The original documents are located in Box 66, folder "FY 1978 Spring Planning Review - HEW (1)" of the James M. Cannon Files at the Gerald R. Ford Presidential Library.

HEW SUMMARY

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Summary Tabulation
Budget Authority
($ in millions)

	1976	1977			1978			1979		
	Current estimate	Current policy	Potential level	Low option	Current policy	Potential level	Low option	Current policy	Potential level	Low option
Open-ended programs and fixed costs (relatively uncontrollable under present law):										
Health										
Medicare (trust fund)	18,556	23,031	23,031	23,031	28,093	27,996	28,093	32,822	32,541	32,822
Medicaid	8,535	----	9,600	9,600	----	10,700	----	----	11,900	----
Income Maintenance										
OASDI (trust fund)	70,782	84,726	81,154	81,154	96,468	90,357	90,357	107,650	100,281	100,281
Coal miners' benefits	1,000	914	914	914	943	943	943	971	971	971
Supplemental security income	5,519	5,910	5,910	5,910	6,227	6,227	6,227	6,663	6,663	6,663
Public assistance:										
- cash benefits	5,902	5,968	6,315	6,315	6,385	6,744	6,385	6,840	7,211	6,840
- socal services	2,805	2,616	2,616	2,616	2,616	2,616	2,616	2,616	2,616	2,616
TOTAL	113,099	123,165	129,540	129,540	140,732	145,583	134,621	157,562	162,183	150,193
Discretionary programs (relatively controllable):										
Health	5,791	14,125	6,602	6,602	14,540	6,866	15,410	15,037	7,088	17,189
Education	8,864	7,870	8,693	8,693	7,627	8,758	7,314	7,871	9,068	7,356
Income maintenance	1,372	1,225	1,482	1,482	1,224	1,428	1,268	1,221	1,425	1,268
Departmental management	140	170	150	150	170	170	170	170	170	170
TOTAL	16,167	23,390	16,927	16,927	23,561	17,222	24,162	24,299	17,751	25,983
Offsetting receipts	-149	-148	-148	-148	-149	-149	-149	-149	-149	-149
Transfer to RRB	-1,083	-1,289	-1,289	-1,289	-1,613	-1,657	-1,657	-1,321	-1,381	-1,381
TOTAL HEW	128,034	145,118	145,030	145,030	162,531	160,999	156,977	180,391	178,404	174,646

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Summary Tabulation
Outlays
($ in millions)

	1976	1977			1978			1979		
	Current estimate	Current policy	Potential level	Low option	Current policy	Potential level	Low option	Current policy	Potential level	Low option
Open-ended programs and fixed costs (relatively uncontrollable under present law):										
Health										
Medicare (trust fund)	17,748	20,506	21,937	21,937	23,096	25,631	22,711	25,613	29,624	24,909
Medicaid	8,456	----	9,600	9,600	----	10,700	----	----	11,900	----
Income Maintenance										
OASDI (trust fund)	73,767	83,863	84,689	84,689	92,780	94,302	92,571	102,009	103,830	99,569
Coal miners' benefits	986	914	914	914	943	943	943	971	971	971
Supplemental security income	5,235	5,806	5,806	5,806	6,227	6,227	6,227	6,663	6,663	6,663
Public assistance:										
- cash benefits	5,902	5,968	6,315	6,315	6,385	6,744	6,385	6,840	7,211	6,840
- social services	2,352	2,620	2,620	2,620	2,616	2,616	2,616	2,616	2,616	2,616
TOTAL	114,446	119,677	131,881	131,881	132,047	147,163	131,453	144,712	162,815	141,568
Discretionary programs (relatively controllable):										
Health	5,885	14,469	6,523	6,523	15,273	7,052	16,945	15,431	7,205	17,462
Education	7,726	7,643	8,420	8,420	7,390	8,384	7,718	7,565	8,724	7,406
Income maintenance	1,422	1,393	1,487	1,487	1,360	1,451	1,317	1,327	1,425	1,289
Departmental management	156	157	152	152	169	154	154	168	168	168
TOTAL	15,189	23,662	16,582	16,582	24,192	17,041	26,134	24,491	17,522	26,325
Offsetting receipts	-149	-148	-148	-148	-149	-149	-149	-149	-149	-149
Transfer to RRB	-1,083	-1,289	-1,289	-1,289	-1,613	-1,657	-1,657	-1,321	-1,381	-1,381
TOTAL HEW	128,403	141,902	147,026	147,026	154,477	162,398	155,781	167,733	178,807	166,363

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Analysis of Changes
(in millions of dollars)

	1977		1978		1979	
	BA	O	BA	O	BA	O
Base estimates (current policy)....	145,118	141,902	162,531	154,477	180,391	167,733
Changes to reach potential (most likely) level:						
A. Uncontrollable:						
Health						
Medicare	-----	+1,431	-97	+2,535	-281	+4,011
Medicaid	+9,600	+9,600	+10,700	+10,700	+11,900	+11,900
Income Maintenance						
OASDI	-3,572	+826	-6,111	+1,522	-7,369	+1,821
Public assistance: cash benefits	+347	+347	+359	+359	+371	+371
B. Discretionary programs:						
Health	-7,523	-7,946	-7,674	-8,221	-7,949	-8,226
Education	+823	+777	+1,131	+994	+1,197	+1,159
Income Maintenance	+257	+94	+204	+91	+204	+98
Departmental management	-20	-5	----	-15	----	----
D. Transfer to RRB	----	----	-44	-44	-60	-60
Total potential (most likely) level	145,030	147,026	160,999	162,398	178,404	178,807
Changes to reach high alternative target:						
A. Uncontrollable						
Health						
Medicare	----	----	+97	-1,640	+281	-2,890
Medicaid	----	----	-10,700	-10,700	-11,900	-11,900

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Analysis of Changes Con't.
(in millions of dollars)

	1977		1978		1979	
	BA	O	BA	O	BA	O
Income Maintenance						
OASDI	---	---	---	-826	---	-1,522
Public assistance: cash benefits	---	---	-359	-359	-371	-371
B. Discretionary programs:						
Health	---	---	+8,327	+9,365	+8,647	+9,134
Education	---	---	-932	-616	-1,000	-869
Income maintenance	---	---	-82	-56	-82	-61
Total high alternative target	145,030	147,026	157,350	157,566	173,979	170,328
Changes to reach medium alternative target:						
A. Uncontrollable:						
Income maintenance						
OASDI	---	---	---	-180	---	-539
B. Discretionary programs						
Health	---	---	-371	-93	-443	-279
Education	---	---	-152	-20	-152	-115
Total medium alternative targets	145,030	147,026	156,827	157,273	173,384	169,395
Changes to reach low alternative target:						
A. Uncontrollable						
Health						-1,825
Medicare	---	---	---	-1,280	---	
Income Maintenance						
OASDI	---	---	---	-725	---	-2,200

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Analysis of changes con't.
(in millions of dollars)

	1977		1978		1979	
	BA	O	BA	O	BA	O
B. Discretionary programs						
Health	---	---	+588	+621	+1,897	+1,402
Education	---	---	-360	-30	-560	-334
Income maintenance	---	---	-78	-78	-75	-75
Total low alternative target	145,030	147,026	156,977	155,781	174,646	166,363

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Outlays
(in millions)

	1971	1972	1973	1974	1975
A. Uncontrollable:					
Health					
Medicare	7,875	8,819	9,479	11,348	14,781
Medicaid	3,362	4,601	4,600	5,818	6,840
Income Maintenance					
OASDI	35,874	40,157	49,090	55,867	64,658
Coal miners benefits	319	418	952	1,000	968
Supplemental security income	---	---	41	2,257	4,779
Public assistance					
-- cash benefits	5,486	6,559	5,922	5,423	5,121
-- social services	794	1,932	1,614	1,472	2,048
TOTAL	53,710	62,486	71,698	83,185	99,195
B. Discretionary programs:					
Health	3,266	3,754	4,341	4,450	5,406
Education	4,601	5,195	5,511	5,516	7,080
Income maintenance	775	894	987	1,133	1,338
Departmental management	39	58	55	83	126
TOTAL	8,681	9,901	10,894	11,182	13,950
C. Offsetting receipts	-28	-30	-29	-40	-42
D. Transfer to RRB	-626	-749	-802	-931	-1,010
TOTAL HEW	61,737	71,608	81,761	93,396	112,093

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

RECONCILIATION OF MARCH 25 ESTIMATE AND BASE
(in millions of dollars)

	Budget authority	Outlays
I. Reconciliation of 1977 base:		
March 25 estimate	145,164	142,165
Administration initiatives:		
Swine influenza program	---	+110
FDA laboratory inspection	+16	+13
Ethnic heritage	+2	---
Basic opportunity grants:		
1976 supplementals (net)	---	-106
1977 amendment	+279	---
Library resources:		
TQ supplemental	---	+9
1977 amendment	+62	+20
Completed congressional action:		
Continuing resolution level -- allied and public health		+3
Child development (Labor-HEW bill)	+20	+17
Reestimates:		
Medicare costs	+3	+160
OASDI	-183	-158
Supplemental security income	---	-104
Assistance to refugees from Cambodia and Viet Nam	---	+28
Work incentives (in DOL estimate)	-260	-260
Public assistance-savings legislation	+9	+9
Special Institutions	+4	+9
Other	+2	-13
TOTAL, 1977 base	145,118	141,902
II. Base for 1978 through 1981:		
1978	162,531	154,477
1979	180,391	167,733
1980	196,685	181,559
1981	216,993	197,634

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Summary of Agency Totals
(in millions of dollars)

	1977	1978	1979	1980	1981
Budget Authority					
Base estimate	145,118	162,531	180,391	196,685	216,993
Most likely level (Base and budget threats)	145,030	160,999	178,404	193,958	211,575
High alternative target	145,030	157,350	173,979	xxx	xxx
Medium alternative target	145,030	156,827	173,384	xxx	xxx
Low alternative target	145,030	156,977	174,646	xxx	xxx
Outlays					
Base estimate	141,902	154,477	167,733	181,559	197,634
Most likely level (Base and budget threats)	147,026	162,398	178,807	195,881	213,442
High alternative target	147,026	157,566	170,328	xxx	xxx
Medium alternative target	147,026	157,273	169,395	xxx	xxx
Low alternative target	147,026	155,781	166,363	xxx	xxx

MBO

1978 Spring Planning Review
Department of Health Education and Welfare
Management By Objectives

Background

DHEW presently has two objectives tracking systems. The Operational Planning System (OPS) is probably the classic Federal MBO system; has been in Departmental use for six years; includes forty-five FY 1976 objectives in six major operating agencies (see Attachment A); emphasizes tangible results and program implementation objectives; is managed by the Assistant Secretary for Administration and Management; and is presided over by the Undersecretary.

In addition to OPS, in January 1976 five General Departmental Objectives were published by the Secretary (see Attachment B). These are broadly-phrased objectives, covering those existing activities which merit greatest Departmental attention, and constituting an agenda for discussion rather than Secretarial performance directives. Some 20-30 supporting projects have been identified, and the Undersecretary is developing followup mechanisms.

Status

- DHEW has not had Presidential MBO's since FY 1975 (see Attachment C), and views personal Presidential participation as necessary to reentry.
- The last OMB-DHEW management conference was held in October 1974; the last internal OPS conference cycle was completed in April 1976; and FY 1977 OPS objectives should be developed and ready for use by October 1, 1976.
- OPS objectives generally do not include the design, conduct or use of major evaluation initiatives (there are two Education Division exceptions).

- Review procedures for the General Departmental Objectives are under present consideration; schedule information for these objectives and supporting projects is not yet available.

- Secretary Weinberger formerly conducted OPS management conferences; Undersecretary Lynch presently chairs the OPS conferences and has day-to-day responsibility for the status of General Departmental Objectives.

Outlook

1. Presidential participation may be critical to DHEW cooperation with OMB in future management initiatives. Explicit discussion of the reasons for this view, and the kind of Presidential participation desired, might be useful in planning future initiatives.

2. OPS objectives largely ignore DHEW's $30 million-plus annual program evaluation effort. MBO techniques might be useful in designing and using evaluations; particularly as between Departmental and operating agency evaluation officials.

3. General Departmental Objectives appear abstract and somewhat uneven in priority content. Clarification of the content and use of selected objectives (e.g., regulation reforms, incentive development or State/local partnerships) might be useful in understanding Secretarial management techniques.

Attachment A

FY 1976 OPERATIONAL PLANNING SYSTEM OBJECTIVES

Office of Civil Rights

1. Promote Equal Educational Opportunities for Women and Minorities in Institutions of Higher Education

2. Promote Equal Employment Opportunities for Women and Minorities Within Institutions of Higher Education

3. Comply With the Adams v. Weinberger Court Orders Relating to the Enforcement of Title VI of the 1964 Civil Rights Act in 17 States

4. Implement the Initial Phases of the Title IX Anti-Sex Discrimination Enforcement Program

5. Conduct Compliance Programs For Enforcement of the Lau v. Nichols Supreme Court Decision Relating To Bilingual Instruction for National Origin Minority Children

6. Implement an Enforcement Program for Section 504 of the Vocational and Rehabilitation Act of 1973 which Prohibits Discrimination Against the Handicapped

Education Division

1. Improve Operations of the Guaranteed Student Loan Program in Order to Reduce Defaults and Other Abuses

2. Develop, with States, Procedures for Identifying All Handicapped Children as Required Under the Education Amendments of 1974

3. Conduct and Coordinate Five Studies, Required by Congress, To Provide Information Necessary to Design More Effective Programs in the Area of Compensatory Education

4. Carry Out NIE's Reading and Language Research Agenda by 1) Completing Short-Term Policy Research on Whether the Part Played by Grades 1-3 in the Failure to Learn to Read Has Been Overrated In Contrast With Grades 4-6; and 2) Conducting Long-Range Research on the Roles of Motivation and Information Processing in Increasing Literacy

5. Implement the Education and Work Initiatives Designed in FY 1975 To Reduce The Isolation Between Educational Institutions and the World of Work (As Called for by President Ford)

6. Continue to Implement a Department Wide Bilingual Education Program to Ensure That National Origin Minority Children Participate with Equal Effectiveness in Public Education Programs

7. Develop and Implement a Division Wide Dissemination Program for Educational Products and Knowledge

Office of Human Development

1. Implement Initiatives To Improve the Capacity of State and Area Agencies for the Aging To Carry Out Their Programs More Effectively

2. Continue to Implement the Comprehensive Employment and Training Act of 1973 (with the Department of Labor)

3. Implement Initiatives to Assist State and Local Governments and Other Entities to Improve Their Foster Care and Adoption Procedures and Programs

4. Develop an Implementation Plan To Achieve A One Third Reduction by 1980 in the Number of Mentally Retarded Persons Residing in Public Institutions

5. Increase the Number of Severely Disabled Persons Rehabilitated through State Vocational Rehabilitation Programs

6. Implement An Inter Agency Effort (Under the Direction of the DHEW Committee on Children) to Work Intensively With Four States To Improve The Delivery of Services To Children In Specific High Priority Areas of Concern

7. Implement the Provisions of the Head Start Act of 1974 To Ensure That 10% of the Head Start Enrollment Opportunities in Each State Are Made Available to Handicapped Children And That Special Services Are Provided To These Children

8. Implement Initiatives for Improving the Well Being of Indians as Proposed by the Interdepartmental Council on Indian Affairs

9. Implement An Inter Agency Effort to Address the Problems of Child Abuse and Neglect

10. Implement An Inter Agency Effort to Address the Problems of Runaway Youth

Public Health Service

1. Implement the Health Resources Planning and Development Act of 1974

2. Continue To Implement the Health Maintenance Organization Act of 1974

3. Develop a Standardized Medical Terminology and Coding System For Recording the Results of Physician/Patient Visits or Encounters Which Are Reimbursed Through Federally Financed Health Care Programs

4. Continue To Implement the Professional Standards Review Organizations Program and Implement the Quality of Care Monitoring System for the End Stage Renal Disease Program

5. Implement Improvements to the Department's Long Term Care (i.e., Nursing Home) Standards Enforcement Program

6. Develop and Implement Improvements to the Department's Home Health Care Programs

7. Implement Efforts To Reduce the Unmet Health Needs of Indians

8. Reduce the Incidence of Sexually Transmitted Disease and Continue Screening and Treatment Efforts For Existing Cases

9. Assist Health Service Delivery Project Grantees To Reduce Operating Costs and To Increase The Amount of Funds Collected From Outside Sources

10. Implement a Child Health Initiative Including Improved Immunization Services, Maternal and Child Health Program Services and Provision of Support Services to the Early and Periodic Screening, Diagnosis and Treatment Program

Social and Rehabilitation Service

1. Continue To Implement the Early and Periodic Screening, Diagnosis and Treatment Program

2. Implement Cost Control and Management Improvements to the Medicaid Program

3. Continue To Implement Quality Control and Management Improvements to the Aid to Families with Dependent Children Program

4. Implement a Redesign of the Work Incentive (WIN) Program (with the Department of Labor)

5. Implement Title XX of the Social Security Act (Social Services Amendments)

6. Implement Title IV-D of the Social Security Act (Child Support Amendments)

Social Security Administration

1. Stabilize Hearings Workloads By Processing All 25,000 Cases Remaining Under the Black Lung Program and By Processing an Additional 192,000 Cases Under Other Social Security Programs

2. Implement Program and Operating Improvements for the Supplemental Security Income Program

3. Improve Claims Processing Times and Implement Other Operating Improvements For the Disability Insurance Program

4. Develop Major Legislative Proposals To Bring Social Security Programs Into Sound Actuarial Balance, To Increase the Predictability of Program Costs and To Establish a Rational and Stable Automatic Cost Benefit Increase System

5. Complete the Initial Phase of a Six Year Master Plan for the Development of the Future SSA Process. ("SSA Process" refers to the total of all the technological, management and operational systems and mechanisms needed to support SSA's programmatic responsibilities)

6. Complete the Process of Verifying Alleged Social Security Numbers For, or Issuing New Numbers To, Approximately 23.5 Million AFDC/Medicaid Recipients

Attachment B

General Departmental Objectives

I. To improve the quality of our impact on the people we serve and constantly to refine the processes of the Department to that end.

   a. Regulation reforms

   b. Penalty review and incentive development

   c. A review of public grievance processes

II. To open the Department to a greater degree of citizen involvement and public interaction.

   a. "Visitor's" programs, to include a lawyers' panel and a "scholar in residence"

   b. National student internships in the Department and a program for journalism interns

   c. A citizen's participation education projects

   d. Permanent feedback loops into the Department for general public reaction and suggestions -- perhaps through polls

   e. An expanded green sheet

   f. Elaborations on the use of voluntary associations

III. To contribute to the improvement of the public debate on social policy and to the thoughtful restatement of the proper relation between people and their government.

   a. Seminars on major policy issues

   b. A "community" for the social policy research components of the Department

c. A task force on reassessing Departmental objectives -- a post Mega group

IV. To develop partnership with the other branches and levels of government since, with the diffusion of authority over health, education, and welfare affairs, such coalitions are indispensable to being effective.

a. With State and local governments:

1. A Department task force on State relations

2. A program to exchange staffs with State and local institutions

3. Use of the Regional Directors -- to include a staff exchange program between the regional and central offices

b. With Congress

c. With other Executive Departments (to include developing Cabinet level initiatives)

V. To give continuing attention to a management structure that properly reflects the heterogeneous nature of the Department, the need to develop broad and integrated social policy, and the special mandates of HEW -- all leading to the improvement of the Department as an institution.

a. A review of the basic organizational design of the Department utilizing a permanent body of staff and consultants

b. Greater involvement of the Departmental staff in Department-wide concerns

c. Special programs: a more responsive and effective investigative force

Attachment C

LISTING OF DHEW'S FY 1975 OBJECTIVES TRACKED UNDER THE PRESIDENTIAL MANAGEMENT BY OBJECTIVES SYSTEM

1. Complete Pre-Implementation Planning for the Comprehensive Health Insurance Program.

2. Develop and Submit to Congress the Administration's Proposal to Replace the Present Multiplicity of Welfare Programs with a Single Program of Income Supplementation.

3. Implement Initiatives to Contain the Rise of Health Care Costs.

4. Develop a Consistent and Comprehensive Strategy to Define the Federal Role in Financing Elementary and Secondary Education.

5. Implement the Professional Standards Review Organizations Program.

6. Implement the Health Resources Planning and Development Act of 1974.

7. Implement the Department's Manpower Management Program.

8. Obtain the Enactment of Legislation to Establish a Department of Human Resources.

9. Reduce Error Rates in the Aid to Families with Dependent Children Program in Each State to a Maximum of 3% for Ineligibility, 5% for Overpayments and 5% for Underpayments.

Attachment C

LISTING OF DHEW'S FY 1975 OBJECTIVES
TRACKED UNDER THE PRESIDENTIAL
MANAGEMENT BY OBJECTIVES SYSTEM

1. Complete Pre-Implementation Planning for the Comprehensive Health Insurance Program.

2. Develop and Submit to Congress the Administration's Proposal to Replace the Present Multiplicity of Welfare Programs with a Single Program of Income Supplementation.

3. Implement Initiatives to Contain the Rise of Health Care Costs.

4. Develop a Consistent and Comprehensive Strategy to Define the Federal Role in Financing Elementary and Secondary Education.

5. Implement the Professional Standards Review Organizations Program.

6. Implement the Health Resources Planning and Development Act of 1974.

7. Implement the Department's Manpower Management Program.

8. Obtain the Enactment of Legislation to Establish a Department of Human Resources.

9. Reduce Error Rates in the Aid to Families with Dependent Children Program in Each State to a Maximum of 3% for Ineligibility, 5% for Overpayments and 5% for Underpayments.

HEALTH

1978 Spring Planning Review
Department of Health, Education, and Welfare
Health Programs
Overview

HEW health programs are popular, costly, and growing fast. They represent Federal intervention at almost every point in the health care system--the conduct of research; the support of physician and other health professional education; the review of medical practice; the financing of health services through payment for services as well as through grants and contracts; direct provision of services through PHS hospitals and the Indian Health Service; and the regulation of foods, drugs, and cosmetics.

As the table at Attachment A indicates, Federal outlays for HEW health programs are estimated to grow from $32 billion in 1976 to $61 billion in 1981, an increase of 90% in 5 years, or an average of 14% annually. Rising budgets, principally for Medicare and Medicaid, stem from large increases in the costs of medical care--outdistanced only by energy and food price rises over the last few years. Growth of Federal programs that support biomedical research, health education and health services reflects their popularity in Congress and strong constituencies. Appropriation levels have uniformally exceeded Presidential requests over the last 4 years and new narrow categorical health programs are authorized over Administration objections and Presidential vetoes.

Administration Health Policies. In essence, the Administration's health policies reflect a specific concept of the appropriate Federal role:

-- in health services, to rely on broad and more equitable health financing programs, i.e., the health block grant and Medicare for the aged and disabled, rather than narrowly targetted project grants;

-- in health financing, to introduce cost-sharing to curb unnecessary utilization, to limit reimbursement increases in order to stem the inflationary spiral of health costs, and to provide catastrophic protection;

-- in health professions training, to limit the Federal responsibility to addressing geographic and specialty maldistribution in the most critical professions, i.e., physicians and dentists, in the short run, and, over time, to terminate preferential direct Federal subsidies for the education of health professionals; and

-- in food and drug safety and in biomedical research, to recognize the continuing and legitimate Federal responsibility and to permit gradual growth in funding in response to additional responsibilities and increased costs.

Health Programs and A Balanced Budget in 1979. The table at Attachment A displays a growing gap between the potential or most likely levels and the current policy levels for health programs. In 1977, the outlay difference is $3.1 billion. The outlay difference grows to $5.0 billion in 1978 and $7.7 billion in 1979. Attachment B indicates that enactment of the 1977 potential will increase outlays by $2.1 billion in 1978 and $1.9 billion in 1979 even if the Administration is able to secure implementation of low option policy levels in 1978.

Attachment C displays the President's 1977 Budget request, the amounts in S. Con. Res. 109 for the Health function, and the differences which amount to Congressional increases of $1.3 billion in budget authority and $3.5 billion in outlays. Essentially, S. Con. Res. 109:

-- rejects all but $300 million of the Medicare cost savings proposal of $1.5 billion;

-- rejects the health block grant proposal--at least for 1977;

-- accepts a $9.3 billion Medicaid estimate that will necessitate a $300 million savings from the current HEW estimate of $9.6 billion for Medicaid; and

-- funds the remainder of the programs in the health function at $7.2 billion in budget authority and outlays. This is an increase of $1.1 billion in budget authority and $300 million in outlays over the 1977 current services estimate and an increase of $2.2 billion in budget authority and $1.4 billion in outlays over the President's request.

The "current policy" levels shown at Attachment A for 1977, 1978, and 1979 are premised on Congressional acceptance in those years of the rejected 1976 proposals and funding levels.

Thus, it appears that a climate of unreality increasingly pervades the debate on health budget levels. It is nevertheless desirable to maintain the current policy because:

-- unless the Administration continues to maintain a conceptually based and clear statement of the appropriate Federal role in health--especially with increasingly limited Federal resources--the Congress will not consider other alternatives to its presently chartered course;

-- a large dollar gap may force recognition by Congress and the public that the Government must find ways to limit health spending;

-- there are good program arguments underlying the current policy proposals; and

-- with limited Federal resources in the future, holding down nonessential Federal health spending can provide fiscal room to address newer and higher priorities.

The issues that follow attempt to present health programs by activity, i.e., research, training, and services (the block grant). In addition, issue papers are included on Medicare, the Center for Disease Control, and national health insurance planning.

Attachment A -- Summary Tabulation
Attachment B -- Alternatives Assuming Enactment of 1977 Potential Level and Back-Up Table
Attachment C -- S. Con. Res. 109 and 1977 Budget
Attachment D -- Summary of Recommendations
Attachment E -- Relation of Potential to Previous Estimates
Attachment F -- Evaluations--Major Program Areas

5/11/76

Attachment A

1978 Spring Preview
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Summary Tabulation

Health Programs
($ in millions)

		1976	1977			1978			1979			1980			1981		
		Current Policy	Current Policy	Potential	Low Option	Current Policy	Potential	Low Option	Current Policy	Potential	Low Option	Current Policy	Potential	Low Option	Current Policy	Potential	Low Option
National Institutes of Health	BA	2,301	2,165	2,532	2,165	2,165	2,785	2,165	2,165	2,980	2,165	2,165	3,189	2,165	2,165	3,411	2,165
	O	2,121	2,327	2,474	2,327	2,265	2,667	2,265	2,169	2,795	2,169	2,165	3,010	2,165	2,165	3,226	2,165
Alcohol, Drug Abuse, and Mental Health Administration	BA	879	540	960	540	452	885	452	440	890	440	433	890	433	427	890	427
	O	896	771	832	771	622	974	622	511	945	511	438	868	438	432	890	432
Food and Drug Administration	BA	209	243	243	243	247	267	247	247	267	247	247	267	247	247	267	247
	O	222	240	240	240	246	266	246	247	266	247	247	267	247	247	267	247
Center for Disease Control	BA	285	110	174	110	110	179	110	110	184	110	110	189	110	110	194	110
	O	167	246	282	246	131	191	131	114	179	114	110	184	110	109	189	109
Health Services Administration	BA	1,331	542	1,592	542	533	1,641	533	533	1,649	533	533	1,552	533	533	1,555	533
	O	1,281	967	1,499	967	850	1,835	850	800	1,907	800	700	1,788	700	600	1,818	600
Health Resources Administration	BA	718	445	1,023	445	431	1,009	431	428	1,006	428	427	1,002	427	427	1,002	304
	O	1,115	829	1,108	829	610	1,022	610	530	1,005	530	492	1,027	492	469	1,034	455
Assistant Secretary for Health	BA	68	78	78	78	100	100	100	112	112	112	126	126	126	142	142	142
	O	83	88	88	88	97	97	97	108	108	108	123	123	123	139	139	139
Medicare	BA	18,556	23,031	23,031	23,031	28,093	27,996	28,093	32,822	32,541	32,822	36,849	36,259	36,849	45,351	44,237	45,351
	O	17,748	20,506	21,937	19,356	23,096	25,631	21,496	25,613	29,624	23,413	28,455	34,109	25,655	31,625	39,033	28,075
Medicaid	BA	8,535	--	9,600	--	--	10,700	--	--	11,900	--	--	13,300	--	--	14,800	--
	O	8,456	--	9,600	--	--	10,700	--	--	11,900	--	--	13,300	--	--	14,800	--
Health Block Grant	BA	--	10,002	--	10,002	10,502	--	11,302	11,002	--	13,102	11,502	--	15,000	12,100	--	16,500
	O	--	9,001	--	9,001	10,452	--	11,252	10,952	--	12,548	11,452	--	14,000	12,121	--	15,000
TOTAL	BA	32,882	37,156	39,233	37,156	42,633	45,562	43,433	47,859	51,529	49,959	52,392	56,774	55,890	61,592	66,498	65,779
	O	32,089	34,975	38,060	33,825	38,369	43,383	37,569	41,044	48,729	40,440	44,182	54,676	43,930	47,907	61,201	47,222

5/11/76

1978 Spring ing Review
Department of Health, ducation, and Welfare
Health Programs
Alternatives Assuming Enactment of Potential Level in 1977

Attachment B

		1977	1978					1979				
		Potential	Potential	High	Medium	Low	Low, Low	Potential	High	Medium	Low	Low, Low
National Institutes of Health	BA	2,532	2,785	2,646	2,301	2,165	2,165	2,980	2,704	2,301	2,165	2,165
	0	2,474	2,667	2,609	2,542	2,430	2,430	2,795	2,647	2,402	2,275	2,275
Alcohol, Drug Abuse, and Mental Health Administration	BA	960	885	531	522	522	483	890	510	492	492	441
	0	832	974	921	919	919	914	945	631	621	621	588
Food and Drug Administration	BA	243	267	247	247	247	247	267	247	247	247	247
	0	240	266	246	246	246	246	266	247	247	247	247
Center for Disease Control	BA	174	179	123	110	110	102	184	128	110	110	102
	0	282	191	176	158	158	155	179	155	137	137	129
Health Services Administration	BA	1,592	1,641	562	562	533	533	1,649	553	553	533	533
	0	1,499	1,835	1,126	1,126	1,106	1,106	1,907	948	948	928	928
Health Resources Administration	BA	1,023	1,009	482	478	431	218	1,006	479	475	428	217
	0	1,108	1,022	790	784	737	579	1,005	651	645	598	416
Office of the Assistant Secretary for Health	BA	78	100	100	100	100	100	112	112	112	112	112
	0	88	97	97	97	97	97	108	108	108	108	108
Medicare	BA	23,031	27,996	28,093	28,093	28,093	28,093	32,541	32,822	32,822	32,822	32,822
	0	21,937	25,631	23,991	23,991	22,711	22,032	29,624	26,734	26,734	24,909	24,123
Medicaid	BA	9,600	10,700	--	--	--	--	11,900	--	--	--	--
	0	9,600	10,700	--	--	--	--	11,900	--	--	--	--
Health Block Grant	BA	--	--	10,502	10,502	11,302	11,302	--	11,002	11,002	13,102	13,102
	0	--	--	10,452	10,452	11,252	11,252	--	10,952	10,952	12,548	12,548
Total	BA	39,233	45,562	43,286	42,915	43,503	43,243	51,529	48,557	48,114	50,011	49,741
	0	38,060	43,383	40,408	40,315	39,656	38,811	48,729	43,073	42,794	42,371	41,362

5/11/76

Attachment

Attachment

1978 Spring Planning Review
Department of Health, Education, and Welfare
Reductions to Target
Health Programs
(Outlays in $ millions)

		Base	1978	1979
Total Potential Level		xxx	43,383	48,729
A. Changes to get to High Option				
Medicare--reaffirm 1977 budget proposals	1978	25,631	-1,640	
	1979	29,624		-2,890
NIH--allow a 5% annual growth rate for research over the 1977 potential and implement current phase-out training policy in 1978	1978	2,667	-58	
	1979	2,795		-148
Medicaid--continue to advocate block grant	1978	10,700	-10,700	
	1979	11,900		-11,900
CDC--accept likely congressional add-ons	1978	191	-15	
	1979	179		-24
HRA--continue 1977 budget policies in health professions education, planning, and construction	1978	1,022	-232	
	1979	1,005		-354
ADAMHA--allow a 5% annual growth rate for research over the 1977 potential and implement current policies for training and service programs in 1978	1978	974	-53	
	1979	945		-314
Block Grant--reaffirm 1977 budget proposal	1978	--	+10,452	
	1979	--		+10,952
HSA--reaffirm 1977 budget policies, except for an IHS increase of $20 million	1978	1,835	-709	
	1979	1,907		-959
FDA--oppose congressional add-ons	1978	266	-20	
	1979	266		-19
Subtotal, High Option		xxx	40,408	43,073

		Base	1978	1979
B. Additional Changes to get to Medium Option				
NIH--maintain 1976 appropriation level and training phase-out	1978	2,667	-67	
	1979	2,795		-245
CDC--continue 1977 budget policies	1978	191	-18	
	1979	179		-18
HRA--hold statistics and services research to lower levels	1978	1,022	-6	
	1979	1,005		-6
ADAMHA--maintain 1976 appropriation level for research	1978	.974	-2	
	1979	945		-10
Subtotal, Medium Option		xxx	40,315	42,794
C. Additional Changes to get to Low Option				
Medicare--lower 7% and 4% reimbursement limits to 5% and 2-1/2%, respectively, and increase proposed 10% HI coinsurance to 15%	1978	25,631	-1,280	
	1979	29,624.		-1,825
NIH--maintain 1977 budget policies	1978	2,667	-112	
	1979	2,795		-127
HRA--limit student assistance to service scholarships and eliminate capitation in 1981	1978	1,022	-47	
	1979	1,005		-47
Health Block Grant	1978	--	+800	
	1979	--		+1,596
HSA--hold IHS funding to the 1977 level	1978	1,835	-20	
	1979	1,907		-20
Subtotal, Low Option		xxx	39,656	42,371

		Base	1978	1979
D. Further Possible Reductions				
HRA--eliminate capitation grants in 1977	1978	1,022	-158	
	1979	1,005		-182
CDC--reductions in noncommunicable disease areas	1978	191	-3	
	1970	179		-8
ADAMHA--terminate training--other than research training--by the end of 1979 and initiate 5% annual decrease in drug abuse support in 1978	1978	974	-5	
	1979	945		-33
Medicare--retain $500 and $250 caps, but do not remove length of stay limits	1978	25,631	-679	
	1979	29,624		-786
Total, with Further Possible Reductions		xxx	38,811	41,362

5/11/76

1978 Spring Preview
Department of Health, Education, and Welfare
Health Programs
S. Cong. Res. 109 - 1977 Budget

(Outlays in $ billions)

		President's Budget	S. Cong. Res. 109	Change
Medicare	BA	23.0	22.8	-0.2
	O	19.6	21.4	+1.8
Medicaid	BA	--	9.3	+9.3
	O	--	9.3	+9.3
Health Block Grant	BA	10.0	--	-10.0
	O	9.0	--	-9.0
Other Health Programs	BA	5.0	7.2	+2.2
	O	5.8	7.2	+1.4
Total	BA	38.0	39.3	+1.3
	O	34.4	37.9	+3.5

5/11/76

1978 Spring Preview
Department of Health, Education, and Welfare
Health Programs
Summary of Recommendations
($ in millions)

		1976	1977				1978				1979			
		Current Policy	Current Policy	Potential	Low Option	Recom.	Current Policy	Potential	Low Option	Recom.	Current Policy	Potential	Low Option	Recom.
National Institute of Health	BA	2,301	2,165	2,532	2,165	2,301	2,165	2,785	2,165	2,301	2,165	2,980	2,165	2,301
	O	2,121	2,327	2,474	2,327	2,382	2,265	2,667	2,265	2,377	2,169	2,795	2,169	2,296
Alcohol, Drug Abuse, and Mental Health Administration	BA	879	540	960	540	540	452	885	452	452	440	890	440	440
	O	896	771	832	771	771	622	974	622	622	511	945	511	511
Food and Drug Administration	BA	209	243	243	243	243	247	267	247	247	247	267	247	247
	O	222	240	240	240	240	246	266	246	246	247	266	247	247
Center for Disease Control	BA	285	110	174	110	110	110	179	110	110	110	184	110	110
	O	167	246	282	246	246	131	191	131	131	114	179	114	114
Health Services Administration	BA	1,331	542	1,592	542	542	533	1,641	533	533	533	1,649	533	533
	O	1,281	967	1,499	967	967	850	1,835	850	850	800	1,907	800	800
Health Resources Administration	BA	718	445	1,023	445	445	431	1,009	431	431	428	1,006	428	428
	O	1,115	829	1,108	829	829	610	1,022	610	610	530	1,005	530	530
Assistant Secretary for Health	BA	68	78	78	78	78	100	100	100	100	112	112	112	112
	O	83	88	88	88	88	97	97	97	97	108	108	108	108
Medicare	BA	18,556	23,031	23,031	23,031	23,031	28,093	27,996	28,093	28,093	32,822	32,541	32,822	32,822
	O	17,748	20,506	21,937	19,356	20,506	23,096	25,631	21,496	23,096	25,613	29,624	23,413	25,613
Medicaid	BA	8,535	--	9,600	--	--	--	10,700	--	--	--	11,900	--	--
	O	8,456	--	9,600	--	--	--	10,700	--	--	--	11,900	--	--
Health Block Grant	BA	--	10,002	--	10,002	10,002	10,502	--	11,302	10,502	11,002	--	13,102	11,002
	O	--	9,001	--	9,001	9,001	10,452	--	11,252	10,452	10,952	--	12,548	10,952
Total	BA	32,882	37,156	39,233	37,156	37,292	42,633	45,562	43,433	42,769	47,859	51,529	49,959	47,995
	O	32,089	34,975	38,060	33,825	35,030	38,369	43,383	37,569	38,481	41,044	48,729	40,440	41,171

5/11/76

Attachment E

1978 Spring Preview
Department of Health, Education, and Welfare
Relation of Potential to Previous Estimates
Health Programs
($ in millions)

Program		1976	1977	1978	1979
March 25 Estimate	BA	32,582	37,135	42,636	47,833
	O	31,924	34,690	38,370	41,027
Medicaid reestimate	BA	+162	--	--	--
	O	+162	--	--	--
Medicare reestimate	BA	--	+3	-7	+22
	O	--	+160	-4	+13
Congressional add-ons	BA	+3	--	--	--
	O	--	+3	--	--
Presidential initiatives	BA	+135	+16	+4	+4
	O	+5	+123	+3	+4
Current Policy, Subtotal	BA	32,882	37,154	42,633	47,859
	O	32,091	34,976	38,369	41,044
Alcohol, Drug Abuse, and Mental Health Administration	BA	--	+420	+433	+450
	O	--	+60	+352	+434
Food and Drug Administration	BA	--	--	+20	+20
	O	--	--	+20	+20
Center for Disease Control	BA	+14	+64	+69	+74
	O	+12	+36	+60	+65
National Institutes of Health	BA	+41	+367	+620	+815
	O	+4	+147	+402	+626
Health Resources Administration	BA	+38	+578	+578	+578
	O	+38	+279	+412	+475
Health Services Administration	BA	--	+1,050	+1,108	+1,116
	O	--	+532	+985	+1,107
Medicare	BA	--	--	-97	-281
	O	--	+1,431	+2,535	+4,011
Medicaid	BA	--	+9,600	+10,700	+11,900
	O	--	+9,600	+10,700	+11,900
Health Block Grant	BA	--	-10,002	-10,502	-11,002
	O	--	-9,001	-10,452	-10,952
Potential Threat Total	BA	32,975	39,231	45,562	51,529
	O	32,145	38,060	43,383	48,730

5/11/76

Attachment F

National Institutions of Health (NIH)

Evaluations--Major Program Areas

Underway

-- NIH research training programs.

Planned

Should Be Undertaken

-- Objectives of NIH on campus research program and design measures of accomplishments.

Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA)

Evaluations--Major Program Area

Underway

-- ADAMHA clinical trials to determine the way in which ADAMHA can best target its resources in this activity.

-- ADAMHA service delivery programs.

Planned

-- Community mental health centers (CMHC) follow-up.

-- ADAMHA long-term follow-up on the treatment outcome of former clients in drug abuse and alcohol treatment projects.

-- Saint Elizabeths Hospital manpower analysis.

Should Be Undertaken

-- Projected needs for different types of mental health related personnel; necessary teaching inputs for adequate training; and cost effectiveness of training alternative types of personnel.

-- Effectiveness of mental health prevention efforts.

-- Impact of and the cost/effectiveness of the full spectrum of mental health related treatment modalities and delivery systems.

Medicare/Medicaid

Evaluations--Major Program Areas

Underway

-- Prospective hospital reimbursement methods--cost-savings.

-- Ambulatory surgery--as an alternative to inpatient care.

-- Physician reimbursement--cost implication of fee schedule vs reasonable cost methods.

-- Incentive contracting for Medicaid operations.

-- Eligibility and payment errors in Medicaid.

-- Rand health insurance experiment--effects of cost-sharing on medical care use.

Planned

-- Hospital rate regulation--impact and methodology.

-- Physician extenders--costs and productivity effects of different reimbursement methods.

-- Early and Periodic Screening Diagnosis and Treatment--assessment of community organization and delivery alternatives and impact on health.

-- Long-term care--costs of alternatives.

-- Extent of health insurance coverage.

Should Be Undertaken

-- Efficacy of various medical treatment options, particularly where existing patterns differ widely in expense.

-- Development of improved standards for assessing reasonableness of hospital costs.

Food and Drug Administration (FDA)

Evaluations--Major Program Areas

Underway

Planned

-- New FDA enforcement program to assure the proper conduct of animal and clinical tests designed to determine the safety and efficacy of new drugs.

Should Be Undertaken

-- Clinical laboratory regulation.

Health Services Administration (HSA)

Evaluations--Major Program Areas

Underway

-- PSRO evaluation, including:

- cost projection study
- evaluation of concurrent review
- methodology development

Planned

-- Continued PSRO evaluation--effects on costs and quality.

Should Be Undertaken

-- Evaluation of quality of services provided by the Indian Health Service both in its hospitals and through contract with non-Indian facilities.

Health Resources Administration (HRA)

Evaluations--Major Program Areas

Underway

-- Physician extender training and development study.

Planned

-- Area Health Education Centers (AHEC) program.

-- Health Planning Activities including the Composition of the Governing Boards and the Health Planning Information Clearinghouse.

-- Family Practice Programs

-- NCHS minimum data sets.

Should Be Undertaken

-- The necessary cost of producing health professionals.

-- Impact of the Federal Government on the development of medical facilities.

1978 Spring Planning Review
Department of Health, Education, and Welfare
Issue #1: Health Research Activities

Statement of Issue

What should be the nature and extent of Federal support for health research?

Background

The Federal Government--through 17 agencies--will spend more than $3 billion in 1977 for biomedical, behavioral, and health services research and health statistics. Based upon the 1977 budget, health research outlays in 1977 will account for 13% of total Federal research and development expenditures. The National Institutes of Health (NIH) will support about two-thirds of total Federal health research through grants, contracts, and on-campus research.

Over the last four years, budget requests for HEW health research have generally been below the previous appropriation levels due mainly to Administration and congressional disagreement on the appropriate growth rate for NIH funding. The 1977 budget request is $144 million below the 1976 appropriation.

Alternatives

#1 & #2. Maintain the level proposed in the 1977 budget for health research.

#3. Seek the 1976 appropriation level in 1977 and 1978 for health research.

#4. Allow a limited growth rate of 5% in health research in 1977 and 1978 using the 1977 potential level as a base.

Analysis

Major issues associated with Federal support for health research are: overall funding levels and rate of growth; the relationship of budget decisions for health research with other Federal research and development programs; the extent to which research institutions should share research costs with Federal sponsors; the need to apply health research to the formulation of current health policies; and the allocation of resources for research within the health agencies.

Alternative #1 (low alternative)

This alternative would hold the planning ceiling for health research at the 1977 budget level of $2.36 billion or $144 million below the 1976 appropriation. It offers a choice of four strategies to permit HEW to maintain programs at this level: (a) return to the grant-in-aid concept, (b) elimination of selected funding mechanisms, (c) reductions in the number of projected new research awards, or (d) cost savings in intramural research activities.

(a) The first strategy would require research institutions to shoulder a defined proportion of research costs. HEW has all but nominally abandoned the grant-in-aid concept in which Federal funds assist but not fully subsidize an investigator to perform research. Although HEW appropriation language endorses the grant-in-aid concept by prohibiting full Federal reimbursement of grant costs, HEW administration of this provision has required only token contributions from some institutions. Yet, universities and other non-profit institutions benefit not only from operating income, but also from increased prestige, faculty expansion and diversification, and acquisition of equipment and facilities.

A requirement that institutions finance a consistent percentage of total research costs would acknowledge the benefits accrued, but not accounted as income. More importantly, it could create an incentive for the institution to control accelerating direct and indirect costs due to salary and benefit increases, energy consumption, and poor administration. Direct Federal savings from a fixed cost-sharing rate would depend upon the rate selected, as current cost-sharing contributions range from 1-15% of costs. Some savings should follow from tighter enforcement of even the existing cost-sharing agreements, although Federal and institutional administrative costs could increase as a result.

Another approach to cost-sharing would be to exclude certain costs from Federal reimbursement, such as salary levels at a rate higher than the Federal pay ceiling or travel expenses to professional meetings. A salary ceiling would place grantees on a par with Federal researchers and might facilitate recruitment and retention of Federal scientists. Such a ceiling would, however, arouse criticism as a form of "wage control" for only an isolated segment of the private work force. Universities would be free, of

course, to supplement any salaries paid under a Federal grant. Savings from a salary ceiling would be uncertain because HEW is unable to estimate the number of researchers receiving salaries above that rate and the extent of funding of higher rates. A restriction on travel costs for professional meetings would require researchers to finance travel necessary for their professional development. Net Federal savings, however, would be less than $10 million, since travel costs would be tax deductible as business expenses.

The adoption within HEW health programs of such cost-sharing measures would raise questions of equity because they would have equal justification in other Federal research and development programs. Opponents of cost-sharing, such as the President's Biomedical Research Panel and the Commission on Federal Procurement, would object to any application on the grounds that the Federal Government should not financially penalize researchers and institutions for performing research to meet national needs. In order to compensate for lost revenues, universities would probably require researchers to perform heavier teaching and administrative duties and to bring in other sources of income such as clinical services and tuition. This could not only distract investigators from research, but might have secondary effects upon university hospital costs and the need for student aid.

(b) The second broad strategy is to exclude from the budget those research funding mechanisms which do not contribute directly to the conduct of research. Examples would be institutional subsidies through biomedical research support grants ($43 million) and construction grants ($25 million). Administration attempts to eliminate major "research resource" programs over the past five years have failed. Congress has strongly criticized such attempts in committee report language, appropriated continuation funds, rejected rescission proposals, and even included specific appropriation language for one program, construction grants for new cancer facilities, which the Administration opposed. The 1977 budget again excludes funding for biomedical research support grants. Only a cluster of small programs for minorities, young investigators, and visiting scientists remain to be proposed for the first time for phase out.

(c) A third strategy would require the agency to make reductions in commitments to on-going research or projected new awards. If agencies make no changes in commitment levels through cost-sharing or termination of grants,

maintenance of the 1977 budget level in 1977 would fund less than half of competing renewals and no new awards. Within the constraints of the current budget policy, research agencies would undoubtably choose to protect investments in basic laboratory and clinical investigations at the expense of projects, such as clinical trials, which apply existing knowledge to current medical practice.

(d) A fourth strategy would entail restrictions on travel and the purchase of equipment and supplies by NIH on-campus researchers. As in the cost-sharing strategy for researchers at academic institutions, NIH researchers would be required to pay travel costs to professional meetings they believe necessary for their professional development. A limitation on the purchase of new equipment and major laboratory supplies would require that NIH seriously pursue the idea of equipment pools and authorize purchase of new equipment at a lower rate, say 15% less, than that of 1976. The ceiling letter would instruct HEW to make recommendations on cost savings within the NIH intramural program, including restrictions on travel and equipment purchases.

Alternative #2 (low alternative)

This alternative would also hold health research at the 1977 budget level in 1977 and 1978 with provision for increased cost-sharing. Its objective, however, is to ensure that health research funding addresses the major policy needs of other health programs, such as quality assurance or cost control. It proposes that the planning ceiling letter require that HEW make recommendations on the feasibility of adoption within the health agencies of the British customer/contractor system of research.

Under a customer/contractor system, health service, financing, and regulatory agencies would define research objectives and control limited funds to commission NIH to perform specific research tasks. Agencies that need particular research results would have the opportunity to purchase research according to assessments of: (1) the nature and magnitude of a health care problem, (2) the breadth and depth of Federal involvement, and (3) relevant trends in attitudes and practices of health professionals. Examples are an evaluation of the effectiveness and cost of coronary care units or emergency medical services in the treatment of heart attacks, clinical trials of the effects of tranquilizers on the institutionalized aged, or "human and economic impact" statements on elaborate life support systems such as kidney dialysis. Adoption of a system would require transfer of part of the NIH budget (e.g. $50 million) to the Assistant Secretary for Health or

individual agencies such as the Bureau of Quality Assurance or FDA, on the understanding that the funds would be invested in NIH research which addressed the policy needs of the "customer" agency.

NIH currently performs research that serves objectives such as quality assurance or health care cost control, but it relies mainly on "scientific roulette" to achieve the coincidence in a given project of intrinsic scientific interest and applicability to Federal health programs. Although NIH participates in inter-agency task forces and occasionally undertakes research for FDA or CDC on request, the Assistant Secretary and the other health agencies have no real leverage over NIH funding. NIH enthusiasm for deliberately "targeted" projects diminishes markedly whenever the agency perceives its resources as "constrained."

By contracting for research through NIH, health agencies could benefit from NIH's prestige, personnel, and advisory committee structure. The transfer of funds from NIH would facilitate agency investment in research without diverting resources from on-going programs. If the fund transfer were limited to $50 million, at least initially, NIH would benefit from increased "consciousness" of health policy problems without depleting its resources for laboratory and clinical investigations with no immediate applicability to current health care. If necessary, a "floor" for resources for such investigations could be established. The customer/contractor system could begin to affect the separation of resources between "core" research and clinical trials and demonstrations that many research advocates, including the President's Panel, have called for.

Implementation of this system would require that health agencies have some personnel with enough familiarity with biomedical research to enable them to formulate reasonable research objectives. Certain agencies such as FDA or CDC already possess expertise, but SSA or SRS might have to rely upon the Assistant Secretary for Health or the Bureau of Quality Assurance. A potential increase in staff in the "customer" agencies could be offset by reductions in some agency intramural efforts on the grounds that agencies could now legitimately call upon NIH to perform research. The customer/contractor approach could facilitate consolidation of various PHS research components, especially ADAMHA research, into NIH.

Another option which could achieve similar integration of health research, service, financing and regulatory functions would be a single appropriation for health research within HEW. Such an appropriation would, however, decrease the control of both the Administration and Congress over the policies and operations of the health agencies.

Alternative #3 (medium alternative)

This alternative would maintain health research at the 1976 appropriation level in 1977 and 1978. As in Alternative #2, the planning ceiling letter would require that HEW make recommendations on cost-sharing reforms and the adoption of the customer/contractor system of research. The choice of the 1976 appropriation level for 1977 and 1978 would recognize that it is highly unlikely that Congress will reduce funding of health research to meet the 1977 budget level.

Alternative #4 (high alternative)

This alternative would provide an annual growth rate for health research of approximately five percent. It addresses the problem of the accelerating expense of research due to: (1) increasingly sophisticated instrumentation, (2) requirements for highly trained research assistants to perform more and more complicated tasks, (3) increasing emphasis on clinical investigations and trials which are far more costly than fruit fly experiments, and (4) the additional effort necessary to understand the more complex biological problems that have remained unresolved. It acknowledges the difficulty of implementing more rigorous cost-sharing procedures, terminating "research resource" programs, and restricting the level of research commitments and new awards--all in the face of congressional opposition.

Budgetary effects (outlays in billions)

	1978	1979	1980	1981
#1. Low alternative	2457	2374	2429	2432
#2. Low alternative	2457	2374	2429	2432
#3. Medium alternative (OMB recommendation)	2587	2518	2582	2547
#4. High alternative	2768	2829	3000	3142

Implementation of OMB recommendation

We recommend adoption of Alternative #3 with an instruction to HEW in the planning ceiling letter to undertake studies on the feasibility of cost-sharing reforms and a customer/contractor system for health research and make recommendations in the submission of the 1978 budget. The instruction would read:

"The 1978 HEW budget submission should present alternatives and the Department's recommendations with respect to the present cost-sharing procedures for research grants, including changes which would increase institutional shares of research costs. With respect to the health agencies, the budget submission should analyze and make recommendations upon the application of a customer/contractor research system to health research, e.g., a system which would allow health program agencies to set mission-oriented research objectives and commission with special funds research projects at NIH. Your budget submission should also offer alternatives and recommendations upon cost savings in intramural health research programs, such as limitations on travel and equipment purchases."

Attachment

5/11/76

Attachment

1978 Spring Planning Review
Department of Health, Education, and Welfare
Health Research Activities
($ in millions)

				1977					1978					1979					1980		1981	
		1975 Actual	1976 Current Policy	Potential	Alt. 1 Low	Alt. 2	Alt. 3 Medium	Alt. 4 High	Potential	Alt. 1 Low	Alt. 2	Alt. 3 Medium	Alt. 4 High	Potential	Alt. 1 Low	Alt. 2	Alt. 3 Medium	Alt. 4 High	Potential	Alt.3 OMB Rec.	Potential	Alt.3 OMB Rec.
National Institutes of Health	BA	1938	2178	2346	2059	2059	2196	2346	2599	2062	2062	2199	2463	2794	2127	2127	2264	2586	3003	2271	3225	2271
	O	1758	1969	2341	2203	2203	2258	2341	2481	2160	2160	2272	2424	2609	2072	2072	2199	2470	2824	2265	3040	2234
(To be distributed to other health agencies)	BA	--	--	--	--	--	--	--	--	--	(50)	(50)	--	--	--	(50)	(50)	--	--	(50)	--	(50)
	O	--	--	--	--	--	--	--	--	--	(20)	(20)	--	--	--	(41)	(41)	--	--	(50)	--	(50)
Alcohol, Drug Abuse, and Mental Health Administration	BA	134	142	142	127	127	142	142	146	127	127	144	150	146	127	127	144	158	146	144	146	144
	O	114	145	145	135	135	145	145	145	130	130	145	148	145	127	127	145	154	145	145	145	144
Food and Drug Administration	BA	35	36	37	37	37	36	37	37	37	37	36	39	37	37	37	36	41	37	36	37	36
	O	27	28	29	29	29	28	29	35	35	35	35	38	39	39	39	38	39	40	39	37	36
Center for Disease Control	BA	41	52	58	50	50	52	58	63	50	50	52	61	68	50	50	52	64	68	52	68	52
	O	42	51	46	38	38	52	46	59	48	48	54	59	64	52	52	55	61	67	52	67	52
Health Services Administration	BA	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	O	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Health Resources Administration	BA	50	52	52	48	48	52	52	52	48	48	52	55	52	48	48	52	58	52	52	52	52
	O	50	52	52	48	48	52	52	52	48	48	52	55	52	48	48	52	58	52	52	52	52
Assistant Secretary for Health	BA	1	8	14	14	14	8	14	8	8	8	8	15	8	8	8	8	16	8	8	8	8
	O	4	7	8	8	8	8	8	8	8	8	8	15	8	8	8	8	16	8	8	8	8
Medicare	BA	8	12	12	12	12	12	12	12	12	12	12	13	12	12	12	12	14	12	12	12	12
	O	6	9	11	11	11	11	11	12	12	12	12	12	12	12	12	12	13	12	12	12	12
Medicaid	BA	6	6	13	13	13	6	13	13	13	13	6	14	13	13	13	6	15	13	6	13	6
	O	6	6	9	9	9	6	9	13	13	13	6	14	13	13	13	6	15	13	6	13	6
Total	BA	2216	2489	2677	2363	2363	2507	2677	2933	2360	2360	2512	2813	3133	2425	2425	2577	2955	3342	2584	3564	2584
	O	2010	2270	2644	2484	2484	2563	2644	2808	2457	2457	2587	2768	2945	2374	2374	2518	2829	3164	2582	3377	2547

5/11/76

1978 Spring Planning Review
Department of Health, Education, and Welfare
Issue #2: Training for Health Professions Careers

Statement of Issue

What should be the nature and the extent of the Federal role in the training of health professionals and related personnel?

Background

Since 1970 the Federal Government--mostly through HEW's categorical training programs, institutional subsidies, and student assistance--has spent over $1 billion annually to accomplish the following:

-- expand the supply of various health professionals and biomedical and behavioral researchers;

-- expand and improve the teaching capacities of various institutions;

-- develop new types of health personnel;

-- develop and provide short-term specialized and/or continuing education programs for Federal employees, individuals employed by federally supported service programs, and others;

-- assist States, localities and others in the planning and development of State wide and regional health professions education programs that address local health personnel, licensing, and certification needs; and

-- research, evaluate and demonstrate existing and new training curriculums and methodologies.

Since 1974, Presidents have proposed limiting the direct Federal role in health professions education subsidies because of:

-- the projected increases in the numbers of health professions graduates indicate that additional Federal stimulation is not necessary;

-- the social equity question of continued taxpayer subsidy of the training of persons generally destined to enjoy socially prestigious, high-paying professions; and

-- Federal funds should instead address geographic and specialty distribution of health professionals.

Attachment A displays the various HEW health training activities. This table does not include an estimated $275 million of Medicare and Medicaid funds which support intern and residency training. Categorical HEW State formula programs, e.g., alcohol and drug abuse formula grants, are used by States and localities for training. Other agencies, e.g., the Department of Defense and the Veterans Administration, support health training activities as an adjunct to their missions.

The President's 1977 Budget proposed the following major policies:

-- institutional support to the medical, osteopathic, and dental (MOD) schools in return for meeting conditions designed to improve geographic and specialty distribution;

-- phase out of institutional grant support for long-term and short-term training of other professions and the training of graduate students in life and behavioral sciences;

-- future direct student assistance for the MODs would be limited to scholarships that require a public service commitment;

-- limited support for special education projects aimed at addressing specialty, geographic, disadvantaged, public and allied health personnel problems;

-- a limited number of postdoctoral research fellowships, pending the evaluation required by Congress of the National Academy of Sciences of the shortages of researchers; and

-- a general reliance on Office of Education student assistance programs.

While the 1977 budget proposed continued institutional support solely for MOD schools, many other health professions schools argue that the importance of services rendered by their graduates, e.g., psychologists, nurses and social workers call for special Federal subsidies.

While seemingly willing to decrease the level of Federal support for some programs slightly, Congress generally seems intent on continuing all of the training programs of the past as well as adding new ones, i.e., public health and health administration. Besides the pressure from well organized interest groups, Congress is concerned that if Federal support were withdrawn many of the training institutions might go under or have to decrease their training capacity. Congress may attempt to resolve the specialty distribution problem by requiring HEW to control directly the number, types and location of medical residencies.

The President's 1976 request was $570 million. The 1976 current estimate level of $731 million reflects congressional override of the President's veto of the Labor-HEW bill. The 1977 request level and the 1978 current policy level are based on the original 1976 budget request and are thus substantially below "commitment" levels.

Alternatives

#1. Continue to support the existing policy proposals based on the 1977 budget request. (OMB recommendation)

#2. Continue to support the existing policies and proposals, but adjust the 1977 request and 1978 planning ceiling to reflect the 1976 appropriations.

#3. Continue to support the existing policies and proposals, but adjust the 1977 request and 1978 planning ceiling to reflect acceptance of the potential 1977 level.

#4. Accept anticipated congressional funding levels in 1977 and 1978, but submit legislation to require pay back and geographic and specialty distribution conditions of other than MOD institutions.

Analysis

The issues center around the appropriate Federal role in health professions education. Underlying all of the problems in determining the Federal role in health professions education are a number of critical questions:

-- how much should it cost to educate the various health professions?

-- in the absence of any idea as to necessary costs, why should the Federal Government underwrite those costs?

-- should the trend be to nationalize medical schools through increasing Federal funding and regulation and, if so, how?

Alternative #1 (low alternative)

This alternative would continue support for the 1977 budget proposed levels. If adopted in 1977 and 1978, the Administration proposals--whose funding levels are below normal "commitments" in some areas--would significantly lower the direct Federal support for health professions education. Certain health professions (MODs) would continue to be singled out for capitation grant subsidies. Except for service-based student assistance, limited postdoctoral research fellowships, education of Federal personnel, and limited development and demonstration of selected health education activities, the Federal Government would rapidly phase out its support of health professions education--including technical assistance to States and localities and special short-term training programs.

Health professions students would rely on general student assistance programs (e.g., guaranteed loans) and other sources (e.g., part-time employment and/or working spouse)--as is the case with most other higher education students--to meet a larger share of their education expenses. The training institutions would have to find other sources of revenues, e.g., raise tuition and gain additional State, local and private support, or decrease program levels, e.g., reduce overhead and faculty.

The capitation requirements and the service commitment provisions were designed to provide leverage to induce MOD schools to be more attentive to geographic and specialty maldistribution. Whether or not this approach will ultimately solve the problems in the long run, however, is not apparent. Students can buy their way out of the scholarship agreements. Furthermore, it is not certain that the less attractive geographic areas will be able to retain the health professionals after they have fulfilled their commitments. The institutional support proposal commits the Federal Government to long-term subsidies for which there will be enormous pressures for increases. In the long run, as health professionals continue to increase and more students enter the shortage areas and specialties, an "oversupply" of personnel may result, that will more likely add to the inappropriate utilization and cost of health services.

The Administration's current proposals represent a moderate and targetted attempt to deal with system-wide changes in the key health professional area (MODs). Based on past experience and current congressional deliberations, Congress will probably not accept phase out proposals and will increase the funding levels for institutional support. In addition, Congress may mandate additional Federal regulatory responsibilities to address specialty maldistribution among physicians.

Alternative #2 (low medium alternative)

This alternative would maintain the same policies as in Alternative #1, but the 1977 budget request and 1978 planning levels would be adjusted to reflect the higher 1976 base. HEW would prefer levels consistent with program "commitments." Congress would probably still reject the proposed funding levels as too low.

Alternative #3 (high medium alternative)

This alternative would accept anticipated congressional levels in 1977. In 1978, the current policies would again be proposed.

Alternative #4 (high alternative)

This alternative would accept anticipated congressional levels in 1977 and 1978, but would require service pay back and geographic and specialty distribution conditions for students and institutions receiving special Federal assistance. The Federal role in system-wide leverages aimed at allocating training resources to meet perceived national needs would be expanded. This represents an abandonment of attempts to phase out direct Federal support for health professions education.

Budgetary effects (outlays in millions)

	1978	1979	1980	1981
#1. Low alternative (OMB recommendation)	568	526	407	403
#2. Low Medium alternative	687	646	548	506
#3. High Medium alternative	847	736	616	563
#4. High alternative	957	942	917	938

Implementation of OMB recommendation

HEW should be given the OMB recommended ceiling.

Attachment

Attachment A

1978 Spring Planning Review
Department of Health, Education, and Welfare/Health Programs
Health Professions Training
(BA in $ millions)

	1975 Actual	1976 Current Estimate	1976 Potential	1977 Alt. #1 OMB Rec.	1977 Alt. #2	1977 Alt. #3	1977 Alt. #4 Potential	1978 Alt. #1 OMB Rec.	1978 Alt. #2	1978 Alt. #3	1978 Alt. #4 Potential	1979 Alt. #1 OMB Rec.	1979 Alt. #2	1979 Alt. #3	1979 Alt. #4 Potential	1980 Alt. #1 OMB Rec.	1980 Alt. #4 Potential	1981 Alt. #1 OMB Rec.	1981 Alt. #4 Potential
Health Resources Administration (Total)	610	441	479	323	354	598	598	307	352	354	582	305	350	352	580	305	577	305	577
Professions Education	(605)	(436)	(474)	(323)	(354)	(593)	(593)	(307)	(352)	(354)	(577)	(305)	(350)	(352)	(575)	(305)	(572)	(350)	(572)
MOD	329	221	255	228	245	354	354	228	245	245	338	228	245	245	336	230	333	230	333
VCPP	69	19	23	15	23	47	47	13	21	23	47	11	19	21	47	8	47	8	47
Nursing	122	110	110	38	44	116	116	28	44	44	116	28	44	44	116	29	116	29	116
Allied and Public Health	63	62	62	32	32	62	62	32	32	32	62	32	32	32	62	32	62	32	62
Non-specific Special Projects	22	24	24	10	10	14	14	6	10	10	14	6	10	10	14	6	14	6	14
Research Training	3	1	1	--	--	1	1	--	--	--	1	--	--	--	1	--	1	--	1
Short Term Training and Other	2	4	4	--	--	4	4	--	--	--	4	--	--	--	4	--	4	--	4
National Institutes of Health (Total)	155	125	166	106	147	186	186	103	144	183	186	38	79	118	186	31	186	31	186
Professions Education	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Research Training	154	124	165	105	146	185	185	102	143	182	185	37	78	117	185	30	185	30	185
Short Term and Other	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Alcohol, Drug Abuse, and Mental Health Administration (Total)	116	103	103	36	71	103	103	25	48	73	103	14	29	44	103	9	103	6	103
Professions Education	75	67	67	24	45	67	67	16	28	46	67	6	13	26	67	1	67	--	67
Research Training	15	15	15	6	12	15	15	5	10	12	15	5	8	9	15	5	15	5	15
Short Term and Other	26	21	21	6	14	21	21	4	10	15	21	3	8	9	21	3	21	1	21
Health Services Administration (Total)	68	59	59	10	14	59	59	10	14	14	59	10	14	14	59	10	59	10	59
Professions Education	44	36	36	8	10	36	36	8	10	10	36	8	10	10	36	8	36	8	36
Research Training	16	17	17	1	2	17	17	1	2	2	17	1	2	2	17	1	17	1	17
Short Term and Other	8	6	6	1	2	6	6	1	2	2	6	1	2	2	6	1	6	1	6
Center for Disease Control (Total)	9	3	4	3	4	4	4	3	4	4	4	3	4	4	4	3	4	3	4
Professions Education	8	2	3	2	3	3	3	2	3	3	3	2	3	3	3	2	3	2	3
Research Training	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
Short Term and Other	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Total BA	958	731	811	478	590	950	950	448	562	628	934	370	476	532	932	358	929	355	929
Outlays	988	858	902	683	758	881	881	568	687	847	957	526	646	736	942	407	917	403	938

5/11/76

1978 Spring Planning Review
Department of Health, Education, and Welfare
Health Programs
Issue #3: Medicare

Statement of Issue

Should the Administration modify its reform proposals for the Medicare program?

Background

Medicare costs have been rising by 16% annually since 1970, primarily reflecting rising hospital costs and physicians' fees. Utilization patterns vary widely, e.g., surgery rates and lengths of stay for the same diagnoses and procedures are over twice as high in some areas as in others. The program is administered through private contractors on the basis of non-competitive, cost-reimbursement contracts. Administrative costs per claim vary by more than 2:1 among different contractors.

The 1977 budget proposed extensive Medicare reforms to:

-- expand catastrophic protection by limiting required cost-sharing to $500 for hospital services and $250 for physician services annually and by removing length of stay limits for hospital and nursing home care;

-- provide financial incentives against overutilization of services and finance improved catastrophic benefits by establishing a 10% coinsurance rate for hospital and nursing home care and increasing the deductible for physician services with rises in social security cash benefits; and

-- restrain program costs and health inflation by limiting increases in Medicare reimbursements to 7% per diem for hospitals and 4% per service for physicians during the next two years while longer range reimbursement policies are under development.

If enacted in 1976, these proposals would reduce outlays by $1.5 billion in 1977 and $7 billion annually by 1981.

Through the new budget process, the Congress has begun to consider catastrophic health protection and hospital reimbursement limits, although at about a 10% rate rather than the proposed 7% per diem limit. As in previous years, the increased cost-sharing has not proved popular in the Congress. The congressional budget resolution called for $500 million of Medicare savings, partially offset by $200 million of benefit increases. Nevertheless, legislative action is not likely this year.

Alternatives

#1. Revise proposals to eliminate cost-sharing except to cover benefit liberalizations.

#2. Continue support of present proposals. (OMB recommendation)

#3. Propose further reductions: lower reimbursement limits to 5% per diem for hospitals and 2-1/2% for physicians and increase proposed hospital cost-sharing from 10% to 15%.

#4. In addition to Alternative #3, withdraw proposal to eliminate limits on hospital and nursing home stays.

Analysis

Proposed reductions in Medicare outlays encounter several obstacles. Benefits are generally seen as an entitlement based on past contributions of social security taxes (for hospital insurance) and payment of a heavily subsidized monthly premium (for physician insurance). Although the trust funds are underfinanced over the 1975-2000 actuarial period, near term tax increases produce substantial surpluses into the 1980's. Finally, government savings, particularly for physician services, may be in part passed on to the aged and disabled.

Alternative #1 (current law level)

Most national health insurance proposals call for greater Medicare spending than under current law. The Comprehensive Health Insurance Plan (CHIP), for example, would add about $2 billion annually in health benefits for the aged. In this environment, substantial Medicare reductions are unlikely to be enacted. If the Medicare legislation is viewed as a short-run budget expedient which will soon be reversed, Congress is even more likely to defer action until the Administration has submitted a national health insurance plan in which economies can be balanced by additional spending. Perhaps the best proposal that could now be enacted would be to restructure the program within present expenditure projections, e.g., by offsetting catastrophic protection with cost-sharing reforms and imposing reimbursement limits.

Alternative #2 (high and medium alternatives)

Arguing for continued support of the present proposals is the fact that they would restrain outlays and can be justified as programmatically sound. Moreover, for the first time, the Congress has responded--through Budget Committee recommendations-- to Administration Medicare reform proposals. A reaffirmation of the proposals may continue to foster debate and possible action within the Congress.

Alternative #3 (low alternative)

The proposed 7% per diem limit on hospital reimbursement has been generally regarded as too low in the Congress--where discussion has centered on a 10% figure--and a limit on physician fees has not been seriously considered. Nevertheless, further reductions could be proposed in these reimbursement rates, e.g., from 7% to 5% per diem for hospitals and from 4% to 2-1/2% for physicians, on the basis that the present Administration proposal--allowing 14% for hospitals and 8% for physicians over a two year period--will have been already consumed by congressional inaction in the first year. In addition, the proposed coinsurance rate of 10% for hospital and nursing home care could be raised to 15%. Either reduction to the present proposal would be arbitrary, but could be justified on the basis of overall budget targets.

Alternative #4 (low, low alternative)

A further set of reductions could come from dropping the Administration proposal to provide unlimited hospital and nursing home care under the catastrophic insurance proposals. Present law provides for 90 days of care per benefit period, plus an additional 60 "lifetime reserve" days, and 100 days per benefit period in a nursing home. The Administration's proposal to remove these limits would affect about 85,000 enrollees. Since these benefit liberalizations have not been enacted, it could be more acceptable to drop this proposal than to repeal existing benefits.

Budgetary effects ($ in billions)

		1978	1979	1980	1981
Trust fund income*	BA	(28.0)	(32.5)	(36.3)	(44.2)
Present law level	0	25.6	29.6	34.1	39.0
High and medium alternative (OMB recommendation)	0	23.1	25.6	28.5	31.6
Low alternative	0	21.5	23.4	25.7	28.1
Low, low alternative	0	20.8	22.6	24.7	27.0

*Not substantially affected by outlay changes

Implementation of OMB recommendation

Advise HEW to plan its 1978 budget request on the basis of the current proposal.

Attachment: Medicare estimates

Attachment

1978 Spring Planning Review Options
(Outlays in $ millions)

	1977	1978	1979	1980	1981
Potential	21,937	25,631	29,624	34,109	39,038
High and Medium Option Changes (Alternative #2)					
1. Medicare--reaffirm 1977 budget proposals					
Cost-sharing					
Hospital insurance (HI) (10% coinsurance)	-1,730	-2,020	-2,340	-2,690	-3,090
Physicians insurance (SMI) (dynamic deductible)	-130	-293	-412	-506	-595
	-1,860	-2,313	-2,752	-3,196	-3,685
Catastrophic					
Hospital insurance (HI) ($500 cap - remove stay limits)	+1,130	+1,350	+1,620	+1,910	+2,270
Physicians insurance (SMI) ($250 cap)	+208	+634	+753	+898	+1,070
	+1,338	+1,984	+2,373	+2,808	+3,340
Reimbursement limits					
Hospitals (7% per diem)	-730	-1,905	-3,240	-4,780	-6,530
Physicians (4% per service)	-179	-301	-392	-486	-538
	-909	-2,206	-3,632	-5,266	-7,068
Subtotal	-1,431	-2,535	-4,011	-5,654	-7,413
Low Option--Additional Reductions (Alternative #3)					
1. Medicare					
Lower reimbursement limits					
Hospitals (5% per diem)	-200	-500	-900	-1,300	-1,800
Physicians (2-1/2 % per service)	-50	-100	-150	-200	-250
	-250	-600	-1,050	-1,500	-2,050
Raise proposed cost-sharing					
Hospital insurance (15% coinsurance)	-900	-1,000	-1,150	-1,300	-1,500
Subtotal	-1,150	-1,600	-2,200	-2,800	-3,550
Low,Low Option--Additional Reductions (Alternative #4)					
1. Medicare					
Catastrophic					
Retain $500 cap, but do not remove stay limits	-580	-679	-786	-906	-1,039

1978 Spring Planning Review
Department of Health, Education, and Welfare
Issue #4: Health Services--The Health Block Grant

Statement of Issue

Should the Administration modify the health block grant proposal?

Background

The 1977 budget proposed to consolidate 16 health programs, including Medicaid, into a $10 billion block grant in order to give States greater flexibility in meeting the health care needs of the low-income population and to assure a more equitable distribution of Federal health services spending. Future funding was proposed to increase $500 million per year and, after 1980, by any additional amounts necessary to assure that no State ever received less than it actually received in 1976.

Alternatives

#1. Drop the health block grant proposal and base 1978 budget planning on congressional rejection of the block grant.

#2. Modify the health block grant by dropping Medicaid. Fund the grant at expected congressional action levels and propose Medicaid reforms.

#3. Reaffirm support for the health block grant at the proposed budget levels. (OMB recommendation)

#4. Reaffirm support for the health block grant proposal at higher budget levels than currently proposed.

Analysis

Alternative #1

The health block grant will probably not be enacted by the Congress. Although there has been some support for the concept, the proposal goes in the opposite direction from a strong congressional tide toward greater Federalization and narrow categorization of health care programs. The substantive committees have not scheduled hearings on the proposal and are not expected to do so. The funding for the block grant is below what Congress will probably enact for the individual programs by $1.2 billion in 1977 and $4.3 billion in 1981. This erodes support for the proposal from both potential beneficiaries and from the State and local governments who might otherwise be its strongest advocates.

Alternative #2

Alternative #3 (high and medium alternatives)

The inclusion of Medicaid has been one of the most widely questioned features of the health block grant proposal.

Arguments for including Medicaid in the block grant:

-- The block grant reflects a fundamental Administration view that States must have a major role in the financing and administration of health care programs. Inclusion of Medicaid permits States the broadest flexibility to design programs to meet health needs of their population and to balance their health spending against other spending priorities.

-- The block grant in effect "caps" currently open-ended Federal Medicaid expenditures. States already make most of the decisions concerning eligibility, benefits, and reimbursements rates, and costs have been increasing over 20% annually. A clearly limited Federal payment encourages States to take action to control health costs, e.g., through health planning, licensure, prospective hospital budgeting and rate regulation, and improved delivery systems.

-- The health block grant more equitably allocates Federal funds than the present Medicaid formula.

Arguments against including Medicaid in the block grant:

-- The Congress will not enact sweeping Medicaid reform except in replacing it with national health insurance legislation.

-- A limit on Federal Medicaid increases leaves States and localities with an ever-increasing burden to provide health care for the low-income population. States may reduce eligibility and benefits, and curtail freedom of choice and the role of the private sector by paying for care only in State or county-operated facilities.

-- The inclusion of Medicaid is a step in the opposite direction from uniform health insurance eligibility and benefits. As such, it is fundamentally at odds with most of the national health insurance designs.

-- The Chairman of the House Budget Committee has endorsed a gradual approach to health service program consolidation without Medicaid. The Chairman would consolidate the existing formula-type health grant programs first and the project grant programs later.

If Medicaid were excluded from the block grant, the reductions that were considered in 1977 in the absence of the block grant could be proposed in the 1978 budget:

-- the 1976 budget recommendation to reform the matching rate for the high income States;

-- a 10% limit on program growth; and

-- applying the 7% Medicare hospital limit to Medicaid hospital payments.

Alternative #4 (low alternative)

The key funding concern for potential supporters of the block grant concept is a comparison of the proposed funding levels with what the Congress is otherwise likely to provide. If the proposed grant is too far below that mark, beneficiaries and States and local governments will probably determine that it is in their best interest to continue the present programs. If, on the other hand, the Administration decides that the health block grant is going to be the basic element of its health strategy then additional funding--even above the level of present law--would make sense in order to gain enactment.

At any given level of funding for health activities, the block grant should be a priority for additional resources. It is the critical program proposal that differentiates the Administration's position on the Federal role in health services financing delivery from that of Congress, as reflected in the increasing number of narrow categorical health service programs and the increasing pressure for Federalized national health insurance.

Budgetary effects (outlays in billions)

	1978	1979	1980	1981
#1. Potential level alternative	12.3	13.5	14.9	16.4
#2. Separate Medicaid alternative	11.4	12.4	13.5	14.6
#3. High and Medium alternative (OMB recommendation)	10.6	11.0	11.5	12.1
#4. Low alternative	11.4	12.6	14.0	15.0

Implementation of OMB recommendation

Advise HEW to plan its 1978 budget request on the basis of the current proposal, but consider increasing the amounts in the block grant over the current proposal at Director's Review in the fall.

Attachment

1978 Spring Planning Review
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Programs
(BA in $ millions)

Attachment

Programs		1975 Actual	1976 Estimate	1977 Budget	1977 Potential	1978 Current Policy OMB Recom.	1978 Potential	1979 Current Policy OMB Recom.	1979 Potential	1980 Current Policy OMB Recom.	1980 Potential	1981 Current Policy OMB Recom.	1981 Potential
Alcohol, Drug Abuse, and Mental Health Administration		(340)	(350)	(220)	(340)	--	(340)	--	(340)	--	(340)	--	(340)
Community Mental Health Centers		213	216	131	216	--	216	--	216	--	216	--	216
Alcohol -- projects		65	68	33	56	--	56	--	56	--	56	--	56
-- formula		52	56	46	56	--	56	--	56	--	56	--	56
Program Direction		10	10	10	12	--	12	--	12	--	12	--	12
Center for Disease Control		(56)	(56)	--	(56)	--	(56)	--	(56)	--	(56)	--	(56)
Rat Control		13	13	--	13	--	13	--	13	--	13	--	13
Lead-based Paint		9	9	--	9	--	9	--	9	--	9	--	9
Immunizations		6	6	--	6	--	6	--	6	--	6	--	6
Venereal Disease		28	28	--	28	--	28	--	28	--	28	--	28
Health Services Administration		(757)	(789)	--	(849)	--	(859)	--	(870)	--	(870)	--	(870)
Comprehensive Health Centers		200	197	--	197	--	197	--	197	--	197	--	197
Family Planning		101	101	--	101	--	101	--	101	--	101	--	101
Migrant Health		24	25	--	25	--	25	--	25	--	25	--	25
State Formula Grants		90	90	--	90	--	90	--	90	--	90	--	90
Maternal and Child Health		295	322	--	322	--	322	--	322	--	322	--	322
Emergency Medical Services		37	34	--	84	--	94	--	105	--	105	--	105
Quality Assurance		--	--	--	10	--	10	--	10	--	10	--	10
Payment to Hawaii		1	1	--	1	--	1	--	1	--	1	--	1
Hypertension		--	4	--	4	--	4	--	4	--	4	--	4
Hemophilia		--	3	--	3	--	3	--	3	--	3	--	3
Home Health		--	3	--	3	--	3	--	3	--	3	--	3
Program Direction		9	9	--	9	--	9	--	9	--	9	--	9
Health Resources Administration		(122)	(184)	(2)	(306)	(2)	(306)	(2)	(306)	(2)	(306)	(2)	(306)
Health Planning		90	90	--	190	--	190	--	190	--	190	--	190
Construction		22	82	--	108	--	108	--	108	--	108	--	108
Program Direction		10	12	2	8	2	8	2	8	2	8	2	8
Office of Human Development		(54)	(56)	--	(56)	--	(56)	--	(56)	--	(56)	--	(56)
Development Disabilities		52	54	--	54	--	54	--	54	--	54	--	54
Program Direction		2	2	--	2	--	2	--	2	--	2	--	2
Social and Rehabilitation Service		(6,988)	(8,562)	--	(9,627)	--	(10,727)	--	(11,927)	--	(13,327)	--	(14,827)
Medicaid		6,966	8,535	--	9,600	--	10,700	--	11,900	--	13,300	--	14,800
Program Direction		22	27	--	27	--	27	--	27	--	27	--	27
Health Block Grant		--	--	10,002	--	10,502	--	11,002	--	11,502	--	12,190	--
Total	BA	8,317	9,997	10,224	11,234	10,504	12,344	11,004	13,555	11,504	14,955	12,192	16,455
	O	8,216	10,357	10,068	11,253	10,638	12,297	10,988	13,514	11,480	14,934	12,124	16,423

5/11/76

1978 Spring Planning Review
Department of Health, Education, and Welfare
Issue #5: Future of the Center for Disease Control (CDC)

Statement of Issue

What should be the future funding and program direction of the Center for Disease Control (CDC), now that its primary mission--the control of communicable diseases--has been largely accomplished?

Background

The Communicable Disease Center, as it was initially called, was established in 1946 as a descendant of an emergency World War II agency responsible for the control of malaria in the United States. In the 1950's, the Communicable Disease Center expanded its mission from malaria to other communicable diseases such as tuberculosis, polio, syphilis, typhoid fever, and childhood diseases such as measles and diptheria.

As these diseases sharply declined in incidence in the 1950's and 1960's (see Attachment A), the Center began to take on a number of noncommunicable disease programs, e.g., anti-smoking public education, urban rat control, lead-based paint poisoning prevention, occupational safety and health research, regulation of interstate clinical laboratories, and some aspects of birth defects, leukemia, and family planning research. An analogy to CDC's shift in function is the evolution of the March of Dimes and Christmas Seals organizations from targeting on polio and tuberculosis--which are now in sharp decline--to birth defects and chronic diseases.

In recognition of CDC's programmatic shift, the agency's name was changed in 1970 to the Center for Disease Control. Last year, the HEW Assistant Secretary for Health designated preventive health as one of his top priorities and named CDC as the focal point for all preventive health activities in HEW. HEW budget requests for CDC in the past two years have emphasized new preventive health programs.

At the present time, one preventive health program--the National Institute of Occupational Safety and Health (NIOSH)--accounts for 25% of CDC's budget. NIOSH performs research on occupational hazards and forwards proposed standards to the Occupational Safety and Health Administration in the Department of Labor (DOL) and the Mine Enforcement and Safety Administration in the Department of Interior (DOI). NIOSH is growing far more rapidly than any other part of CDC. The Administration has proposed annual increases for NIOSH of about 10% in recent years, and the Congress has always added substantially to the Administration requests. Both Congress and the Administration have been generally holding the rest of the CDC budget level in recent years.

NIOSH's growing size and importance has led NIOSH officials to comment confidentially that the NIOSH-CDC relationship is a case of "the tail wagging the dog." Indeed, when the Public Health Service was reorganized in 1970 and NIOSH was placed in CDC, many NIOSH officials believed the structure should have been just the reverse.

In most previous budget decisions, CDC has been restricted to the communicable disease area. The reason has been that most of CDC's noncommunicable disease programs overlap programs in other parts of HEW, such as the National Institutes of Health (birth defects and leukemia), and Health Services Administration (family planning), and the Social Security Administration (clinical laboratory regulation). (See Attachment B.)

To date, this attempt to restrict CDC to the communicable disease area has not succeeded. The effort has been undercut by the assignment of new noncommunicable disease programs to CDC, and by the growth of such programs through appropriations in excess of requests. The culmination of this change in role was P.L. 93-354, the "National Diabetes Mellitus Research and Education Act," which amended the sections of the Public Health Service Act which authorize CDC activities to read "communicable and other diseases" rather than just "communicable diseases." The Administration opposed this amendment.

The recent swine flu immunization initiative more than doubled the President's 1976 Budget request for CDC from $133 million to $268 million.

Alternatives

#1. Maintain the status quo--decide on a piecemeal basis on proposed new noncommunicable disease programs for CDC, and allow HEW to establish new noncommunicable disease programs at CDC at its own discretion if able to do so within existing resources.

#2. Transfer all CDC noncommunicable disease programs which overlap other HEW programs to the other parts of HEW with similar programs, and do not allow new duplicative noncommunicable disease programs to be started at CDC. Transfer funding for occupational safety and health research to DOL and DOI, and establish a customer-contractor relationship between the two departments and NIOSH, such that DOL and DOI determine the research to be undertaken at NIOSH.

#3. Do not allow new duplicative noncommunicable disease programs to be started at CDC, and gradually cut back personnel in noncommunicable disease program areas in which core functions can be accomplished more efficiently with fewer personnel. Consider the possibility of a shift in occupational safety and health research funding to DOL and DOI in the 1978 budget review. (OMB recommendation)

Analysis

The basic issue is what to do with an agency which no longer requires the same level of resources to achieve its original purposes. HEW has proposed to keep the agency intact without any reductions in staff, and to shift some of the staff to a new function--the broad area of preventive health. HEW has also proposed to add new staff to the agency for new preventive health programs.

Alternative #1 (high alternative)

HEW would adamantly oppose any downgrading of role for CDC on the grounds that the Federal Government must maintain its capacity and expertise to control

outbreaks of communicable disease and to improve preventive health measures. Moreover, any reduction in CDC's role would necessitate disbanding some of CDC's staff, and would risk a loss of morale among remaining staff.

Alternative #2 (low low alternative)

Noncommunicable disease activities now account for over 50% of CDC's budget, and this proportion is bound to grow if left unchecked. "Preventive health" is an enormously broad area, and HEW has indicated it will continue to propose and self-initiate new preventive programs for CDC. Moreover, "preventive health" is not a clearly distinguishable category, and most health programs throughout HEW have preventive components.

There would be some budgetary savings if CDC's current noncommunicable disease programs were to be consolidated with similar programs elsewhere. Most savings would come, though, in heading off future increases for program expansions and additions. It is questionable how many CDC staff would try to move to other agencies if Alternative #2 were adopted since CDC is located in Atlanta and virtually all other Federal agency headquarters are in Washington.

The advantage of shifting funding and direction over NIOSH research to DOL and DOI is that the research could be more closely tailored to meet those agencies' regulatory needs. At present, NIOSH has produced and transmitted to DOL about 30 proposed occupational safety and health standards in its six years of existence, but DOL has promulgated only one of those standards. One of the main reasons for this backlog is that DOL must perform additional cost-benefit and technological feasibility studies after receiving the proposed NIOSH standard.

More of these second type of studies might be incorporated in NIOSH research if control of NIOSH research were shifted to the regulatory agencies. NIOSH, CDC, and HEW would strongly oppose such a move on the grounds that,

-- a separate research agency assures objectivity of research and a check on the regulatory agency--as Congress fully intended in the 1970 Occupational Safety and Health Act;

-- the scientific expertise necessary to direct research resides in NIOSH, not DOL or DOI;

-- DOL and not NIOSH is responsible for the backlog in standards promulgation, and NIOSH should not be penalized for its past productivity in formulating standards; and

-- DOL, DOI, and NIOSH have made progress in the past two years in coordinating activities and designing NIOSH research to best meet the needs of DOL and DOI.

Alternative #3 (medium and low alternatives)

There would not be a major dismantling of present CDC staff, thus allowing continued utilization of their expertise by the Federal Government. On the other hand, there are several programs within CDC that appear to be operating with inflated staffs as a result of decreases in their core activities brought about by decreases in the incidence of communicable diseases. For example, the Bureau of Laboratories has a staff of 856 even though its core responsibilities--regulating interstate laboratories and analyzing difficult laboratory specimens for which the Bureau has the sole capability in the country--could probably be accomplished with less than half that number. About half of the Bureau of Laboratory staff is now mainly engaged in research on new laboratory analytical procedures, and large private sector laboratories perform similar research. CDC maintains, however, that the research is necessary to attract and retain top-flight scientists to perform the core duties of the Bureau.

Alternative #3 would be designed to (1) stop the growth of new noncommunicable disease programs at CDC, (2) reduce the "filler" activities that have developed over the years as a result of the decline in communicable diseases, and (3) allow the continuation of noncommunicable disease programs in which CDC is already engaged, but at reduced staff levels if a detailed review proves that the key functions can be performed more efficiently with fewer personnel.

Budgetary effects (outlays in millions)

	1978	1979	1980	1981
#1. High alternative	149	132	129	134
#2. Low Low alternative	128	106	102	102
#3. Medium and Low alternatives (OMB recommendation)	131	114	110	109

Implementation of OMB recommendation

The planning letter should not make any specific reference to a limitation on CDC activities but, during the preparation of the 1978 Director's Review materials, CDC should not be allowed to expand into new noncommunicable disease program areas. The planning letter should advise HEW to work with DOL and DOI to present their recommendations during the 1978 budget review concerning the advisability of a shift of occupational safety and health research funding to DOL and DOI.

Attachments

Attachment A

Incidence of Selected Communicable Diseases in the U.S. 1925-1975

Diseases	1925	1930	1935	1940	1945	1950	1955	1960	1965	1970	1975
Botulism	-	-	-	-	-	20	16	12	19	12	15
Diptheria	95,109	66,576	39,226	15,536	18,675	5,796	1,984	918	164	435	277
Encephalitis	-	715	1,047	1,030	785	1,135	2,166	2,341	2,703	1,950	3,017
Hepatitis A & B	-	-	-	-	-	2,820	31,961	41,666	33,856	64,107	47,469
Leprosy	-	-	-	-	40	44	75	54	96	129	154
Malaria	100,534	98,491	137,513	78,129	63,763	2,184	522	72	147	3,051	424
Measles	225,027	419,465	743,856	291,162	146,013	319,124	555,156	441,703	261,904	47,351	24,319
Meningitis	-	-	-	-	-	-	-	1,593	2,329	6,480	4,142
Mumps	-	-	-	-	-	-	-	-	-	104,953	59,100
Pertussis (whooping cough)	152,003	166,914	180,518	183,866	133,792	120,718	62,786	14,809	6,799	4,249	1,583
Poliomyelitis, total	6,104	9,220	10,839	9,804	13,624	33,300	28,985	3,190	72	33	7
Rabies in man	76	59	77	41	43	18	4	2	2	2	2
Rheumatic fever	-	-	-	-	-	-	-	9,022	4,998	3,227	-
Rubella	-	-	-	-	-	-	-	-	-	56,552	16,344
Salmonellosis	-	-	-	-	649	1,233	5,447	6,929	17,161	22,096	-
Tetanus	-	-	-	-	-	486	462	368	300	148	95
Tuberculosis	-	-	-	102,984	114,931	121,742	76,245	55,494	49,016	37,137	33,644
Typhoid Fever	-	-	-	-	4,211	2,484	1,704	816	454	346	386
Venereal diseases:											
Syphilis	-	-	-	-	351,767	217,558	122,392	122,003	112,842	91,382	26,015
Gonorrhea	-	-	-	-	313,363	286,746	236,197	258,933	324,925	600,072	1,033,239
Other venereal diseases	-	-	-	-	10,261	8,187	3,913	2,811	2,015	2,152	-

Attachment B

CDC Noncommunicable Disease Programs and Counterparts Elsewhere in HEW
($ in millions)

	CDC Program		Similar HEW Program		Comments
	Personnel	Funding	Agency & Program	Funding	
Clinical laboratories:					
Regulation	100	2	SSA-Medicare laboratory regulation	8	
Specimen analysis	330	7			
Research on laboratory procedures	429	9			
Occupational safety & health research	694	40			
Urban rat control project grants	14	13			Proposed for consolidation in State health block grant
Lead paint poisoning prevention project grants	26	9			Proposed for consolidation in State health block grant
Health education:					
Anti-smoking	14	2			
Coordination of HEW health education programs	22	3			CDC designated as lead agency for HEW health education program coordination in 1974
Cancer and birth defects research	30	1	NCI and HRA - cancer & birth defects epidemiologic surveys	31	CDC funding from NCI through interagency agreement
Family planning services evaluation	35	1	HSA-family planning services	101	CDC funding from AID through interagency agreement
Nutrition research	15	1	FDA, NIH, HRA, AOA & Agriculture	33	
Fluoridation research & technical assistance	10	1			CDC designated lead HEW agency for fluoridation by Assistant Secretary Cooper in 1975
Total	1,719	89			

1978 Spring Planning Review
Department of Health, Education, and Welfare
Issue #6: National Health Insurance Planning

Statement of Issue

What, if any, guidance should be provided to HEW with respect to planning for national health insurance (NHI)?

Background

Although the President initially supported the Comprehensive Health Insurance Plan (CHIP) developed by HEW, his position has changed. In his last State-of-the-Union message, the President said, "We cannot realistically afford federally dictated national health insurance providing full coverage for all 215 million Americans. The experience of other countries raises questions about the quality as well as the cost of such plans. But I do envision the day when we may use the private health insurance system to offer more middle income families high quality health services at prices they can afford and shield them also from catastrophic illnesses." More recently, the President said: "I don't think that a National Government-sponsored health insurance program has worked very well as far as the patient is concerned in any country where it has been tried, and that is particularly true in Great Britain and several other countries. So I don't think it is the best way to improve health care. Number two, it would be very expensive, and I don't think we could afford it. But the principal reason I am opposed to it is that it has not worked, and I don't think it will work. Secondly, the cost would be substantial, and the Federal budget could not afford it at the present time."

Moreover, the health block grant proposed by the President can be viewed as conceptually inconsistent with federally mandated national health insurance (NHI). It can also, however, be seen as moving toward a more equitable financing system, which is one of the objectives for an NHI proposal. The block grant proposal differs substantially from the CHIP proposal and most NHI proposals in three respects:

-- Over time, the block grant reduces Federal spending in financing health services below the levels that would be required by current law and

congressional funding trends. The CHIP proposal would call for an initial $8-10 billion increase above current law levels.

-- The block grant also fixes an upper limit on Federal spending. The CHIP proposal committed the Federal Government to open-ended liability and 75% Federal matching.

-- The block grant allows States extensive flexibility in determining eligibility, benefits, and program administration. CHIP would have sharply reduced State discretion by federally specified eligibility and benefits and Federal requirements for State regulation of health providers and the health insurance industry.

The long-run budgetary picture and competing claims on budget margins must also be considered in determining whether HEW should be provided guidance to undertake NHI planning. Tax reductions, welfare reform, energy independence, and housing allowances, etc., may have higher priority than additional Federal spending for NHI. Some assurance that health costs can be controlled should also be a prerequisite to an Administration NHI initiative. Moreover, there does not exist an adequate data base that:

-- identifies who has coverage now;

-- indicates who does not receive services or has catastrophic expenses now because of lack of coverage; or

-- defines the problem accurately enough to allow cost calculations with confidence.

The Administration may, nevertheless, want to develop an integrated strategy for both NHI and welfare reform. For example, the Federal Government could assume an increasing share of welfare costs, with States required to use their resulting budget savings to supplement the health block grant as the major approach to meeting NHI objectives for expanded assistance to low income populations. Assignment of responsibility for improved health financing and cost control to

the States makes program sense because they are better able to integrate financing and delivery aspects of the health system and regulate the health sector at regional and local levels. The wide variations in per capita health spending, e.g., more than 2 to 1 among States, also argues that the amount of assistance needed by citizens at the same income level will vary by area and that uniform, i.e., Federal, standards may not be the optimal approach for relating funding and need for assistance. This type of strategy could reform welfare programs and expand health financing on the basis of Federal-State cooperation without requiring all benefit improvement be financed from the Federal Treasury with attendant Federal regulation.

The Administration may also want to expand future Federal contributions to health care through the block grant and finance the added funding by tax reform. The Federal tax code currently subsidizes health insurance by excluding employers' contributions toward premiums from employees' taxable income. The tax code also reduces health care costs to individuals and encourages the purchase of insurance by permitting itemized deductions for certain expenses for health care and health insurance premiums. In 1977, the revenue loss from these tax expenditures is estimated at $6.3 billion--$4.2 billion for employer contributions and $2.1 billion for itemized medical deductions. The deduction of employer contributions has been criticized as being unnecessary as well as promoting purchase of excessive insurance, as was pointed out in the 1977 Council of Economic Advisers Annual Report. These tax preferences favor those with higher incomes who can best take advantage of employer group insurance or of itemized deductions. Reform or elimination of these provisions could provide substantial funding for expansion of the health block grant or development of an NHI proposal. Planning guidance could require HEW and Treasury to consider reform or elimination of these provisions to expand health insurance coverage and benefits for lower income persons without changes in the net Federal budget margins.

Alternatives

#1. Provide guidance to HEW to develop NHI options on funding and coverage. Such options would include improvement of the data base to accurately identify the kinds and extent of health insurance coverage available. Any NHI planning would assume the enactment of the block grant and State and local responsibility for financing health care for the low income.

#2. Prepare for the President an OMB options paper on alternative strategies for welfare reform and NHI insofar as State and Federal roles are concerned. Direct HEW to develop data on health insurance coverage. (OMB recommendation)

#3. Do not provide NHI planning guidance to HEW.

Discussion

Alternative #1

Specific NHI guidance makes sense if the Administration is prepared to propose NHI legislation in the 1978 budget. Any legislative proposal should recognize that at least a year of further debate would probably be needed for enactment and another year and a half or more before implementation.

Alternative #2

An overall policy and strategy planning process--resulting in an internal memorandum to the President for his guidance--has the advantage of providing a broad menu of possibilities for the President's consideration and of permitting longer range priorities to be established. This process could result in options being developed during the 1978 budget development, further directions to agencies in mid-November, and announcement of broad objectives and plans in the State-of-the-Union message and budget documents.

Alternative #3

If, however, the budgetary picture or other considerations rule out NHI proposals through 1980-1981, there is no point in a special request of HEW in the planning letter to develop any policy options.

Implementation of OMB recommendation

We recommend Option #2, preparation of an OMB memorandum seeking broad policy guidance to obtain the President's views on priorities and strategies for the 1978-1981 period. In addition, the planning guidance to HEW would request improved data on present health insurance coverage.