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12. HEALTH

Table 12–1. Federal Resources in Support of Health
(Dollar amounts in millions)

Function 550	1993 Actual	2001 Estimate	Percent Change: 1993–2001
Spending:			
Discretionary budget authority	20,697	38,884	88%
Mandatory outlays	79,775	138,907	74%
Credit Activity:			
Direct loan disbursements	78	.....	–100%
Guaranteed loans	340	32	–91%
Tax expenditures	53,295	99,750	87%

Since 1993, the Clinton-Gore Administration has worked to expand access to affordable quality health care for all Americans. When President Clinton took office in 1993, the ability of the Nation's health care system to deliver high quality care was in question and the public health delivery system was badly in need of repair: many children were not immunized against deadly diseases; cigarette use among youth was increasing; the number of HIV/AIDS deaths was spiraling; and, mental health was a low priority. Health care costs were rising at a rapid rate and the rate of the uninsured—especially uninsured children—was growing. Fraud and abuse plagued the Medicare and Medicaid programs and the Medicare Trust Fund was projected to be insolvent by 1999.

In the past eight years, the Clinton-Gore Administration has significantly improved the Nation's health care system. The strong economy, preventing medical fraud and abuse, and the Balanced Budget Act (BBA) of 1997 extended the solvency of the Medicare Trust Fund to 2025. Chief among the Administration's accomplishments to expand health care coverage to the uninsured is the creation of the State Children's Health Insurance Program (SCHIP). Enacted in the BBA of 1997, SCHIP now provides coverage to over three million children and has helped reduce the number of uninsured children. The Administration has also been successful in expanding Medicaid coverage options to other vulnerable groups of uninsured, including workers with disabilities, women with breast cancer, and low-income families.

In addition to expanding access to health care, the Administration initiated targeted efforts to improve the quality of care by promoting patient protections in managed care, protecting patients' privacy, establishing programs to reduce medical errors, and working to eliminate health disparities. Federal Government spending and tax incentives have provided direct health care services; promoted disease prevention; furthered consumer, occupational, and patient safety; and, promoted research. The results of these Federal activities include measurable improvements in the health of Americans. For example:

- life expectancy increased from 75.5 years in 1993 to an all time high of 76.7 years in 1998;
- the infant mortality rate decreased from 837 deaths per 1,000 live births in 1993 to 720 deaths in 1998, a decrease of 14 percent;
- United States deaths related to HIV infection decreased dramatically from 37,267 deaths in 1993 to 13,426 deaths in 1998, a decrease of 64 percent; and,

- the teenage pregnancy rate declined from 116 pregnancies per 1,000 teenage women in 1990 to 98 pregnancies in 1996, a decrease of 16 percent.

The Federal Government is expected to spend about $178 billion on health-related activities and allocate about $100 billion in tax incentives in 2001, compared to $100 billion in Federal spending and $53 billion in tax expenditures in 1993.

Health Care Services and Financing

Medicaid: Since 1993, the Administration has worked to expand Medicaid coverage to children and families, provide important new health insurance options for people with disabilities, improve the quality and availability of long-term care services, and protect the fiscal integrity of the Medicaid program. This Federal-State health care program served more than 33 million low-income Americans in 2000, including a fourth of the Nation's children. Medicaid is the largest single purchaser of maternity care as well as of nursing home and other long-term care services. The Federal Government spent almost $118 billion on the program (57 percent of the total) in 2000 while States spent approximately $89 billion (43 percent).

Expanding Coverage: Over the past eight years, the Administration has expanded coverage to a number of vulnerable uninsured groups.

- The President signed the Ticket to Work and Work Incentives Improvement Act of 1999, which created new coverage options for workers with disabilities. The Administration also took regulatory action giving States flexibility to expand coverage to tens of thousands of people with disabilities who will no longer need to impoverish themselves to qualify for benefits.
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) gave States the flexibility to expand Medicaid coverage to more families, and put aside $500 million for States to simplify their eligibility systems and to conduct outreach. The President has taken several actions to improve coverage for those moving from welfare to work, including guidance to States to ensure that families that remain eligible for Medicaid do not lose their health care coverage, and the creation of a performance bonus for States with high or improved rates of coverage.
- The President signed legislation granting Medicaid eligibility to uninsured women with breast and cervical cancer and to young people leaving the foster care system. Coverage will be provided to approximately 22,000 women diagnosed with breast cancer and to 24,000 youth leaving foster care per year, when these options are fully implemented.
- The Administration has actively worked with States to develop Medicaid waivers that expand coverage and test new delivery and financing arrangements within the budget of the existing program.

Long-Term Care Initiative: To encourage the development of long-term care insurance and ensure that those who need long-term care services receive them, the President promoted a comprehensive long-term care initiative, including tax incentives for long-term care, a new State option to support families who provide long-term care, and the availability of private long-term care insurance for Federal employees. The Administration approved over 200 Medicaid home and community-based waivers nationwide, helping hundreds of thousands of people receive critical health care services at home rather than in an institution. The Health Care Financing Administration (HCFA) issued guidance to the States to assist them in addressing the Supreme Court's Olmstead decision, which moves States towards providing services to people with disabilities in the "most integrated setting" appropriate.

Program Integrity: The President successfully worked with the Congress to enact legislation that curbed double-digit growth in Disproportionate Share Hospital payments in the early 1990s. In October 2000, the Administration issued a proposed regulation aimed at curbing questionable State reimbursement practices through the manipulation of upper payment limits for certain public providers. The regulation was issued in January 2001.

State Children's Health Insurance Program (SCHIP): In an effort to reduce the growing number of uninsured children, SCHIP was one of the Administration's highest priorities in the BBA of 1997. The single largest investment in children's health care since the creation of Medicaid in 1965, SCHIP provides $40 billion over 10 years for States to expand health insurance coverage to uninsured children in families with too much income to qualify for Medicaid but too little to afford private coverage. States have broad flexibility to design their programs, while beneficiaries are protected through basic Federal standards. All fifty States, the District of Columbia and the five U.S. Territories have implemented SCHIP.

HCFA and the States have succeeded in meeting the SCHIP/Medicaid goal of decreasing the number of uninsured children by enrolling children in SCHIP and Medicaid. In 1999, the number of uninsured children declined for the first time since the Census Bureau began collecting health insurance data in 1987. Medicaid enrollment increased by more than a million children in 1999, while over three million children were enrolled in SCHIP as of January 2001.

The Administration has sought to build on the goals of SCHIP. In its 2001 Budget, the Administration proposed a 10-year, $76 billion initiative that would convert SCHIP into the FamilyCare Program and provide coverage to uninsured parents of children currently enrolled in SCHIP. The Administration has also sought to expand outreach activities to ensure that all children eligible for federally-sponsored health insurance programs receive coverage.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA): The Administration worked to secure enactment of the BIPA, which invests about $35 billion over five years to address some of the overly aggressive payment reductions from the BBA of 1997 and provide enhanced beneficiary protections in Medicare and Medicaid. The bill:

- increases payments to safety net, rural and teaching hospitals, and other health care providers;
- extends Medicaid coverage for people leaving welfare for work;
- makes it easier for States to enroll uninsured children in Medicaid and SCHIP; and,
- improves Medicare preventive benefits.

The BIPA builds on the Balanced Budget Refinement Act of 1999 which also addressed the adequacy of provider payments.

Nursing Home Quality Initiative: The President worked to improve the quality of long-term care by helping States strengthen nursing homes enforcement tools to ensure that facilities meet Federal quality standards, and by increasing Federal oversight of nursing home quality and safety standards. This funding has allowed States to improve and target nursing home inspections and respond to resident and family complaints more quickly.

Public Health Care Services

Health Research: The Administration has increased funding for biomedical research at the National Institutes of Health (NIH) by over $10 billion, almost doubling the 1993 level of $10.4 billion. The Federal Government's support of basic and clinical biomedical research is a key to improving human health. The priority the Administration has placed on funding for biomedical research has led to tremendous advancements in the diagnosis, treatment, and prevention of disease and illness in the last eight years.

- On June 26, 2000, NIH announced the completion of the sequencing of the human genome, which has the potential to revolutionize the ways health professionals diagnose, treat, and cure disease.
- In response to findings that putting babies on their backs to sleep decreases the risk of Sudden Infant Death Syndrome, NIH launched a national Back to Sleep public education campaign in 1994 to heighten awareness among parents and health care providers.
- NIH-funded researchers were able to uncover new therapies to prevent breast cancer in high-risk populations.

- NIH-funded research also led to the development of new immune-based therapies to prevent rejection of transplanted organs.

Children's Hospital Graduate Medical Education (GME): Medicare is the largest explicit financier of physician training in the United States. Since free-standing children's teaching hospitals do not serve the elderly, they qualify for almost no Federal Medicare GME support. To level the playing field in GME financing, and to ensure that the health care work force includes sufficient numbers of physicians trained to care for children, this Administration proposed funding in 2000 specifically for Children's Hospital Graduate Medical Education. In 2001, $235 million was provided, a 487-percent increase over the 2000 funding level of $40 million. Through this investment, the program seeks to increase the number of residents who train in children's hospitals by providing a level of Federal GME support more consistent with other hospitals.

Patient Safety: In response to a December 1999 Institute of Medicine study reporting that preventable medical errors may cause up to 98,000 deaths in the United States annually, the Administration launched a new initiative aimed at improving patient safety. The Agency for Healthcare Research and Quality will pursue a $50 million research agenda in 2001 and plans to create a new Center for Patient Safety. In 2001, the Food and Drug Administration (FDA) received a 35-percent increase in funding over 2000, to $27 million, to fund the modernization of its existing adverse event reporting systems. Information on adverse events and medical errors is submitted to the FDA by doctors, consumers, manufacturers, and other medical professionals.

Public Health Regulation and Safety Inspection: The Administration has increased funding for FDA by 57 percent from $826 million in 1993 to $1.3 billion in 2001. This increase, in conjunction with the 1997 FDA Modernization Act, signed into law by President Clinton, has reduced review times for new drugs, medical devices, and biologics. For example, average drug review times have decreased since the beginning of the Administration from nearly three years to just over one year. Consumers now have improved access to breakthrough medical technologies that can improve and save lives, while being assured that new products are both safe and effective.

Food Safety Initiative: In 1997, the President announced the Food Safety Initiative, a comprehensive initiative to improve food safety and reduce foodborne illness. In 1998, the President created the President's Council on Food Safety to strengthen coordination and planning across the Federal food safety agencies. Funding for the Food Safety Initiative at the Department of Health and Human Services (HHS) increased from $114 million in 1997 to $257 million in 2001, an increase of 125 percent (see Table 12–2). This additional funding allowed for increased FDA inspections of high risk food production facilities and improved outbreak response, surveillance, and public education by both the Centers for Disease Control and Prevention (CDC) and the FDA. Illness from bacterial foodborne pathogens decreased by 20 percent from 1997 to 1999.

The landmark Pathogen Reduction/Hazard Analysis Critical Control Point (PR/HACCP) rule was also published in 1994, modernizing the Nation's meat and poultry inspection system for the first time in nearly 100

Table 12–2. Food Safety Initiative

(Budget authority, dollar amounts in millions)

	1997 Actual	2001 Enacted	Percent Change: 1997–2001
Department of Agriculture	57	165	189%
Department of Health and Human Services	114	257	125%
Total	171	422	147%

years by utilizing more science-based approaches to inspection. Preliminary foodborne illness surveillance data suggest that significant reductions in the incidence of foodborne illnesses have occurred since FSIS began adoption of the HACCP system. Salmonellosis (salmonella enteritidis) declined 48 percent from 1996 to 1998, and Campylobacteriosis declined 26 percent from 1996 to 1998. These gains were achieved not only through vigorous product testing for deadly pathogens, but also through daily inspection provided by more than 7,000 Food Safety and Inspection Service (FSIS) inspectors and veterinarians.

Funding for the FSIS in the U.S. Department of Agriculture (USDA) increased from $495 million in 1993 to $697 million in 2001, an increase of 41 percent. FSIS inspects the Nation's meat, poultry, and egg products, ensuring that they are safe, wholesome, and not adulterated. In 1994, the Department of Agriculture Reorganization Act established the Office of the Under Secretary for Food Safety and consolidated USDA food safety inspection activities in a new public health mission area of USDA within FSIS.

Smoking as a Public Health Problem: Tobacco use is the second leading cause of death in the United States, and is the largest preventable cause of death. Over 400,000 people die prematurely each year due to tobacco-related illnesses. The Administration has undertaken concerted, comprehensive efforts to make clear the public health menace that smoking represents, particularly to our Nation's youth, and to back up those efforts with specific policy, legislative, and revenue proposals.

- *Education and prevention efforts to curb youth smoking:* In 2001, more than $100 million was provided for the Centers for Disease Control's tobacco education and control efforts—a tenfold increase since 1993. The focus of these efforts was to deglamorize tobacco, warn young people of its addictive nature and deadly consequences, and help parents discourage their children from taking up the habit.
- *Price increases and penalties to reduce youth smoking:* Public health experts agree that the single most effective way to cut youth smoking is to raise the price of cigarettes and other tobacco products. The BBA of 1997 increased cigarette excise taxes by 10 cents per pack (from 24 cents to 34 cents) in January 2000, which adds an additional five cent excise tax per pack in January 2002. Since 1997, smoking rates for youths aged 12–17 have decreased from 19.9 percent to 15.9 percent in 1999.

  The Administration's last three budgets have pressed for further, major cigarette price increases and have included strong disincentives for the tobacco companies to stop targeting children. To build on the momentum of price increases stemming from the Tobacco Settlement Agreement between tobacco companies and the States, the Administration's 2001 Budget proposed a combination of additional excise tax increases and a youth smoking assessment. Congress failed to enact these proposals.
- *Authority to regulate tobacco products:* In 1995, the Administration and the FDA wrote strong, effective rules to prevent children under age 18 from buying any tobacco product, anywhere in the United States. The FDA was also prepared to end tobacco advertising aimed at young people. In March 2000, the Supreme Court ruled that the FDA must have explicit authorization from the Congress before it can regulate tobacco. In response, the Administration has urged the Congress to give the FDA's tobacco regulations the force of law, building on bipartisan efforts in 1998 where a clear majority of Senators backed explicit legislative authority for FDA to regulate tobacco.
- *Justice Department litigation against tobacco companies:* The Administration is also pursuing litigation against tobacco manufacturers for deceiving the public about the dangers of smoking. This lawsuit is part of a continuing effort to hold tobacco companies accountable for their conduct and to force the industry to forfeit all illicit profits. The Administration has repeatedly urged the Congress to provide the necessary funding to continue these Justice Department litigation efforts. The Administration succeeded in persuading

the Congress not to legislate limitations and, therefore, funding to continue this litigation remains available for 2001.

Childhood Immunizations: In 1993, the President launched a major Childhood Immunization Initiative to improve immunization rates among children in the United States. As part of this initiative, the Administration established the Vaccines for Children (VFC) program in 1994 to ensure the availability of recommended vaccines for low-income children. Since 1993, the Administration has tripled funding for childhood immunizations from $341 million in 1993 to over $1 billion in 2001—an increase of 300 percent. Childhood immunization rates are now at an all-time high, with 90 percent of children receiving critical vaccines by the age of two.

Domestic and Global HIV/AIDS: The Administration has demonstrated its leadership in addressing HIV/AIDS, both domestically and internationally, through funding increases for research, prevention, and treatment activities. Since 1993, research on HIV/AIDS at NIH has doubled, from $1.1 billion to an estimated $2.2 billion in 2001. This research has increased our understanding of HIV dramatically and led to the development of highly effective antiretroviral therapies that have extended the lives of people with HIV/AIDS. Funding for domestic HIV/AIDS prevention has grown from $498 million in 1993 to $788 million in 2001, an increase of $290 million, or 58 percent, which has helped reduce the rate of newly reported HIV/AIDS cases in infants due to perinatal transmission by 73 percent. The Administration has also increased funding for the Ryan White CARE Act by 369 percent, or $1.4 billion, from 1993 through 2001, enabling approximately 500,000 people to access HIV/AIDS related medical and support services each year, including lifesaving drug therapies. The Administration's contribution to the HIV/AIDS epidemic in the United States has resulted in a 70-percent decline in HIV/AIDS mortality since 1995 and AIDS is no longer among the top 15 causes of death—it was the eighth leading cause in 1996.

To address the HIV/AIDS epidemic internationally, in 1999 the Administration established the Leadership and Investment in Fighting an Epidemic (LIFE) Initiative, an interagency effort to slow the spread of HIV/AIDS abroad, primarily in sub-Saharan Africa. With USAID and the Departments of Defense and Labor, the Centers for Disease Control and Prevention received $35 million in 2000 and $105 million in 2001, an increase of $70 million (199 percent) for prevention activities internationally. The U.S. funding will contribute to the United Nations goal of reducing the incidence of HIV infection 25 percent among 15–24 year olds by 2005.

Mental Health: The Surgeon General's 1999 report on mental health states that one in five Americans is living with a mental health disorder, and that less than two-thirds of adults with severe mental illness receive

Table 12–3. Government-wide HIV/AIDS Spending

(Budget authority, dollar amounts in millions)

Agency	1993 Actual	2001 Enacted	Percent Change: 1993–2001
Health and Human Services	3,708	10,110	173%
Social Security Administration	675	1,312	94%
Veterans	299	358	20%
U.S. Agency for International Development	117	330	182%
Office of Personnel Management	175	293	67%
Housing and Urban Development	100	258	158%
Defense	155	110	–29%
Justice/Bureau of Prisons	5	15	200%
Labor	1	12	–1,100%
Other agencies	1	1	.....
Total	5,236	12,799	144%

treatment. Reflecting its commitment to improving mental health, it supported the law that gives parity to mental health benefits in private health plans. The Administration also increased funding for mental health services through the Substance Abuse and Mental Health Services Administration. The 2001 funding level for Mental Health is $782 million, a $151 million increase over 2000, more than doubling the 1993 level. The largest part of this increase is an additional $64 million for the Mental Health Block Grant, which supports State efforts to develop community-based systems of care for the most seriously mentally ill where patients can receive the necessary treatment and supports to live self-fulfilling, productive lives. This increase will bolster States' youth violence abatement programs, jail diversion programs for youth, post-incarceration and post-hospitalization programs, suicide prevention programs for youth and the elderly, and will better equip States in responding to the mental health needs of persons moving from welfare to work. Increases for mental health services also include:

- $42 million for Knowledge Development and Application activities;
- $25 million for new Targeted Capacity Expansion grants for early intervention and prevention, as well as local capacity expansion;
- $9 million for Children's Mental Health Services;
- $6 million for grants to assist the homeless; and,
- $5 million for grants to ensure protections for the mentally disabled against abuse, neglect and civil rights violations.

Substance Abuse Treatment and Prevention: Funding for substance abuse treatment and prevention services has increased by $501 million, or 31 percent, since 1993. The 2001 funding level of $2.1 billion includes $1.67 billion for the Substance Abuse Block Grant to assist States in their efforts to prevent and treat substance abuse. In 2001, Block Grant funding will serve over 1.6 million people. While national levels of illicit drug use among 12–17 year olds increased from 1992 until 1997, a combination of Federal, State, and local investments in treatment and prevention has contributed to a 21-percent decline in that population's rate of use between 1997 and 1999.

Family Planning: Since 1970, the Title X—Family Planning program has been the cornerstone of a national network to reduce unintended pregnancy and prevent adolescent pregnancy. The Federal effort has contributed to a 17-percent decline in the teenage pregnancy rate since it peaked in 1990. The Administration has increased family planning funding by 46 percent from $173 million in 1993 to $254 million in 2001. In addition to providing contraceptive services and abstinence education, the family planning program also finances sexually transmitted disease prevention and treatment, including the prevention of HIV transmission. Since 1996, the number of HIV tests administered by family planning clinics has increased by over 50 percent enabling more HIV infected individuals to enter into care and treatment. The Administration has consistently fought legislative riders limiting women's access to contraceptive health services. For example, in 2001, the Administration fought successfully to exclude language that would have restricted public health funds for emergency contraception health services in primary and secondary schools.

Indian Health Service (IHS): The Administration has demonstrated its commitment to addressing major health problems affecting Native Americans and Alaska Natives through a $1.2 billion, or 58-percent, funding increase for the IHS since 1993. This funding enabled IHS to improve the quality and access to basic medical care for Native Americans, and also target a number of health problems, such as diabetes, that disproportionately affect Native Americans. IHS efforts in monitoring, prevention education, and treatment have resulted in an eight percent improvement in the average blood sugar levels of IHS' diabetic patients between 1994 and 1999.

Racial Disparities in Health: In 1998, the President established the national goal of eliminating disparities in health status among racial and ethnic groups by the year 2010 in six key health areas where minority groups were disproportionately affected: infant mortality, cancer, immunizations, cardiovascular disease, HIV/AIDS, and diabetes. As part of

this effort, $10 million was provided in 1999 to fund demonstration projects to better understand and address these racial disparities in health. In 2001, these projects were funded at $38 million, an increase of $28 million, or 279 percent. Through the Agency for Healthcare Research and Quality, the Administration invested more than $40 million annually in 2000 and 2001 to fund health disparities research. In 1999, the Administration created the Initiative to Address HIV/AIDS in Racial and Ethnic Minority Communities, with a $167 million investment in HIV/AIDS research, prevention, and treatment to reduce disparities. This investment has since grown to $357 million in 2001. In 2001, NIH will establish the Center for Research on Minority Health and Health Disparities to lead NIH's efforts to reduce health disparities. NIH conducts over $1 billion of research annually on minority health and health disparities.

Consolidated Health Centers: Through a network of roughly 700 clinics, the Consolidated Health Centers provide preventive and primary care services to over nine million patients in the poorest rural and inner city areas. These services reduce hospitalizations and emergency room use and help prevent more expensive chronic disability care. Funding for Consolidated Health Centers has increased by 71 percent from $683 million in 1993 to $1,169 million in 2001. Through this funding, Consolidated Health Centers will continue their efforts to eliminate health disparities by assuring access to high-quality healthcare.

Community Access Program (CAP): In 1999, the Administration launched a new initiative to coordinate health care systems, increase the volume of services delivered, and establish an accountability system to ensure adequate care for the uninsured. CAP grant funds will be tailored to meet a community's health care needs, including developing management information systems, streamlining patient intake, coordinating patient referral arrangements, and providing comprehensive services for the uninsured. In 2000, $25 million was awarded to 23 communities and, with the $125 million provided in 2001, at least 100 new communities will receive CAP grants.

Response to the Threat of Bioterrorism: Over the past three years, the Administration has marshalled substantial resources to deal with emerging threats relating to potential terrorist use of biological and chemical weapons. These efforts are part of a broader, multi-agency effort to address counterterrorism. HHS funding for medical and public health preparedness related to these threats has increased from $16 million in 1998 to an estimated $326 million in 2001. Key components of the Administration's bioterrorism strategy include establishing a medical stockpile of vaccines and therapeutics, improving vaccine research and development, intensifying public health surveillance activities, conducting medical responder training and exercises, and supporting State and local governments to help prepare for potential bioterrorist threats.

Consumer Product Safety Commission (CPSC): The CPSC is an independent Federal regulatory agency that helps keep American families safe by reducing the risk of injury or death from consumer products. CPSC safety standards annually prevent approximately 150 to 200 infant deaths from poorly designed cribs. Since 1993, financing for CPSC's efforts to develop voluntary safety standards, enforce mandatory standards, and recall harmful products has grown by 24 percent from $42 million in 1993 to $53 million in 2001.

Workplace Safety and Health

In 2001, the Federal Government will spend more than $670 million per year—almost 40 percent more than 1993—to promote safe and healthful conditions for over 100 million workers in six million workplaces, through the Department of Labor's Occupational Safety and Health Administration and Mine Safety and Health Administration. Through a combination of enforcement, compliance assistance, strategic partnerships, and regulatory approaches, these agencies protect workers from illness, injury, and death caused by occupational exposure to hazardous substances and conditions. Their efforts have contributed to significant improvements in the Nation's workplaces.

From 1993 to 1998, the most recent year for which data are available, the overall occupational injury and illness rate has dropped 21 percent, to a record low of 6.7 cases per 100 thousand full-time equivalent

workers. The mining industry experienced a 28-percent reduction in its occupational injury and illness rate during the same period.

From 1993 to 1999, the number of occupational fatalities dropped four percent, from 6,271 to a record low of 6,023. Mine fatalities, which during the 1970s ranged from 200 to 300 per year, in 1999 numbered 79.

Federal Employees Health Benefits Program (FEHBP)

Established in 1960 and administered by the Office of Personnel Management (OPM), the FEHBP is America's largest employer-sponsored health benefit program, providing over $19.5 billion in health care benefits a year to about nine million Federal workers, annuitants, and their dependents. About 85 percent of all Federal employees participate in the FEHBP, and they select from more than 250 participating health plans across the country. The FEHBP is widely viewed as a model health care program. Many of the accomplishments noted below are examples of this leadership.

OPM has greatly improved the quality and quantity of health plan information provided to enrollees, consumer protections, and the scope of health benefits covered by the program. In 1993, the annual health benefits open season guide provided program enrollees little more than cost information regarding the program's participating carriers. By 1999 these materials had been enhanced to provide accreditation, performance, and customer satisfaction information in plain language consumers can easily understand. The FEHBP became fully compliant with the President's Patients' Bill of Rights in 2000, providing enrollees even stronger rights of information disclosure, choice of providers and plans, rights of complaint and appeal, and other consumer protections.

Between 1993 and 1999, FEHBP benefits were greatly expanded. OPM adopted several important benefits policies to improve access to women's health services. They include: benefits for the diagnosis and treatment of infertility problems; benefits for mammography screening consistent with National Cancer Advisory Board recommendations; coverage for breast reconstructive surgery; coverage for high dose chemotherapy in conjunction with bone marrow transplants for breast and certain ovarian cancers; guaranteed hospital stays for mastectomy, as well as for maternity conditions subject to the Newborns' and Mothers' Health Protection Act of 1996; direct access to obstetricians and gynecologists consistent with the President's Patients' Bill of Rights; and, the provision of a full range of contraceptive drugs and devices approved by the Food and Drug Administration.

In addition, OPM provided guidance to FEHBP-participating carriers on family-focused services: i.e., the provision of benefits for childhood immunizations; offering supplemental dental and vision coverage; benefits for routine screening and diagnostic testing for colorectal cancer and other diseases; making health plan pre-authorization and referral procedures customer-friendly; and, other customer service enhancements. Also, the FEHBP's benefit structure now provides parity in the provision of mental health and substance abuse benefits, and FEHBP carriers are instituting initiatives to improve health care quality through the prevention of medical errors and enhancements in patient safety.

OPM implemented premium conversion in the FEHBP in 2000. Under this arrangement, Federal employees use pre-tax dollars to pay health insurance premiums to the program. Premium conversion uses Federal tax rules to let employees deduct their share of health insurance premiums from their taxable income, thereby reducing their taxes and making health coverage more affordable.

Long-Term Care Insurance Program: Since 1998, OPM worked with the Administration, the Congress, and other stakeholders to bring about the enactment of a group long-term care insurance program for Federal employees and retirees, United States Postal Service employees and retirees, active duty and retired military personnel, and certain qualified relatives. Passed in 2000, the Act enables approximately 13 million people to choose long-term care insurance by October 2002, on an enrollee-pay-all basis. OPM is in the process of developing a flexible long-term care product, including provisions for nursing

home care, personal care, home health care, and adult day care.

Tax Incentives

In the past eight years, the Administration has improved health tax policy. The Administration supported allowing self-employed people to deduct a part (60 percent in 2001, rising to 100 percent in 2003 and beyond) of what they pay for health insurance for themselves and their families. The Health Insurance Portability and Accountability Act of 1996 added a number of tax incentives as well, including clarifying the taxation of qualified long-term care insurance premiums, expenses and benefits; modifying the taxation of accelerated death benefits under life insurance contracts; and expanding penalties provided under the Consolidated Omnibus Budget Reconciliation Act of 1995 to enforce group health plan portability, access, and renewability requirements. The Administration has also supported the development of drugs for certain rare diseases or conditions through the Orphan Drug Credit.