S. HRG. 104–875

WELFARE AND MEDICAID REFORM

HEARINGS

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

ON

S. 1795

JUNE 13 AND 19, 1996

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COMMUNICATIONS

WELFARE AND MEDICAID REFORM

THURSDAY, JUNE 13, 1996

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, Hatch, Simpson, D'Amato, Moynihan, Bradley, Rockefeller, Breaux, Conrad, Graham, and Moseley-Braun.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please come to order. I know that members will have plenty of questions for Secretary Shalala, and I want to allow as much time as possible to explore the details of the pending legislation with her.

Therefore, I have a short statement, and then I will recognize Senator Moynihan for his. I would ask the others to please keep their statements as brief as possible, let us say, 2 minutes.

First, let me welcome you here, Dr. Shalala. It is always a great pleasure to be with you and have you before us.

On May 22, I introduced S. 1795, the Personal Responsibility and Work Opportunity Act of 1996. An identical bill was introduced in the House of Representatives.

My colleagues in the House and I made every effort to meet the goals adopted by the Democrat and Republican Governors earlier this year. I believe that if we find the political will, we are, indeed, close to welfare and medicaid reform. This is no time to abandon the bipartisan work of the Governors. Indeed, it is time to redouble our efforts.

Under S. 1795, welfare spending in 2002 will be $243 billion. Now, this is 24.5 percent higher than spending for these programs in 1997. Today, these programs account for 11.9 percent of Federal outlays. If S. 1795 and the overall spending levels provided under the President's fiscal year 1997 budgets were adopted, welfare spending would increase as a percentage of total Federal outlays to 13 percent.

Those who would contend that we do not provide protections for our vulnerable citizens simply have not examined the legislation, or, worse, these critics are intentionally misleading those in need.

The real threat to these programs and the people they serve is the uncontrolled growth in Medicaid. The National Association of State Budget Officers recently reported that, given the growth rate of medicaid, it is not surprising that medicaid expenditures have increased as a percent of total State expenditures, rising from 10.2 percent in 1987 to 19.2 percent in 1995.

As medicaid's share of State spending has increased, it appears to be absorbing resources for other State programs, particularly for other human service programs such as AFDC and general assistance.

S. 1795 meets the four primary goals of the NGA medicaid solution. First, these goals state that the basic health care needs of the Nation's most vulnerable population must be guaranteed.

S. 1795 guarantees coverage and benefits for poor children, children in foster care, pregnant women, senior citizens, persons with disabilities, and families on welfare. If anything, the legislation goes beyond the NGA resolution in terms of setting guarantees.

Second, the growth in health care expenditures must be brought under control. While slowing the rate of growth, the Federal commitment to medicaid remains intact. Even after reform, medicaid spending will rise faster than Social Security. The Federal Government will spend an estimated $827 billion between 1996 and 2002 on medicaid, an average annual increase of approximately 6 percent.

We have met the President half way in terms of medicaid savings. The difference between us is less than 2 percent of the total Federal cost of medicaid. That is a difference of about two dimes a day per beneficiary.

The third goal is that the States must have maximum flexibility in the design and implementation of cost-effective systems of care. Among a number of provisions in meeting this goal, S. 1795 repeals the Boren Amendment, as requested by the Governors. It frees the States from Federal restrictions which impede movement into managed care. There would no longer be a need for waivers.

Fourth, States must be protected from unanticipated program costs resulting from economic fluctuations in the business cycle, changing demographics, and natural disasters. S. 1795 includes an open-ended supplemental umbrella mechanism to provide additional funds for unexpected growth and guaranteed populations, as well as certain specified optional populations.

It is estimated that States will receive $26 billion of Federal supplemental umbrella funds over the next 6 years. It could cost more if, as the Secretary suggests, the guaranteed populations grow faster than the increases in the base allotments. The fact is, the CBO baseline has declined by $55 billion since March 1995, in part because enrollment is not growing as fast as previously projected.

Secretary Shalala may raise some questions today about how this supplemental umbrella works. Well, there may be some misunderstandings about this complex mechanism and its relationship to the base allotment work. I want to assure members that the clear intent of this legislation is to cover all guaranteed citizens, and I am happy to clarify this point.

I think it is unfortunate that the administration has characterized medicaid reform as a poison pill. The Governors clearly under-

stand that medicaid reform is a critical component of moving families from welfare to work, and I believe the President, as a former Governor himself, understands this point as well.

More than 3 years ago, President Clinton told the Nation's Governors that many people stay on welfare, not because of the checks, they do it solely because they do not want to put their children at risk of losing health care or because they do not have the money to pay for child care. The President said, we will remove the incentive for staying in poverty. That is precisely the purpose of S. 1795.

On the eve of the NGA proposal, the President again encouraged the bipartisan Governors group to try to reach agreement on a number of issues that are important to your people and to us here in Washington, including medicaid and welfare.

S. 1795 did not create the linkage between welfare and medicaid. That was done more than 30 years ago when medicaid was created. Eloise Anderson, the director of the California Department of Social Security recently told me that 20 percent of the single moms on AFDC would immediately leave the welfare rolls if medicaid benefits for their children were guaranteed.

As we move the Governors' proposal forward, I look forward to working with everyone on the committee to make this a successful effort. American families are counting on us.

Now, I am pleased to yield to my friend, Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, I want to thank you for this opportunity and to acknowledge, wistfully, that you had 1 day of unanimous committee. It all went by. I guess every chairman has one such day, and now we get back to normal.

I would say three things, sir. I think you will find our side very much shares your concern about medicaid. It is not a program to be described as out of control, but, possibly the way it is now designed, uncontrollable.

I think you have heard me say that, thanks to Dr. Podoff back here, we took the fact that medicaid doubled in the 8 years of Ronald Reagan, then doubled again in the 4 years of George Bush. If you make that a progression, a geometric progression, it doubles on December 29 of this year.

We have a Federal baseline of 9.7 percent. Call that 10 percent. That means it doubles every 7 years. Your plan is 6 percent, which means it will double in about 11 years. The administration wants 7 percent, which means it doubles in 10 years. These are unsustainable rates, and they are quite divergent from medical costs, which are stabilizing, and to an extraordinary degree, something we did not anticipate at all 5 years ago. This has something to do with long-term care. About 35 percent of medicaid is long-term care. It has become something you cannot touch because of the nursing homes. They are a formidable lobby, and we all know that.

The second point I would like to make is that, simply—and it is not a competitive thing, but it ought to be stated—that this bill before us is a reconciliation bill. It reduces the rate of increase. I cannot help it, but that is what you are stuck with.

The CHAIRMAN. That is accurate.

Senator MOYNIHAN. That is accurate. It does that with respect to AFDC and medicaid, but then all of the money is used up for the tax cut.

In 1993, we put through this committee—and Senator Breaux is there to show the scars—the largest revenue increase and program reduction in our history. We cut the deficit in half.

We also cut the number of Democrats in the House of Representatives in half, which is a problem that lingers, and I think a lesson that has been absorbed on the other side. They are all for a balanced budget, but not for reducing outlays, heaven forbid, or increasing revenues.

But we have now a projected deficit for this fiscal year of $130 billion, and we are in a primary surplus. For the first time since the administration of President Kennedy and a few months of Johnson, the Federal Government is taking in more revenue than it is spending on programs. The difference is interest payments. That is a turn-around, and I would hate to see it lost, but we will see what happens.

Finally, on the question of welfare. Our goals are not that different, but I think sometimes if we are in disagreement over specifics it may be because we feel—some of us feel—the situation out there is so much worse than the Nation realizes.

We have the 5-year limit and you are out. It would not be any problem for about half the children who enter AFDC who come in and off in 2 years. But the average stay is 13 years, which I think the Secretary will confirm. Last year, we got the Office of Management and Budget to release the study of H.R. 4, the analysis one in the Department of Health and Human Services asking, what would be the impact on children of this program? The result was, we learned at length, it would put 1.2 million children into poverty. I mean, those are the numbers.

Mr. Gibbons and I have asked for a similar report on the effect of the bill that has just passed the house, the bill before us, and also for the bill that President Clinton sent. He sent us a bill and I have introduced it on request, as a courtesy to the President.

I hope the Secretary will tell us that she will be able to get us these numbers in the near term. I see Secretary Baine is here. I am sure she and Wendell Premiss can do this calculation. I hope it will be done so we will have some numbers in front of us, as we realize what we are doing.

But, again, thank you, sir. Let me associate this Senator with the thought that medicaid has got to be rethought, or none of us will be here.

The CHAIRMAN. Just let me make a couple of comments, Senator Moynihan. The President, of course, has also proposed tax cuts, and I think it is erroneous to try to tie the two together. As the Washington Post said in an editorial several weeks ago when that effort was made, it is, to be candid, political and not a fact.

Of course, what we do in the tax range hopefully can have a positive effect on the growth of the community, but we can debate that further later.

So at this time I would like to call on Senator Breaux.

OPENING STATEMENT OF HON. JOHN BREAUX, A U.S. SENATOR FROM LOUISIANA

Senator BREAUX. Thank you very much, Mr. Chairman. I welcome the Secretary to our hearing, and look forward to hearing her comments.

Mr. Chairman, I happen to believe that good policy is good politics, and bad policy is bad politics, and you cannot change that fact. So I think that anytime we in the middle of a political season enact good policy, it should go to everybody's credit, Republicans and Democrats alike.

I think we have a situation here that we are very close to an agreement on a welfare proposal. I think that this committee and this Congress, in a bipartisan fashion, could write a welfare plan that the President would sign and that would be good policy and that would be good politics.

But I think we are still far away from an agreement in a bipartisan fashion on medicaid. Therefore, I think when you have a situation where Congress can agree on one thing but not on two things put together, the obvious answer is to separate the two and do what we can agree on and continue to work on what we cannot agree. I think that suggestion has great merit, and we ought to consider it.

The problem with the medicaid plan is that it is not the plan that the Governors came to this committee in February and said they agree upon. They had an agreement in February, they testified. We took that recommendation, and the committee staff and the committee members worked on it. What we have today in this proposal is not what the NGA recommended in a bipartisan fashion.

So, I think it is clear that no one should say that what we are writing or working on is a united proposal from the National Governors' Association which they support. They do not. Some do, some do not. That is where the disagreement lies.

I would ask that we, as an example of that, make part of our record the letter that was sent to Chairman Roth by three of the six Governors who participated in this process, who point out that this is not their proposal.

The letter is signed by Governor Roy Romer of Colorado, Governor Lawton Chiles of Florida, and Governor Bob Miller of Nevada. They worked very hard with the Republican Governors, who did a good job and worked together. But the product that we have now does not reflect that agreement.

I think that we would be, number one, mistaken to say it does, and number two, it would be a mistake, I think, to enact something where there is so much disagreement, because it is not going to get enacted. It is not going to become law. So, let us separate what we can agree on, what can become law, from that that cannot.

I would just highlight a couple of things that make it clear why this proposal that we are working on is inconsistent with the NGA policy that they enunciated in February.

First, the financing formula does not guarantee coverage. If you have coverage without sufficient funding, you are not guaranteeing coverage. I think that they change the base allocation. The Gov-

ernors recommended the years 1993, 1994, or 1995 as the base; this proposal picks the year 1996, a major, major difference.

The NGA policy says, "A formula for growth must account for estimated changes in each State's case load." This bill is completely different from that. It does not take that into consideration. There is no guarantee, in the real sense, per person for increases in the case load in individual States, which the Governors recommended.

Second, the growth rates and allocation to each State are severely constrained by floors and ceilings. That simply means that some States who have a higher growth rate than that ceiling get short-changed, and those that have a lower growth rate are going to have an advantage, because they are going to get more than they actually need. That is totally inconsistent with what the NGA recommended to this committee.

The NGA policy called for an umbrella fund that would guarantee States a per beneficiary payment for actual enrollees to guarantee if you have a person otherwise eligible they will be covered. This umbrella only covers unanticipated increase in case loads for 1 year. What happens to the rest of the years? There is no guarantee if a State has a huge increase in the number of eligible people.

So it goes on and on, and we can bring this out in the hearings. But I think, Mr. Chairman, this letter ought to be part of the record. I mean, I think we should continue to work. I am optimistic we can reach an agreement, but we do not have it yet. We are very close on welfare. We should do what we can, and postpone what we cannot.

The CHAIRMAN. I would be happy to include your letter.

[The letter appears in the appendix.]

The CHAIRMAN. I would ask also that with the Democratic letter, the Republican Governors' Association letter to a number of members of the House and Senate, including myself, thanking us for the fact that we do make real excellent progress in moving towards meaningful medicaid and welfare reform, be included.

They say that, "The extraordinarily close parallels between the NGA policy and H.R. 3507, S. 1795 satisfy the objectives to an extent that may be unprecedented in the recent history of Federal legislation." So there are Governors that feel very strongly that we have met the requirements of the NGA.

We will, of course, proceed with the consideration of this legislation at a later time, and if there are ways and means of strengthening it, that would be the time to seek to do so.

[The letter appears in the appendix.]

Senator MOYNIHAN. Mr. Chairman, could I just make a quick remark?

The CHAIRMAN. Yes, Senator Moynihan.

Senator MOYNIHAN. The letter from the Democratic Governors is addressed to you, and only to you.

The CHAIRMAN. I would like to get a copy.

Senator MOYNIHAN. They sure as hell did not address it to me. I think the Democratic Governors have disgraced themselves in this regard. They thought they were going to get some easy, free money out of the Federal Government, and it turned out they were not, so they backed off. In the meantime, the true situation of chil-

dren in our great cities was a matter of, evidently, no concern. That is my view. I do not ask anybody to share it.

The CHAIRMAN. Thank you, Senator Moynihan.

Senator Grassley.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Obviously, Senator Moynihan, there are a lot of people that do share your view, and I am one of those because we do kind of lose sight of the children in this whole battle, because we have seen welfare reform work in some States, even the President's endorsement of that in some States.

Those States are doing things that are not too far removed from what is already in these programs. I think it is because there is still a feeling that the only answer to this welfare problem is just exactly what Washington can dictate to the States. I think there is an unwillingness to give this power up in Washington. Basically, it is the old story of Washington knows best.

I would hope that a President that said he wanted to end welfare as we know it will eventually tell us what he is for and quit vetoing bills that end welfare as we have known it, and puts children first. We have not done that. So, I appreciate very much what Senator Moynihan has said.

The CHAIRMAN. Senator D'Amato.

OPENING STATEMENT OF HON. ALFONSE M. D'AMATO, A U.S. SENATOR FROM NEW YORK

Senator D'AMATO. Thank you very much, Mr. Chairman. It is good to see the Secretary here. certainly welcome her here.

Madam Secretary, I am very much concerned about the lack of progress that we are making with respect to the waivers which New York State, in particular, has submitted. It has really now gone well beyond the point of tolerance. I believe that it may even be approaching the case of deliberate recalcitrance on the part of the administration or the HCFA people in responding in a manner that is appropriate.

We started a process, the State, in terms of asking for some waivers that goes back well over a year. I have letters that you have written to the Governor, a letter dated January 31, in which you say that we are involved in this process of reviewing the 1,115 waiver proposals in the Partnership Plan.

Only when things seem to hit a certain level of national interest do we get some more. There have been numerous meetings, letters exchanged. But I have to tell you, no progress is really being made.

Now, it has to appear, to me, that what we have is a reluctance on their part. And this is not just a New York problem, this is a problem that many Governors in many States have indicated repeatedly that there is not the kind of adequate response.

It does not mean you have to sign off on all 1,115, but, by gosh, a year and a half has gone by and there has not been any substantial progress made. There is no sense in having lots of meetings and telephone calls if we are not going to begin to sign off on some of these so States can begin to develop a range in the variety of

proposals, obviously with the proper oversight that you would expect from the State.

I think our State has got a tremendous record in terms of caring, in terms of making available the best in terms of medical services and facilities. Indeed, we have been accused by a number of my colleagues of having gamed the system and having one of the most costly, et cetera.

So if we are attempting to deal with reducing costs in a way that will still guarantee quality care, we need some help. And I have to tell you, I just got a release or a fax from my budget director. It says, on March 17, 1995, New York submitted its waiver to implement a medicaid managed care program State-wide. That is 15 months ago.

The President has publicly stated on numerous occasions that the administration would expedite its review of such waivers. In fact, expedited waiver approvals was the administration's stated alternative. It goes on and on. This approval delay is depriving the State of New York from delivering quality health care services to our medicaid recipients in a more cost-effective manner.

Our State has submitted an unprecedented level of detail to HCFA and has had numerous conference calls with HCFA representatives. Can you explain why it has taken the administration 15 months to review this waiver, and when a decision is going to be reached?

Now, you can nitpick anything to death, and there may be very real questions there that have to be answered. But, Madam Secretary, no one is pushing this. It is languishing. I think it now borders on either neglect, either lack of resources, lack of will, or deliberate conduct. I hope it is not the latter. If it is that we need to put more resources and priorities on it, then I ask you to do this. I would hope that you could explain the situation. It is intolerable. Fifteen months.

Now, it is wrong. If there are areas of disagreement, then we should get it out on the table with the professional people, let them know so they can address it. I am not going to get into workfare, welfare, and political sloganeering, but I am going to tell you, let us address this problem.

This is the first time that I have raised this publicly, but I can assure you, because we are talking about a situation that would enable us to do a better job in a more cost-effective way, and I think that should be the goal of the Federal Government and with our States and with our Governors, Republicans, or Democrats, it does not make a difference.

So, I want you to know that I am going to continue to persist in this. This is just the beginning.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, the Governors, both Republicans and Democrats, of course, have expressed great concern about the slowness and red tape of waivers under existing programs, so this is a matter that needs to be addressed.

Senator MOYNIHAN. Mr. Chairman, may I just make a point, that Senator D'Amato was speaking about a waiver——

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN [continuing]. Which was a request for the use of managed care in medicaid.

Senator D'AMATO. That is correct.

Senator MOYNIHAN. And, as I was saying earlier, medicaid, at a minimum, the costs are doubling every 7 years. You cannot sustain this.

The CHAIRMAN. We cannot sustain that.

Senator D'AMATO. Mr. Chairman, if I might, it will bankrupt our State. It is bankrupting our State. We have counties were 100 percent of the real property tax levy, the moneys that are collected, plus additional, go just to the payment of medicaid.

Suffolk County, Long Island. I think their 1994–1995 budget figure, $140 million was collected in real property taxes by the county, and I think they paid every penny of that over to medicaid, $140 million, plus an additional $10 million that they took——

Senator MOYNIHAN. The county's share.

Senator D'AMATO. The county's share. Just the county's share of medicaid. Now, are we talking about——

The CHAIRMAN. I do want to proceed, Senator D'Amato.

Senator D'AMATO. But I just want to say, this should not be some abstract kind of thing. I mean, we are choking the ability of people to live and we are going to need some help.

The CHAIRMAN. All right. Let us move on now to Senator Graham.

OPENING STATEMENT OF HON. BOB GRAHAM, A U.S. SENATOR FROM FLORIDA

Senator GRAHAM. Thank you, Mr. Chairman. Mr. Chairman one of the most positive things that has happened in recent months was the announcement at the end of last year that there had been an agreement among Republican andDemocratic Governors on reform of medicaid. There was truly a bipartisan spirit. This Congress committed to use that spirit as the basic point of departure for the development of any medicaid legislation.

In that context, I am extremely distressed at the letter which was sent by three Democratic Governors, including our former colleague and the Governor of my State, Lawton Chiles, that I understand was sent at the request of the Chairman, which indicates the degree to which the bill that is before us now diverges from that bipartisan spirit.

I will not belabor the letter, which I understand my colleague, Senator Breaux, has already put into the record. But I will point to one issue which was, in many ways, the centerpiece of that bipartisan agreement, and that was the so-called umbrella fund.

If you will recall, there had been a Republican preference for straight block grants, that is, fixed amounts of money each year which would go the States. The Democrats had a contrary position, which was referred to as a per capita cap that would have recognized changes, whether they were caused by demographics or economics, in the case load from State to State.

One of the geniuses of the compromise was the concept of using a block grant approach for the base allocation, but having an umbrella on top of that to deal with unexpected changes in the number of beneficiaries within a particular State.

Now, Mr. Chairman, an umbrella and a parasol look very much alike, until it starts to rain. We had an umbrella system which was supposed to provide protection for States which had an economic thunderstorm or which had an unexpected growth in the number of people moving into the State, or the number of people becoming eligible for medicaid.

What we have substituted is a parasol; it looks nice, it is figurative, but when it starts to rain it is not going to give very much protection. As an example, the parasol that we have now says that you can get funds for 1 year if you have an unexpected change in demographics, but beyond that you are out of luck.

So if your State goes into a recession and you add an additional 100,000 people to your medicaid roll, you will get additional Federal funds for the first year, but, if your recession happens to last more than 12 months, beginning the second year those 100,000 have to be paid 100 percent by the State out of its restricted block grant. That is a parasol, not an umbrella.

So, Mr. Chairman, I would hope that we would try to go back to that spirit of bipartisanship which gave us such promise just a few months ago, and make the modifications that will bring this legislation to the reality of its title. That is, a representation of the bipartisan spirit of the Governors, working with the Congress, to try to reform a system that is not, in my opinion, broken, but a system which does require some surgical correction. We can provide that in a bipartisan spirit, and I hope we will.

The CHAIRMAN. You were not here at the time this matter came up before, Senator Graham, but in my opening statement I made it very clear that the intent of the legislation is to cover all guaranteed citizens. The umbrella is somewhat complex, and there seems to be some misunderstanding, but that is something that we could correct. I would be glad to make sure that the intent is clear.

Next, is Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, I concur with what Bob Graham said. Yesterday, I thought, was an incredible day of bipartisanship, and I just sensed in the Chairman's answer to Senator Graham, again, a reaching out for trying to make that hold over to this whole area, too. I hope you will, because there is just an awful lot of work to be done on this.

I mean, a lot of the same old problems are there about State scams, which West Virginia actually was one of the original scammers of. But I guess what bothers me, and I will just focus on this for 60 seconds, is the question of the abused and neglected children problem, in terms of, obviously, the welfare reform bill.

I think I really have the impression that last year that we agreed in a bipartisan manner not to change Federal programs designed to protect abused and neglected children. The Finance Committee, in fact, held a special hearing on the subject and there seemed to be a strong feeling that way.

Unfortunately, the new proposal changes Federal programs for such children. Now, it is not all bad. The foster care and the independent living programs are retained as entitlements, and that is

good. But there are a lot of troublesome changes, and that has to do with converting the child welfare program into a block grant. I am just 100 percent against that concept, however one approaches it.

States also should have to maintain 100 percent of their effort in child welfare, I believe, Senator Graham, not for 1 year, but for 2 years. But the last 3 years, States can reduce their maintenance of efforts down to 75 percent. Believe me, they will.

The number of cases of abused and neglected children are growing. How can we put ourselves in a position where we put abused and neglected children are more risk? There are many, many problems here that we have to work on.

I thank the Chairman.

The CHAIRMAN. Thank you.

Senator Bradley.

OPENING STATEMENT OF HON. BILL BRADLEY, A U.S. SENATOR FROM NEW JERSEY

Senator BRADLEY. Thank you very much, Mr. Chairman.

Madam Secretary, let me see if I can get you to focus a little bit on the welfare and State role in the welfare reform efforts, and in particular have you think about, when we talk about the Federal role in AFDC and the waiver requirement in order to get something changed in how it works and what you would like to do to experiment, I would like to focus on the New Jersey experiment several years ago, the one that denied benefits to families on welfare that had an additional child, that was among the elements of this welfare reform, benefits for the additional child would not be given.

I am interested in getting at how the processed worked, because I think what all of us want is to reform welfare. We want a welfare system that is more responsive. We want a welfare system that does not make welfare a way of life, but I am concerned about the direction that we might be taking.

Now, in the waiver process in the New Jersey case, did HHS deny or delay New Jersey's move toward the idea, which at the time was very controversial, at all?

Secretary SHALALA. I am sorry. Are we in the question period?

The CHAIRMAN. No, we really are not.

Senator BRADLEY. Oh. These are opening statements. I do not have an opening statement. [Laughter.]

Secretary SHALALA. The answer is no, but I will go on with my——

Senator BRADLEY. I will be very interested to hear your opening statement. I wondered why Senator D'Amato's sounded more like a speech than a question. But I do not have an opening statement.

The CHAIRMAN. We will give you further opportunity, Senator Bradley.

Senator D'AMATO. It was.

The CHAIRMAN. Senator Moseley-Braun.

OPENING STATEMENT OF HON. CAROL MOSELEY-BRAUN, A U.S. SENATOR FROM ILLINOIS

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman. I listened a little bit earlier, and I must say I find it almost ironic, the debate over whether or not the Republican Governors and the Democratic Governors agree on national welfare and medicaid reform.

I think it most ironic because our reliance on their recommendations overall—and I do not mean to say anything bad about the Governors, and I know there are a lot of arguments that they are closer to the people, et cetera, or are elected by the same folks as we are.

But the fact of the matter is, reliance on leadership from the Governors in this area is tantamount, in some regards, to an abdication of our responsibility as Senators.

I mean, it is our job to be concerned about what happens to our National community. It is our job, of course, focusing in on our States and representing our States to reflect and promote those interests, as I know everybody certainly on this committee does as a regular matter.

But it is also our job to be concerned about what happens to us as Americans as part of a national community, and that is not reflected in the approach that says to the Governors, here is a huge national problem; you go figure it out.

We have essentially turned over to them a set of concerns that, frankly, are fundamentally in conflict. So that, I think, is kind of at the core of the problem here. I mean, when you look at this bill, we repeat the Federal standard for defining disability nationally. It says, you go figure out what a disability is.

So if a child in Arizona has sickle cell and somehow or another—and I just made up sickle cell; let me pick something else, cystic fibrosis—and they come up with one set of standards that allow for that child to receive a certain amount of services, and a child with the exact same condition in Iowa or Illinois has to function under another set of standards, what, are we going to set up 50 different sets of standards for disability in this country?

That does not make sense to me, particularly given the mobility of the American people. People move from State to State. So that child from Arizona could then move to Illinois or Iowa and find out that the services or the health care that was available in one State is not available in the next. That is what we are setting up, Mr. Chairman with this approach.

I can go down to other examples, even the welfare part of it. Part of the experiment addressed a waiver program, taken out of the Wisconsin experience, to transfer to a work program.

Everybody says work is a good thing; it is like motherhood, apple pie, and the flag. Of course we want people to get off welfare, and of course we want people to take care of themselves and their babies, and of course we want them to go to work. That is not debatable.

But the question is, how transferrable can a program from a State with 200,000 AFDC recipients and a 3.7 unemployment rate in 1995 be to a State that has three million AFDC recipients and

a 7.8 percent unemployment rate, or in my own State, 690,000 AFDC recipients and a 5.2 unemployment rate.

I mean, we cannot abdicate our duty here. Senator Graham raised the question about the umbrella. How is that going to work when one State has sudden unemployment, or an industry went under, as happens overnight sometimes? I am going to get off my soap box, Mr. Chairman. I just want to finish my statement here.

My point is this. We have to look at this issue with the perspective our responsibility as trustees of the national interest. We have to look at this issue as part of our responsibility to the children.

I have a chart—and my time is almost up—on the point I have been making from the very beginning, on the welfare part of this debate. The majority of the people receiving AFDC are children, and the majority of them are children under six.

We are making all our decisions based on the 32 percent. These are 1995 numbers, too. These are new numbers. We are making all of the decisions talking about the lazy welfare cheats, or whatever, the adults, the 32 percent who will not get off their duff and go to work. That is driving this debate. But what about these people? Two-thirds of the people are going to be the victims of our decision making, or the beneficiaries, to be kind about it.

So I just keep coming, and I asked the question when we started down this road almost a year ago. Unfortunately, we have not, I do not think, gotten much further than we started off. But what about the kids? That is all I have to say.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. I want to get going with the witness, Mr. Chairman, so I have no comments. I came to hear Dr. Shalala.

The CHAIRMAN. Thank you, Senator Chafee.

Dr. Shalala.

STATEMENT OF HON. DONNA E. SHALALA, PH.D., SECRETARY OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SHALALA. Thank you very much. Good morning, Mr. Chairman, Senator Moynihan, members of the committee. It is my distinct pleasure to appear before you today to discuss the medicaid and welfare reform proposals introduced by Chairman Roth and others on May 22.

As the Congress continues to consider ways to reform medicaid and welfare and pursue a balanced Federal budget, we appreciate the opportunity to state clearly the President's vision for reform in these areas.

The Clinton Administration believes that we must balance the budget by the year 2002 and give more responsibility to the States and local communities, but we must do it in a way that is consistent with the values of our Nation. As the President has said time and time again, we can balance the budget and find common ground without turning our backs on our values, our families, and our future.

In medicaid, we have proposed legislation to give the States the flexibility that they need, while maintaining a strong Federal/State partnership built on a foundation of shared resources, accountability, and a real guarantee of coverage for the most vulnerable Americans.

In welfare, the President has submitted to the Congress a welfare reform bill that will replace the current welfare system with one that demands responsibility, strengthens families, protects children, and provides States with broad flexibility and the resources they need to get the job done.

We strongly hope for legislation that builds upon these principles and the recent bipartisan initiatives from the Nation's Governors and moderate Republicans and the Democrats in both Houses of Congress.

The President is committed to balancing the budget and enacting real welfare and medicaid reforms. However, the President also has made it clear that the current strategy of the majority in Congress to link welfare reform to unacceptable changes in medicaid will leave him no choice but to veto the entire package.

We call on Congressional leaders to abandon the "poison pill" strategy that is designed to provoke a veto. We strongly support the bipartisan efforts of the Governors, and the Breaux-Chafee and Castle-Tanner groups to reform welfare without gutting medicaid.

Let me note, in particular, the fine work of Senators Chafee and Breaux, and the members of their bipartisan group on both medicaid and welfare reform. While we have yet to review many details and still have some concerns, I think the willingness of Senators of good will to join together across the aisle to agree on meaningful reforms is an example to us all.

The President believes their proposals could very well be the foundation for a broad bipartisan effort to enact meaningful reforms.

Let me spend a few minutes discussing the medicaid proposal made by the Republican leadership. medicaid provides vitally important health and long-term care coverage for approximately 37 million Americans, including 18 million children, six million senior citizens, and four million Americans with disabilities.

The Clinton Administration is dedicated to strengthening and improving medicaid so it can continue to fulfill the promise of our country to millions of children, elderly, and disabled Americans and their families.

During our first 3 years in office, the administration approved 12 State-wide medicaid demonstration programs. This compares to a total of one such demonstration approved under all the previous administrations combined.

These demonstrations allow States to experiment with new methods of coverage and cost containment. As a result, when implemented, 2.2 million Americans who were previously uninsured now have secure coverage.

The President's medicaid reform proposal builds on this experience by providing States with extraordinary new flexibility to better manage their programs, to pay providers of care, and operate managed care and other arrangements.

The President's plan would eliminate waiver requirements for enrollment of beneficiaries in managed care plans and in-home and community-based care. It would eliminate the Boren Amendment and do away with a string of rules of regulations.

But the one thing the President's plan would not do, is to end the Federal guarantee for people covered by this vital program. The

President's medicaid reform plan is based on three core principles in addition to broad flexibility.

First, the need for a real, enforceable Federal guarantee of coverage to a defined benefit package. Second, appropriate shared Federal and State financing. Third, quality standards, beneficiary protections, and accountability.

Last year, the President vetoed the Republican medicaid reform plan because it failed to meet any of these principles. In February of this year, the National Governors' Association approved the outlines of a bipartisan medicaid reform plan.

As I testified myself before this committee in March, while we had concerns, we believe the Governors' medicaid plan held some promise and we were hopeful that, once more details were known, there would be a real basis for medicaid reform.

Unfortunately, the medicaid bill introduced last month by the Republican leadership in Congress moves us further away from the bipartisan reform envisioned by the Governors and much closer to the Republican legislation that the President vetoed last year.

We agree with the views expressed by the Democratic Governors in their letter to Chairman Roth which said, in part, "The Republicans' medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by the President last year, and rejected by the Governors at our winter meeting."

Let me be clear. The new Republican bill, like its predecessor, fails to meet the President's basic principles for medicaid reform. If this bill is sent to the President, I will recommend that he veto it and send it back to Congress.

Let me very quickly explain my reasons. First, in order to guarantee coverage we must guarantee eligibility, benefits, and enforcement. The Republican plan could deny guaranteed coverage to millions of Americans eligible for medicaid. This includes millions of children between the ages of 13 and 18 and many Americans living with disabilities. It also includes those who are trying to move from welfare to work.

Second, the bill allows States to limit the amount, scope and duration of benefits and allows States to differentiate benefits for separate parts of a State. Third, the bill eliminates most Federal enforcement of eligibility and benefits. On balance, we find no real guarantee of coverage or benefits.

In the area of financing, we find the Republican bill abrogates the historic partnership between the Federal Government and the States. Under this partnership, medicaid dollars have always followed State decisions to cover the people who are in need.

Let me repeat this. Under this historic partnership, medicaid dollars have always followed State decisions to cover the people who are in need. Yet, 91 percent of the Federal medicaid dollars provided for under the Republican bill are distributed by a block grant formula driven by annual growth caps; only five percent of block grant funds are distributed according to need.

The Republican plan also includes an umbrella fund, only 3 percent of the total funds, to assist States that experience an increase in enrollment due to economic downturn or other circumstances.

At first glance, this proposal appears to help the States in need and is similar to the one advanced by the NGA. A closer look, how-

ever, reveals that this protection is quite temporary in nature and would leave many States exposed.

A State that experiences an increase in enrollment would receive money from the umbrella fund to cover only the first year of those costs. But if that enrollment persists into a second or a third year, the umbrella fund money disappears and the States are left holding the bag.

I would note that the Republican bill would reopen the huge and dangerous loopholes that were closed just a few years ago by this committee. This bill would allow States to use provider donations and tax schemes to produce some or all of the money they were required to contribute.

At the same time, the Republican bill increases the Federal Matching Assistance Percentage, or FMAP. That would increase the Federal share of medicaid spending from 57 to 63 percent.

Because the FMAP changes could encourage the States to reduce their contribution to the program, the result would be a much deeper reduction in medicaid spending than the $72 billion in reduction in Federal spending.

According to the Center on Budget and Policy Priorities, the total reduction could be more than $250 billion over 6 years, when you look at both State and Federal funds.

Finally, the Republican medicaid bill would eliminate the existing structure for quality assurance and beneficiary protection. There are no standards for managed care plans. States could charge the adult children of beneficiaries who are in the hospital, and it eliminates most limits on cost-sharing.

In conclusion, Mr. Chairman, the new Republican medicaid plan is fatally flawed. It should not be approved by the Congress.

Mr. Chairman, I would now like to turn to welfare reform. As we have worked to enhance State flexibility under medicaid in the absence of national reform legislation, the administration has also worked with States to transform their welfare systems to require work, to promote parental responsibility, and to protect children.

Over the last 3 years, we have worked with Governors and with other State and local elected officials, within the framework of the Family Support Act, to give 39 States the flexibility to design welfare reform strategies that meet their specific needs. These efforts are directly affecting approximately 10 million recipients throughout the country, or 75 percent of all welfare recipients nationwide.

These efforts have begun to pay off. Welfare case loads have dropped by 1.3 million since January of 1993, a decline of about nine percent. A larger percentage of those still on the rolls are engaged in work and related activities. Food stamp rolls have also gone down, and so have teen birth rates. At the same time, child support collections have gone up as the administration has worked diligently to improve collection efforts.

While we have made great progress on welfare reform through welfare reform waivers within the context of the Family Support Act, executive actions, and other initiatives, we still believe that we need national welfare reform legislation.

As part of his balanced budget plan, the President has proposed a comprehensive welfare reform proposal that would require work, promote parental responsibility, and protect children.

The President has made it clear that, if Congress sends him a clean welfare bill that follows these fundamental principles, he will sign it. However, the President has also made it clear that real welfare reform should not be attached to harmful proposals such as the elimination of guaranteed health coverage for poor children, for pregnant women, and for people with disabilities.

There are good signs of bipartisan work in this area. We are pleased that the Chairman's bill, S. 1795, reflects some of that significant progress that has been made on welfare reform since the President was forced to veto H.R. 4. It incorporates a number of key changes recommended by the administration, and contained in the National Governors' Association and the Breaux-Chafee proposals.

The Breaux-Chafee proposals are steps in the right direction. We would urge the committee to build on this bipartisan ground. Unfortunately, the bill does not address several issues that are of concern to the administration, particularly in providing States with the resources and the incentives to protect children, to ensure accountability, and to move people from welfare to work.

While we applaud the inclusion of many of the provisions endorsed by numerous Democratic and Republican Senators and Governors, the new Republican bill still fails to include other provisions that have earned bipartisan endorsement.

For example, the new Republican bill cuts $51 billion in welfare spending over the next 6 years. These cuts are far greater than any of those proposed by the National Governors' Association or the administration. The cuts in food stamps and benefits to legal immigrants are particularly steep.

In addition, the Republican bill would allow States to substantially reduce their own spending on programs serving low-income families, compounding the impact on poor children and families.

We are particularly concerned that Senate bill 1795 prohibits States from providing a safety net for children by not allowing the States to use block grant funds to provide non-cash assistance or vouchers for children in families who are subject to the 5-year time limit.

Further, the new Republican bill does not maintain the guarantee for medical assistance for all of those currently eligible, or for those who reach the 5-year time limit. Senate bill 1795 fails to continue the transitionalmedicaid coverage for families leaving welfare for work.

The bill also fails to provide adequate protection for States in the event of economic downturns. The contingency fund is set at too low a level——

The CHAIRMAN. I would ask that you try to sum up.

Secretary SHALALA. I am almost finished.

The CHAIRMAN. Please proceed.

Secretary SHALALA. And my longer testimony is in the record.

The CHAIRMAN. It will be incorporated.

Secretary SHALALA. The contingency fund is set at too low a level and does not allow for the further expansions during poor economic conditions and periods of increased need.

The new Republican bill also makes deep cuts in the Food Stamp program, which would take the form of a reduction in benefits to

families with high shelter costs and a 4-month time limit to childless adults. It would permit States to replace the Food Stamp program with a block grant, jeopardizing the nutrition and health of millions of children, of working families, and the elderly.

While the administration supports strengthening requirements on sponsors of immigrants, we are also distressed that the bill maintains immigration provisions from H.R. 4 imposing restrictions well beyond those approved in the House and Senate immigration bills.

The Breaux-Chafee proposal appears to address many of the administration's concerns and would strengthen State accountability efforts, welfare to work measures, and protections for children.

Mr. Chairman, the American people want Congress to pass a bill that the President can sign that honors our values and ensures fiscal integrity. They want a bill that promotes work and responsibility, and also protects children. They want a bill that supports families who play by the rules and rewards those who work hard to support themselves. They want a bill that ensures accountability for the use of taxpayers' funds. In short, they want real welfare reform.

I know that the President shares my hope that, with the bipartisan leadership of this committee, we can address the critical issue of welfare reform this year. Let us take those final steps together, so that together we can meet the needs of the people of this country.

Mr. Chairman, I want to thank this committee for once again giving me the opportunity to testify, and I look forward to answering your questions.

[The prepared statement of Secretary Shalala appears in the appendix.]

The CHAIRMAN. Thank you, Madam Secretary.

The President's budget calls for $59 billion in medicaid savings. Now, if Federal spending is reduced, is State spending reduced also by a proportionate amount?

Secretary SHALALA. We would expect State spending also to be reduced by a proportionate amount, depending on the mix.

The CHAIRMAN. Is this a cut? Does the President cut medicaid spending?

Secretary SHALALA. Well, it certainly slows down the growth of medicaid spending. The actual number of dollars that are spent are increased.

The CHAIRMAN. That is not my question. My question is, does the President cut medicaid spending when it is $59 billion in medicaid savings?

Secretary SHALALA. Is your question, is savings a cut if it slows down growth?

The CHAIRMAN. My question is, does the President cut medicaid spending when he calls for $59 billion in medicaid savings?

Secretary SHALALA. Well, if you are talking about a cut——

The CHAIRMAN. Could I have a yes or a no answer?

Senator ROCKEFELLER. The answer is yes.

Secretary SHALALA. It is a cut from what current law provides because there is a per capita cap in the President's proposal, and it is certainly below what currently would be spent.

The CHAIRMAN. So the President is calling for a cut in medicaid. You are answering that yes.

Secretary SHALALA. Yes.

The CHAIRMAN. Let me turn to the medicaid guarantee. Now, you suggest that, under the Governors' proposal and the legislation, the medicaid guarantees are somewhat hollow. Under current law, what percentage of medicaid recipients are covered because their entitlement is mandated by Federal law?

Secretary SHALALA. All of them are. All of them get the basic comprehensive package.

The CHAIRMAN. My question is, what percentage of medicaid recipients.

Secretary SHALALA. Oh. You are talking about mandatory versus optional services.

The CHAIRMAN. That is correct. That is correct.

Secretary SHALALA. It is about half. It is about 47 percent, and it varies from State to State, as you well know. They have more optional benefits in Senator Moynihan's State, for example.

The CHAIRMAN. But less than half are mandated.

Secretary SHALALA. That is right.

The CHAIRMAN. The others are optional.

Secretary SHALALA. They are optional. The optionals, though, are built on top of the mandatory expenditures.

The CHAIRMAN. Does that mean that the other recipients, the optional recipients, are covered only because the States have chosen to include them in the program; is that correct?

Secretary SHALALA. Yes.

The CHAIRMAN. Now, let us turn to expenditures.

Secretary SHALALA. Senator, let me make sure I make this clear. What the States do, is they add some new people, but all of them get the same benefit package.

The CHAIRMAN. Well, we will get to benefits.

Secretary SHALALA. All right.

The CHAIRMAN. But what I am asking is what you said, and I think I agree.

Secretary SHALALA. That is right.

The CHAIRMAN. Under 50 percent are mandated, the others are optional——

Secretary SHALALA. Right.

The CHAIRMAN [continuing]. As a basis of the action of the State, by choice of the State.

Secretary SHALALA. Right. That is right.

The CHAIRMAN. Now, what percentage of medicaid expenditures are mandated by Federal law?

Secretary SHALALA. I will have to look it up. Mandatory people, 55.1 percent; optional people, 14.8 percent. The chart over here, Senator.

The CHAIRMAN. Right. But my question is, what percentage of medicaid expenditures are mandated by Federal law?

Secretary SHALALA. 55.1 percent are people, and 45.3 percent are the expenditures.

The CHAIRMAN. 45.3 percent of the mandatory services.

Secretary SHALALA. Mandatory services. $55.1 billion.

The CHAIRMAN. So now we find that optional services for the mandatory is 28.7 percent.

Secretary SHALALA. Right.

The CHAIRMAN. Or 23.6 percent. In other words, those are optional services on the part of the State.

Secretary SHALALA. Those are optional services on the part of the State.

The CHAIRMAN. Yes. Then, you see, we have optional people. There, 14.8 million are covered because of State choice; is that correct?

Secretary SHALALA. I think those are billions of dollars in expenditures. That is an amount in billions of dollars in expenditures.

The CHAIRMAN. No, I am sorry.

Secretary SHALALA. $14.8 billion is for the mandatory services.

The CHAIRMAN. That is correct.

Secretary SHALALA. That is 12 percent of the mandatory services. That is 12 percent of the total.

The CHAIRMAN. That is, 12 percent of the people are optionally covered by choice of the State; is that correct?

Secretary SHALALA. No, it is 12 percent of spending, Senator.

The CHAIRMAN. Spending. Yes. All right.

Secretary SHALALA. So $14.8 billion is spent on optional people as the States have expanded their program beyond what is required. That is 12.2 percent of spending.

The CHAIRMAN. So if we look at the optional people and the optional services, how much does that total?

Secretary SHALALA. $69.9 billion, 57.5 percent of total spending. Optional services are 42.5 percent of total spending. I think the point here is very clear, that the money has followed State decisions. The system is set up so that the money follows State decisions.

The CHAIRMAN. But it is correct, is it not, to say that it is only by State choice that 14.8 million people are covered, $14.8 billion——

Secretary SHALALA. Is spent.

The CHAIRMAN [continuing]. Is spent on optional. Optional services include 28.7 billion and 23.0 billion expenditures. Those are optional on the part of the State; is that correct?

Secretary SHALALA. Yes. $23 billion is spent on optional people, which is a State decision.

The CHAIRMAN. Now, if mandatory services to mandatory populations account for less than 50 percent of medicaid payments, does that mean there are no guarantees for half of the program under current law?

Secretary SHALALA. Yes.

The CHAIRMAN. Now, Madam Secretary, your criticism seems to be that if States are allowed to choose whom they will serve and what benefits will be provided, that means there are no guarantees in the program for those individuals and services.

Let me read from the current Federal regulation, Section 440.225, Optional Services. "Any of the services defined in Subpart A of this part that are not required under Section 440.210 and 440.220 may be furnished under the State plan, at the State's op-

tion." What does this mean, other than State may choose whether or not to provide optional services? May I ask you to answer the question?

Secretary SHALALA. Yes. These are additional services for both the mandatory population, as well as for optional people. It is at the State's discretion. But the point I was making, was that this bill changes who is covered.

The CHAIRMAN. Let me continue with my line of questioning. You also talk about guarantees and terms of enforcement. Now, as this chart shows, medicaid expenditures for mandatory services provided for mandatory people accounted for $55 billion in 1994, out of total medicaid spending of $121 billion. So, under current law, States could take almost $70 billion out of the medicaid program without your permission; is that not correct?

Secretary SHALALA. It is correct that the States can make decisions about their optional services. Absolutely.

The CHAIRMAN. Well, what is stopping the States from doing exactly that, if allowed under current law?

Secretary SHALALA. Well, their own decision making.

The CHAIRMAN. So does this mean that the enforcement mechanism under current law is hollow?

Secretary SHALALA. But the point about——

The CHAIRMAN. May I ask you to answer the question? Let me put it this way. What is stopping the States from doing exactly that, if allowed under current law; does this mean the enforcement mechanism under current law is hollow?

Secretary SHALALA. What is stopping the——

The CHAIRMAN. Yes. I mean, these optional services, the people that are optionally covered. There is nothing, as you said, to prevent States from canceling it. So my question is, does this mean the enforcement mechanism under current law is hollow?

Secretary SHALALA. No. The enforcement mechanism applies to individuals who are covered by Federal and State law, and there are optional services that the States can put in place or can decide to change under current law.

The CHAIRMAN. Well, the point I want to make is that over 50 percent of the services provided are now optional. The Governors are not canceling them, they are supplying them. So I think it is unfair to assume the worst about the Governors, the State legislators, that if we go to the proposal we are offering, that they are not going to continue in good faith to supply services.

Their practices, shown by the current situation, is that they are going far beyond the mandatory requirements of the law, more than 50 percent, so there is a will and an interest on the part of the States to do more than required by government. I just think to call our enforcement hollow is not correct.

Secretary SHALALA. Senator, I think the point that was being made about enforcement is that this would be the first federally-mandated program that did not have a Federal right of action attached to it, which is the fundamental point we were making about enforcement.

I think Senator Hatch, himself, raised the issue of whether that was, in fact, constitutional to have a program without a Federal right of action, an individual right that was bestowed, a Federal

guarantee, without a Federal right of action. We simply raised that question as it being inappropriate.

The CHAIRMAN. Well, my time is up. But I would just make the observation that, of course, under the proposed legislation the beneficiaries have a right of action at the State level and there are appeals on up to the Supreme Court.

But, most importantly, the Secretary of Health and Human Services is given the authority to initiate suits for either individuals or otherwise to ensure compliance with the law.

Secretary SHALALA. Senator, if I may just make a comment about your point about mandatory, our problem with this bill is the mandatory program. Some of the mandatory requirements are being eliminated.

There is an elimination, for instance, of adolescents being covered. The definition of disability is left to the State. So, the mandatory groups are, under this bill, put at risk.

The CHAIRMAN. Under our legislation, we guarantee coverage of the same groups that are covered under current law. There is no change there. But my time is up.

Senator Moynihan.

Senator MOYNIHAN. Madam Secretary, may I implore you to think of a better term that optional people?

Secretary SHALALA. And mandatory people.

Senator MOYNIHAN. It is just one of those things.

Secretary SHALALA. I think, sir, this is not our chart.

Senator MOSELEY-BRAUN. Senator Moynihan.

Secretary SHALALA. This is the Chairman's chart.

Senator MOSELEY-BRAUN. Before you get started, would you yield just for a little observation, question, or whatever you want to call it?

Senator MOYNIHAN. Of course.

Senator MOSELEY-BRAUN. Is it not a fact the law provides that the States can decide not to have a medicaid program at all if they want to?

Senator MOYNIHAN. I suspect that is the case with most Social Security provisions.

Senator MOSELEY-BRAUN. All right. So the idea of mandatory people and mandatory services, in the first instance, kind of flies in the face of what the law already is, getting past the humor of the whole idea of mandatory and optional people.

But the second point then is, given that the States can decide not to have a program at all, what this legislation says is that, even if they do decide they want to have such a program, they can decide to change the definition of the people who are covered, or the services that are provided, so there will be no more mandatory at all on any part of the chart.

The CHAIRMAN. That is not correct. There is a guarantee for the same groups.

Senator MOSELEY-BRAUN. None of it is mandatory right now, Mr. Chairman. That is my point. I did not mean to interrupt Senator Moynihan, but I just wanted to bring up that point.

The CHAIRMAN. You are correct, the State can cancel out the program.

Senator MOSELEY-BRAUN. All right.

Senator MOYNIHAN. Can I go to a bipartisan matter. On page two you write, "Before I continue, let me note, in particular, the fine work of Senators Chafee and Breaux, and the members of their bipartisan group on both medicaid and welfare reform. The President believes their proposals could very well be the foundation for a broad bipartisan effort in this regard."

Now, Madam Secretary, one of the key provisions of the Chafee-Breaux proposal was the adjustment of the Consumer Price Index to more accurately reflect cost of living changes. We have before us the Boskin Commission proposal, 1.0 percent reduction; the Chafee-Breaux proposed 0.5 percent, which is about a one-sixth reduction. They got about $125 billion out of that.

Does the President support an adjustment of the Consumer Price Index?

Secretary SHALALA. I was commenting only on the welfare and medicaid proposals, not on the rest of the bill in terms of the President's interests and his signal about——

Senator MOYNIHAN. I did not think I was going to catch you, but I am going to try. Madam, would you go back and tell them that Senators Chafee and Breaux got 46 votes on that day in the Senate, and Senators Simpson and Kerry got an additional seven.

So on that day, 53 Senators voted to adjust the Consumer Price Index to bring it closer to what many believe to be an accurate statement of the cost of living. A 1 percent reduction gives you $1 trillion over 12 years. You are broke. We are all talking about it here. We are broke.

Just one other thing, but it seems to me more important than, perhaps, it does to others. You say on page 23 that teen birth rates have gone down. Now, you have said that before here. The President has said it in a formal statement.

Madam Secretary, what is the evidence that teen birth rates have gone down? Now, mind you, birth rates have been going down in this country for two centuries, but that is not true with teen birth rates, partly, I assume, the age of menarche is now down to, I believe, below 12 years. There has been a decline from 1990 to 1993. There have been 3 years of a decline. The present rate is where we were in 1960. We continued to go down to 1965, and the secular trend is up. Why do you say it is down?

Secretary SHALALA. I am referring to the CDC data that you referred to. The birth rates for teens between 15 and 19 declined four percent between 1991 and 1993. The birth rate for teenagers between 15 and 17 declined two percent from 1991 to 1992, and remained stable in 1993. That is different than the teen illegitimacy ratio, which you know, because that is driven by a different set of data.

Senator MOYNIHAN. What is the illegitimacy ratio for teens now? It is 72 percent.

Secretary SHALALA. 72 percent.

Senator MOYNIHAN. Yes.

Secretary SHALALA. Now, that is also related to the number of teenagers who were married who did not have children during that period.

Senator MOYNIHAN. Could I just say, I do not think a demographer would take a 3-year dip in a secular trend that has been

going on for 40 years as being significant. We do not have numbers for 1994 or 1995. The more important number is the illegitimacy ratio, do you not think?

Secretary SHALALA. Well, Senator, the illegitimacy ratio is important. I think the general point that I believe you have made to all of us for years is significant—that teen pregnancy rates, by any measure, are too high in this country and are creating a disaster for us in relationship to social policy in this country.

Senator MOYNIHAN. But the secular trend is very clear since 1965, down, then up. There is no equivalent in our social experience of this event.

Thank you, Mr. Chairman. Check out the CPI, though. They might use a trillion dollars here and there. It helps.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you very much, Mr. Chairman, and thank our Secretary for testifying.

I said earlier that I thought that good policy is always good politics and bad policy is not. I think that we are pretty close to having some agreement on an approach on welfare, and I think we are more separated by our positions on medicaid.

Would the administration support separating the two issues if we can get an agreement on one and not the other, or does the administration feel that they are tied together or joined together at the hip, we have to do them both?

Secretary SHALALA. No. The administration would support the separation of the two bills. They are joined at the hip in the sense that the welfare bill must take care of the transition into medicaid and deal with the issue of whether people, when they reach the time limit, may be continued on medicaid.

Senator BREAUX. But do you think that we could craft—I am not saying what the final product would look like—a welfare bill that would be sent to the President, signed by the President, and still spend time on medicaid at a later date to get it done?

Secretary SHALALA. Absolutely.

Senator BREAUX. I am really disturbed, and I think Senator Moynihan touched on this, about teen pregnancy. There was an article in the New York Times this morning that public costs of teenage pregnancy is put at $7 billion this year, that taxpayers will spend nearly $7 billion just this year to deal with social problems resulting from recent births by girls under the age of 18. The President is supposed to highlight a $30 million in the budget for the prevention of teenage pregnancy.

Can you comment on that? My State has just some terrible numbers on this issue. We are sort of at the bottom of all the lists of things that are good and the top of the list of all of the things that are bad in many of these areas, and it is very, very disturbing. My State has one of the highest teen birth rates in the Nation, 53 births per 1,000, the 48th highest in the Nation. It is declining. That is encouraging, but it is still very bad.

Can you comment on what type of approach we are going to be receiving in this area?

Secretary SHALALA. Well, I think while the coverage indicated the cost, what it did not reflect is a very careful description of what actually happened to the children of teenagers.

They tended to be low birth weight babies, they had childhood health problems, they were more likely to be physically abused and neglected, they performed poorly in or they dropped out of high school. So the heavy costs are not just the financial costs, but the impact on the children.

We have a proposal—and the President will be talking about this—this afternoon in our 1997 budget for a new national teenage pregnancy prevention program, again linked to community-based strategies. What we know from a report that we did last year on successful programs is that strategies need to be comprehensive and they need to be community-based.

The Federal Government can be a partner, but we cannot reduce teenage pregnancy rates in this country by a single government program. We need a community-based strategy; teachers, parents, church leaders working with communities.

I can take you to a program put in place in rural Oregon, to address their teenage pregnancy rates. It is a community-based program that actually has brought those rates down.

As we find more programs that work, a combination of funds plus enormous public local-based efforts—there is one in New York, the Children's Aid Society Program that I think I have spoken about before, which combines schooling with tutoring, with health programs in East Harlem, and which has been very effective.

Senator BREAUX. I do not want to spend all of my time on that. We look forward to the announcement of the new plan.

Let us talk about medicaid. I tried to raise objections. It is very clear, we are not looking at a bipartisan NGA plan in the bill that is before this committee. It started off bipartisan and it split up. Can you outline for the committee the essential problem areas with the bill before the committee?

We have talked about the changes in the disability definition, we have talked about changing the categories of those who are going to be covered, that the current law phases it in from age 13 to 18. We have talked about the funding formula, we have talked about the deficiencies in the umbrella plan, which is only for 1 year.

Can you give to the committee, if you could in a short statement, all right, Congress, here are the deficiencies; we would like you to fix it in the following way?

Secretary SHALALA. Well, the first issue will be eligibility, and that is, who participates in the program. The program repeals adolescent coverage, so you cannot say that it guarantees all the current groups. Youngsters between 13 and 18—and we have been phasing them in—are no longer in a required category.

Second, it eliminates the Federal definition of disability, which means different definitions around the country. That is a serious problem for someone who is disabled, and it would give us 50 different definitions. So, two very large groups.

Third, women who are currently on AFDC could lose both their AFDC and their medicaid; only if they got pregnant would they be able to keep their medicaid under this bill.

The first issue is eligibility. The second issue is, what is the benefit package; what are we buying for this amount of money? Again, that is left to the Governors with sort of general rules. But the nature of the benefit package is no longer guaranteed. In addition to

that, the enforcement mechanism is changed. There no longer is a Federal right to enforcement.

Finally, the financing is changed. The provider and donation taxes which this committee eliminated now can be used again to make up the State share, which means not only that this bill reduces the amount of Federal money, but it simultaneously allows the States to take out huge amounts of State money and continue to get the Federal money by using funny taxes as a way to attract it.

Finally, the Democratic Governors raised the issue, they broke the agreement; money no longer follows beneficiaries. The block grant, with its floors and ceilings, no longer follows beneficiaries and there is no economic stabilizer here. What happens if a State has an economic downturn that lasts more than a year? The State has no additional money coming in.

Those are the major problems with the bill, which are pretty fundamental.

The CHAIRMAN. We do have a number of Senators who want to ask questions, so we had better proceed.

Senator Grassley.

Senator GRASSLEY. If we proceed down the road that the Governors want to go and Senator Roth's legislation takes it, it seems to me like it really is welfare reform. It seems to me anything short of demonstrating a great degree of confidence in Governors, State legislators, and local people is probably more along the lines of waiver reform and not really expressing confidence in the grassroots of America to make these decisions and to care for people, as I think local people have as much concern as we do, and more faith and confidence in Washington.

I suppose that I look at what we have tried to do on welfare reform in the past and compare that to what the States have done and have really felt that States have really moved forward.

Now, one of the efforts to move forward is in Wisconsin, and they have applied for waiver.

Secretary SHALALA. Senator Grassley, I am recused on any question on Wisconsin, so I am afraid you cannot ask me.

Senator GRASSLEY. I cannot ask you. All right.

Secretary SHALALA. I would have to leave the room if you wanted to ask Secretary Bane.

Senator GRASSLEY. No. I do not want to do anything that hurts your job, but I sure would have liked to have asked you who was going to get approved.

Secretary SHALALA. It is my legal status, I think.

Senator GRASSLEY. Well, let me just make this point then about it. The President has spoken favorably of the Wisconsin plan, and I would expect that, since the President spoke favorably of it, that it would be approved just like that.

We do not know if it will be approved. I know you cannot comment on it, and I am not going to ask you to do that. But it does demonstrate, because we do not have an answer two weeks after the President said he was in support of it, and there is a process of screening and negotiating going on, just exactly why we are trying to move this legislation.

Otherwise, we are in this situation where 50 different Governors, including 19 Democratic Governors, under present law, have to come, hat in hand, on bended knee, to Washington, DC to get approval. We always have to meet this test of what is an appropriate welfare reform, is that Washington knows best.

I am going to move on then.

Secretary SHALALA. Senator Grassley, if I might answer the first part of your question. To be fair to all three of these plans, to Breaux-Chafee, to the Republican bill, and to the President's bill, all of them give tremendous flexibility to the Governors.

The issue of flexibility is not in dispute here. Fitting resources with our goal of moving people from welfare to work—having a better fit between the numbers, the strong work requirements and the targets we want to reach, and the kind of resources that are necessary, and protecting children—is what we are disputing here.

But, of the three bills, and two of them we have spoken very favorably about, we have some deep concerns about the resources and the protections in the Republican bill, which we have made quite clear. But there is no debate about flexibility.

Senator GRASSLEY. I think the end result means that the plan does not allow the flexibility that would be dictated.

Secretary SHALALA. Senator Grassley, we have approved 60 waivers. There could be no better demonstration of the willingness, understanding, and desire of this administration, to be flexible.

Senator GRASSLEY. But it takes months and months to get some of those waivers.

Secretary SHALALA. We did, in 3½ years, more than twice the number of all of the previous administrations put together.

Senator GRASSLEY. Well, I know how long it took myState of Iowa to get a waiver, let us say that. I know that for a fact.

You made the point that our Republican medicaid plan departs from what all the Governors agreed to in February. In your comment about the eligibility requirement you criticized the fact that the Federal standard for defining disability was repealed.

Now, I am reading from the February Governors' document on eligibility. It says, "Consistent with statute, adequacy of State plan will be determined by the Secretary of HHS." And then before that it says, "States must have maximum flexibility in the design and implementation of systems of care." It also says, "Persons with disabilities, as defined by the State in their State plan."

So when we have this, these statements in this plan, is it not fair to say that the Roth plan provided what the Governors wanted and they did it unanimously in their February statement? I do not see where you can say that this is anything different than what the Governors said, based upon their own statement.

Secretary SHALALA. I did not, Senator Grassley. The significant difference between the Roth plan and the Governors and the reason—the Democratic Governors have objected—the core of their objection—is the financing mechanism.

The formula, no longer has money following individuals, which was the core of the Governors' agreement. That is why the agreement has fallen apart. When I testified previously on the Governors' plan. I objected, and we raised serious questions about States defining disability State by State in the Governors' plan. So,

we are being consistent here. It is that core funding that held the Governors' agreement together, and without it the Democratic Governors stepped away.

The CHAIRMAN. Senator Rockefeller.

Senator ROCKEFELLER. Madam Secretary, I am going to try to ask in rapid-fire order four questions, so I think they only require short answers.

What is your view as to what you think States will do under this current proposal of the Chairman on medicaid reform; is it not likely that they will spend significantly less on health care for the poor, for the disabled, for children of pregnant women? There is, I think, one new study out saying that the States will spend $185 billion less. So what do you think this will do to health care for the poor?

Secretary SHALALA. Well, I think that the concern is not simply the Federal portion, but your point, that the States will pull large amounts of State resources out to draw down the Federal moneys, substituting these provider and donation taxes to keep the Federal money.

Senator ROCKEFELLER. Second, there are about two million nursing home residents. Does this bill give those people the same protection of quality of care and protection for necessary nursing home services as current law, or will seniors who qualify and count on medicaid today for help with nursing home care be at risk, in fact, for themselves having to pay more for their own health care services under the Chairman's bill?

Secretary SHALALA. In our reading of the bill, it no longer has the same kind of guarantee or a guaranteed benefit package. It puts every category at risk, including nursing home residents.

There have been some changes in this bill since the original Governors' bill to protect, for instance, the assets of adult children for nursing home residents. But according to this bill, the State could go after the assets of the adult children of elderly persons who are in a hospital.

Senator ROCKEFELLER. Third, given the dramatic rise in reports of child abuse and neglect and some cases of fatalities resulting from this, I, as I have said, am very troubled by block grants and reducing the States' financial commitments to abused and neglected children.

No. 1, what is your view on the Child Protection Block Grant, and under a block grant is there any assurance that States will invest in prevention—preventing—child abuse, especially given the budget squeeze. Is there a danger that States would, therefore, only get into crisis intervention and investigation, so to speak, instead of the prevention and the family support programs, which have proven that they work.

Secretary SHALALA. Of all of the American tragedies, as you well know, there are already 20 States under court order in this area. We would be opposed to anything that would reduce the resources in child welfare services, our oversight in child welfare services, or the ability to go into court to insist on protections for abused children.

The President has, in the clearest possible terms, said that a block grant of any part of child welfare services is unacceptable.

These are the most vulnerable, the most difficult kinds of cases. We need to keep our resources and we need to keep our oversight at the same time.

Senator ROCKEFELLER. I will ignore my fourth question simply to say, I thought your point was very fair and should be clearly noted, that when you were answering in discussion with the Senator from Iowa, you pointed out that the President has given an enormous number of waivers to States to do what they want, more than all previous efforts of Presidents combined. That is a fact and is something that should be noticed.

If Iowa received it in a slower amount of time than they wanted, still they received it, and so have many other States. I think the administration has tried very, very hard on the whole question of flexibility and State waivers.

Thank you, Mr. Chairman.

The CHAIRMAN. I would just say to Senator Rockefeller on the Federal standards for nursing care, that the legislation I proposed does continue the Federal standards and the same enforcement, so there is not a change in that area.

Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Thank you, Mr. Chairman. I was almost surprised. I am so accustomed to being the last voice in the room.

Madam Secretary, delighted to see you again this morning. I wanted to ask, I have been looking at some of the numbers here and I think it is of vital importance that, particularly as we talk about some of these complicated subjects and we throw around millions, billions, and trillions of dollars, the numbers like crazy, that we never lose sight of the fact that, in the final analysis, there is a human face to all of these issues.

There are people, real people, involved with the kinds of decisions that are being taken up in this committee, and about which you have been an advocate, Madam Secretary.

So in that regard, I wanted to go over—because I was really tickled by the idea of mandatory and optional people—the enrollment in the medicaid program, the 32.1 million people on medicaid.

Some 3.7 million of them are elderly, 4.9 million are blind, 16.1 million of them are children, only 7.4 million of them are adults and families. So that is who we are talking about when we talk about both mandatory and optional people. Almost 5 million blind people in the country, and over 16 million kids, and almost 4 million old people.

Now, the spending, by contrast to those numbers—well, it is not exactly contrast—59 percent of the spending that we do, all these billions of dollars that we are talking about here, 59 percent of that goes to elderly and disabled people to serve their health care needs.

I am particularly concerned because, as we work through the formula and as this program developed under the Social Security Act, there was a provision put in for hospitals that provide services to this population that are impacted because of the poverty of the area or region that was specifically the most called-upon institutions for servicing this population that we have just been talking about.

They were called disproportionate share hospitals. Disproportionate share. Maybe it was disproportionate share of the troubles, or disproportionate share of the demand, but the fact is, these institutions got to serve more elderly, more blind people, kids, and sick adults than others.

The disproportionate share hospitals, which, again, were the most stressed under the present situation even, accounted for some 14 percent of the medicaid spending. This bill gets rid of disproportionate share altogether. So my question is, does it just fall off the edge of the earth? What happens?

What are the plans, or how do you make up for 14 percent of all this money that clearly was needed for something? It is not like these hospitals are luxury cabin cruisers or anything. These are people who are struggling just to keep their doors open to serve populations of sick people.

So if this 14 percent of the spending is not available, what are we going to see, just a rash of closing hospital doors in poorer communities throughout this country? That is my question.

Secretary SHALALA. The Republican bill does fold the disproportionate share hospitals into the block grant, and there is no guarantee that the money will then flow back to the institutions that have been getting the money up until now. I think you have made the point very well.

The second point is, if you pull this much money out of the system, those hospitals are still impacted. Those hospitals that serve medicaid recipients, whether it is managed care or the institutions that they use, will still get significantly less money, and in this case, less of the States' share because of the ability of the States to pull their money out. So, it is a double hit here.

Senator MOSELEY-BRAUN. So we are likely, then, to have a real conflict in terms of these hospital doors closing.

Secretary SHALALA. It will be a particular hit on rural hospitals, which are very fragile, which is a point I made when I testified here in March. Those hospitals that are currently in the red, if you pull this much money out of the system and do not guarantee special protections for institutions that serve those who are underserved, then they are put even more at risk.

Senator MOSELEY-BRAUN. So I misspoke. You are correct, and I appreciate your correcting me, Madam Secretary I misspoke when I said urban populations. My comment is, it is not just urban, it is rural. In fact, some of the most poignant stories and comments I have received have been from rural hospitals in my State, which is largely agricultural and is a large rural population. So that is a real, real prob'em for us in the rural communities, as well as the urban ones.

The second issue, and I think that Senator Rockefeller kind of touched on this, I think, when he talked about the change that limited the States' capacity to use provider taxes and donations in their medicaid mix.

The CHAIRMAN. We are running out of time, and we do have a vote coming up.

Senator MOSELEY-BRAUN. All right. Yes, sir. No problem. I will save my question for later. Thank you very much.

The CHAIRMAN. Thank you.

Senator Simpson.

Senator SIMPSON. Mr. Chairman, I thank you. How are you, Madam Secretary?

Secretary SHALALA. Fine, Senator.

Senator SIMPSON. Good to see you, always. If I see you at the Arena Stage some evening, we will do it again. I enjoyed that with you. You are a remarkable woman.

Just a little bit of summary. What Senator Moynihan is saying is so real. Here is a man that was part of the Blue Ribbon Commission to save Social Security, which means really saving Medicare, medicaid, SSI, all the rest. We cannot do that unless we do something with CPI. Boy, there were plenty of us that stepped up to the plate a few days ago and went after that.

Senator CHAFEE. Ten members of this committee. Ten out of the twenty.

Senator SIMPSON. Yes. Ten of the twenty members of this committee, bipartisan. And that vote on that Chafee-Breaux amendment, do not miss it. Of course, you would never know it from the media; it was like a sparrow belch in the midst of a typhoon for them.

But you can be assured that 46 people, 24 Democrats and 22 Republicans, went right to the core of responsible legislating. It was a remarkable thing. Then, of course, the Kerrey-Simpson proposal is tougher yet because it provides and talks about the sinful thing called Social Security, which no one is supposed to utter during an election year.

But you are a trustee. You have a different role, and it is one of high responsibility. This is your signature. This is you. You are a trustee of the Social Security system. In this document, this summary, all of you are saying that there is no long-term solvency in these systems. None. Short-term solvency, yes. You can continue to address that.

Then all of you agree that in the year 2012, everything begins to go to hell. There is no other way to describe it, because the payroll taxes are not sufficient to pay next month's benefits. You know that, we know that, the President knows that, Bob Dole knows that; we all know that.

We continue to prattle on about children and seniors and the disabled and everybody else, and there will not be enough to do anything for anybody, because that is discretionary activity, most of it, or should be, or will be. We cannot do anything with Medicare, medicaid, Social Security, Federal retirement, and certainly cannot do anything about interest on the national debt.

We even have people still talking about the fact that somehow we are raiding or looting the Social Security system. How does following the dictates of your trusteeship where it says, "In all trust funds, assets that are not needed to pay current benefits or administrative expenses, the only purposes for which trust funds may be used, are invested in special-issue U.S. Government securities guaranteed as to both principal and interest and backed by the full faith and credit of the United States Government."

If that is done, how is that called raiding or looting the Social Security system, please?

Secretary SHALALA. I do not think it is.

Senator SIMPSON. I do not think it is either, because it is not.

Secretary SHALALA. Senator, on your other point, I take my trustee responsibilities very seriously. When I testified for the administration specifically on Medicare, I laid out very carefully where I thought there was agreement between Republicans and Democrats for a short-term fix that would buy us 10 years in Medicare, combined with a bipartisan commission to look at the long-term issues.

So I think that, to be fair to those of us who are trustees, we have done the hard work to look at both plans and defined where we could get agreement, and have offered to sit down. We should take the controversial things off the table, do the short-term fix, but set up a bipartisan commission.

I believe Senator Dole put in a bill for such a bipartisan advisory commission. We did not put details in our proposal because we wanted to be able to make sure that it was bipartisan and it met both parties' requirements.

We would be happy to work with this committee on these issues. We are pledged to it. We know a lot about where we think the agreement would be in the short-term to make sure that the Medicare trust fund, in particular, has 10 years, while we look at the longer term strategy.

Senator SIMPSON. I agree, and that likely will come. You make that recommendation here. Just a comment. I think Senator Roth was asking about the race to the bottom, but I do not see how we can continue to talk about that fear.

Governor Engler testified before this committee in February that 62 percent of current medicaid spending is spent on optional services that the States are not required to cover. Under this chart, they are spending 51.7 percent on optional services that they are not required to provide. So if they wanted to race to the bottom, I mean, they would have been in full gallop. What is this about?

Secretary SHALALA. This is about whether current recipients, the most vulnerable people in this country, will continue to be covered and protected by laws of the land with enormous flexibility for the States on the delivery systems.

But it is a fundamental debate about whether these populations, who are the most vulnerable in our society, whether we will continue to have some national standards to protect them and to protect the quality of the benefit package that taxpayers are paying for.

It is not about flexibility. We have both demonstrated our commitment to flexibility by approving more waivers than at any time in the history of this country in the shortest period of time. It is about whether there are going to be some standards and some protections for children, for the elderly, and for the disabled in theUnited States of America.

Senator SIMPSON. Well, Madam Secretary, I would certainly say that that is exactly what this bill does. We have guaranteed benefits in this bill which are stunning. We have guaranteed benefits for hospital service, physician service, laboratory, X-ray, immunizations for children, prenatal care, nurse/midwife, pediatric, family nurse practitioner, nursing facility, home health care. Now, that is what we have in here as guarantees. Senator Chafee has worked

on this, Senator Roth has worked on this. We do have these guarantees.

I think it is absurd to try to just continue on, not you, but in a year where, if the portrayal is simply that the evil Republicans are busting ketchup bottles over children's heads in cafeterias and throwing bed pans out of the senior citizens' homes, and pitching veterans off the top of the VA hospitals, the American people will figure that that ain't the truth come November 5.

Secretary SHALALA. Nor have you ever heard those sentences from me, Senator.

Senator SIMPSON. Not from you. I did qualify that.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. I thank the Chairman. Let me just say that, on this question of guarantees, I think it is very important to recognize the difference here between current law and what is being proposed. Under current law, the Federal Government provides support for everyone who is eligible.

If we go to a block grant program, which I would call a blank check program, under a block grant the amount of money is fixed. Then what happens is there is a tremendous incentive for States to take people off the rolls. It is very clear, unmistakable, that that is the case.

Let me just add, one of the things that I think I find very concerning is the integrity of Federal funds. Let me just give you an example of what has happened, what has been going on here. There has been a huge shell game going on in this country, and I think many people are not aware of it.

Let me just give you one example from Michigan. In Michigan, they levied a tax on the University of Michigan Hospital of $489 million, so they got $489 million into the State treasury. Then they turned right around and gave it back to them in DSH payments. What was the net effect here? Well, it had no effect on the State of Michigan's budget, it had no effect on their hospital, but the State got, as a result of this charade, $276 million of Federal funds.

I have got loads of examples of States playing these games. Under the proposal we have before us, the protections that have been put in place to prevent this are out the window.

I can assure you what is going to happen. I can predict here today, without any fear of contradiction because we all know it is going to happen, the protections are taken away from this kind of sham and Federal resources are going to be tapped, not to supplement State funds, but to replace them.

In fact, if you are really creative, we have sat down and gone through some examples of what one could do. I will tell you what you could do. You could almost replace 100 percent of State money that is going out today to help these folks and replace it with Federal money. That is a fact. Now, I really do not get it. I do not get what is conservative about this; I do not get what is responsible about this; and I do not get what is good public policy about this. This is merely opening the floodgates. I can understand why the Governors were unanimously in favor of this.

This is the greatest scam ever put together. Let us just tap right into the Federal Treasury and take those Federal dollars and replace the State dollars that they are spending and that they are

having to raise. Let those guys in Washington take the heat for levying the taxes and raising the money, and we will spend it.

That is a great deal. I can understand why Governors like that deal. That is not my idea of much in the way of public policy. That is just playing a financial game in order to relieve States of their obligations and their responsibility.

I would like to go to another matter, and that is a question of bipartisanship. I thought it was very interesting when Senator Dole spoke the day before yesterday. I found it very moving because he recounted, what are the things that he is proud of that he has done around here, and how did it happen?

What Bob Dole said, was that he was proud of things that he had accomplished on a bipartisan basis. What were the things? Saving the Social Security system, food stamps, aid for people with disabilities. Those are the things that he was proud of. Without exception, they were things that he had accomplished on a bipartisan basis.

That is what is lacking here. There has been no bipartisanship. The Chairman promised, when the Governors were here, he was going to work together. He has not done that. There has been no bipartisanship here at all. For that reason, it is going to fail, and that is a tragedy.

We have an opportunity here, on a bipartisan basis, to fix welfare, to fix Medicare, to fix medicaid, to get our fiscal house in order. I would say, Senator Chafee andSenator Breaux led an effort that put an outline on the table of how we could do it.

I would just like to ask, Madam Secretary, if something that was close to what the Chafee-Breaux group has put on the table with respect to welfare and medicaid reform came to the President, would the President sign it?

Secretary SHALALA. The President has indicated that, certainly with the welfare reform piece, it looks pretty close. I have not heard his comment on the particular medicaid proposals. But I think the point is, we would like a bipartisan bill, and that Breaux-Chafee comes closer to our own recommendations than any of the other bills.

Senator CONRAD. Thank you.

The CHAIRMAN. Senator Chafee.

Senator CHAFEE. Thank you, Mr. Chairman.

I appreciate the kind comments you made in response to Senator Conrad, and also in your statement about the Breaux-Chafee bill.

I would point out that that was a package, and when people signed on to that package they signed on to the totality. Included, as Senator Moynihan mentioned, was a key part of it, the CPI, the change in the Consumer PriceIndex, which, as I mentioned, out of the 20 Senators on this panel, received 10 votes.

But I think we would make a mistake if we advanced on the assumption that, if you split it up and took the medicaid or you took the welfare, that we would have the same support of either Republicans or Democrats on the particular individual measures. We went on as a package.

I would not want to commit myself, and I certainly could not commit the others, to saying, all right, it is bipartisan, you are going to get the same vote; we will all stick with the individual parts of it. That is the first point.

The second point I would like to make, is I would like to just briefly follow up on what Senator Simpson said. I think the most serious social problem facing this country is not what we are doing in welfare, it is not what we are doing in medicaid, it is the condition of these funds, theMedicare fund and the Social Security fund. If that Medicare fund goes broke and we do not have it available for, what, 39 million or 33 million seniors, we will have real problems in this country.

I think, Madam Secretary, that to a greater degree than you have, you should be shouting from the rooftops the problems that are in these programs. I know you did in the report you made, but that is not something that I think—yes, it made the front page in the New York Times once, or perhaps twice, but this is really a problem our country faces, and it can be corrected.

Now, maybe the solution is a bipartisan commission, such as Senator Moynihan was on with Alan Greenspan and Senator Dole, John Heinz, and the others. So, I would hope that you would be more vocal, if you could, about the dangers, the perils, that those funds are in.

Now, two things, quickly. I have great problems with this piece of legislation before us about the children. As you have pointed out, we now cover up to age 12, and each year add a year. That is very low-cost compared to those over 65. Do you know what a child costs?

Secretary SHALALA. Under $1,000 per child, to cover a child with insurance, depending on the State, of course. My guess is it would be between $750 and $1,000 a year to cover a child.

Senator CHAFEE. All right. Now, you are talking a lot bigger dollars when you are talking seniors, obviously.

Secretary SHALALA. Right.

Senator CHAFEE. We do cover them, but we do not mandate coverage of the children. I think that is a mistake.

Now, a bit about SSI. Under the pending proposal, States are required to provide medicaid coverage to individuals who qualify for cash assistance under the SSI program, but only if they are over 65. What happens to those who are under 65 who are SSI eligible, under medicaid?

Secretary SHALALA. Well, the problem is, if you go into a block grant and simply give the States the discretion to define who is disabled, then you obviously are taking away a guarantee of a certain benefit package.

Senator CHAFEE. Now, under the current law—and if you would listen carefully to this, because it is a little bit tricky or difficult—as interpreted by the courts, the States must provide medicaid coverage for abortions in the case of rape, incest, or life of the mother. That is the law of the land now, as interpreted by the courts. This legislation would change that and it would allow States not to cover abortions in such cases. Am I correct in that?

Secretary SHALALA. You are correct.

Senator CHAFEE. So this is quite a big departure in that particular area.

Secretary SHALALA. It is, indeed.

Senator CHAFEE. Now, furthermore, as you know, there is no Hyde amendment permanently in the medicaid legislation. It comes up every year in the appropriation.

Secretary SHALALA. That is right.

Senator CHAFEE. This legislation would write the Hyde amendment into the permanent underlying legislation; is that correct?

Secretary SHALALA. That is correct.

Senator CHAFEE. So instead of us having an opportunity to tinker, as we have over the years, each year it comes up with the appropriations bill, and we can make adjustments if we wish, if we do not, we can tighten it, ease it, or whatever we want on the Hyde amendment in the appropriations bill annually. We could not do that anymore if this legislation were in effect; is that true?

Secretary SHALALA. That is correct. Without changing the——

Senator CHAFEE. Without changing the underlying law, which would not come up before us except after X years, whatever the reauthorization period is. Well, it becomes the underlying statute.

Secretary SHALALA. The underlying statute in an entitlement. Well, in a block grant, I should say.

Senator CHAFEE. And, therefore, would not come up until some later time we chose to do it.

Well, I see my time is up, Mr. Chairman.

Senator MOYNIHAN. The Chairman has had to go vote. He will be returning.

Senator CHAFEE. He has had to go vote.

Senator MOYNIHAN. Well, you might wish to.

Senator D'Amato.

Senator D'AMATO. Thank you.

Madam Secretary, I am not going to raise any issue as it relates to the legislation that is being discussed today because you have made clear your views, and I have read your testimony quite carefully. I note that, throughout your testimony, you speak and you reference with some detail a number of waivers the various States have obtained.

I want to return to the question of the 1115 waiver. I think I said 1,115 waivers. It is known as Section 1115, but that waiver which the State of New York has submitted back in March of 1995 which would allow the State to incorporate various managed care proposals that we have submitted to HCFA.

Now, I understand the concern to ensure the quality of care, but you know the history of our State. The fact is, it is a very noble and laudatory history as it relates to making available care to the neediest.

I am asking if you cannot give us some timeline when there will be a waiver granted. If there are deficiencies in the proposal, let us discuss them and get it done. I cannot understand why you cannot do it in a day, or 2 days, or 3 days, given it has been there for 15 months.

Senator MOYNIHAN. If my colleague would yield, Tennessee has essentially the proposal New York is asking for, is that not the case?

Senator D'AMATO. Yes. So, Madam Secretary, can you enlighten us?

Secretary SHALALA. Well, first, I think there are some differences. Let me say that we are currently working with the State. Let me talk a little about the New York waiver. When the overall waiver authority was originally set up it was obviously a demonstration authority with an evaluation. I mean, this was to give the States an opportunity to try out some new ideas.

The New York waiver is the largest waiver in the history of this country. We are talking about 10 percent of the total medicaid recipients in the whole country, and 20 percent of the expenditures. It is huge.

What the State wants to do is to move very quickly large numbers of this population into managed care. As you well know, Senator, while it has had some old HMOs, the movement into managed care is relatively recent in the State of New York.

So we are talking, for instance, about 95,000 people with AIDs, without a managed care industry that has had a lot of experience with people with AIDs. That is just one example.

Our discussions with New York cover the following issues, which we are obligated to address. The project must be budget neutral. That is hard to do, as the budget situation in New York keeps changing while there are budget negotiations going on now. So, we are pinning down the budget neutrality issue.

The adequacy of the health plan capacity, which is how many managed care entities exist, is another issue. As you know, during this period the State has had to clamp down on some marketing fraud that has been going on, so we have to make sure that the plans are there, that they are quality plans, and that the State has a mechanism in place for that oversight.

We need to be sure proper marketing and enrollment procedures are in place, which the State and the city have conceded that they have had some problems getting into place. All of these things have to be in place for a final approval.

There are special health care needs. I gave you the AIDs example. There is not a lot of managed care experience in this country, particularly in a State that has a very high percentage of people with special needs.

Managed care has had most of its experience outside of the special needs categories, so there are questions about how people who have special needs will be handled as part of the managed care transfer.

We have had to get data from the States, and you said this means more data than they have ever presented before. It is not more data than any other State presented. We have a long history with approving these waivers, so the data requests in New York are not something new, they simply did not have some of this data because of the way that they handle their data.

The point is, it is a huge, complex waiver in a State that wants to move very quickly to managed care. We have approved waivers moving very quickly before. I do not start with a New Yorker's bias about managed care, as many New Yorker's have. In fact, I come most recently from a State in which almost everybody is covered with managed care. So it is a large, complex waiver and we are working our way through each of the issues.

Finally, the advocacy groups and the interest groups, as you well know in dealing with New York, had to be listened to in a process of public hearings.

So, to be fair to us, I think our process has been disciplined. Every State would like to do this tomorrow. Every State that we have worked with, everybody wants to move too quickly. If you look at the Tennessee experience, you will know that we slowed them down and they still had problems putting that system in place. What we do not want is a disaster on our hands in New York.

So, Senator, I can assure you that we are working very carefully with the State. We are getting in the final data base that we need to achieve budget neutrality. This was not set up in any way other than to make sure it was absolutely budget neutral.

There are changes in reimbursement levels, in the size and scope of benefit packages, in coverage of the optional eligible groups that are being discussed now as part of the process, and those have to be folded into the proposal.

As you well know, I have a long history in New York, and a respected history in New York. I would in no way be doing something in relationship to a State I love that is inappropriate, other than protecting what you would expect me to do, to make sure we have asked very hard questions and that the State has all the pieces in place for what is going to be a revolution in the nature of health care.

Finally, let me say to you, I am concerned about the academic health centers in New York and the impact of a massive movement of population from fee-for-service and from the way in which the academic health centers have served these populations to managed care, and I need to be assured that this population, much of whom traditionally has been served by academic health centers, that those institutions, which are the finest in the world, are part of the process as opposed to going through significant financial and personnel changes beyond what they are already doing. So, that is part of the equation here.

New York, as both of you well know, is always more complex than the rest of the world. Being careful is what you want me to do as part of this process, and there is no bias here, but rather an understanding of how large and complex this undertaking is.

Senator D'AMATO. Well, I thank you for your explanation, but I think I have to add something, at least an observation. Certainly I do not think that you would be suggesting that Dr. DeBono, the Commissioner of Health would simply say, well, everybody now, you are off and you are all into managed care.

I mean, the concerns you expressed would come and be very bona fide—and I am not suggesting that your concerns are not bona fide—if you were to say that that is what they are going to do. The implementation, obviously, is not going to take place overnight or within a period of days. It will give to the State, though, the ability to move into this area of managed care.

So I have to suggest, your explanation and reason for the time-consuming process, you made it sound as if the State is going to say to you overnight, almost in a willy-nilly fashion, that we are going to simply move everybody in one fell swoop within a period of time to managed care. That is not the case.

Secretary SHALALA. No. No.

Senator D'AMATO. But that is what your explanation suggested to this Senator.

Secretary SHALALA. No. But what the State is asking for is permission to mandate as opposed to a voluntary system, which they can currently do. They do not need my permission for the voluntary system of moving people into managed care. What they want, and what we want to make sure of, is that there is a plan. Not the first-year plan, but all the other years in terms of the capacity. That is what we are working on now with the State.

Senator D'AMATO. By the time you wait to get every one of those questions answered in detail, there will be another budget, there will have to be another study of budget neutrality, and it will never come to pass. You are going to study this to death.

I am suggesting that the approach that has been utilized to date by the Federal Government is simply, in its final analysis, a blockage and a denying of the State of the ability to move forward.

It would seem to me that, between what you have advocated and maybe what the State asks for, we can begin to implement a program that will give them the ability to begin to move populations into managed care.

Secretary SHALALA. Senator, they can move populations into managed care now. The question is the mandatory side of that.

Senator D'AMATO. Well, then they cannot. You are denying them the ability to do that. No, no.

Secretary SHALALA. On a voluntary basis. Which of these questions, Senator, should I not answer, budget neutrality, the adequacy of the plans, whether special populations are protected?

Senator D'AMATO. You know something? They have answered these questions, and you keep raising more questions. You can raise questions from now to the end of kingdom come, and they will never be able to answer the questions because you will have more, and new, and new, and further, and further. This is 15 months. My budget director and my Governor say that they are making no progress, that they have hit a wall, a bureaucratic wall, because you have enough special interest groups—and some of them are good groups and well-intentioned.

There has been no one who has fought harder to see to it that the graduate medical programs in New York are protected, to give additional flexibility to fight for the formulas to see that they are fairer than Senator Moynihan and myself. So let us not put that out on the table.

You say we trust the Governor, but, on the other hand, he is just going to close down all of the great teaching institutions, that they are going to just willy-nilly do this? Now, come on. Let us say that some people have some common sense.

I just think I want to know if you are going to move this process or if it is going to continue at this deadly crawl, because that is what it is. I guess we continue to get stonewalling, and that is the way I see it.

Secretary SHALALA. Well, Senator, I have indicated to you that the process is moving along.

Senator D'AMATO. No. You gave me a great bureaucratic speech to a failure to respond. You give great lessons here and say, yes, we have given you flexibility, but you have not.

The CHAIRMAN. I do not want to interrupt, but I will. I think the time has come to complete this hearing.

Senator D'AMATO. Well, Mr. Chairman, let me simply say this. I have not found, Madam Secretary, unfortunately, your answers to be adequate as it relates to how we are going to eventually deal with this. If it is in the same methodology that you put forth, then I just have to say that you make wonderful statements, but they vary with the facts and what is really taking place.

Secretary SHALALA. Senator, I rest on our record.

Senator D'AMATO. The record has been a deplorable record as it relates to granting the relief that New York has requested, and I have not even gone into other waiver things, in dealing with bad debts, and how we can deal with them, and giving us the flexibility.

The CHAIRMAN. Senator, I would like to move on to the hearing.

Senator D'AMATO. I have to go down and vote.

The CHAIRMAN. I want to thank you, Madam Secretary.

Secretary SHALALA. You are welcome.

The CHAIRMAN. It has been, I know, a full morning. I hope you enjoy your lunch.

Secretary SHALALA. Thank you.

[Whereupon, at 12:21 p.m., the hearing was concluded.]

WELFARE AND MEDICAID REFORM

WEDNESDAY, JUNE 19, 1996

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10 a.m., in room SD–215, Dirksen Senate Office Building, Hon. William V. Roth, Jr. (chairman of the committee) presiding.

Also present: Senators Chafee, Grassley, D'Amato, Lott, Moynihan, Conrad, and Graham.

OPENING STATEMENT OF HON. WILLIAM V. ROTH, JR., A U.S. SENATOR FROM DELAWARE, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will please come to order. This is the fifth day of hearings the committee has held on the critical issues of welfare and medicaid reform this year.

Nearly 4 months ago, the Nation's Governors told this committee that Governors believe it is critical that Congress pass, and the President sign, the three major bills of welfare reform, medicaid, and employment and training during the next month.

And, while it did take a little longer than a month to translate about a dozen pages of the Governors' outline into an 1,100 page bill, S. 1795 is true to the policies unanimously endorsed by the Governors.

Now, last week the committee received testimony from Secretary Shalala on the President's welfare and medicaid proposals. There is a fundamental difference between the President and the Governors. The difference is whether or not the Governors and State legislators and judges can be trusted to run the $2.4 trillion welfare system, and the essence of the opposition to S. 1795 is that the States cannot be trusted.

The Clinton plan is built on the premise that Washington must control their decisionmaking. Well, today we will hear an entirely different perspective. The committee will hear from people who have the responsibility to actually run the welfare programs.

It is their experience which demonstrates that it is time to move the waiver process. One of the basic flaws of the existing system is, while State officials have the responsibility to administer these programs, they do not have the authority they need to effectively run the programs. That authority is dispensed by Washington one drop at a time.

The number of waivers is far less important than the content. Merely citing the number of waivers also does not tell us what the

Secretary did not approve. Democratic and Republican Governors alike tell us that the current welfare system is overly burdened with years of Federal regulations that have hamstrung the States' ability to provide care to those in need.

The States are proving in a variety of ways that they can deliver necessary services at lower cost if they are allowed the flexibility to apply innovative lessons learned from the private sector.

Perhaps more importantly, today's hearing is a reminder that the present debate is not only about the future of the particular programs, it is about the future of the relationship between the States and the Federal Government as well.

Last week, Secretary Shalala spoke about the Federal-State partnership. All too often, tension between Washington and the States have turned it into an adversarial relationship.

The administration has unfortunately characterized medicaid reform as a "poison pill." In fact, the greater threat to the Federal-State partnership is to do nothing about medicaid. Both partners are suffering from the acute effects of uncontrolled spending. We simply cannot wait for the partnership to dissolve from bankruptcy.

I look forward to hearing from the panel of experts who will help us to understand how welfare and medicaid reform might work to change the status quo.

I now yield to Senator Moynihan.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. Mr. Chairman, once again, thank you for your courtesy in holding these hearings and the energy which you have put into it, the openness to having witnesses of all range of opinion, which is characteristic, I think, not just of your chairmanship, but of this committee.

A general point with respect to the Governors and this general talk of the need to come hat in hand, all sorts of images, to get changes in the welfare arrangements. I think it is the case—and I look forward to anybody confirming or not—if there is any Governor in the country who does not want to have a welfare program, all they have to do is say no. It is not obligatory. This is 1935 legislation. Of course, the legislature has to agree, but if you do not want a welfare program, just say we do not want it. If you do not want an unemployment insurance program, say you do not want it.

This is the peculiar structure of public administration in the 1930's. The Federal Government would not have dreamed of mandating such a thing. They gave incentives. If you want the Federal Government to help pay for your program and welfare, well, you have to obviously have one. But, if you do not want one at all, you do not need one.

The States now do run these programs. I wish somebody would just settle this for us. How many people work in the Department of Health and Human Services on Aid to Families with Dependent Children and how many people collectively work in the State governments on this thing? The ratio would be about 1,000 to 1.

Professor Ellwood, would it be about 1,000 to 1? Yes. On that order. Yes.

We had the Wisconsin waiver which was presented in a context which brought the support of both President Clinton and our former Majority Leader, our revered Bob Dole. But it is 400 pages long because there are so many people involved and things involved. It apparently does have problems, some of which rise to the level of constitutional problems.

There is the question of, do recipients have a right to a hearing if their benefits are withdrawn? Well, the Supreme Court has ruled that they do, as a constitutional right, Congress having created this program as an entitlement.

Then there is a question of residency requirements. Now, it seems to me we have to assert that we are a Federal Government. There is a national government around here. Citizens have the right to travel from State to State. The constitution is very careful about lots of provisions about the validity of laws in one State being upheld in another State, and such matters.

I am not going to instruct you, sir, on these matters on which you are singularly gifted and knowledgeable. But providing for the common rights of citizenship within all of the States is one of the first things the Federal Government did and it ought to continue to do, in my view.

On the other hand, clearly the time has come to encourage the States to be innovative in an area where they have so been. In 1988, we worked hard on legislation, the Family Support Act, which passed the Senate 96 to 1, that had its principal inspiration the things States had begun to do.

It took two generations for State governments to realize that the program that began as Federal support for widows' pensions, which began at the beginning of the century, had changed in character. I think they have responded, and my view is to encourage them to continue to do so, and we can discuss the ways in which we might do that. End of monologue.

The CHAIRMAN. Thank you, Senator Moynihan. You make a number of very pertinent points. I do think the point about the Governors being free to cancel programs is, indeed, very relevant for the reasons we were pointing out when Secretary Shalala was here.

There seems to be a certain amount of distrust as to what the Governors would do. Would they not continue to properly fund these programs? In fact, not only are the programs voluntarily put into effect, but many of those that are covered and many of the benefits that are included are optional. So, I do think that this mistrust is wrongly placed.

Senator MOYNIHAN. But you would also agree that we have the most decentralized public assistance program of any industrial democracy.

The CHAIRMAN. I will leave that to your expertise. Well, thank you, Senator Moynihan, for your statement.

I would now call the first panel to discuss welfare reform. We are, indeed, very pleased to have on this panel Arnold Tompkins, who is director of the Ohio Department of Human Services; Charles Hobbs, who is Senior Fellow at the American Institute for Full Employment; and David Ellwood, Professor of Public Policy at the John F. Kennedy School of Government.

Gentlemen, please come forward. Gentlemen, it is, indeed, a pleasure to have each and every one of you here. We would ask that you summarize your testimony and limit your statements to 5 minutes each, then members will have 5 minutes for questions.

Professor Ellwood, shall we start from the left and work to the right?

Professor ELLWOOD. I refuse to comment.

STATEMENT OF HON. DAVID T. ELLWOOD, ACADEMIC DEAN AND MALCOLM WIENER PROFESSOR OF PUBLIC POLICY, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY, CAMBRIDGE, MA

Professor ELLWOOD. Thank you, Mr. Chairman. It is a pleasure to be here. I have enjoyed working with this committee over the years.

Welfare reform has got to be, first, foremost, about work. About work because we believe in work as a value, but also work because I think it is the best way to reduce poverty among children and to help our families. Ultimately, welfare reform has got to both increase work and reduce poverty among our children.

If we believe that, then it seems to me that we have got to do two things. We have got to make sure that we help working families, and we have got to make sure that States continue the partnership and do their fair share.

If we do not do those two things, I think the danger of a race to the bottom of the unintended consequences of this kind of bill are very great. This is not about flexibility, though I think flexibility is very important and valuable. This is really about how we encourage the system to fundamentally change and orient itself toward work?

Let me start with this first proposition: if you believe in work you have got to help working families. One of the things that I like very much in the work done so far is your expanding support for child care. That is absolutely vital, because if you are going to ask people with children—many of them young children—to go to work, they are going to leave child care.

But that leaves me perplexed about some other features, other things under discussion by this committee. For example, cutting the Earned Income Tax Credit is, very simply, cutting the pay of working families. There is no other way to think about it, it seems to me.

I cannot understand why you would eliminate transitional medicaid assistance. What you are saying to people when they go to work is, by going to work we no longer guarantee you some medical coverage and therefore you are putting your children at risk. Is that the message we want to send to people that go to work?

Finally, I think it is very important to realize what you are asking of States and what they can and cannot do. One way to think about this is to add together the AFDC public assistance block grant, the child care money, and all the work and training money, and divide by the number of poor children in the State. Ask, how much money is there? In some of the higher benefit States, the block grant is perhaps $40 or $50 per poor child per week; not a lot, but at least a starting point.

But in some of the lower benefit States, especially in the South, you are talking about $12 to $15 per poor child per week for child care, for training, and for public assistance. Now, there is just not very much you are going to be able to do with that. States cannot do the impossible, but they can do the possible. So you very much have to worry, are you putting States in a position where ultimately they will not be able to achieve the goal of work

That brings me to the second point. As this committee knows well, welfare money is shared—the cost of welfare is shared—between the Federal Government and the State governments. The Federal Government has been picking up about 55 percent, but in some States it is as high as 80 percent.

I, therefore, am very perplexed as to why any savings should not be shared between these parties as well. It is very easy to reduce welfare expenditures. One way to do it is simply to cut benefits, another way to do it is cut people off.

A much harder way to do it is to get people into work, because oftentimes you are going to have to spend money up front. Well, all of those reasons can lead to reductions in cost. Why shouldn't those things be shared between the States and the Federal Government given that we have such a tight budgetary situation?

The danger, unfortunately, in the current bill is that States will cut benefits in whatever they would like—until they reach their maintenance of effort—because all the savings go to the State, even if 80 percent of the money came from the Federal Government.

Worse from that, States have the ability to move money around between block grants. So you can take money out of, say, the cash assistance block grant and put it into something like social services where the State has been paying a large amount of money on its own, and so you can displace it.

States can take more money out of the block grant from the Federal Government than they pay in themselves in some States. So the real danger here is that States will take money out of the system, and they have a very strong incentive to do so.

Now, no State wants to hurt poor children, of course. But if you are put into a situation where (a) the State does not have the resources to realistically put people to work, (b) every dollar they cut they save all that money, even though 80 percent of the money came from the Federal Government, you have got a real danger that some States will say, you know, it is a lot easier to cut people off or move people to the State border than it is to move people from welfare to work.

All it takes is a recession or some other problem, and at least a few States will cut its benefits. Then a neighboring State fearing immigration implements similar cuts, and quickly you can get a race to the bottom. I think it is a very real danger. And this problem is easy to solve without spending any money.

Instead of having a maintenance of effort rule, which is impossible to enforce and arbitrary in many ways, go back to a match system. You can keep block grants; I am not a fan, but you can keep them. Just use the match. Make every State dollar matched with Federal dollars up to this cap.

Quickly, two other points. I also do not understand in this structure why you have the 5-year absolute time limit for families on

welfare. We have given States all of this flexibility, we just heard why States should be trusted, and so forth.

Why is this one imposed by the Federal Government? We know from everything we have seen that this will increase poverty among children. It will happen. It is a very serious problem. If you believe in giving States flexibility, you ought to give them that flexibility.

A final point, very quickly. This is not in your area of jurisdiction, but I think one of the most dangerous aspects of the stuff I have seen is block granting food stamps. It is the one national safety net designed to make sure no child goes hungry.

In the long run, over recessions and everything else, if you start down that road—which is currently a 100 percent federally funded program—the danger of hunger among our children is very real and the long-term consequences of that is quite serious.

Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement of Professor Ellwood appears in the appendix.]

The CHAIRMAN. Mr. Hobbs.

STATEMENT OF CHARLES D. HOBBS, SENIOR FELLOW, AMERICAN INSTITUTE FOR FULL EMPLOYMENT, WASHINGTON, DC

Mr. HOBBS. Thank you, Mr. Chairman and members of the committee. I feel privileged to be able to come and testify before you today, so thank you very much.

I would like to start, Senator Moynihan, by saying that this business about the States being able to shut off their program reminds me, when I was younger I was in a debate with a Jesuit priest. What I found was, as soon as I admitted there was a God, I was headed right for the Roman Catholic Church. I think that is what happens to the States.

Senator MOYNIHAN. Did you make it? [Laughter.]

Mr. HOBBS. No, sir. I stopped at the Episcopal Church and then went backwards from there.

The States really have not been, in my opinion, able to stop welfare programs because of the fantastic pressure that the Federal Government puts on them to do that, and all of the money that they throw at it.

Over the years, that money has continued to grow. For instance, some of the Southern States and Western States are drawing as much as 80 percent Federal share. It is awfully hard to turn that down when you are in a relatively poor State.

I am here today to speak in support of S. 1795. I have to start by saying it is an enormous and very complex bill. In fact, I have been traveling lately and I was not able to take it all along to read because my doctor put a weight restriction on what I can carry. I think it is something like 1,300 pages.

We are always worried about the devil in the details, and there are a lot of details in this bill. I am not here to say that every one of them is correct and is going to work, but there are two principles in S. 1795 that I think are absolutely essential to the continuing reform of welfare, which I feel is already being reformed significantly by the States.

One of those principles is the State control of spending, and of the determination of how their programs are going to look and operate. The second, is the principle that work replaces welfare.

I am going to talk more about the second than the first, but I have been working with a lot of the States. We formed the American Institute for Full Employment about a year ago to help States design a full-employment program as a part of their welfare reform efforts.

Page 3 of my written testimony shows you what States have already enacted into law, and gotten waivers and are now operating. There are four or five other States that are currently in the process of developing a full employment program.

I am going to talk today about Oregon and Mississippi. The full employment concept is one that immediately attaches public assistance recipients to the work force either at the point of entry into the system with eligibility determination or redetermination, which takes place in AFDC every 6 months.

At that point, a person entering the system will go directly from the eligibility worker, even before they have filled out all the forms, to a job placement specialist either from the employment service in that State or from the private sector. So, we try to get them into jobs and into work as quickly as possible. In this case, work comes first.

The other attributes that have to go into this program, and they are essential, the training, education, counseling, and so forth, take place once the person has been either put in a job, or, absent being able to be put on a job, into a work experience program.

The temporary subsidized training-oriented jobs are the heart of the program. My own estimate is that probably 60 percent of current AFDC recipients can be placed in or find their own unsubsidized job, and that has been borne out by our statistics from these programs.

But there is a group of 20–30 percent who are going to need some transition. We cannot just set them out on the street and say, go get your own job. It does not work that way. They have been on welfare too long, and the dependency that has been built in by the welfare system keeps them really from being viable workers at that point.

So what we do is put them into a subsidized for a 4-, 6-, or 9-month period in which the employer will train them to do the work, provide a mentor from their permanent employee staff to help them get into the work force, and we back them up with all of the support services that we think they need.

Medicaid, for instance, continues during this subsidized job, child care is guaranteed, transportation also, and then once they get into an unsubsidized job they fall into the Jobs Program with a year of transitional benefits.

So far, this seems to be working. The heart of this program is a ladder of opportunity. Every move made by a participant in this program up that ladder guarantees more spendable income than they had before, going from pure welfare in any State to a subsidized minimum wage job with the ITC, will bring them up significantly. In a State like Mississippi, for instance, $250–300 a month is a typical increase in spendable income.

The next step is unsubsidized employment, where they get another raise even if the unsubsidized job is at minimum wage. That job, by the way, at minimum wage will put them above the poverty level in the current setting if they are a typical family. That ladder of opportunity is absolutely essential.

Just let me say some things about two of the States, Oregon and Mississippi, the first two that have shown dramatic results. Test counties in Mississippi, for instance, are showing a decline in AFDC population seven times what the rest of the State is.

In Oregon, they are having an 80 percent success rate in placing people from subsidized jobs into unsubsidized jobs. So the program is working at both ends, getting people to work and getting them into a dependence-free unsubsidized employment market.

I will end with that. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Hobbs appears in the appendix.]

The CHAIRMAN. Mr. Tompkins.

STATEMENT OF ARNOLD R. TOMPKINS, DIRECTOR, OHIO DEPARTMENT OF HUMAN SERVICES, COLUMBUS, OH

Mr. TOMPKINS. Mr. Chairman, members of the committee, it is with great pleasure that I come here to speak to you today and it is an honor to do so.

Three and a half years ago I left Washington, DC, being here most of my life, as well as working at the Department of Health and Human Services for the previous 8 years. During that time, in that capacity I was Assistant Secretary for Management and Budget and served other many capacities while here in Washington at that agency.

During that period of time, State and local officials came to Washington and asked us for waivers. At that time we looked at them very skeptically and I looked at them pretty skeptically myself.

We were concerned, by and large, with what the financial hit will be to the Federal Government if we gave them these waivers. We looked at issues where they are going to get away from maintaining the programs that we thought were so vital, and all sorts of other instances, basically, where they are going to cheat the Federal Government.

As I have gone to the State I have kind of had a new experience going to States, and I think it might be a good idea for a lot of our Federal bureaucracy to maybe spend time with States and local governments to better understand the differences in what people have to do and the trials and tribulations they have to face every day.

As I came to Washington, I was told by State and local officials that I did not know what I was talking about. I went to the State, and the county and local officials told me I did not know what I was talking about. So maybe one day I will get it straight when I go to the very local, bottom of the chain, of government.

In order to meet the needs of low-income individuals, I agree with Mr. Hobbs and Mr. Ellwood. We must provide them with services and assist them in finding productive jobs in becoming self-sufficient. Being self-sufficient is not just making them come to de-

partment level, we are getting them to have jobs that will provide them income that will make them not have to be dependent on the system one way or the other.

Today we spend in our categorical programs, and we estimate in our State, about 85 percent of our time figuring out where people can go, the types of programs that they are in, and going through all of the arduous paper work, and what have you, and spending about 15 percent of our time finding productive employment and working with them to provide job training, educational benefits, and what have you.

We would like to flip that. We are now, in Ohio, turning it around to spending 85 percent of our time for looking for productive employment, for looking at those issues that will help people become self-sufficient, and only spending 15 percent of our time doing it.

It is very difficult today to do that with all of the categorical programs and eligibility requirements, and whatever, that basically go to the point of trying to figure out whether someone is on the program that should not be on the program. We should spend more of our time trying to figure out how we can assist people to become productive employees.

As has been said, in other States we have seen a system where a lot of things have been happening in the last 2 to 3 years, in particular. Since 1992, the State of Ohio has decreased its welfare recipients by 28 percent. This year alone, we have saved over $200 million in our ADC payments.

On that basis, we are now looking at taking a lot of money we save and plowing it back into the program, not only looking to save money in order to have a better budget balance, but also putting it back in the program.

I have to disagree a little bit with those that say that States cannot be trusted, that they would take this money and put it toward other things. We would like to have the flexibility to take it and put it in other parts of the program that need funds, and, categorically, it is very difficult to do that. You can only do the State portion of the funds, not the Federal portion.

I had a county director tell me one day, in budgeting for these things, like if you had a family budget and you had the money you had for maintenance of your house, you had money going toward payments for a new room in your house, and then you had vacation money.

He said, 1 day you wake up and you find, I have got an overload of vacation money, but I cannot spend it for maintenance. My water heater goes out, so therefore I cannot use water. I will have no hot water, but I will be able to go on vacation.

So it is a similar thing that we are running from in the State and we need to be able to transfer money as the need arises.

In Ohio, we are developing a system that goes toward employment and goes to employment first. On top of getting people employed, we are getting them close. Some of the issues that come up in the block grant are that we are not going to cut people off, we are going to do a lot of evil things to folks.

Well, the point in fact is, I think by going through the process we have in the last couple of years we are getting better to people,

we are getting more closely to families. We are interacting more than we have in the past, and in the future. I think it will be more where designed programs individually fit, not as a collective group that we think will fit everybody's needs, which they usually do not.

The other major point I would like to say at the end of this, is there is a big economic issue here that is more than just the welfare issue. The economic issue is very prevalent in Ohio right now. We have a labor shortage. We have more and more companies coming to our department than ever before saying to us, look, we need employees. We look at the high schools, and 2-year colleges, and college, and we do not see enough potential employees coming out of that.

So, we are working with the School-to-Work program. Our welfare reform is trying to blend our employment services programs with our welfare programs to do a universal approach to finding jobs for folks across the State and providing more and more workers for our employers.

So, with that, I think it is not just an issue of moving people out of welfare, it is an issue of also looking at low-income people to make sure that they have enough funds in order to be viably secure and safe.

Thank you very much.

The CHAIRMAN. Thank you, Mr. Tompkins.

[The prepared statement of Mr. Tompkins appears in the appendix.]

The CHAIRMAN. As I said earlier, we will limit questions to 5 minutes per person.

There has been a lot of discussion, of course, about the Wisconsin Works program. I would like to ask the panel, should the Wisconsin Works waiver be approved, and if your answer is no, why not? Mr. Ellwood?

Professor ELLWOOD. Well, I have not seen all the details of the plan. I think the broad outline seemed very appealing. It is focused on work, it is designed to provide child care, and so forth.

However, Senator Moynihan mentioned a number of things that I would find worrisome. There is talk about child care, and yet no guarantee of child care if people are expected to work. There is no guarantee that people will not displace other workers, and there are concerns—constitutional concerns, as I understand it—about whether new residents in the State are treated differently, or whatever.

So the devil is in the details, as Mr. Hobbs has discussed. So, unfortunately, I think there are some issues, but I think the broad outlines have many appealing features in it.

The CHAIRMAN. Mr. Hobbs.

Mr. HOBBS. Mr. Chairman, when I was in the White House I helped get approvals for Tommy Thompson's first set of waivers for Learnfare. Since then, he has made fantastic progress in Wisconsin.

I have read all the details of the waiver package and I firmly believe it should be granted, and granted quickly. Wisconsin is a fairly substantial State, and it will take time to implement this program.

I think we are looking probably at a year or more before it actually gets into full operation, but it seems to me that, of the sorts of things that are being done around the country in the various States, Wisconsin has put into one package that is, I think, a coherent package in which we can begin to see what legitimate management structure should be used and the role of private sector, particularly in a State program.

Let me make one comment about child care. I have analyzed Wisconsin's child care laws and regulations and I think they are greatly overstated. Let me give you just one example. It says in one of the regulations that no child care facility can be within 500 feet of any building that houses farm animals.

So what we are saying here is that if somebody gets off a school bus and goes into a farmhouse and there is a chicken coop 450 yards away, they cannot be licensed as a child care facility. Those sorts of regulations redound around the States, particularly the Eastern and Midwestern States, and I think are a tremendous deterrent to a logical, safe, and good child care system.

So I think that is an issue that has to keep being addressed, but it should not be addressed, I believe, on the basis that we are doing too little in the child care area. Instead, we should be looking at how much in addition to that we are doing through these laws and regulations and what kind of barrier we are putting to reasonable child care because a bunch of people in the child care industry wanted to keep the competition out.

The CHAIRMAN. Thank you.

Mr. Tompkins.

Mr. TOMPKINS. I agree as well that the proposal should be approved. Basically, when we look at the conceptual framework of the Wisconsin program they are actually coming forth with a proposal that is based upon real-time experience, experience and several waivers that they have had in several of their counties, and what have you. It is based on things that they have already done, and want to go further.

One of the things that is very appealing that we are also looking at that they have actually gone forward with is waivers to look at, how do you meld your employment services issues with your welfare issues to be able to design a program that fits the individual on a basis of how to get them to be self-sufficient?

Maybe it is not the guarantees in the normal way we talk about guarantees, but when I have gone to Wisconsin and looked at some of their programs they basically are working and if you look at the program, there is going to be a lot of money in this program and a lot of child care.

I think one of the problems that they had, as I remember, was that when they were delivering this in their State legislature, was that it was going to cost a great deal of child care money to do this.

So I think the aim and the conceptual framework of what they are trying to do, it may not be the guarantees that Washington is used to, but basically they are going to provide a lot of services to people across the spectrum, low-income people as well. I think that is why a lot of us would like to get rid of eligibility. We would probably even go further than eligibility requires us to today.

The CHAIRMAN. Mr. Hobbs, you stated in your prepared testimony that medicaid and child care are guaranteed to welfare families participating in the program, and for at least a year after they move from subsidized to unsubsidized employment.

Based on your experience, would a substantial percentage of welfare families leave cash assistance if they are guaranteed health insurance and child care?

Mr. HOBBS. Absolutely. Our program has not yet had any serious challenge from people who are participating in the program about its fairness. In fact, in Oregon, which was the first State to start this program, welfare recipients who are progressing through the subsidized work have come forward to offer to testify, if anybody should file suit to try to stop the program, on the basis of its advantages to them.

There is no question in my mind that medicaid is an essential increment that has to go through the transitional period, and that not enough attention has been paid to that transition.

It is also clear that if the income levels of minimum wage, even with EITC added to it, and even though that is considerably more than the welfare provides, the child care must be available at no or low cost. My own preference is to have a small co-payment system for child care that increases with the salary and time that passes for somebody.

Professor ELLWOOD. Mr. Chairman, may I comment on that, just very briefly?

The CHAIRMAN. Yes. I have one more question. Please be brief.

Professor ELLWOOD. This is one area where I think the panel completely agrees. You have got to do things to support working folks. I think one of the concerns that people may not realize, is that this bill actually does a lot of things to make medicaid less available to working families. The guarantee of 1-year transitional aid which you referred to is no longer in this bill; it becomes a State option.

There are various other ways in which medicaid can be cut for families. I think that is going in precisely the wrong direction if you are trying to encourage people to work.

The CHAIRMAN. Mr. Tompkins, you state that the net result of the Federal disapproval of part of the Ohio waiver is that, "recipients who do not want to become self-sufficient do not have to, and the responsibility to find employment is shifted from the individual to that State."

Now, why are these distinctions about personal responsibility so important in welfare reform, and why are time limits so important to welfare reform?

Mr. TOMPKINS. Basically, we feel as though the guarantees, the entitlement nature of things, foster—I guess I had a comment by another one of my directors, who said we are institutionalizing welfare. We are making people feel as though they are in institutions, in a way.

Some people in our system have, by the mere fact that the economy is pumped up, left the rolls. I guess maybe more than half of our folks have done that. The other half are wavering between whether I can do it or whether I cannot do it.

The issue is, we provide a lot of services to folks, and we are even talking about providing more services. But people have to sometimes, I think, realize that that is not unending, it has to stop somewhere and they have to take some responsibility with this.

We have now set up a contract basis between the individual and the department, saying we will provide certain things and you must do certain things to get to that end.

So personal responsibility, instead of always that the State needs to do this, the Federal Government needs to do this, the local government needs to do this, there is a part there that the individual recipient needs to do something here too, and to get them back up on their feet.

Also, we are working extensively with our nonprofit and our profit agencies to work with us, that are in the neighborhoods and what have you. I remember working with Mr. Hobbs on neighborhood enterprises and certain things of that nature that have to be brought in this program when you are looking at time limits and other things.

Basically, we see that time limits is a thing there, but basically we do not feel as though, after a period of time of providing all these services—in our State, when we look at time limits, we say 15 percent right off the bat would not have to adhere to them if there are some problems that they cannot be employed.

Then as well, we have a good cause part of that, so those that cannot find jobs because of inability to do them, or what have you, would not have to worry about the time limits, but those that can and just need a little incentive to do here, we think we need to do that.

So it is basically a perception, a symbolic thing of seeing how to position ourselves that it is not just always government, but it that the person has some responsibility as well.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Thank you, Mr. Chairman. Thank you for that question that got the Wisconsin waiver up, and the very intelligent responses.

Just one point on work. If it was not for a somewhat poisonous political atmosphere in Washington in 1935, the AFDC program would be run from the Department of Labor. It was intended that the whole Social Security program should be in the Department of Labor. At that time, the one immediate effect was unemployment insurance.

But Frances Perkins knew that there would not be people down here on this committee, and so forth, who would think much of that—the Labor Department was suspect—so she created the Federal Security Agency and typically Frances Perkins said it would look best for the President if I do not get this under our empire.

I guess I would also like to say, Mr. Hobbs, you know, the public never says its thanks very well. We would not have the Family Support Act today without you. You were absolutely stalwart in the Reagan Administration.

I would like to say, Mr. Tompkins, that you and Governor Voinovich would not have the Ohio First Program without the Family Support Act; right, sir?

Mr. TOMPKINS. That is correct.

Senator MOYNIHAN. Yes. You are working under existing legislation, working energetically and effectively. I am pleased to hear that. The Midwestern unemployment rates are staggering. Governor Thompson has said, in the State capitol, Madison, the unemployment rate is 1.5 percent.

As an old Labor Department type, I can tell you, you cannot have an unemployment rate of 1.5 percent. That is just, people leave jobs and they are unemployed temporarily because they desired to leave their work and go into another job.

But we also have this awful problem which has come upon us, unexplained, difficult to deal with, and that is the problem of out-of-wedlock births. All of our talk about welfare is simply in response to this social change.

In Ohio, sir, 33 percent of all children born in 1993 were, as you were observed, out-of-wedlock; 66 percent in Cleveland. That is not unusual. Parts of New York would be the same ratio.

We do not have experience with this. Dealing with it is not dealing with unemployment. You are not just dealing with a problem of, how do you find work? If only the automobile companies would start hiring.

That is right. There are those of us who just simply want to be careful about what we do. We want to see Ohio go forward and Ohio First work, and Wisconsin work, and so forth. Therefore, to Mr. Ellwood, who is the source of much of our enlightenment in this field and some of our problems with the idea of time limits, time limits as you have described them with just sort of a drop-deadline, in the course of the debate on H.R. 4 we obtained from the Department of Health and Human Services an estimate that the H.R. 4 was a combination of things, and would put a 1.5 million additional children in poverty, and the ones who are already below the line would be more deeply so. That changed the atmosphere on our side, anyway, and the President finally vetoed that bill.

Would you estimate the effect of this bill, with its 5-year time limit, and so forth?

Professor ELLWOOD. Senator, I did not do those estimates, so I cannot give you a definitive answer. I hope that you will get one, because I think it is very important, before voting on this bill, to have such numbers.

But just, based on looking at the changes between H.R. 4 and this new bill, I cannot see how more than 100,000 or 200,000 folks would be affected. So it is certainly 1.2–1.5 million kids still, using that methodology. I see more kids in poverty. It is a combination of lots of different factors, but, again, I would say it is a comparable number. It has not been changed very much.

Senator MOYNIHAN. Thank you. That is our problem. I just wish we would all show the humility that is in order in the face of this baffling social change we are dealing with. We are not alone. The Canadians, British, and the French are having the same problems. It is sort of post-industrial. I do not know.

But, when you have a city like yours, in Cleveland, or Detroit, or mine, and Chicago, and such, there is something wrong. This is new. We are trying to make our way carefully. I thought we had

done so in 1988, and we ought to continue to do so. Perhaps I was wrong; I admit very little knowledge.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Chafee.

Senator CHAFEE. Thank you very much, Mr. Chairman.

I would like to ask the panel here about the comment that Mr. Tompkins made, which I certainly agree with, on which he says on page 3 that, "Ohio has a labor market that could absorb a significant number." So it seems to me the key thing is to have the jobs available. If the jobs are not there, then how can people go to work?

I am not trying to stir up the minimum wage debate here, but I am of a belief that there ought to be something in the minimum wage—when and if we increase it—that provides some incentive for an employer to take a chance on a welfare recipient, male or female, to come to work.

Is there anything to that, whether it can be a training differential, and not limited to just people 19 or under? What do you say to that, Mr. Tompkins? Of course, you are from a State where you do not have to worry about that right now because you have the jobs.

Mr. TOMPKINS. We have the jobs, but the issue, Senator, is that a lot need to get the training and what have you. One of the biggest issues that are facing us is that we do not have enough trained people to sufficiently fill those jobs. We have several companies saying that they will have to decrease their production because of that.

But the subsidized issue here, I think, is a good one. We have a program we call Communities of Opportunity that we put in a year ago that basically does that using welfare payments. If a person is making $8 an hour, for instance, if the job was $8, we calculate that our welfare payments and other payments added up to about $3.50 to $4.00.

So for a year, year and a half, we will gradually change that, but over a year we will subsidize 50 percent of that job so they will take a chance on that person while they are being trained, and what have you.

So I think it is a great idea, and we have had——

Senator CHAFEE. I want to know, what is the great idea?

Mr. TOMPKINS. The great idea is the subsidizing to assist. If you could have the thing in the minimum wage where you could get some subsidization for people up to a certain amount to do that, I think would be a good thing.

Senator CHAFEE. Well, the subsidization, I presume, would come in the differential.

Mr. TOMPKINS. Exactly.

Senator CHAFEE. In other words, you cannot expect the employer to subsidize with cash. Maybe this idea makes no sense, but it just seems to me that I come from a State that does not have, regrettably, jobs available at the plastics company you were referring to, Mr. Tompkins, or whatever. We have been consistently running high unemployment.

Now, currently we are down below the national average, but that is a bit unusual for us. So you can say to everybody, you have got to be off the welfare rolls within 2 years, but where do they go? So I think there is something to this idea, but maybe I am all wet. What do you say, Mr. Ellwood?

Professor ELLWOOD. Senator, first of all, the point is absolutely right, people have got to have someplace to go. I applaud the goal of trying to find jobs, and lowering minimum wage is certainly one strategy. The problem with that strategy, of course, is you also have to remember these are families trying to raise kids. You are asking them to go from welfare to work, and then they are going to have to support their families. If they are getting paid less, that may help the employer, but it does not help the individual.

Senator CHAFEE. Paid less than what, on welfare?

Professor ELLWOOD. If you have a sub-minimum wage. In other words, for these folks, the whole point is to make sure, if you work, you are not poor. There is an alternative, and both of your other witnesses have talked about it, which is to subsidize the jobs. Take the money that used to be a welfare check and use that to create subsidized employment. That way the——

Senator CHAFEE. I do not quite get this. How do you subsidize the employment? Let us say the minimum wage is $5. Just take that, for example.

Professor ELLWOOD. Yes.

Senator CHAFEE. Now, if he hires this person, under the current law we have to pay him $5. But the employer says, this person does not have the skills, does not have the experience, does not have the drive, really, or the training, a high school drop-out. I will take him at $4.50, but I would not at $5. Now, where does the subsidy come in; is the subsidy to the employer or the employee?

Professor ELLWOOD. The employer.

Mr. TOMPKINS. The subsidy would be to the employer. We would like it go to the employer because it seems like a check to the person. So, in other words, we would take maybe that 50 cents which we would have paid them if they were on welfare, which is much less than what they would have gotten on welfare, so that they are still getting the $5, but basically we are assisting and would wean them off of that, saying that after a year or so or whatever, that that person now would be productive.

Senator CHAFEE. But what is in it for the employer?

Mr. TOMPKINS. Because now they would pay the $4.50 while this person is not as productive as they could be, but in a year or so they would be.

Senator CHAFEE. I guess I am mixed up. The 50 cents goes to the employer.

Mr. TOMPKINS. Right. Right. Correct.

Senator CHAFEE. All right.

Let me just ask you one other thing. Is there any suggestion that when somebody is on welfare and they go to work, he or she goes to work, you all recommend that the medicaid be continued, that child care be continued. I can understand all that.

What do you say about the person who is not on welfare who is doing all of these same things without the medicaid, without the child care. Is there any suggestion that that person might say, let

me go to welfare and come back, and then I will be much better off with all of this?

Mr. TOMPKINS I think, if I could, that some of the things that people do not like about the medicaid block grant, there may be some issues there as well, but I think the big issue is that we are looking at and we are pursuing to going to 100 percent of poverty, and we may even go further in providing and de-linking welfare from health care, which I think has to happen.

So basically it gets at your point, if people at certain income levels, because of whatever—and it gets really to the health insurance issue across the country, it is not just the welfare issue. So I think we have to begin, and our State is looking at some way to de-link, if we could have some flexibility maybe——

Senator CHAFEE. In other words, that low-income person who had never been on welfare would be entitled to the medicaid.

Mr. TOMPKINS. Yes. Now, maybe we could not give them the whole medicaid benefit, and that is what we would like to have some flexibility to do.

Professor ELLWOOD. The first test is, if you are working you should not have to worry about this. That is just clearly where you have got to be.

Senator CHAFEE. Yes. But that is not the situation.

Professor ELLWOOD. Well, the problem, therefore, is what do you do about someone who is on welfare, they get medicaid—that is still in the law—and they go off? I think, for the short term, you say, look, we are going to give you some transitional medicaid. I think that is better than simply——

Senator MOYNIHAN. We do now.

Professor ELLWOOD. We do now. It was in the Family Support Act, passed 96 to one. I think that is far better than saying, when you leave welfare you may lose that entirely and immediately.

Senator CHAFEE. All right. Thank you, Mr. Chairman.

Senator MOYNIHAN. Could I say to my friend, Senator Chafee, what he is talking about is the original marriage penalty.

The CHAIRMAN. Senator Graham.

Senator GRAHAM. Thank you, Mr. Chairman. I want to thank the members of the panel for a very constructive and illuminating discussion. I would like to move into a couple of different areas. As I arrived, Mr. Ellwood was discussing how this welfare reform initiative was going to be financed.

A significant amount of the way in which it is going to be financed is by reducing the current benefits for legal aliens in this country. This bill, for instance, calls for a total ban, retroactively applied, on SSI and food stamps for most legal aliens, as an example. It has been calculated the total estimated savings from legal aliens in this bill over the next 7 years are in excess of $20 billion.

My question is, what do you anticipate—and I would ask this question of all three of you—will be the impact on those communities with large numbers of legal aliens, such as the community representing by our Ranking Member, and Senator D'Amato, as well as my own State, of that scale of a reduction of social service benefits for legal aliens?

Professor ELLWOOD. You obviously come from a State where I think you know the answer to that, there will be some very signifi-

cant problems. I think it is perfectly reasonable to expect sponsors, for example, to take more responsibility.

I think we have been not as vigilant as we might be on that score, but there are situations where sponsors become poor themselves, where people have been here for a very long period of time, contributed, become poor, and so forth.

I think this bill just goes way too far. Remember we are talking about legal immigrants, people who are here legally. I think sponsors ought to have responsibilities, but if the sponsors become unable to take care of the person or they have been here a long time and contributed, I do not see why they should not be eligible for some of the same benefits that citizens are.

I think the danger is, in certain communities, you are just going to have a really devastating reaction, especially as it just happens instantaneously and retroactively. You are changing the rules in the middle of the game.

Mr. HOBBS. Senator, I feel as Mr. Ellwood does, but with some reservations. That is, in my opinion, I guess I have reached the point after all these years where I consider most of the estimates made in Washington, DC, by either party, or by administration or Congress to be preposterous.

If the legal alien issue was put into the bill because it was supposed to be a cost saver, I think it is totally unnecessary because what is happening around the country is, with the decline in the AFDC population and that spreading out as a wave through the whole public assistance arena, I think that the estimates way back here which are generally static estimates based on past experience, because that is all anybody can use to project here without any imagination, I think that we are going to find that he cost problem is solved very, very quickly, that is within 2 to 3 years after the States are free to put in strong work programs, and after they associate themselves with the private sector in a public/private partnership whereby we can use the techniques and the people who have maintained our private employment services over the years. As we have seen in Oregon and Mississippi, we find declines in case load that are very significant.

We also find, since both of those States have had declining AFDC case loads for 3 years, that we are not at the point of creaming people who are automatically qualified for jobs and, therefore, we have an easy time placing them, we are down to the hard-core cases, 10, 15 years on AFDC, and still we are finding that the jobs are there, that is, the employers come forward with the jobs.

In the first 3 weeks of the program in Oregon, 1,700 employers volunteered to get into this program, to use subsidized labor going to unsubsidized. And not only the employers, but the people have much more capability who are on AFDC and other public assistance programs than we have ever given them credit for. We have sold out those people on the basis that they cannot work because there is something wrong with them, either from childhood, or inherited, it does not really make any difference. But it is not true. It is not true.

The people that are coming into this program now who have been on welfare a long time, as soon as they find themselves a job, the counselor says, all right, you are going to go out and interview on

this job. You watch them come in, angry, with their kids because they were going to be made to work, and you watch them go out with a tremendous self-confidence boost that was never there before through the welfare system.

Senator GRAHAM. So your answer is, it is unnecessary because there is going to be enough saving within the welfare system itself to achieve these financial objectives.

Mr. HOBBS. Well, I do not know how you do that in the current Washington, DC environment. Everybody goes on the numbers that are generated, whether they are generated up here on the Hill or down at OMB. As I said, there is really very little thinking about what the impact is going to be of this program.

In fact, I would say that it is going to be greater than even the numbers we can tell you right now, because we are operating under waivers. We are not operating under the law, we are operating under waivers, which are temporary in nature and which are difficult to get up here, even now.

The eight States that are doing the Full Employment Program, they averaged more than 9 months to get their waivers from this administration. I do not think that that is unusual; it certainly was not unusual in previous ones.

Senator GRAHAM. Excuse me, Mr. Hobbs. But I wanted to get back to the question of legal aliens, and Mr. Tompkins' assessment of what it would mean in Ohio.

Mr. TOMPKINS. I think that there is a problem there. I do not know, in the wisdom of the people who put this bill together, what they were thinking on some of these things. But, basically—and I agree with most of it—our State does not have as big a problem as your State does in that area.

We view it, and the Governor viewed it, as being something that we could use the savings from what we had to continue to support the people on that basis. We even put more money in some of our illegal aliens programs, as it is now. I think it has to be a combination of some sponsors, a combination of other things.

But the big issue here, if we had the flexibility, if your State had the flexibility, of looking at things and not such categorical programs, that a lot of things, you could put these folks in a lot of the job training programs and other things that would ameliorate some of the costs that you are paying now.

So the flexibility to transfer things from things, and working with people holistically. I think we are getting into fighting over illegal aliens, refugees, and people with yellow hair, and green hair, and everything. We just keep doing that. We have 52 ways of being on medicaid. So you keep going on, and on, and on like that, you spend most of your money and your time doing that.

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Thank you, Mr. Chairman. I want to thank this panel as well. I would say to the Chairman, I think this is really an excellent panel that you have brought before us today. It has certainly been useful in my own thinking.

I would like to go to Mr. Ellwood. In your testimony, you point out under one of your principal points, "States must be expected to do their fair share," that is your headline for a part of your presentation, and you make the point that, under this bill, States would

be able to shift Federal dollars for State dollars, and instead of State dollars being a supplement to Federal dollars, that they would actually be replaced by Federal dollars.

This is something I find very, very troubling. It is as though some people have not gotten the message that we have a budget deficit here at the Federal level. Some people have not gotten the message that the debt of the United States has gone up fivefold since 1980.

We are about the business of passing legislation that would allow States to reduce their own level of responsibility and just tap into the Federal Treasury and get Federal dollars to replace their own. That is not my idea of medicaid reform. That is not my idea of welfare reform. That is not my idea of a fiscal plan for the United States.

I have got a chart to try to put this in perspective, because I find this one of the most troubling parts of this whole proposal. We are spending, I am told, at the State and Federal level, over the period of time covered by this legislation, about $190 billion for income support and work. $190 billion.

As I understand this proposal, States would be allowed to go to a 75 percent maintenance of effort. In other words, they would be able to reduce by 25 percent what they are doing now.

Over the period of time, that would mean a $32 billion loss in terms of what States are doing. In addition, they are allowed certain transferability. They would be able to use these Federal dollars and replace State dollars in areas where States have typically taken virtually all of the responsibility. That would mean a potential loss due to transferability of $28 billion.

Now, that is $60 billion of potential withdrawal of State money, replaced by Federal money or not replaced at all. They reduce what they do and get tapped into the Federal Treasury. The $190 billion that I referenced earlier is the total State and Federal expenditure during this period, up to 2002.

So a third of the money that is currently being spent could be just eliminated by State governments reducing what they are doing. Is that an accurate assessment?

Professor ELLWOOD. I think it is. I would also point out, there is an easy way to solve this problem that does not cost any money to the Federal Government. This is a partnership.

When we talk about giving States more flexibility and so forth, that is fine. All right. I am a believer in State flexibility. I have done much more work with States over the years than the Federal Government, even though I served here for a couple of years.

But let us not at the same time create incentives for States to withdraw money. Right now, if you spend an extra dollar you get a matched dollar; if you spend a dollar less, you get a matched dollar. Under this provision, if you spend a dollar less you keep it, even if that dollar originally was given to you by the Federal Government.

It seems to me, if this is a partnership in terms of financing, it ought to be a partnership in terms of savings. If States decide to spend less, fine. Then the Federal Government ought to get less, and the States get less. That has two effects. One, is it encourages States to do it, and second of all, it helps prevent the incentives

for a race to the bottom. I am not saying every State would withdraw its money. Many would not; some will try and spend more.

But the point is, in changing the way you financed it from a match to a maintenance of effort rule you have inadvertently given States a strong incentive to cut back and that will tend to push toward race to the bottom. Again, it has nothing to do with State flexibility, it has to do with financing.

Senator CONRAD. I really think we have to do something in this area. As I understand it, the red bar, the $32 billion, would be State dollars that would be lost if States spend at 75 percent of their 1994 levels. Again, this is in relationship to a total pool of money of $190 billion over this 6-year period. So $32 billion could be taken out by States going to 75 percent maintenance of effort.

On the transferability, that would be a case—correct me if I am wrong—of States simply getting money from the Federal Government to replace their own funding. So that gives you a total of $60 billion that could be withdrawn, some of it just a reduction in expenditure in these programs, another part of it a substitution effect, Federal dollars being received instead of State dollars. Is that your interpretation?

Professor ELLWOOD. Yes, I think that is correct.

The CHAIRMAN. I would point out to the distinguished Senator that the $28 billion must be spent for other purposes for these same individuals.

Senator CONRAD. Well, I understand that. But this is in situations where the States now take the responsibility—either a majority of the responsibility or the full responsibility—and they are in a situation, under this legislation, that would allow them to replace their effort for Federal effort.

Now, we have seen them engage in these scams before. I tell you, you look at what Michigan did, or our friends in Louisiana did, coming up here and passing provider taxes, then they would get Federal match, and it was just a shell game to replace State dollars with Federal dollars.

Now, I do not think we want to be party to that kind of activity. That is truly turning a block grant into a blank check.

The CHAIRMAN. Mr. Tompkins.

Mr. TOMPKINS. I think what you are looking at, this game is played today, Senator. The way the system is set up now—when I was at HHS, in fact, and was acting in the position Mr. Ellwood was in—basically this goes on all the time.

Now, if one senses there is a block grant of funds and one uses those in there, I daresay that in a lot of instances some States would actually lose money in your scenario. Most States would spend more than 75 percent. Most States would spend more than 100 percent, basic, on that. So saying that $60 billion, $32 billion, is way over-estimated.

Furthermore, the $28 million, most of the funds that we want to transfer are from areas that we already match with the Federal Government, so it is all part of the same pot of money.

All I want to do now is to say, if I have child care money that is partially financed with the Federal money and I have got ADC which is financed with Federal money, I have less ADC recipients,

but if I want to put more money into child care for more low-income people, I would do that. It is still the dollar I put in.

Senator CONRAD. Well, wait just a minute. I have dealt with a lot of negotiations with a lot of folks. Why, if they do not intend to do this, do they insist on the possibility? Look, they can be given the flexibility to transfer these funds without the potential of this kind of hemorrhage.

I, for one, would not think I had discharged my responsibility if I simply create a circumstance in which States are able to put a pipeline right into the Federal Treasury and replace their dollars, their responsibility, with Federal dollars.

And you are right, it has gone on in the past. I cited for this committee in the previous hearing the extraordinary examples, one after another, of States engaging in financial hijinx in order to replace their own dollars with Federal dollars. That ought not to be what we are about.

Mr. TOMPKINS. We need to change the system so that does not happen. The system can only be changed if you do it in a way that—HCFA, for years, had provider taxes. I was there in the middle of that. Basically, at that point in time I said there is no way ever, under any regulations, will you ever deter it, because basically if you do one thing one way, they will find another way to do it. People make their living off of doing this.

If you basically just want it out in a simplistic way, saying what we have to put up, what you will put up, make it very simple, this cannot happen. The transferability issue is basically saying, if I have got a bunch of money that I am putting part in, you are putting part in, I want to be able to transfer within that.

Right now, we have 26 basic categorical programs that we put money into. All we are saying in those 26 programs, if one area I am doing well in, I would like to put some other area that I am already putting money in. I am not gaming you.

Senator CONRAD. But, wait a minute. I can read this legislation. You are right, we ought to change things, but we ought not to change things for the worse and we ought not to construct a situation in which there is a positive incentive for States to replace their own dollars they are currently spending with Federal dollars. That, to me, makes no sense.

Professor ELLWOOD. Senator, I think that is exactly the point. Use a match.

The CHAIRMAN. We have to move on. His time is up.

Senator D'Amato.

Senator D'AMATO. Thank you, Mr. Chairman.

Let me ask the panel, is there some kind of a figure that might reflect what the profile on the average family, AFDC, is in this country? Maybe you have to look at regions; I do not know. But, in other words, is it 2.3 people, 1.3 being children, one being a single parent? What kind of profile is there, if we have one? Professor Ellwood, would you know?

Professor ELLWOOD. I guess the median person is what I would take, probably 1.9 children.

Senator D'AMATO. 1.9 children.

Professor ELLWOOD. So 2.9 household size.

Senator D'AMATO. All right.

Professor ELLWOOD. Probably a high school drop-out, median, although there is a non-trivial number of high school graduates, even some college graduates. About 40 percent are white, non-Hispanic, about 40 percent are African-American, and the remainder are predominantly Hispanic, and then some other groupings. Since the program is designed primarily for single parents, the household head is usually a woman. Roughly half now, the children were born out-of-wedlock, the mother is unmarried.

Senator D'AMATO. 50 percent?

Professor ELLWOOD. Something like that. Senator Moynihan probably has the most current figures. He tracks them carefully.

Senator D'AMATO. Yes.

Professor ELLWOOD. I do not know whether there are other characteristics I can be helpful on than that. I would also emphasize, if you then——

Senator D'AMATO. Is there a time? In other words, what is the average time on AFDC?

Professor ELLWOOD. Yes. The answer is, it is very heterogeneous. There are really kind of three groups. It is roughly a third, a third, a third. There is a short-term group that is on, is off within a couple of years. There is a kind of cycling group, a group that goes on, comes off quickly, but then loses their job or leaves their job, whatever, comes back on, goes off, goes on, goes off. Those are people that often end up staying for a fairly long period of time; 70 percent of folks leave within the first years, but three-fourths of them come back.

Then there is a final group that is very long-term, and that is about a third. There are lots of ways to ask these questions, and so forth. The very long-term group is the most difficult group in all of these settings.

They are the group that, if you go with a 5-year time limit, for example, they are people who have very poor educations, very limited work experience, maybe multi-generational. Those are folks that are going to be in very, very serious trouble if you just simply cut them off and do not put them in a subsidized job, or something of that sort.

Senator D'AMATO. It seems to me that that is kind of important, trying to get an understanding of what we are dealing with, because everybody has these grand solutions, including yours truly, and they are not really predicated, in many cases, upon the realities of what we are dealing with. I think you have to look at that.

Let me say to you, does everybody believe that work is really the central key to attempting to get people self-reliant? Do we all agree about that?

Mr. HOBBS. Senator, I think it is the essential key. If you look at a program of work subsidy, for instance, and whether or not you can bring people up in income as well as build their self-confidence toward self-reliance, what you find is that they add a little bit to the statistics about families, that there are not many large families in the welfare system.

As soon as you get above the level of three children, you are down to less than 10 percent of the active case load, so it is relatively easy. In those cases, by the way, where we have found fami-

lies of large size, we actually add a supplement to the subsidized wage to make sure that they are not losing anything.

But the reason work is so important, is that there is a dependent attitude that has been built by the welfare system. The only way to remedy that dependent attitude is to make people understand how to become and feel independent, as well as having the reality of the income to go with it from work.

Now, I am sorry that I cannot accept these numbers about the population being a third, and a third, and a third. My experience, which is fairly extensive at this point, is that you cannot break them down that way. That is a breakdown that exists in a dependent welfare system. A breakdown that exists in a work-oriented public assistance program is entirely different.

Senator D'AMATO. So where you see, in our limited experience or what we say is limited and work, what did you characterize it as, as a work what?

Mr. HOBBS. As a work program, one that puts people to work and brings them out of dependency.

Senator D'AMATO. No. You characterized it as a system, a work-dependent system.

Mr. HOBBS. The public assistance system, centered on AFDC, is essentially a dependency-inducing and supporting system.

Senator D'AMATO. All right. Then you contrasted that with—and I do not want to put words in your mouth; I want to hear from you—a what, a work program?

Mr. HOBBS. The work program, in which people work instead of collecting AFDC.

Senator D'AMATO. All right. So you want to give us some numbers on that? In other words, you said you did not agree with this one-third, one-third, and one-third.

Mr. HOBBS. I will go back to my original numbers which I stated a little bit ago.

Senator D'AMATO. Go ahead.

Mr. HOBBS. That is there are at least 60 percent of the AFDC case load who can go to work tomorrow and hold down a job and become self-sufficient over a period of a year to 2 years. That is, where they are going to be——

Senator D'AMATO. Now, you are saying 60 percent of the load, you believe, over a period of time, within a year, could be relatively independent.

Mr. HOBBS. Yes, sir.

Senator D'AMATO. All right.

Mr. HOBBS. And the second group is what I would characterize as people who need transitional help, that is, they are not familiar enough with the work site and they are not familiar enough with how to get along and do the job to be able to do it, but they have the inherent capability. I would say that is about 30 percent.

It is less than 10 percent, in my opinion, for whom we need to be concerned about a permanent kind of program which will, even in most of these cases, with enough concentration, will bring them to the point where they can do jobs.

Senator D'AMATO. All right. If I might, Mr. Chairman.

Dr. Ellwood, I am not asking you to sign off on specific numbers here, but would you believe that you are really talking about 10,

15 percent of the population will always have difficulty, will not be able to be suitable for jobs?

Professor ELLWOOD. No, I think it is higher than that.

Senator D'AMATO. You think it is higher.

Professor ELLWOOD. I have looked at a lot of State programs and I have spent a lot of my life looking at welfare dynamics. I do not know where the figures come from, and Mr. Hobbs has worked hard on these various issues, but——

Senator D'AMATO. I do not want to cut you off, but that little red light is on and I would just like to make one observation.

No. 1, I absolutely believe, and I understand from staff, that we are going to be considering, Mr. Chairman, the retention of medicaid coverage for people leaving welfare for work, and that is something that we are actively looking at. I will not support a bill that does not have that.

I absolutely believe that if you are going to get people off of welfare—and I believe in Workfare—I think it is absolutely a must. I do not think we have been doing nearly enough. I think we have to give the States greater flexibility, and I am sorry we did not get a chance to ask some of the snafu. But we really need to provide that medicaid during that year, because we just make it impossible.

Last, but not least, I think our tax system is just horrible and it discourages working families, working poor. We are talking about welfare here. I think Senator Moynihan mentioned, and I think you mentioned, Mr. Chairman, what about the people who are out there not receiving any assistance, working day and night, trying to feed a family, making a gross income of $15,000, or $16,000 or $17,000, they have two or three kids, boy are they being taken advantage of. This business about an Earned Income Tax Credit, that is nonsense, because the system is being gamed.

The CHAIRMAN. We do have another panel.

Senator D'AMATO. Well, I am going to finish, Mr. Chairman.

The CHAIRMAN. I would appreciate it.

Senator D'AMATO. You do not want me to wait for another round. I do not really think you do. And I missed my opening comments anyway.

So I just want to make this observation, and I will do it sooner rather than later, if you will let me, and shorter.

It just seems to me that we ought to raise substantially the level by which income taxes kick in. Take a family of four people; they should not be paying taxes. Let them earn up to $20,000 a year and forget about taxing them. Then you do not have people beating on the Earned Income Tax Credit. If you want to encourage people to go out and work, let them keep their money and you will see how the system will improve.

So you want to talk about meaningful tax reform, let us start it. We want to get people off of welfare. Let us start it at a level where it is going to work. This is not a Republican plan, a Democratic plan, it is just common sense. All of the people who are paying people off the books, and doing these nonsense things, you really solve a lot of problems.

Now, it is going to cost money. So what? Everything costs money. I would rather see us, if we are going to begin this business of giv-

ing tax relief, let us encourage the system of why people should go out to work. So I would just share that with you.

I think that if you ask the people who work in the poverty area, they will tell you that will probably do more than all of the nonsense that we are talking about, because all we are going to do is talk about this.

The CHAIRMAN. As you know, high on our priorities is tax reform.

Senator Grassley.

Senator GRASSLEY. I will not ask for equal time.

The first point would not be a question, but a point. It comes from Mr. Tompkins making a comment about Ohio taking 5 months to get your waiver request implemented for your Ohio First program, and then you evidently had conditions placed on it that changed the plan quite significantly from what you had originally approved.

I think that with a lot of the legislation we could have here, that we would end up not really with welfare reform, but just with waiver reform if we keep too much control in Washington, DC.

Now, the Secretary of HHS last week indicated that they wanted so much flexibility, and that it was not debatable, that waivers would be almost automatic. But the principle is, the extent to which States, for themselves, can make a judgment of what the best welfare reform is for them, it seems to me, to be significant.

We must move away from the place where Ohio takes 5 months to get a significantly modified plan approved or Iowa takes 8 months to get a significantly different plan approved to the place which produces not only good policy, but a bill that is politically achievable here in Washington.

Mr. TOMPKINS. I've spent a great deal of time in Washington. I was born and raised in Washington, so I am an anomaly as it exists already, I guess, in life. It has become a political football one way or the other. The essence, the conceptual framework of S. 1795 was the National Governors' Association proposal.

Now, there are some issues of funding here and there, and there is an issue of whether we are talking a year and a half or 6 months here for certain things, but the essence of it is basically there. I think I was in some of the negotiations with my Governor on this, and it was very tough because it was back and forth from Republican Governors and Democratic Governors, and what have you. But I think it took a long way to get there, so it was there.

So there are some exceptions, true, but I think the basic elements of what was proposed are in S. 1795, and I think it is very important that we do them.

Mr. HOBBS. Senator.

Senator GRASSLEY. Go ahead, please. Yes.

Mr. HOBBS. I have observed over the years that the only way a State will get waivers is if it is able to put a significant amount of political force behind the waiver request here in Washington.

I have also observed in the last 10 years that the ability to get waivers in a timely way, and sometimes to get them at all, is directly proportionate to the popularity of the President, because what happens when you get into the waiver business is the appointees are only operating on an exception basis; who is really de-

termining the contents of those waivers and the scheduling of them is a bureaucracy that has been here for a long, long time.

That is why this bill is so important, to get out of the business where you never know when you come back here whether you are going to get a waiver or not, no matter what its virtue, because the process itself is so convoluted and is controlled in a bureaucratic manner.

Senator MOYNIHAN. Mr. Chairman.

The CHAIRMAN. Yes, Senator Moynihan.

Senator MOYNIHAN. Could I just comment on a point of information I think the committee would be interested in, and I know our panel, in response to Senator D'Amato's question.

Toward the end of the last Congress we passed the Welfare Indicators Act of 1994, being very much aware, as I think Dr. Ellwood, Mr. Hobbs, and Secretary Tompkins would agree, there is an extraordinarily limited amount of information on a subject this central.

We had it by an annual report. The first will be issued October 31 of this year, to be modeled on the economic report of the President, the Employment Act of 1946. We had large expectations for this; not the first report, nor the fifth, but by the time the economic report had its 10th annual edition, we knew a lot more about the American economy than we had ever thought possible. It is in response to just the kind of questions that you were asked that we hope we will——it will take some time, but I am sure it is a good thing we have started.

The CHAIRMAN. Well, gentlemen, I want to thank you. I think your testimony has been extremely helpful, and we appreciate your taking the time to be here with us today. Thank you very much.

It is now my pleasure to call the second panel to discuss medicaid reform, and this panel includes Virginia State Senator Stephen Martin; Charles Baker, who is Secretary of Administration and Finance for the State of Massachusetts; and Dr. Karen Davis, who is president of the Commonwealth Fund in New York, New York.

Again, we will ask the witnesses to please summarize their testimony and limit their statements to 5 minutes each.

Dr. Davis, why do we not start with you?

STATEMENT OF KAREN DAVIS, PH.D., PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NEW YORK

Dr. DAVIS. Thank you, Mr. Chairman and members of the committee, for this opportunity to testify on the future of the medicaid program.

Medicaid serves as our Nation's most important health care safety net. It covers 36 million of our poorest and sickest Americans. It is particularly important today, as the health care system is going under enormous change and as many health care institutions, such as academic health centers, are increasingly feeling financially vulnerable.

Medicaid is really the lynch pin that we have as a Nation to assure access to health care as we are undergoing these changes, and major changes to medicaid could have unintended consequences for essential health care institutions, as well as the quality of health care for all Americans.

I would like to just flip through some charts at the back of my testimony. In Figure 1, we know that medicaid and medicaid helped reduce the numbers of uninsured in the 1960's and 1970's, but since then the erosion of employer-based health insurance has increased the numbers of uninsured, as the kinds of jobs in the American economy that are increasingly available do not carry health benefits.

Figure 2, from the Kaiser Commission on the Future of Medicaid, on which I am pleased to serve, indicates that 30 percent of all Americans are either uninsured or depend on medicaid for coverage.

Figure 3 reports on a current study in five States which finds, for example, that in Florida almost half of people with incomes below 250 percent of poverty—that is about $35,000—are either on medicaid or are uninsured. So, any reduction in medicaid coverage has the consequence of risking an increase in the uninsured.

Figure 4 indicates that medicaid has done a good job of covering poor children. We now have 85 percent of poor pregnant women and infants covered by medicaid, about 88 percent of poor children under the age of six, and about 61 percent of poor children between the ages of 13 and 18.

Figure 5 indicates how important medicaid is to health insurance coverage for low-income women. About one in five women with incomes below twice the poverty level depend on medicaid for coverage, but about a third are uninsured.

Many women lose medicaid when they get a job or their wages go up, and, in fact, a recent study for the Commonwealth Fund found that two-thirds of women leaving medicaid become uninsured.

You see in Figure 6 the length of time that women are on medicaid. About 37 percent of women on medicaid are on more than 5 years, and any arbitrary time limits on welfare that also limited coverage for medicaid could result in more women being uninsured.

Figure 7 notes that the poorest, most disabled Americans also depend on medicaid and account for about two-thirds of the outlays for medicaid. Elderly adults, and the disabled often cost eight times what it costs to cover a child. The elderly depend on medicaid for long-term care coverage and also to supplement Medicare and pay Medicare's premiums and cost-sharing.

We know what happens when people do not have medicaid and they are uninsured. Figure 8 indicates that they are unable to get needed care, they often postpone care. Figure 9 documents that the uninsured are much less likely to get preventive care, such as mammograms and Pap smears.

Turning to some of the proposals under consideration by the committee, I would just tick off some of my concerns in Figure 10. I think my most fundamental concern is the change from the entitlement nature that medicaid now has. All health insurance is entitlement. Employer health benefits are entitlement. They cover a defined set of workers for a defined set of benefits.

A modified block grant no longer requires that medicaid provide health insurance to 36 million Americans. States could just use the money to pay budgets of psychiatric facilities, they could use the money to give block grants to counties, or give money to public hos-

pitals. That is quite different from providing health insurance coverage to 36 million Americans and could markedly increase those who are uninsured.

We know in the proposal that children ages 13 to 18 would not receive phased-in coverage by the year 2002. There are also losses of coverage for some of the elderly poor and disabled who would be dependent upon State definitions of disability.

We note that, under the proposal, while there is a list of benefits, there is no limit on a State's ability to set limits on amount, duration, and scope, no guarantee that children would be treated for conditions that are detected when they are screened, cost-sharing could be imposed that would keep people from getting services, providers could balance bill extra amounts to patients, nor would there be any guarantee of quality standards or oversight of managed care as States move rapidly in that direction, legal recourse for beneficiaries, nor is there adequate fiscal capacity on the part of States in times of recession or to deal with higher health care costs.

In my view, medicaid is very much a national responsibility. We should all be concerned about seeing that babies are born healthy and that, with cuts in funding, we are simply not going to be able to cover those in need today. I think there is a lot of evidence indicating that, if anything, medicaid should be covering more people, not fewer people. Thank you.

The CHAIRMAN. Thank you, Dr. Davis.

[The prepared statement of Dr. Davis appears in the appendix.]

The CHAIRMAN. Senator Martin.

STATEMENT OF HON. STEPHEN H. MARTIN, VIRGINIA STATE SENATOR FOR THE 11TH DISTRICT, RICHMOND, VA

Senator MARTIN. Thank you, Mr. Chairman, for this opportunity. As a State legislator from Virginia, I am a member of the American Legislative Exchange Council, otherwise known as ALEC, which is the Nation's largest individual voluntary membership organization of State legislators, with over 3,000 Democrat and Republican legislators as members.

I am the chairman of the Welfare Subcommittee of the ALEC Task Force on Health and Human Services and serve on ALEC's national board of directors.

The Health and Human Services Task Force is composed of a broad cross-section of private and public sector members, over 200 members of that task force. For half a decade, my task force has grappled with the issue of developing policies for model legislation in the States that provide a safety net for people who are less fortunate, but without destroying State and Federal budgets.

Congress and the States are struggling with spiraling medicaid and welfare costs. To address this problem, the States need to be allowed to manage these programs free from Federal mandates regarding individual entitlements, eligibility groups, benefits, payment rates, and financing structures.

States are already experimenting with privatization, managed care, and other medicaid options. Given the flexibility to experiment, the States will develop successful, workable solutions to medicaid costs.

Concerning welfare reform, we must craft welfare programs that provide its recipients with an opportunity and hope for self-sufficiency. The States are innovators. In this, as in so many other public policy areas, the States sometimes are ahead of the Federal Government.

These innovations include enforcing child support, the establishment of paternity, incentives for school attendance of children of AFDC recipients, packaging food stamps and AFDC benefits in the form of cash which is used to subsidize private sector jobs, allowing recipients to accumulate money for medical expenses in a medical savings account, and creating medicaid systems in combination with a managed care approach, as Tennessee has done.

Most recently, the State of Wisconsin has been in the spotlight for Governor Thompson's W–2 program. If granted a Federal waiver for the program, welfare, as Wisconsin residents know it, will be eliminated and replaced with a system in which recipients will have hope for the future rather than being trapped in a state of government dependency.

In Virginia, Governor Allen's welfare program became effective on July 1, 1995. I was the chief patron, along with Senator Early of Chesapeake, Virginia, on this legislation.

The Virginia plan has a work requirement. During the eligibility period, recipients will be able to accumulate up to $5,000 in a savings account for business incubation, will have access to child care, and will receive protection from State income taxes.

After 2 years, though, cash benefits cease. Child care, medical, and transportation assistance can continue for another 12 months. We have already witnessed the success of these reforms because of the incentives which they have created.

As evidenced by these plans, the Federal Government does not have a corner on compassion. In assuming so, you miss an opportunity to benefit from State public policy innovation and competition and inevitably you end up micromanaging at high cost the process of delivering services to those who do qualify.

Some have suggested establishing Federal requirements by attaching so-called conservative strings to the disbursement of funds in a block grant. But this still implies that the States need to be told what to do. It also assumes that what works in Montana will work in New Jersey, but both assumptions are false. Mandates from conservatives who think they know what is best are no more desirable than mandates from liberals.

In determining how much each State shall initially receive in federally collected tax dollars, the formula should not attempt to redistribute funds from one State to another, capping at a certain percentage of poverty. If you do not, States that have broadly expanded their programs will receive a disproportionate share of Federal dollars.

I would hope that block grants would be transitional. If the States were to raise revenue for medicaid and welfare directly and managed their own programs, spending could be reduced at a savings to the taxpayer. Such a savings would require a willingness to reduce taxes as the States pick up the responsibility for revenue and management of their own programs.

The ultimate goal should be to phase out the Federal role and delivery of welfare and medicaid services. However, in the meantime, Federal aid should take the form of block grants, distributed according to a formula based on population, but not tied to a State match. States should be granted maximum discretion to develop their own programs.

I recommend that you act on the assumption that your State counterparts have the compassion, understanding, and the will to serve the best interests of the citizens and the States they are elected to represent.

I thank you, Mr. Chairman, again for this opportunity to testify before your committee.

The CHAIRMAN. Thank you, Senator Martin.

[The prepared statement of Senator Martin appears in the appendix.]

The CHAIRMAN. Mr. Baker.

STATEMENT OF CHARLES D. BAKER, SECRETARY OF ADMINISTRATION AND FINANCE FOR THE STATE OF MASSACHUSETTS, BOSTON, MA

Mr. BAKER. Thank you, Mr. Chairman. I appreciate very much the opportunity to testify today before the committee on behalf of S. 1795, the Personal Responsibility and Work Opportunity Act of 1996.

Clearly, Federal reform of medicaid and AFDC are both long overdue, and we welcome the opportunity to support your efforts to overhaul these deeply troubled programs.

As the former Secretary of Health and Human Services in Massachusetts, I have strong opinions on both of these issues, but I have been asked to focus today on medicaid, so I will.

There are charts that I do not think need that much explanation that I have included with my testimony about our experience with our program on the spending side over the course of the last few years. Overall, we have about 680,000 recipients, and about a $3.3 billion program.

Five hundred seventy-five thousand of our medicaid recipients account for about 55 percent of the program's funding, or about $1.8 billion. Those are the under-65s. The over-65s, which represent about 15 percent of the program population, utilize 45 percent of the money.

Medicaid is talked about many times as being a program for the poor and disabled. One thing people should remember, is that a huge chunk of the funding is actually supporting the over-65 population.

I believe that Massachusetts, despite what in many cases have been enormous bureaucratic complexities, has been quite successful in turning our program away from being a traditional, provider-driven, fee-for-service plan and into becoming a more sophisticated purchaser of health care services in recent years.

Over this period of time, the growth in our spending rate has gone from 18 to 22 percent per year in the late 1980's, to something closer to three to 5 percent per year for the last several years.

Virtually all of this reduction in the run rate on spending has been achieved without dramatic reductions in either eligibility

standards or benefit levels. Much of it has been due to our efforts to ensure that people are receiving the right care in the right setting, at the right price.

Some of it has certainly been controversial, and much of it has required a willingness to think differently about the role of the program. But, overall, most people—even our most vocal critics—give the program high marks.

Along the way, we have also been successful at securing additional Federal funds to support a wide variety of other State Health and Human Services initiatives, many of which involve Federal medicaid spending, but are not part of our traditional medicaid program.

Therefore, while we have been able to control the spending increases in our core program to less than 4 percent per year for the past several years, we have also managed to increase Federal support for other State programs more successfully than any other State in New England.

These efforts, many of which have required painstaking negotiations with the Federal Government, illustrate the programmatic and financial imperative for change. On the one hand, Massachusetts has had a great deal of success in dramatically reducing the growth in our State medicaid program, but it took years to negotiate and remains an ongoing subject of State and Federal discussions.

On the other hand, we have also been able to continue to replace what were previously 100 percent State dollars with 50 percent Federal dollars for a number of other programs at the same time.

Simply put, I believe that medicaid will continue to suffer programmatically and financially as long as it operates as an unlimited reimbursement program at the Federal level that worries more about process and regulation than it does about goals, objectives, and outcomes.

So I am here today to say that I am an enthusiastic supporter of many of the reform proposals for medicaid outlined in S. 1795. I believe they will go a long way toward fixing what is wrong with this program, they will provide the Federal Government with a manageable financial obligation to the States, ensure that certain populations such as poor children, the disabled, and elders continue to be covered, and move much of the focus of the State-Federal relationship away from regulation micromanagement and into the more appropriate task of reviewing and auditing program goals and objectives.

I will give you just one example of what I mean by this. Everyone in health care who deals primarily with the mentally ill understands that payors are relying more and more on non-hospital-based settings for delivering crisis intervention services to the mentally ill.

In many cases, these services can be delivered closer to home, closer to family members, closer to peers, and they are also far more friendly and normal environments in which people can be served.

They are also a lot less expensive than traditional inpatient care, yet many States—and I would include Massachusetts among them—have had a very difficult time incorporating this low-cost al-

ternative into their existing medicaid plans, even if they have a Federal waiver.

This is because Washington, most of the time, is more interested in the mechanics of the plan than it is in the outcome or the objective. This gets into a whole discussion about what exactly is a medicaid reimbursable service and what is not.

We came up with a lower cost, more appropriate—and in many cases better—alternative to traditional hospital setting services for people with acute mental illness and had to go to war with the Federal bureaucracy to get to the point where the Federal Government would let us substitute this better, less expensive alternative for the traditional medicaid benefit. This makes little or no sense.

On the financing side, there is simply no way the existing relationship can be sustained. States like Massachusetts have too much to gain by manipulating the existing reimbursement structure, and as long as the rules permit us to do so, we will. To do anything else would invite public and political scorn back home.

The current political culture is quite clear: every State should secure every available dollar of Federal funding to which it is likely to be entitled, and to do less than that is considered by most to be a dereliction of duty.

Therefore, any medicaid reform is going to require the Federal Government to reach some kind of an accommodation with the States on the absolute growth in Federal medicaid spending, and I think this proposal before you is a good way to get there.

The CHAIRMAN. Thank you, Mr. Baker.

[The prepared statement of Mr. Baker appears in the appendix.]

The CHAIRMAN. As I said in my opening remarks, one of the principal differences between the legislation before us and the current situation is the question of trust, trust in the States. Those in opposition seem to be saying that, if we turn it over to the States, they are going to immediately do far less.

Yet the fact is, and the figures show, in 1994, most of the current spending on medicaid is optional. You will see down in one corner of the chart that the total amount spent in billions for medicaid in 1994 was $121.7 billion. Of that $121.7 billion, only $55 billion was mandatory. It was mandatory because it was spent on mandatory people for mandatory services.

But most of the spending is optional. States covered many people on an optional basis. The mandatory services for the optional was $14.8 billion. The optional services for the mandatory people was $28.7 billion, and $23.1 billion for the optional people. So you have a total of $66.5 billion spent optionally, as compared with the $55.1 billion.

Now, the point of this is that the States currently, on a voluntary, optional basis, are spending far in excess of what is mandatory. So I think the attacks on the States, that they would not do their job, is not borne out by the facts, or why would they be providing all these optional services? Do you have any comment, Dr. Davis?

Dr. DAVIS. First of all, for some of the optional services, such as prescription drugs, it is cost-effective for States to cover them for mandated populations, otherwise people are going to wind up in the hospital for a condition that could have been maintained at

home. So it is optional, but it is cost-effective, and not to cover it winds up costing the States more money.

The other point to make, is that States, as Mr. Baker has said, have been quite ingenious about shifting on to matched funds people whom they used to pay for totally themselves.

So, for example, you take the mentally retarded population, in the past the State would have paid 100 percent of that. If they can make them disabled and it's an optional coverage, then they can get Federal matching.

The CHAIRMAN. But when they were spending 100 percent, that was on a voluntary basis.

Let me ask you, Senator Martin.

Senator MARTIN. Well, not only does the evidence suggest that, but the fact is, Mr. Chairman, that those who send us to represent them in the State offices by their votes also send the Congressmen here with that same trust and same confidence, and we are accountable to those same people.

I think that we have evidence that suggests that we are trustworthy in many regards beyond simply that chart. And we do, indeed, have the compassion and concern for our constituents, and if we do not, they would turn us aside, just as they would you, at the ballot box.

Mr. BAKER. Can I just make one quick comment on that as well?

The CHAIRMAN. Yes, Mr. Baker.

Mr. BAKER. I view the existing proposal as trust, but verify, to coin a phrase. Many people characterize this as a blank check to the States. I do not see it that way at all.

In fact, some of what I see in here is exactly what the Federal Government should have been doing for the last 25 years and has not been doing, which is worrying about whether or not the processes and procedures and programs that are actually being paid for with State and Federal dollars are making things any better.

Over the course of the last 30 years, particularly with regard to a lot of the medicaid stuff, we have used procedural and regulatory mechanisms as an escape for a more important objective, which is whether or not the people that we are trying to serve are being appropriately, adequately, and clinically served by the program that we are paying for.

Usually in a lot of these demonstration programs, for example, there is a huge bureaucracy at both the State and Federal level that gets into an enormous food fight over every single detail of the mechanics of implementation, and then at the end people toss $500,000 in to do a "evaluation" of whether or not the thing was successful.

Well, the thing I like the most about this, is in many ways you are flipping the paradigm and saying that the primary objective of this State-Federal relationship should be on program goals and objectives, independent evaluations, and a much more substantive and significant approach toward trying to figure out whether or not what people are doing is actually making a difference. This is missing from the current program, and represents a huge flaw in the way it works. This also explains why it is so hard at the State level to convince the Federal Government that what everybody else in the private sector is doing to better serve the disabled and poverty

populations is something that ought to be done under existing medicaid standards.

The CHAIRMAN. I think that rewarding those that perform and achieve their goals is a very, very significant change and development.

One final question. The impact on State budgets of the uncontrolled growth of medicaid. What effect has that had on State budgets, on education, law enforcement; would you care to comment on that, Senator Martin?

Senator MARTIN. I can simply say that the budget crunch, the budget stress that comes from these entitlement programs, indeed, makes it far more difficult to meet the public safety demands and the education demands in the States. We have been able to deal with it in the State of Virginia, but I think we can provide a cost savings and we, in fact, can provide probably better service to our constituents while saving that money.

Dr. DAVIS. I think the most rapid growth in medicaid occurred in the late 1980's and early 1990's, when States were gaming the system through provider taxation and donation schemes. It looked like it was State money, but it was really a way of getting the Federal Government to effectively pay most of the program.

Once that was tightened up, the medicaid program has slowed down. It is now under 9 percent. There are some who have testified before the Kaiser Commission that indicates we may be more at a 5 or 6 percent rate of growth in the future.

So I think that some of this talk about how rapidly medicaid has grown was really just a way in which the States were shifting money onto the Federal Government through various mechanisms.

The CHAIRMAN. Mr. Baker, any comment?

Mr. BAKER. I think the fact that medicaid growth may be down to something like 9 percent is nothing to celebrate. Most other programs in Health and Human Services are treated in the context of total spending on Health and Human Services.

If medicaid spending—which is usually in most States, including mine, about half of the Health and Human Services budget—is growing at 9 percent a year and the overall growth rate that HHS has been allocated based on the budget process in each State is something closer to the rate of inflation—which has been around 3 percent lately—that means HHS has to take 6 percent or more in real dollars out of everything else in Health and Human Services to fund the 9 percent growth rate in medicaid.

Part of the reason we got so aggressive about reforming medicaid was because it was literally chewing its way through the rest of the Health and Human Services system when we took office.

There is no question that people have been able to play a whole variety of games to deal with the net State cost of the program. But the truth of the matter is, most of those games have been pretty well dissipated by previous legislation, and I think the real challenge on a going forward basis for people who care about Health and Human Service programs—and I happen to be one of them—is if you do not take reforming and managing your medicaid program seriously, you are kidding yourself if you think there is going to be money there for WIC, or early intervention, or a whole host of the other programs that people purport to support.

Senator MARTIN. Mr. Chairman, I know you need to close, but I would like, if you do not mind, state that we in Virginia did not implement provider taxes and our increases were the same.

So, according to our Department of Medical Assistance Services, the EPSTT—which is the children's program—and the change in eligibility requirements which created an increase in eligibility, as has been our experience, have created the greatest increase for us.

Dr. DAVIS. But I think, nationally, what we know is that children account for only 18 percent of all medicaid dollars. It is a small part of the spending. The bulk of the money is going for the elderly and disabled. It has been important to expand that coverage to poor children.

As I pointed out, we now have 85 percent of poor children—young children—covered by medicaid, and without that they would be uninsured, women would not be getting prenatal care, children would not be getting immunizations, they would not be getting off to a healthy start in life. So I think that expansion of coverage actually is one of the promising things that has happened in the medicaid program in the last 10 years.

Mr. BAKER. I would just say, our immunization program in Massachusetts, which has the highest penetration rate in the country, does not have anything to do with our medicaid program.

Senator MARTIN. And the NGA plan protects this children's program.

Dr. DAVIS. Well, it repeals coverage for children 13 to 18, so it is not the case that it does cover them, nor does it guarantee that they would continue to have health insurance or that conditions that are detected when children are screened would be paid for by medicaid to be treated.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Mr. Chairman, I thank this panel for clarifying and thoughtful observations. I want to say to Senator Martin, through you to the legislators, be careful how quickly you want to disengage from the Federal Government; you might find that it happens faster than you ever supposed. I leave you with that thought.

Senator MARTIN. We do not want to disengage, we want a balanced system and shared responsibility.

Senator MOYNIHAN. I know what you mean, but when you set yourself up for a block grant it is so easy to cut block grants just a little bit, 4 percent, and then the next year 6 percent.

Mr. Baker talked about the problem of mental illness. I have very direct experience with this. I was in Governor Harriman's office in New York in the 1950's when, at Rockland State Hospital, the first tranquilizer was developed from rauwolfia. We determined to use it systemwide.

I came down here with the Kennedy Administration and they were beginning to think the same thing. The last public bill signing ceremony President Kennedy had was the Community Mental Health Centers Construction Act of 1963, and he gave me a pen.

We were going to de-institutionalize. We were going to empty out the State hospitals and then we were going to treat persons in 2,000 community mental health centers which were to have been built by 1980's, and thereafter one per 100,000 population.

I often thought if some person present had said, Mr. President, before you sign that bill, can I tell you that we are not going to build 2,000, we are going to build 450 and then we are going to forget that we ever did it, but we will empty out the hospitals, I think he would have put his pen down and said, well, do you want people sleeping on grates as they do along Constitution Avenue right now, and so forth? Indeed, that is what happened.

Suddenly we have this problem called the homeless, which in New York, in an endless capacity to get things wrong, we have defined there is a problem the lack of affordable housing. It is called schizophrenia. You are not getting much help.

You try to use medicaid for it because it is the only thing available to you. But is there any State in the country that does not have a homeless problem, and is there anyone who would think it is not basically, in large measure, a problem of mental illness?

Dr. DAVIS. Well, I think you make a very good point, that medicaid is very important for people with mental illness or mental retardation. It is a major source of financing their care.

One of the concerns I have about the proposal under consideration by the committee, is it would permit Federal funds to be used for budgets of State psychiatric facilities, so it is kind of going back to the old day, which are currently not eligible for Federal funding, and it would move people into managed care, let States do so without any Federal oversight or quality standards, even if these plans did not have the kinds of psychiatrists, mental health services that people with complex problems need, and they could impose cost-sharing, which has been a major problem with employer coverage of mental health services.

Senator MOYNIHAN. I would just make the point that, if there was one example of a hugely failed social experiment in the last half century, it was de-institutionalization.

Mr. BAKER. I think you have got to combine the civil commitment law changes with that.

Senator MOYNIHAN. I think probably that, too. Yes. A fair point.

Mr. BAKER. The system, over time, actually did a fairly good job in starting to develop the community-based capacity. But the problem was, you had no hook, once you got somebody stabilized and they went back out into the community, to keep them involved in a treatment regime.

Senator MOYNIHAN. Do not tell that to any Republicans around here. They will find a Federal judge who did it, then God knows what trouble that will be.

Senator MARTIN. Senator Moynihan, my first public service office was on the Mental Health Board in my area, in one of the largest jurisdictions in the State of Virginia, and I served two terms there. I can tell you, the issues that we had to grapple with in terms of the waiting lists in many areas were as a result of lack of preparedness for this de-institutionalization process. It was just done and it was not thought through.

Senator MOYNIHAN. It happened, bang.

Senator MARTIN. It just happened. I have now founded an organization that has 17 homes for mentally disabled adults, and we are trying to deal with it, but that was a major failure.

Senator MOYNIHAN. Yes.

Dr. DAVIS. I think there is a lesson today with managed care, if we tried to move to that too rapidly without careful planning for people, that we could have the same kind of disruptions in our current system. There was mention made, for example, of Tennessee's moving to managed care, and I think the speed with which that was done really created major instability in the health care system.

Senator MOYNIHAN. Could I just leave you with the thought that, if there is one problem that managed care will bring about, just as a normal consequence of effective change, it will be with the academic health centers and the teaching hospitals.

Dr. DAVIS. Absolutely. I could not agree more. I think it is one of the reasons why making major changes in medicaid right now is not a good idea, because many of these institutions are having to cope with changes that are happening in the private sector.

Senator MOYNIHAN. This committee passed a bill in the last Congress to provide a premium on health care insurances to produce $15 billion a year for academic health centers and teaching hospitals. It never got reported, but a clear majority of this committee was for it. We are moving toward this problem.

Mr. BAKER. It is also a better way to fund it. I think the current way we fund medical education and research is stupid.

Senator MOYNIHAN. Yes. Do it directly; you are a medical school, here is some money.

Mr. BAKER. Furthermore, here is what we, the paying entity, would like to see you worry about. One of the major problems that faces both the medicaid program and the Medicare program is Alzheimer's disease. From a funding point of view, from a family point of view, no matter how you cut it, this is an enormous problem that faces us and it is just going to get worse as the population ages.

But there is very little money that is currently being spent by Medicare and medicaid that they are paying as a result of the bumps that hospitals get in reimbursement under medicaid and medicaid for medical education, teaching, and research that is funding anything that has to do with Alzheimer's.

The vast majority of the money that is being spent on Alzheimer's research is being spent by the private sector because there is a huge opportunity there for them, and more power to them.

But if someone were to say to me, where do I think Medicare should spend the enormous sums of money that it currently spends through its reimbursement system to support teaching and medical education, where would they get the biggest bang strategically, it would be in Alzheimer's research. I would say, in many cases, the same thing about medicaid.

The other research piece medicaid should support would be AIDs, which is not, for the most part, how AIDs research gets funded. I think the fact that you folks move toward a more defined mechanism for financing teaching, medical education, and research is one of the really great causes for celebration in this session.

Senator MOYNIHAN. Would you go out and celebrate it and tell somebody?

Mr. BAKER. Absolutely.

Senator MARTIN. Mr. Chairman.

The CHAIRMAN. Senator Martin.

Senator MARTIN. The Senator from New York has made a statement that I agree with in terms of the rush to de-institutionalize, however, in that particular situation preparation had not been made.

In this particular instance, however, States are already running the programs and we are already at risk for reduced funding of mandated programs that are before us. I do not think there is the lack of preparedness that we faced with the de-institutionalization.

Dr. DAVIS. It varies from State to State.

Senator MOYNIHAN. My time is up, Mr. Chairman.

The CHAIRMAN. I think we have to move on, yes.

Senator Graham, please.

Senator GRAHAM. Thank you, Mr. Chairman. Again, I thank you for having brought us this outstanding panel.

I am going to make a pragmatic, political observation in which I have a high level of confidence, and that is, the chances are that there will be zero medicaid reform passed in 1996. I say that with great sadness, because I think, clearly, we need to have some change.

My concern is that we are allowing what individuals or groups see as the perfect to be not only the competitor of, but the terminator of, the good, because I sense that there is a large core of commonly shared analysis of medicaid problems and what the remedies to those should be.

I would like to suggest, therefore, that maybe we should turn our attention toward developing what I would call a consensus medicaid bill. It may not be as far as any of us would like it to be, but which actually might have a chance of securing sufficient bipartisan support and support between the Congress and the White House to become law in 1996.

I would like to suggest what I think ought to be some of the elements of that consensus, and then ask each of you to comment on my list and suggest additions.

I would put on my list of a consensus medicaid reform bill—and these are not necessarily in any priority order—No. 1, recognizing the State's rights to adopt, without Federal approval, a variety of proven enhancements to medicaid, which would include health management organizations as a means of delivering services, community-based services for the elderly, and other proven alternative delivery systems.

No. 2, to allow those programs on an individual basis which have proven to be effective, to move from a demonstration process into a permanent process within the State.

No. 3, a repeal of the Boren Amendment. No. 4, the use of performance-based rather than process or procedural-based means of evaluation of State programs. Finally, the reduction of and the eventual phasing out of the inappropriate disproportionate share hospital provisions and the substitution of, as has been suggested, some more rational way to reimburse hospitals which are providing a disproportionate amount of care for the indigent.

Those would be a starting list of what I think could be a consensus medicaid reform program. I would be interested in your comments.

Dr. DAVIS. That is very constructive, to look for a consensus. In the health care reform debate there was a consensus around issues like universal coverage of low-income people, and certainly moving to have uniform income standards as a basis of eligibility of health insurance.

Certainly looking for consensus is a very constructive thing to do. I am concerned about anything that would repeal the current medicaid statute, as the proposal under consideration by the committee would do.

In terms of the five elements that you have ticked off, community-based care has been shown to be a better way of getting long-term care services to disabled and elderly people so they can be cared for at home.

Managed care—my concern there would be going too fast, too quickly. For example, mandatory enrollment without giving people a choice of what kind of a system they want to be in could be detrimental.

Quality standards are important. If you were to say States can cover people under managed care so long as it is voluntary, so long as it meets quality standards, like accreditation by the National Committee for Quality Assurance, then that would deal with a lot of my concerns, that we have Federal oversight and standards in place.

In terms of demonstrations that have worked, certainly there should be a basis of moving forward. In terms of payment of providers, I think medicaid has always tried to buy health care on the cheap, truthfully.

One of the things that bothers me, whether it is managed care or fee-for-service, if we set the rates too low, we may have some sub-standard providers. But the things you are emphasizing in terms of performance-based standards, people would agree with.

I am concerned about the disproportionate share proposal, because I know how vulnerable teaching hospitals and public hospitals are to those funds. I would have to see that we were really providing a guarantee of financial stability for those institutions.

Senator MARTIN. Senator, I would say that on the first one, the issue of recognizing the right to adopt that which is proven, I hope that you would keep in mind that States are, in fact, the proving grounds. We would like for you to remember that.

On the others, the repeal of the Boren Amendment, we support that. If you can figure out a way to find a better way to finance education and the indigent care, which of course is the issue of disproportionate hospital care, we would welcome that.

The CHAIRMAN. Do you want to hear from Mr. Baker?

Mr. BAKER. Just a couple of thoughts. First, when the 50 Governors of the United States vote 50 to 0 to support something that sounds a lot like a consensus proposal to me. In many ways, they are also being asked to bear, I would argue, at least an equal share of the financial liability that is associated with it. If that is not enough political consensus to move it forward, shame on us.

More specifically, getting demonstrations out of the demonstration process and into the mainstream is a very complicated process. I think it is unfortunate that it has become so complicated to do, and that would be a great place to start.

We are continuing to negotiate on the extension of our managed care waiver, which I think everybody agrees for the most part has worked pretty well. The amount of time and effort that people invest in continuing to negotiate renewals is time that could be spent on far more important things.

I think the move from process to product in terms of what you want Federal oversight to look like——

Senator GRAHAM. From process to performance.

Mr. BAKER. I am thinking of product as the same thing. That is absolutely the direction that that relationship should go in, but everything my colleague next to me said leads me to believe that that is going to be a real hard slog, because most people prefer process to performance because it is easier. I think you will have a real hard time making that happen.

The Boren Amendment, for example, is just a goofy way to establish some baseline for payment. To tell you the truth, it does not work. There are many instances in which the medicaid program in Massachusetts is paying far more than private plans are paying for a variety of services because of the Boren Amendment and the peculiar nature by which it gets interpreted.

I think my definition of whether or not you are getting an adequate price is a function of how many providers are playing, and I think the way to deal with whether or not the medicaid program is paying an appropriate price is to determine how many providers, in fact, you are doing business with. If medicaid is getting it on the cheap, well, good for medicaid.

Part of the peculiar nature of the way these programs work is the public sector is always the chump when it comes to what we pay versus what many other people who are more sophisticated are paying.

Finally, I think the real issue with disproportionate share is not the provider tax programs, which I think everybody would acknowledge got kind of out of hand for a while, but the more traditional DSH stuff. This does, in fact, as it is most narrowly defined, provide some support for institutions in a variety of places that would be difficult to do without.

If people wanted to choose to finance that through some other mechanism other than a DSH mechanism, that would probably not be a bad idea. But I think the really narrow piece that was the original purpose associated with disproportionate share does provide for some financial support for a variety of institutions, many of which are located in really poor areas where they are, in many cases, the primary point of access for a whole variety of things, and losing a lot of them would be a big problem.

The CHAIRMAN. I have one final question of you, Mr. Baker. There has been a lot of criticism of the proposal to lower the matching rate for a number of the States. What is the real impact of changing the FMAP on the States in the medicaid program?

Mr. BAKER. Well, most of the 50/50 States—New York being another—are very high State share medicaid spending States, so they are already making a greater effort with their own money than most other States in terms of investing their own money in supporting the medicaid program.

Sixty/forty does not cost the Federal Government a nickel in the context of how the rest of the formula is structured over the 5 years, or 7 years, of the proposal. What you are really doing more than anything with the 60/40 is providing the 50/50 States—which frankly are not going to be the beneficiaries of a lot of the incremental funding that is available through this legislation because they do not have, most of the time, the key indicators that are going to drive the increases that are going to be associated with this plan—a mechanism by which they can manage their funds in a more flexible manner. I do not think that change ought to be that big a deal to much of anybody.

You still have to get your plan approved by the Secretary, you still have to participate in all of the audit requirements that are tied to the legislation as it has been presented, and you are not going to get any more Federal money over the life of the legislation than you would get otherwise.

All you are really getting is an opportunity to have a little more flexibility as a very high State share medicaid State to manage the impact that is associated with going from a reimbursement program to something that looks more like a fixed financial partnership over the life of the bill.

The CHAIRMAN. Again, I want to thank this panel. I think it has been an outstanding one, and we appreciate the contributions you have made.

Senator MOYNIHAN. Thank you all.

The CHAIRMAN. The committee is in recess.

[Whereupon, at 12:25 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF CHARLES D. BAKER

Thanks very much for the opportunity to testify before the Committee today on S.1795, the "Personal Responsibility and Work Opportunity Act of 1996." Clearly, federal reform of Medicaid and AFDC are both long overdue, and we welcome the opportunity to support your efforts to overhaul these deeply troubled programs.

Let me begin by commenting briefly on Medicaid reform. As the former Secretary of Health and Human Services in Massachusetts, I have strong opinions on both issues, but I have been asked to focus my remarks today on Medicaid. I believe that Massachusetts, despite the enormous bureaucratic complexities involved, has been quite successful in turning our Medicaid program away from being a traditional, payor-driven, fee-for-service plan, and into becoming a sophisticated purchaser of health care services in recent years.

Over this period of time, our growth rate in spending has gone from between 18 and 22 percent per year in the late 1980s to something closer to 3 to 5 percent per year for the past several years. Virtually all of this reduction in the run rate on spending has been achieved without dramatic reductions in either eligibility standards or benefit levels. Much of it has been due to our efforts to insure that people are receiving the right care in the right setting at the right price.

Some of it has certainly been controversial, and much of it has required a willingness to think differently about the role of the program, but overall, most people - even our most vocal critics - give the program high marks.

Along the way, we have also been successful at securing additional federal funds to support a wide variety of state health and human service initatives, many of which involve federal Medicaid spending, but are not part of our traditional Medicaid program. Therefore, while we have managed to control the spending increases in our core Medicaid program to less than four percent per year for the past several years, we have also managed to increase federal support for state programs more successfully than any other state in New England.

These efforts, many of which have required painstaking negotiations with the federal government to pursue, illustrate the programmatic and financial imperative for change. On the one hand, we have had some success in dramatically reducing the growth in state Medicaid spending in Massachusetts, but it took years to negotiate, and remains an ongoing subject of state-federal discussions. On the other hand, we have been able to continue to replace what were previously 100 percent state dollars with 50 cent federal dollars for a number of other programs at the same time.

Simply put, Medicaid will continue to suffer programmatically and financially as long as it operates as an unlimited reimbursement program at the federal level that worries more about process and regulation than it does about goals, objectives and outcomes.

Therefore, I come before you today as an enthusiastic supporter of many of the Medicaid reforms proposed in S.1795. They will go a long way toward fixing what's wrong with this program. They will provide the federal government with a manageable financial obligation to the states, insure that certain populations, such as poor children, the disabled and poor elders, continue to be covered, and move much of the focus of the federal/state relationship away from

regulation micro-management, and into the more appropriate task of reviewing and auditing program goals and objectives.

For example, everyone understands that health plans are relying more and more on non-hospital-based settings for delivering crisis intervention services to the mentally ill. In many cases, these services can be delivered closer to the patient's home and closer to his or her family members and friends. They are also much less threatening environments, and are much less expensive than traditional inpatient care. And yet many states, including Massachusetts, have a difficult time incorporating this low cost alternative into their existing Medicaid plans, even if they have a waiver. Why? Because Washington is more interested in the mechanics of the plan than it is in the objective or the outcome.

On the financing side, there is simply no way the existing relationship can be sustained. States like Massachusetts have too much to gain by manipulating the existing reimbursement structure, and as long as the rules permit us to, we will. To do anything else would invite public and political scorn back home. The current political culture is quite clear: Every state should secure every available dollar of federal funding to which it is entitled. To do less than that is a dereliction of duty.

Therefore, the federal government must reach an accomodation with the states on the absolute growth in federal Medicaid spending, and I think the proposal before this Committee is a good one. It protects the existing state/federal relationship by building off the existing base, establishes appropriate adjustments for demographic differences, creates an umbrella mechanism to deal with unforseen consequences, and maximizes financial flexibility at the state level within a defined set of financial parameters.

With regard to welfare reform, I'll only make a couple of brief points. First, welfare reform must be about work, self-sufficiency and child support. This bill gets high marks from me on all three of these key components. In fact, much of this law conceptually resembles the plan we are already implementing in Massachusetts. Since the enactment of our new plan, we have seen an extraordinary decline in our AFDC caseload - from about 100,000 cases in February of 1995 to just over 84,000 today. Of those who remain, almost 20,000 will be working by the end of this year, in either paid employment, subsidized employment or community service. And while some people scoff at community service, I would point out to this Committee that the average length of time spent in community service jobs by our two-parent AFDC families has been less than four months, as most have found employment - either with the organization that offered them the chance to do community service, or with another employer - pretty quickly.

Finally, maintaining a seamless relationship for recipients leaving welfare and entering the workforce requires a coordinated relationship between Medicaid and AFDC. I would urge this Committee to maintain the current legislation in its existing form, so that Medicaid, AFDC and SSI are treated as a package. Changes in each profoundly affects the financing and programmatic role of the others, and to treat them separately would be a mistake.

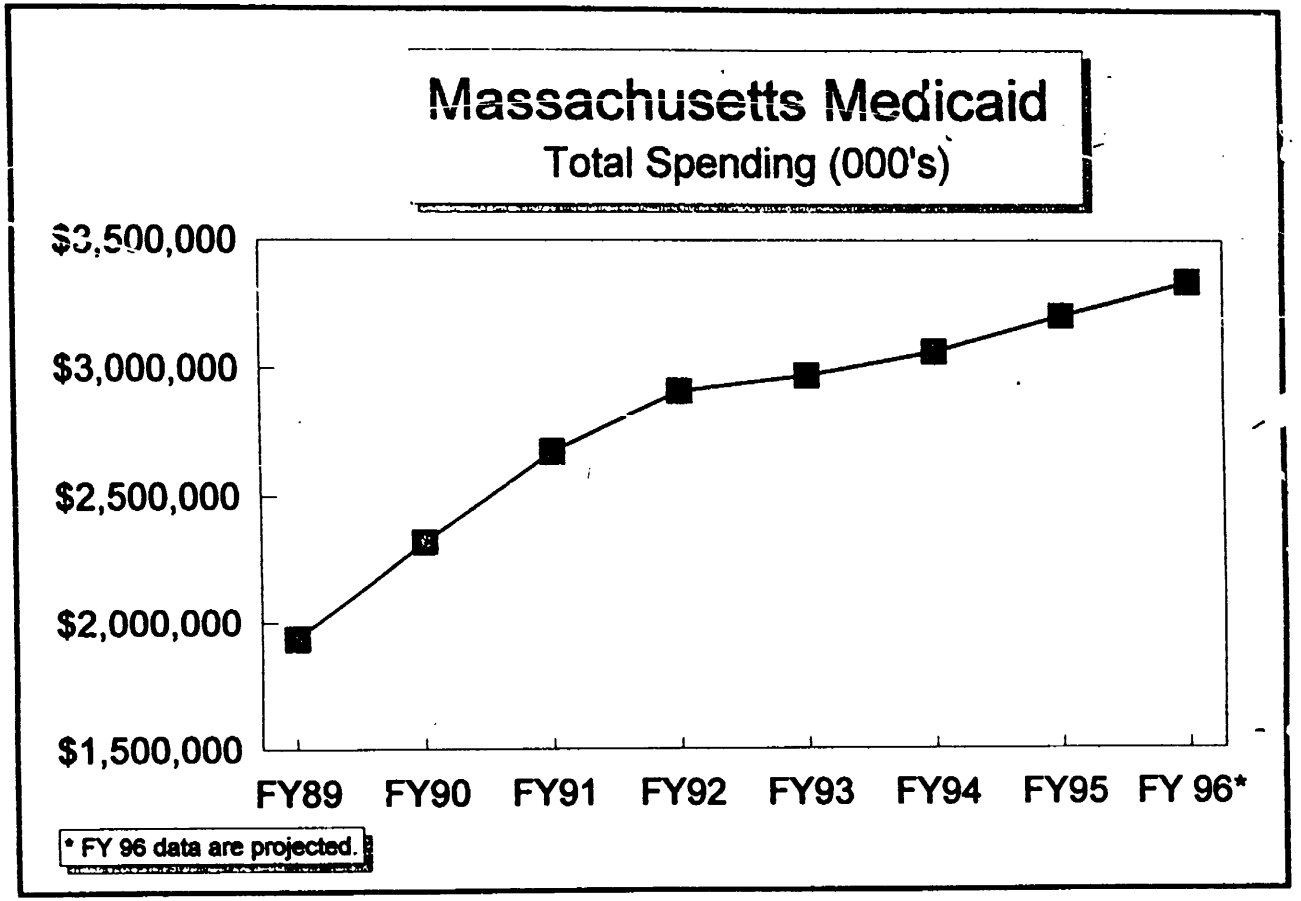
I thank you for the opportunity to testify before the Committee, and look forward to any questions you may have for me at this time.

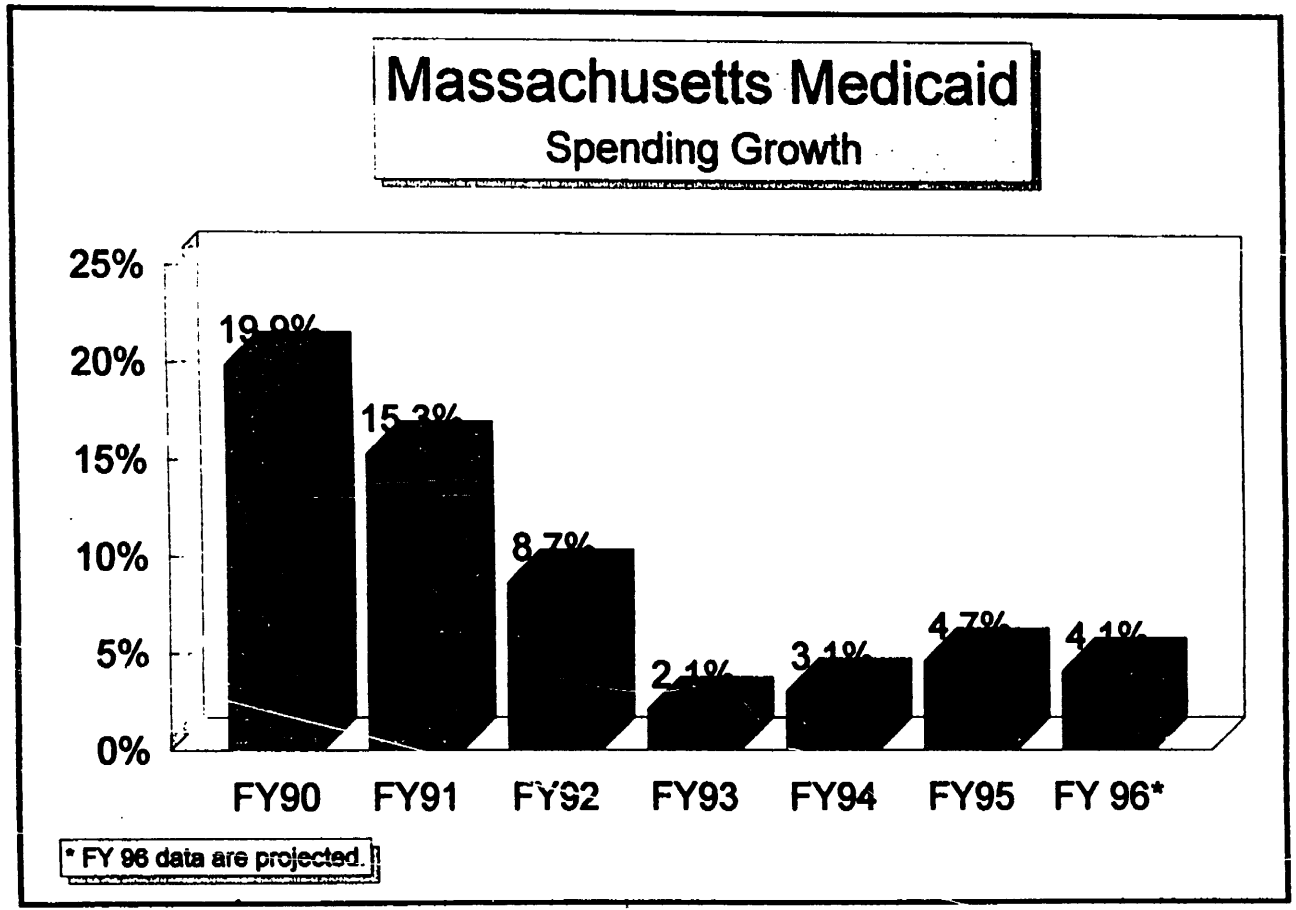
Medicaid Expenditures ($000) by Date of Service	FY89 as of 6/29/91	FY90 as of 11/30/92	FY91 as of 11/30/92	FY92 as of 9/30/93	FY93 as of 6/31/94	FY94 as of 12/31/94	FY95 as of 12/31/95 Annualized	FY 96 Projected
Acute Inpatient	341,632	437,976	472,378	519,436	397,843	372,109	344,962	377,841
Acute Outpatient	131,499	172,828	208,068	211,867	170,826	177,507	201,886	203,367
Acute Outpatient	21,081	12,932	80,601			137,710	153,924	
Dental Clinics (OPD)	102,036	150,485	108,696	16,911	19,169	22,465	27,892	
Clinics - CHC	8,375	9,411	10,755			17,332	20,068	
Chronic Hospital	140,839	140,338	204,498	184,944	178,513	157,866	143,622	148,903
Chronic Hospital	124,042	117,355	179,221					
State Institutions	16,797	22,982	27,125					
State Facility Ownership	0	1	152					
Nursing Home	789,930	886,636	1,012,106	1,064,306	1,102,676	1,144,236	1,179,476	1,222,076
SNF	357,887	345,110	174,159					
ICF	384,156	350,643	155,239					
Case Mix	17,887	190,282	681,261					
Specialized Nursing Units	0	0	1,446					
Community Long Term Care	101,449	131,521	140,436	161,866	176,841	193,424	213,670	246,997
Home Health	61,481	73,068	70 303	74 838	75,457	79,959	89,432	
Adult Day Care	11,769	13,970	15,165	17,259	17,669	18 948	20,307	
Adult Foster Care	2,123	2,742	4 104	5,904	7,642	10,055	11,762	
Transitional Living	7,643	9 357	9 814	11,485	0	0	12,032	
Private Duty Nurse	8,176	17,105	21,758	26 645	30,888	33,679	33,901	
Hospice	109	681	1,527	2,527	4,866	6,990	9,518	
Independent Living	10,368	14 598	17,764	23,197	40,040	43,793	36,627	
Practitioners	144,730	173,139	193,808	219,196	211,994	235,808	244,822	278,279
Physician	116,164	129,119	153,669	175,365	168,934	176,641	188,073	213 331
Group Practice		8,684	4,077	3,680	3,678	4,468	5,376	
Dentist	22,856	28,819	31,253	34,402	38,062	42,120	51,121	
Other Practitioners	5,710	6,517	4,808	3,748	1,320	1,771	1,952	61,948
Ancillary Services	178,324	205,130	226,806	273,763	205,782	241,368	289,368	432,773
Pharmacy	114,690	132,684	153,099	191,098	215,221	246,937	280,770	292,212
Laboratory	8,225	9,711	8 460	7,151	8,336	8,945	9 830	
Radiology	1,065	1,559	2,099	2,890	3,513	3,606	3,805	
Special Ancillaries	8,122	9 208	8,907	7,761	9 306	10 442	10,800	140,561
Vision Care	3,815	4,314	4,568	4,852	5 243	5,419	5,746	
Transportation	18,770	21,438	23,823	29,027	28,229	29,760	34,994	
Medical Supplies	20,639	26,206	27,550	33,984	35,934	36,259	43,466	
Managed Care	36,606	63,914	79,681	117,029	176,662	222,429	218,360	188,289
Early Intervention	3,330	3,871	5,021	6,528	7,133	7,746	9,306	
Family Planning	1,702	1,946	2,053	2,186	2,223	2,020	2,049	
HMO	30,535	48,056	71,557	108,771	165,160	209,699	202,417	180,289
Capitated Services	0	0	0	0		0	0	
PACE	38	38	1,046	1,527	2,319	2,948	4,580	
Community Care Connection	0	0	0	0		0	0	
Other/Unclassified	3	3	4	17		4	0	
Case Management					16	12	7	
Community Mental Health	84,717	119,756	142,999	157,328	78,864	88,346	68,866	76,970
ICF/MR Type A	12,062	13,798	14 758	15,801	17,127	0	0	
ICF/MR Type B	6,924	8,492	8,900	10,704	11,521	0	0	
Day Habilitation Services	12,588	15,026	16,985	20,065	21,638	23,174	26,572	
Mental Health - CHC	32,066	46,654	56 975	72,238	18,058	20,408	24,685	
Psychiatric Day Treatment	5,722	6,702	7,166	9,158	4,981	4,780	5,361	
Outpatient Psychiatric Services	0	0	0	0		0	0	
Inpatient Drug Detox	198	901	1,048	0		0	0	
Methadone Services	1,592	4,077	6 000	13,262	3,278	3,993	4,991	
Psych IP Under 21	13,565	24,105	28,977	16,100	2,252	3,013	4,256	
Mental Health Management Services		0	0	0	171,194	172,489	179,888	181,808
Total Medicaid Expenditures	1,936,943	2,330,636	2,675,849	2,909,933	2,979,436	3,041,747	3,206,181	3,336,994

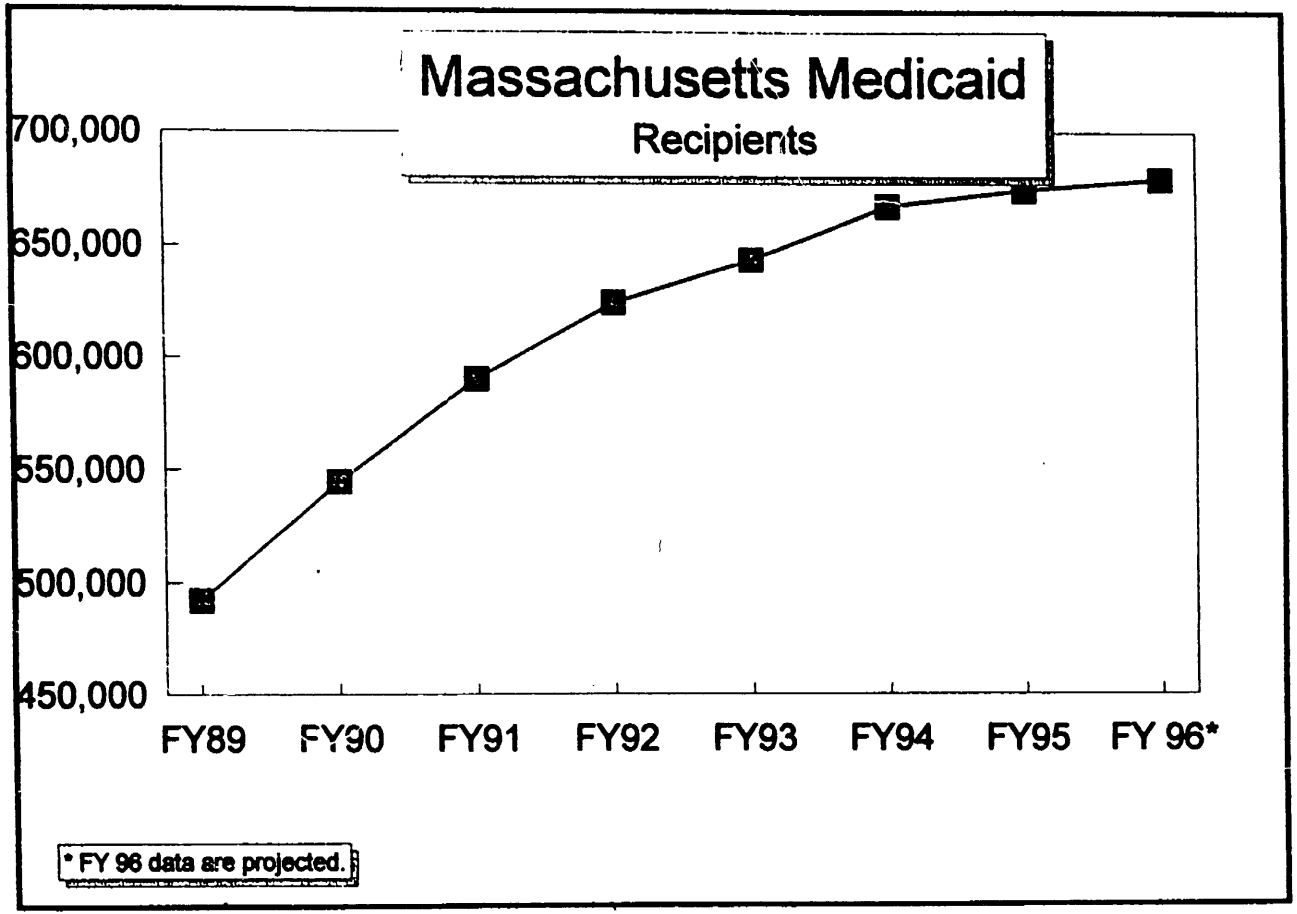
Medicaid Expenditures ($000) by Date of Service
Summary Provider Services

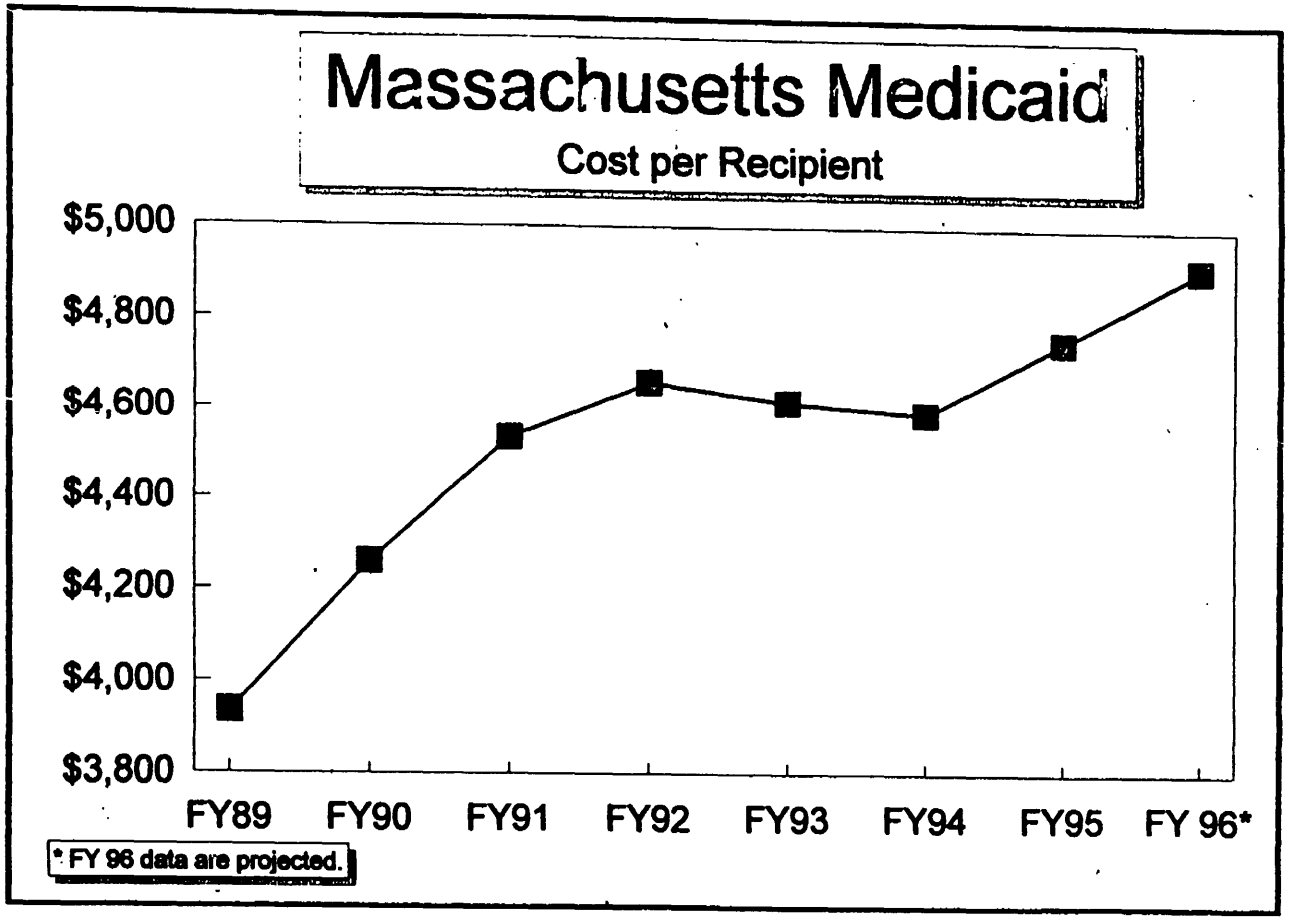
	FY89 as of 6/29/91	FY90 as of 11/30/92	FY91 as of 11/30/92	FY92 as of 9/30/93	FY93 as of 6/31/94	FY94 as of 7/31/95	FY95 as of 12/31/95 Annualized	FY 96 Projected
Acute Inpatient	361,632	437,976	472,278	519,626	397,883	373,039	344,942	377,841
ER / Outpatient	131,492	172,828	209,862	211,087	170,525	177,507	201,866	203,367
Chronic Hospital	140,839	140,336	206,498	184,944	178,513	167,866	143,022	140,903
Nursing Home	789,930	886,036	1,012,106	1,064,306	1,102,676	1,144,236	1,179,476	1,222,078
Community Long Term Care	101,649	131,521	140,436	161,866	176,561	193,424	213,670	246,997
Physician	116,164	137,803	187,746	179,046	172,612	181,109	193,449	213,331
Other Practitioners/Dentists	28,566	36,336	36,759	40,150	39,362	43,891	53,073	61,948
Pharmacy	114,690	132,664	153,099	191,098	215,221	266,937	280,770	292,213
HMO	30,836	48,066	71,567	106,771	166,160	209,699	202,417	180,289
MMMA	0	0	0	0	171,194	172,450	179,000	181,800
Other Mental Health	84,717	119,758	142,809	157,336	78,866	86,346	66,866	75,970
Miscellaneous	46,709	78,294	83,531	92,923	102,252	107,161	134,573	146,561
Total Medicaid Expenditures	1,938,943	2,330,626	2,675,849	2,909,033	2,970,436	3,062,678	3,204,181	3,336,994

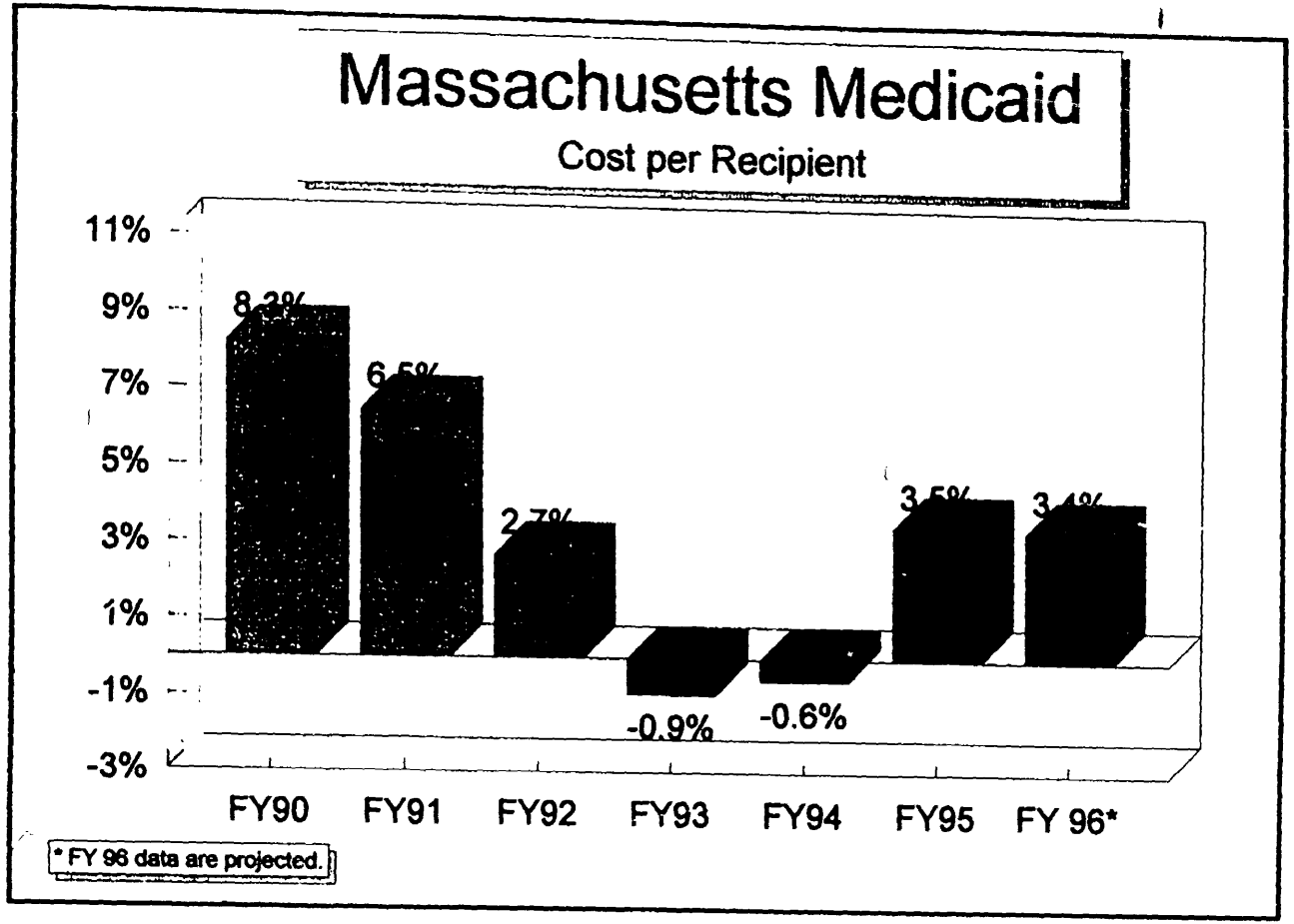
Massachusetts Medicaid Trends *	FY89 as of 6/29/91	FY90 as of 11/30/92	FY91 as of 11/30/92	FY92 as of 9/30/93	FY93 as of 6/31/94	FY94 as of 7/31/95	FY95 as of 12/31/95 Annualized	FY 96 Projected
Total Program								
Total Medicaid Expenditures	1,935,943	2,320,626	2,675,869	2,909,033	2,970,435	3,061,747	3,204,181	3,336,994
% Change Over Prior Year		19.9%	15.3%	8.7%	2.1%	3.1%	4.7%	4.1%
Recipients	491,946	544,718	589,920	624,421	643,526	666,980	674,317	679,037
% Change Over Prior Year		10.7%	8.3%	5.8%	3.1%	3.6%	1.1%	0.7%
Cost per Recipient	$3,935	$4,260	$4,536	$4,659	$4,616	$4,590	$4,752	$4,914
% Change Over Prior Year		8.3%	6.5%	2.7%	-0.9%	-0.6%	3.5%	3.4%
Long Term Care								
Community Long Term Care	$101,669	$131,521	$140,435	$161,855	$176,561	$193,424	$213,670	$246,997
% Change Over Prior Year		29.4%	6.8%	15.3%	9.1%	9.6%	10.5%	15.6%
Institutional LTC	$900,769	$1,026,373	$1,218,603	$1,249,150	$1,281,088	$1,302,092	$1,322,497	$1,362,978
% Change Over Prior Year		13.9%	18.7%	2.5%	2.6%	1.6%	1.6%	3.1%
Total Long Term Care	$1,002,438	$1,157,894	$1,359,038	$1,411,005	$1,457,649	$1,495,516	$1,536,166	$1,609,975
% Change Over Prior Year		15.5%	17.4%	3.8%	3.3%	2.6%	2.7%	4.8%
Non-Long Term Care Expenditures	$933,505	$1,162,732	$1,316,831	$1,498,028	$1,512,786	$1,566,231	$1,668,015	$1,727,019
% Change Over Prior Year		24.6%	13.3%	13.8%	1.0%	3.5%	6.5%	3.5%

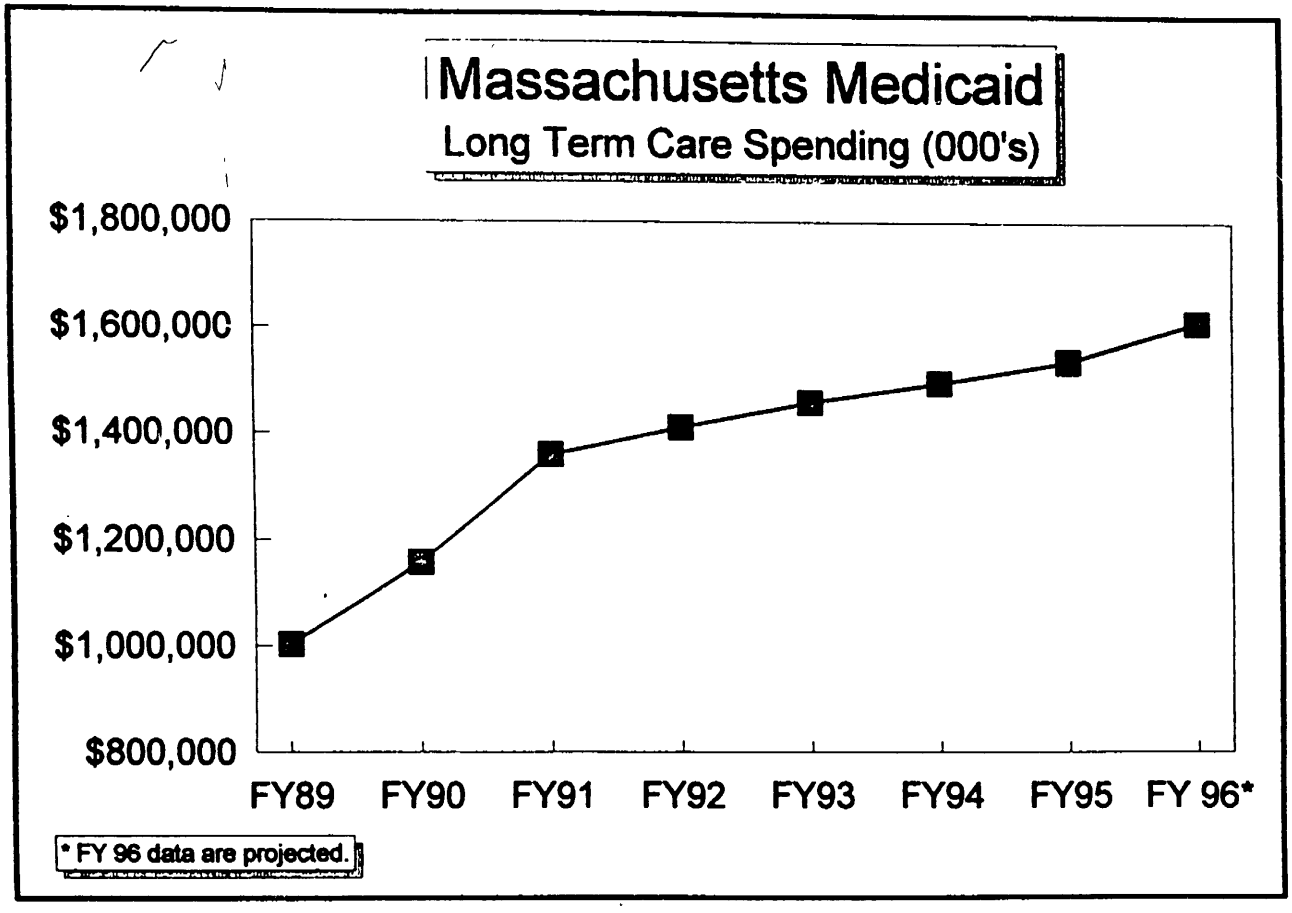

Massachusetts Medicaid
Total Spending (000's)
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
FY89
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.

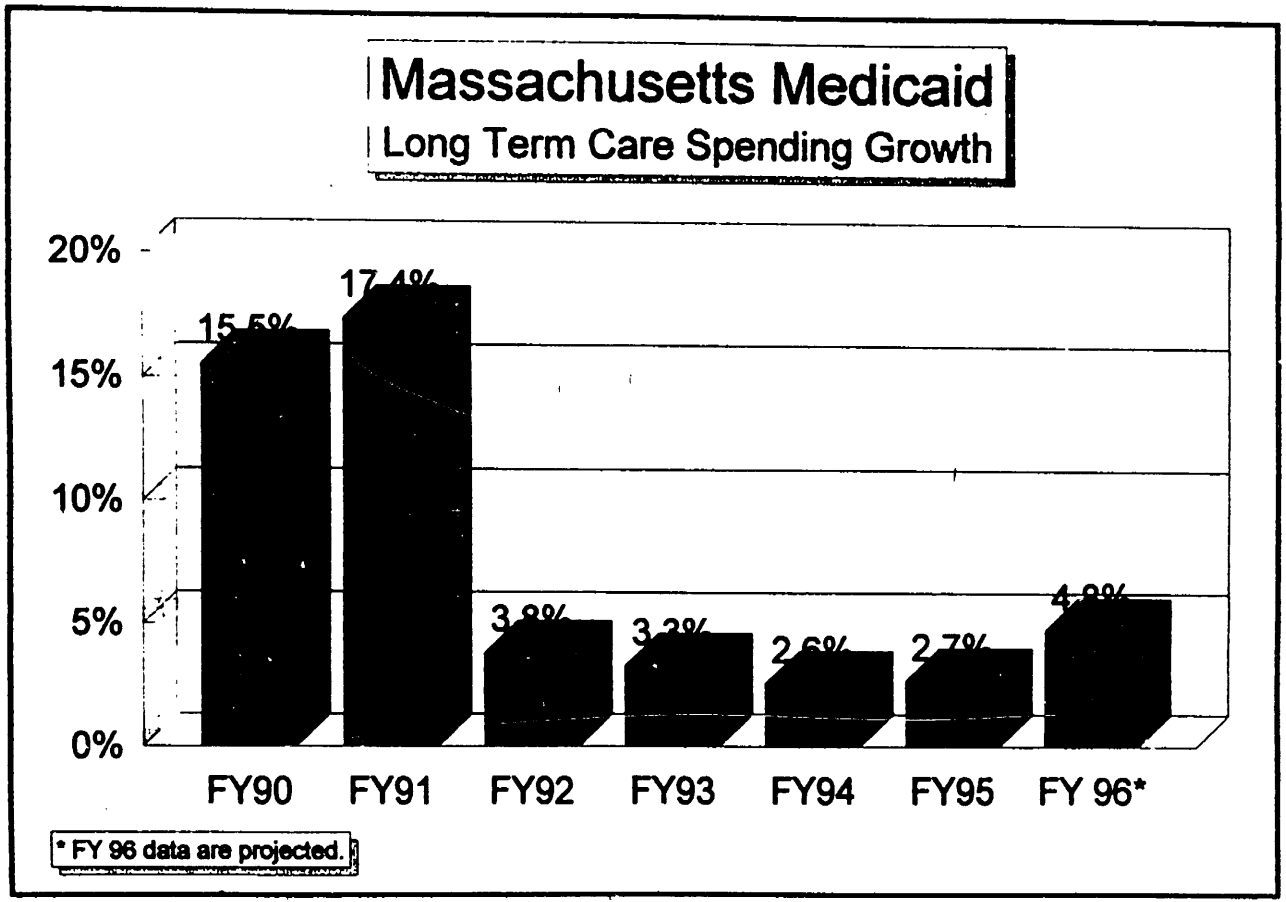

Massachusetts Medicaid
Spending Growth
25%
20%
15%
10%
5%
0%
19.9%
15.3%
8.7%
2.1%
3.1%
4.7%
4.1%
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.

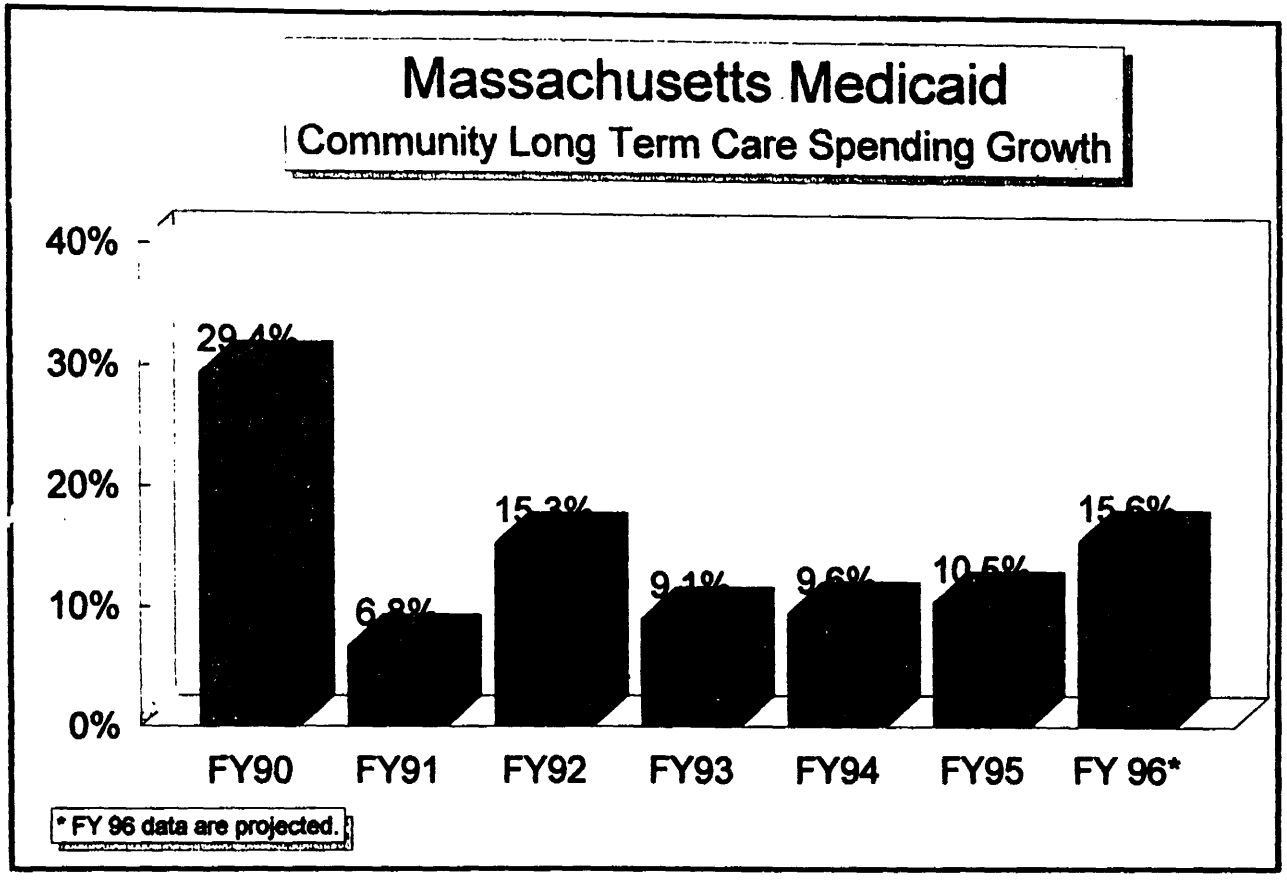

Massachusetts Medicaid
Recipients
700,000
650,000
600,000
550,000
500,000
450,000
FY89
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.

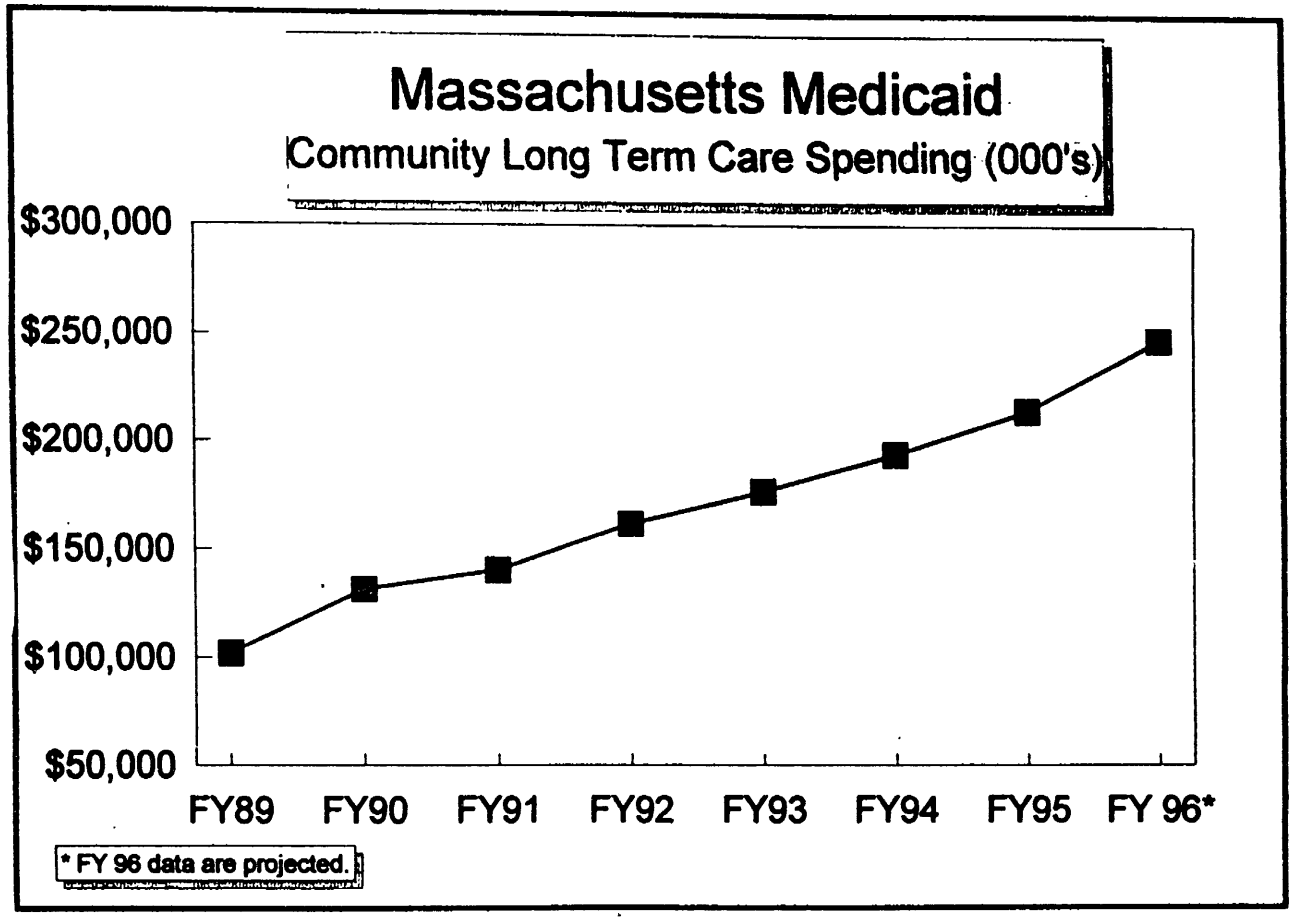

Massachusetts Medicaid
Cost per Recipient
$5,000
$4,800
$4,600
$4,400
$4,200
$4,000
$3,800
FY89
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.

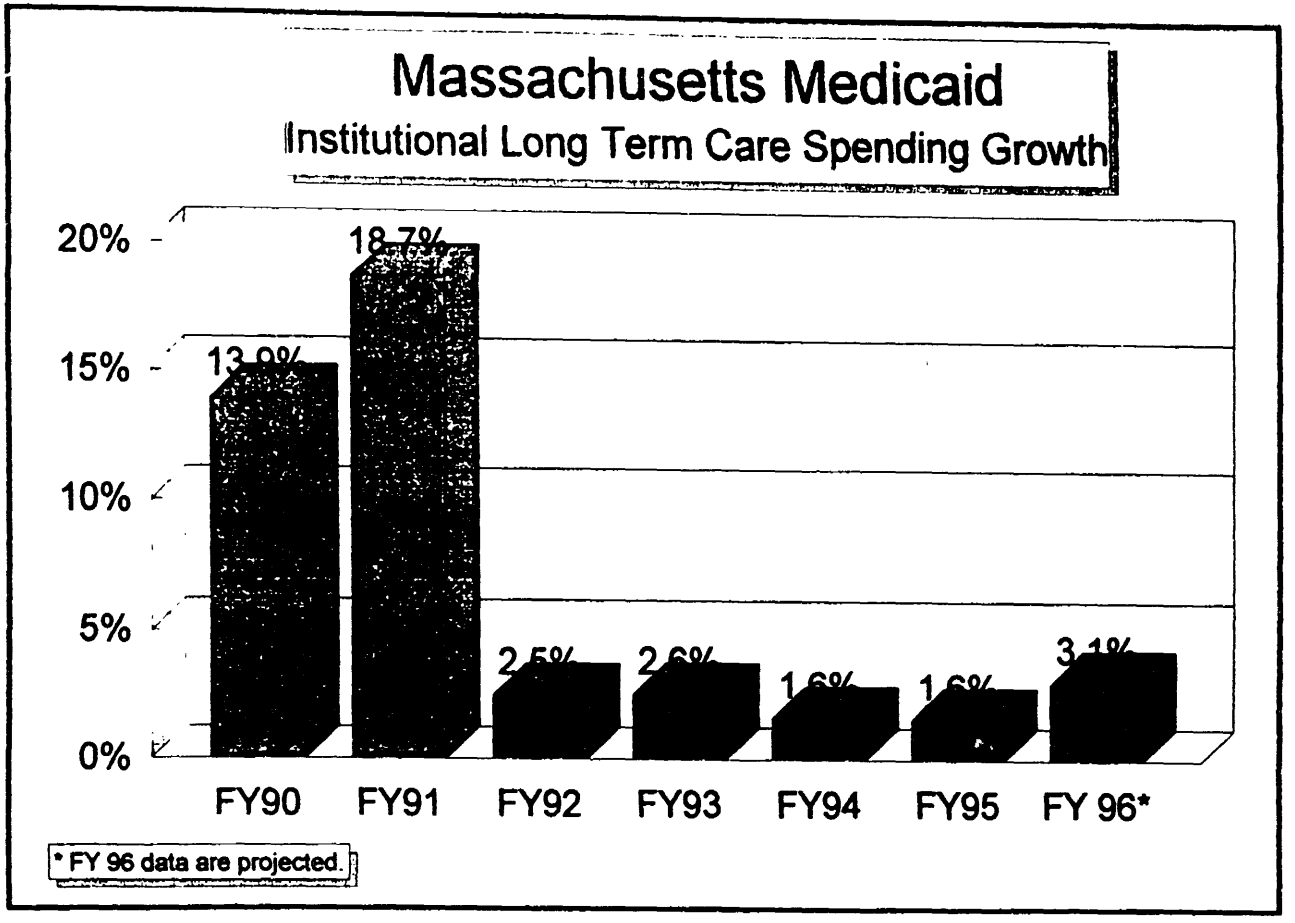

Massachusetts Medicaid
Cost per Recipient
11%
9%
7%
5%
3%
1%
-1%
-3%
8.2%
6.6%
2.7%
-0.9%
-0.6%
3.5%
3.4%
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.


Massachusetts Medicaid
Long Term Care Spending (000's)
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
FY89
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.


Massachusetts Medicaid
Long Term Care Spending Growth
20%
15%
10%
5%
0%
15.5%
17.4%
3.8%
3.2%
2.6%
2.7%
4.9%
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.


Massachusetts Medicaid
Community Long Term Care Spending Growth
40%
30%
20%
10%
0%
29.4%
6.8%
15.3%
9.1%
9.6%
10.5%
15.6%
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.


Massachusetts Medicaid
Community Long Term Care Spending (000's)
$300,000
$250,000
$200,000
$150,000
$100,000
$50,000
FY89
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.


Massachusetts Medicaid
Institutional Long Term Care Spending Growth
20%
15%
10%
5%
0%
18.7%
2.5%
2.6%
1.6%
1.6%
3.1%
FY90
FY91
FY92
FY93
FY94
FY95
FY 96*
* FY 96 data are projected.

PREPARED STATEMENT OF KAREN DAVIS

THE NATION'S HEALTH CARE SAFETY NET FOR THE POOR

Thank you, Mr. Chairman, for this invitation to speak before the Committee on the future of the Medicaid program. Medicaid serves as a health care safety net for 36 million of our nation's poorest and sickest people. It is vitally important to assuring that those in need of health care receive it. In a health care marketplace under intense pressure to provide care at lower cost, it is essential to assure that the most vulnerable are not excluded. As managed care plans, academic health centers, hospitals, physicians, and other health care providers respond to the demands of employers and government to provide care at lower cost, the availability of free care for those who are uninsured is increasingly jeopardized. Medicaid is the linchpin in the nation's strategy to assure access to health care for low income Americans, while using market incentives to increase the efficiency with which that care is provided.

Any changes in the Medicaid program need to be carefully considered to assure that it continues to serve its essential mission of providing health insurance coverage to low income Americans most in need of health care—women and children, disabled and elderly people. Today, I would like to review Medicaid's role as a health care safety net, describe who depends on Medicaid for health insurance coverage, outline why this coverage is vital in assuring access to needed health care services, and examine the implications of proposed changes.

MEDICAID'S ROLE IN PROVIDING HEALTH INSURANCE COVERAGE

The American economy has undergone enormous restructuring to meet the demands of an internationally competitive world. Its success in doing so has been vital to economic growth and employment. One unfortunate side effect, however, has been the loss of jobs that provide good health insurance coverage to workers—and especially to dependents. The numbers of uninsured have risen steadily since the mid-1970s—driven largely by the erosion in employment-based health insurance coverage. Today 40 million Americans are uninsured—18 percent of those under age 65.

Without Medicaid—however—this picture would be even more bleak. An ongoing study of health coverage and access in seven states by the Henry J. Kaiser Family Foundation and The Commonwealth Fund has found that almost half of families with incomes below 250 percent of the federal poverty level (approximately $35,000 for a family of four) are either uninsured or depend on Medicaid for coverage. To put it starkly—without Medicaid half of nonelderly Americans with low or modest incomes would be uninsured. Any changes to Medicaid that would result in an increase in those without health insurance coverage is of grave concern.

The Kaiser Commission on the Future of Medicaid, on which I am pleased to serve, has documented the importance of Medicaid in providing a basic safety net of health insurance coverage for the most vulnerable Americans. A recent Commission report pointed out that in 1994 Medicaid covered 33.5 million people—more than 1 in 8 Americans—including nearly 17 million children, 7.5 million parents (mostly mothers), 5.4 million blind and disabled persons, and 3.8 million elderly persons.[1] For each of these groups Medicaid covers a broad range of services to meet their complex needs.

Health Insurance for Children

The one bright note in trends of health insurance coverage is expansion of Medicaid to cover more poor children and pregnant women. These expansions, accomplished by raising income eligibility standards for young children and pregnant women, have been able to offset otherwise steep declines in private insurance coverage. As a result, forty percent of all pregnant women and infants are now covered by Medicaid, assuring financing for essential prenatal care, delivery, and well baby care.[2] Among poor families, 85 percent of pregnant women and infants are covered by Medicaid, 6 percent are privately insured, and 9 percent are uninsured. Similarly among poor children ages one to five, 88 percent are covered by Medicaid, 5 percent are privately insured, and 7 percent are uninsured.

Medicaid coverage tapers off for low income children six years or older, and the rate of uninsured children increases. Among poor children ages 6 to 12, 78 percent

[1] The Kaiser Commission on the Future of Medicaid, The Medicaid Program at a Glance, December 1995.

[2] John Holahan and Shruti Rajan, Medicaid Coverage of Low Income People, prepared for the Kaiser Commission on the Future of Medicaid, March 1996, and special tabulations from the Current Population Survey requested by the author.

are covered by Medicaid, 9 percent are privately insured, and 13 percent are uninsured. As of 1994, 61 percent of poor children ages 13 to 18 were covered by Medicaid, 13 percent were privately insured, and 26 percent were uninsured. Under current law, Medicaid coverage of poor children ages 13 to 18 will be fully phased in by the year 2002.

Health Insurance Coverage for Low Income Women

Medicaid is an important source of health insurance coverage for many low income women. Twenty-two percent of women with incomes below twice the federal poverty level rely on Medicaid for assistance in paying health care bills.[3] One in five women on Medicaid is in fair or poor health, and poor health or pregnancy are major reasons women obtain Medicaid coverage.

Despite this important coverage, mothers of poor children are not well protected. A recent Commonwealth Fund study found that nearly a third of poor and near-poor women are uninsured. Pregnancy affords many low income women temporary Medicaid coverage; one fourth of all non-elderly women who enroll in Medicaid do so because of pregnancy. However, pregnant women qualifying for Medicaid's income standards for pregnancy are covered only for their term of pregnancy and 60 days post-partum, and then only for care related to the pregnancy. Coverage may continue after the birth of her children only if a mother qualifies for Medicaid through welfare, which has much lower income eligibility standards. For many poor women, coverage ends with the pregnancy; 15 percent of the women leaving Medicaid do so because of childbirth.

Women leaving Medicaid typically do not receive private health insurance. Among the reasons women lose Medicaid are obtaining a job (typically without private health insurance), getting a raise, becoming married, or going off welfare. Nearly two-thirds of them will become uninsured.

Any change in welfare assistance runs a risk that it will increase the numbers of uninsured women. Currently, coverage under Aid to Families with Dependent Children qualifies mothers of dependent children for Medicaid coverage. If arbitrary limits are placed on time for welfare eligibility or women move into training or employment, Medicaid coverage could be lost. Currently, Medicaid provides for continuation of coverage for one year for working women who lose AFDC because of an increase in earnings from work. Neither low income women nor their employers are likely to be able to afford coverage without subsidies.

Health Insurance for the Disabled

As a safety net for health and long-term care, Medicaid pays the cost of care for the nation's poorest and most disabled individuals. It assists individuals with the most catastrophic of illnesses—children with chronic conditions that can leave them disabled for a lifetime, trauma survivors like Christopher Reeve but without his financial resources to pay for round-the-clock care, adults with mental illness and retardation that require extensive care in the community or in an institutional setting. The average cost for a severely retarded individual on Medicaid, a population that is generally not covered by most private insurance, can exceed $50,000 per year.

Long-Term Care and Supplemental Health Insurance for Medicare's Poor

For 4 million low income elderly people and 6 million low income people with disabilities, Medicaid provides both health insurance and long-term care coverage. In its long-term care role, Medicaid pays for home- and community-based services and is the dominant source of public financing for nursing home care. In its insurance role, Medicaid is a supplementary insurance program for low income aged and disabled Medicare beneficiaries, paying Medicare's premiums, deductibles, and coinsurance and covering additional services, most notably prescription drugs.

From the perspective of how Medicaid dollars are spent, Medicaid is predominantly a program serving the low income aged and disabled population. The elderly and disabled constitute 27 percent of Medicaid beneficiaries, but account for 59 percent of spending because of their intensive use of acute care services and the costliness of long-term care in institutional settings. The per capita cost of an elderly beneficiary is eight times that for a child on Medicaid.

[3] Pamela Farley Short, Medicaid's Role in Insuring Low-Income Women, The Commonwealth Fund, May 1996. Based on analysis of the 1990 panel of the Survey of Low Income and Program Participation.

CONSEQUENCES OF BEING UNINSURED

The U.S. has a market-driven health care system. Those with good health insurance are increasingly viewed as "customers" whose business is sought by managed care plans and an array of health care providers. Those without health insurance or the ability to pay, however, are dependent on charity care from a limited number of public hospitals, teaching hospitals, community health centers, or other health care safety net providers. The ability of the uninsured to obtain health care has never been good, and in the future it will be increasingly scarce as financial pressures on safety net providers intensify.

Studies have documented that the consequences of being uninsured include failure to get preventive care, inadequate maintenance of chronic conditions, and adverse health outcomes. The 1993 Kaiser/Commonwealth Fund health insurance survey found that 34 percent of the uninsured failed to receive needed care, and 71 percent postponed needed care.[4]

The uninsured are much less likely to obtain preventive care. For example, 52 percent of uninsured women did not obtain a Pap smear in the last year, compared with 36 percent of insured women, and 69 percent of uninsured women ages 40 to 64 did not get a mammogram, compared with 38 percent of insured women.[5] We also know that those with chronic illnesses who are uninsured are least likely to receive proper maintenance and continuous care, with the result that untreated conditions such as hypertension or diabetes can lead to serious health consequences.

Mounting stresses on safety net health care providers—public hospitals, teaching hospitals, community health centers, and others that have traditionally served poor and uninsured people—are rapidly eroding the capacity and willingness to provide uncompensated care. These stresses include: cutbacks in state and local government funding, the diversion of Medicaid revenues to managed care organizations, proposed reductions in disproportionate share funding under Medicare and Medicaid, and reduced ability to cross-subsidize care as managed care plans demand reduced payment rates as the price of entry into networks. As financial pressures on hospitals and other health care providers mount, the health consequences for the uninsured are likely to intensify.

MEDICAID SUBSTITUTE: A HOLLOW PROMISE

Financial pressures on the federal government and on state governments of financing health care for low income Americans have led to an understandable desire to replace the current Medicaid program with a block grant and achieve budgetary savings. But the numbers of low income Americans in need of health insurance coverage can not be wished away. The disabled will not become well. Nursing home patients with Alzheimer's or other disabling conditions will continue to need round-the-clock care. Employers of low-wage workers are not spontaneously going to begin paying for health insurance. Nor is it easy to find savings in a program that has always tried to purchase health care at a lower rate than that paid by private insurers or Medicare. Certainly, changes that would improve efficiency, reduce fraud and abuse, and encourage employers to cover the working poor should be pursued—but state and federal policy makers have strived for over two decades to identify and implement such changes with only modest success. The reality is that providing health insurance to the sickest and poorest Americans is a costly undertaking, and as good a case could be made that we are spending too little as that we are spending too much.

Concerns raised by the Medicaid substitute proposal under consideration by the Committee include: 1) the change from an entitlement program to a modified block grant; 2) lack of guaranteed benefits; 3) lack of federal managed care standards and safeguards; and 4) lack of enforcement.

Entitlement to Health Insurance

Entitlement has become a maligned term. But all health insurance is by its nature entitlement. Employers entitle workers to a set of health benefits which they obtain through fee-for-service health insurance plans or through managed care plans. Essential to the nature of health insurance coverage is that it defines who is covered, what is covered, and how providers will be paid.

Under the Medicaid substitute proposal "eligibility" would be retained for:

- pregnant women and children up to age 6 up to 133 percent of poverty;

[4] Davis et al., "Health Insurance: Size and Shape of the Problem," Inquiry, Volume 32, Number 2, Summer 1995.

[5] E. Richard Brown et al., Women's Health-Related Behaviors and Use of Clinical Preventive Services, The Commonwealth Fund, October 1995.

- children age 6 to 12 up to 100 percent of poverty;
- recipients of AFDC below national average of those covered by a new welfare program defined by the state;
- the disabled as defined by the state or the disabled on SSI;
- the elderly meeting SSI income and asset standards; and
- Medicare cost sharing for Qualified Medicare Beneficiaries (Medicare beneficiaries up to 100 percent of poverty).

States would have great flexibility to define income and assets potentially resulting in loss of coverage for many of those now covered. States would have the option of covering other individuals currently covered by Medicaid and anyone with income under 275 percent of poverty, but without additional federal matching funds to meet the cost of this expanded coverage.

Some people now covered by Medicaid would no longer be entitled to health insurance coverage. Under current law, children ages 13 to 18 in families with incomes up to the poverty level would be phased in by the year 2002. No provision is included for their coverage—reducing Medicaid coverage for 3 million adolescents by 2002. States could define disability to exclude people with HIV disease, substance abuse, mental illness, or any other disability without support at the state level. Many elderly poor could also lose coverage. No provision is made for picking up Medicare premiums, as current law does for Medicare beneficiaries with incomes up to 120 percent of poverty. Low income elderly now covered at the option of a state by virtue of spend-down or medically needy provisions would also appear to be excluded.

Guaranteed Benefits

But the real problem with the proposal is not only who would be covered, but what they would be covered for. The proposal does not require that beneficiaries receive health insurance coverage or coverage under a managed care plan. States could simply reimburse selected providers for bad debts incurred rendering health care services to eligible groups, rather than provide health insurance coverage. Or, the state could use federal funds to cover the budgets of state psychiatric facilities. The difference between insurance and payments to providers is an important distinction. Studies show that the uninsured who rely on free sources of care systematically receive less care. Without guaranteed health insurance coverage, the uninsured put off obtaining care, go without preventive services, and do not receive ongoing medical attention to chronic conditions such as hypertension and diabetes—with life-threatening consequences. There is a world of difference between insurance coverage and limited subsidies to health care providers to care for the poor.

Even if a state decides to continue providing health insurance coverage to beneficiaries, there is no guaranteed benefit package. The proposal indicates that the following benefits remain guaranteed for core covered populations: inpatient and outpatient hospital services, physician services, prenatal care, nursing facility services, home health care, family planning services and supplies, laboratory and x-ray services, pediatric and family nurse practitioner services, nurse midwife services, and Early and Periodic Screening Diagnosis and Treatment Services (redefined so that a state need not cover all Medicaid optional services for children). Other benefits are optional including after two years community health centers and rural health clinics, and long term care options are broadened (presumably including room and board residential care facilities not meeting nursing home standards).

What really matters, however, is that states would have complete flexibility in defining amount, duration, and scope of services. States, for example, could limit hospital days to five days of coverage or require beneficiaries to pay substantial cost sharing for covered services. Benefits could be different in different areas of the state and for different population groups. Current provisions that require hospitals, physicians, and other Medicaid health care providers to accept Medicaid as payment in full would be repealed—leaving beneficiaries vulnerable to supplemental charges by providers. Nor would the federal government provide any standards or oversight regarding the level of provider payments. A list of services, without any guarantee of how many services from what providers at what cost to beneficiaries, is a hollow promise of coverage.

Managed Care

One strategy states have increasingly used to contain the growth in Medicaid outlays is enrollment of Medicaid beneficiaries in managed care plans. Today, most states are aggressively moving low income beneficiaries, especially children and adults, from fee-for-service care into managed care plans. This year, 30 percent of Medicaid enrollees nationwide will be enrolled in Medicaid managed care plans. Many states are planning to expand managed care enrollment to disabled bene-

ficiaries, although there is only limited experience in managed care for this population.

However, many states have wanted to move more swiftly, rely more heavily on Medicaid-specific plans, restrict the freedom of choice of beneficiaries to be cared for by their own physician, and require mandatory enrollment in state-selected managed care plans. Under current law, such proposals must be reviewed and approved under a waiver authority. Under the proposal states could pursue managed care without the need for federal approval and without safeguards that guarantee beneficiaries choices of enrolling in quality managed care plans or staying in traditional Medicaid.

States' experiences with managed care to date have been quite variable. Where quality plans exist and states have moved in a gradual carefully planned way toward expanding the choices available to beneficiaries, Medicaid beneficiaries have had wider access to primary care.[6] When implemented without sufficient planning and quality standards, the move to managed care has been at best chaotic and at worst destabilizing to current systems of care in low income communities.

Legal Recourse

The proposal would repeal Title XIX of the Social Security Act. Current protections in the law would be lost, including limits on cost-sharing, mandatory assignment by providers, enforcement of nursing home quality standards, and prohibitions against discriminating against certain groups of beneficiaries based on their age or medical condition or geographic location. Individuals could only bring law suits with regard to eligibility, not benefits, and through state courts not federal courts. Providers and health plans are specifically excluded from the right to bring suit.

State Fiscal Capacity

The fiscal capacity of states to finance health care for the poor is quite variable. Poor states have always had poorer programs. States that have higher health care costs are hard hit. No state can risk having a more generous Medicaid program, and higher state tax rates, without fear of either attracting low income families with serious health problems to the state or more to the point, discouraging business from locating and remaining in the state.

Nor with state constitutions requiring balanced budgets can states afford to expand coverage in times of economic recessions. States are thrown into fiscal crisis when the business cycle slumps—sales tax revenues decline and unemployment compensation increases. Yet it is also the time that jobs are lost, including jobs with health insurance coverage, poverty increases, and the need for publicly funded health insurance coverage for low income people increases. A federal umbrella fund would assist states fiscally in times of economic downturn, but there would appear to be no guarantee that the unemployed and poor would get the health insurance coverage they need.

Health insurance coverage for the poor, disabled, frail elders, and unemployed is clearly a national responsibility—not an individual or local community responsibility. It is not a problem that markets or individual responsibility can solve. Nor is it strictly a local matter. All Americans should be concerned with assuring that a baby gets a healthy start in life—not just the residents of the state in which that child is born. It is a national concern—and we should be examining options for moving toward uniform national standards of eligibility, benefits, and quality standards—not dismantling the nation's most important health safety net for the poor.

THE CHALLENGE AHEAD

Medicaid is indisputably our nation's most important health care safety net for low income Americans. At a time of great stress in our health care system, rising numbers of uninsured, and stresses on public hospitals, teaching hospitals, and other sources of care for the uninsured, we should be expanding Medicaid funding—not repealing it, substituting a block grant, and achieving federal budget savings of $72 billion over the next six years.

Rather than increasing the fragility of our safety net, we need to reengage the issue of expanding health insurance coverage. Modest, pragmatic steps should be explored. Medicaid has proven a successful vehicle for insuring low income children and pregnant women. We need to explore ways of continuing coverage for low income mothers who work. We need to accelerate, not repeal, expanded coverage for

[6] "Managed Care and Low Income Populations: A Case Study of Managed Care in Minnesota" and "Managed Care and Low Income Populations: A Case Study of Managed Care in California" prepared by Mathematica Policy Research, Inc., for The Henry J. Kaiser Family Foundation and The Commonwealth Fund, May 1996.

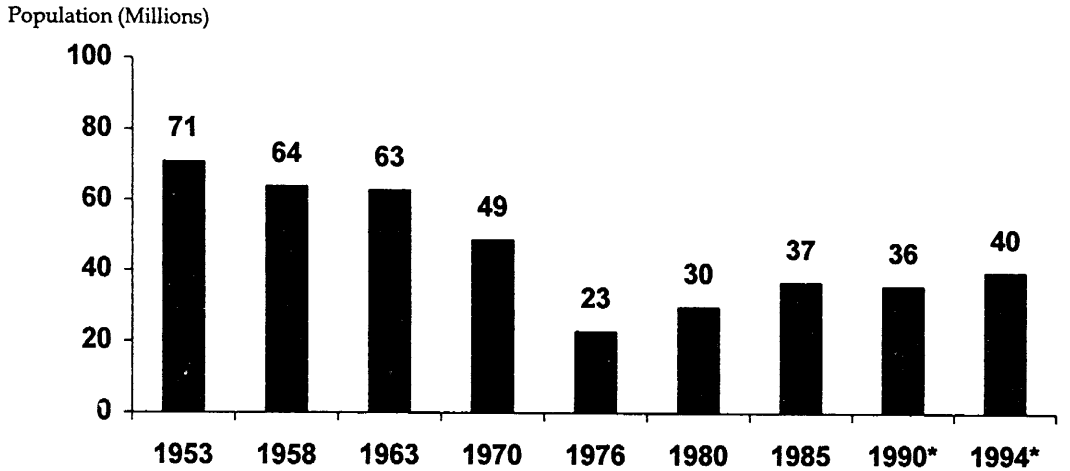
poor children ages 13 to 18. We need to expand Medicaid eligibility and provide federal matching for low income working families—perhaps starting by making such coverage optional for states with matching federal funds.

But this coverage needs to guarantee vulnerable Americans access to quality health care. For some Americans, a high quality managed care plan is an attractive option, providing a regular place to turn for preventive and primary care. Others, however, need complex care for serious illnesses and disabilities. Care must be taken to assure that Medicaid beneficiaries can enroll in a system that best meets their needs. The recent experience of states point to the need for federal quality standards, safeguards, and oversight as Medicaid changes with the changing health care system.

As this evolution takes place, Medicaid should strive to become a model program for both poor and working families, for healthy babies and disabled seniors. It should become a vehicle for expanding coverage to the nation's uninsured—not shrunk at a time of great vulnerability. It deserves our attention and support. Thank you.

THE UNINSURED: 1953-1994

Erosion of Employer Coverage Takes its Toll in Last 15 Years



*Survey questions change in 1988 and 1994, lowering the number of uninsured.
Source: USDHEW, Health Interview Survey 1953-76. CPS survey 1980-93.
1980-85 Health Care Financing Review 1994; 1989-93, EBRI, 1996.

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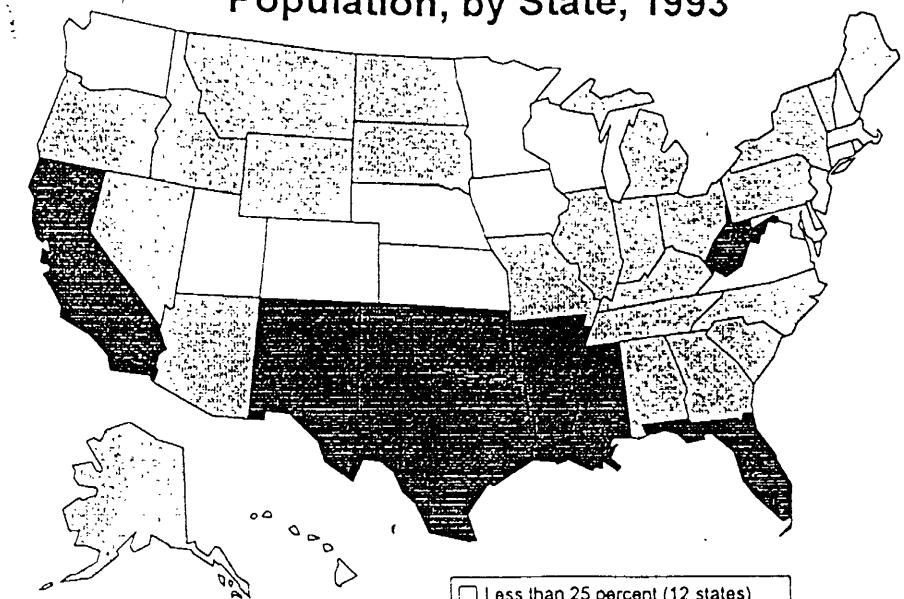
FIGURE 1

At-Risk Population Under Age 65 as a Percent of Total Population, by State, 1993



lote: 'At-risk' is defined as either uninsured or on Medicaid.
stimates for WY and ND based on 1990-1992 average.
Includes the Distnct of Columbia.
ource: EBRI, 1995; Winterbottom, et al., 1995.

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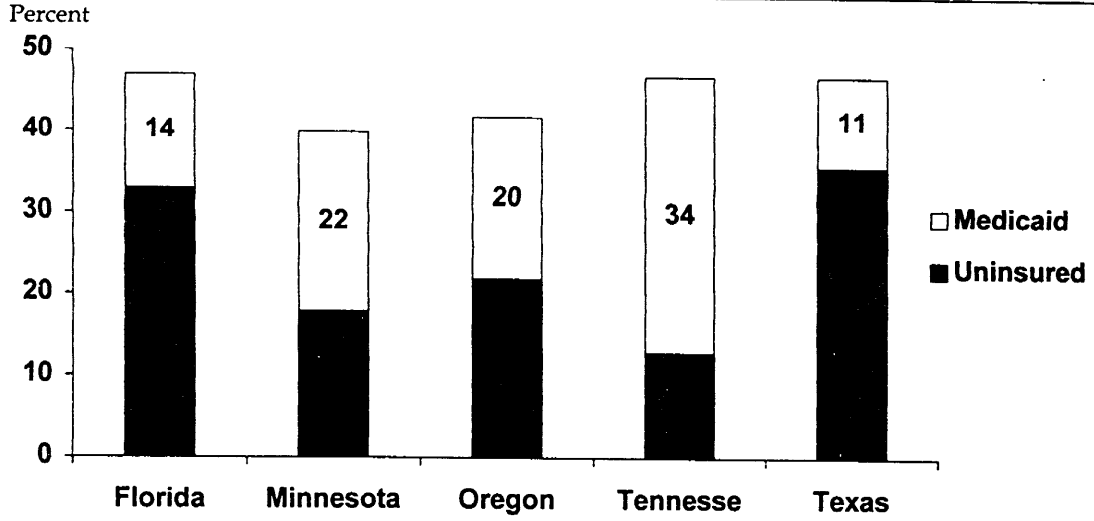
FIGURE 2

Low Income Populations at Risk



"Low income" includes individuals with incomes below 250% of the poverty level

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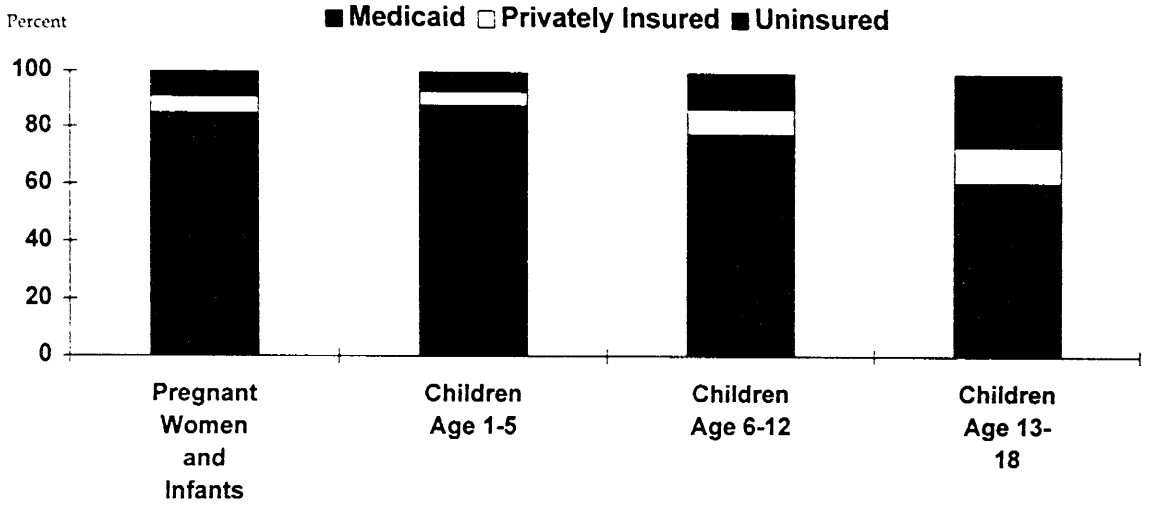
Kaiser/Commonwealth Low Income Survey, 1995-1996
Louis Harris and Associates, Inc.

FIGURE 3

Insurance Coverage of Low Income Pregnant Women and Children, 1994



Source Urban Institute Tabulations From the 1994 March Current Population Survey, February, 1996.

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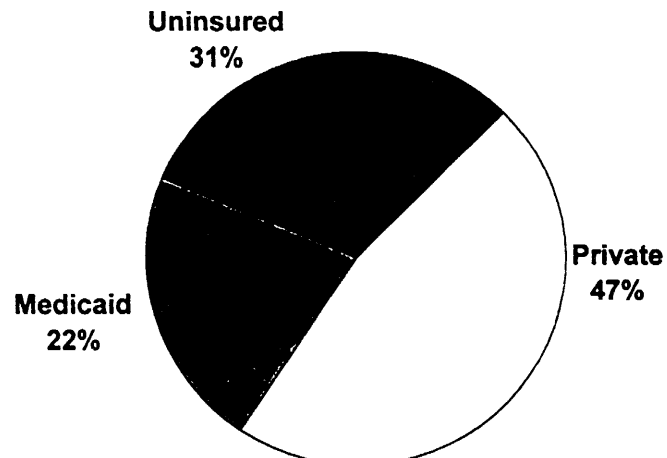
FIGURE 4

Health Insurance Coverage of Low Income Women
Percent Distribution by Insurance Group



Source: Pamela Farley Short, 1996, based on Survey of Income and Program Participation, 1990 Panel

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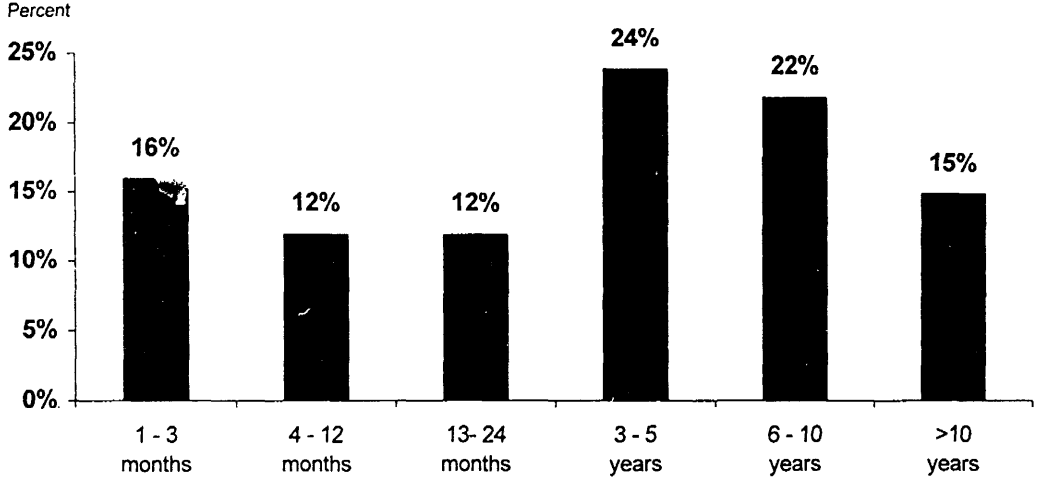
FIGURE 5

Time on Medicaid

Percent Distribution of Adult Women with Medicaid



Source: Pamela Farley Short, 1996, based on Survey of Income and Program Participation, 1990 Panel

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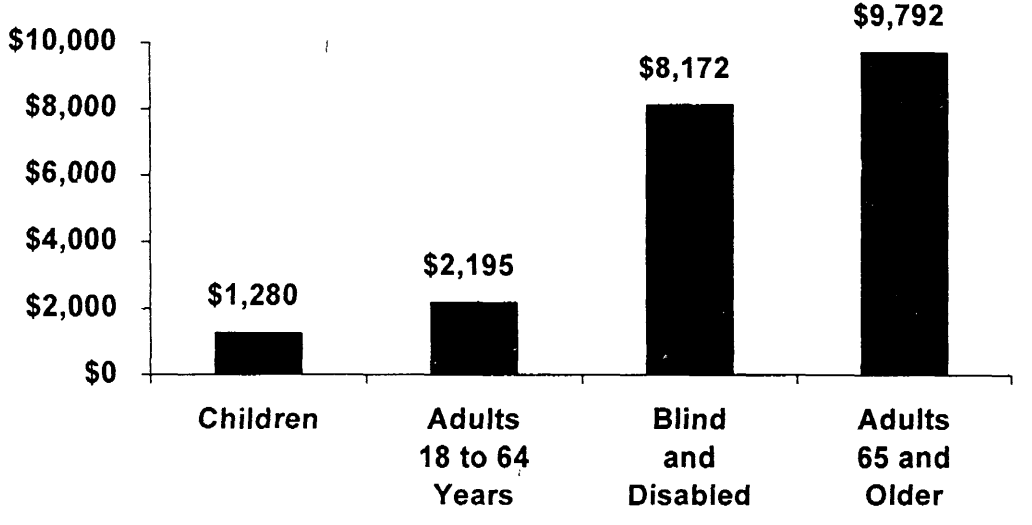
FIGURE 6

Medicaid Expenditures Per Beneficiary, 1994



Source: The Kaiser Commission on the Future of Medicaid; The Urban Institute analysis of HCFA 2082 and HCFA 64 date, 1995.

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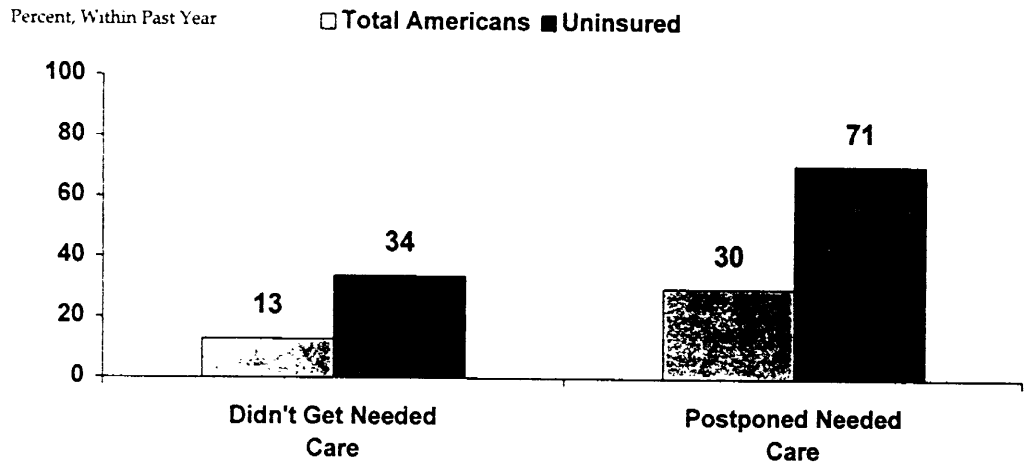
FIGURE 7

Uninsured Most Likely to Go Without Needed Care



Kaiser/Commonwealth Fund Health Insurance Survey, 1993
Louis Harris & Associates, Inc..

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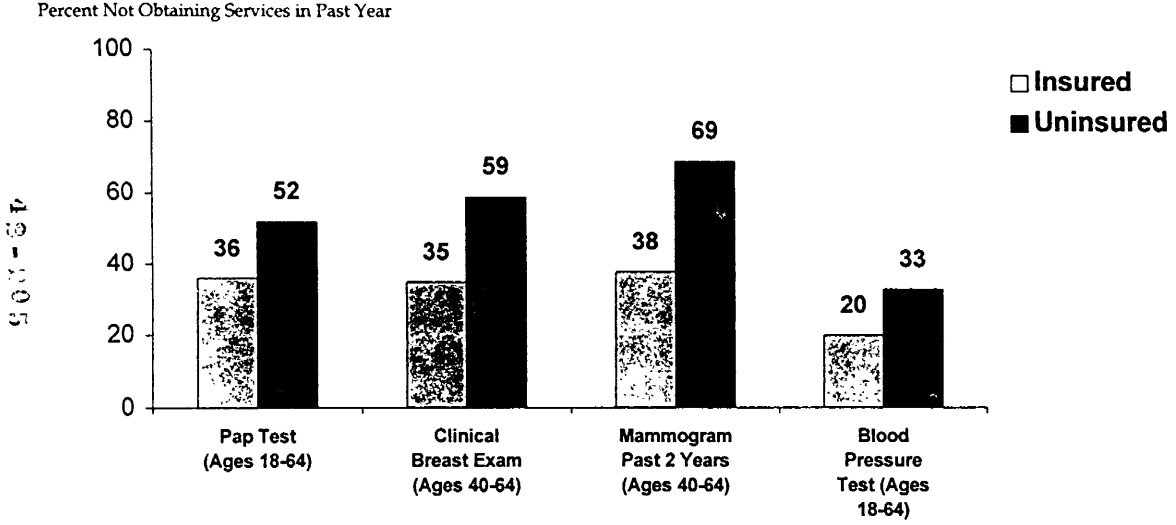
FIGURE 8

Women Without Selected Clinical Preventive Services by Insurance Status, 1991



Source: Brown, et al., Women's Health-Related Behaviors and Use of Clinical Preventive Services, October, 1995

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FIGURE 9

Medicaid Substitute

- Entitlement to Health Insurance
- Guaranteed Benefits
- Managed Care
- Legal Recourse
- State Fiscal Capacity

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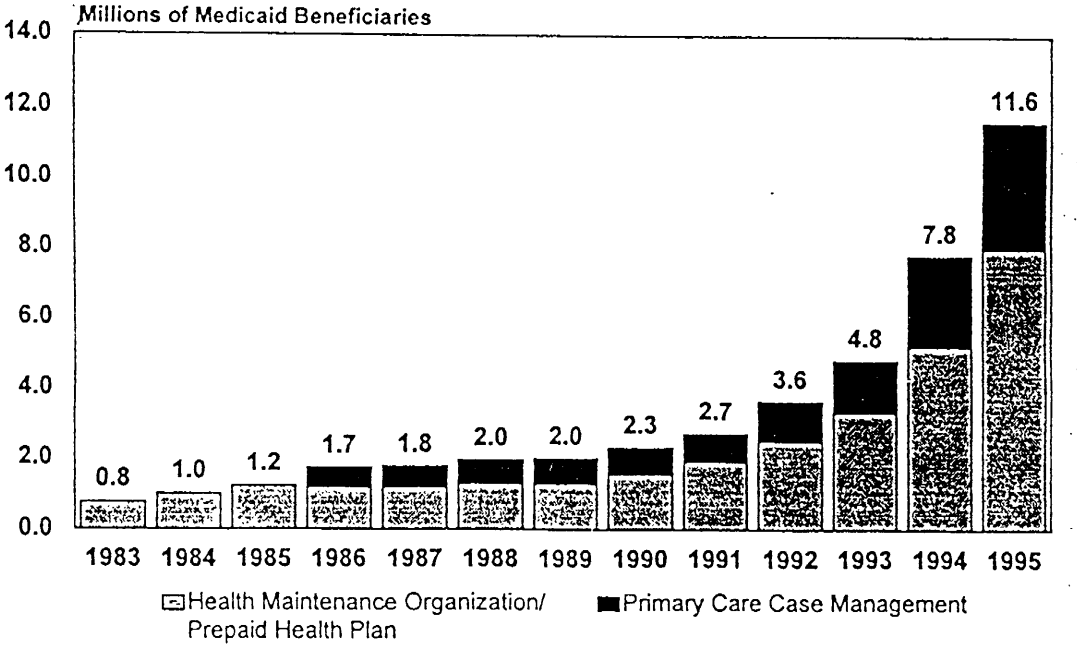
FIGURE 10

Growth in Medicaid Managed Care Enrollment, 1983-1995



Source: Health Care Financing Administration, 1996.

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FIGURE 11

PREPARED STATEMENT OF DAVID T. ELLWOOD

Mr. Chairman and members of the Committee, it is a pleasure to have the opportunity to appear before you again today.

All my life I have fought for real welfare reform, reform fundamentally rooted in the values of work and responsibility and family and community. I have fought for reform mostly because I believe that the only way to really help our children and preserve our future is to ensure that families are given a hand rather than a hand out. I even believed, some say naively, that welfare reform could bring people together, that we could escape some of the stereotyping and "us versus them" attitudes that too often characterize reform debates. After all, the harshest critics of welfare remain the recipients themselves.

I have been saddened and distressed by the twists and turns of welfare reform. The work-focussed reforms proposed by the President and by Republicans in 1993 and earlier years often seemed lost in the frenzy of budget cuts and political hostility of the past year. Happily, at least some states have taken leadership in doing the hard work of advancing welfare reform. I think the Family Support Act, developed with the leadership of this committee, especially Senator Moynihan, is finally taking hold.

Yet at the federal level, real welfare reform may yet fall victim to presidential politics and political expediency. Any welfare reform worthy of the name ought to do two things: get many more people working and leave fewer children poor. It is easy to reduce poverty by raising benefit levels, but that will surely come at the expense of less work. It is equally easy to assert one is increasing work by simply cutting people off welfare, but one will surely increase poverty in doing so.

Real welfare reform—reform that reduces poverty by increasing work—is not easy to achieve. It requires supporting people who play by the rules, and getting tough with people who refuse to do so. But I am fearful that the current round of reform proposals are more likely to simply reduce benefits and cut people off than move people from welfare to work. The danger of a race to the bottom is very real. And the tragedy is that one can create much of the flexibility that states want and need to get people to work without creating incentives that will ultimately lead to more poor children.

Let me offer 5 simple messages:

- If you believe in work-oriented welfare reform, you must support people who work. Real reform requires a strong EITC, and resources to support work, training, child care and medical coverage for workers. If the task is too great and the resources too limited, some states will be forced to simply cut people off, and the race to the bottom may begin.
- States must be expected to do their fair share. The current bills allow states to withdraw their support for work and shift burdens to the federal government.
- Avoid mandating cold turkey time limits.
- Do not block grant food stamps.
- Monitor state performance and learn from it.

Support for Working People

For far too long the welfare system has stood in the way of people who wanted to work. Conservatives are right—incentives do matter. So if you want to encourage work, you must make work pay. I applaud the expanded resources you put in for child care. That is the right thing to do and the right message. Therefore I am completely perplexed about why this Congress has simultaneously suggested cutting support for the EITC, transitional Medicaid, and work programs.

The Earned Income Tax Credit, the program Ronald Reagan called the most pro-work, pro-family antipoverty program in existence, has been expanded in Republican and Democrat administrations alike. The EITC is a pay raise for the working poor. Cutting it across the board is a pay cut for working families. Targeted cuts that reduce fraud are good and necessary. But simply cutting benefits wholesale sends the worst possible message to families who are trying to live the American dream.

I am also deeply concerned that the current legislation removes the requirement that states provide one year's Medicaid coverage for persons leaving welfare for work. Most states that are serious about welfare reform are moving in the opposite direction—expanding transitional medical aid for those who leave welfare to work. Why would we want to send a message to those who are doing what we ask that the penalty for going to work is medical insecurity for their children?

Finally there is the matter of work requirements. It is perfectly appropriate to expect people to work if they are to continue receiving aid. But it costs money to create jobs, to provide child care, to offer training—money that pays off in the long run,

but money nonetheless. Simply mandating work requirements while cutting resources to states will force some states to simply cut people off, rather than getting them work.

There is precious little money in these bills, especially for poorer states. One way to think about the total money available for supporting work and families is to add together the total amount of money provided in the block grants for cash aid, work programs, training, job placement and child care in the year 2000. Dividing this total by the number of poor children we find that the amount of federal aid per poor child for everything ranges from $40–$50 per poor child per week in higher benefit states like Massachusetts or California to $12–15 per week per poor child in lower income states like Mississippi and Arkansas. Fifteen dollars for work, cash aid, child care and training. If we add in state contributions , we are talking perhaps $20 per poor child per week. Let's be realistic. That is not enough to put many people to work with child care and training. And remember, benefit levels are very low in these states, so that welfare savings from moving people from welfare to work will be small.

When a recession hits, things will look even tougher. There will be many more needy people and many fewer jobs. Particularly for poorer states, Federal rules about work levels may be simply unsustainable.

States cannot and will not do the impossible. But they will do the possible. The possible is to cut people off, to offer less service, to provide less child care for the working poor not on welfare. Some states may find it much easier to move people from welfare to the state border than from welfare to work. And so the race to the bottom may begin. Even governors and legislators who want to focus on work-based reform may find the economic and political consequences too serious in the face of the activities of nearby states. At least in some states welfare reform may be about cutting people off and moving them around—not about work.

But cuts needn't only occur at the state level. Who will defend the welfare block grant when the hard work of further slowing of Medicare or finding money for tax cuts is before the Congress? How can a set of block grants long endure that gives some wealthier states three times more money per poor child than it gives to poorer states?

And so the danger is welfare reform becomes a way to cut people off and cease supporting our children. Welfare reform should be about work.

Expecting States to Pay Their Fair Share

If taxpayers across the nation are contributing resources for welfare reform, it seems legitimate to ask taxpayers in each state do their fair share. States should not be allowed to displace federal dollars, especially new federal dollars with old state ones. Yet the proposal allows just that. It requires only a 75% maintenance of effort and allows 30% of funds to be redirected.

Currently the federal government provides an average of 55% of the costs of welfare, and as much as 80% in some states. In a state where 2/3s of the dollars spent on aid to the poor come from the federal government, it is easy to argue that any savings ought to be shared in proportion to contributions, especially if savings are caused by simply reducing benefits to poor children. But with a 75% maintenance of effort rule, even if it can be enforced, the federal grant remains the same regardless of state savings unless or until the state falls below the maintenance of effort. So the entire savings generated by cuts in benefits or from getting people off welfare (so long as state's spend their minimum maintenance of effort) would go directly into the state treasury. At a time when the federal deficit is so serious, such a policy makes little sense.

The provision which allows state funds to be redirected also constitutes an opportunity for displacing state funds with federal ones. Block grant money can be moved into the areas such as social services where states have been funding a large share of costs on their own. Federal dollars are shifted from one program to another offsetting state dollars.

Finally, maintenance of effort provisions are notoriously hard to define and even harder to enforce. Since penalties cannot be imposed unless effort falls below some fixed dollar amount, the definition of what counts and the determination of where state money is really being spent is absolutely critical. Proving that effort has actually fallen below some level is often impossible. Eventually, maintenance of effort rules will probably be eliminated or not enforced.

The problem is not caused by state flexibility. It is not caused by block grants. It is caused by removing the match. There is no reason one cannot have a block grant with a state match. Even if one favors block grants, a far better solution is to set block grant levels in whatever manner seems fair, and to continue to insist that federal dollars be matched with state funds. States would have all the same

flexibility with far less of an incentive to race to the bottom. One can lower the match rate somewhat if the goal is state fiscal relief, but it is vital that a match be maintained. If a state does not draw down its full allocation, the remaining money could be put in a reserve fund to help other states which need additional resources. This would help the lower benefit states which may need more resources for work or child care, without costing the federal government anything more.

A match would sharply reduce incentives for state cuts. And it would also increase the political viability of the block grants in Washington, since the allocations would continue to be linked to what states were willing to spend, not simply a formula from the past. Indeed, in my view the best mechanism we have to prevent a race to the bottom is one that does not cost the federal government a dime—the state match. States and the federal government currently share the responsibility and the risks for the costs and the benefits of welfare reform. I think they are both simpler and fairer than complicated maintenance of effort rules.

Avoiding Cold Turkey Time-Limits Dictated By Washington

I continue to be deeply troubled by the differing interpretations of time limits in state and federal plans. I strongly favor time-limits on cash aid for the healthy. At some point people ought to be expected to work if they are to receive further aid. But I vehemently oppose cold turkey time-limits where people are cut off arbitrarily after some period, even if they are willing to work and report that they cannot find a job. There are times and places and people for whom no work is available. Simply cutting them off will create further desperation.

If one insists on work after a time limit is reached, preferably in an unsubsidized job, but in a subsidized private, non-profit or public job if necessary, then one can ensure that no child will suffer when the parents are willing to work and help themselves. Any publicly subsidized jobs should pay the minimum wage and probably not receive the EITC. Then if there really are private jobs available, people will have a strong incentive to take them. Since I believe there usually are some private sector jobs available, few subsidized jobs will likely be needed. But if people really cannot find work, what happens to them if we simply cut off aid?

If we really are moving toward flexible state based reforms with capped funding, I see no logic whatsoever to having cold turkey time limits after five years imposed by Washington. If we trust the states in so many other aspects, why not trust them with this decision? Rigid cold-turkey time limits will in many circumstances create significantly more poverty among our children. Why should Washington dictate this provision with the potentially draconian results? Leave it as a state option. If you insist on maintaining the five year limits, then the 20% exemption should be increased significantly.

Staying Away From Food Stamp Block Grants

I realize that food stamps is not in the jurisdiction of this committee. But I believe protecting food stamps as the one fundamental element of a national safety net is absolutely essential. Nothing is more essential to our future than having children who are adequately fed. Food stamps assures that regardless of where a child lives, regardless of the resources available in the state, the family should have enough resources to buy food. Coordinating food stamp rules with AFDC makes sense, allowing cash-out demonstrations makes sense. But welfare reform is proceeding quite well without putting this essential child nutrition program at risk.

Monitoring State Performance and Learn From State Successes and Failures

I applaud the fact that some money for research is included in the legislation, but I continue to wish that more could be done to monitor the well being of children and to ensure that particularly innovative programs are carefully evaluated. Much of the rapid progress in recent years in welfare reform has come from the fact that state waivers nearly always included strict demonstration rules. The truth is that states often resisted doing careful demonstrations on their own, and that the waiver rules forced them to be evaluated. As a result we have learned more in the past decade than we learned in a generation prior to this period. Current demonstrations will likely end. New information will be even harder to find.

A related but different concern comes from the need to monitor the well-being of children in states. If federal dollars are going to help poor children, we really need to keep track of how children are faring. Ideally, there would be grounds for federal intervention when children's situation is seriously deteriorating. States must be expected to report in detail on what is happening to their children.

Next Steps

I do not know whether welfare reform will pass again this year. I fear reason and the well-being of children will be mixed far too heavily with simplistic sound bites

and often ugly political dynamics now that we have moved to the election season. I think you should wait until next year. You can do much better than this. In the meantime, state innovation and reform will continue. One thing should not wait, however. The bipartisan child support enforcement provisions. If welfare reform does not move forward, child support enforcement should be moved separately.

Welfare reform is fundamentally about our future. If the reform you pass unleashes a race to the bottom and leads to the ultimate decay of federal support for state efforts to help people help themselves, the legacy of this effort could be a cruel one indeed. If instead, it helps people really move to work and reduces poverty, then we are all better off. I am very worried that the outcome will be the former rather than the latter.

If you do proceed, I cannot emphasize enough how important it is to reinstate some form of state match and to eliminate the food stamp block grant option. Neither will cost the federal government anything. But they could make a very big difference in determining whether this conception of welfare reform is the start of a race to the bottom or a new beginning for at least some families and children. There is too much at stake to risk our children's future.

PREPARED STATEMENT OF CHARLES D. HOBBS

My name is Charles D. Hobbs. I am a senior fellow at the American Institute for Full Employment and I'm here today to speak on behalf of the Institute in support of S. 1795, the "Personal Responsibility and Work Opportunity Act of 1996."

S. 1795 is a very large and complex piece of legislation. It is hard to follow because there is so much of it. But existing welfare laws and regulations are incredibly complex and prescriptive in the greatest detail, and welfare reform legislation must address things as they are.

Nonetheless, there are two clear concepts in S. 1795 that are basic and essential to the correction of the ills of the existing welfare system. One is the concept of work replacing welfare as the basis for improving family and community financial and social health. The other is the concept of creating useful public assistance programs from the bottom up rather than the top down, with the various states empowered to design and operate programs to meet their unique needs and circumstances. It is because these concepts are clearly advanced, even in the forest of detailed prescriptions, that we support S. 1795.

THE AMERICAN INSTITUTE FOR FULL EMPLOYMENT

The American Institute for Full Employment is a privately funded, not-for-profit center for the development of programs that expand and enhance employment opportunities for American workers, and especially for those who have been conditioned to accept public assistance as a substitute for the opportunities and rewards of paid work. Our goal is full employment—universal access to jobs with career potential for all who need and seek them. We believe that goal can best be met by stimulating public/private partnerships within the states that will encourage the efforts of private sector employers, large and small, to train and employ new workers.

Welfare reform is becoming synonymous with work. Pervasive public disgust with the national welfare system, combined with the growing awareness that we are wasting the human resources we need to build a more competitive work force, has shifted the focus of the welfare debate from the delivery of benefits to the development of jobs and ways to prepare people for them.

The Institute's major contribution to this debate is the Full Employment Program, a welfare replacement concept that has been developed over the past six years and adapted to meet a wide variety of specific state and local needs and circumstances. The Full Employment Program moves public assistance recipients into the active work force by converting public assistance benefits to wage subsidies for transitional, training-oriented, predominantly private sector jobs. More than a dozen states have taken an interest in the Full Employment Program, and eight of them have enacted into law state-specific versions which are now in various stages of implementation. This testimony describes the general concept of the Full Employment Program and highlights two operating versions: Oregon's JOBS-Plus and Mississippi's Work First.

The Institute is also a proponent of increasing the relative power of the states to control social policies and funding. For five decades, from the mid-1930s to the mid-1980s, the pendulum of social policy control swung hard toward Washington, D.C. as the federal government steadily usurped traditional state powers by creating a profusion of ever more expensive national programs. But in the past decade, with clear evidence of the failure of these programs to meet public expectations, a cadre

of strong governors and other state and local elected officials has led an effort to shift the balance of power back toward the states. We actively support that shift, and offer the Full Employment Program as evidence of how and why public assistance can be restructured for economic growth and social progress.

STATES WITH VERSIONS OF THE FULL EMPLOYMENT PROGRAM

State	Program Name	Legislation Date Approved	Waivers Date Approved	Operational Date
Oregon	Oregon Full Employment Program (6 Pilot Counties)	Ballot Measure 7 November 1990		
	JOBS Plus (6 Pilot Counties)	June 1993	September 1994	November 1994
	JOBS Plus (Statewide)	June 1995	April 1996	July 1996
Mississippi	Work First	July 1993	December 1994	October 1995
Arizona	Job Start	May 1994	May 1995	November 1995
Virginia	Virginia Initiative for Work, Not Welfare (VIEW)	April 1995	July 1995	July 1995
Delaware	A Better Chance	May 1995	June 1995	October 1995
Massachusetts	Full Employment Program	February 1995	August 1995	November 1995
Maryland	Family Investement Program	April 1996	Pending	Anticipated 10/96
Wisconsin	Wisconsin Works (W-2)	April 1996	Pending	Anticipated 9/97

HIGHLIGHTS OF THE FULL EMPLOYMENT CONCEPT

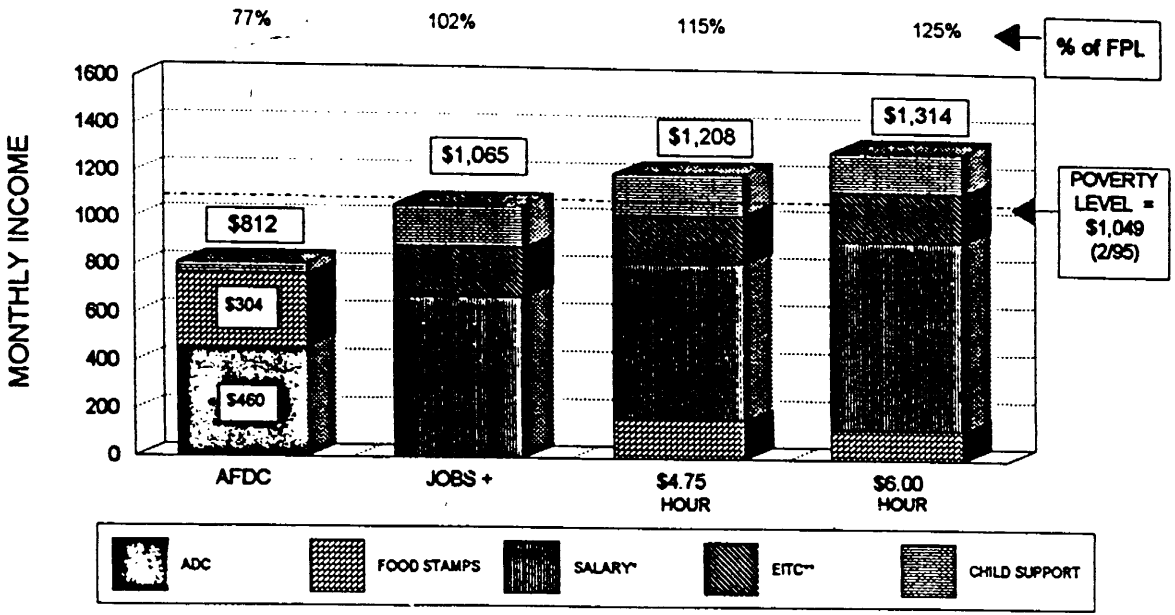
Full Employment is a job and worker development concept that moves welfare and other public assistance recipients into the active workforce and out of dependency on government support. It goes beyond welfare reform to a vision of jobs for all who need them and a larger and better prepared work force to meet the needs of our citizens and the challenge of international competition.

For those in need of public assistance, a Full Employment Program in their state means:

- *Immediate attachment to the work force.* Anyone seeking public assistance and able to work is placed immediately in a job leading to permanent employment and self-sufficiency.
- *Temporarily-subsidized, training-oriented jobs at minimum wage or higher, plus the Earned Income Tax Credit (EITC), for those unable to get unsubsidized jobs immediately.* These "trial" jobs prepare participants for regular, unsubsidized jobs. Public assistance benefits are pooled and converted to wage subsidies. No increase in spending is needed, and savings from reduced dependency are virtually certain.
- *A ladder of job opportunities, with rising spendable income at each step.* A subsidized Full Employment job provides more spendable income than public assistance, and an unsubsidized job provides more spendable income than a subsidized job, as shown on the accompanying Welfare to Work chart. The first unsubsidized job, even at minimum wage, will raise the typical family above the poverty line.
- *Guaranteed supportive services throughout the transition to self-sufficiency.* Medicaid and child care are guaranteed to welfare families participating in the program and for at least a year after they move from subsidized to unsubsidized employment.

WELFARE TO WORK

SPENDABLE INCOME FOR 1 ADULT & TWO CHILDREN



*SALARY = GROSS WAGES MINUS TAXES, FICA, CHILD CARE COSTS AND & $75 MISCELLANEOUS EXPENSES

**EITC = EARNED INCOME TAX CREDIT 60% OF EITC IS AVAILABLE IN MONTHLY PAYCHECK REMAINING 40% AVAILABLE AS A REFUNDABLE TAX CREDIT AT THE END OF THE YEAR THIS CHART DEPICTS THE FULL EITC AMOUNT CHART ASSUMES CHILD CARE COSTS OF $526 PER MONTH

NETP95

OREGON ADULT & FAMILY SERVICES DIVISION 1-31-96

For employers—large and small, public and private, profit and non-profit—a Full Employment Program in their state means:

- *A larger labor pool from which to recruit workers.* Many public assistance recipients are ready, willing, and able to go to work immediately, but are discouraged from doing so by the public assistance system, which often penalizes people for leaving it.
- *The chance to try out new workers at new jobs at little or no wage cost.* Subsidized temporary workers learn and perform assigned jobs that meet all Federal Unemployment Tax Act (FUTA) suitability requirements and do not displace regular workers. Employers are encouraged to hire successful participants as regular employees.
- *The opportunity to contribute to the reduction of the public assistance burden.* Welfare roles are declining in every state with a Full Employment Program. When it comes to solving the welfare problem, "Only work works."

FULL EMPLOYMENT PIONEERS

Oregon

The first legislative enactment of the Full Employment concept was by a state electorate: the voters of Oregon. In November, 1990, Ballot Measure 7, the Oregon Full Employment Program, won 58 percent of the vote statewide, with affirmative margins in 35 of 36 counties. Measure 7 called for a three-year, six-county test of subsidized, training-oriented employment as a replacement for welfare and unemployment insurance benefits, with the expectation that replacing obligation-free benefits with wages for work on real jobs would reduce welfare dependency and speed the progress of participants into permanent, unsubsidized employment.

But even though Measure 7 by itself had the force of law, its proponents found that the wheels of government—both state and federal—can grind slowly. It took two and one-half years for the governor and the legislature to agree on rules for implementing Measure 7. (Their major contribution was to change the name from "Full Employment" to "JOBS-Plus" in order to upstage the electorate in taking credit for the program.) And it took the federal government another 15 months to approve the waivers from federal law necessary for JOBS-Plus to operate.

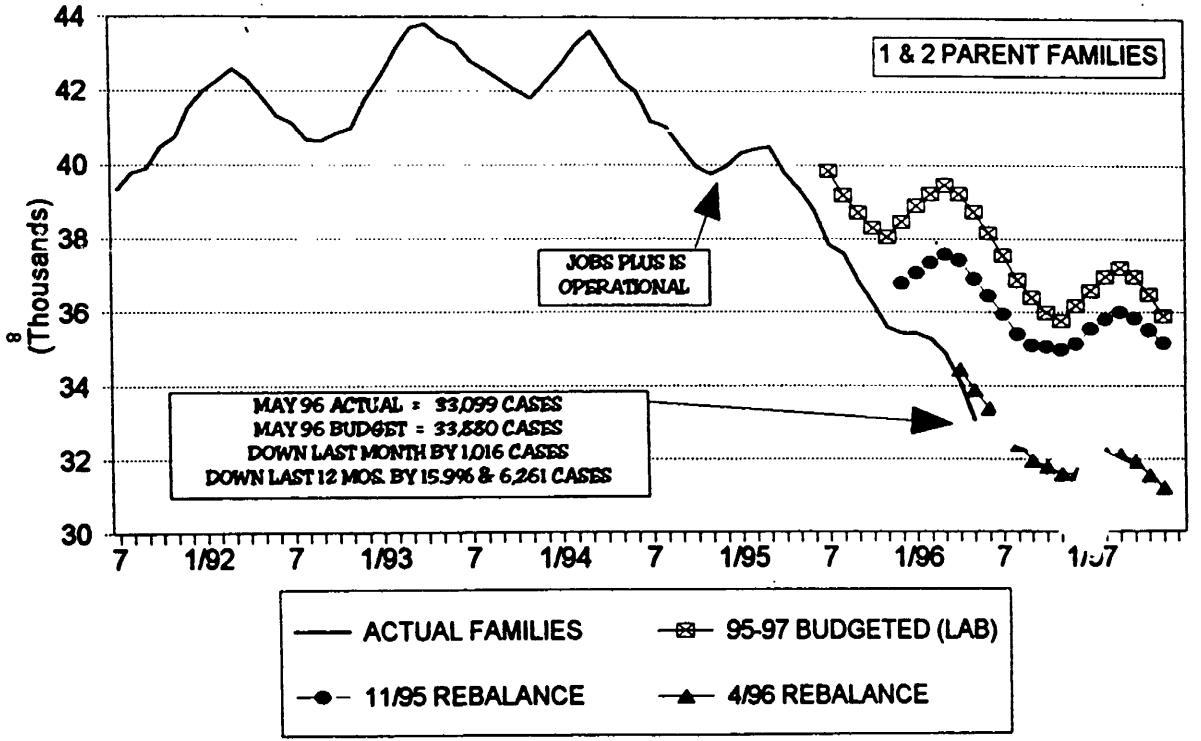
So it wasn't until November, 1994 that JOBS-Plus began to place public assistance recipients into subsidized jobs. Early concentration was on Aid to Families with Dependent Children (AFDC) and Food Stamp cases, and the results were immediate and dramatic. Within a month the AFDC caseload had begun to fall below the traditional pattern of cyclical growth, and within three months it began an actual decline which has continued and steepened over the past year. As the accompanying caseload chart shows, total cases are down by 15.9 percent in the last 12 months and by more than 24 percent since the beginning of 1994. Caseload projections have been revised downward three times, yet actual cases continue to fall below the latest downward estimates. Savings already generated by the declining caseload are $97 million, $37.8 million to the state and the remainder to the federal government.

In the test area, 1,700 employers, mostly small businesses, volunteered an interest in participating in the program. But the need for placing participants in subsidized jobs was much less than expected, because record numbers of participants, in preference to subsidized jobs, took the initiative to find their own unsubsidized jobs. In the first 14 months of operations, only 353 participants needed to be placed in subsidized training positions, while 1,389 JOBS-Plus eligible participants went into regular jobs without having to be placed in JOBS-Plus positions. In addition, four out of five subsidized workers are finding unsubsidized jobs during their participation in JOBS-Plus.

Based on the initial success of the six-county pilot program, the Oregon Legislature passed, and Governor John Kitzhaber signed into law in June, 1995 a bill extending JOBS-Plus to the entire state, and the federal government approved the expansion in April, 1996. In the next phase of implementation, starting in July, 1996, increased emphasis will be given to placement of unemployment compensation beneficiaries. In addition, private staffing companies will provide job placement services on an experimental basis.

OREGON AFDC CASELOAD

ACTUAL & BUDGETED



Mississippi

Mississippi was the second state to enact Full Employment legislation. Mississippi's version, called Work First, was signed into law by Governor Kirk Fordyce in July, 1993. The name Work First reflects the program's goal of early attachment to the work force as the best antidote to welfare dependency. Work First is being tested in six counties with 27 percent of the state's welfare caseload. Due to long delays in getting federal waivers, operations did not begin until October, 1995 in Hinds county (Jackson), and were phased-in, county by county, over the following three months.

To promote quicker access to job placement assistance, Mississippi has redesigned its welfare eligibility and case management functions so that those applying for AFDC or Food Stamps are sent to job counselors immediately, even before their welfare eligibility is finally determined. Those for whom unsubsidized jobs can be found are thus diverted from AFDC and require less or no Food Stamp benefits. Child care and Medicaid are guaranteed for the first year of employment, even for those who have not completed the welfare eligibility process.

Another feature of Work First is the use of private staffing companies, together with the Mississippi Employment Security Commission, to carry out the job development/job placement functions. Administrative costs of employer recruiting, worker preparation, and job placement are greatly reduced because private staffing companies absorb those costs in fees to their client employers.

Work First results to date are remarkable, even at this early stage of implementation. Through the end of March, 1996, 3,501 welfare cases had been assigned to Work First, and 633 had been placed in jobs: 352 unsubsidized and 281 subsidized. The combined AFDC/Food Stamp caseload in the six test counties is declining at 1.41 percent per month—seven times the rate of the rest of the state. Total AFDC payments are also declining—at 11.4 percent for the September, 1995 to April, 1996 period in the test counties, compared to only 4.4 percent in the rest of the state. Even the number of Food Stamp households has declined by 836 in the test counties, while rising by 616 in the rest of the state.

PREPARED STATEMENT OF HON. STEPHEN H. MARTIN

Thank you, Mr. Chairman, for this opportunity. As a State legislator from Virginia, I am a member of the American Legislative Exchange Council, otherwise known as ALEC, which is the Nation's largest individual voluntary membership organization of State legislators, with over 3,000 Democrat and Republican legislators as members.

I am the chairman of the Welfare Subcommittee of the ALEC Task Force on Health and Human Services and serve on ALEC's national board of directors.

The Health and Human Services Task Force is composed of a broad cross-section of private and public sector members, over 200 members of that task force. For half a decade, my task force has grappled with the issue of developing policies for model legislation in the States that provide a safety net for people who are less fortunate, but without destroying State and federal budgets.

Congress and the States are struggling with spiraling Medicaid and welfare costs. To address this problem, the States need to be allowed to manage these programs free from federal mandates regarding individual entitlements, eligibility groups, benefits, payment rates, and financing structures.

States are already experimenting with privatization, managed care, and other Medicaid options. Given the flexibility to experiment, the States will develop successful, workable solutions to Medicaid costs.

Concerning welfare reform, we must craft welfare programs that provide its recipients with an opportunity and hope for self-sufficiency. The States are innovators. In this, as in so many other public policy areas, the States sometimes are ahead of the Federal Government.

These innovations include enforcing child support, the establishment of paternity, incentives for school attendance of children of AFDC recipients, packaging food stamps and AFDC benefits in the form of cash which is used to subsidize private sector jobs, allowing recipients to accumulate money for medical expenses in a medical savings account, and creating Medicaid systems in combination with a managed care approach, as Tennessee has done.

Most recently, the State of Wisconsin has been in the spotlight for Governor Thompson's W-2 program. If granted a federal waiver for the program, welfare, as Wisconsin residents know it, will be eliminated and replaced with a system in which recipients will have hope for the future rather than being trapped in a state of government dependency.

In Virginia, Governor Allen's welfare program became effective July 1, 1995. I was the chief patron, along with Senator Earley of Chesapeake, Virginia, on this legislation.

The Virginia plan has a work requirement. During the eligibility period, recipients will be able to accumulate up to $5,000 in a savings account for business incubation, will have access to child care, and will receive protection from State income taxes.

After two years, though, cash benefits cease. Child care, medical, and transportation assistance can continue for another 12 months. We have already witnessed the success of these reforms because of the incentives which they have created.

As evidenced by these plans, the Federal Government does not have a corner on compassion. In assuming so, you miss an opportunity to benefit from State public policy innovation and competition and inevitably you end up micromanaging at high cost the process of delivering services to those who do qualify.

Some have suggested establishing federal requirements by attaching so-called conservative strings to the disbursement of funds in a block grant. But this still implies that the States need to be told what to do. It also assumes that what works in Montana will work in New Jersey, but both assumptions are false. Mandates from conservatives who think they know what is best are no more desirable than mandates from liberals.

In determining how much each State shall initially receive in federally-collected tax dollars, the formula should not attempt to redistribute funds from one State to another, capping at a certain percentage of poverty. If you do not, States that have broadly expanded their programs will receive a disproportionate share of federal dollars.

I would hope that block grants would be transitional. If the States were to raise revenue for Medicaid and welfare directly and managed their own programs, spending could be reduced at a savings to the taxpayer. Such a savings would require a willingness to reduce taxes as the States pick up the responsibility for revenue and management of their own programs.

The ultimate goal should be to phase out the federal role and delivery of welfare and Medicaid services. However, in the meantime, federal aid should take the form of block grants, distributed according to a formula based on population, but not tied to a State match. States should be granted maximum discretion to develop their own programs.

I recommend that you act on the assumption that your State counterparts have the compassion, understanding, and the will to serve the best interests of the citizens and the States they are elected to represent.

I thank you, Mr. Chairman, again for this opportunity to testify before your committee.

PREPARED STATEMENT OF HON. DANIEL PATRICK MOYNIHAN

Mr. Chairman: On May 24th, nearly three weeks ago, Representative Sam Gibbons and I wrote to Dr. Alice Rivlin, Director of the Office of Management and Budget, to request an analysis of the impact on poverty of the legislation before us today. How many children would be forced into poverty by this bill? It is a simple question to which the Administration, hopefully, will soon give us a simple answer.

I hope we will not forget recent history on this issue. Eight months ago, shortly after the Senate passed its version of H.R. 4, the Work Opportunity Act, I learned that the Administration had completed a study of the bill concluding that it would push more than one million children into poverty. Yet the White House would not release the study, even after being asked by a number of reporters.

On October 24, 1995, at the first and only meeting of the conferees on the welfare bill, I publicly called for the report to be released. I said:

> Just how many millions of infants we will put to the sword is not yet clear . . . Those involved will take this disgrace to their graves. The children alone are innocent.

Three days later, on October 27, 1995, the Los Angeles Times carried a front-page story by Elizabeth Shogren with this headline: "Welfare Report Clashes With Clinton, Senate." It began:

> A sweeping welfare reform plan approved by the Senate and embraced by President Clinton would push an estimated 1.1 million children into poverty and make conditions worse for those already under the poverty line, according to a Clinton Administration analysis not released to the public.

On November 7, 1995, after twelve of the welfare bill conferees wrote to Dr. Rivlin to ask that the report be released, she produced a careful analysis showing that 1.2 million children would be forced into poverty by the Senate-passed bill. (She also reported that 2.1 million would be pushed into poverty by the House-passed bill.) In a follow-up analysis on December 6th, Dr. Rivlin indicated that the conference agreement would plunge 1.5 million children below the poverty line.

One month later, on January 9, 1996, President Clinton vetoed the conference agreement.

When the Administration completes its analysis of the pending bill, which I hope and trust will be soon, we should not be surprised to find that more than a million children would be pushed into poverty if it were to be enacted. This bill is not much different from the Personal Responsibility and Work Opportunity Act of 1995, which the President rightly vetoed.

Like last year's bill, this legislation would end the 61-year-old Federal guarantee of assistance to states for dependent children, Title IV–A of the Social Security Act, Aid to Families with Dependent Children. Like that bill, this legislation would require states to cut off millions of poor children after five years. We estimated that a five-year time limit would cut off 3,552,000 in the year 2001, and 4,896,000 children by the year 2005. In New York City alone, we would cut off 184,600 children in 2001. More than two-thirds of these children—68.5 percent—would be black or Hispanic.

To make matters worse, the pending legislation would permit states to cut off children even sooner. Indeed, this bill is even harsher than the vetoed 1995 bill because it *prohibits* states from using Federal block grant funds to provide any form of assistance after the time limit is reached.

I have also asked the Administration for an analysis of the poverty impact of the President's new bill, S. 1841, the Work First and Personal Responsibility Act of 1996, which I introduced by request on June 5th. These estimates will be important for us to be able to gauge the likely impact of these bills on children, whom, after all, we are trying to help bring out of poverty. I look forward to receiving the results of these studies. I cannot imagine the President will sign any legislation that would cast a million children into poverty. As he told a group of journalists in a discussion about welfare at the White House on November 1, 1995:

> If I'm convinced that it's going to hurt children, I'm not going to go along with it . . . Our whole focus as a nation ought to be how can we strengthen families and strengthen work? . . . Cavalierly putting a bunch of kids back below the poverty line is not my idea of doing that.

The President should veto this combined Medicaid and welfare bill not only because of its disastrous impacts on children, but also because the combined cuts in the two measures are being used to pay for a huge and unnecessary tax cut. Under the Budget Resolution to be voted on by the full Senate later today, the Finance Committee is instructed to achieve $98 billion in savings, of which it is assumed $72 billion will come from cuts in Medicaid and $26 billion from welfare. An additional $26 billion in cuts to the Food Stamp program are assumed, to be made by the Agriculture Committee. Total savings to be achieved: $124 billion over six years.

As it happens—it must be a coincidence!—that is almost precisely the amount needed to pay for the whopping $122 billion tax cut included in this legislation. A $500 per child tax credit is a fine idea, and one I might support—if we had the money, if the budget were balanced. But we don't and it's not.

The Budget Resolution, and this reconciliation bill, take us completely off the deficit reduction path we agreed to take in 1993. Yes, I would say to my friend the Chairman, we did raise taxes in the Omnibus Budget Reconciliation Act of 1993. In an exchange with Senator Dole on the floor, I jokingly called it the largest tax increase in history. Actually, the tax increases in OBRA 93 were nothing compared with the enormous tax increases enacted during World War II. Before World War II, most people *did not* pay income taxes. Between 1939 and 1944, personal and corporate income taxes rocketed from 2.5 percent of GDP to 17.2 percent of GDP—a 600 percent increase. In 1994, personal and corporate income taxes were about 10.5 percent. The income tax increases in OBRA 93 affected only the wealthiest 1.2 percent of Americans.

So we make no apologies for 1993. We're proud of the dramatic deficit reduction achieved under that legislation. We have cut the deficit by more than half, from $290 billion in 1992 to an estimated $130 billion for the current fiscal year. We have full employment, no inflation, and a primary surplus for the first time since the 1960s.

OBRA 93 included *$500 billion* in deficit reduction over five years. $600 billion, counting the reduction in the deficit premium on interest rates. And how much defi-

cit reduction will be achieved under this first reconciliation bill? A whopping *$2 billion.* The rest of the savings from the cuts to Medicaid and welfare, the Federal programs for our poorest citizens, will be squandered on tax cuts. Appalling, as I am sure Secretary Shalala will agree.

PREPARED STATEMENT OF HON. DONNA E. SHALALA

Mr. Chairman, Senator Moynihan, members of the Committee, it is my distinct pleasure to appear before you today to discuss the Medicaid and welfare reform proposals introduced by Chairman Roth and others on May 22nd.

As the Congress continues to consider ways to reform Medicaid and welfare and pursue a balanced Federal budget, we appreciate the opportunity to state clearly the President's vision for reform in these areas.

The Clinton Administration believes that we must balance the budget by the year 2002 and give more responsibility to the states and local communities. But we must do it in a way that is consistent with the values of our nation. As the President has said time and time again: We can balance the budget and find common ground -- without turning our backs on our values, our families, and our future.

In Medicaid, we believe we can give the states the flexibility they need, while maintaining a strong federal-state partnership built on a foundation of shared resources, accountability to the taxpayers, and national protections for the most vulnerable Americans. That is why the President has proposed a common sense plan, and that is why he has refused to sign legislation which breaks our promises.

As part of his balanced budget plan, the President has submitted to the Congress a welfare reform bill entitled the "Work First and Personal Responsibility Act of 1996". The President's bill would replace the current welfare system with one that demands responsibility, strengthens families, protects children, and provides states with broad flexibility and the resources they need to get the job done. It is a comprehensive proposal that reflects the common principles held by those in and out of Congress who have worked tirelessly to reform our nation's welfare system. We strongly hope for legislation that builds upon these principles and the recent bipartisan initiatives from the nation's governors and moderate Republicans and Democrats in both houses of Congress.

The President is committed to balancing the budget and enacting real welfare and Medicaid reforms. However, the President has also made it clear that the current strategy of the majority in Congress to link welfare reform to unacceptable changes in Medicaid will leave him no choice but to veto the entire package. We call on Congressional leaders to abandon the "poison pill" strategy that is designed to provoke a veto. We strongly support the bipartisan efforts of the governors and the Breaux-Chafee and Castle-Tanner groups to reform welfare without gutting Medicaid.

Before I continue, let me note in particular the fine work of Senators Chafee and Breaux and the members of their bipartisan group on both Medicaid and welfare reform. While we have yet to review any details and still have some concerns, I think the willingness of Senators of good will to join together across the

aisle to agree on meaningful reforms is an example to us all. The President believes their proposals could very well be the foundation for a broad bipartisan effort in this regard.

Let me begin by discussing Medicaid.

Medicaid

Medicaid provides vitally important health and long-term care coverage for approximately 37 million Americans and their families:

- It provides primary and preventive care for 18 million low-income children;
- It covers 6 million individuals with disabilities -- providing the health, rehabilitation, and long-term care services that would otherwise be unaffordable for these individuals and their families;
- It covers 4 million senior citizens -- including long-term care benefits that provide financial protection for beneficiaries, spouses, and the adult children of those requiring nursing home care.
- Finally, it pays the Medicare premium and cost sharing for low income seniors, thus putting the benefits of Medicare within reach.

The Clinton Administration is dedicated to strengthening and improving Medicaid so that it can continue to fulfill the promise of our nation to millions of children, elderly, and disabled Americans and their families. To achieve this goal, this Administration has worked vigorously in partnership with the states to test innovative new approaches to delivering and financing care for Medicaid patients. During our first 3 years in office, this Administration approved 91 major Freedom of Choice waivers and waiver renewals, which allow states to enroll beneficiaries in managed care plans. We have also approved 163 new and renewed Home and Community-Based Services waivers, which enable states to use home care as an alternative to costly nursing home care, and allow people with disabilities to live in their communities. In addition, since January 1993 we have approved 12 statewide Medicaid demonstrations, compared to a total of one such demonstration approved under all previous administrations combined. Some statewide demonstrations expand access to the uninsured, others test new methods for delivering mental health services, and still others implement simplified eligibility requirements.

The flexibility provided by these waivers has allowed states to improve the efficiency with which they provide care. Some states have used the resulting savings to cover additional populations with unmet health care needs. When all of the currently approved demonstrations are implemented, nearly 2.2 million individuals who did not receive Medicaid coverage will be eligible for services.

As part of his balanced budget plan, the President has proposed a carefully designed and balanced approach to Medicaid

reform which builds on this experience. His plan preserves the essential elements of Medicaid (title XIX of the Social Security Act) while making important changes that will give states unprecedented flexibility to meet the needs of the people they serve. The President's plan is built upon three core principles: (1) the need for a real, enforceable Federal guarantee of coverage to a congressionally-defined benefit package; (2) appropriately shared Federal and state financing; and (3) quality standards, beneficiary protections, and accountability.

The President's plan fulfills these principles while contributing Federal savings to the balanced budget plan through reductions in disproportionate share hospital payments and the use of a per capita cap on Federal matching payments that adjusts automatically to changes in state Medicaid enrollment and changes in the economy. The President's plan also provides states far greater flexibility to better manage their programs, pay providers of care, and operate managed care and other arrangements with reasonable Federal requirements to maintain programmatic and fiscal accountability.

As you know, the President strongly opposed the Medicaid proposals passed by Congress last year because they failed to meet his core principles. The Congress repealed the Medicaid program and replaced it with a new "Medigrant" program that did not provide meaningful Federal guarantees of eligibility or benefits. The Congress also put forward a "block-grant" funding mechanism that breached the 30 year Federal commitment with the states to share in changes in state Medicaid spending that left states with the full financial responsibility for providing health care to individuals who would qualify for services in the future due to unanticipated enrollment increases or economic downturns.

Last February, the National Governors' Association approved the outlines of a bipartisan Medicaid reform plan. As I testified before this Committee in March, we believed the governors' plan -- produced through a bipartisan process-- held some promise and we were hopeful that, once more details were known, there would be a real basis for Medicaid reform. The governors clearly worked very hard to move the debate forward. At the same time, however, I discussed the Administration's concerns with some key elements of the governors' plan.

Last month, the Republican majority in both Houses of Congress introduced a revised version of their Medicaid bill, which I will discuss today. Unfortunately, this bill moves us further away from the bipartisan reform envisioned by the governors, and much closer to the Republican legislation that the President vetoed last year. Our view is shared by the Democratic governors who were instrumental in crafting the NGA agreement. In a May 29 letter to Senator Roth, four Democratic governors stated that:

> "[The Republicans'] Medicaid proposal is far from the NGA agreement and appears to be more like the proposal vetoed by

the President last year and rejected by the Governors at our winter meeting.... [A]ccording to our early calculations, 96 percent of the funding under this new formula is distributed precisely in the same manner as your earlier bills proposed. You have created a block grant for this program with essentially the same language and parameters of the vetoed bill -- a block grant that denies a safety net for our most vulnerable citizens."

Let me be clear: the new Republican bill, like its predecessor, fails to meet the President's basic principles for Medicaid reform. If this bill is sent to the President, I would recommend that he veto it.

I will now discuss why the new Republican Medicaid plan fails to meet each of the President's three core principles.

The Federal Guarantee of Coverage and Benefits

The Federal "guarantee" of coverage and benefits is at the core of the Medicaid program. Unfortunately, the term "guarantee" has been assigned very different meanings in the context of the current Medicaid debate. When we use the term guarantee in the context of a Federal statute like Medicaid, we mean a real guarantee, composed of three interrelated components: definitions of 1) eligibility; 2) benefits, and 3) enforcement.

Eligibility: Let's begin with eligibility. The new Republican bill would deny millions of Americans the Federal guarantee of Medicaid eligibility that they now have under current law. The bill repeals the phase-in of the Federal guarantee of Medicaid coverage for children ages 13 to 18 in families with income below the Federal poverty level -- a bipartisan coverage expansion signed into law by President Bush.

In addition, the new Republican bill repeals the Federal standard for defining disability and replaces it with language that could mean 50 separate state definitions. This has the effect of making Medicaid coverage and benefits for those with disabilities uncertain and variable across the nation. For example, some states could use restricted definitions of disability that result in very limited coverage for those whose needs are pronounced and among the most costly. In fact, States might be forced to narrow their definitions of disability in order to cope with lower Federal funding levels. In such situations, narrow state definitions of disability could preclude individuals with HIV, certain physical disabilities, or mental illness from receiving critically needed services under Medicaid. We should not turn back the clock on those with disabilities by permitting 50 different state definitions for purposes of Medicaid coverage.

The new Republican bill also eliminates the current law requirement that Medicaid be provided for one year to persons who leave welfare in order to join the workforce. By eliminating this guarantee, the Republican proposal could discourage

individuals from leaving welfare and set back our efforts to reform the welfare system.

Finally, the new Republican bill gives states the authority to impose additional eligibility limits based on age, residence, employment or immigration status, or more restrictive definitions of assets and income. This provision will enable states, if financially necessary, to restrict eligibility even among those people who supposedly are "guaranteed" coverage.

Benefits: Eligibility is only one component of the guarantee. The next question is "eligibility for what?", which brings us to benefits. The new Republican bill "guarantees" some benefits for those populations who are "guaranteed" eligibility. But this guarantee is hollow. Many loopholes make it essentially meaningless.

One loophole in the "guarantee of benefits" relates to the adequacy of the benefits. Current Medicaid law and regulations already give states substantial flexibility in defining the amount, duration, and scope of benefits, and states have used this flexibility to tailor Medicaid packages to their unique circumstances. This latitude is tempered by a very reasonable constraint -- benefits must be "sufficient to reasonably achieve their purpose." The Republican bill removes this sensible provision, giving states complete flexibility on amount, duration, and scope. Thus, states could "guarantee" coverage for hospital and physician services, but -- if forced to do so -- could limit this coverage to unreasonably low levels such as 3 days of hospital care and one physician visit per year. This type of guarantee is meaningless for persons who truly need medical care.

Another loophole in this "guarantee" is the new elimination of current law standards of comparability and "statewideness" of services. Without these standards, some states could offer different coverage and benefit packages in different parts of the state, or to different groups based on their age or diagnosis. Eliminating requirements for comparability and statewideness leaves states free to discriminate against persons who live in certain areas, who have specific diseases (such as AIDS), or who lack political clout (such as children).

The new Republican bill also severely curtails the treatment services which must be provided under the Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. Under the Republican bill, children must be screened for a range of health problems, but treatment is only required for dental, hearing, and vision problems. If a child is diagnosed with any other medical problem, they are not guaranteed treatment. Therefore, an asthmatic child would not be guaranteed coverage for treatment, such as asthma-controlling drugs or inhalers. Diagnosis without treatment is bad medical care and a wasteful use of taxpayers' dollars.

Enforcement: The third essential component of the Federal guarantee is enforcement. Implicit in the concept of defined populations and defined benefits is the notion of a meaningful

enforcement mechanism. A Federal cause of action for beneficiaries assures that those seeking a remedy for the deprivation of medical care receive the same due process rights everywhere in the United States. The new Republican bill requires states to provide a state right of action, but eliminates the Federal right of action for individuals and providers who assert that a state is violating Federal Medicaid laws. The only access to Federal court for such claims would be if the Secretary brings the action to Federal court on behalf of the individual or if the individual petitioned the U.S. Supreme Court for review of a decision of a state's highest court. By denying beneficiaries access to the Federal courts, the Republican bill eliminates individuals' guarantee to enforceable Federal benefits. Thus, Medicaid would confer a Federal right to benefits but lack a Federal enforcement mechanism - a virtually unprecedented situation.

Provider suits against states have caused great problems for the states. Under the Administration's plan, the Boren Amendment and related provider payment provisions would be repealed, thereby eliminating these causes of action by providers. Thus, the Administration's plan resolves states' concern about their exposure to providers' suits in Federal court, and does not undermine beneficiaries' ability to enforce their Federal guarantee to coverage and benefits.

On balance, when we assess the three components required to make any guarantee real -- the definitions of eligibility, benefits, and enforcement -- we find that the so-called "guarantee" of Medicaid coverage and benefits contained in the new Republican bill is neither real nor enforceable for beneficiaries. This is not about whether the governors can be trusted. They can be trusted, which is why our proposal offers states unprecedented flexibility in program management and why we have worked with so many states on their innovative demonstrations. The issue is whether an individual, regardless of where he or she lives, is guaranteed meaningful coverage.

Financing

The President's second principle for Medicaid reform is an appropriate financing structure -- namely, one that maintains the Federal-state partnership that has been at the heart of the Medicaid program for 30 years. Under this partnership, Federal dollars follow the people, meaning that the Federal government shares responsibility with the states for increased costs associated with increases in enrollment. As with the Federal guarantee of coverage and benefits, the new Republican bill falls far short of meeting this principle.

This newest financing structure is simply the MediGrant II block grant formula, dressed up with a tiny embellishment to pay lip service to the governors' principles that funding must automatically adjust for enrollment.

To demonstrate this point, I will walk through each component of the financing structure of the new Republican bill.

Base Allotment: The first component of the Republican

funding system is called the base allotment. These allotments, which account for an average of 96 percent of total Federal spending over the 6 year period are distributed to states based on a formula that includes factors such as "needs-based amounts" and "program need". Given this structure, at first it might appear that each state's base allotment is determined based on its actual need, including enrollment growth and caseload changes.

However, the base allotment is not what it seems. Only 5 percent of this 96 percent of funding is actually distributed based on need. The remaining 91 percent is distributed to states based on annual caps. Under this system, states' allotments are determined through the use of "floors" and "ceilings", rather than by the results of the needs-based formula. Each year, between 44 and 49 states' allotments are determined through a floor or ceiling. For these states, the new Republican bill is a block grant with a new name.

Furthermore, even the 5 percent "needs-based" funding does not truly reflect the financial need of states in their Medicaid programs. This is because it is determined by the number of poor people in a state rather than Medicaid enrollment growth. As a result, if the number of Medicaid enrollees in a state increases but the number of poor people does not, the state's base allotment would not increase.

Umbrella Fund: The second component of the financing structure is called the "umbrella fund", and it consists of supplemental Federal money that is to be distributed to states with high enrollment growth. But if the Republican umbrella is the states' only protection against the costs of high enrollment growth, the states are going to get drenched. The entire umbrella fund accounts for only 3 percent of all CBO estimated Federal Medicaid spending; thus, it could provide only a fraction of what states would need in times of recession. In addition, it covers enrollment increases only for the year of the increase -- not for any later years during which the new enrollees continue to receive Medicaid. Thus, if a state suffered a three-year recession that caused its Medicaid enrollment to rise, it could get umbrella funds for new enrollees for their first year, but could be forced to bear the entire cost of these enrollees for any later years during which they remained on Medicaid.

Assume that the recession begins in year 2. This recession causes a dramatic increase in the state's enrollment, which triggers an umbrella payment to assist the state in covering the costs of these new enrollees. In year three, however, the state's enrollment remains at the same level as in year two, but this time there is no umbrella payment, because these payments are based only on changes in enrollment from the previous year, not total enrollment. Thus, the state is forced to bear the cost of the much higher enrollment with the same amount of Federal assistance as it received in year one.

Pools for Undocumented Aliens and Indians: The final component of the financing structure is $4.3 billion to assist

states in providing care for undocumented aliens and Native Americans. The first pool is allocated across the 15 states with the highest numbers of undocumented aliens. The second pool is allocated among all states that have Indian-funded health facilities or programs.

Changes in FMAP and Taxes and Donations Laws

In addition to replacing the current financing partnership with a block grant to states, the new Republican bill also includes two changes in the way states finance their share of Medicaid costs. It increases the rate of Federal contribution to Medicaid (known as the FMAP) for many states, thereby reducing the amount of funds necessary to collect Federal matching funds. It also repeals the restrictions on states' use of provider tax and donation financing mechanisms.

While these proposals are appealing to many states, they raise significant concerns. Specifically, the proposed changes to the FMAP will raise the Federal share of national Medicaid spending from 57 percent to 63 percent. In addition, the FMAP changes could encourage states to reduce their contributions to the program, resulting in even deeper reductions in total Medicaid spending than this bill suggests. The new Republican bill will reduce total Federal spending on Medicaid by $72 billion over 6 years. But total reductions in Medicaid spending could be far greater. The Center for Budget and Policy Priorities estimates that states could reduce their own spending on Medicaid by about $185 billion over 6 years without decreasing the amount of Federal funds for which they are eligible. Thus, the new Republican bill could lead to a total reduction of approximately $257 billion in Medicaid spending over the next 6 years.

Defining and revising the appropriate Federal and state contributions and spending levels through matching formula or other means always will be one of the most difficult issues to settle in any Medicaid reform plan. There is no question that these matters merit careful attention in the long-term. The President's plan proposes to gain advice from an intergovernmental advisory commission on the appropriate relationship between Federal and state funding before the Congress proceeds to change the current distribution.

The new Republican bill also would permit unconstrained use of provider tax and donation financing approaches for the "state" share of Medicaid. These are the same financing approaches that were widely used by some states in the early 1990s to increase their Federal Medicaid payments without actually increasing state Medicaid spending.

During the late 1980s and early 1990s, many states took advantage of these types of financing mechanisms, costing the Federal government billions of dollars and helping to drive annual Medicaid spending growth rates to well over 20 percent. Congress responded in a bipartisan fashion by limiting the provider tax schemes and completely outlawing the donations schemes. Now, the Republican bill seeks to remove these

restrictions that were passed with overwhelming bipartisan support just a few years ago. Without these restrictions, states would be free to finance significant portions of the state share without contributing any real state dollars, leading to substantially lower support overall for the Medicaid program.

In summary, the new Republican bill fails to meet the President's second principle for Medicaid reform -- a financing structure that maintains the Federal-state partnership that has been at the heart of the Medicaid program for 30 years. Neither does it meet the financing principles agreed to on a bipartisan basis by the governors. The governors' proposal reflected a willingness to assume a greater responsibility for the management of the Medicaid program, but only if they had a strong financial partner to help meet the costs. The NGA proposal was designed to provide this Federal-state partnership, and was based on a funding mechanism that protected states from the full costs associated with actual changes in enrollment. The money was supposed to follow the people, in order to protect states from unexpected, uncontrollable enrollment increases. When the latest Republican proposal was released, it did not take the Democratic Governors long to realize that the centerpiece of their deal was no longer part of the mix.

Protecting beneficiaries, families, and taxpayers

This brings me to the President's third principle for Medicaid reform: protections for beneficiaries, families, and taxpayers. Once again, the new Republican bill fails to meet the President's principle.

The new Republican bill would repeal title XIX and create a new title for the Medicaid program. This has the effect of seriously compromising the framework for quality standards, beneficiary and family financial protections that limit families' out-of-pocket costs, and program accountability.

Out-of-Pocket Costs: This bill reduces or eliminates many long-standing family and beneficiary protections. For example, it would permit states to require adult children of Medicaid beneficiaries to contribute to the cost of their care, except for long-term care. In addition, the bill grants states broad discretion to impose cost-sharing requirements on Medicaid beneficiaries. It imposes minimal cost-sharing limits only for certain services to children and pregnant women below poverty, leaving other women, children, and most disabled and elderly fully exposed to potentially serious financial consequences. This lack of limits on cost-sharing is another factor which effectively undermines these persons' "guarantee" of eligibility and benefits.

In addition, while the bill retains current law provisions designed to protect spouses and other relatives of nursing home patients from excessive liability for the cost of care, repeal of the more general cost sharing protections significantly minimize these protections. For example, nursing home residents who have spent down their income to become eligible for Medicaid could be charged any level of cost-sharing to help pay for long term care

services. In addition, services included in the nursing home benefit could be reduced, leaving the spouses or children of nursing home residents to bear the full cost of these services. Furthermore, states could charge elderly or disabled persons any level of premium, which could be set so high as to effectively exclude them from the program.

Quality Assurance Requirements for Managed Care: In addition, the new Republican bill makes no mention of quality assurance requirements or monitoring responsibilities for Medicaid managed care. This is a serious concern since Medicaid managed care enrollment is increasing so dramatically. About one-third of beneficiaries now are in managed care, a 140 percent increase in enrollment over the past three years. The President's plan recognizes the need for updating managed care quality standards. It replaces some outdated approaches with a quality improvement program that must include appropriate standards for Medicaid-contracting health plans and data analysis that tracks utilization and outcomes.

Fiscal Accountability: Finally, we recognize that the Federal government finances well over half of Medicaid spending nationwide, at a cost to Federal taxpayers which is growing to more than $100 billion a year. The Federal government has a responsibility to those taxpayers to ensure that these funds are spent efficiently and appropriately.

Fulfilling this responsibility requires imposing a minimal amount of reporting and monitoring requirements on states. There are ways, similar to the approach taken in the President's plan, that would provide states with expanded flexibility in management and operation of their Medicaid programs, while ensuring accountability for funds at the same time. Unfortunately, the new Republican bill, includes no quality assurance requirements or monitoring responsibilities for Medicaid managed care, and it contains no mechanism to ensure that changes in benefits and cost-sharing do not jeopardize the sufficiency of coverage. Thus, under the Republican bill, the Federal government will finance a greater percentage of the Medicaid program, but taxpayers will have fewer assurances that their money is being well spent.

In summary, like its predecessor last fall, the new Republican bill fails to meet the President's third principle -- protecting beneficiaries, families, and taxpayers.

Let me conclude on Medicaid by focusing on one fundamental structural issue -- whether we approach the task of Medicaid reform by making changes in the current title XIX of the Social Security Act, or by repealing that program and replacing it with a new title. We support reform, not repeal, of title XIX. The potential unintended consequences of repealing and replacing this program are staggering -- for states, beneficiaries, providers, and the Federal government, especially when you consider that it would reopen thirty years of settled litigation. The Congress can address many of the most pressing concerns about any Medicaid reform plan by amending the current law.

We in the Administration believe that Medicaid must be financed through a Federal-state partnership that ensures Federal funding and provides a real, enforceable guarantee of coverage for a defined package of health and long-term care benefits. The President's plan proposes unprecedented flexibility for the states to operate their programs, pay providers, and use managed care and other delivery arrangements, while retaining and revising key standards related to quality and beneficiary financial protections. The President's proposal would achieve those objectives in a way that would also help to balance the budget by 2002.

Welfare Reform

Mr. Chairman, I would now like to turn to welfare reform. As we have worked to enhance state flexibility under Medicaid in the absence of national reform legislation, the Administration has also worked with states to transform their welfare systems to require work, promote parental responsibility, and protect children.

Over the last three years, within the framework of the Family Support Act, we have worked with governors and other state and local elected officials to give 39 states flexibility to design welfare reform strategies that meet their specific needs. These efforts are directly affecting approximately 10 million recipients throughout the country, or 75 percent of all welfare recipients nationwide. States, led by governors of both parties, are now demanding and supporting work; time-limiting assistance; requiring teens to stay in school and live at home; strengthening child support enforcement; and strengthening families.

The President also has worked with the Congress to expand the Earned Income Tax Credit to help make work pay more than welfare. This program, which President Ronald Reagan said was the most pro-family, pro-work initiative undertaken by the United States in the last generation, means that, in 1994, millions of families with children with incomes under $28,000 paid less in income tax than they would have if the laws hadn't been changed in 1993.

The efforts we have taken at both the Federal and state levels have begun to pay off. Welfare caseloads have declined by 1.3 million since January of 1993 -- a decline of about 9 percent. A larger percentage of those still on the rolls are engaged in work and related activities. Food Stamp rolls have gone down. Teen birth rates have gone down. At the same time, child support collections have gone up, as the Administration has worked to improve state collection efforts, the IRS's offset of income tax refunds, and the ability of the Federal government to make Federal employees accountable for the support they owe their children.

We continue to move ahead. On May 10, the President directed the Department of Health and Human Services to implement an initiative to strengthen parental responsibility among teen parents. This initiative builds on the belief -- which I'm

confident is shared by this committee, Congress, and the states -- that encouraging parental responsibility must remain a bipartisan imperative.

The President's initiative includes four actions: requiring all states to submit plans for requiring teen mothers to stay in school and prepare for employment; cutting through red tape to allow states to reward teen mothers who finish high school, in addition to sanctioning those who don't; requiring all states to have teen mothers who have dropped out of school return to school and sign personal responsibility plans; and challenging all states to require minor mothers to live with a responsible adult. With these actions, we're focusing on one of the key components of welfare reform: parental responsibility. And we're putting young mothers on the right path, toward employment and self-sufficiency.

The Need for Legislative Action

While we've made great progress on welfare reform through welfare reform waivers, executive actions, and other initiatives, we still need national welfare reform legislation. As part of his balanced budget plan, the President has proposed a comprehensive welfare reform proposal that would require work, promote parental responsibility, and protect children. The President has made it clear that if Congress sends him a clean welfare reform bill that follows these fundamental principles, he will sign it. However, the President has also made it clear that real welfare reform should not be impeded by attaching harmful proposals to it, such as the elimination of guaranteed health coverage for poor children, pregnant women, and people with disabilities.

Fortunately, we have begun to approach bipartisan consensus on a framework for welfare reform legislation based on these fundamental principles. We believe that the governors have moved the debate forward and increased the likelihood that Republicans and Democrats will produce bipartisan solutions to reforming our welfare system. Senators Chafee and Breaux and their colleagues have also moved us much closer to that goal, and, as I said earlier, we greatly appreciate the great amount of time and outstanding leadership they have committed to this process. We are pleased that the Chairman's bill, S. 1795, reflects some of the significant progress that has been made on welfare reform since the President was forced to veto HR 4.

It is now up to this Administration and this Congress to build on the spirit of these efforts to reach our mutual goals: flexibility for the states; incentives for AFDC recipients to move from welfare to work; increased parental responsibility; and protections for our most precious resource, our children.

The New Republican Bill (S. 1795)

As I mentioned, the Chairman's new bill, S. 1795, makes important improvements to the H.R. 4 conference bill. It incorporates a number of key changes recommended by the

Administration and contained in the NGA and the Breaux-Chafee proposals. These are steps in the right direction, and we would urge the Committee to build on this bipartisan ground. However, the bill does not address several issues that are of concern to the Administration, particularly in providing the resources and incentives to protect children, ensure accountability, and move people from welfare to work. And, instead of stand-alone welfare legislation the Administration has repeatedly requested, the new bill continues to link welfare reform with unacceptable Medicaid changes.

We appreciate the steps the Chairman has taken to provide additional protections for children and families in the new Republican bill. The important modifications you have made to H.R. 4 move the legislation much closer to the President's vision of true welfare reform. We are particularly pleased that S. 1795:

- reflects an understanding of the child care resources states will need in implementing welfare reform by adding $4 billion for child care above the level in the conference report for H.R. 4. These proposals improve upon H.R. 4, which did not provide child care resources needed for those required to move from welfare to work and low-income working families at-risk of welfare dependency.
- adopts several provisions from last year's Senate-passed bill -- including exemptions from the time limit; a true state option on implementing a family cap; and requirements that teen mothers live at home and stay in school.
- remains the annual spending cap on Food Stamps, which will preserve the program's ability to expand during periods of economic recession and help families when are most in need.
- no longer includes the provisions for a child nutrition block grant demonstration proposed in H.R. 4, which would have undermined the program's ability to respond automatically to economic changes and maintain national nutrition standards.
- recognizes the importance of child support enforcement to welfare reform and includes all of the major proposals for child support enforcement reform in the President's bill.
- retains the safety net for abused and neglected children, adopted children and children in foster care by continuing critical federal entitlement programs for them.
- removes the two-tiered benefit system for low income disabled children, and ensures full benefits for all eligible children under the SSI program.

The new Republican bill makes other improvements to H.R. 4 that will strengthen states' abilities to move people from welfare work. For example, S. 1795 makes improvements to the performance bonus provisions contained in H.R. 4 by establishing a separate funding stream to pay for bonuses. It increases the cash block grant contingency fund modestly and adds a more responsive trigger based on the Food Stamps caseload. Consistent with the NGA proposal, S. 1795 gives states some more flexibility to run work programs by allowing job search for up to 12 weeks and allowing teen parents in school to count toward the work requirements.

While we applaud the inclusion of many of the provisions endorsed by numerous Democratic and Republican senators and governors, the new Republican bill still fails to include other provisions that have earned bipartisan endorsement.

For example, S. 1795 incorporates almost all of the cuts that were in the bill the President vetoed -- a total of $51 billion (excluding Medicaid) over 6 years under CBO's new baseline. These cuts are far greater than those proposed by the NGA or the Administration. The cuts in Food Stamps and benefits to legal immigrants are particularly deep. In addition, unlike the Administration's bill, the Republican bill would also allow states to substantially reduce their own spending on programs serving low income families, compounding the impact on poor children and families.

We are particularly concerned that S. 1795 actually decreases state flexibility by prohibiting states from providing a safety net for children -- by not allowing them to use block grant funds to provide non-cash assistance or vouchers for children in families who are subject to the 5 year time limit. No such prohibition was contained in H.R. 4 and it is difficult to understand why the leadership has moved in this direction.

Further, the new Republican bill does not maintain the guarantee for medical assistance for all those currently eligible or those who reach the five year time limit. And, as I mentioned previously, S. 1795 fails to continue transitional Medicaid coverage for families leaving welfare for work.

In addition, S. 1795 also fails to provide adequate protection for states in the event of economic downturns. The contingency fund is set at too low a level and does not allow for further expansions (above the $2 billion cap) during poor economic conditions and periods of increased need.

The new Republican bill also makes deep cuts in the Food Stamp program, which take the form of a reduction in benefits to families with high shelter costs and a four month time limit to childless adults who are not give a work slot. It would also permit states to replace the Food Stamp Program with a block grant, jeopardizing the nutrition and health of millions of children, working families, and the elderly.

S. 1795 includes no changes to the unduly harsh and uncompromising immigration provisions that were contained in the H.R. 4 Conference bill. While the Administration supports

strengthening requirements on the sponsors of immigrants for SSI, Food Stamps, and AFDC, S. 1795 requires a permanent SSI and Food Stamps ban for virtually all legal immigrants and a 5-year ban on all other Federal programs, including Medicaid, for new immigrants. There are no exemptions for immigrants who become disabled after entering the country, families with children, or for individuals who have been working for a few years and lose their job. The proposal also unfairly shifts costs to states with high numbers of immigrants.

Another concern is the transfer authority to the Social Services Block Grant (SSBG) in the proposed cash assistance block grant. Transfers to SSBG could result in the substitution of Federal dollars for state dollars in a range of state social services activities, potentially reducing or even eliminating the effective state maintenance of effort levels required for the cash block grant.

The Breaux-Chafee proposal addresses many of the Administration concerns and would strengthen state accountability efforts, welfare to work measures and protections for children. It provides one of many foundations upon which this Committee should build to reach our mutual goals: flexibility for the states; incentives for AFDC recipients to move from welfare to work; increased parental responsibility; and protections for children.

The American people want Congress to pass a bill that the President can sign -- that honors our values and ensures fiscal integrity. They want a bill that promotes work and responsibility, but also protects children. They want a bill that supports families who play by the rules and rewards those who work hard to support themselves. They want a bill that ensures accountability for use of taxpayer funds. In short, they want real welfare reform.

Mr. Chairman, let me restate the Administration's commitment to enact bipartisan welfare reform legislation. I know the President shares my hope that, with the leadership of this committee, the bipartisan cooperation that existed in 1988 will surface again to address the critical issue of welfare reform this year.

CONCLUSION

The last time I testified before this committee, I was encouraged that the governors' bipartisan efforts appeared to be moving us toward a solution that could meet the President's principles. Since that time, the Breaux-Chafee group in particular has worked hard to build on the balanced approach envisioned in the NGA Medicaid and welfare agreements. I can assure you that this Administration stands ready to work with the members of this committee and the entire Congress to enact both a balanced budget and Medicaid and welfare reform legislation. We are confident that we can reform the welfare system to promote work and responsibility and protect children, and design a reformed Medicaid program that will meet the needs of beneficiaries, states, and taxpayers. We look forward to working in a bipartisan way to enact both Medicaid and welfare reform legislation of which we can all be proud.

Mr. Chairman, I want to thank this Committee for giving me the opportunity to testify today, and I look forward to answering your questions.

PREPARED STATEMENT OF ARNOLD R. TOMPKINS

Mr. Chairman and distinguished members of the Committee, thank you for asking me to join you today to discuss welfare reform.

I am Arnold Tompkins. I oversee the Ohio Department of Human Services for Governor George V. Voinovich. My department and our 88 county partners administer state and federal human services programs—such as Medicaid, Aid to Families with Dependent Children, child support and numerous child welfare programs—that serve more than 1.5 million low-income Ohioans.

It is a real pleasure to be back in Washington testifying before Congress. On the plane over I was reminiscing about all the times I came to the "Hill" during my days as Assistant Secretary for Management and Budget and other positions at the U.S. Department of Health and Human Services. During those eight years at HHS, state and local officials often came to see me about innovative approaches they wanted to implement to reduce welfare dependency. Quite frankly, I wasn't a very receptive audience. I didn't understand their perspective, their day-to-day challenges. I thought we had all the answers at the federal level.

After three years in Ohio, I now understand what they meant. I told C-SPAN during a recent interview that all federal bureaucrats and presidential appointees should have to first serve at the state or local level to get a good grasp on reality. If my friends at HHS had that experience, they would understand why we need block grants and why the President should sign S. 1795. Only by ending the federal individual entitlement will this proposal provide states sufficient flexibility to continue to pursue innovations that promote personal responsibility and self sufficiency. For the first time, states will be able to design programs that work best for their citizens.

Governor Voinovich and the rest of the nation's governors know that S. 1795 is extraordinarily similar to the policy they developed at the National Governors' Association annual meeting. The nation's governors and my colleagues in other state human services agencies are extremely pleased with this legislation and commend you for moving toward real reform. I also would like the committee to know that strong support for S. 1795 exists in Ohio's state legislature and county governments. Governor Voinovich and the rest of Ohio will do whatever is necessary to help you enact this legislation.

Mr. Chairman, I won't review S. 1795 item-by-item. I will use my time to explain to the committee why the State of Ohio, our county partners and Ohio taxpayers want this bill to become law, and why we deserve a chance to truly end welfare as we know it.

Last August, Governor Voinovich signed into law the most comprehensive welfare reform plan in Ohio history. Our welfare reform package, called OhioFirst, is based on encouraging personal responsibility, improving employment opportunities, increasing child support collections, and providing support for families. Our reforms were designed to change the basic philosophy of the federal welfare system. We have shifted the focus away from getting people on assistance to getting people off welfare and into jobs. Satchel Paige once said, "The only place you can find success before work is in the dictionary."

This paradigm shift will help caseworkers treat individuals as human beings, not just as another case number. Caseworkers will no longer focus on eligibility, forms and every last detail of your life. They now can assess clients needs and what assistance is available to help families remain intact and off welfare. While we have taken the first step to break the old system, much more has to be done to truly shift the welfare paradigm. S. 1795 would give us that flexibility and opportunity.

Ohio's plan enjoyed overwhelming support from legislators on each side of the aisle, as well as advocacy groups ranging from the Children's Defense Fund to the Catholic Conference. Ohio recognized that the welfare status quo of despair and dependency could not continue. We realized that Ohio could not wait for the federal government. We knew we had to build on our history of welfare reform innovation with a renewed emphasis on personal responsibility and employment.

Ohio's success is reforming welfare has been well documented. Since April 1992, the number of AFDC recipients in Ohio has decreased from 746,862 to 538,400—a 28 percent reduction. Our AFDC expenditures have decreased from a 1992 peak of $977 million to an estimated $774 million this year. We have built upon our strong economy with a series of programs designed to promote employment and encourage self-sufficiency. Ohio has increased by five times the state funding for day care. We have increased child support collections by 41 percent since 1991. Ohio recently gained national attention for our innovative Learning, Earning and Parenting (LEAP) program, designed to help teen mothers stay in school, graduate and become employed. And, Ohio leads the nation in the number of AFDC recipients participat-

ing in the JOBS program—more than 40,000 people or 46 percent participation rate as of 1996.

This "work first" approach is not uncommon in state welfare reform initiatives. However, Ohio is unique in that the labor market could absorb a significant number of the unemployed, if those individuals were properly trained and motivated. Employers from all across the state have contacted me expressing concerns about the lack of a young, skilled pool of potential employees in the pipeline to fill vacant positions. Our challenge is to reshape the welfare system as an economic development tool. We must work collaboratively with the employment services, education and housing systems to develop, attract and keep a strong workforce in our state.

To illustrate my point, two years ago a plastics company in Ohio reported that one out of every three workers left the company within the first year of their employment. The company's long-term survival was threatened and the traditional systems were unable to help. We were able to help by providing training to low-income individuals and establishing a link between the company and a two-year college. Now only one out of every twenty individuals leaves within the first year of employment.

We know Ohio could do more to break the cycle of dependency. After Governor Voinovich signed OhioFirst into law last summer, my department spent two months developing the required federal waiver application. The Clinton administration took another five months to approve the waiver, but with conditions that significantly changed what Ohio had overwhelmingly approved.

Governor Voinovich has been a vocal critic of the long, drawn-out, micro-managed federal waiver process. He has often said that once the elected officials of a state pass a measure developed with widespread community support, the federal government should not be in a position to disapprove or alter the plan. But unless S. 1795 becomes law, states will continue to be at the mercy of the federal bureaucracy.

In Ohio's case, the Clinton administration either did not approve or attached restrictions to one-fourth of our waiver application—restrictions that Ohio Democrats and Republicans, liberals and conservatives, advocacy groups and taxpayers had rejected in the development of our welfare reform package. Ohioans worked together for months to come up with a carefully-balanced package of incentives and sanctions designed to help recipients move from dependency to self-sufficiency. This balance was upset and our consensus undercut by the federal government.

The Clinton administration is requiring Ohio to do such things as continuing to provide Medicaid to adult recipients guilty of welfare fraud. They also cut a huge hole in our three-out-of-five year time limit for welfare benefits. We recognize that merely cutting recipients off does little to change their life. Our time-limit includes good cause and other exemptions for those who are unable to work and provides support services up front so that parents can support their family at the end of three years. Unfortunately, HHS stripped the portion of our plan that required recipients to be off welfare within three years, unless the state ensured the recipient of employment that paid more than the individual would receive by staying on welfare. The net result of the waiver process is that recipients who don't want to become self-sufficient don't have to and the responsibility to find employment is shifted from the individual to that state.

We are extremely disappointed, but Ohio will not stand by and let the federal welfare system create a cycle of dependency where families grow accustomed to relying on monthly checks instead of taking control of their lives. We have already resubmitted those portions of our plan that the Clinton administration denied or altered. We must be freed from this federal interference and allowed to help our citizens build better lives for their families.

A good example of the flawed federal waiver process is our LEAP program. Ohio has operated the LEAP program for five years with notable success. Unfortunately for Ohio, our waiver was only good for five years. When we asked for a waiver to continue the program we were informed by HHS that there is no authority to extend an existing waiver. Therefore, we had to modify a successful program just to be able to continue to help teenage mothers stay in school.

Now, President Clinton has mandated that all states implement a LEAP program. Ironically, the other 49 states are in a position to operate a program that Ohio had been running for years with great success. Only Ohio is forced to run through the bureaucratic maze of the federal waiver process. It seems that waiver system is set-up to discourage innovation and leadership, and encourage follow-the-leader.

Mr. Chairman, I know Congress has done its part. Unfortunately, due to two presidential vetoes, the issue of giving states flexibility to tackle the problem of welfare dependency remains before us. Ohio, like many other states, has suffered because of it.

In addition to the denied waivers I discussed earlier, Ohio's counties have felt the disappointment associated with the veto of the welfare block grant. The legislation Governor Voinovich signed last year included an attempt to foster local flexibility in the implementation of welfare reform through several county demonstration projects. When the legislation was designed and approved, Governor Voinovich and the Ohio legislature were very optimistic that states would receive a welfare block grant.

Five Ohio counties, incorporating everything from urban Cincinnati to Appalachian southeast Ohio, spent tremendous amounts of time and energy developing community-based welfare reform strategies. These strategies included drug testing for recipients, eliminating categorical eligibility and funding streams in order to address emergent needs throughout the community, and combining work and training dollars to provide services to populations beyond AFDC recipients. Although these were not ideas included in our statewide welfare reform efforts, Ohio would like to be able to test these strategies. Just as states need the flexibility, so to do counties. Ohio's 88 counties are as diverse as the 50 states. What works in Cincinnati may not work in Sidney, and what is a priority in Belmont may not be so important in Columbus. I spend many years in this system and I firmly believe that welfare reform will not succeed without community involvement, without neighborhood solutions to local problems.

Implementing these county proposals without a federal block grant would be nearly impossible since each would require federal law changes and federal waivers. Obviously, these counties and the communities who helped design those proposals are extremely frustrated.

However, Governor Voinovich is determined not to let their efforts be wasted. My department will prepare yet another federal waiver application for those common items in the county proposals. Several good ideas will be lost or delayed while we wait for federal block grants. I fully expect another year to slip by before we can implement these innovative ideas—another year of filling out paperwork, arguing our case and waiting for federal approval with restrictive conditions.

These county proposals demonstrate why Congress and President Clinton must make S. 1795 law. Not only would states be able to operate better welfare programs, but for the first time local communities would have the opportunity to end welfare as they know it. It is time, Mr. Chairman and members of the committee. It is time to give us a chance.

In order to be successful in welfare reform, states must be able to go beyond the existing entitlement programs. Welfare reform cannot and must not start and finish with human services. As our caseloads continue to go down, we are left with the hardest to place individuals in our system. We need to be able to work more closely with our schools, the communities, the private sector, and other state and federally administered programs to effectively address poverty. S. 1795 would give us that opportunity. Ohio looks forward to its passage and President Clinton's signing of this legislation into law.

Thank you.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

(SUBMITTED BY KENNETH L. EVANS. M.D., CHAIR, BOARD OF DIRECTORS)

My name is Kenneth L. Evans, M.D. I am a practicing family physician from Oklahoma City, Oklahoma, and serve as Chair of the Board of Directors of the American Academy of Family Physicians. The Academy is comprised of 83,000 practicing family physicians, family practice residents, medical students and other individuals with an interest in family medicine. It is my pleasure to submit this written statement for inclusion in the official record of the June 19 Senate Finance Committee hearing on the *Medicaid Restructuring Act of 1996 (S. 1795).*

The Medicaid Predicament

Since its inception 31 years ago, the Medicaid program has become an important source of medical services for nearly 37 million low-income children, pregnant women, and disabled and institutionalized people. According to a recent statement to the House Commerce Committee by Secretary of Health and Human Services Donna Shalala, Medicaid offers primary and preventive care for 18 million low-income children; comprehensive services for 6 million Americans with disabilities; long-term nursing home care for 4 million senior citizens; and payment of premiums and other cost sharing for low-income seniors that, because of their low income, are dually eligible for Medicare and Medicaid. In its role as a medical assistance safety net, the Medicaid program is in many tangible ways a success story.

The safety net, however, has been slowly unraveling for some time and is now poised to burst. In some states, Medicaid consumes more than 20 percent of the budget. Annual growth rates in federal Medicaid expenditures presently average 10 percent, an amount more than double the inflation rate. Uncontrollable growth in Medicaid spending is exacerbated by the demographics of the beneficiary population. The aging of America has resulted in a populace that lives longer and often requires costly and labor intensive, long-term care services that absorb two-thirds of overall Medicaid resources. By contrast, low-income children and teens that comprise 57 percent of program beneficiaries receive less than one-fourth of Medicaid dollars. The present situation, characterized by limited financing that is allocated disproportionately, ensures that no one beneficiary group, let alone all of them, receives sufficient resources for delivering covered services to all eligible persons.

Furthermore, rigid federal guidelines often discourage state-level innovation in plan design that might boost access while limiting costs. In the face of such programmatic inflexibility, many states must obtain special waivers. In response

to state requests, the Administration to date has approved 91 Freedom of Choice waiver applications and renewals, which enable states to enroll beneficiaries in managed care plans. The Administration has also sanctioned 163 new and renewed Home and Community-Based Service waivers that permit states to use home care in place of nursing home care, and enable people with disabilities to remain in their communities instead of institutions. In addition, the Administration has approved 12 statewide Medicaid demonstration waivers, known as Section 1115 waivers. The process of obtaining any of these special waivers is costly and time-consuming. More to the point, however, is the fact that these waivers represent a temporary and imperfect response to the ongoing fiscal and programmatic limitations challenging the effectiveness and viability of the Medicaid program. Indeed, the onslaught of waiver applications begs the obvious question: Why not replace this piecemeal approach to Medicaid state plan design with comprehensive national reform?

The American Academy of Family Physicians' Viewpoint

Family physicians are fully aware of the strengths and deficiencies of the Medicaid program since approximately 11 percent of our patients are covered by Medicaid. As a result of our individual and collective experience with the program, the Academy realizes that corrective action must be taken soon to ensure that Medicaid fulfills its original mission without bankrupting federal and state budgets. Therefore, the Academy is pleased that during the 104th Congress lawmakers from both parties have likewise recognized the urgency of the Medicaid situation and developed a number of proposals, such as S. 1795, for restructuring this troubled program.

As the effort to restructure the Medicaid program moves through the reconciliation process, the Academy urges Congress to guarantee that this legislation will bring our health care system closer to achieving universal coverage by increasing the number of Americans with health care insurance. Lowering the number of covered individuals is contrary to Academy policy on health insurance. With this overriding principle in mind, we hope that the *Medicaid Restructuring Act of 1996* emerges from the reconciliation process with strong bipartisan support for program improvements that guarantee all of our nation's most vulnerable citizens finally receive medical care.

The Medicaid Restructuring Act of 1996

Many features of this legislation merit Academy support, such as provisions that allow:

- state flexibility and experimentation with the design of Medicaid benefit plans and delivery systems, but with one important qualification -- restructured plans must include a defined benefit package that emphasizes primary and preventive health care services;

- states' discretion to determine which medical conditions warrant the expenditure of limited health care resources under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program; and

- retention of federal nursing home quality and safety standards that were enacted as part of the Omnibus Budget Reconciliation Act of 1987 (OBRA'87).

However, the Academy is concerned about the following elements of the proposal and would urge they be substantially modified or else removed from the legislation:

- flexibility with respect to program eligibility for children age 13-18 years and the disabled is unacceptable for the Academy believes such a policy would result in higher numbers of uninsured individuals -- an undesirable result that is wholly inconsistent with our policy relating to health insurance. The Academy recommends that this provision be replaced with one that provides uniform (not state determined) national eligibility criteria based on income rather than eligibility for public assistance. In addition, the program should include coverage for the homeless and otherwise medically uninsurable individuals;

- the Vaccines for Children (VFC) program should be restored to guarantee that Medicaid-eligible *and* underinsured children continue receiving free vaccinations. Vaccinations for children are too important a preventive measure to be subject to an arbitrary cut as in the current version of this legislation and, for this reason, the Academy strongly encourages that the VFC program be fully restored as part of any Medicaid legislation considered by Congress;

- a private right of action for providers must be preserved to ensure that family physicians and other health care providers have direct access to federal courts for settling program disputes involving reimbursement, participation standards, or other possibly questionable features of state Medicaid plans;

- the provision allowing states to specify in their Medicaid plan the providers that may deliver covered items and services resembles too closely the present law's minimum qualifications policy, which requires that providers of obstetrical and pediatric services to Medicaid recipients be board certified in those specialties. The Academy adamantly opposes the requirement for board certification. Physicians should be allowed to deliver all services to beneficiaries that are within the scope of their training and experience. For this reason, the Academy recommends that this provision be removed from the legislation; and

- the proposal to allow states to pay a lower, Medicaid rate to medical providers in lieu of the Medicare rate for services delivered to Qualified (dually eligible) Medicare Beneficiaries should be eliminated from the legislation. The QMB population is especially vulnerable financially and, in most cases, could not afford out-of-pocket cost sharing for medical services. To protect access and coverage for these beneficiaries, the policy of paying the Medicare rate for QMB medical services should be continued.

Conclusion

Reform of the federal-state Medicaid program will have a profound effect upon the health care system as a whole. The Academy hopes that this undertaking will yield a program that at last extends essential health care coverage to all eligible individuals in a fiscally and medically responsible manner. Please do not hesitate to call upon the American Academy of Family Physicians as you proceed with work on the *Medicaid Restructuring Act of 1996.* Thank you.

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

The Medicaid program is of great concern to older Americans. Approximately two out of every three nursing home residents rely on the Medicaid program—our nation's only long-term care safety net.

The new proposal—S. 1795—is a clear improvement over the legislation passed by the Congress last year and vetoed by President Clinton. AARP is pleased that the new proposal would:

- maintain current nursing home quality and enforcement standards. (The successful 1987 law is critical to nursing home residents and their families. Unfortunately, the regulations implementing the law would be repealed.)
- maintain current spousal impoverishment protections. (These protections ensure that the spouses of nursing home residents will not be forced into poverty.)
- maintain current financial protections for poor and low-income Qualified Medicare Beneficiaries. (These provide essential protections against premiums, deductibles and copayments for Medicare beneficiaries who cannot afford them.)
- prohibit states from forcing adult children to pay for their parent's nursing home care. (Earlier proposals could have presented serious financial burdens for the adult children of nursing home residents.)
- prohibit states from placing liens on the homes of nursing home resident's spouses. (Earlier proposals could have forced the spouses of nursing home residents to sell their homes.)

Although these essential consumer protections for low-income older Americans are now included in the revised bill, a number of serious concerns remain. For these reasons, AARP cannot support the bill at this time and urges Congress to defer action until additional improvements can be made.

- An overarching concern is the repeal of most of Title XIX, rather than amending—even significantly—current law. This will create many potentially unintended outcomes, compromising important consumer protections.
- The current entitlement would be eliminated and the guarantee of coverage would be seriously eroded for individual Medicaid beneficiaries. Specifically:
  - —States would no longer be required to cover all individuals within currently mandated eligibility categories.
  - —States expanding coverage or experiencing growth in Medicaid enrollment would no longer be assured of receiving a sustained contribution of federal dollars to help pay for such improvements or expansions. Given the expected rapid growth in the need for home and community care, this is extremely troubling.
  - —Individuals unfairly denied coverage could no longer bring suit in federal court for relief. In addition, it appears that state suits would be limited to disputes over coverage for particular benefits, not eligibility for Medicaid in general.
  - —Guaranteed coverage for children over age 12 would be explicitly repealed.
- Current income and asset eligibility standards would be repealed. States could count the value of a person's home in determining whether the applicant meets the asset test for Medicaid. In general, most states require a single person to have assets below $2,000 before becoming eligible for Medicaid coverage. However, current law excludes certain assets from eligibility determinations, including a person's home, a car with a market value up to $4,500; household goods and personal effects worth up to $2,000; burial spaces and up to $1,500 for burial expenses; and life insurance with a face value of up to $1,500. The new proposal would repeal these exclusions. This could result in individuals (including those living in the community) being required to give up important resources in order to become eligible for Medicaid.
- States would be permitted to severely limit services by placing restrictions on the scope and duration of services rendered (e.g. limiting the number of covered hospital or nursing home days). States would also be allowed to vary coverage based on length of residency in the state, where individuals live and on the nature of their particular disability.
- By repealing current protections, states could impose new out-of-pocket costs on low-income beneficiaries. Specifically:
  - —States would have complete discretion in imposing cost-sharing for services (under current law, any cost sharing must be "nominal"), potentially making benefits unaffordable and inaccessible, or necessitating contributions from family members.
  - —Current rules specifying which nursing home items and services are Medicaid covered and which ones must be paid for out-of-pocket would be repealed.

States could limit what Medicaid covers and shift new costs onto low-income nursing home residents.

- Two provisions in the legislation would significantly reduce states' financial responsibility for Medicaid at the expense of beneficiaries and the federal government:
  —Thirty-seven states would be permitted to reduce their Medicaid contribution while still receiving the maximum federal funding match. According to the Center on Budget and Policy Priorities, this could reduce total Medicaid spending (state and federal) by $250 billion over 6 years; and
  —States could engage in provider "taxes and donations" schemes that would permit permit states to receive federal matching dollars without actually spending state money. In 1991, in response to alarming increases in Medicaid costs and reports that some states were misusing federal Medicaid funds, a bipartisan Congress overwhelmingly passed legislation to prohibit such inappropriate tax and donation gimmicks.
- Older Americans who are eligible for both Medicare and Medicaid ("dually eligible") could be required to go into HMOs or other managed care plans that have strict limits on choice of doctors.
- States could pay for QMB services at Medicaid rates, rather than higher Medicare rates as required under current law, thereby jeopardizing access to some providers. It is unclear whether states could charge beneficiaries the difference between the two rates.
- Current minimum standards regarding nursing home estate recovery and transfers of assets would be repealed. Under current law, if an asset is transferred for less than fair market value, it will be counted as being available to nursing home residents when they apply for Medicaid eligibility, unless the transaction took place more than 36 months prior to the application for eligibility. Repealing this provision risks severe burdens and penalties for nursing home residents and their families. For example, a grandparent who helped a child or grandchild with college tuition or a down payment on a first home many years before nursing home admission—while he or she was healthy and could not have predicted an oncoming illness—could be denied Medicaid coverage. States could also apply new rules retroactively.

STATEMENT OF THE COUNCIL OF WOMEN'S AND INFANTS' SPECIALTY HOSPITALS (CWISH)

(SUBMITTED BY JAMES WHITING, EXECUTIVE VICE PRESIDENT, THE WOMEN'S HOSPITAL OF GREENSBORO)

The Council of Women's and Infants' Specialty Hospitals (CWISH) represents ten of the United States' largest hospitals dedicated to the delivery of high risk obstetrical and neonatal care to mothers and their infants. CWISH appreciates this opportunity to express its views with regard to S. 1795, the Medicaid Restructuring Act. Medicaid reform is of enormous interest to CWISH because Medicaid payments constitute approximately 20% to 45% of the care provided at CWISH hospitals.

Because the major decline in infant mortality over the past 25 years is largely attributable to better access to the specialty perinatal services provided at hospitals such as ours, access to these services must be preserved in any Medicaid bill approved by the Finance Committee. Indeed, the Finance Committee expressly recognized the importance of access to specialty perinatal care in its fiscal year 1996 reconciliation recommendations (attached in pertinent part). CWISH urges the Finance Committee to again include this report language on access to high risk obstetrical and neonatal services in its 1997 reconciliation recommendations (see further discussion at number one below).

CWISH is concerned that S. 1975, as introduced, may impede access to quality high risk obstetrical and neonatal services. Accordingly, CWISH asks that the following core principles be reflected in any Medicaid reform plan approved by the Committee:

- Preserve Access to Medically Necessary Preventive, Primary and Specialty Care;
- Assure Access to High Risk Obstetrical and Neonatal Services;
- Assure Adequate Payment to Providers of High Risk Obstetrical and Neonatal Services; and
- Assure Appropriate Compensation to Hospitals that Serve a Disproportionate Share of Indigent Patients.

CWISH additionally asks that the Finance Committee:

1. ***Include Attached Report Language on High Risk Obstetrical and Neonatal Services*** - Section 1521(b) of S. 1975 directs states to develop strategic objectives and performance goals relating to reductions in infant mortality and morbidity. As mentioned above, studies show that access to specialty perinatal care has greatly contributed to declines in the infant mortality rate. Accordingly, ***CWISH urges the Committee to include critical report language encouraging states to put in place protections so that pregnant women and babies receive the basic, specialty and sub-specialty care they need in the facility appropriate to their level of risk.*** The Finance Committee expressly recognized the importance of access to this care in its fiscal year 1996 reconciliation recommendations (attached in pertinent part) and CWISH urges that this same language be included in the Finance Committee's fiscal year 1997 reconciliation recommendations.

   Should the Committee also choose to include a specific benchmark, CWISH suggests the inclusion of one of the goals articulated in the U.S. Public Health Service's Healthy People 2000: *"Increase to at least 90% the proportion of pregnant women and infants who receive risk-appropriate care."*

2. ***Include High Risk Obstetrical and Neonatal Services in the Definition of Covered Hospital Services*** - A clause should be added to § 1501(a)(2)(A) of S. 1975 that expressly includes high risk obstetrical and neonatal services under covered hospital services.

3. ***No Arbitrary Coverage Limits on Medically Necessary Guaranteed Services*** - Consistent with the bill's requirement that certain benefits be assured, states' "complete flexibility in amount, duration, and scope of services" should not allow, for example, discharge of Medicaid-covered patients unless medically appropriate. Thus, CWISH urges the Committee to amend the legislation so that once a Medicaid patient qualifies for one of the guaranteed benefits (*i.e.*, inpatient and outpatient hospital services), all medically necessary care will be provided.

4. ***Continuous Eligibility*** - Coverage for women who are Medicaid eligible when they become pregnant and coverage for their newborn infants should be required to be continuous from the beginning of prenatal care through the first year of life. This would foreclose, for instance, administrative delays in Medicaid coverage of newborn babies born to Medicaid-eligible mothers.

5. ***Flexibility in Service Delivery*** - Health care delivery systems that participate in a state's Medicaid program should be required to have a sufficient number of providers of specialty services, **specifically including perinatal specialty care,** to ensure that such care is available and accessible. In addition, health care delivery systems should also be required to provide states with assurances that payments to providers are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities.

6. ***Disproportionate Share Hospitals (DSH)*** - States should be required to have a Medicaid DSH program and to target DSH payments to those providers that serve a disproportionate share of low income individuals, specifically including specialty perinatal hospitals.

CWISH looks to the members of the Finance Committee to ensure that the above-noted issues are addressed so that CWISH hospitals will be able to continue providing quality high risk obstetrical and neonatal services to pregnant women and infants in their communities, regardless of economic need.

Please call CWISH Washington Counsel Sally Rosenberg (202/778-8056) and Karen Sealander (202/778-8024) of McDermott, Will & Emery with questions or for additional information.

Thank you for this opportunity to submit our views.

Enclosure

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104th Congress
1st Session

COMMITTEE PRINT

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104–36

BALANCED BUDGET RECONCILIATION ACT OF 1995

COMMITTEE RECOMMENDATIONS AS SUBMITTED TO THE BUDGET COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 67

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

PETE V. DOMENICI, *Chairman*

OCTOBER 1995

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States and has added materially to the burden of program administration.

On numerous instances, HCFA has attempted to disallow State claims for Federal match money because of alleged technical flaws in plan documents. Although the HHS Departmental Appeals Board and the Federal courts have in many instances overturned these disallowance determinations, particularly where the substance of the State operation was in compliance with the general purpose of the law and the emphasis of "form over substance," the appeal process is not always successful and adds unnecessary costs and burdens to program administration.

HCFA has also disapproved amendments to reimbursement rates set forth in State plans on numerous occasions because the State failed to meet rigid regulatory public notice requirements, even where all affected interests were fully on notice of the changes.

The constant interruption of Federal funding caused by these regulatory actions, and the burden put on the States that have to respond to and oppose them, is not necessary to protect the Federal fiscal integrity. Such "oversight" does not lead to improved services for recipients—nor is it meant to. Rather, this type of Federal intervention merely serves to perpetuate a Federal bureaucracy that is too large, too focused on finding fault, however technical and insubstantial, and too far removed from the significant problems of program administration.

It is time to do away with this kind of regulatory oversight, and instead empower States to run their programs with only those Federal provisions that are truly necessary to assure that program funds are used for purposes intended by the broad aims of the program.

Proposed Change

States will be required to establish a written plan describing all the specific details of its programs and make the plan available to the general public. States must also submit a copy of the plans to the Secretary of HHS. States must identify objectives and goals for providing health care services, and the manner in which the plan is designed to meet the objectives and goals.

Goals and objectives related to rates of childhood immunizations, reductions in infant mortality and morbidity, and children with special health care needs will be required. Studies show that the high risk obstetrical and neonatal services provided at Level III regional specialty hospitals have contributed to the decline in U.S. infant mortality over the last 25 years. The Committee encourages States to put in place protections so that pregnant women and babies receive the basic, specialty and sub-specialty care they need in the facility appropriate to their level of risk, including Level III regional specialty care, in keeping with *The Guidelines for Perinatal Care,* American Academy of Pediatrics/American College of Obstetricians and Gynecologists.

States' plans must describe in detail the following information:

1. How the State intends to spend its program funds;
2. State agency roles and responsibilities;
3. The population groups the State plans to cover;
4. Eligibility requirements;

JOINT STATEMENT OF CONCERNED INDIAN TRIBES AND TRIBAL ORGANIZATIONS

MISSISSIPPI BAND OF CHOCTAW INDIANS
ONEIDA TRIBE OF INDIANS OF WISCONSIN
SENECA NATION OF NEW YORK
MENOMINEE TRIBE OF INDIANS OF WISCONSIN
METLAKATLA INDIAN COMMUNITY (ALASKA)
ST. REGIS MOHAWK TRIBE
SITKA TRIBE OF ALASKA
OGLALA SIOUX TRIBE (SOUTH DAKOTA)
STOCKBRIDGE-MUNSEE BAND OF MOHICAN INDIANS (WISCONSIN)
FORT BELNAP TRIBES (MONTANA)
JAMESTOWN S'KALLAM TRIBES (WASHINGTON)
HOOPA VALLEY TRIBE (CALIFORNIA)
SUSANVILLE INDIAN RANCHERIA (CALIFORNIA)
ROSEBUD SIOUX TRIBE (SOUTH DAKOTA)
CONFEDERATED SALISH AND KOOTENAI TRIBES (MONTANA)
ALASKA NATIVE HEALTH BOARD
BRISTOL BAY AREA HEALTH CORPORATION (ALASKA)
NORTON SOUND HEALTH CORPORATION (ALASKA)
MANILAQ ASSOCIATION (ALASKA)
ARCTIC SLOPE NATIVE ASSOCIATION (ALASKA)
SHOSHONE PAIUTE TRIBES OF DUCK VALLEY INDIAN RESERVATION (NEVADA)
KODIAK AREA NATIVE ASSOCIATION (ALASKA)
YUKON-KUSKOKWIM HEALTH CORPORATION (ALASKA)
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM
EASTERN ALEUTIAN TRIBES, INC. (ALASKA)
CHUGACHMIUT TRIBAL HEALTH CORP. (ALASKA)

To the Chairman and Members of the Senate Finance Committee:

We welcome the opportunity to present this statement concerning the Indian health provisions of the Medicaid Restructuring Act as included in S. 1795.

The Indian tribes and tribal organizations who submit this statement operate or represent federally-funded health care programs for American Indians and Alaska Natives in various states. Altogether, there are over 500 hospitals, health centers, clinics and village health stations in the Indian health provider network. These facilities are operated either by the Indian Health Service or by Indian tribes and tribal organizations throughout the country,

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Questions may be directed to the co-sponsors listed at the end of this Statement or to Carol Barbero, Hobbs, Straus, Dean & Walker, Washington, D.C. (202-783-5100) or Rana Altenburg, Broydrick & Associates, Washington, D.C. (202-637-0637).

including in some of the most remote parts of our land. More than 1.4 million Indian and Alaska Native people depend on this provider network as their primary source of health care.

Indian Medicaid Objectives. As Congress proceeds to restructure the Medicaid program, we ask you to be guided by the following paramount objectives:

FIRST: Medicaid coverage for the Indian health care provider network -- IHS, tribal and urban Indian health programs (collectively referred to as "I/T/Us") -- must be maintained and protected.

SECOND: Indian health care is -- and should remain -- a federal responsibility, not a state responsibility. Funding for Medicaid services to Indians/Alaska Natives through I/T/Us should be supported 100% by federal funds, with no state match required. This arrangement is intended to preserve the government-to-government relationship between the United States and Indian tribal governments.

Analysis of S. 1795 Provisions. IHS facilities, as well as tribal and urban Indian health facilities have come to depend upon Medicaid as a vital source of supplemental funding. The Indian provisions of S. 1795 -- primarily section 1511(h) -- put at risk Indian health provider access to Medicaid reimbursement. We outline specific problems below:

•The Supplemental Allocation for Indian Health Service and Related Facilities is woefully underfunded. The $500 million aggregate six-year funding level is less than one-fifth of the need estimated by IHS and tribal representatives -- $2.7 billion over six years.

•The Indian Allocation in sec. 1511(h)(2)(D) seems to have been quantified without any regard to historical Medicaid collections at I/T/Us or to anticipated collections by those providers. For example:

> *For FY97, the bill would provide only $72 million to fund Medicaid reimbursements at IHS, tribal and urban Indian facilities. This sum represents less than 60% of the Medicaid collections that will be made by the IHS facilities alone in FY96 ($121 million), and less than 25% of the amount needed to fund collections for all I/T/Us in FY97 -- $312 million.*

•*IHS and related facilities have no access to the emergency "umbrella" fund authorized for states with excess growth in certain population groups.* IHS and tribal representatives have repeatedly cautioned that since there is no universal source of information on which to precisely calculate I/T/Us' potential Medicaid collections, provision must be made for an under-estimate. But we have no protection from shortfalls because Indian/Alaska Natives served by I/T/Us have no protected status under the bill or the umbrella fund created in section 1511(g) for states.

•*The mechanism for distribution of the Indian allocation is unworkable*. The bill would make states eligible to get funds from the Indian allocation *based on the total number of Indian people in the state*, rather than on the level of Medicaid-eligible services provided at I/T/Us. The distinction is important. Many Medicaid-eligible Indian people live off-reservation and receive medical services from non-I/T/U providers. The amount a state receives from the Indian allocation should be related to the Medicaid-eligible services provided at I/T/Us, not on the entire Indian population in the state.

•There is an error in the bill's provisions that identify which states would be eligible to access funds from the Indian allocation, and the providers to whom payments from the Indian allocation can be made. We believe the intent was that all I/T/Us would be eligible for reimbursements from the Indian allocation, and that any state with one or more I/T/Us would be eligible to access Indian allocation funds. But the cross-references to the provision that describes the I/T/Us erroneously cite only to the sub-paragraph on IHS facilities (the "I's" in the I/T/U abbreviation). Obviously, these references should be to the collective I/T/U network of IHS-funded providers. [See §§1511(h)(1); 1511(h)(2)(B); and 1512(f)(3).]

•Sec. 1503 would allow State plans to assess premiums and require co-payments for Medicaid coverage, which presumably would be used to help the State meet its match requirement. No such assessments should apply to Medicaid-eligible Indians/Alaska Natives served at IHS or related facilities because a 100% FMAP applies to services rendered by those providers. We would ask that an express statement to this effect be included in the bill.

Importance of Medicaid to the Indian Health Service Provider Network. Medicaid is a vital resource for IHS-funded providers. While most funding for Indian health care comes through appropriations to the IHS, that budget is chronically inadequate and does not supply sufficient resources to fully address the health needs of Indian and Alaska Native people. This is why Congress expressly made IHS facilities eligible for Medicaid (42 U.S.C. § 1396j), and Indian health providers have come to rely on these additional resources for services to Medicaid-eligible Indian people.

Most I/T/Us are located on or near reservations and remote Alaska Native Villages. Indian poverty in reservation areas is 3.9 times the average for the U.S. as a whole -- 50.7% compared with 13.1%. And the poverty rate for Indian children in reservation areas is 60.3%, or three times the national average. (1990 Census). Thus, the IHS provider network has a high Medicaid-eligible patient population level.

The IHS has recognized that poverty is widely associated with both poor health status and diminished access to health care. But funding for Indian health care services to Indian people, primarily supplied by the IHS budget, is low when compared with other groups in the U.S. population. Even if the *entire* IHS health services budget were devoted to direct health care (which it is not) the FY96 budget would produce only **$1,257 per capita** for the more than 1.4 million Indian

people who depend on the IHS provider network for most of their health care. The per capita amount is even lower when the non-direct care elements such as IHS headquarters and area office staff expenses; contract support costs for tribally-contracted programs; and health education are removed from the calculation.

Compare this with a FY94 health care expenditure level of **$2,764 per capita** projected for the U.S. civilian resident population (1993 HCFA report "Health Care Financing Review"). For that same year, FY94, the IHS per capita health care expenditure was only **$1,149,** according to HCFA.

The per-person health care spending estimates reported in press material distributed with the Medicaid Restructuring Act state that Medicaid funding from state and federal sources will provide an average of **$4,038.03 per person** in poverty in 1996. *This is more than three times the per-person amount supplied by the IHS health services budget in FY96.*

These statistics reveal that changes in the Medicaid program will have major implications for the health care needs of poor mothers, children, disabled, elderly and other Medicaid-eligible Indian/Alaska Native people. Uninterrupted I/T/U access to this source of funding is critical to these providers which, in most locations, are the only source of health care available.

It is important to keep Indian Medicaid a *Federal* responsibility. S. 1795 establishes a 100% FMAP for medical services provided by IHS and related facilities. We strongly support this provision, as it signals the sponsors' intention that the Medicaid services provided by these facilities is a federal responsibility. But a fully-funded Indian Allocation is also essential to achieving this objective. If this Allocation is not adequately funded, the un-met burden will either be shifted to the States or will go un-funded. Either outcome is unacceptable.

If it was intended that the un-met burden be shifted to the states, it is not so stated in the bill. But by failing to supply enough funds in the Indian allocation to pay even the *known* collections from the IHS-owned facilities (let alone collections from tribal and urban facilities as well), this will be the result. As noted above, in FY96, the IHS facilities alone will collect $121 million, but S. 1795 would only supply $72 million to the Indian Allocation for the following year, FY97.

This would mean that a sizable portion of what has been a total federal responsibility would be shifted to the States when the Indian allocation is depleted. Since the bill continues the existing law's 100% FMAP for Medicaid services provided at IHS facilities, technically, all federal dollars would be used to make these reimbursements. But of course, this would mean that fewer federal dollars are available for a State's other Medicaid obligations, thus obliging the State to meet those obligations with State resources.

This burden-shifting to the States creates a distinct incentive for state plans, especially those that contract with managed care providers with capitated rates, to exclude I/T/Us from eligible provider status. When a Medicaid-eligible

Indian is served by an I/T/U that has been denied eligible provider status, the State Medicaid program saves money by not having to pay for the health care supplied. And since the mission of the IHS-funded facilities is to provide health care to Indians/Alaska Natives, those facilities cannot turn these Medicaid-eligible patients away. We would also add that in many areas of Indian Country, there is no other provider from which to seek health care.

If a state does not provide eligible provider status to I/T/Us, the I/T/Us would be serving Medicaid-eligible patients with *no* Medicaid reimbursement. This, in fact, is what is happening *now* in some States who are designing managed care programs under Medicaid waivers.

We do not believe that the sponsors of S. 1795 intended to create such disincentives to full participation in the Medicaid program by IHS, tribal and urban Indian health programs. The cure for this defect is to fully fund the Indian Allocation and to require state plans to include I/T/Us as Medicaid-eligible providers.

We believe that the States concur with the policy of full funding for the Indian allocation. During last year's debate on the Medicaid Transformation Act, Governors from ten states with high Indian/Alaska Native populations expressly sought a separate Indian allocation to reimburse States 100% for Medicaid payments to I/T/Us. And the National Governors Association's February, 1996 Medicaid policy paper sought creation of a separate "special grant" for reimbursements to IHS and related facilities (I/T/Us) which would be accessed without a State matching contribution.

Premiums and Cost-Sharing. As noted above, Section 1503 of the Medicaid Restructuring Act would allow States to assess premiums and require co-payments from most Medicaid beneficiaries. It would be incompatible with the whole notion of federal responsibility for Indian health if these state premium or co-payment requirements could be imposed on Medicaid-eligible Indians/Alaska Natives served by the IHS provider network to which a 100% FMAP applies. This 100% FMAP implements the special responsibility of the United States for Indian health care, one of the several responsibilities the United States took on in return for the land and other resources relinquished by tribes. In essence, Indians/Alaska Natives truly have the first pre-paid health plan. They should not now face a possible state-imposed assessment for health care provided by IHS-funded programs.

We therefore ask the Committee to amend the bill to include an express prohibition against imposing any premium or cost-sharing obligations on Indians/Alaska Natives served by I/T/Us.

Tribal Consultation. We are pleased that the bill (Sec. 1573) seeks to require a state plan to mention how it will provide medical assistance to IHS facilities and to encourage consultation with Indian tribes. We would ask, however, that this section be amended (1) to include mention of all facilities in the IHS provider network -- IHS, tribal and urban Indian programs, as described

in Sec. 1512(f)(3) -- and (2) to require that these providers be eligible for Medicaid reimbursement under the state plan.

We thank the Committee for this opportunity to share our views on this critical program. Questions concerning the issues discussed in this statement may be directed to any of the sponsoring tribes or tribal organizations, or to Carol Barbero at Hobbs, Straus, Dean & Walker, Washington, D.C., [202-783-5100] or Rana Altenburg, Broydrick & Associates, Washington, D.C. [202-637-0637]. Your consideration of our comments is very much appreciated.

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STATEMENT OF THE DEMOCRATIC GOVERNORS' ASSOCIATION

(SUBMITTED BY GOVERNORS MILLER, ROMER, CHILES, AND CARPER)

In February, the Nation's Governors unanimously endorsed proposals to reform our welfare and Medicaid systems. We testified before you with our Republican colleagues on our shared hope for bipartisan reform of the Medicaid and welfare systems this year. Since that time the Republican leadership has introduced S. 1795, a bill to reform the Medicaid and welfare systems. We submit written testimony to offer our comments on this bill.

Medicaid

We want to say in the clearest terms possible: the bill before you does not reflect the NGA agreement as it pertains to Medicaid. We know. We were the governors who negotiated that agreement.

Before we discuss how S. 1795 differs in critical and substantial ways from the NGA agreement, we must say that we are troubled by public statements that have been made about this proposal. The congressional majority took our bipartisan work and spent more than three months developing legislation. During that period there was no contact either by members of the committees or staff with the bipartisan NGA, with Democratic Governors or our staff. While committee staff were drafting this bill, a bipartisan group of governors continued to meet to develop the details of the NGA proposal. We reached greater clarity on issues including the funding formula, the definition of disability, policies on comparability and state-wideness of benefits and policies related to amount, scope and duration of benefits. The results of these negotiations are not included in S. 1795.

We understand and respect the Finance Committee's responsibility and authority to draft Medicaid legislation. Our only objection is to the content of S. 1795 and efforts to describe that bill as the NGA proposal.

How the bill is inconsistent with the NGA agreement on Medicaid

The most obvious failing in the bill is in the financing formula. S. 1795 essentially recreates the block grants in earlier bills, thereby abandoning the NGA policy. The funding formula is critical because a guarantee to provide coverage without sufficient funding is a meaningless guarantee.

The NGA policy calls for a base allocation to each state using 1993, 1994 or 1995 actual Medicaid expenditures. The bill is inconsistent with the policy. The bill uses the 1996 numbers that appeared in the Medigrant bill. While these figures were generated with the input of Republican Governors, Democratic Governors were not invited to participate in this process. Many states have discovered that the figures in the bill do not match any actual data for that state. Actual baselines must be used if the bill is to comply with the NGA policy.

The NGA policy says that the formula for growth must account for estimated changes in each state's caseload. The growth portion of the formula in the bill is completely different. It has two serious flaws. First, the formula in the bill is not based upon an estimate of caseload or changes in case-mix.

This is entirely inconsistent with the NGA policy which is based upon the principle that federal funds should follow the people served by the program.

Second, growth rates in the allocation to each state are severely constrained by floors and ceilings. These constraints prevent states from actually receiving the funds associated with expected caseloads. The floors and ceilings so completely overwhelm the so-called "needs-based formula" that states would not have their needs met at all. At least 15 states are fully capped in advance. No matter how much the expected caseload might increase in Florida or Nevada, those state's allocations will increase by no more than 7.22% per year because that is the program cap. Meanwhile, many other states are guaranteed a significant rate of growth (4.33%) even if they are losing population and caseload.

The NGA policy calls for an umbrella fund that guarantees states a per-beneficiary payment for actual enrollees who were not accounted for in the growth estimates. The fund in S. 1795 is entirely different and inadequate. First, it is impossible for the fund to cover enrollees not included in the estimates because. as noted above, there are no estimates of caseload in the bill's formula. In addition, the umbrella only covers unanticipated caseload for one year. If a state experiences a recession that lasts more than one year (not an uncommon event) the umbrella is of no use. It is inappropriate to require states to cover certain populations and then not provide one dollar of federal support for people whose coverage is "unanticipated."

The NGA policy says that disproportionate share hospital (DSH) funds will not grow for states where DSH accounts for more than 12 percent of the Medicaid program. The bill does not comply with this provision. Instead, even states with excessive DSH programs will have the full growth rate in the formula applied to their DSH funds.

The dynamics of a capped medical assistance program are very different from those of the current Medicaid program. Under current law, if one state receives excess money, either through the DSH program or other means, the burden falls on the federal taxpayer, but not on other states. Under the proposed Medicaid block grant, states would be in competition for limited resources. Where the bill diverges from NGA policy and provides a higher level of funding for certain states, those funds are taken directly from the citizens of another state where they may be needed simply to support a basic Medicaid program.

The NGA formula was crafted with great care to balance legitimate, competing needs. S. 1795 fails to adhere to that formula, and has upset that careful balance. Because the formula has been modified in a manner that will assist certain states, some governors will certainly support the formula in the bill. However, this committee should not interpret support by those governors as a statement that S. 1795 is consistent with the NGA funding principles.

Committee staff has indicated they had no choice but to reject the NGA formula because GAO could not generate state-specific funding estimates using the NGA formula. That complaint rings hollow. The staff made no effort to work with us to clarify the formula. We can only interpret this excuse as a cover for the staff's desire to return to the block grant formula negotiated in a partisan process and rejected by the NGA.

While closer to the NGA proposal in some of its other features, the bill contains other serious flaws in its design of the program. The NGA proposal says that the guarantees of coverage and the set of benefits "remains" for certain populations and certain services. Some of the features of the bill so fundamentally change the nature of that guarantee that one cannot say that those guarantees remain -- certainly not in a form anything like what the NGA proposal contemplated. Specifically, permitting unlimited copayments and deductibles, residency requirements, family financial responsibility, and other similar provisions completely undermine the guarantee of health care services to our most needy citizens.

We raise these issues not because we do not trust states or because we believe the federal government needs to tell states how to administer their programs. Rather, we believe these provisions are important to guarantee the continued commitment of the federal government to this program. If states in difficult budget times can dramatically scale back coverage while receiving the same amount of federal funds, political support for this program at the federal level will wane. We believe there is value in a federally-defined safety-net, while we desire the flexibility to administer our programs in the most appropriate manner. We believe that the flexibility to define away the guarantee of coverage will undermine the program and harm all states.

There are some areas where Democratic Governors fought for a position in the NGA policy, but we were not successful. We knew that, to achieve bipartisan consensus, we needed to give on some issues in order to gain on others. As we read S. 1795, it largely reflects the negotiating position of the Republican Governors when we began bipartisan discussions in November of 1995. Rather than retaining the balance the governors negotiated, the bill picks and chooses issues, adopting the positions Republican Governors felt were most critical, while rejecting the most important issues for the Democratic Governors. Since S. 1795 strays so far from our compromise, we think it is important to bring to the committee's attention some of the issues where Republican Governors prevailed.

S. 1795 changes the federal matching formula, creating the possibility that more than $120 billion of state funds will be withdrawn from the Medicaid program over the next seven years while states continue to draw federal matching funds. The bill eliminates the guarantee of coverage for poor children age 13 to 18 that is being phased in under current law. It eliminates the standard federal definition of disability that is used to establish Medicaid eligibility. All of these provisions are consistent with our policy, but warrant the same reexamination that you have undertaken with respect to the formula. If the committee is going to consider legislation that is not based upon NGA policy, it should take a close look at each of these issues.

Governors negotiated a Medicaid policy in good faith. This Congress has rewritten our agreement and attempted to pin our bipartisan name on a bill that was written without the participation of a single Democratic Member of Congress or Democratic Governor. We would like very much to work with you on this issue. However, that work needs to proceed on the same bipartisan basis the Governors used. These important issues will never be resolved if partisan politics guide your work.

Welfare

While serious and significant differences remain on how to reform the Medicaid system, the same is not true for welfare.

And although there is no doubt that welfare and Medicaid are inextricably linked in practice, it has not been the position of the NGA that they must be united in one legislative package. We believe that a strategy that insists on linking welfare and Medicaid dooms hope of bipartisan agreement and legislative success for reform of either program.

We believe that the welfare title of the Republican leadership's bill represents strong, positive movement in the welfare debate. S.1795 is significantly better than H.R. 4 in many respects and reflects the bipartisan agreement of Governors in many important areas.

S.1795 includes $4 billion in additional resources for child care. The NGA bipartisan welfare agreement recommended the inclusion of $4 billion in additional resources for child care. S.1795 supports governors in their understanding that adequate child care is critical to the success of welfare-to-work efforts. Access to affordable, quality child care is the number one barrier to self-sufficiency faced by mothers currently receiving benefits.

S.1795 includes $2 billion for an economic contingency funds for states. NGA recommended that there be at least $2 billion in economic protection for states in times of economic downturns and/or increases in unemployment or child poverty. S. 1795 supports the funding levels recommended by the NGA and includes a more responsive trigger, consistent with the NGA agreement.

S. 1795 includes additional resources for performance incentives for states. The NGA proposal recommended the inclusion of incentives in the form of cash bonuses to states that exceed specified employment-related performance target. Governors believe that, along with state sanctions for poor performance, there should be rewards for states that perform well.

There are, however, some areas where S. 1795 does not reflect the NGA agreement.

S. 1795 does not include the NGA recommendations on how to measure work participation.

Governors believe that in order to measure work participation states must count individuals who leave welfare for work. If states are not permitted to count persons who leave the roles to go to work in the work participation rate, the work measure is flawed and states' ability to succeed according to prescribed participation rates will be severely diminished. We urge Congress to revise the work participation calculation to reflect the NGA agreement.

S.1795 caps the excess shelter deduction in the Food Stamp Program. Although the Food Stamp Program is not within the jurisdiction of the Finance Committee, it is important to note that S. 1795 does not reflect the NGA agreement in this area.

NGA recommended that the cap on the shelter deduction included in H.R. 4 be rejected by Congress. A cap on the excess shelter deduction in the Food Stamp Program would have a disproportionate impact on the poorest families with children and would result in over a $1 billion more in savings from the Food Stamp Program. We urge Congress to eliminate the cap on the excess shelter deduction in the Food Stamp Program.

S. 1795 includes unnecessary restrictions on states' access to the economic contingency fund.

The NGA policy supports the $2 billion contingency fund included in S. 1795, however, S. 1795 includes additional restrictions on states' access to the contingency fund not supported by NGA policy. The contingency fund must be adequately funded and appropriately responsive to states' economic circumstances. We urge Congress to eliminate the unnecessary restrictions on states ability to draw down assistance.

S. 1795 includes a 20 percent reduction in funds for the Social Services Block Grant (SSBG).

States use a significant portion of their SSBG funds for child care assistance for low income families. It is counterintuitive to include new money for child care in one instance and snatch it away in another. We urge you to reject the additional cuts in the Social Services Block Grant.

S. 1795 includes new restrictions on states' abilities to provide services to families. The NGA supports time-limits as applied to cash assistance. The NGA policy does not support the application of a time-limit on non-cash assistance. S. 1795 would prohibit states from using the block grant for important work supports such as transportation vouchers or job retention counseling. It would also prohibit state discretion to provide in-kind services in particular circumstances. We urge Congress to impose the time-limit on cash assistance only.

Although we have used this opportunity to discuss some of the remaining issues on welfare reform, our primary message on welfare continues to be that we believe bipartisan welfare reform is within reach. Congress has come a great distance on welfare in the last year and S. 1795 is consistent with the NGA welfare policy in many important areas. We urge Congress begin bipartisan discussions on welfare and to move a welfare bill as soon as possible.

It has always been our hope that legislation to reform both the welfare and Medicaid programs could be enacted this year. The content of S. 1795 suggests that the governors' proposal on welfare is within reach, while our proposal on Medicaid is not likely to be adopted by this Congress. We would be very disappointed to see welfare reform lost in a battle over Medicaid. Therefore, unless this Congress is willing to substantially modify its approach to Medicaid, we would urge you to enact welfare reform in a separate bill and allow states to continue our efforts to improve this program.

REPUBLICAN GOVERNORS ASSOCIATION
NOW AMERICA'S MAJORITY

June 10, 1996

The Honorable Thomas J. Bliley, Jr.
Chairman
House Committee on Commerce
2125 Rayburn House Building
Washington, D.C. 20515

The Honorable William V. Roth, Jr.
Chairman
Senate Committee on Finance
205 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable William Archer
Chairman
House Committee on Ways and Means
1102 Longworth House Building
Washington, D.C. 20515

The Honorable E. Clay Shaw, Jr.
Chairman
Subcommittee on Human Resources
1102 Longworth House Building
Washington, D.C. 20515

Dear Chairmen Roth, Bliley, Archer and Shaw:

We commend you on the excellent progress you have made in moving toward meaningful Medicaid and welfare reform. During our annual National Governors' Association meeting, our objective was to produce policy that would serve as a guide for federal legislators in restructuring the Medicaid and welfare programs. The extraordinarily close parallels between the NGA policy and HR 3507/S 1795, the "Personal Responsibility and Work Opportunity Act of 1996" and the "Medicaid Restructuring Act of 1996," satisfies this objective to an extent that may be unprecedented in the recent history of federal legislation.

HR 3507 and S 1795 differ significantly from the vast majority of federal legislative initiatives in that they are based on reform principles developed by the nation's governors and experts who actually run the programs that are being reformed. As legislators at the local, state and federal levels seek to restore balance in their lawmaking and regulatory relationships, this achievement is a landmark step forward.

More important than its respect for state and local experience, however, is the Medicaid Restructuring Act's provisions that promise the more effective, personally responsive and higher quality medical assistance needed by millions of vulnerable Americans. Like the NGA policy, the Act guarantees coverage to protect pregnant women, children, the elderly, the disabled and public assistance recipients. The Act also guarantees a generous package of benefits also addressed in the NGA policy, including a wide array of services provided by

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hospitals, physicians, nurse practitioners and nurse midwives; nursing facility and home health care providers; and community and rural health centers.

The similarities between the NGA policy and the Medicaid Restructuring Act extend to the financing structure as well. The Act establishes three distinct funding sources which will distribute more money to all states and territories than has ever been available under the current Medicaid program: a caseload-driven "base allotment" which employs differential rates of growth to remove existing disparities in the state funding; an open-ended "umbrella fund" which provides additional resources on a per capita basis to states experiencing unanticipated program needs; and special grants to states in which Native Americans reside and with large populations of illegal aliens. This financing structure is more responsive and equitable than any other reform proposal we have reviewed.

Finally, the Medicaid Restructuring Act embraces the NGA policy concerning consumer protection, operation flexibility and program integrity. In fact, the Act retains current law with regard to recipient protections that extend to spouses and adult children of nursing home residents. The Act also provides states with unprecedented flexibility to operate and administer their Medicaid program to foster much-needed innovations and improvements in service delivery. The Act strengthens existing measures to prevent waste, fraud and abuse and to insure internal and independent audits and evaluations.

Like the NGA policy, the Personal Responsibility and Work Opportunity Act includes important revisions to HR 4 supported by the nation's governors. These include: an additional $4 billion for child care; an additional $1 billion for the Contingency Fund; a reduction in mandatory hours of work for single parents from 35 to 25 hours per week; an increase in the exemption from the 5-year time requirement from 15% to 20%; a delay in the effective date for data reporting and penalty provisions; elimination of the two-tier structure for Supplemental Security Income; expansion of state funding for child support enforcement; and complete restoration of the entitlements on foster care and adoption.

Most importantly, the Personal Responsibility and Work Opportunity Act recognizes that continuation of the current failed welfare system is unacceptable. The piecemeal waiver process is too little, too late and too slow for people who need help. This burdensome process allows Washington bureaucrats to sit in judgment over welfare packages developed in our states. While the current system only allows us to tinker around the edges, this Act will allow the states to move boldly and aggressively on initiatives to break the cycle of dependency and make welfare a hand up instead of a hand out.

In short, the NGA policy on which the Medicaid Restructuring Act is founded establishes important coverage and benefit guarantees while protecting consumers and transforming the Medicaid program into a less bureaucratic and more responsive health care safety net that can better meet the needs of disadvantaged individuals and families. The NGA policy on which the Personal Responsibility and Work Opportunity Act is founded calls for a restructured welfare system that reallocates responsibilities among levels of government, maximizes state flexibility and focuses on work and self-sufficiency. With the additional funding and enhanced flexibility this legislation provides, we are confident that the states will be able to provide medical assistance to many more vulnerable Americans and move more people from the welfare rolls and onto payrolls.

Again, we commend you for your efforts, as well as for your heartfelt commitment to the health and welfare needs of American families and for your willingness to respect and involve the input and experience of America's laboratories of democracy -- the states.

Sincerely,

Governor John Engler

Governor Steve Merrill

Governor Michael O. Leavitt

JE/lr:dc

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