6. STRENGTHENING HEALTH CARE

> *We still have a lot of work to do. But the answer to the problems of the great American middle class, the answer to the problem of curing the American deficit, the answer to the problem of dealing with the challenge of educating a new generation of Americans for a new, highly competitive economy—surely the answer to those problems is not to break down the one thing we have done right completely, which is to keep faith with our elderly people.*
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> President Clinton
> July 1995

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

With this in mind, our challenge is to build on the existing health care system—to protect its strengths and address its weaknesses—as the President has tried to do for the last three years. It is not to do as others would—that is, to tear it down.

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

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

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

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

In addition, the budget proposes $26.9 billion, a $1.2 billion increase over 1996, for a wide range of public health services as well as research and regulatory activities that promote public health.

- The services range from community health centers in inner cities, to clinics on remote Indian reservations, to research activities at prestigious universities and medical schools. Public health clinics provide immunizations for uninsured children, dental care for the underinsured, and prenatal

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

care for millions of low- and moderate-income women. Other public health services that help those in need include the Ryan White program, which gives States and cities the resources to deliver vital services to people with AIDS.

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

STRENGTHENING MEDICARE

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

The plan saves $124 billion over seven years, as estimated by the Health Care Financing Administration's Office of the Actuary. The Administration is proposing policies that save $124 billion in Medicare using either the Administration's or CBO's "baseline" (i.e., projection of Medicare spending). The Administration will work with Congress to ensure that any plan that the President proposes will save $124 billion as estimated by CBO.[2]

Provider Payment Reforms and Program Savings

- *Hospitals.*—The budget reduces the annual inflation increase, or "update," for hospitals; reduces payments for hospital capital; reforms payments for graduate medical education; and begins to reform the payment method for outpatient departments while protecting beneficiaries from increasing charges for those services.
- *Managed Care.*—The budget reforms payments by using reasonable rate-of-growth limits on updates for managed care payments and reducing the current geographic variation in payments.
- *Physicians.*—The budget reforms physician payments by paying a single update for all physicians[3] and replaces current "volume performance standards" with a sustainable growth rate.
- *Home Health Care/Skilled Nursing Facilities.*—The budget implements interim payment reforms, leading to separate prospective payment systems for home health care and skilled nursing facilities.
- *Fraud and Abuse.*—The budget introduces aggressive and comprehensive policies to stamp out Medicare waste, fraud, and abuse, and extends and enhances Medicare's secondary payor policy to ensure that Medicare pays only when it should.
- *Other Providers.*—The budget freezes or reduces payments for durable medical equipment and ambulatory surgical centers.
- *Beneficiaries.*—The budget continues, but does not increase, the requirement that beneficiaries pay 25 percent of Part B costs through the monthly Part B premium; it imposes no new cost increases on beneficiaries.

Provisions to Improve Rural Health Care

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

[2] The Administration expects that, for technical reasons—e.g., different assumptions about how fast Medicare spending will grow, and how providers and beneficiaries will behave—the Congressional Budget Office (CBO) will estimate that the Administration's plan saves slightly less. In that event, the Administration has identified a way to close the gap—specifically, by changing the legal formula for paying hospital outpatient departments to better reflect actual costs.

[3] The hospital update will be based on a single "conversion factor," or base payment amount, replacing the current three conversion factors, effective January 1, 1997.

provides grants to promote telemedicine and rural health outreach.

Provisions to Expand Choices and Add Preventive Benefits

The budget expands and improves Medicare managed care by:

- ensuring beneficiary protections while increasing the types of plans—including Preferred Provider Organizations and Provider Sponsored Networks—available to seniors and people with disabilities; and
- instituting a coordinated annual open enrollment process—similar to that used by the Federal Employees Health Benefits Plan—during which beneficiaries use comparative information to choose among managed care and supplemental insurance options.

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

STRENGTHENING MEDICAID

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

The budget saves $59 billion over seven years by imposing a per-person limit on spending, and cutting Disproportionate Share Hospital payments and retargeting them to hospitals that serve large numbers of Medicaid and uninsured patients. As with Medicare, the Administration expects CBO to make somewhat different estimates about how much the budget would save in Medicaid. In this case, too, the Administration will work with Congress to ensure that any plan that the President proposes saves $59 billion under CBO estimates.

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

Program Savings

- *Per-person cap.*—A per-person cap on Medicaid growth would limit spending to a reasonable level, while retaining current eligibility and benefit guidelines. This approach guarantees that the elderly, people with disabilities, pregnant women, and children who depend on Medicaid would remain eligible for health benefits, while it slows increases in spending to levels that States and the Federal Government can support. In contrast to a block grant, the Administration's plan protects States facing population growth or economic downturns.
- *Disproportionate Share Hospital Payments (DSH).*—The budget gradually reduces DSH payments and retargets them to hospitals that serve a large proportion of Medicaid and uninsured patients, including children's and public hospitals. It provides special payments for Federally Qualified Health Centers, Rural Health Clinics, States with large numbers of undocumented immigrants, and States moving into the new system.

Provisions to Increase State Flexibility

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

- *Boren amendment.*—The plan repeals the "Boren amendment" for hospitals and nursing homes, allowing States more flexibility to negotiate provider payment rates.
- *Managed care.*—The plan allows States to adopt managed care without Federal waivers.
- *Home- and community-based care.*—The plan allows States to move populations who need long-term care from nursing

homes to home- and community-based settings without Federal waivers.

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

Protections for the Most Vulnerable

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

MAINTAINING AND EXPANDING COVERAGE FOR WORKING AMERICANS

Reforms to Make Health Coverage More Accessible and Affordable

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

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

Health Insurance for the Temporarily Unemployed

The budget gives premium subsidies to individuals who lose their health insurance when they lose their jobs, to pay for private insurance coverage for up to six months. States would receive funding to design and administer the program, which would provide coverage for about 3.8 million Americans a year. During the four-year period for which this program is authorized, a Commission would study and provide recommendations to the Administration and Congress as to making it permanent.

PROMOTING PUBLIC HEALTH

The budget continues our Nation's critical investment in basic biomedical research, an investment that plants the seeds for lifesaving advances in medicine. The budget proposes $12.4 billion for NIH, a $467 million increase over 1996 and a 20 percent increase since 1993. Further, the budget advances our efforts to eradicate, once and for all, the dreaded disease of polio. And it supports childhood immunizations, which have proven their cost-effectiveness time and again.

The budget continues the President's strong commitment to HIV/AIDS prevention and treatment. It increases funds to prevent HIV transmission by $34 million over 1996 levels. It increases Ryan White funding by $32 million over 1996 to ensure that our most hard-hit cities, States, and local clinics can assist those with AIDS. It increases funding for potentially life-prolonging therapies, including some of the newly-discovered drugs that show so much promise in treating AIDS. It increases support for drug treatment—one of the most effective forms of HIV prevention. And it increases AIDS research funding at NIH in the continuing search for effective treatments, vaccines, and a cure.

The budget also gives substance abuse treatment and prevention a 17 percent increase, helping expand efforts against drugs.

And it increases support for the Indian Health Service (IHS) by eight percent—keeping our Nation's commitment to Native Americans and continuing efforts to promote Tribal administration of IHS programs.

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

Ryan White HIV/AIDS Treatment Grants: The budget proposes $807 million for activities authorized under the Ryan White CARE Act, an increase of $32 million over 1996. This level would fund grants to cities disproportionately affected by the HIV epidemic; to States to provide medical and support services; to community-based organizations to provide HIV early intervention services; and to support pediatric AIDS demonstration activities. In addition, the Administration has sought more funds for State AIDS drug assistance programs funded under Title II of the Ryan White program—to finance newly-discovered life-prolonging AIDS therapies, some of which are beginning to receive Food and Drug Administration approval. Under this Administration, funding for Ryan White grants has risen by 89 percent. The budget for 1997 would increase Ryan White funding by 132 percent since 1993.

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

Indian Health Service: The budget proposes $2.4 billion for the IHS, a $186 million increase. IHS clinical services—often the only source of medical care on isolated reservation lands—grow by $138 million, maintaining our commitment to Native Americans. The budget allows the Tribes to continue taking greater responsibility for managing their own hospitals and clinics; it increases the "contract support costs" that help underwrite Tribal activities by 31 percent, to $201 million. In addition, the budget proposes a major new initiative to bring water and sewer lines to those Native Americans still without adequate access to these basic necessities. This initiative would ensure that about 4,000 more Native American homes receive water and sewer lines—a step which has been critical to improving public health.

Substance Abuse Treatment and Prevention: The budget increases support for State substance abuse treatment and prevention activities by $67 million, to $1.3 billion. The budget reiterates support for Performance Partnerships, which would give States more flexibility to better design and coordinate their substance abuse prevention and treatment programs, and better target resources to local priority areas. In addition, it increases funds for substance abuse demonstration and training activities by $140 million, to $352 million. The budget establishes a $20 million Substance Abuse Managed Care Initiative that, with the rapid growth of managed care, would help to establish service guidelines and design quality assurance, monitoring, and evaluation systems. This strong support for substance abuse activities would enable hundreds of thousands of pregnant women, high risk youth, and other under-served Americans to receive drug treatment and prevention services.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): WIC reaches over seven million women, infants, and children a year, providing nutrition assistance, nutrition education and counseling, and health and immunization referrals. As a result of funding increases under President Clinton, WIC participation has grown by nearly 25 percent in the past three years. The budget proposes $3.9 billion, to serve 7.5 million individuals by the end of 1997, fulfilling the President's goal of fully funding WIC in four years.

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

The budget also includes a major $47 million initiative in the Department of Health and Human Services (HHS) to eradicate polio—preventable through immunizations—throughout the world. (This HHS funding comes in addition to polio-eradication efforts that the Agency for International Development supports.) Polio is already gone from the Western Hemisphere. This shows that, like smallpox, polio can be wiped from the face of the earth, sparing all children from this crippling disease and saving the United States the hundreds of millions of dollars we now spend to immunize against it.

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