/* Part two of the White House estimates of the effect of health reform on the budget follow. */
Pages 40 - 50

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Department of Veterans Affairs: Third Party Receipts

BUDGET PROJECTIONS

Fiscal Year	1995	1996	1997	1998	1999	2000	1995-2000
Third Party Receipts	0	- 600	-1,700	4,300	4,500	-4,700	-15,800

POLICY DESCRIPTION

Under reform, VA will collect receipts from a variety of sources, including premium payments from Health Alliances.

KEY TECHNICAL ASSUMPTIONS

The number of veterans currently using VA medical care will not change under reform. Receipt estimates are based on average premium and copayments projected under health care reform that VA is expected to receive. Based on the phase-in of health care reform, reimbursements are estimated at 15 percent in 1996, 40 percent in 1997, and 100 percent in 1998 and later years. Detailed VA data on current users relies on a 1987 survey.

BACKUP DOCUMENTATION

(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Department of Veterans Affairs: Reimbursement from Medicare

BUDGET PROJECTIONS

Fiscal Yr.	1995	1996	1997	1998	1999	2000	1995-2000
Medicare Collections	0	0	0	-225	-300	-300	-825

POLICY DESCRIPTION

Under reform, VA health plans will collect reimbursement from Medicare when VA care is provided to a Medicare eligible, non-service connected, higher-income veteran.

KEY TECHNICAL ASSUMPTIONS

The number of veterans currently using VA medical care will not change under reform. Medicare reimbursements to VA are equal to the average actual cost per Medicare beneficiary. Based on the phase-in of health care reform, collections are estimated at 75 percent in 1998 and 100 percent in 1999. Detailed VA data on current users relies on a 1987 survey.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Veterans Health Care Investment Fund

BUDGET PROJECTIONS

Fiscal Yr.	1995	1996	1997	1998	1999	2000	1995-2000
Health Care Investment Fund	1,000	600	1,700	0	0	0	3,300

POLICY DESCRIPTION

These resources will help VA implement and operate under the President's national health care reform.

KEY TECHNICAL ASSUMPTIONS

n/a

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Department of Defense health care for dependents and retirees.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Category	0	-100	-200	-500	-500	-500	-1800

POLICY DESCRIPTION

Assumes DoD pays all costs for dependents of active duty personnel, retirees and dependents of retirees who enroll in the DoD medical plan. DoD will pay 80 percent of the premium cost for non-working beneficiaries who enroll in other health plans. Employers of DoD dependents and retirees are assumed to pay the normal employer payment. This payment will go to DoD for

beneficiaries who choose a military plan.

KEY TECHNICAL ASSUMPTIONS

Average cost per capita for the DoD health plan was determined using data provided by RAND and the DoD. We have assumed that the same proportion of beneficiaries who choose the DoD system today will enroll in the DoD health plan in the future.

During the transition, savings are estimated at 15 percent in 1996, 40 percent in 1997, and 100 percent in 1998 and later years.

The cost estimates assume that in areas where there are no military facilities, DoD will use health alliance plans if running DoD's own plan in those areas would be more costly.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Savings to the Department of Defense resulting from Medicare paying DoD for care now provided by DoD to eligible beneficiaries.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Category BA	0	-200	-500	-1,300	-1,400	-1,400	-4,800

POLICY DESCRIPTION

Beginning Oct. 1, 1995, DoD will be reimbursed by Medicare for care provided to Medicare eligible DoD beneficiaries who choose DoD health plans.

KEY TECHNICAL ASSUMPTIONS

DoD estimates that it will provide $1.268 billion in medical services to persons over age 65 in FY 1993. Medicare estimates it pays 90 percent of costs. Payments are assumed to phase in at the rate of 15% in FY 1996, 40% in FY 1997 and 100% thereafter.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Savings to the Department of Defense resulting from payments to DoD for health care of non-working retirees between the age of 55 and 65.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Category	0	0	0	-200	-300	-300	-800

POLICY DESCRIPTION

The Government will assume 80 percent of the cost of health care for non-working early retirees.

KEY TECHNICAL ASSUMPTIONS

DoD currently pays the cost of health care provided to its non-working retired beneficiaries. This estimate assumes that DoD will continue paying twenty percent of the cost of the care. The funds shown are an estimate of 80 percent of the cost of health care for non-working beneficiaries who would choose to use DoD health care under national reform. The estimate assumes the

same percentage of non-working retirees who choose DoD health care today would choose DoD health care under national reform.

Payments are assumed to begin Jan. 1, 1998.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY
Federal Employees Health -- coverage for Federal annuitants age 55-65, not yet medicare-eligible.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	-1.1	-1.7	-1.9	-4.8*

POLICY DESCRIPTION
Annuitants without Medicare coverage obtain coverage through the alliances. Annuitants in this group would be eligible for a Government discount for the employer share of premiums. Savings above result from shifting the employer-share of premiums away from the Government as an employer (from the OPM "Government Payment for Annuitants" account) and onto the broader Government early retiree discount program.
KEY TECHNICAL ASSUMPTIONS

-- After January 1998, Government, as an employer, makes no contributions to premiums for Federal annuitants in this group until they become Medicare-eligible (i.e., Government subsidy program pays 80% of the alliance premium and Federal annuitants pay the remaining 20%).

-- Includes savings for non-Postal annuitants and the portion of savings for Postal Service annuitants attributable to pre-1971 service (savings attributable to post-1971 creditable service would accrue to the U.S. Postal Service; savings for pre-1971 creditable service would accrue to the Federal Government).

OUTSTANDING ISSUES

-- Cost sharing and benefit assumptions for supplemental plans.

-- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal annuitants not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

*Row does not total due to rounding.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY
Federal Employees Health -- coverage for Federal annuitants age 65 or older, not Medicare-eligible*, or under age 55, not yet Medicare-eligible.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	-0.1	-0.2	-0.3	-0.6

POLICY DESCRIPTION
Annuitants without Medicare coverage obtain coverage through the alliances. The Federal Government, as an employer, makes a contribution toward premium costs.

*In general, the group of annuitants age 65 or older, not Medicare-eligible, is comprised of Federal employees who retired before January 1, 1983 and did not have enough employment outside Government to qualify for Medicare.

KEY TECHNICAL ASSUMPTIONS

-- Annuitants under age 55 (not yet Medicare-eligible) or age 65 or older (not Medicare-eligible) are not eligible for the Government subsidy program. An employer contribution for the alliance premiums would be paid out of the OPM "Government Payment for Annuitants" account.

-- Includes savings for non-Postal annuitants and the portion of savings for Postal Service annuitants attributable to pre-1971 service (savings attributable to post-1971 creditable service accrue to the U.S. Postal Service; savings for pre-1971 creditable service accrue to the Federal Government).

OUTSTANDING ISSUES

-- Cost sharing and benefit assumptions for supplemental plans.

-- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal annuitants not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY
Federal Employees Health -- coverage for Medicare-eligible Federal annuitants.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	-0.0	-0.0	-0.0	-1.6	-1.8	-2.1	-5.5

POLICY DESCRIPTION

Annuitants with Medicare obtain additional coverage through an OPM-administered supplemental Medicare wrap-around plan ("medigap"). The Federal Government, as an employer, makes a contribution toward the premium costs.

KEY TECHNICAL ASSUMPTIONS

-- Annual premium cost for comprehensive medigap (1994 preliminary estimate): $1,273 single; $2,545 family.

-- Government pays an employer-share of the medigap premium of approximately 72% (the rate in use today under FEHB; paid via the OPM "Government Payment for Annuitants" account). Annuitants pay the remaining 28%. (Note: because the "medigap" premiums are estimated to be much lower than current FEHBP premiums, annuitants are still likely to be better off than they are today.)

-- All Medicare-eligible annuitants enroll in Medicare Parts A and B, and elect to be covered by the OPM medigap.

-- Assumes the same benefit levels for current and future annuitants.

-- Includes savings for non-Postal annuitants and the portion of savings for Postal Service annuitants attributable to pre-1971 service (savings attributable to post-1971 creditable service accrue to the U.S. Postal Service; savings for pre-1971 creditable service accrue to the Federal Government).

OUTSTANDING ISSUES

-- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal annuitants not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY
Federal Employees Health -- Payments to Medicare

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	0.1	0.1	0.1	0.3

POLICY DESCRIPTION

Approximately 115,000 Medicare-eligible annuitants under FEHBP have declined the optional Part B coverage available from Medicare. Without FEHBP (or another insurer), these annuitants would lack insurance coverage for physician services. Annuitants in this group who wanted to be covered by Part B after FEHBP terminated, would have to pay a late enrollment penalty. This policy assumes that the Government, as an employer, would pay the late enrollment penalty amount on behalf of these annuitants.

KEY TECHNICAL ASSUMPTIONS

-- Average penalty is 10 years (based on each year the individual could have elected coverage but did not).

-- OPM would pay the late enrollment penalty amount on an annual basis. The payments would be funded out of the OPM

"Government Payment for Annuitants" account.

-- Medicare has additional costs for benefit amounts incurred by these annuitants once they enroll in Part B. These costs are absorbed by Medicare (they are not a liability for OPM). The increased costs to Medicare for the benefit amounts are estimated at: 1994-1997: $0; 1998: $0.3; 1999: $0.3; 2000: $0.3.

-- Note: to the extent that annuitants without Part B coverage decided to elect coverage through the alliances rather than through Medicare, the estimated penalty and benefit payment costs would be reduced.

OUTSTANDING ISSUES

-- Although for estimating purposes it was assumed OPM would pay the penalty amount on an annual basis, no decision has been made regarding whether the penalty would be paid annually or in a lump sum.

-- Cost sharing arrangements for the U.S. Postal Service and the Federal Government for penalty amounts for Postal Service annuitants.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY

Federal Employees Health -- coverage for the active workforce (non-postal).

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-00
	0.0	0.0	0.0	-0.7	-1.1	-1.5	-3.3

POLICY DESCRIPTION

Federal employees receive coverage through the alliances.

Federal workers residing abroad receive coverage through a residual FEHBP.

KEY TECHNICAL ASSUMPTIONS

-- Average annual employer-share of premiums under reform (1994 preliminary estimates): $1,546 single; $2,125 married couple without children; and $2,479 family with children.

-- Government contribution rate for employees abroad at 80% of a fee-for-service premium.

-- Current Federal workforce is reduced by approximately 252,000 active employees between 1994 and 1999 in accordance with the President's September 11 memorandum on streamlining bureaucracy.

OUTSTANDING ISSUES

-- Cost sharing and benefit assumptions for supplemental plans.

-- Assumptions and costs during the transition period (1996 through 1997) for coverage and premium contributions for Federal workers not currently covered by FEHBP, but who reside in states that become "participating states" prior to January 1998.

-- No assumption or allowance has been made regarding disposition of any remaining FEHBP reserve funds.

Pages 51 - 69

BACKUP DOCUMENTATION

BUDGET CATEGORY

Public Health Service

BUDGET PROJECTIONS: (billions of dollars)

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Budget Authority	1.1	3.0	3.8	4.2	4.1	3.7	19.9
Total Outlays	0.4	1.5	2.6	3.3	3.7	3.8	15.3

Details of the Public Health Service initiatives planned as part of health reform are shown in the following tables in this section. These budget estimates are presented in terms of proposed Budget Authority. Actual outlays will differ somewhat from the BA because of differences of timing. Total outlays for the PHS initiatives are shown above.

[Page 51]

PUBLIC HEALTH SERVICE

Health Care Reform Budget

Public Health Initiative
(Dollars in Millions)

Program/Activity	FY '95 Incrmnt	FY '96 Incrmnt	FY '97 Incrmnt	FY '98 Incrmnt
Capacity Expansion/Enabling				
Community/Migrant Health Cntrs	$100	$100	$100	$100
Capacity Expansion	200	500	600	700
Enabling Services	0	200	300	300
Subtotal	300	800	1,000	1,000
Workforce				
National Health Service Corps	50	100	200	200
Health Professions 1/	20	200	200	200
Academic Health Centers	3	4	5	5
Subtotal	73	304	405	405
School-Based Health				
School Related Health Services	0	100	275	350

School Health Education	50	50	50	50
Subtotal	50	150	325	400
Health Research Initiatives				
Prevention Research (Sect 3201)	400	500	500	500
Health Service Research (Sect. 3202)	150	400	50	600
Subtotal	550	900	1,000	1,100
Indian Health Supplemental Services	40	180	200	200
Mental Health & Substance Abuse	100	150	250	250
Public Health Services Core	12	325	450	550
Priority	0	175	200	200
Subtotal	12	500	650	750
TOTAL	$1,125	$2,984	$3,830	$4,205

---------- Continued

Program/Activity	FY '99 Incrmnt	FY 2000 Incrmnt	Six Year Total
Capacity Expansion/Enabling			
Community/Migrant Health Cntrs	$100	$100	$600
Capacity Expansion	500	200	2,700
Enabling Services	300	100	1,200
Subtotal	900	400	4,500

Workforce			
National Health Service Corps	200	200	950
Health Professions 1/	100	100	820
Academic Health Centers	5	5	27
Subtotal	305	305	1,797
School-Based Health			
School Related Health Services	400	400	1,525
School Health Education	50	50	300
Subtotal	450	450	1,825
Health Research Initiatives			
Prevention Research (Sect 3201)	500	500	2,900
Health Service Research 150 (Sect. 3202)	600	600	2,850
Subtotal	1,100	1,100	5,750
Indian Health Supplemental Services	200	200	1,020
Mental Health & Substance Abuse	250	250	1,250
Public Health Services			
Core	650	750	2,737
Priority	200	200	975
Subtotal	850	950	3,712
TOTAL	$4,055	$3,655	$19,854

Health Security Act
Public Health Initiatives

The President's Health Security Act includes a $20 billion initiative over the next 6 years to expand Public Health Service activities that are essential to successful implementation. This initiative begins with $1.25 billion in FY 95, $2.98 billion in FY 1996, grows to $4.2 billion in FY 1998, and levels off at $3.6 billion in FY 2000. The additional resources in FY 1995 and FY 1996 represent an increase of 5 percent and 14 percent respectively over the resources available to PHS in appropriations bills (conference action) for FY 1994.

These PHS initiatives are central to achieving the prevention, access, quality, and cost effectiveness goals articulated in the President's plan. These initiatives, included in Title III and Title VIII of the Health Security Act, are divided into seven major elements:

* Workforce Priorities - A new national council on graduate medical education (GME) is established to allocate specialty positions in a manner that: expands training capacity to support a shift to training 55 percent of new physicians in primary care; expands recruitment and financial assistance programs to increase the number of minority students in the health professions; and supports expansion of priority nurse training initiative including advanced practice nursing, faculty development, school nurse training, and development of data systems.

* Health Research Initiative are expanded to

-- Provide research on prevention and high cost/debilitating diseases (e.g. Alzheimer's disease) and areas such as children's health, breast cancer, and reproductive health and translate advancements into the health delivery system to help control health care costs and improve the quality of life.

-- To accelerate health services research including quality measurement and improvement, efficiency, and effectiveness of the health care delivery system.

* Core Functions of Public Health Programs and Preventive Health - support for public health agencies and community-based organizations to improve the health of populations and to control

health care costs through:

* Core Public Health - to reduce preventable disease and disability and their attendant costs to the personal health care delivery system by supporting states to strengthening their state and local health departments' capacity to carry out core public health functions that protect whole communities from infectious diseases, environmental hazards, and preventable injury and provide population-based prevention education and community mobilization regarding behavioral and environmental risks.

-- National Initiatives Regarding Preventive Health - to achieve measurable reductions in preventable disease, disability. and death by supporting public and private non-profit agencies at the community level to address priorities defined through the Health People 2000 process with community-based, innovative interventions affecting special population groups and involving regional and state variation in level of need.

* Health Services for Medically Underserved Populations - Capacity expansion and enabling initiatives are essential to ensure that underserved populations have access to the services to which they are entitled under the Health Security Act. Activities include support for:

-- the development of practice networks and community-based health plans;

-- information systems and telecommunications linkages;

-- acquisition, construction, or renovation of delivery sites; major equipment purchases; establishing financial reserves; and other capital needs of health care providers;

-- expansion of Community and Migrant Health Centers (C/MHCs); and

-- the provision of outreach and enabling services to ensure that low-income, hard-to-reach, and culturally diverse populations are able to use the health care system effectively;

-- expand from 1,600 to 8,000 by 2005 (when full effects are felt) the number of National Health Service Corps (NHSC)

providers available to serve underserved populations;

* Mental Health and Substance Abuse - support is expanded for wrap-around services for the most vulnerable populations of our society, which includes over 2.5 million persons in poverty who are homeless, seriously mentally ill, or diagnosed to have mental health and/or substance abuse problems.

* Comprehensive School-related health activities - by FY 1999 provide health services to 3.2 million students in 3,500 schools with a high proportion of low-income populations. Also, a $50 billion health education program will be implemented for children in grades Kindergarten through 12.

* Indian Health - expand enabling services to help raise the health status of American Indians and Alaskan populations to that of the rest of the United States covered under teh Health Security Act.

Health Security Act
Public Health Initiative
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 1 - Community and Migrant Health Centers

FY1995	Fy1996	FY1997	FY1998	FY1999	FY2000	Fy1995-2000
$100	$100	$100	$100	$100	$100	$600

The Community and Migrant Health Center program is a successful program that currently provides a range of primary care, specialty care, and enabling services to 6.8 million American living in Federally-designated underserved areas. Twice as many projects are approved in this program than can currently be funded. An additional investment of $100 million annually over six years will expand the reach of this program to an additional 2 million individuals, meeting 7% of the current unmet capacity

needs in underserved areas.

[Page 55]

Health Security Act
Public Health Initiative
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 2 - Initiative for Access to Health Care
Subparts A, B, and C

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$200	$500	$600	$700	$500	$200	$2,700

This transitional program supports capacity expansion in underserved areas in ways that build on existing resources in each community and that are responsive to local circumstances and needs. With a $2.7 billion investment over six years, the program will fully address the estimated need for information system and telecommunications (exclusive of highway costs) in underserved areas; provide all federally-funded and other practitioners in underserved areas with the skills and support the need to form practice networks or health plans; meet most of the need for new practice sites in underserved areas; support renovations to improve the practice environment for 3800 practitioners working in C/MHCs and other existing sites in underserved areas; and address much of the capital needs of rural and public hospitals.

[Page 56]

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 2 - Subpart D: Enabling services

Fy1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$0	$200	$300	$300	$300	$100	$1,200

This program ensures that low income, hard to reach, culturally diverse populations have access to the services to which they are entitled under reform by providing them with the supplemental services they need to use the health care system effectively. With a $1.2 billion investment over six years, the program will support the provision of transportation, translation, outreach, follow-up, and child-care services to 6 million individuals not served by other programs.

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle E - Health Services for Medically Underserved Populations

Part 3 - National Health Service Corps

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$50	$100	$200	$200	$200	$200	$950

The National Health Service Corps assures the availability of physicians and other health professionals in severely underserved rural and urban communities. Of the 72 million Americans who live in underserved areas, 33 million currently lack a regular source of care. The NHSC provides scholarships and repayment of student loans to health professionals who agree to serve at least two years in these areas.

The NHSC would be expanded by increasing the number of NHSC scholarships and loan repayments from approximately 800 in 1994 to 1,800 in 1996 and to 2,800 in 1998 and subsequent years.

The NHSC field strength would grow from its level of 1,600 providers in 1993 to 5,300 providers serving over 8 million people in 1998. NHSC field strength would plateau at about 8,000 providers by the year 2005. Placements are prioritized by severity of need and these providers would serve the most difficult to reach one-third of underserved communities with

providers distributed fairly evenly between rural and urban sites.

Health Security Act
Pubic Health Initiatives
(Dollars in Millions)

Title III, Subtitle A - Workforce Priorities Under Federal Payments
Institutional Costs of Graduate Medical Education: Workforce Priorities

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 1995-2000
$20	$200	$200	$200	$100	$820

The nation currently trains far too many physicians in specialties and too few in primary care. This distortion of the workforce contributes to the high cost of care. There are also too few mid-level professionals trained and the workforce lacks diversity to assure adequate access to care for all groups in the population.

In a new system with more limited specialty training, the number of new medical school graduates who choose primary care training programs needs to increase from present level of 4,000 per year to 9,000 or 55 percent of all new graduates. Similarly, estimates indicate that the number of mid-level providers should increase from the current 2,500 per year to 5,000 per year. Finally an estimated 23,000 minority students could benefit from expanded recruitment programs, with about 8,500 students in such programs now.

Funds support the transition of physician training to primary care by increasing Federal assistance for primary care programs by 50%. These funds help meet the need for more graduates who choose primary care by supporting faculty and curricula development and expansion of 2,500 additional positions. Mid-level providers will increase to about 4,000 graduates per year to meet 80 percent of the projected need. Minority recruitment programs will expand to reach about 12,500 students each year, about 50% of the projected goal. Support for physician

retraining programs will begin an effort to redirect physicians currently trained as specialists into primary care. Expanded support will be provided for a range of nursing programs, including school nurse training, geriatric nursing, development of innovative education and practice models, and other priority nursing projects. Public health training support will also increase.

[Page 59]

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle B - Academic Health Centers

FY 1995	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 1995-2000
*	*	*	*	*	*	*

The Health Security Act establishes formula payments to Academic Health Centers (AHCs) to assist eligible institutions with costs incurred by virtue of their training function. These funds will help cover such costs as: reduced rate of productivity of faculty due to teaching responsibilities; uncompensated costs of clinical research; and exceptional costs including treatment of rare diseases, treatment of unusually sever conditions, and providing other specialized health care.

The President's Health Security Act contemplates stronger ties between academic health centers and providers in urban and rural areas. The Act authorized grants to assist academic health centers establish referral networks and educational alliances in such areas.

* A new Academic Health Center account is established (outside the PHS initiative) to fund these activities as follows: 1996, $3,100 million; 1997 and 1998, $3,200 million; 1999, $3,700 million; and 2000, $3,800 million.

[Page 60]

Health Security Act
Public Health Initiatives

(Dollars in Millions)

Title III, Subtitle G - Comprehensive School Health Education; School Related Health Services

Part 5 - School Related Health Services

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$0	$100	$275	$350	$400	$400	$1,525

Only 500,000 children in America's middle and high schools have access to school based or school-linked clinics. Yet, according to a 1992 Department of Education survey, 5.4 million students age 10-19 in 9,411 middle and high schools with a high prevalence of poverty and other risk factors (schools where at least thirty percent of the student are eligible for subsidized meals) are estimated to be in need of these services. These young people, who frequently engage in high risk behaviors, experience multiple non-financial barriers to health care. These barriers included reluctance to seek help, lack of parental availability, and lack of knowledge about what help may be available and how to get it. This initiative will improve access to health and psycho-social services to up to 3.2 million children in over 3,500 schools (priority will be given to schools with the highest percentage of children in need) by providing health services where they spend most of their time. As a result of targeting services in high-need areas, there will be a reduction in the preventable morbidity and mortality that children and adolescents experience. Grants to states and local consortia will support the provision of services at sites throughout the country in areas of greatest need.

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle G - Comprehensive School Health Education; School Related Health Services

Parts 2, 3, and 4

FY1995	FY 1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$50	$50	$50	$50	$50	$50	$300

The health problems that plague our children and adolescents, and the adults they become, are cause primarily by behavioral patterns usually established during youth. Research has shown that initiation of these behaviors can be delayed, reduced, or prevented through school based health education programs. Yet U.S. Department of Education data show only 12 percent of 10th graders and 2 percent each of 11th and 12th graders received any health education credits in school. This initiative will provide grants to every state as well as 20 of the largest Local Education Agencies to enable them to implement comprehensive school health education programs. It contains waiver authority to leverage existing health education monies. State education and health agencies will be expected to collaborate in developing plans targeted to students at highest risk while integrating new funding with existing categorical funding to provide comprehensive health education services.

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle C: Health Research Initiatives
Prevention Research

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$400	$500	$500	$500	$500	$500	$2,900

Prevention research is the foundation for clinical preventive services an public health interventions which are integral components of efforts to reduce the burden of avoidable disease, disability, and death. A renewed emphasis on prevention research is necessary to ensure the availability of effective preventive measures against existing disease, as well as new and emerging threats to the health of Americans. Progress in preventing disease will help to offset escalating acute health care costs and the disproportionate impact of disease and disability among women, minorities, and the elderly.

NIH is the Federal Government's lead agency for biomedical and behavioral research and has the expertise to plan, coordinate, and implement a prevention research agenda to support health care reform. Prevention research findings will be translated into, or appropriately integrated with personal health services and public health programs to maximize the impact of prevention research on

disease reduction and improved health status.

The Prevention Initiative will contribute to more effective and efficient measures to prevent the onset of disease and disabilities that now affect tens of million of Americans. For example, delaying the onset of Alzheimer's disease by an average of five years would cut in half the costs associated with this disease, currently estimated at $90 billion annually.

[Page 63]

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle C: Health Research Initiatives
Health Services Research

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$150	$400	$500	$600	$600	$600	$2,850

The DHHS supports a broad based program of investigator-initiated and directed research on cost, quality, and access issues in health care delivery. This research will inform practitioners, managers, purchasers, providers, and consumers under the Health Security Act. The basic principle underlying the President's Health Security Act is that we can provide better quality of care to more people at less cost. To support the achievement of these objectives, DHHS will expand its research program to: 1) develop the science base on what works best in medical care to identify practice variations with unnecessarily high costs and no added clinical benefit; 2) develop quality and performance measures and related information to assist consumers, practitioners, and plans in making good health care decisions; 3) significantly expand medical effectiveness research and practice guidelines development, dissemination and evaluation to improve the treatment decisions made by physicians, thereby contributing to cost-containment by reducing unnecessary care; 4) design and test clinical and administrative data systems and technologies to expedite administrative simplification and lower administrative costs; 5) investigate and assess the organizational, clinical, and financial alternative adopted by states during initial reform to refine and improve subsequent implementation; 6) develop approaches for improving the efficiency and equity of reimbursement and provider payment systems; and 7)determine the impact of improved primary care on access to care.

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title VIII, Subtitle D - Indian Health Service

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$40	$180	$200	$200	$200	$200	$1,020

The IHS provides comprehensive medical and public health services to the 1.3 million American Indians living on reservations. American Indians have among the poorest health status of all Americans: 40% reduction in years of productive life; tuberculosis rate 6 times higher than other Americans; and infant mortality 1.5 times higher than whites. Isolated living conditions, poverty, lack of available public health services, and inadequate access to care will contribute to poorer health status.

Historic legal and ethical obligations require that the Federal Government provide health care and public health services to American Indians and Alaskan Natives. These obligations continue under the Health Security Act. But, health insurance alone will not improve the health of American Indians. Given existing resources only 45% of American Indians receive the necessary personal, community and environmental-based public health services. Only about half of American Indians receive necessary enabling services such as outreach, transportation and translation services.

Additional funding will improve the health status of American Indians to a level closer to other Americans. Funds will increase enabling services by 2.7 million additional home and other visits, one-half million nursing visits and additional transportation and translation services to an additional 240,000 American Indians by FY 1998. Improved services will be targeted to lower rates of diabetes, alcoholism, injuries, and to improve immunization coverage.

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle F - Mental Health; Substance Abuse

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$100	$150	$250	$250	$250	$250	$1,250

While health insurance will cover most direct acute mental health and substance abuse treatment costs, it will not ensure access to services. Research clearly shows that enabling services, such as outreach, transportation, child care, and translation services are necessary to get persons with serious substance abuse and chronic mental health conditions into treatment. Beneficiaries will include 2.5 million persons in poverty who are homeless, seriously mentally ill, or diagnosed to have both mental health and substance abuse problems. This would meet approximately one-quarter of the need nationwide. Funds would be distributed to States using the existing formula for mental health and substance abuse block grants.

Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle D - Core Functions of Public Health Programs;
National Initiatives Regarding Preventive Health
Part 2 - Core Functions of Public Health Programs

/* This section assesses the investment in prevention and includes projections of savings related to HIV prevention. */

Fy1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$12	$325	$450	$550	$650	$750	$2,737

The Health Security Act cannot meet its national cost containment targets if full advantage is not taken of opportunities to prevent unnecessary disease -- opportunities largely accessible through public health programs. These functions are necessary to protect whole communities from infectious disease, environmental hazards, and preventable injury and to provide population-based prevention education and community mobilization regarding behavioral and environmental health risks. Yet the resources available to support the core functions of public health are only about half the level necessary to meet basic responsibilities.

Between 1981 and 1993, support for the basic public health functions fell from 1.2% to 0.9% of national health care expenditures. Concurrently, additional demands were imposed on public health agencies by problems such as HIV infection, childhood vaccine-preventable diseases, tuberculosis, violence, and the health and social service needs of young, single mothers and their children. There is a vital need to assist state and local health agencies to rebuild and strengthen their capacity to carry out their basic responsibilities for population-based programs, which have the potential to prevent diseases that otherwise drive up personal health care service utilization and cost billions of dollars to treat. Through this grant program, the Health Security Act will support states and communities to meet approximately 8% of estimated need to repair the eroded infrastructure by the year 2000. The returns to this program in terms of cost savings from reduced disease incidence - even using conservative assumptions -- will substantially exceed the investment.

The Health Security Act
Public Health Initiatives
(Dollars in Millions)

Title III, Subtitle D - Core Functions of Public Health Programs;
National Initiatives Regarding Preventive Health
Part 3 - National Initiatives Regarding Health Promotion and Disease Prevention

FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	FY1995-2000
$0	$175	$200	$200	$200	$200	$975

Prevention opportunities related to behavioral risks, physical and social environment, and appropriate use of clinical preventive services have been defined and quantified in the national prevention agenda contained in Healthy People 2000. Through community-based prevention approaches, it is possible to dramatically reduce premature mortality and chronic disease and disability. The need is to support public and not-for-profit agencies in devising approaches that mobilize communities to improve health of whole populations, thus effecting savings to the overall health care system. A competitive grants program will support large-scale, multi-site community-based prevention innovations, with findings from these projects disseminated through public health information network to other communities

across the nation. Examples of priorities of this program and prevention of the initiative of Smoking by Children and Youth, prevention and violence, and reduction of behavioral risks contributing to chronic diseases such as heart disease, cancer, stroke, and adult-onset diabetes.

[Page 68]

Public Health Service Off-sets

Many current Public Health Service (PHS) programs provide 'gap-filler' health service to uninsured individuals. Some PHS programs provide direct health services to selected uninsured populations, while others support disease-specific or treatment-specific medical services. For example, PHS grants support State immunization programs.

The Health Security Act assurance of univeral coverage and a comprehensive benefits package directly addresses many of the 'gaps' that PHS fills. The services currently provided piece-meal through public health programs will be covered uniformly under the comprehensive benefits package, such as immunizations. Preventive, mental health and substance abuse services, and many disease-specific services, are covered under the benfits package.

As health reform progresses, there will be an opportunity to redirect PHS resources to higher priority programs

PHS Off-sets
(outlays in $ billions)

	FY95	FY96	FY97	FY98	FY99	FY00	FY95-00
Offset/ Redirection OL	0.0	(0.3)	(0.9)	(1.8)	(2.4)	(2.6)	(8.0)

[Page 69]

Pages 70 - Glossary

BUDGET CATEGORY

Special Supplemental Food Program for Women, Infants, and

Children (WIC)

BUDGET PROJECTIONS (OUTLAYS IN BILLIONS)

Fiscal Years	1995	1996	1997	1998	1999	2000	20001
Increase in regular appropriations	0	.2	.2	.2	.3	.3	.3
Special fund	0	.2	.4	.4	.4	.4	.4
Total	0	.5*	.6	.6	.7	.7	.7

* Total does not add to rounding.

POLICY DESCRIPTION

The Special Supplemental Food Program for Women, Infants, and Chilldren (WIC) has been proven to play a key role in health promotion by providing nutritional supplements to pregnant women and young chiledren. WIC services to pregnant women have been found to reduce medical costs the first 60 days after birth. WIC also increases micronutrient intake among infants and children, thus reducing conditions such as iron deficiency anemia. Fully funding WIC is a strong priority of the President's and builds on our commitment to preventative and primary care. The bill seeks to guarantee full funding for WIC by the end of FY 1996 by creating a special fund to supplement annual appropriations. The amounts in the fund will automatically become available for WIC if appropriations bills include the amounts shown in the first line in the table below.

FY	1996	1997	1998	1999	2000
	(BA in millions)				
Regular appropriation HCR anticipates	3,660	3,759	3,861	3,996	4,136
Special fund	254	407	384	398	411
Full funding level	3,914	4,166	4,245	4,394	4,547

KEY TECHNICAL ASSUMPTIONS

The cost estimate for the WIC provision in the bill is the difference between current services and full funding.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(Outlays in $ billions)

BUDGET CATEGORY
Academic Health Centers and Graduate Medical Education

BUDGET PROJECTIONS

FY	1995	1996	1997	1998	1999	2000	'95-00
Gross	5.93	6.3	6.75	8.0	9.5	9.6	46.08
Medicare Offset	-5.9	-3.6	-3.6	-3.6	-4.0	-3.9	-24.6
Net New Spending	0.03	2.7	3.15	4.4	5.5	5.7	21.48

POLICY DESCRIPTION

The "Gross" spending line represents the policy commitment to Academic Health Centers and Graduate Medical Education support for physicians, nurses, and other health professionals. The Medicare Offset represents proposed law IME and current law DME payments for physicians (DME for nonphysicians is assumed to continue to flow to Academic Health Centers).

KEY TECHNICAL ASSUMPTIONS
The projections of IME/DME dollars are made by OACT consistent with their appraisal of overall health reform and the Medicare

savings package in general.

[Page 72]

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Program for Poverty-Level Children with Special Needs

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
	0	264	869	2,453	3,025	3,157	9,768

POLICY DESCRIPTION

A new Federally-funded program will provide certain medically necessary and appropriate items and services (that are not in the comprehensive benefit package and are not Medicaid long-term care services) to qualified low-income children.

KEY TECHNICAL ASSUMPTIONS

The estimate assumes that Federal expenditures would be limited to total (Federal and State) Medicaid spending for these services in FY 1993 in participating States, trended forward through the year of implementation for each State by the appropriate growth rates in 9003(a). Thereafter, the annual Federal expenditure limit is trended forward by the growth rates in 9003 (b).

[Page 73]

This estimate includes administrative costs, which are not explicitly accounted for in the legislation. The estimate also differs from the legislation in the calculation of the annual Federal expenditure limit: (1) The estimate trends FY1993 expenditures for wrap-around services by projected spending growth for these services for children; (2)1934 (d)(2)(A)(i) requires that FY1993 spending also be adjusted to take into

account annual increases or decreases in the number of qualified children; (3) the legislation requires that FY93 spending for these wrap-around services be trended forward according to a schedule that does not take into account when States become participating States. This estimate applies the trend factors noted in 9003(b) for spending in each State in the year following the year in which it becomes a participating State.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Long-term care: New Federal spending for community-based program

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
community LTC program	0	4,500	7,800	11,000	14,700	18,700	56,700

POLICY DESCRIPTION

The new community-based LTC program is a capped entitlement to States to finance community-based care for the severely disabled (i.e., disability with at least 3 ADLs). The program is not means-tested but includes an income-scaled coinsurance schedule. The Federal matching rate for the program is a approximately 28% higher than current Medicaid FMAP in each State.

KEY TECHNICAL ASSUMPTIONS
Estimates are from ASPE/Lewin-VHI long-term care model, the key components of which are outlined in the attached document. Figures reflect phased-in funding of total program costs according to the following schedule: 20% in 1996, 30% in 1997, 40% in 1998, 50% in 1999, 60% in 2000, 80% in 2001, and 100% in 2002. Thereafter, the capped amounts are trended forward by CPI and the percentage change in the severely disabled population. Absolute capped amounts are derived from the following assumptions (per Lewin-VHI): 3.1 million individuals are eligible for the program; 80% of eligibles participate in the program; elderly participants receive approximately 120 visits per year;

physically disabled adults and children receive approximately 122 visits per year; mentally retarded participants receive care 365 days per year. Costs per visit are assumed to be $56 for elderly and physically disabled patients, $85 for mentally retarded (in 1993 dollars). Per ASPE, the capped amounts now include the Federal share of

[Page 75]

administrative costs. No Medicaid offset dollars are included in these capped amounts.

[Page 76]

KEY COMPONENTS OF HOME AND COMMUNITY-BASED CARE PROPOSAL

NUMBER OF ELIGIBLES

1993 estimates in thousands

total --	3,090
children --	150
adult physical --	420
MR/DD --	270
elderly --	2,250

The estimates are based on a number of different data sources used for different age groups in an attempt to use the best available data source.

* Children -- For persons under age 18, both the 1989 National Health Interview Survey (NHIS) and the 1987 National Medical Expenditure Survey (NMES) were used to estimate the number of children with at least three of five ADLs.
* Working-Age Adults -- For persons age 18 to 64, the 1990 Survey of Income and Program Participation (SIPP) was relied upon to estimate the number of persons who required help with at least three of five ADLs. SIPP

was also used to estimate the number of persons who have severe or profound mental retardation or developmental disabilities (MR/DD). Because SIPP does not have data on levels of MR/DD, we used data from Charles Lakin at the University of Minnesota to estimate the total number of community-dwelling persons with severe or profound MR/DD (approximately 220,000 in 1990).

* Elderly -- The 1989 National Long Term Care Survey (NLTCS) was used to estimate the number of elderly who would be eligible. The NLTCS provides a large sample of elderly Medicare beneficiaries with disabilities that have or are expected to last at least three months. The data were used to estimate the number of persons with at least three of five ADLs or a similar level of cognitive impairment. A similar level of cognitive impairment was defined as: 1) missing four of ten questions on the Short Portable Mini-Mental Status Questionnaire (SPMSQ); and 2) demonstrating one of the following: disability in at least one of the cognitive Instrumental Activities of Daily Living (IADLs) of medication management, money management, or telephoning; evidence of a behavior problem; or disability in one or more ADLs.

PARTICIPATION RATE

total --	77%
children --	60%
adult physical --	65%
MR/DD --	77%
elderly --	80%

AVERAGE EXPENDITURES

1993 estimates of average expenditures under fully phased-in program

	Average Annual Total Expenditures		Average Annual Public Expenditures	
	Per Eligible	Per User	Per Eligible	Per User
TOTAL	$9,320	$12,150	$8,415	$10,970
Children	$4,100	$6,830	$4,100	$6,830
Adult Physical	$4,440	$6,830	$3,900	$6,000
MR/DD	$24,095	$31,290	$24,095	$31,290
Elderly	$8,840	$11,100	$7,950	$9,940

CURRENT LAW PROGRAMS AFTER REFORM

Medicare -- assumed unchanged

Other Federal Sources (OAA & VA) -- assumed unchanged

State Supported Programs --

expenditures estimated for severely disabled are incorporated into match rate on an aggregate basis

$1.7 billion current law state-only spending in 1993 for the eligible population has been distributed among

the states according to the estimated distribution of MR/DD state-only spending by state

state spending for other populations assumed to remain unchanged

Medicaid --

In 1993, we estimate $7.1 billion for Medicaid home and community-based care expenditures; this is less than HCFA actuaries $8.8 billion and more than the annualized first three

quarters of HCFA 64 data at $6.5 billion

One-half of current Medicaid home and community-based care spending ($3.55 billion) is assumed to be for persons eligible for the program.

The estimate of one-half of current Medicaid home and community-based care expenditures for the eligible population is based on NMES data and HCFA form 64 and 372 data. For Home Health, Personal Care, and Home and Community-Based Waivers, the distribution among all elderly, adult disabled and children who are Medicaid home and community-based care recipients and the subset that would be eligible for the program is based on 1987 NMES data. These data indicate that approximately 50 percent of Medicaid expenditures are for those meeting the severely disabled criteria. The split between MR/DD Medicaid Home and Community-Based Waiver recipients and others is based on a Congressional Research Service paper by Richard Price ("Medicaid Home and Community-Based Care Program," 92-902 EPW). This report indicated that approximately 65 percent of Home and Community-Based Care Waiver expenditures in 1991 were for persons with MR/DD. Based on data from the 1987 NMES Institutional sample for residents of small (beds less than 16) MR facilities, we assumed that 47 percent of these expenditures were for persons with severe or profound MR/DD (those eligible for the program).

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ billions)

BUDGET CATEGORY
Net Federal Discount Payments to Alliances (Capped Entitlement)

BUDGET PROJECTIONS

FY	1995	1996	1997	1998	1999	2000	'95-00
Gross Discounts	0	12.8	35.7	96.3	100.6	103.6	349.0
State Maintenance of Effort	0	-2.5	-7.4	-20.6	-21.7	-22.6	-74.9
Net Discounts	0	10.3	28.3	75.7	78.9	81.0	274.1

POLICY DESCRIPTION

Although all Americans will be asked to contribute to the cost of their health care, there are some groups that will not be able to meet their full contribution: low income families, individuals who have lost their jobs, and small businesses. Low income households and all firms in regional alliances are eligible for premium discounts. Low income households without access to low cost-sharing plans are also eligible for discounts on their out-of-pocket expenses. There are special discounts for early retirees as well. No firm in the regional alliance will pay more than 7.9% of payroll, and small, low-wage firms will pay less, according to a specified schedule. These numbers also reflect a direct grant program for state and local governments as employers ($2B over the period). State maintenance of effort payments (detailed documentation follows this page) to alliances offset Federal discount payments. The Federal liability is capped at

the Net Discounts amount, to ensure fiscal responsibility.

[Page 80]

Discount eligibility summary:

20% share:	households with AGI less than 150% of poverty, no household pays more than 3.9% of AGI for this portion;
80% share:	households with less than at least one full-time worker which have AGI - wages - unemployment compensation + tax exempt interest less than 250% of poverty;
out-of-pocket:	households with AGI less than 150% of poverty without access to an HMO;
7.9% payroll cap:	all firms in the regional alliance;
small-firm schedule:	firms with fewer than 75 employees and average wages less than $24,000. The self-employed are treated as a firm of size one for the 80% share.

KEY TECHNICAL ASSUMPTIONS

Discount estimates came from a collaborative estimation process involving HCFA/OACT, AHCPR, Treasury, and the Urban Institute models. The actual numbers used were from the HCFA/OACT model. An additional 15% contingency was added to the point estimate of the premium discounts. This 15% is an allowance or "cushion" to cover potential behavioral responses that are difficult to model.

[Page 81]

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Medicaid: State maintenance-of-effort payments to alliances.

BUDGET PROJECTIONS

Fiscal Years	1995	1996	1997	1998	1999	2000	1995-2000
Non-DSH:							
Alliance-covered services		-1890	-5570	-15590	-16270	-16970	-56,290
State share of new wrap-around program		-70	-230	-640	-790	-820	-2,550
Less ER svcs for undocumented persons		70	180	470	490	510	1,720
DSH:		-630	-1800	-4880	-5100	-5320	-17,730
TOTAL:		-2520	-7420	-20640	-21670	-22600	-74,850

POLICY DESCRIPTION
Each State contributes a maintenance-of-effort (MOE) payment to alliances that is equal to the level previously spent for services in the standard benefit package for non-cash Medicaid recipients and for wrap-around services for children who receive AFDC or SSI benefits. Medicaid will continue to provide emergency services to undocumented persons and current State spending for these services is netted out of the MOE computation.

KEY TECHNICAL ASSUMPTIONS

State phase-in schedule assumes States with 15% of Medicaid spending implement 10/1/95; States with 25% implement 10/1/96; and States with the remaining 60% of spending implement 10/1/97.

KEY TECHNICAL ASSUMPTIONS (cont.)

The State contribution is based on the State share of spending for non-cash recipients (comprehensive benefits package only); cash children (wrap-around services only); and DSH spending

attributable to non-cash recipients in FY 93, trended forward according to national projected growth rates for Medicaid through the first year of implementation. Projected annual growth rates will be those included in section 9003 of the Health Security Act. Following the first year of implementation, the MOE is trended forward according to the 1 + general health care inflation factor (section 6001) multiplied by 1 + the annual percentage increase in the US population that is under age 65. States assumed to phase-in on fiscal year basis.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY
Information Systems and Quality Assurance

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	Total FY95-00
	Estimated						
Cost	891	248	248	250	250	260	2,147

POLICY DESCRIPTION

The Health Security Act specifies that the Federal government would help develop and maintain the new health information systems and would perform quality assurance activities in the new system.

KEY TECHNICAL ASSUMPTIONS

The estimate includes pricing for the following major administrative functions: support of information systems , support of the National Quality Management Program, and technical assistance to alliances, plans and states. The estimate assumes that, in addition to new resources, existing resources could be used to help support the quality assurance and information collection activities of the National Quality Management Program.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Monitoring of Alliances and States

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	Total FY95-00
Est. Cost	63	120	205	240	250	262	1,140

POLICY DESCRIPTION

The Health Security Act specifies that the Federal government would be responsible for overseeing certain state and alliance functions. Major monitoring activities would include: overseeing the financial operations of alliances, ensuring that plans and alliances adhere to applicable regulatory requirements, and overseeing the premium targets.

KEY TECHNICAL ASSUMPTIONS

The estimate assumes a number of Federal auditing functions, and includes costs associated with the hiring and contracting of auditors needed to carry out these activities.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Program Oversight and Financial Management

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	Total FY95-00 Estimated
Cost	301	218	242	293	300	300	1,654

POLICY DESCRIPTION

As reflected in the Health Security Act, the Federal government would be responsible for developing rules/standards for the new system, and managing existing Federal programs within the new system.

KEY TECHNICAL ASSUMPTIONS
The estimate includes several oversight functions of the National Health Board, including: updating the comprehensive benefits package, monitoring new drug prices for consumers, development of enrollment rules for plans, monitoring of alliance grievance procedures, development and management of a risk adjustment factor for premiums in the alliances. The estimate also includes the cost of Federal support for antitrust reform, and fraud and abuse activities.

BACKUP DOCUMENTATION
(savings negative, costs positive)
(outlays in $ millions)

BUDGET CATEGORY

Transition to the New System

ADMINISTRATIVE COST BUDGET PROJECTIONS

	FY1995	FY1996	FY1997	FY1998	FY1999	FY2000	Total FY95-00
Estimated Cost	419	360	393	783	39	39	2,033

POLICY DESCRIPTION

As reflected in the Health Security Act, the Federal government would be responsible for helping states make the transition to the new sytem. The Federal government would help administer planning and implementation grants, issue standards, provide technical assistance and approve state plans. The Federal government would also administer a national risk pool for the uninsured during the period before universal coverage fully phased-in.

KEY TECHNICAL ASSUMPTIONS

The estimate reflects the costs of organizing and maintaining a new National Transitional Health Insurance Risk Pool for uninsured individuals. The cost of administering the risk pool would phase-down as universal coverage is phased-in. The estimate also reflects the administrative costs of processing approvals of state plans and waivers for states opting to implement single payer systems, as well as the cost of state planning and start up grants.

Glossary of Acronyms

AAPCC	Average Adjusted Per Capita Cost
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AHCPR	Agency for Health Care Policy and Research
ASPE	Assistant Secretary for Planning and Evaluation (HHS)
CABG	Coronary Artery Bypass Graft
CBO	Congressional Budget Office CEA Council of Economic Advisers
C/MHC	Community/Migrant Health Centers

CPI-U	Consumer Price Index -- Urban Area
CY	Calendar Year
DME	Durable Medical Equipment
DoD	Department of Defense
DSH	Disproportionate Share Payments to Hospitals
ESRD	End Stage Renal Disease
FEHBP	Federal Employees Health Benefits Program
FMAP	Federal Matching Percentage (Medicaid)
FY	Fiscal Year
GDP	Gross Domestic Product
GME	Graduate Medical Education
HCFA	Health Care Financing Administration
HCR	Health Care Reform
HHS	Department of Health and Human Services
HI	Hospital Insurance
HIV	Human Immuno-Deficiency Virus
HMO	Health Maintenance Organization
IADL	Instrumental Activities of Daily Living
ICF/MR	Intermediate Care Facility/Mentally Retarded (facilities)
IME	Indirect Medical Education
LTC	Long-Term Care
MOE	Maintenance of Effort
MR/DD	Mentally Retarded/Developmentally Disabled
MRI	Magnetic Resonance Imaging
MSP	Medicare Secondary Payer
MVPS	Medicare Volume Performance Standard
NHSC	National Health Service Corps
NLTCS	National Long Term Care Survey
NMES	National Medical Expenditures Survey
OACT	Office of the Actuary, Health Care Financing Administration
OBRA	Omnibus Budget Reconciliation Act
OMB	Office of Management and Budget
OPM	Office of Personnel Management
PHS	Public Health Service
PNA	Personal Needs Allowance
QMBs	Qualified Medicare Beneficiaries
QDWI	Qualified Disabled Working Individual
PPS	Prospective Payment System
RVS	Relative Value Scale
RVU	Relative Value Unit
SIPP	Survey of Income and Program Participation

SLMB	Specified Low-Income Medicare Beneficiaries
SNF	Skilled Nursing Facility
SSI	Social Security Income
VA	Veterans Administration
VPA	Vulnerable Population Adjustment
WIC	Women, Infants, and Children

End of Document