u>	<u>1996</u> <u>Request</u>	<u>Request</u> <u>+/-Enacted</u>
Program Level	\$878	\$877	\$897	+\$20
Outlays	\$860	\$868	\$880	+\$12
FTE/1	189	192	194	+2

1/ The 1996 Request includes the effect of transfers from Departmental Management.

Summary

The FY 1996 budget for the Administration on Aging (AoA) provides \$897 million for programs aimed at improving older Americans' quality of life. Programs funded by AoA help senior citizens remain independent and productive. Figure 1 displays the distribution of AoA program spending among Meals Programs, Senior Centers/Supportive Services, and other AoA activities.

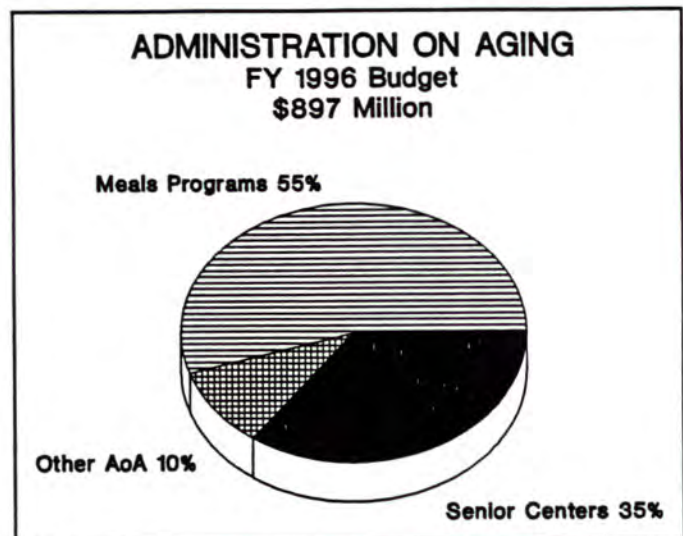


Figure 1

Program Highlights

The FY 1996 budget request will provide funding for:

- A network of 57 State units, 228 Indian Tribal organizations, 657 Area Agencies on Aging, approximately 6,000 senior centers and more than 25,000 service providers throughout the country.
- Over 230 million meals--about half of meal recipients are low-income elders and about 17 percent of recipients are members of minority groups.
- Supportive services including over 40 million rides, over 12 million responses for information and referrals, nearly 10 million personal care services to elderly in need and about one million legal counseling sessions.

- Services for the frail elderly, including an additional 1.3 million personal care services and 700,000 reassuring visits and telephone calls.

AoA serves older persons and their families through the administration of the Older Americans Act and aging-related research and educational projects. As the focal point in the Federal Government for serving older persons, AoA works to advance the dignity and independence of the nations' elderly. By the year 2030, the number of people aged 60 and older will increase to 89 million, while those 85 and older will increase to almost nine million. AoA recognizes the need to address these demographic changes, and is striving to prepare both older and younger Americans for their aging.

Home and Community Based Care

The FY 1996 budget includes an increase of \$19 million to provide grants to States for developing improved home and community-based care for older persons, particularly those with disabilities. Home and community-based care enables older persons to maintain as much of their independence as possible and to avoid or delay institutionalization.

These grants will allow States to develop and/or build improved systems that track and target service delivery. Currently, States are in various stages of developing these capacities. Such systems will enhance the States' capacity to manage and coordinate more effectively the Older Americans Act and other programs that provide long-term care services to vulnerable older persons. The Aging Network has tested the improvement of delivery of home and community based services through infrastructure improvements. Much has been achieved in the development of case management systems, single entry point, pooling resources, and coordination of policy making.

Other FY 1996 funding increases include Indian/Tribal grants (+\$1 million), Elder Abuse Prevention (+\$1 million), and Federal administration (+\$1 million).

White House Conference on Aging

AoA will assist the President in conducting a White House Conference on Aging (WHCoA) on May 2-5, 1995, in Washington, D.C. The WHCoA was authorized by Congress (P.L. 102-375) to heighten public awareness of aging issues, identify problems and develop recommendations that will guide aging policy into the 21st century.

The proposed theme for this year's conference is "America Now and into the 21st Century: Growing Older with Independence, Opportunity and Dignity." Major issues include health care, long-term care, promoting economic security through employment and retirement income/resources, and maximizing housing, support services and quality of life options. Approximately 600 "pre-White House Conferences on Aging" have taken place in all 50 states. More than 13,000 individuals, about 75 percent seniors, have attended these pre-WHCoA events. For the 1995 conference, over 2,200 delegates representing each State, as well as various aging groups, will attend. FY 1996 funding of \$500,000 will be used to close out the conference and to prepare, publish and distribute the WHCoA report.

AoA OVERVIEW

(Dollars in millions)

	<u>1994</u> <u>Actual</u>	<u>1995</u> <u>Enacted</u>	<u>1996</u> <u>Request</u>	<u>Request</u> <u>+/-Enacted</u>
Supportive Services	\$307	\$307	\$307	\$-
Meals:				
Congregate Meals	376	376	376	-
Home-Delivered	<u>94</u>	<u>94</u>	<u>94</u>	<u>-</u>
Subtotal, Meals	\$470	\$470	\$470	\$-
In-home Services-Frail Elderly.	7	9	9	-
Indian/Tribal Grants	17	17	18	+1
Preventive Health	17	17	17	-
Research, Training and Demos.	26	27	45	+19
Ombudsman Services.	4	4	4	-
Prevention of Elder Abuse	5	5	6	+1
Pension Counseling.	2	2	2	-
Federal Administration	16	16	17	+1
White House Conference	<u>1</u>	<u>3</u>	<u>1</u>	<u>-2</u>
TOTAL, AoA Budget Authority	\$878	\$877	\$897	+\$20
<i>FTE</i>	<i>189</i>	<i>192</i>	<i>194</i>	<i>+2</i>

DEPARTMENTAL MANAGEMENT

(Dollars in millions)

	<u>1994 Actual</u>	<u>1995 Enacted</u>	<u>1996 Request</u>	<u>Request +/-Enacted</u>
BA/Income . . .	\$135	\$136	\$134	-\$2
Outlays*	\$132	\$139	\$135	-\$4
FTE	2,503	2,490	2,146	-344**

* Figures exclude outlays from the Public Health and Social Service Emergency Funds (\$50 million in FY 1994 and \$75 million in FY 1995).

** Includes 203 FTE in functional transfers to the Operating or Staff Divisions.

Summary

The FY 1996 budget request for Departmental Management (DM) includes \$134 million in obligational authority. The DM budget includes requests for three separate appropriations--General Departmental Management, Policy Research, and Office of Consumer Affairs.

DM is proposing important changes in its structure consistent with recommendations of the National Performance Review (NPR). The NPR report recommended that HHS conduct a comprehensive review of organizational structure and management systems to determine the appropriate balance between centralized and decentralized functions. In its initial reform effort, HHS is re-structuring its field operations and eliminating administrative support and overhead staff, and has divested those functions to the regional Operating and Staff Divisions.

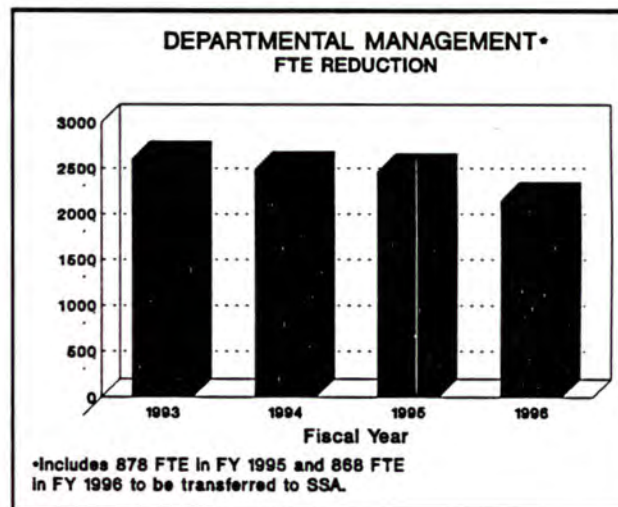


Figure 1

These efforts, including divestiture of functions to the HHS Operating Divisions and savings associated with reengineering and reinvention, will result in the reduction in full-time equivalent staffing in DM from 2,597 FTE in FY 1993 to 2,146 FTE in FY 1996--a reduction of 451 positions, or 17 percent. In addition, 878 DM positions will be transferred to the Social Security Administration (SSA)

when it is established as an independent agency on March 31, 1995. The second phase of reinvention--to be completed by March 31--will focus on the appropriate field structure for the Staff and Operating Divisions and headquarters structure after SSA independence.

General Departmental Management

The FY 1996 budget request for General Departmental Management (GDM) is \$120 million. GDM supports those activities associated with the Secretary's roles as chief policy officer and general manager of the Department. GDM also supports the central policy and administrative management functions performed in DM, including personnel management, administrative and management services, information resources management, intergovernmental relations, legal advice and representation, planning and evaluation, finance and accounting and external affairs. The Working Capital Fund is a revolving fund providing centralized personnel, financial and administrative management services to the Department's components in headquarters and the ten regions. In FY 1996, the regional administrative support services functions and resources under the Working Capital Fund will be transferred to the regional Staff and Operating Divisions. These changes will result in the transfer of 203 FTE to the OP/STAFFDIVs and savings of 54 FTE and \$24 million over five years.

Policy Research

The FY 1996 budget request includes \$12 million for Policy Research (PR) to support grants for research on issues of national significance. Priority issues that PR will examine are those related to health care and welfare reform, at-risk children and youth, aging and disability, improved access to health care and support services, and increased family support and independence.

U.S. Office of Consumer Affairs

The FY 1996 budget request for the U.S. Office of Consumer Affairs is \$2 million. These funds will support presentation of consumer viewpoints within the Executive Branch and publication and distribution of the *Consumer's Resource Handbook* and other consumer information materials.

DEPARTMENTAL MANAGEMENT SUMMARY

(Dollars in millions)

	<u>1994</u> <u>Actual</u>	<u>1995</u> <u>Enacted</u>	<u>1996</u> <u>Request</u>	<u>Request</u> <u>+/-Enacted</u>
General Departmental Management .	\$121	\$121	\$120	-1
Policy Research	12	13	12	1
Office of Consumer Affairs	2	2	2	--
Total Obligational Authority . . .	\$135	\$136	\$134	-2
OASDI Trust Fund	<u>-23</u>	<u>-23</u>	<u>-24</u>	<u>-1</u>
TOTAL, Budget Authority . . .	\$112	\$113	\$110	-3
FTE*	2,503	2,490	2,146	-344

* Figures include Working Capital Fund FTE.

OFFICE FOR CIVIL RIGHTS

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/- Enacted</u>
BA/Income . .	\$22	\$22	\$21	-1
Outlays	\$22	\$22	\$21	-1
<i>FTE</i>	284	297	276	-21

Summary

The FY 1996 budget request for the Office for Civil Rights (OCR) is \$21 million, a decrease of \$1 million from the FY 1995 level. OCR is responsible for enforcing nine major civil rights statutes that prohibit discrimination in Federally-assisted health care and social services programs. These statutes include Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, the Hill-Burton community service assurance, the Age Discrimination Act, authority delegated under the Americans with Disabilities Act, and provisions of the Omnibus Budget Reconciliation Act of 1981 requiring non-discrimination in block grant programs administered by HHS. In addition, OCR is responsible for coordinating the implementation of the Section 504 regulation that prohibits discrimination against persons with disabilities in programs and activities conducted by HHS.

OCR enforces nondiscrimination requirements by processing and resolving discrimination complaints, conducting reviews and investigations, monitoring corrective action plans, carrying out voluntary compliance, outreach and technical assistance activities.

OCR has made significant progress in addressing issues such as race discrimination in access to health care and discrimination against persons with disabilities. In FY 1994, OCR completed 5,967 discrimination complaint and review cases, an increase from 5,434 case closures in FY 1993.

This budget request reflects the continuation of the implementation of OCR's strategic plan. The plan calls for significant re-engineering of OCR's investigative and compliance processes through redesign, streamlining and the use of innovative partnerships both within HHS and at the State and local levels. While FTE usage dropped from 303 in FY 1993 to 276 in FY 1996 (a 9 percent decrease), productivity in closing reviews and complaint investigations is projected to increase by nearly 30 percent. In addition, the FY 1996 budget request includes funds to support outreach initiatives that seek new ways of preventing civil rights problems and addressing potential discrimination in HHS programs.

OFFICE OF CIVIL RIGHTS SUMMARY

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/- Enacted</u>
Total Program Level	\$22	\$22	\$21	-1
OASDI Trust Fund	=	=	=	=
TOTAL, Budget Authority . . .	\$22	\$22	\$21	-1
FTE	284	297	276	-21

OFFICE OF INSPECTOR GENERAL

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
BA/Income . . .	\$100	\$100	\$102	+2
Outlays	\$98	\$101	\$101	--
<i>FTE</i>	1,257	1,265	1,260	+2

Summary

The FY 1996 budget request for the Office of Inspector General (OIG) is \$102 million in total obligational authority, an increase of \$2 million above the FY 1995 level. OIG is charged with: (1) conducting and supervising audits and investigations relating to programs and operations of HHS; (2) providing leadership and coordination for and recommending policies and corrective actions concerning activities designed to promote economy and efficiency in the administration of the Department's programs; and (3) preventing and detecting fraud and abuse in HHS' programs and operations.

In FY 1996, OIG will focus its resources in the following areas: review departmental efforts to improve children's welfare and child support enforcement collection initiatives; evaluate providers and services in the Medicare and Medicaid programs; ensure the effectiveness of the Public Health Service delivery programs; and audit management control systems and financial operations. All of these reviews will assist program managers to improve the health and welfare of program beneficiaries.

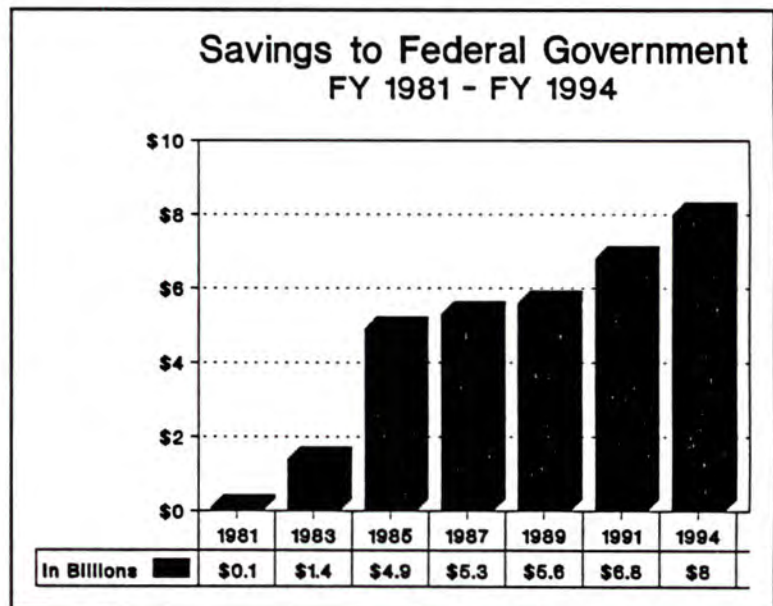


Figure 1

In FY 1994, OIG activities resulted in over \$8 billion in settlements, fines, restitutions, receivables and savings to the Federal Government. The return on investment continues to increase from \$160,000 per

OIG FTE in 1981, to \$6.4 million in 1994, and from \$4 in savings for every OIG budget dollar spent in 1981, to \$80 in savings for every OIG budget dollar spent in 1994.

During the same time period, successful judicial prosecutions rose from 165 in FY 1981, to 1,169 in FY 1994.

Administrative sanctions against individuals or entities that defrauded or abused HHS programs and/or beneficiaries also rose from 39 in FY 1981, to 1,334 in FY 1994.

OIG is streamlining its operations and management structure to minimize costs and ensure that the greatest proportion of resources is concentrated on investigations, audits, and inspections.

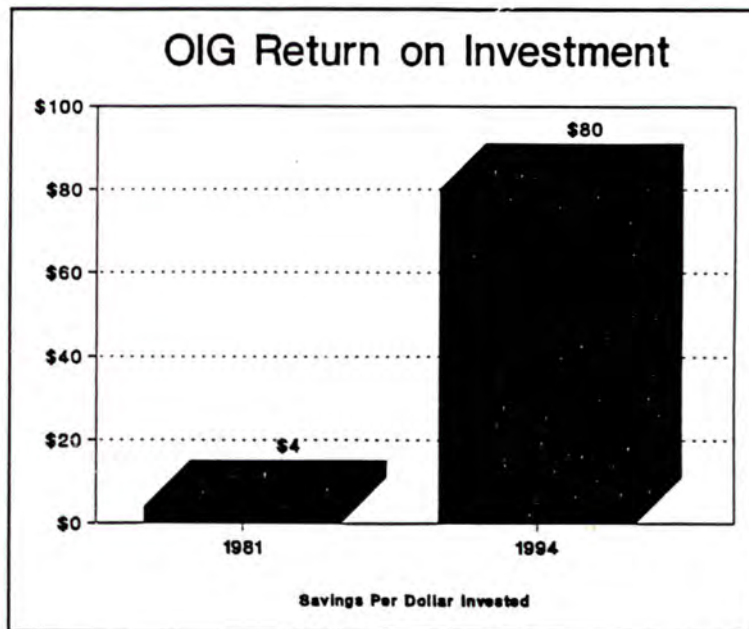


Figure 2

OIG is reinventing its processes and exploring creative ways to effectively deploy its resources to aggressively combat fraud, abuse, and waste in the Department's programs, including:

- The establishment of a Partnership Plan between OIG and State Auditors. Such partnerships will provide broader audit coverage of significant issues in the Medicaid program and lead to a more effective, efficient and economical delivery of health care services and improved use of audit resources. In addition to taxpayer dollars recovered, this partnership identifies issues that will result in program improvements and reduce the cost of providing needed services to Medicaid recipients. Partnerships between OIG and State Auditors/Comptrollers in North Carolina, Louisiana, New York, and Massachusetts are already in place.
- The involvement in a nationwide review of the Medicaid prescription drug program in eight States with the National State Auditors Association. OIG plans to expand its involvement in other States to include other health care issues.
- The development of a "voluntary disclosure" program that offers certain Federally-funded health care providers incentives to disclose any fraud and abuse they discover within their companies. OIG is working with the Department of Justice, the Federal Bureau of Investigation and the HHS Office of General Counsel on this program.
- The continuation of a number of on-going initiatives related to home health agencies, durable medical equipment and nursing homes. One new effort underway is a national investigation into the marketing and billing of incontinent care kits and supplies to nursing home residents. Currently, OIG has identified and opened 20 investigations involving 100 subjects with additional cases expected.

OFFICE OF INSPECTOR GENERAL SUMMARY

(Dollars in millions)

	1994 <u>Actual</u>	1995 <u>Enacted</u>	1996 <u>Request</u>	Request <u>+/-Enacted</u>
Total, Program Level	\$100	\$100	\$102	+2
OASDI Trust Fund	<u>-16</u>	<u>-16</u>	<u>-16</u>	=
TOTAL, Budget Authority . . .	\$84	\$84	\$86	+2
FTE	1,257	1,265	1,260	-5